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PC/DC: Police Contact with Distressed Children

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Adolescents & Mental Illness

The proportion of youth aged 13-18 has increased in the 2016 census by 8% (2016)[1]. Whilst most are healthy, there is a significant minority, at least 10% who suffer from a mental illness, which now represents the leading cause of disability worldwide in this age group. Both self-report and semi-structured data in youth (and adults) suggest rising rates of ill health in Ireland[1,2,3]. The early onset of most adult mental illness, 50% by age 15 and 75% by age 18, leaves us in no doubt about the importance of prioritising adolescent mental health (MH) well-being and ignoring it at our peril. The reality, however, is that most illnesses are unrecognised and untreated. Despite the evidence that MH disorders emerging prior to adulthood are more costly to treat by a magnitude of ten, and have greater adverse impact on personal, family and occupation functioning, than those that emerge later in life, early intervention remains aspirational rather than the reality for most[4].

Adolescence, a time of tremendous opportunity for most, is also a time of risk and adversity for a vulnerable group[4]. Significant neuro-biological and socio-behavioural developments are prominent. Developmental plasticity is characterised by neuronal pruning, and altered synaptic connections are shaped by, and influence, behaviour. The limbic system, governed by emotions and novelty seeking, and with a heightened response to rewards and threats develops earlier than the cortical region, and so careful planning, logical thinking and self-regulation lags behind, leaving youth prone to poor judgements and risk-taking behaviour. Self-identity is formed around this stage and is influenced by the interactions with peers, family and other social systems. Positive and supportive reciprocal engagements with adults in authority help shape youth's responsible and prosocial behaviour. Negative or absent engagement may direct the youth down a road of escalating anti-social behaviour, marginalisation and contact with the youth justice system.

Adolescence and An Garda Síochána

Two common adolescent issues are presented as examples of a complex interplay between adolescent mental ill-health and engagement with An Garda Síochána and the youth justice system: ADHD and the use of alcohol.

The complex association between ADHD and criminally related behaviour is becoming increasingly recognised. Although evidence-based effective treatment exists, this is reliant on the young person being referred to and accessing MH services. Long waiting lists, lack of recognition, and negative attitudes to mental illness in gate keepers remain barriers for many and remain prevalent in Irish society[5]. Delays in treatment bring a risk of comorbid illness, such as

conduct disorder, substance misuse and offending behaviour, most especially in boys with ADHD, and compounded by family adversity and lower socioeconomic status.

Adolescence frequently marks the commencement of alcohol consumption for a significant number of our youth. Whilst we can take some solace from recent HSBC reports of the reduction in alcohol use and drunkenness in 11 to 15-year-olds, from 12% in 2010 to 5% in 2014, the fact that 5% of 15-year-old boys drink weekly is no reason for complacency[2]. The picture is even more concerning in older adolescents with regular monthly use of alcohol and cannabis[2]. Harmful drinking reduces self-control and increases risky behaviours, and is the main offence which brings youth into contact with the Garda Síochána, accounting for almost a fifth of youth crimes[6].

An Garda Síochána are called upon to manage and provide assistance across a wide range of situations and scenarios concerning MH, and their involvement as **'first responders'** has increased substantially over the past few decades. In the UK, the College of Policing estimate that approximately 15–20% of police time is spent on incidents linked to MH[7]. Although similar data in Ireland is lacking, police are often involved in escorting individuals to psychiatric facilities, as an applicant under Section 9 of the MH Act, intervening in potentially volatile situations in primary health care or residential settings, and/or assisting families/carers during a crisis. Some of these encounters may be associated with mental illness in the young person. Given the legal obligation of the Gardaí to respond to calls for assistance 24 hours a day - 365 days a year they are often the only service available to the public in times of crisis. Given the lack of out of hours CAMHS and emergency social service, the Gardaí, often without any prior MH knowledge or training, are faced with the difficulty of knowing how best to manage the situation with respect to the young person[8]. At times this has meant that youth with significant mental illness have been placed in 'holding cells' overnight while awaiting access to appropriate MH assessment. For some, it has meant entering the youth justice system without the necessary MH screening. A survey conducted in St Patrick's Institution which provided care for youth aged 16-21 found that 23% screened at reception had an at-risk mental state, and similar rates are found in youth (15-17) attending Oberstown Children Detention Campus[9]. Specifically, rates of ADHD amongst prisoners are very high, ranging from 9% in Irish studies to 25% internationally [10]. Given the population base rate of 6%, this is far in excess and suggest either under detection, or inherent risk in ADHD of impulsive risk-taking, including substance misuse, offending behaviour and recidivism. Indeed, this phenomenon, of over-representation of mentally ill within the justice system, is so profound that policy makers and practitioners have labelled this trend the 'criminalisation of the mentally-ill' [11].

Current Position & Future Directions

Irish policy landscape surrounding mental ill health, youth justice, policing strategy and child protection has flourished in recent years with the introduction of landmark directives such as the Diversion Program for Young Offenders'[12] the Joint Working Protocol for An Garda Síochána/Tusla[13]. The Public Health (Alcohol) Act passed in October 2018 may also be an important deterrent in youth alcohol consumption[14]. However, there is a scarcity of evidence-based research investigating how such policies are put into practice. This dearth of scholarship has inadvertently led to a lack of understanding regarding the complex relationship between An Garda Síochána and matters of MH, particularly in the area of youth justice. Even less is known about adolescent pathways to crisis MH care once first responders (the Gardaí) are called upon to intervene and assist, or the impact faced by the police of being placed in a vicarious position and lacking support.

Investing in youth also requires investing in care givers and care providers. The impact on the Gardaí acting as first responders in managing challenging behaviour, volatile and dangerous situations without adequate training and support cannot be underestimated. It can contribute to work-related stress, burnout and reinforce negative interactions. The recently released Operational Review of Oberstown Detention Campus[15] highlights the difficulties faced by staff and youth residents, with injuries, sick leave, resignations and sacking. It was of note that of 49% of staff did not have up-to-date training in behaviour management and psychological support was not available, both of which have been addressed in their recommendations.

There is an urgent need for Gardaí to be given the necessary training to help them recognise and effectively manage interactions with youth with possible mental illness. They also need personal support in terms of the impact of dealing

with stressful cases, often in the absence of readily available appropriate services. Services responsible for the management of mental illness need to be accessible 24/ 7, and need to have a good working relationship with the Gardaí. However, even equipped with adequate knowledge of mental illnesses, and the presence of accessible services, ongoing negative attitudes to mental illness and treatment will continue to limit diversion to appropriate MH services. Such stigmatising attitudes to mental illness, long-standing and worldwide, will need to be prioritised if any change is to happen. Although evidence base for effective police training is lacking, the recent prioritisation of this area by the Police Authority, the reversal of the decision by the Minister for Children to withhold publication of the Oberstown report and calls for action from 'contributory experts' in this field of forensic psychiatry attest to the urgency and opportunity in this complex area[9,15]. Just as adolescence may be seen as a critical window of opportunity for youth, now might present the window of opportunity for the government to solidly commit to supporting youth MH and wellbeing, and reverse their downward grading in previous Children Alliance reports. With new openness and resolve, supported by the evidence, our youth might finally be allowed to reach their potential.

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