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Psychological Society

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Position Paper

Children and Young People with Neuro-Disabilities in the Criminal Justice System



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For further information on this work please contact the Society’s Policy Team via policyteam@bps.org.uk

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The Issue

In the UK children and young people with neuro-disabilities are often failed by society and the criminal justice system. There is an over emphasis on costly incarceration and secure care facilities, and a lack of understanding of neuro-disabilities and their potential impact on young people. Assessments and interventions are poorly timed and have led to a system where children and young people are not properly screened for conditions until they enter a secure estate. By which time such young people are in a cycle of reoffending (see appendix 1).

Calls to Action

1. Wider recognition and understanding of neuro-disabilities in children and young people across health, social, education and justice agencies.
2. Earlier assessment and intervention of neuro-disabilities in children and young people before coming into contact with the criminal justice system.
3. Screening for neuro-disabilities in children and young people at earlier stages within the criminal justice process.
4. Adoption of neuro-disability assessments when developing offender management plans to ensure appropriate neuro-rehabilitation is provided.

Purpose

This position statement details the Society's views on children and young people with neuro-disabilities coming into contact with the criminal justice system. In this paper we recommend a way forward towards achieving a more appropriate range of interventions that address the needs of children and young people with neuro-disabilities before they come into contact with the criminal justice system as well as steps that can be taken to more appropriately manage children and young people should they come into contact with the criminal justice system.

For the purposes of this paper the term children and young people refers to anybody up to the age of 25. This is in line with changes brought in through the Children and Families Act 2014. Children and young people in prison aged 15–24 represent 24 per cent of the total prison population. This position statement is not intended to be used in a legal context, but is a statement of recommendations the Society believes could assist in reducing the number of children and young people with neuro-disabilities coming into contact with the criminal justice and improving the outcome for those children and young people should they ultimately reach that stage.

Defining Neuro-Disabilities

Neuro-disabilities encompass a range of conditions, including attention deficit hyperactivity disorder (ADHD), autism spectrum disorders (ASD) and traumatic brain injuries (TBI) (for a more complete list see appendix 2), and may be caused by a wide range of factors that compromise brain function. These can include genetic factors, pregnancy related complications including foetal alcohol and drug syndromes, birth trauma, acute injury and illness.

Neuro-disabilities can result in problems with memory and concentration, decreased awareness of an individual's emotional state, poor impulse control and poor social judgement. These associated problems have all been linked to an increased risk of crime and can make it more difficult for those individuals to engage effectively in their judicial proceedings or to benefit from traditional forms of forensic rehabilitation.¹

Neuro-Disabilities and the Criminal Justice System

- 30 per cent of juvenile offenders have sustained a previous brain injury²
- 14 per cent have possible intellectual disability (IQ under 69)³
- 32 per cent have a borderline intellectual disability range (IQ 70 to 79)⁴
- 30 per cent of the youth prison population have clinically diagnosed ADHD⁵
- 50 per cent of individuals convicted for non-violent crimes have a past history of TBI compared with only 5–15 per cent in comparison samples⁶
- Violent offenders have disproportionately more lesions in their brains, particularly in frontal areas.⁷

The most often represented neuro-disability in the criminal justice system is TBI, the leading form of acquired brain injury (ABI). Whilst only 10 per cent of the general population have experienced a head injury, a recent study in England found that 60 per cent of young people in custody reported suffering a TBI,⁸ with this figure consistent with others globally.

TBI most commonly occurs in young people and equally affects males and females in their early years; however, as they enter their teenage years males are much more likely to suffer a TBI.⁹ Common causes of TBI included road traffic accidents, sporting injuries, falls and fights.

