

Youth Forensic Services Development

Guidance for the health and disability sector on the development of specialist forensic mental health, alcohol and other drug, and intellectual disability services for young people involved in New Zealand's justice system

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The Guideline in Brief

Youth forensic services are specialist mental health and alcohol and other drug (AOD) services for young people with mental health disorders, AOD problems and/or intellectual disabilities (under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCC&R Act)) who have offended or are alleged to have offended and are involved in New Zealand's justice system.

This document provides guidance on improving the range, quality and national consistency of the youth forensic services that are available. It is intended for those who have responsibility for planning, funding and providing youth forensic services including District Health Boards (DHBs), non-governmental organisations and the Ministry of Health.

This document is designed to:

- encourage and disseminate good practice
- assist, over time, with the achievement of greater consistency in the quality of services and the way they are delivered across the country
- provide guidance on cost-effective models of care to assist DHBs to make best use of existing funding.

The document is aligned with the new Mental Health Nationwide Service Framework, which includes service specifications and reporting requirements, and guidelines for the administration of the IDCC&R Act. It is intended that it will be used to inform future purchasing of services.

Release of this document does not signify that there will be additional funding for implementation. However, it is anticipated that, where the guidance is implemented, enhanced models of care will enable services to respond to people's needs in cost-effective ways, potentially leading to efficiency gains and, in some cases, the capacity to provide increased volumes of services within existing funding pathways.

Why develop youth forensic services?

Studies have shown that 40 to 60 percent of youth who have offended have mental health and/or AOD disorders, a proportion that is significantly higher than that in the overall population of young people. Conduct disorder, emotional disorders, attention disorders and substance abuse are the most common types of problems amongst youth who have offended. Co-existing mental health and AOD problems are more prevalent amongst youth who have offended than in the overall population of young people. Young Māori are over-represented amongst young people with mental health and/or AOD problems, and amongst youth who have offended.

The need for this work was identified in *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006) and was prioritised by the joint DHB and Ministry of Health Te Kōkiri Work Group. The health sector has a statutory obligation to provide secure inpatient care and treatment for the most vulnerable young people with intellectual disabilities and/or who are most severely affected by mental

illness and addiction and who are involved with the justice system. There are currently no such inpatient services in New Zealand. Many DHBs and other stakeholders involved in the development of this document have identified youth forensic services as an area in which they are currently doing some development work.

Although youth forensic services are currently provided in each of the regions, they are underdeveloped when compared with forensic services for adults and the child and adolescent mental health service (CAMHS) sector. In addition, there are critical gaps in service provision.

The guideline sets out underpinning principles and a framework for service provision, including workforce requirements.

A comprehensive youth forensic service should provide:

- triage and screening
- court liaison services
- specialist assessment services
- specialist interventions to treat mental health and AOD problems
- habilitation and rehabilitation services for eligible youth with an intellectual disability
- access to secure inpatient beds
- consultation and liaison with other health, mental health and AOD services
- transition support as appropriate to a CAMHS, a youth or adult AOD service, an adult mental health service, an adult forensic mental health service, or Disability Support Services
- mobile in-reach¹ services to Child, Youth and Family (CYF) youth justice residences and youth units in prisons
- community re-integration planning.

The guideline proposes that strong consideration should be given to developing youth forensic services as entirely or predominantly kaupapa Māori services, particularly in areas where young Māori comprise a majority of youth appearing before the courts.

The guideline contributes to the Government's strategic priority to address criminal offending through such initiatives as Drivers of Crime and Fresh Start. The key directions in this document are supported by the Minister of Health.

¹ 'In-reach' refers to clinical interventions (assessment, risk assessment, treatment, consultation liaison, discharge planning etc) provided by community-based mental health and AOD services in the justice setting in which youth are detained (or to support those working with them).

1 Introduction

Purpose of the guideline

Youth forensic services are specialist mental health and alcohol and other drug (AOD) services for young people with mental health disorders, AOD problems and/or intellectual disabilities (under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCC&R Act)) who have offended or are alleged to have offended and are involved in New Zealand's justice system. Youth forensic services will cover eligible children and youth from the age of 10 years through to their 18th birthday, or beyond until their 20th birthday if developmentally appropriate.

Youth forensic services in this country have developed from local initiatives without a national system or model to guide them. In some regions services are well developed but in others they are underdeveloped compared with forensic services for adults and the child and adolescent mental health service (CAMHS) sector. New Zealand has no secure inpatient beds for youth with an intellectual disability or mental health or AOD problems who have offended.

The purpose of this document is to provide guidance to improve the range, quality and national consistency of the youth forensic services that are available. The guideline sets out a framework for service provision, describes the required components of a well-developed service, and offers advice on workforce requirements.

