# PROJECT FACT FOR MINORS

## Fostering Alternative Care for Troubled Minors

(JUST/2015/RCHI/AG/PROF/9578)

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## FINAL REPORT

APRIL 2018

FACT Fostering Alternative Care for Troubled Minors

CATÓLICA CEDH - CENTRE FOR STUDIES IN HUMAN DEVELOPMENT PORTO

Funded by Rights Equality and Citizenship (REC) programme of the European Union

## 1. Preface

### 1.1. The Project context

In Portugal, until the child reaches the age of 18 (following the concept of child defined by the Committee on the Rights of the Child), 3 distinct levels of judicial intervention can be applied when he/she has committed a fact qualified as crime by the penal law, depending on child's age when the crime is committed:

**1.** Below 12 years old, children can only be subject to protection measures within the scope of the *Promotion and Protection Law for Children and Young in Danger* (Law n° 149/99, of 1st of September);

**2.** Children aged between 12 and 16 years old fall under the responsibility of the Juvenile Justice System and can be subject to a youth justice measure, including custodial measures;

**3.** Youths aged between 16 and 18 years old fall under the Adult Justice System, as 16 are the minimum age for criminal responsibility in Portugal, and can be subject to penal measures.

Therefore, taking into account the scope of the project, we have focused on youths aged between 12 and 16, to who can be applied juvenile justice measures, which are based in the *Youth Justice Act* (Law n° 166/99, of 14th of September). The general principle of this law is the need to educate the children for the Human Rights and to promote an adequate socialization process. Young people who perpetrate, between 12 and 16 years old, an act qualified as crime by the penal law are subjected to custodial measures, under the *Youth Justice Act* (Law n° 166/99, of 14th of September), which aim youth offenders' socialization and education for law compliance and for fundamental values of living in society. Custodial measures are executed in Educational Centers, when the child's behaviour is considered a crime, and whose penalty would be more than five years if practiced by an adult. These children can be placed in an open, semi-open or closed regime, according to the level of liberty and autonomy ascribed to them. The placement on these facilities is organized in residential units with secure accommodations.

The concept of "Alternative Care" specifically designed for these children (who are under penal measures and have mental health problems) is a process under development, since the law is strict about the measures that must be applied to children who are in the scope of the project. Also, for this reason, an Educational Center has proved to be the most appropriate and feasible setting to develop and implement the process of capacity building. Although these constraints,

data collected through the several interviews, meetings and focus group with Experts, show that there is motivation and that are already being taken steps to strengthen the intervention on mental health issues in the existing contexts, as well as that are intentions to create alternative answers to the existing model, namely through a greater connection and integration of these children in the community[1].



The educational guardianship procedure provides several measures aimed at providing a child-friendly environment and steps should be taken, as far as possible, to promote the education and development, and not a punitive setting. Children's dignity and maturity, as well as their physical, intellectual and psychological health must be respected and, according to the socialization principle, they keep all their social rights as long as they are not incompatible with the placement, keep all their family and social ties to the maximum extent possible, as well as their educational and social activities.

The *Youth Justice Act* also guarantees to the young person a specific set of rights through all legal proceedings, among which be assisted by an expert in psychiatry or psychology whenever required for the purpose of evaluating the need for the application of an educational measure. Also, during internment youths have the right to an appropriate hospital and medical care, including regular clinical supervision, such as medical exams, medical treatments, medication, vaccination, and screenings.

### 1.2. The actors involved

Throughout all phases of the project we have been trying to involve several key actors (in-depth interviews, focus groups, meetings with the National Advisory Board) who have diverse professional activities (e.g., judges, public prosecutors, academic/researchers, psychologists, psychiatrists, politicians, social workers, social educators, family doctors, teachers, other professionals from the protection system), but who are involved with youths at risk, in conflict with the law and with mental health issues. Moreover, in order to amplify the effects on the different systems implicated in the process of taking care of these young people, through contacts promoted with professionals, we have also been involving institutions with different roles, namely the Commission for the Protection of Children and Young People at Risk, the General Direction of Reinsertion and Prison Services, the General District's Attorney of Porto, the Center for Judicial Studies, the Pedopsychiatry Department of Magalhães Lemos Hospital, Porto City Hall, Universities, Private Institutions of Social Solidarity (e.g., Santa Casa da Misericórdia).

[1] This idea will be explained later on this report: section 5.


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Although there are some obstacles, there is a general accordance and recognition on the importance of settling a common platform/multiagency intervention, and on the need to an effective cooperation between the different systems/institutions who are involved in the intervention process with youths executing internment measures in juvenile facilities, and who are diagnosed with psychological/psychiatric problems and with both therapeutical and socio-educational needs.



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## 2. Project objectives



In the Portuguese context several weaknesses and obstacles are already well identified, regarding a multi-agency approach when working with young offenders with mental health problems. However, the lack of economic and human resources difficult the implementation of time consuming's strategies. Even so, steps are being taken in order to fill the identified gaps and concerns with the mental health services provided to children and adolescents have been highlighted in several national documents (e.g., National Program for Mental Health, 2017, National Rehabilitation and Reintegration Plan - Juvenile Justice, 2013).