Research has shown that 30 per cent and 26 per cent of the youth and adult prison populations respectively have clinically diagnosed ADHD¹⁰ representing a five-fold and ten-fold increase above general population rates. Similar over-representation of ADHD has been found in police custody and probation service settings.^{11, 12}

Compared with controls, a younger age of engagement with the criminal justice system has been reported for offenders with ADHD together with significantly higher rates of recidivism.^{13, 14, 15} They have been found to have a greater susceptibility to police questioning and interrogation,¹⁶ higher incidents of aggression in custody,^{17, 18, 19} greater psychopathology,^{20, 21} greater history of substance use and drug dependence,^{22, 23} greater

associated impairment,^{24, 25, 26} and increased rates of health risk behaviours.²⁷

The same pattern of earlier incarceration, and significant reoffending has been shown in TBI²⁸ and there is substantial co-morbidity with other problems, such as mental health and drug misuse.

Despite such high prevalence rates of neuro-disabilities in the criminal justice system, there remains no universal mechanism for screening young people at first contact with the criminal justice process; instead assessments are only conducted when a young person enters a secure estate. We very much welcome the fact that young people who enter the secure estate are assessed on the Comprehensive Health Assessment Tool (CHAT).²⁹ This has a section that is designed to identify neuro-disabilities such as ADHD and TBI. We also welcome new guidelines for commissioners of services for children and young people in custody that recommend the need to assess and manage such neuro-disabilities in these settings.³⁰ However, much can be done before such children and young people enter the secure estate that we believe would bring cost savings – human and economic.

This failure of the socio-health-education and forensic systems leads to a situation where offender management plans routinely fail to consider neuro-disabilities and as a consequence the mental and physical health needs of these children and young people remain unmet for many years. Importantly, research has shown that there is a link between neuro-disabilities, such as TBI, and entering custody from an earlier age, incarceration for longer sentences, greater rates of reoffending and committing violent crimes.³¹

Given the current neglect of neuro-disabilities within society and the criminal justice process, there exists an opportunity to deliver improved outcomes for these children and young people both within secure settings and through earlier interventions. Additionally, there remains an opportunity to secure significant economic savings, both in terms of direct costs to the public purse and through associated costs by reducing offending and improving social outcomes.

Calls to Action

Call to Action 1 – Early Intervention

The British Psychological Society believes that children and young people should be screened for neuro-disabilities within education and community settings where appropriate. The Society calls for the following recommendations to be implemented:

- A. The Society calls for screening of neuro-disabilities to take place earlier, such as at the time of a second fixed term exclusion from school. The second school exclusion must trigger screening for neuro-disabilities and conduct disorders as well as a child's maturity, and vulnerability of offending.
- B. Appropriate versions of the Comprehensive Health Assessment Tool (CHAT) screening tools must be used in the community with those children and young people at risk of offending and entering the criminal justice system. Community agencies (such as Youth Offending Teams (YOTs), schools, local authorities, social

workers and healthcare professionals) must be able to screen children and young people for acquired brain injury (ABI) and neuro-disabilities. A lead agency must be identified by means of a named person who is responsible for advising the child or young person.

- C. The CHAT screening systems should be appropriate to assess young people up to the age of 25. It has been developed for young people, but would be relevant for young adults, and similar screening systems would be desirable in older groups.

Call to Action 2 – Screening and Rehabilitation

The Society believes children and young people should be screened for neuro-disabilities upon contact with the Criminal Justice System (CJS). The Society calls for the following recommendations to be implemented:

- D. The Society calls for a screening tool that can be used in custody suites to screen for neuro-disability, mental health conditions and drugs of addiction. This screening tool must also consider someone's vulnerability to crime (e.g. suggestibility or learning disability) and maturity for engaging with the justice process (e.g. ability to follow proceedings). This screening should inform court proceedings and pre-sentencing reports.
- E. The Society calls for appropriate rehabilitation and support pathways to enable those with an identifiable neuro-disability to receive appropriate education, training and care while in detention and to make a successful transition back into the community following a period of detention.
- F. Preventative and rehabilitative interventions need to account for cognitive limitations of this group (e.g. R and R2).^{32, 33} This includes offending behaviour programmes run by probation and youth offending services and other evidence-based programmes that are aimed at diversion from custody.

