Introduction

Mental health problems have increased for children and young people since the 1940s to affect an estimated one in five of the general population¹ and more than one in ten children aged 11 – 16 years has a diagnosable mental disorder.² The incidence of adverse mental health among young people who offend is more pronounced for a variety of reasons:

- The risk factors that may predispose young people to criminal behaviour, such as social and economic deprivation, inconsistent, erratic or harsh parenting, also predict mental health problems in the general population of children. There is an overlap between those variables associated with delinquency and mental ill health.

- Various aspects of offending may also exacerbate mental health problems. Engaging in high risk behaviour, which is typical of many young people who break the law, can itself give rise to emotional disturbance, through for instance witnessing greater levels of violence and injury to self, friends and relatives as part of a criminal lifestyle.

- At the same time, interactions with the youth justice system, particularly the experience (or the threat of) custody, can themselves be stressful increasing the chances that young people will suffer from anxiety and depression. Custody can also lead to homelessness, loosen family and community ties, or reduce prospects for education, training and employment, each of which is associated with a greater potential for adverse mental health.³

Estimates of the prevalence of mental health difficulties among young people involved in the youth justice system vary widely. A recent review of the literature notes that findings of a psychiatric diagnosis, for those engaged with criminal justice agencies in the community, range from 25% to 77%. For children in custody, the figures are significantly higher, ranging from 46% to 81%. The review concludes that:

'a conservative estimate based on these figures would suggest that the rates of mental health problems are at least three times as high for those within the criminal justice system as within the general population'.⁴

The statutory requirement in the Crime and Disorder Act 1998 for health authorities to contribute staffing resources to youth offending teams (Yots) is an explicit recognition of the importance of the relationship between health and youth crime. Health professionals within Yots have increasingly focused on mental health, particularly since the provision of additional funding through the 2000 spending review allowed the appointment of named drugs workers in each team. The Youth Justice Board (YJB) has also prioritised the delivery of appropriate services to children who display mental health difficulties by establishing a performance measure for Yots which requires them to refer to the Child and Adolescent Mental Health Service (CAMHS) those who display acute problems for a formal assessment to commence within five working days of receipt of the referral. Assessment in non-acute cases should commence within 15 working days.⁵

Mental health legislation, in particular the Mental Health Act 1983 (MHA), contains a range of provisions dealing
with persons involved in criminal proceedings. The provisions are not age specific and apply equally to young people and adults. In practice, despite the undoubted relationship between youth offending and mental ill health, such measures are used infrequently, in part because they are intended to cover more serious cases of mental disorder. Nonetheless, on occasions where there is potential for mental health legislation to be invoked, it is important that youth justice practitioners are familiar with the possible outcomes.

The current briefing paper aims to provide an overview of mental health legislation as it relates to young people in the criminal justice system. It draws heavily on Working with mentally disordered offenders, a training pack developed by Nacro's Mental Health Unit.

The definition of mental disorder

Mental disorder is defined in s1(2) of the MHA as: ‘mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind’.

While the scope of mental disorder is thus quite broad, the Act also stipulates that a person may not be classified as mentally disordered, for the purposes of the legislation, by reason of ‘promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs’.7

Four categories of disorder are distinguished:

- **Mental illness** – not further defined within the legislation
- **Severe mental impairment** – defined as ‘a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct’
- **Mental impairment** – defined in the same way as the above with the exception that the phrase ‘severe impairment’ of intelligence and social functioning is replaced by ‘significant impairment’. The difference is thus one of degree, rather than type.
- **Psychopathic disorder** – meaning a ‘persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct’.

It is helpful to distinguish the first two categories from the second two since different legal consequences can ensue where a young person is classified as suffering from mental illness or severe mental impairment. In some circumstances, a diagnosis of mental impairment or psychopathic disorder is not on its own sufficient to invoke some of the provisions of the MHA. The condition must also be treatable. For the purposes of this paper, therefore, the first two forms of disorder are referred to as type A disorders, while mental impairment and psychopathic disorder are referred to as type B.