For example, the **National Plan for Mental Health (2007-2016)** has established a set of goals and concerns about mental health care in Portugal, in particular the need to improve the mental health care delivering and the promotion of the articulation between health professionals; more specifically, concerning to children and youth at risk, and in the scope of primary health caregiving, which ensures the provision of care in mental health, was defined the need to create support groups for infant mental health, which should articulate with community structures (e.g., Children and Youth at Risk Protection Committee); when children are integrated in the justice system or under the state protection they must have support in the institutions, in order to benefit from interventions to improve their mental health resources, namely to change dysfunctional behavioural patterns; and a task force should be developed to define guidelines to answer to the several problems of children and youth at risk.

Additionally, the abovementioned document identifies a set of weaknesses in the organization of mental health services for children and adolescents, which include: inadequate information systems; mental health workers with poor training in the mental health of children and adolescents; little awareness of the importance of child and adolescent mental health issues compared to other health issues; poor coordination between the different levels of performance; weak intersectoral collaboration; precarious processes of quality improvement; and a poor distribution of resources.

Efforts should be made to implement good practices due to the fact that, according to data provided by the first National Epidemiologic Study on Mental Health (Caldas de Almeida & Xavier, 2009), Portugal has one of the highest prevalence of mental illness in Europe; a significant proportion of people with severe mental illness remain without access to mental health care; and many of those who have access to such care still do not benefit from the intervention models considered essential in terms of psychosocial treatment and rehabilitation. Therefore, one of the

goals of the **National Program for Mental Health** until 2020 is to create 500 places for children/adolescents in integrated mental health care (Direção-Geral da Saúde, 2017).

Taking into account the latest developments in different areas of knowledge (e.g., psychology, sociology, criminology) on young people committing crimes, the **National Rehabilitation and Reintegration Plan - Juvenile Justice - 2013-2015** stresses the need to work with young people in order to avoid recidivism and to develop life projects socially adjusted to the rules of coexistence in society (e.g., health care, education, vocational training, work, cultural and sports initiatives, interaction with the community). Moreover, this document highlights the importance of considering the developmental specificities of this population and having as guiding principles the qualification of the evaluation and the intervention directed to the criminal behavior (the need of education in law compliance, risk of recidivism, multi-systemic factors involved, mental health problems), intra and interinstitutional articulation, as well as the implementation and operationalization of a case management methodology, technically and scientifically sustainable.



Particularly concerning the Portuguese juvenile justice system, the law does not envisage a specific and separated 'therapeutically custodial measure', in which youth offenders in need of mental health assistance could benefit from psychiatric and/or psychological treatment during detention specifically designed to address their needs (Bolieiro, 2010 cit. in Carvalho, 2014). Furthermore, "although the current legal framework foresees the creation of specialized Centers or residential units that should provide therapeutic programmes specifically designed for those with personality disorders or serious addictive behaviours, such units and programmes have not been fully implemented" (Carvalho, 2014, p.19). In fact, there are therapeutic communities, but these are mainly targeted to minors at risk with problems related to substance abuse. Also, in some cases youths can be placed in units for adults, due to the lack of resources, psychological support and psychiatric outpatient treatment available, and medication is provided.

Nonetheless, when a youngster is placed in an Educational Center to execute a custodial measure, mental health care is provided when mental health problems are evaluated as important aspects to be addressed. Therefore, a Personal Educational Plan (P.E.P) is developed with each youngster, which may address mental health interventions. However, other issues remain unquestioned, namely the type of mental evaluation conducted, which entities are providing the mental health responses, and the kind of monitoring applied. Facing this scenario, Portuguese custodial interventions on youth justice may comprise mental health assistance, but without any kind of specialized, integrative and standardized guidelines for practice.

In fact, the most recent report of the **Commission for Monitoring and Supervision of Educational Centers (2015)** highlights the existence of poor and inadequate mental health responses, since the majority of institutionalized youths actually suffer from psychiatric disorders. This report warns that the number of young people with pathologies requires an urgent definition of intervention lines specifically aimed at this population and professionals strongly agree that it is very important to improve structures and practices, in order to meet these youths' needs.

Based on information provided by this document, from a universe of 186 young people placed in Educational Centers, 82 had psychological/psychiatric disorders, were taking medication (under medical prescription) and were having psychological and/or psychiatric monitoring (1 appointment each 3 or 6 months). Although there has been a decrease in the number of young people who are medicated, this continues to be high, with many situations of anxiety and difficulty sleeping. It is also highlighted the existence of a reduced number of situations of youths who, due to their cognitive levels and their mental situation, should be targeted by the health system and not by the educational tutelary system. This data is supported by the results yielded in a recent research conducted by Rijo and colleagues (2016) on mental health problems in male young offenders, concluding that the 122 participants placed in juvenile detention facilities presented a high prevalence of mental health disorders (93.4%), as well as a high comorbidity rate (e.g., mental health disorder and substance abuse).

Another report elaborated by the **National Prevention Mechanism (2016)** has identified as main limitations the insufficient identification of juvenile pathologies and prevention of delinquent behavior, especially in young people between 12 and 14 years of age; some shortcomings in the response of some valences in the area of mental health regarding periodic appointments and follow-up; and also a deficient specific action in cases of young people who present, at the same time, mental health problems and deep behavioural pathologies. Data from the Educational Centers also point out behavioural disorders (e.g., violent behaviours, relational difficulties, problems in abiding to norms and rules), substance abuse, psychiatric disorders and the presence of multiple risk factors (e.g., family dysfunction/attachment disorders, child abuse and neglect, abandonment, history of truancy and expulsion from school, lack of family and social support).