Call to Action 3: Training and Guidance

In line with the United Nations Convention on the Rights of the Child for supporting children with specific needs, the Society believes that:

- A. Professionals involved in the care and education of children and young people, including, health visitors, GPs, teachers, health, criminal justice and social care staff, need to be provided with training and guidance material in neuro-disabilities to enable appropriate screening, management and rehabilitation support.
- B. Additional support should also be made available for parents and care givers of assessed children to enable them to provide appropriate support in the home environment.
- C. Training should form part of the core curriculum for teachers, health and social care staff to assist in identifying neuro-disabilities before children and young-people reach the criminal justice system.
- D. Training for staff, specifically in CAMHS, should always ensure awareness of neurodisability and relevant risks of offending and potential interventions

Call to Action 4 – Commissioning

- A. Commissioning guidelines need to be drawn up and implemented by those procuring services to ensure appropriate screening and rehabilitation support for those with neuro-disabilities.
- B. Commissioners of services for children and young people must demonstrate adequate commissioning of services for people with neurodisabilities.

Call to Action 5 – Data Sharing

- A. Data sharing must be built in to the system to ensure all professionals in contact with the child or young person have access to all the necessary data to support the needs of the child or young person.

Call to Action 6 – Research

- A. The Society calls for further research into health economics models of early intervention for young people with neuro-disabilities who are at risk of offending/re-offending.
- B. The Society calls on funding bodies to identify key research themes for investigation in the area of neuro-disabilities and offending/re-offending behaviour.

Appendix 1 – Youth Secure Estate³⁴

Youth Offender Institutions (YOIs)

- 40–440 beds in size, usually divided into smaller units of 30–60 beds
- Accommodation for 15–17-year-old boys and some 17-year-old girls
- Currently 11 in England and Wales, eight male and three small female units. Nine are run by HM Prison Service and two by private contractors
- YOIs provide 15 hours' education a week (plus 10 hours' purposeful activity)
- Average cost of a place is £65,000 a year
- 73% reoffending rate.

Secure Training Centre (STCs)

- Purpose-built custodial facilities for 12–17-year-olds
- 58–87 beds divided into small blocks holding 5–8 young people
- There are currently four STCs, all run by private contractors
- STCs provide 25 hours' education a week
- Average cost of a place is £178,000 a year
- 70% reoffending rate.

Secure Children's Homes (SCHs):

- Smaller facilities run by local authorities with 8–40 beds
- Provide for 10–17-year-olds, including some of the youngest and most vulnerable
- Also accommodate children looked after by local authorities where courts have authorised that they may be detained for welfare reasons
- Provide 30 hours' education a week
- Average cost of a place is £212,000 a year
- 76% reoffending rate.

Appendix 2 – List of Neurodisabilities

Childhood neurodisability occurs when there is a compromise of the central or peripheral nervous systems due to genetic, pre-birth or birth trauma, and/or injury or illness in childhood. This definition includes a wide range of specific neurodevelopmental disorders or conditions, with common symptoms including: muscle weakness, communication difficulties, cognitive delays, specific learning difficulties, emotional and behavioural problems and a lack of inhibition regarding inappropriate behaviour.

- Intellectual disabilities
- Specific learning difficulties
- Communication disorder
- Attention deficit hyperactivity disorder (ADHD)
- Autism spectrum disorders (ASD)
- Traumatic brain injury (TBI)
- Epilepsy
- Foetal alcohol syndrome.

Co-morbid Neurodisabilities

TBI is often linked to other problems. Mental health issues are very common in offender group.^{36, 37, 38} Alcohol and drug misuse is often a complicating factor in violence.³⁹ Mental health and drug misuse issues may well be independent of TBI but may also be a result of TBI (see⁴⁰ re: mental health post-TBI).⁴¹ Also, these problems may start early.^{42, 43} A recent study of the mental health needs of 301 young offenders in the UK (aged 13 to 18) reported that one in five had significant depressive symptoms, one in ten had anxiety or post-traumatic stress disorder (PTSD) symptoms and one in ten had self-harmed in the past month.⁴⁴ One in ten had alcohol problems and one in five had drug problems. Aggressive behaviour towards people and property was reported in one in four and one in five respectively. TBI and neuro-disabilities would not only increase the chance that someone develops such disorders, but also makes intervention more complicated. Therefore it is vital that they are assessed for to improve treatment outcomes.