It should be noted that these are legal – as opposed to medical – classifications. Terms such as depression or schizophrenia, by contrast, represent medical diagnoses and such expressions do not appear in the legislation. The common feature of the three categories of disorder explicitly defined by the MHA is the reference to ‘abnormally aggressive or seriously irresponsible conduct’ which helps to delineate the kinds of behaviour that the legislation is designed to accommodate.

**Underlying principles**

There are two general principles which ought to govern decision making in relation to children who offend and may also be suffering from a mental disorder. First, Government policy recognises the desirability of diverting mentally disordered persons from the criminal justice system wherever possible. More specifically, prosecution should be avoided unless the public interest requires it. Where court action is considered necessary, suitable non-penal disposals should be sought wherever possible.

Second, the fact that a young person is subject to criminal proceedings does not undermine his or her right to mental health assessment, care and treatment equivalent to that available to the non-offending community. The MHA Code of Practice notes that young people with mental health difficulties may be particularly vulnerable in police detention or in custody and that professionals should take particular care to reduce the risks of self-harm or suicide. The Code also notes the complexity of the legal framework governing children and young people. It suggests, for instance, that the choice of whether the MHA or the Children Act 1989 is the most appropriate legislation, in an individual case, should be governed by the predominant needs of the child at the time. The least restrictive option consistent with the care and treatment objectives for the child should be sought. Any intervention required by virtue of their mental disorder should be the ‘least restrictive possible’ and result in the least possible segregation from family, friends and community. Wherever possible, any placement should be with young people of their own age, and separate from adults. While the Code does not deal specifically with children in the youth justice system, such comments are suggestive of how decision making might best be approached in such cases.

**Diversion in practice**

There is, on the face of it, something of a tension between the principle of diversion and the reprimand and warning scheme introduced by the Crime and Disorder Act 1998, since the latter entails a presumption of a formal criminal justice outcome for any youth offending, no matter how trivial. It also requires prosecution where a young person has exhausted his or her complement of two pre-court options. Government guidance on the operation of the final warning scheme makes no reference to issues of mental health.
Nonetheless there may be circumstances in which the police would take the view that diversion is an appropriate course. Where, for instance, they consider that a young person may be suffering from a mental disorder or have any concerns about his or her mental state or capacity, the police are obliged to arrange for him or her to receive appropriate clinical attention by an appropriate health care professional as soon as possible. In the first instance, it is likely that the police forensic examiner will be asked to examine the young person but this may lead to a full assessment under the MHA by an approved doctor and an approved social worker. If such an assessment indicates that an admission to hospital is necessary – either on a voluntary or compulsory basis (the latter is frequently referred to as ‘being sectioned’) then, depending on the level of seriousness of the alleged offences, the police may decide not to pursue criminal proceedings. Moreover, if there is evidence of mental disorder requiring treatment in the community through a referral to CAMHS or support through children’s services, the police could decide to take no further action in relation to the offence.

Where the police charge a young person, the Crown Prosecution Service (CPS) is required to review the case in order to confirm whether it is in the public interest to proceed with prosecution. The Code for Crown Prosecutors indicates that in the case of a young person who has previously received a reprimand and a final warning, prosecution will normally be required unless there are ‘clear public interest factors’ against such a course. In coming to a decision, however, the CPS should take into account any negative impact of court proceedings on the young person’s mental health, and whether he or she was suffering from significant mental ill health at the point the offence was committed. Where the CPS is satisfied that that the probable effect on a young person’s mental health outweighs the interests of justice in the particular case, it should consider discontinuing the proceedings, though the seriousness of the offence remains an important factor.

‘Crown prosecutors must balance the desirability of diverting a defendant who is suffering from significant mental or physical ill health with the need to safeguard the general public.’