According to data from the abovementioned report, 31 youths (in a population of 150) with mental disorders and 20.6% of the total number of young people hospitalized were diagnosed in 5 Educational Centers (total of 6 institutions): 13 youths between 12 and 16 years old and 18 youths over 16 years old. The diagnoses performed, which are the responsibility of the

competent health institutions, were grouped into 4 main categories: a) Bipolar Disorder/Attention Deficit/Hyperactivity Disorder/Conduct Disorder, b) Borderline personality structure/disturbance of opposition and behavior, c) Depression/toxic consumption/mood disorder without further specification and cognitive deficit of slight degree and without mental/mental retardation changes, and d) Post-traumatic stress/anxiety. Moreover, in this respect it was found that out of a population of 150 young people, 94 had psychological counselling (62.7%), 44 were being followed by a pedopsychiatrist or a psychiatrist, 38 accumulated both types of intervention in the area of mental health, 49 young people were taking medication, and 6 were waiting for the appointment of a specialist.

Despite this situation, the same report also identifies positive practices, concluding that there is an adequate articulation between the Educational Centers and the health units of the respective area of residence, namely with regard to the attribution of a family doctor to young people, appointments of specialty consultations, complementary diagnostic and treatment exams. The Educational Centers carry out the appropriate therapeutic follow-up of the young people, and systematic interventions in this area have been identified in some cases.

With regard to the functioning of the Educational Centers, several programs have been carried out to satisfy specific educational needs associated with delinquent behavior:

**1. GPS25 – Growing Pro-Social Social Program** - intervention in delinquent behavior, with a view to achieving a social position in accordance with current social norms. The Growing Pro-Social—GPS program was developed aiming to prevent antisocial behavior and also the rehabilitation of delinquent youths, through the promotion of emotional recognition and regulation in relation to cognitive functioning (changing dysfunctional core beliefs about the self and others) (Brazão, Motta, & Rijo, 2013).

**2. ERECC** - Emotional Regulation and Cholera Control Strategies - a group intervention aimed at helping young people to reduce cholera activation in aggressive young people, in the sense of a self-control posture.

**3. ERC** - Stimulate Cognitive Resources - development of cognitive skills, with influence in the domains of language, psychomotricity, perception and decoding, memory and reasoning.

**4. Artways** - Education and Training Policies against Violence and Juvenile Delinquency - a group intervention aimed at acquiring behavioural skills and preventing violence.


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The juvenile detention facilities also have specific programs for suicide prevention - identification of warning signs and referral of young people to emergency services - as well as plans for the prevention of anxiety and depression in a residential context through psychological support at the Educational Centers and advisory services for young people, the implementation of unit meetings and the GPS25 program, as well as medical appointments and follow-ups in the field of pediatrics and psychiatry. The psychological intervention carried out in the Educational Centers focuses on the follow-up of young people hospitalized in compliance with educational tutelary measures (carried out according to the diagnosed needs) and on the performance of personality skills in the context of technical advisory services to the courts and prior to the judicial decision.

In the period between 2011 and 2013, the General Directorate of Reinsertion and Prison Services (DGRSP) has also promoted the Project for Juvenile Justice Psychotherapeutic Assessment and Intervention - PAIPA (cofinanced by the European Commission) with the objective of analysing the prevalence of mental disorders, identifying the development of an intervention model aimed at young people who comply educational measures and carrying out a survey of good practices of evaluation and intervention for this population (similar to other services at international level). The study involved a sample of 217 youths in compliance with the two most severe measures (internment and educational monitoring), with 63% presenting as the main diagnosis the opposition disorder and behavioural disturbance and 31% with substance abuse. According to the National Plan of Rehabilitation and Reinsertion – Juvenile Justice – 2013-2015 the development of PAIPA would "allow to draw up a short- and medium-term plan for the creation of a differentiated residential unit for the purpose of specialized psychotherapeutic intervention aimed at the treatment of young people with acute clinical conditions, where a therapeutic team can function, which can also, on an outpatient basis, provide support for young people in the area of mental health, accompanied by social reintegration teams" (2013, p.4270). The PAIPA ended up not having sequence.


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## 3. Capacity Building and the two levels of intervention

### 3.1. National Level



Concerning the scope of the project FACT, throughout all phases of the project our focus were youths aged between 12 and 16 to whom can be applied juvenile justice measures. For this reason, an Educational Center – public juvenile detention facility – is the most appropriate and feasible setting to develop and implement the process of Capacity Building.

Globally, and according to the most recent statistics of the DGRSP, in January 2018 the total number of young people admitted to Educational Centers was 152 (136 boys), most of them complying with semi-open measures (107 youths). As for age, 70.39% of them had 16 years (32%) or over. The vast majority (96%) were executing an internment measure, one of the most severe, applied by a judge of the Family and Juvenile Court. Hereupon, this population presents a set of characteristics and specific complexities, which are particularly difficult to address and to treat in a juvenile justice custodial or semi-custodial setting (e.g., behavioral disorders, substance abuse, psychiatric disorders and the presence of multiple personal and familiar risk factors). Thus, when we need to intervene with young offenders the main focus is to promote social reintegration and to reduce recidivism, particularly, it is intended to promote social skills, to reduce drug abuse and health risks associated with consumption, as well as to teach non-violent communication behaviours.