References

- 1 Hughes, N., Williams, H., Chitsabean, P., Davies, R. & Mounce, L. (2012). *Nobody made the connection: The prevalence of neurodisability in young people who offend*. London: Office of the Children's Commissioner.
- 2 Farrer, T.J., Frost, R.B., Hedges, D.W. (2013). Prevalence of traumatic brain injury in juvenile offenders: a meta-analysis. *Journal of Child Neuropsychology*, 19(3), 225–234.
- 3 Indig, D., Vecchiato, C., Haysom, L., Beilby, R., Carter, J., Champion, U., Gaskin, C., Heller, E., Kumar, S., Mamone, N., Muir, P., van den Dolder, P. & Whitton, G. (2011) *2009 NSW Young People in Custody Health Survey: Full Report*. Sydney: Justice Health and Juvenile Justice.
- 4 Indig, D., Vecchiato, C., Haysom, L., Beilby, R., Carter, J., Champion, U., Gaskin, C., Heller, E., Kumar, S., Mamone, N., Muir, P., van den Dolder, P. & Whitton, G. (2011) *2009 NSW Young People in Custody Health Survey: Full Report*. Sydney: Justice Health and Juvenile Justice.
- 5 Young, S., Moss, D., Sedgwick, O., Fridman, M. & Hodgkins, P. (2014). A meta-analysis of the prevalence of attention deficit hyperactivity disorder in incarcerated populations. *Psychological Medicine*. <http://dx.doi.org/10.1017/S0033291714000762>
- 6 Sarapata, M., Herrman, D., Johnson & Aycock, R. (1998). The role of head injury in cognitive functioning, emotional adjustment and criminal behaviour. *Brain Injury*, 12, 821–842.
- 7 Schiltz, K., Witzel, J., Bausch-Holterhoff, J. & Bogerts, B. (2013). High prevalence of brain pathology in violent prisoners: A qualitative CT and MRI scan study. *European Archives of Psychiatry and Clinical Neuroscience*, 263(7), p.607.
- 8 Williams, H. (2012). *Repairing shattered lives: brain injury and its implications for criminal justice*. Barrow Cadbury Trust. Available from www.t2a.org.uk.
- 9 Yates, P.J, Williams, W.H., Harris, A., Round, A. & Jenkins, R. (2006). An epidemiological study of head injuries in a UK population attending an emergency department. *Journal of Neurology, Neurosurgery and Psychiatry*, 77(5), 699–701.
- 10 Young, S. Moss, D., Sedgwick, O., Fridman, M. & P. Hodgkins. (2014). A meta-analysis of the prevalence of attention deficit hyperactivity disorder in incarcerated populations. *Psychological Medicine*, 45(2), 247–258.
- 11 Young, S., Goodwin, E.J. Sedgwick, O. & Gudjonsson, G.H. (2013). The effectiveness of police custody assessments in identifying suspects with intellectual disabilities and attention deficit hyperactivity disorders. *BMC Medicine*, 11(248). doi: 10.1186/1741-7015-11-248
- 12 Young, S., Gudjonsson, G.H, Goodwin, E.J., Jotangia, A., Farooq, R., Haddrick, D. & Adamou, M. (2014). Beyond the gates: Identifying and managing offenders with attention deficit hyperactivity disorder in community probation services. *AIMS Public Health*, 1, 33–42.