Once the court process has begun, the CPS is required to keep the case under review and may discontinue prosecution as new information comes to light. Guidance for crown prosecutors dealing with mentally disordered offenders, for instance, indicates that the implications of a medical report which stated that the strain of criminal proceedings would lead to a deterioration in the defendant’s mental health would have to be considered very carefully.

There may therefore be opportunities for diverting young people with mental health problems from the youth justice system. A complicating factor is that Court Diversion or Criminal Justice Mental Health Liaison Schemes, which would normally aim to promote diversion in appropriate cases for adult mentally disordered offenders, rarely have a presence in the youth court or provide a service to young people under the age of 18 years. Health professionals within Yots will be much better placed than the police and CPS to recognise possible symptoms of mental ill health and, in such circumstances, may have a key role in providing information to those agencies about the mental health of any young person where there is potential for diversion, the possible adverse affects of continued prosecution, and about what forms of intervention might be considered as an alternative to a criminal justice outcome.

Remand provisions

Remand provisions for children and young people are complex and where a young person has mental health problems, there is an increased number of options available. In essence, these fall into two categories: those which are standard criminal justice responses; and those under the MHA which are specific to defendants considered to be mentally disordered.

Bail and refusal of bail

Most frequently where a court has concerns about a young person’s mental state, it will use one of the remand options generally available for young people under 18 years of age under the Bail Act 1976 and associated legislation. As with other cases, the starting position is a presumption in favour of unconditional bail, and conditions may only be imposed, or bail refused, if particular criteria are met.

The young person’s mental health will however be a factor in the decision-making, where, for instance, the court considers that it increases the chance that he or she will commit further offences or fail to attend future court hearings. In the event that the magistrates consider that a medical or psychiatric report would be helpful, they can adjourn the case to facilitate that process. A young person can be remanded on bail with a condition that he or she cooperates with the preparation of a report. Bail can also be refused if the court considers that it would be impracticable to complete the relevant inquiries or prepare the report if bail were granted. In such circumstances, a child under 17 years of age would ordinarily be remanded to local authority accommodation unless certain additional criteria are met. In the case of a 17-year-old, bail refusal results in a remand to custody.

Transfer from custody to hospital

Where a young person is remanded to custody through the standard criminal justice route, the MHA empowers the Secretary of State to direct that he or she be transferred from custody to a specified hospital. A ‘transfer direction’ can be made where the Home Secretary is satisfied, on the basis of reports from two registered medical practitioners – one of whom must be approved by the Secretary of State, under section 12 of the MHA, as ‘having special experience in the diagnosis or treatment of mental disorder’ (an approved medical practitioner) – that:

a) The young person is suffering from a type A form of disorder (mental illness or severe mental impairment) ‘of a nature or degree that makes it appropriate for him to be detained in hospital for treatment’; and

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b) The young person is in urgent need of such treatment.

It is accordingly clear that a transfer direction is to be reserved for cases where there is evidence of serious mental disorder.

The effect of the direction is that the young person is transferred to hospital and must not be released while it remains in force. It ceases to have effect where:

- The young person has not been transferred to the specified hospital within 14 days of the direction being made
- The court finally disposes of the criminal case
- The period of remand expires and is not renewed by the court
- The Home Secretary or the court receives notification from the young person's Responsible Medical Officer or a Mental Health Tribunal Review (MHTR) that detention for treatment is no longer required or that no effective treatment for the disorder can be provided.

Responsibility for applying to the Home Secretary, in the first instance, rests with the senior medical officer in the custodial establishment in consultation with the governor. For most purposes, a court ordered secure remand is considered to be a remand to custody, and a transfer to hospital from a remand to a local authority secure children's home or a secure training centre is then considered to be a remand to hospital for treatment. The maximum duration is the same as for a remand to hospital for a report. A remand to hospital for treatment is not available where the young person is accused of murder.