Globally, concerning therapeutic care and in order to address youths' specific and complex needs, there are several types of programs to develop positive and important habits and skills (e.g., emotional regulation, anger management, therapeutic gains maintenance, relapse prevention). Specifically regarding the intervention conducted in institutional environment, treatment programs have generally shown positive impact on recidivism. Also, behavioral programs are the most effective, institutional programs are most effective when they are applied to individuals with more risk factors, sensitive to the specific needs of their targets and structured in a specific way, also taking into account the type of crime. On the other hand, programs are less effective when strategies are based on non-directive/humanist inspiration group counselling, poorly structured and when do not include assessment needs.

In the Portuguese context, the therapeutic care in Educational Centers is based on a set of key intervention instruments (e.g., Intern Regulations - R.I., general pedagogical guidelines, Personal Educative Project - P.E.P.) and auxiliary intervention programs (e.g., models of technical intervention support, youth's individual dossier). Educational and therapeutic programs (contemplated on P.E.P.) comprise the following areas: school training, vocational guidance and

professional training, socio-cultural and sports entertainment, health education, therapeutic and delinquent special needs satisfaction.

In turn, according to the General and Disciplinary Regulation of the Educational Centers (RGDCE), P.E.P. is the project developed in the context of each Educational Center, a phased programming intervention, differentiating objectives to be performed in each phase and its respective system of positive and negative reinforcements, it is applicable to all regimes (open/semi-open/closed), it has a progressive and phased character, and consists in an appropriate intervention regarding personal and social youth's development. P.E.P. includes the identification of the structure, human resources and other operating aspects of the Educational Center, the educational intervention (to promote the acquisition of basic social skills and education for the law), an individual intervention (to promote self-knowledge, accountability, self-control, life project restructuring), and also the assessment of the intervention performed (results measured through behavioral modification, teaching-learning processes, articulation of intervention, impact). As main strategies it can be highlighted the use of a system of gains or expectation of its acquisition and withdrawal of acquired gains (contingencies control), behavior modeling by educational agents, therapeutic programs of cognitive-behavioral, psychodynamic, systemic orientation, among others, and, moreover, each youth has a social reinsertion technician of reference who manages the entire educational and therapeutic process during internment.



There is also a program that is currently implemented in all Educational Centers – GPS25 - Growing Pro-Social Program – to satisfy specific educational needs associated with delinquent behavior. The Growing Pro-Social—GPS program was developed aiming to prevent antisocial behavior and also the rehabilitation of delinquent youths, through the promotion of emotional recognition and regulation in relation to cognitive functioning (changing dysfunctional core beliefs about the self and others) (Brazão et al., 2013). GPS program mainly resorts in experiential tasks and sessions must be conducted by two professionals. GPS is implemented following a predefined sequence of 25 sessions (a short version of the program) of 90 minutes each, which are grouped into five modules: "(…) (1) increasing knowledge about human communication (acknowledging the ambiguity of human interactions), (2) changing maladaptive interpersonal behavior patterns, then (3) learning about thinking errors and trying to counteract them, later (4) experiencing and understanding the way emotions work and the influence they exert over our mind and behavior and, finally, (5) relating our actual problems and malfunctioning with core issues influencing the way we act and react towards others (…)" (Brazão et al., 2013, p.640). The program also provides follow-up sessions that can be carried out optionally.

### 3.1.1. Capacity Building Strategies and Activities

According to the scope of the Project, the process of capacity building should fit the specificities of each context/country. Thus, after the needs' evaluation process and the prior characterization of our context we considered that the process of capacity building should be implemented through different steps:



1. To disseminate the Project among the different institutions involved in the intervention process.
2. To raise the awareness of different professionals for interinstitutional cooperation.
3. To raise awareness among justice professionals of the importance to promote appropriate and suitable measures for young people's mental health problems.
4. To facilitate the contact/communication between the judicial, educational, health and community contexts, in order to implement a multiagency platform.

Considering these strategies, mainly based on strengthening the knowledge about the specificities of the targeted population, and on the creation of an effective network between different agencies, we had carried out the following activities:

1. Individual meetings (between the project team and the above mentioned key actors/institutions).
2. Creation of the National Advisory Board.
3. 2 Focus Group (in which have participated research team members, professionals from the justice system, health system, key actors of the Educational Center, professionals from the academic/research field).
4. Meetings/discussion/case discussion group, involving team research group, mental health professionals, Educative Center professionals and justice professionals.
5. Symposium next June 2018 (Universidade do Minho) on the topic "Therapeutic Justice".
6. 2 Papers (ongoing work).
7. Two master theses developed under the scope of the project.


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### 3.1.2. Multi-agency Model

Hereupon, based on the elements presented above, on previously identified shortcomings, and on the specific characteristics of our context, we have proposed an alternative model of multi-agency/multi-actor approach to intervene with young offenders with psychological and/or psychiatric problems, with the following 3 main objectives:



1. To boost the multidisciplinary collaboration, particularly between the justice and the health systems – it was important to identify a common goal, a common field of practice, engaging the different institutions/services/professionals.
2. To boost the involvement of community institutions, in order to develop tools and resources to facilitate the alternative care intervention.
3. To base our model on the already existing structures and available resources – it is important to mention that the tasks/roles assigned to the Tutor are time consuming and there are insufficient human resources to implement some proposed strategies (for example, regular meetings with several professionals to discuss cases, to share common obstacles, and to propose new solutions).