- 13 Langley, K., Fowler, T., Ford, T., Thapar, A.K., van den Bree, M., Harold, G., Owen, M.J, O'Donovan, M.C. & Thapar, A. (2010). Adolescent clinical outcomes for young people with attention deficit hyperactivity disorder. *British Journal of Psychiatry*, 196, 235–240.
- 14 Satterfield, J.H, Faller, K.J., Crinella, F.M., Schell, A.M, Swanson, J.M. & Homer, L.D. (2007). A 30-year prospective follow-up study of hyperactive boys with conduct problems: Adult criminality. *Journal of American Academy of Child and Adolescent Psychiatry*, 46, 601-610.
- 15 Young, S., Gudjonsson, G.H., Wells, J., Asherson, P., Theobald, D., Oliver, B., Scott, C. & Mooney, A. (2009). Attention deficit hyperactivity disorder and critical incidents in a Scottish prison population. *Personality and Individual Differences* 46, 265–269.
- 16 Gudjonsson, G.H., Sigurdsson, J.F., Bragason, O.O., Newton, A.K. & Einarsson, E. (2008). Interrogative suggestibility, compliance and false confessions among prisoners and their relationship with attention deficit hyperactivity disorder (ADHD) symptoms. *Psychological Medicine*, 38, 1037–1044.
- 17 Young, S., Gudjonsson, G.H., Wells, J., Asherson, P., Theobald, D., Oliver, B., Scott, C. & Mooney, A. (2009). Attention deficit hyperactivity disorder and critical incidents in a Scottish prison population. *Personality and Individual Differences* 46, 265–269.
- 18 Young, S., Misch, P., Collins P. & Gudjonsson, G.H. (2011). Predictors of institutional behavioural disturbance and offending in the community among young offenders. *Journal of Forensic Psychiatry and Psychology*, 22(1), 72–86.
- 19 Young, S., Goodwin, E.J., Sedgwick, O. & Gudjonsson, G.H. (2013). The effectiveness of police custody assessments in identifying suspects with intellectual disabilities and attention deficit hyperactivity disorder. *BMC Medicine*, 11:248. doi: 10.1186/1741-7015-11-248.
- 20 Gonzalez, R.A., Gudjonsson, G.H. Wells, J. & Young, S. (2013). The role of emotional distress and ADHD on institutional behavioural disturbance and recidivism among offenders. *Journal of Attention Disorders*. Prepublished on July 26, 2013. <http://dx.doi.org/10.1177/1087054713493322>.
- 21 Gudjonsson, G.H., Wells, J. & Young, S..(2012). Personality disorders and clinical syndromes in ADHD prisoners. *Journal of Attention Disorders*, 16, 305–314.
- 22 Gonzalez, R.A., Velez-Pastrana, M.C., Ruiz Varcancel, J.J., Levin, F.R. & Albizu-Garcia, C.E. (2012). Childhood ADHD symptoms are associated with lifetime and current illicit substance-use disorders and in-site health risk behaviours in a representative sample of Latino prison inmates. *Journal of Attention Disorders*. <http://dx.doi.org/10.1177/1087054712461690>
- 23 Young, S., Wells, J. & Gudjonsson, G.H. (2011). Predictors of offending among prisoners: The role of attention deficit hyperactivity disorder and substance use. *Journal of Forensic Psychiatry and Psychology*, 22(1), 72–86.
- 24 Einarsson, E., Sigurdsson, J.F., Gudjonsson, G.H., Newton, A.K. & Bragason, O.O. (2009). Screening for attention-deficit hyperactivity disorder and co-morbid mental disorders among prison inmates. *Nordic Journal of Psychiatry*, 1–7