Remand to hospital for a report

The MHA also provides the court with additional powers over and above those generally available at the remand stage to deal with young people about whom there are mental health concerns. Under s35, if there is reason to suspect that a young person is suffering from a mental disorder, the court may remand him or her directly to hospital to facilitate the preparation of a psychiatric report where it is of the opinion that it is impracticable to obtain such a report if he or she were remanded on bail. This power is available to both the youth court and the crown court where:

a) it is satisfied that the relevant criteria are fulfilled on the basis of oral or written evidence of an approved medical practitioner; and
b) it has evidence from the doctor who would be responsible for preparing the report, or some other person representing the hospital managers, that arrangements have been made for the young person's admission to the hospital within seven days.

The remand can be made in the first instance for up to 28 days, and the young person can be further remanded in his or her absence if additional time is required to complete the relevant assessment up to a maximum of twelve weeks in total.

Remand to hospital for treatment

Under s36 of the MHA, where the young person appears in the crown court, there is an additional power, not available to the youth court, to remand a young person to hospital for treatment at any point up until sentence. The power might be used for instance where there is doubt about his or her fitness to plead (see below). It is available where he or she is diagnosed as suffering from a type A form of disorder (mental illness or severe mental impairment) of a 'nature or degree that makes it appropriate for him to be detained in a hospital for medical treatment'.

In deciding whether the relevant criterion applies, the court must have:

a) written or oral evidence from two registered medical practitioners, one of whom is approved; and
b) evidence from the doctor who would be responsible for the young person's treatment, or some other person representing the hospital managers, that arrangements have been made for the young person's admission within seven days.

The maximum duration is the same as for a remand to hospital for a report. A remand to hospital for treatment is not available where the young person is accused of murder.

The final disposal

Once a case has proceeded to the point at which a final decision as to disposal is to be made, the court again has two broad options. It can dispose of the case by passing any of the sentences generally available to defendants in criminal youth proceedings, or it may make an order under mental health legislation. If the latter route is pursued, the order can be imposed following conviction, but in some circumstances, it is also possible to dispose of the case without recording a conviction.

The 'youth justice route' and the use of supervision orders

In the majority of cases involving children and young people suffering from mental ill health, the court will proceed to sentence in the normal manner taking into account the seriousness of the offence, the personal and social circumstances of the young person, the welfare of the child and the statutory aim of preventing offending.

Where the court is considering the imposition of a custodial sentence or a 'youth community order', it is obliged to obtain a pre-sentence report (PSR), providing an opportunity for the Yot to comment on the relationship between the young person's mental health and his or her offending and propose a suitable disposal designed to address any mental health concerns. In exceptional circumstances, where the relevant criteria apply, the PSR might propose an order under the MHA (see below). In addition, where the young person appears to the court to be mentally disordered, it must obtain and consider an oral or written report, by an approved medical practitioner,
as to his or her mental condition before imposing a custodial sentence.26

Unless the PSR and the medical report advise that the young person requires hospital treatment, the court is likely to dispose of the case through the sentencing provisions generally available to it. However, the requirement to consider such reports does provide an additional safeguard which can be used to reduce the risk that a child suffering from mental ill health will receive a custodial disposal. However, the figures, cited earlier, for the number of young people with mental health problems in the juvenile secure estate, suggest that, at present, that safeguard is not particularly effective.

Depending on the circumstances, the court may impose any of the sentencing options generally available to it. Where the offence warrants it, the disposal will frequently allow for intervention which addresses mental health issues. But it is also important that the fact that a young person suffers from mental ill health should not lead to him or her receiving a harsher penalty than would otherwise be imposed. In the case of relatively minor offending, it may be more appropriate for support and intervention to be offered independently of the sentence of the court.

The supervision order is the most versatile disposal available in youth proceedings. Frequently, it will be possible to accommodate concerns about a young person’s mental health within the confines of such an order, without the need to include a specific requirement in relation to treatment. A supervision order may however also require a young person to undergo treatment for a mental health condition. Such a requirement can be imposed provided that the court is satisfied, on the basis of evidence from an approved medical practitioner, that the condition both requires and is susceptible to treatment but is not such as to warrant a hospital order (see below). The following forms of treatment may be included in the order:

- As a non-resident patient at a specified place
- As a resident patient in a hospital or nursing home
- Under the direction of a registered medical practitioner or psychologist.