Intending to fill some gaps on the articulation between some entities/professionals whose work concerns youth offenders placed in alternative care as a consequence of penal measures, we have designed a broad proposal of a multiagency model which aims to enhance the capacity of professionals, thus allowing them to address some of the previously identified difficulties and to suitable respond to the complex needs of youths with psychiatric/personality disorders. In order to better understand our proposal it is important to briefly describe which entities are involved when a minor commits a crime between 12 and 16 years old, the roles and responsibilities inherent to each one and how they are organized to meet the several demands of the situation.

Thus, after youths' illicit acts are signaling, the Public Prosecutor's Office assumes the investigative role and conducts the interrogations. It may request information from the auxiliary body of the judiciary administration concerning the enforcement of juvenile justice measures – DGRSP.

The DGRSP is the entity responsible for providing a young person's social report and when there is the option for the imposition of a custodial measure in an Educational Center in the open or semi-open regime this report must include a psychological assessment, and in the case of a closed regime psychological assessment in a forensic context is mandatory. DGRSP is responsible for managing the implementation of public policies of crime prevention and the social

reintegration of young and adult offenders, as well as managing the prison services. The DGRSP staff, in local teams or in custodial institutions, is responsible for assisting the youth courts and the public prosecution services concerning the juvenile proceedings. Also provides technical and specialized counselling to the youth courts, psychosocial support to young people and adults involved in lawsuits, in conjunction with the competent public entities and individuals, and promotes the connection between justice administration and community agencies.

Regarding the judge – Family and Youth Court – who enforces the internment measure to be executed in a juvenile detention facility Juvenile justice intervention is the responsibility of the specialized. The young person could also be assisted by an expert in psychiatry or in psychology whenever required for the purpose of assessing the need to apply any educational measure. A juvenile offender who faces a custodial measure and has mental health problems will receive psychiatric and/or psychological treatment during detention. The placement of a young person in specialized centers or units and their enrolment in such therapeutic programs depends on the court's approval.

Already in the Educational Center, each youth has a social reinsertion technician of reference (Tutor) who manages the entire educational and therapeutic process during the internment period, accompanying each case individually and establishing contacts with professionals of other services (e.g., health system, justice system). Therefore we consider that the Tutor is the key person – case manager in our proposed model – throughout the internment period who is in a privileged position to manage the information from different sources (judges, DGRSP's technicians, health professionals, youths' families, and Tutor's evaluation) and to give feedback on the evolution of youths' trajectories. Precisely because the Tutor holds relevant information about young people, within the new multiagency model, the case manager should have a broader and central role regarding the coordination of the actions/decisions taken by the different professionals/entities. Moreover, the Tutor is in a privileged position to promote a better articulation between judges and health professionals as an intermediary, and to facilitate the communication channels between these two systems.

Why do we consider that the Tutor is the key actor for case management and the central element within the new model of a multi-agency approach?

1. Manages the entire educational and therapeutic process during the execution of internment measure;
2. Contributes to behavioral modelling;


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3. Proximity in the relationship between the Tutor and the youngster has a positive value and works as a driving force for change, contributing to the success of the intervention;
4. Therapeutic alliance constitutes a positive and secure attachment with the therapeutic staff (build a strong and consistent relationship);
5. Holds a privileged knowledge about young people, in particular their adherence to the measure and their institutional evolution;
6. Assumes a privileged position/central role in the coordination of the actions/decisions taken by the different professionals/entities;
7. Can improve the coordination between judicial and health systems, providing important information about youths' performance;
8. Can increase magistrates' sensibility/capacity to implement therapeutic measures, contributing for more informed judicial decisions;
9. Facilitates youths' learning process through relational dimension – Tutor advises youths throughout the compliance of the measure, evaluates their behavior and gives feedback on their performance;
10. Can promote a smooth transition from the institutional setting to youths' natural environment through regular contacts with the educational tutelary team on the outside, during the final stage of the measure – after the internment period the responsibility of both the Educational Center and the judicial system is extinguished.

In sum, the implementation of a new multiagency model would avoid a hierarchical communication between entities/professionals and youths' follow-up by the Tutor after the internment period could contribute to consolidate and boost the intervention conducted and to facilitate youths' reintegration in their natural environment. Furthermore, it would be important to organize informal and regular meetings with professionals involved in each process, in order to discuss individual cases (e.g., Tutor, public prosecutor/judge/psychiatrist/psychologist/social worker/professor, other significant professionals), to create specific training opportunities for professionals within the justice system on the therapeutic and intervention needs of young people with psychological/psychiatric problems, as well as to raise awareness among professionals of the justice system about the important role that the Tutor can assume within the intervention process.

In a short-term future we need more opportunities to test our proposed model for a multi-agency/multi-actor intervention.

### 3.2. Transnational Level



Project activities were well supported by the Transnational Advisory Board meetings. The international meetings throughout the project have represented, above all, opportunities for learning and reflection, sharing of knowledge, experiences and good practices and for discussion of perceived common difficulties and solutions to overcome obstacles, enriching the involvement of the key actors in the project activities and objectives.

The fact that these meetings brought together participants with diverse professional activities and countries with different legal frameworks contributed to enrich the moments of discussion on how to respond more adequately to the needs of young offenders in alternative care. So, the institutional coverage was guaranteed for the project activities through the involvement of professionals from distinct types of institutions and who play different roles, namely researchers, actors from the justice system, staff from the Capacity Building context, mental health professionals who conduct the psychiatric intervention process.