- 25 Rosler, M., Retz, W., Yaqoobi, K., Burg, E. & Retz-Junginger, P. (2009). Attention deficit hyperactivity disorder in female offenders: Prevalence, psychiatric co-morbidity and psychosocial implications. *European Archives of Psychiatry and Clinical Neuroscience*, 259, 98–105.
- 26 Young, S., Gudjonsson, G.H, Goodwin, E.J., Jotangia, A., Farooq, R., Haddrick, D. & Adamou, M. (2014). Beyond the gates: Identifying and managing offenders with attention deficit hyperactivity disorder in community probation services. *AIMS Public Health*, 1, 33–42.
- 27 Gonzalez, R.A., Velez-Pastrana, M.C., Ruiz Varcancel, J.J., Levin, F.R. & Albizu-Garcia, C.E. (2012). Childhood ADHD symptoms are associated with lifetime and current illicit substance-use disorders and in-site health risk behaviours in a representative sample of Latino prison inmates. *Journal of Attention Disorders*. <http://dx.doi.org/10.1177/1087054712461690>
- 28 Hughes, N., Williams, H., Chitsabean, P., Davies, R. & Mounce, Luke (2012). *Nobody Made the Connection: The prevalence of neurodisability in young people who offend*. www.childrencommissioner.gov.uk.
- 29 Child and Maternal Health Intelligence Network, Public Health England. (2014). Comprehensive health assessment tool (CHAT). Retrieved 11 August 2014 from www.chimat.org.uk/resource/item.aspx?RID=126554.
- 30 Royal College of Paediatrics and Child Health (2013). *Healthcare standards for children and young people in secure settings*. London: Author.
- 31 Williams, H. (2012). *Repairing shattered lives: brain injury and its implications for criminal justice*. Barrow Cadbury Trust. Available from www.t2a.org.uk.
- 32 Rees-Jones, A., Gudjonsson, G. & Young, S. (2012). A multi-site controlled trial of a cognitive skills programme for mentally disordered offenders. *BMC Psychiatry*, 12:44, <http://dx.doi.org/10.1186/1471-244X-12-44>.
- 33 Emilsson, B., Gudjonsson, G., Sigurdsson, J.F., Einarsson, E., Baldursson, G., Olafsdottir, H. & Young, S. (2011). R&R2 cognitive behaviour therapy in medication-treated adults with adhd and persistent symptoms: A randomized controlled trial. *BMC Psychiatry* 11, 116. <http://dx.doi.org/10.1186/1471-244X-11-116>
- 34 HM Government. (February 2013). *Transforming youth custody: Putting education at the heart of detention*.
- 35 Hughes, N., Williams, H., Chitsabean, P., Davies, R. & Mounce, L. (2012). *Nobody made the connection: The prevalence of neurodisability in young people who offend*. London: Office of the Children's Commissioner.
- 36 Sainsbury Centre for Mental Health. (2009). *Diversion: A better way for criminal justice and mental health*. Available from: www.centreformentalhealth.org.uk/pdfs/Diversion.pdf.
- 37 Bradley, K.J.C. (2009). *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.
- 38 Fazel, S. & Danesh, J. (2002). Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. *The Lancet*, 359(9306), 545–550.

- 39 Grann, M. & Fazel, S. (2004). Substance misuse and violent crime: Swedish population study. *BMJ*, 328(7450), 1233–1234.
- 40 Williams, W.H. & Evans, J.J. (2003). Brain injury and emotion: An overview to a special issue on biopsychosocial approaches in neurorehabilitation. *Neuropsychological Rehabilitation*, 13(1–2), 1–11.
- 41 Walker, R., Hiller, M., Stanton, M., Leukefeld, C.G. (2003). Head injury among drug abusers: an indicator of co-occurring problems. *Journal of Psychoactive Drugs*, 35(3), 343–353.
- 42 Forrest, C.B., Tambor, E., Riley, A.W., Ensminger, M.E. & Starsfield, B. (2000). The health profile of incarcerated male youths. *Pediatrics*, 105(1), 286–291.
- 43 Fazel, M. et al. (2008). Psychopathology in adolescent and young adult criminal offenders (15–21 years) in Sweden. *Social Psychiatry and Psychiatric Epidemiology*, 43(4), 319–324.
- 44 Chitsabesan, P., Kroll, L., Bailey, S., Kenning, C., MacDonald, W. & Theodosiou, L. (2006). Mental health needs of young offenders in custody and in the community. *British Journal of Psychiatry*, 188(6), 534–540.

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