Treatment can however only be specified where the court is satisfied that the appropriate arrangements are in place and that, in the case of resident treatment, a place is available for the individual young person in a particular establishment.27 The duration of the requirement must be specified by the court. It can extend for the whole of the order except that it may not last beyond the young person’s 18th birthday. In the case of a young person over the age of 14 years, his or her consent is required.

In practice, as with other provisions which are specific to mental health, this requirement is rarely used. In part, this may be due to a reluctance in some quarters to diagnose adolescents as being mentally ill, given the stigma which attaches to that label.28 But it also reflects the continued shortage of CAMHS specialist resources in general and residential provision for this age group in particular. Given the scale of mental health difficulties exhibited by children in custody, however, increased specialist provision might allow an expanded use of the supervision order with requirement as treatment for a mental condition as an alternative to custody which is also more flexible and less intrusive than a hospital order.

**Hospital orders and associated provisions**

The MHA provides for responses for children and young people who are diagnosed as having a mental disorder as an alternative to a criminal justice sentence. Section 37 allows the court to impose a hospital order if the young person has been convicted of an offence punishable by a custodial sentence, other than murder, provided the court is satisfied that:

- On the basis of the written or oral evidence of two registered medical practitioners, one of whom is approved, the young person suffers from a mental disorder of a nature or degree which makes it appropriate for him or her to be detained in hospital for medical treatment; and
- In the case of one of type B forms of disorder (mental impairment or psychopathic disorder), such detention is also likely to alleviate or prevent further deterioration of the condition (the condition must in other words be treatable); and
- The order is the most suitable method of disposal; and
- Arrangements have been made to allow the admission of the young person within 28 days of the order being made.

The youth court can also impose a hospital order without recording a conviction where a young person is suffering from one of the type A forms of mental disorder (mental illness or severe mental impairment), if it is satisfied that he or she did commit the offence charged. This power allows a disposal where a young person’s mental health might preclude him or her from participating fully in a trial, or where the offence is relatively trivial and a conviction would be unnecessarily stigmatising. The power is not available in the crown court where other provisions apply (see below).

The effect of a hospital order is that the young person is detained initially for a period of up to six months. The order is renewable (without the further involvement of the court) on similar criteria for a further six months and then subsequently for periods of one year.29 The young person can be discharged at any point by the responsible medical officer, the hospital authorities or (after six months) on the order of a MHRT unless he or she is also subject to a restriction order (see below).30

The use of hospital orders is relatively infrequent in criminal proceedings and has been declining. During 2003/04, for instance, 554 such orders were made on defendants for all ages, a fall of 43% since 1993/94.31 The statistics are not broken down by age, but it might be anticipated that only a small number of orders relate to children under 18 years.
Restriction orders 32
Where the crown court makes a hospital order in criminal proceedings, it can also impose restrictions on the young person’s discharge. If the court considers it necessary to protect the public from serious harm, it may impose a restriction order for a specified period or, more commonly, without limit. Such an order is not available in the youth court and can only be made in the crown court where it has heard oral evidence from at least one of the doctors whose evidence was adduced in relation to the hospital order. In practice, the majority of those subject to hospital orders (58% during 2003/04) are ‘restricted patients’. 33

The effect of the restriction is that the young person cannot be discharged from hospital without the agreement of the Home Secretary or on the authority of a MHRT. The responsible medical officer must submit a report on a restricted patient to the Home Office Mental Health Unit at least once every 12 months. If at any stage, the Secretary of State is satisfied that the restriction order is no longer necessary to protect the public, he or she can order that it should cease to have effect. The young person would then remain subject to the original hospital order.