TAB meetings have also contributed to share strategies to amplify the dissemination of good practices in national contexts and to sensitize professionals for the importance of a real multiagency approach.


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**FACT**

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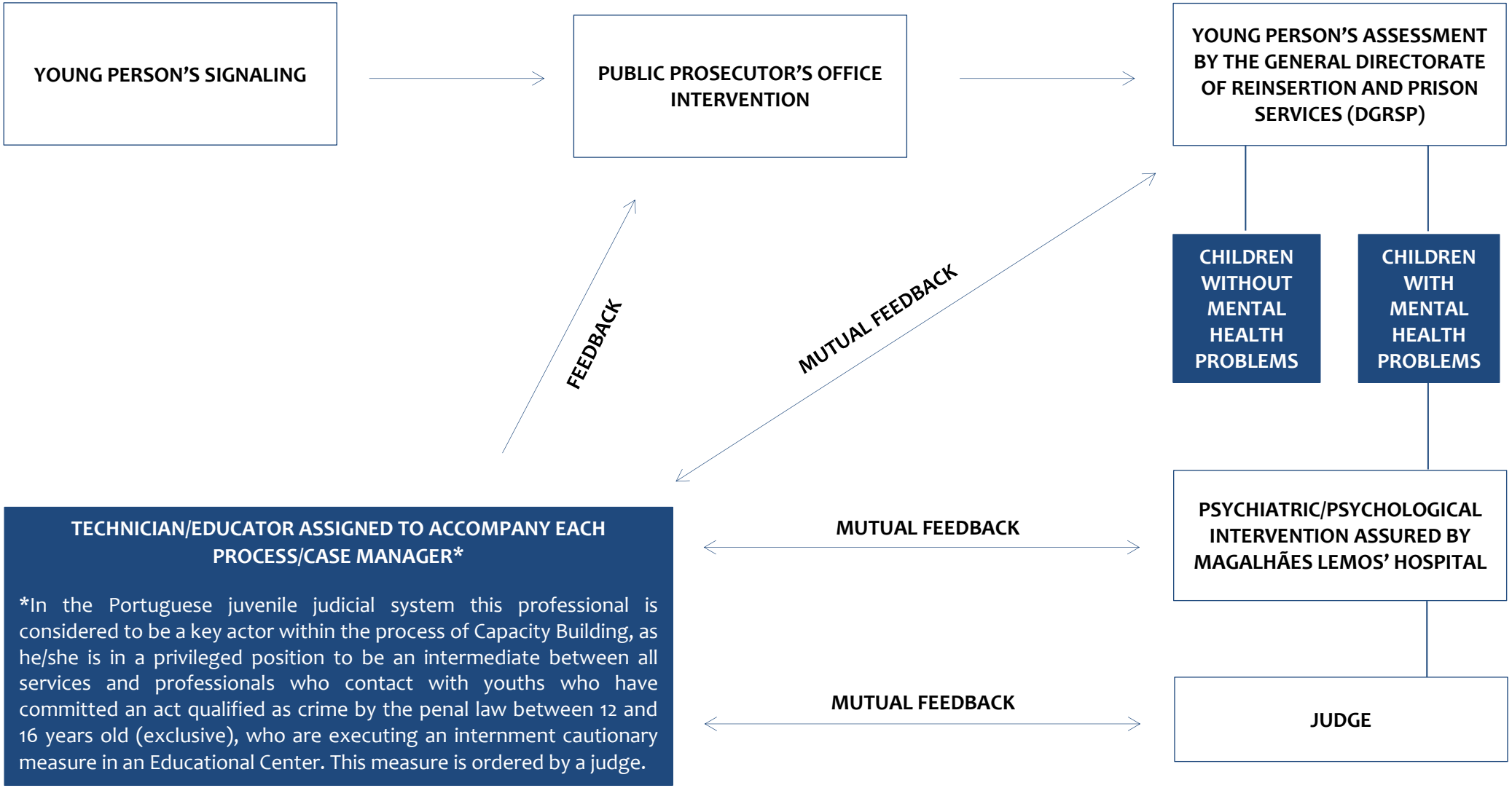
## GENERAL MODEL FOR CAPACITY BUILDING/MULTI-AGENCY APPROACH

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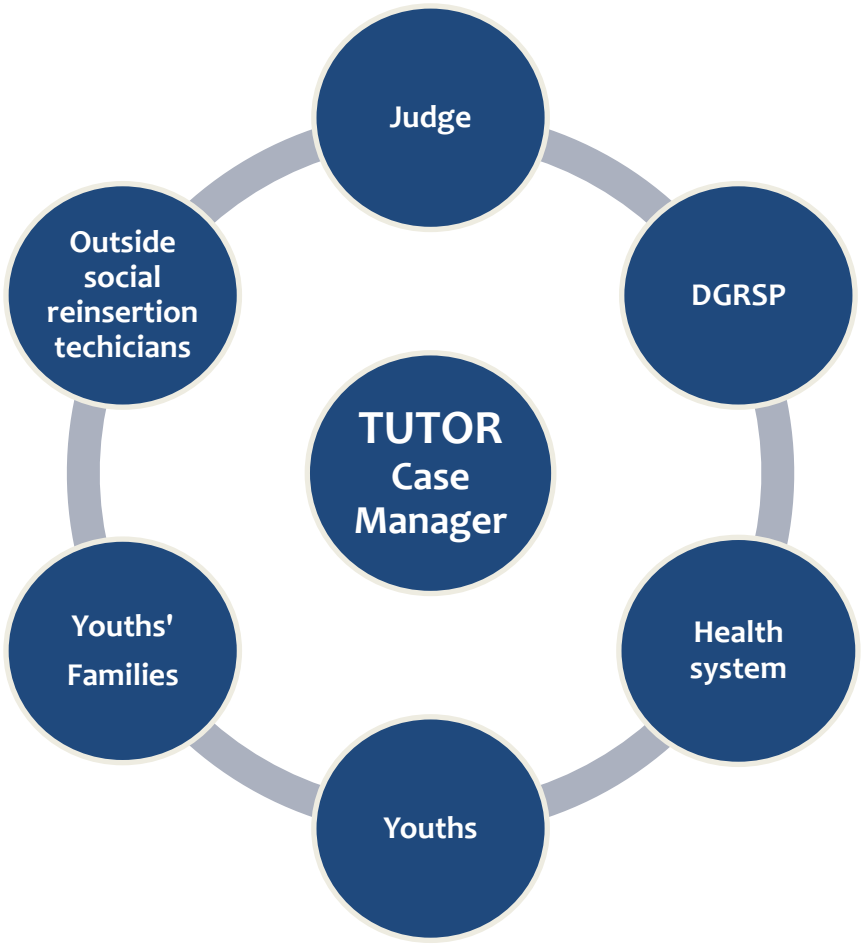


**MULTIDISCIPLINARY APPROACH SINCE THE BEGINNING OF THE INTERNMENT MEASURE AND DURING A SPECIFIC PERIOD AFTER ITS EXECUTION**

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## 4. Results

As stated before, the population targeted by the project FACT presents a set of characteristics and specific complexities, which are particularly difficult to address and to treat in a juvenile justice custodial or semi-custodial setting. Moreover, Portugal has scarce resources regarding a multi-disciplinary and a multi-agency approach, focused on prevention, evaluation, treatment (including emergency treatment) and recovery, with only 3 pedopsychiatry departments available – Lisboa, Porto and Coimbra – not specifically targeted for minors executing custodial measures, which provide internment and medication, each one with capacity to accommodate 10 youths (a new unit is being created in Lisboa, in order to accommodate more 16 children)[2].

In Portugal, the setting of the interventions is a problem – minors' therapeutic and socio-educational cares are assigned to different institutions and services, so the performance of professionals of both health and justice systems seems to be fragmented, which poses serious difficulties to an effective multi-disciplinary/multi-agency approach. Furthermore, professionals do not have time to meet regularly with each other to share cases and to cooperatively find solutions; systems lack specialized knowledge and skills to manage the more severe cases; the placement in the Educational Center is delayed, and consequently the rehabilitation process, being more difficult for professionals to intervene, and increasing the probability of these youths to go to the penal system later in life; and, in our perspective, the aftercare period also presents some shortcomings regarding youths' return to their natural life context[3].

From contacts with professionals from different fields, we can identify a set of both current concerns/lack of good practices, as well as positive measures that are already being implemented or that should be enhanced, regarding intervention with young offenders. These negative and positive aspects represent obstacles and strengths for a multi-actor and a multi-agency approach.

As main concerns we can list the poor cooperation between health and judicial systems, the lack of intervention with families (despite their involvement during the execution of the internment measure), negative perspective of the child protection system intervention, and the insufficient staff. On the other hand, our context for capacity building has priority access to psychiatric appointments, inpatient treatment in acute cases, an effective cooperation between

[2] In Portugal, the national network of mental health care for children and adolescents consists of 3 psychiatry and mental health departments in public Hospitals, 9 local services of mental health, 20 units of community mental health and 9 structures for mental health consultation (Direção-Geral da Saúde, 2017).
[3] According to the *Youth Justice Act* (article 158.º-A), by judicial decision, the execution of internment measures can comprise a period of intensive supervision to be executed in youths' natural environment, and monitored by a team of social reinsertion services. However, this supervision period is not mandatory.


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the Educational Center and the hospital's pedopsychiatry department – informal and fluent communication, and staff is strongly motivated to work with young offenders, although they assume that some of them are "chronic patients" and/or "in the end of the line".



Globally, professionals agree about what seems to work when we intervene with this population, namely individual intense psychotherapy, a therapeutic alliance (secure attachment with the therapeutic staff, building a strong and consistent relationship), medication for behavior control, a psychoeducative approach focused on academic and social skills, to improve the coordination between judicial and health systems, to improve the coordination between child protection system and juvenile justice system, to increase magistrates' sensibility/capacity to implement therapeutic measures, to facilitate professionals' communication (for example, through a fluent networking), to improve the relationship between institutions and families, and to improve after care treatment.