Interim hospital orders 34
Pending a full decision as to the desirability of a hospital order, a youth court or crown court can make an interim hospital order to allow an assessment before the case is finally disposed of where it has heard evidence of two registered medical practitioners, one of whom is approved. An interim order is available on conviction35 where the court is satisfied that the restriction order is no longer necessary to protect the public, he or she can order that it should cease to have effect. The young person would then remain subject to the original hospital order.

Guardianship 37
Where the criteria for a hospital order apply, the youth court or crown court can instead impose a guardianship order providing that:

- the young person is aged 16 years or older;
- his or her mental disorder is of a nature or degree that warrants reception into guardianship; and
- the local social services authority (or other specified person acceptable to that authority) is prepared to act as guardian.

The duration is the same as for a hospital order. The effect of reception into guardianship is that it confers powers on the guardian, to the exclusion of any other person, to require the young person to reside at a specified place, to attend at specified places and times for medical treatment, education, training or employment, and insist that access to the young person is given to any medical practitioner, approved social worker, or any other person specified by the guardian.

The purpose of guardianship is to enable ‘patients to receive care in the community where it cannot be achieved without compulsory powers’. 38 It is however used extremely rarely in criminal proceedings: during 2004 for instance, there were only eight new cases of guardianship following conviction for all ages in England. 39 Although the figures are not broken down by age, it seems unlikely that any of these related to young people aged 16 – 18 years.

Transfer to hospital of young people serving custodial sentences 40
The Home Secretary has powers, analogous to those which exist at the remand stage, to transfer young people serving custodial sentences to hospital. The criteria are similar to those for a hospital order: the young person must be suffering from a mental disorder and, in the case of one of the type B forms of disorder (mental impairment or psychopathic disorder), the treatment must alleviate or prevent a deterioration in the condition. As at the remand stage, a transfer direction can only be made on the evidence of two registered medical practitioners, one of whom must be approved. The responsibility for initiating the application rests with the senior medical officer of the custodial establishment in consultation with the prison governor. The provisions apply to any order for custody or detention made by a criminal court but it is not immediately clear where responsibility to initiate the application resides if a child is serving a custodial sentence in a local authority secure children’s home or a secure training centre.

A transfer direction has the same effect as if a hospital order had been made in the first instance. The large majority (80% in 2003/04)41 are also accompanied by a restriction direction which prevents discharge, in the same way as a restriction order, until the point at which the person would have been released from custody. Thereafter the patient continues to be liable to detention without restriction, and a young person might accordingly spend considerably longer in secure facilities than would have been the case had he or she remained in custody.

Procedures in the crown court for unfitness to plead or insanity 42
In a very small number of cases heard in the crown court, a young person’s mental health might be such as to raise doubts about whether he or she is fit to plead. Home Office guidance suggests that it is good practice in such circumstances for the court, before reaching a decision on the issue, to remand the young person to hospital for treatment, under s36 of the MHA, in anticipation that he or she might as a consequence become fit for trial. 43

It is a matter for the judge, without a jury, to determine whether the young person is fit to plead. In the event that he or she is found unfit to plead, a trial of the
facts will ensue, for the jury to establish whether the young person committed the offences of which he or she is accused. Where the court finds that the defendant is unfit to plead and did commit the acts charged, or that he or she is not guilty by reason of insanity, it has three options as to disposal. It may impose:

- A hospital order under s37 of the MHA, with or without a restriction order
- A supervision order (a provision distinct from the order available in the youth court)
- An absolute discharge.

If the court considers that the young person should be detained, a hospital order will be the appropriate disposal. However, such an order can only be made if the relevant criteria under s37 are fulfilled. An absolute discharge, by contrast, will only be made where the offence is relatively trivial and the court considers that no treatment or supervision is required.

A supervision order made under these provisions is totally distinct from the community sentence available in the youth court of the same name, and is not intended primarily as a disposal for young people. The effect of the order, which can last up to two years, is to place the person under the supervision of a local authority social worker or probation officer. It may require him or her to submit to treatment for the whole of the order, or any shorter specified period, for a mental condition which the court considers requires, and is susceptible to, treatment but is not so serious as to warrant the making of a hospital order.

The disposal is designed to enable support and treatment to be given to the defendant to prevent recurrence of the problem which led to the offending … it is non-punitive and intended solely to provide a framework for treatment.

Consistent with that approach, any young person subject to such an order cannot be required to receive in-patient treatment without his or her consent and there is no sanction for non-compliance. Home Office guidance suggests that it will generally be more appropriate for the supervisor to be an approved social worker rather than a probation officer.

### Conclusion

Despite the considerable overlap between mental ill health and youth crime, it should be acknowledged that most of the provisions described in this paper are used extremely infrequently for children and young people. At the same time, the tensions between the principles which underpin the MHA Code of Practice and those which inform the youth justice system, in combination with the continued inadequacy of mental health services for children and young people in many areas, constitute real barriers to decision-making in cases where young people in trouble also display mental ill health. Nonetheless where the situation arises, it is important that Yots are in a position to influence outcomes in a positive direction.

Effective mental health screening, through Asset and the associated tools developed by the YJB (SQIFA and SIFA), will ensure appropriate referrals to CAMHS at the earliest possible stage. Ensuring access to a broad range of mental health services for young people in trouble can go some way to maximising the opportunities for diverting those who with mental health problems from prosecution, or from the youth justice system all together.

Once criminal proceedings are initiated, the Yot will have a significant role in advising the court and other agencies on the most appropriate course of action. Provision of appropriate information to the CPS, for instance, in relation to the young person's mental health and interventions available to address any problems, may allow some cases to be discontinued on the basis of the public interest criterion.

An effective remand management strategy will ensure a proactive approach to keeping young people in the community, with appropriate levels of supervision, at the remand stage and allow the Yot to influence the decision as to whether to follow a standard criminal justice route or to deploy specialist mental health provisions. Youth justice practitioners might also be able to advise whether an adjournment for a medical report would be helpful in particular cases. In so doing, consideration should be given to the fact that obtaining such a report will generally involve a delay of some four to six weeks.

High quality PSRs, which explore any relevant mental health concerns and address how they might be dealt with effectively, can help to ensure that young people receive treatment where necessary without recourse to harsher sentencing than the offending would generally warrant. In appropriate circumstances, Yots should be well placed to advise on whether a hospital order is preferable to a lengthy custodial sentence.

More generally, decision-making in respect of young people who offend and who suffer mental ill health should be informed by the principles of the right to treatment and the desirability of diverting young people from the youth justice system wherever possible. The choice of outcome at any stage should avoid exacerbating the child's mental health problems, reduce any unnecessary delay, and aim for the least restrictive option which is consistent with the care and treatment objectives for the child and is compatible with the safety of the public. Such an approach might assist in reducing the number of young people inappropriately held in custodial institutions who have mental health problems.

Effective intervention in this complex area of work requires a knowledge of the legislative provisions, skilled assessments and timely access to high quality, specialist service provision.
References