Furthermore, it is important to point out some aspects regarding the intervention process with young offenders, particularly those who suffer from psychological and/or psychiatric problems, which are the following:

- ☒ The need of a deeper knowledge about youths under the scope of the juvenile justice system;
- ☒ Intervention protocols, roles and responsibilities among the competent agencies and professionals are rarely well defined and this may cause uncertainty – juvenile justice professionals are faced with dilemmas for which there is no clear course of action;
- ☒ The complexity of the diagnosis of a mental health problem is also challenging (the difficulty to know what caused the problem, the presence of comorbid diagnosis, the lack of data/knowledge regarding the criteria applied to perform the diagnosis, the difficulty to do a diagnosis during adolescence period);
- ☒ The absence of specific structures to intervene with youths with mental health conditions (the inadequacy of the therapeutic response may lead to chronical psychiatric disorders);
- ☒ "Multi" is a key word – if these youths have developmental and life trajectories that are multiproblematic (e.g., abusive families, substance abuse, low education level, early school leaving, psychological/psychiatric problems) they need a multidisciplinary intervention addressing several areas;


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- ☒ An internment measure can also be a privileged opportunity to change the life trajectory of these young people, that is why it is so important the quality and precocity of the psychotherapeutic intervention – disturbances tend to increase with age;
- ☒ The difficulty to involve different professionals from different areas in the discussion about the project topics;
- ☒ The difficulty to establish clear boundaries between the roles of various services/professionals (these youths are a judicial problem, a social problem, a psychiatric problem?);
- ☒ The current fragile economic situation makes it difficult to implement professionals' specialized training, as well as better conditions for children and youths placed in alternative care;
- ☒ The need of specialized, integrative and standardized guidelines for granting adequate mental health assistance to youths aged 12-16 who are executing a custodial measure in Educational Centers;
- ☒ Institutions rely on the local health services for providing psychiatric services and psychological support, but sometimes the effectiveness of this cooperation is scarce.

Based on the analysis of the data collected (national documents and information provided by several professionals), we have noticed an effort of the national entities to promote good practices in various services and areas related to the intervention conducted with young offenders. However, some gaps remain at the level of network intervention/articulation between professionals – an actual multidisciplinary approach.

We consider that the appropriate intervention model is one involving a multiagency approach which implies several entities, with different and specific roles, working together with and for these youths, addressing their needs and implementing an individually based intervention – a single intervention composed by different professionals. Moreover, a case manager can contribute to a shared case understanding, to integrate the different perspectives, to review intervention process and to adapt intervention, has a privileged knowledge about youths' trajectories inside the institution, and it is in a better position to communicate with all professionals involved in the judicial process.

Although it was not the focus of our model for a new multidisciplinary approach, it is important to mention two key points for future analysis. On the one hand, the need to promote a deeper involvement of youths' families during the intervention process conducted in institutional environment, expecting that youths return to their natural environment and achieve a greater

success of the educational project developed in the institutional setting. This concern was already outlined in the last report of the Commission for Monitoring and Supervision of Educational Centers (2015), concluding that it lacks the model, the technical resources and an effective articulation with the Social Security system. The work with families requires an involvement and co-responsibility right from the beginning of the measure, often involving changing families' behaviours and attitudes. On the other hand, the Commission has suggested a mandatory period for intensive supervision, not only depending on judge's decision.



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## 5. Prospects for the future



When we designed our alternative model for a multi-agency/multi-actor approach we expected to achieve a more articulated and fluent communication between all key actors throughout the intervention process with these youths, particularly between the justice and health systems. In a short-term future we hope to make these professionals more aware of the advantages of the cooperation among them, in responding to the real needs of the population targeted by the project. Settling realistic expectations regarding the impact of the outcomes, we are expecting to influence political choices, firstly, at a municipality level and, then, at a national level. Furthermore, as mentioned above, the development of a different model (out of the Justice setting but in straight cooperation) is foreseen, namely through the creation of structures grounded on the community. From the data collected it was also possible to identify other foreseen measures that seem to reach alternative care approaches, including the development of supervised autonomy units for young people over the age of 16, reinforcement of prevention in fostercare institutions, and development of mental health promotion programs in schools and communities.

Concerning the national reality with respect to mental health services provided to minors executing juvenile justice measures, and taking into account all the aforementioned aspects, there are a set of future challenges to overcome:

- ☒ The critical need to improve mental health services for children and youth involved with justice;
- ☒ To promote a constructive debate between different professionals about the role of the placement (punishment/sanction/care/education);
- ☒ After the project ends, we intend to maintain regular contacts with the elements of the National Advisory Board, as well as to organize other focus groups, in order to maintain the networking, share knowledge/experiences, contribute to overcome common difficulties/obstacles and generate new synergies;
- ☒ It should be implemented regular supervision of the work developed by all professionals involved in these cases and also regular training – for example, to include practitioners of different fields in the same training sessions, in order to clarify legal and mental health issues, and to promote a common language, contributing to an effective fluent networking and facilitating the movement out of each professionals' 'comfort zone';

- ☒ It should be developed a more intensive and systematic family work, aiming to support these youths' parents, youths must be able to feel that they belong to their families for whose they will return in many cases;
- ☒ It would be important to implement measures that are already covered in some documents and legal instruments.



As final remarks, we want to highlight the urgent need "(…) *to design psychotherapeutic interventions that tack the mental health intervention needs of young offenders. The development and delivery of intervention programs should be thoroughly assessed, so research can inform the ongoing clinical practice and vice versa. Finally, it appears important to establish a link with community-based mental health services at the end of the intervention by the juvenile justice services. All of these implications are relevant (…) for the improvement of current practices of the national health and justice systems*" (Rijo et al., 2016, p.11).


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