1 Mental Health Foundation, Bright futures: promoting children and young people's mental health, Mental Health Foundation, 1999
3 Hagell, A, The mental health of young offenders. Bright futures: working with vulnerable young people, Mental Health Foundation, 2002
4 Ibid
5 Youth Justice Board, Corporate and Business Plan 2004/05 to 2006/07, Youth Justice Board, 2004
6 Working with mentally disordered offenders: a training pack for staff in criminal justice agencies, health and social care and the voluntary section, is available as a CD ROM and can be obtained from Nacro's publication department on 020 7840 6427
7 Section 1(3) of MHA
9 Code of Practice: Mental Health Act 1983, Department of Health and Welsh Office, 1999
10 Final warning scheme: guidance for the police and youth offending teams, Home Office and Youth Justice Board, 2002
11 The requirement is contained in the Police and Criminal Evidence Act 1984 Codes of Practice, Code C, Annex E
12 The grounds for compulsory admission to hospital for assessment or treatment are contained in Part II of the MHA. For further details see Working with mentally disordered offenders: a training pack for staff in criminal justice agencies, health and social care and the voluntary section, Nacro, 2005
15 Ibid, paragraph 5.10
17 Findings of the 2004 survey of Court Diversion / Criminal Justice Mental Health Liaison Schemes for mentally disordered offenders in England and Wales, Nacro, 2005
18 For more details, see Bail as it affects young people in court, Youth crime briefing, Nacro, March 2003
19 Ibid
20 For more details, see Remands to local authority accommodation, Youth crime briefing, Nacro, June 2003
21 The provisions for a transfer to hospital are contained in s48 of the MHA
22 In broad terms, young people can only tried in the crown court where they are 'carried' by an adult codefendant, where they are alleged to have committed a grave crime or they have committed a specified violent or sexual offence and might be considered 'dangerous'. For further details, see The grave crimes provisions and long term detention, Youth crime briefing, Nacro, September 2004, and Dangerousness and the Criminal Justice Act 2003, Youth crime briefing, Nacro, June 2003
23 For more details, see The sentencing framework for children and young people, Youth crime briefing, Nacro, December 2003
24 A youth community order is defined in s147 of the Criminal Justice Act 2003 (CJA 2003) as a curfew order, an exclusion order, an attendance centre order, a supervision order or an action plan order.
25 The requirement is contained in s156 of the CJA 2003
26 The requirement is contained in s157 of the CJA 2003
27 For more details, see Supervision orders: an overview, Youth crime briefing, Nacro, September 2002

28 Children, health and crime, Nacro, 1999
29 The criteria for renewal are identical to those for making the initial order except that, in respect of a young person suffering from one of type A forms of disorder (mental illness and severe mental impairment), there is an additional requirement that if discharged, the patient would be unable to care for him or herself, obtain the care which he or she needs, or guard him or herself against serious exploitation.
30 For further details, see Working with mentally disordered offenders: a training pack for staff in criminal justice agencies, health and social care and the voluntary section, Nacro, 2005
31 Inpatients formally detained under the Mental Health Act 1983 and other legislation, Health and Social Care Information Centre, 2005
32 The provision for restriction orders is contained in s41 of the MHA
33 Inpatients formally detained under the Mental Health Act 1983 and other legislation, Health and Social Care Information Centre, 2005
34 The provision for interim hospital orders is contained in s38 of the MHA
35 An interim order is accordingly not available where the youth court is considering a hospital order without a finding of guilt.
36 Provision for mentally disordered offenders, paragraph Bvii(d), Home Office Circular 66/90, Home Office, 1990
37 The provision for guardianship is contained in s37 of the MHA
38 Guardianship under the Mental Health Act 1983, Local Authority Personal Social Services Statistics, Department of Health, 2004
39 Ibid
40 The provisions for transfer are contained in section 47 of MHA
41 Inpatients formally detained under the Mental Health Act 1983 and other legislation, Health and Social Care Information Centre, 2005
42 The provisions are contained in the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 as amended by the Domestic Violence, Crime and Victims Act 2004
45 It might be noted that while a hospital order cannot be imposed following a conviction for murder, the court can make such an order where the young person has been charged with murder and found unfit to plead or not guilty by reason of insanity providing the conditions under s37 are met. A hospital order in these circumstances must be accompanied by a restriction order. If the conditions under s37 are not met, the court's option are limited to a supervision order or an absolute discharge.
46 The Crown court also has the power to make a hospital order under s51 of the MHA without conviction where a defendant has been remanded to custody and subsequently transferred for treatment under s48 of the MHA
47 Provision for the supervision order is contained in Schedule 2 to the Domestic Violence, Crime and Victims Act 2004. It replaces what was previously known as a supervision and treatment order.
49 Ibid
50 See above section on 'Underlying principles'
51 Details of the Youth Justice Board's mental health screening pathway can be found at www.youthjustice-board.gov.uk/PractitionersPortal/Health/MentalHealth/