The document contributes to the Government's strategic priority to address criminal offending through such initiatives as Drivers of Crime and Fresh Start. Drivers of Crime focuses on addressing the underlying drivers of criminal offending within the New Zealand context.² Fresh Start is aimed at the young people who are New Zealand's most persistent young offenders.³ Implementation of this guideline will contribute to a reduction in re-offending by youth who have received mental health and/or AOD services.

Use of the guideline will also deliver the following benefits:

- greater opportunities for early identification and intervention for youth who have offended who are affected by mental health and/or AOD problems
- greater opportunities for improved health outcomes for youth who have offended including opportunities to reverse progression toward long-term experience of serious mental health, AOD and developmental disorders
- increased awareness of the mental health and AOD problems that may lead to offending
- greater opportunities for promoting mental health amongst at-risk young people

² More information on Drivers of Crime can be found at:
<http://www.justice.govt.nz/policy-and-consultation/drivers-of-crime>

³ More information on Fresh Start can be found at:
<http://www.beehive.govt.nz/release/fresh+start+young+offenders>

- improved assessments of young people with intellectual disabilities or mental health and/or AOD problems who have offended, or are alleged to have offended
- improved matching of appropriate interventions to each young person's specific needs
- greater clarity for District Health Boards (DHBs) on what to fund for youth forensic services
- a more holistic and integrated approach to service provision
- access to culturally appropriate services.

Some regions already have well-developed services. It is recognised that each region will progress toward greater national consistency of services from a different starting point.

The document has been informed by evidence-based literature and consultation with key stakeholders involved in the delivery of youth forensic services.⁴

Key points to consider

Five key points need to be considered when planning the delivery of services to respond to the complex needs of young people with mental health and/or AOD problems.

First, most young people who experience mental health and/or AOD problems do not offend. Among those who do, the 'problems' are not necessarily the cause of their behaviour. In addition, the majority of the young people who do offend are unlikely to have been affected by clinically significant mental health and/or AOD problems at the time they committed the offence.

Second, young people with mental health and/or AOD problems who offend almost always come from deprived and disadvantaged backgrounds, characterised by a fragmented family structure, experience of abuse and neglect including long-term involvement with Child, Youth and Family (CYF), multiple 'unsuccessful' foster placements and exposure to adult mental illness and substance abuse, severe adult anti-social behaviour, offending and other harmful situations (such as early access to alcohol and other drugs). Such circumstances are proven psycho-social precursors of mental health, AOD and/or developmental problems in young people (Werry Centre 2009).

Third, in many cases the harm caused by the circumstances outlined above can be fully or partially reversed with appropriate interventions – of which only some fall within the range of responsibilities of Disability Support Services, mental health and AOD services. That is, a trajectory from those experiences toward severe mental health, AOD and/or developmental problems is not inevitable, but averting it does require a range of collaborative interventions by different service providers.

⁴ See Appendix 1 for information about the background to the development of this document.

Fourth, young Māori are over-represented amongst young people:

- with mental health and/or AOD problems
- who have or are alleged to have offended.

The over-representation of Māori in this vulnerable population has major implications. Most significantly, it suggests that strong consideration should be given to developing youth forensic services as entirely or predominantly kaupapa Māori services, particularly in areas where young Māori can be expected to comprise more than three-quarters of those who appear before the Youth Court. The implications of the over-representation of Māori amongst the population of youth who offend are discussed further in setting out the components of youth forensic service delivery in Section 3.

Fifth, careful consideration must be given to the potentially stigmatising effect of being involved with a 'forensic mental health and AOD service', especially for young people.⁵ Although the term 'youth forensic services' is used throughout this document to distinguish youth forensic services from adult forensic services, the Ministry of Health recommends that, as each youth forensic service develops, attention is given to developing a brand or identity that avoids using the phrase 'forensic mental health'.

⁵ This issue was identified many times by key stakeholders during the development of this document.

2 Overview of Youth Forensic Services in New Zealand

This section provides a brief description of:

- the prevalence of mental health and AOD disorders in young people who have offended
- the legislative context
- the youth offending demographic
- the role of youth forensic services
- current functions and organisation of youth forensic services
- identified gaps and issues in service provision.

Prevalence of mental health and/or alcohol and other drug problems in youth who have offended

Although there have been only a limited number of rigorous studies of the prevalence of mental health and AOD problems amongst youth who have offended in New Zealand, international studies have repeatedly reported prevalence rates of mental health and/or AOD disorders of between 40 and 60 percent. A review of the studies (Werry Centre 2009) shows that:

- the prevalence of mental health and/or AOD problems is significantly higher amongst youth who have offended than in the overall population of young people
- conduct disorder, emotional disorders, attention disorders and substance abuse are the most common types of problems amongst youth who have offended
- co-existing mental health and AOD problems are significantly more prevalent amongst youth who have offended than in the overall population of young people
- there are important gender differences in the nature and types of mental health problems experienced by young people who have offended – males are more likely to have externalising disorders, such as conduct disorders, while females are more likely to have internalising disorders, such as depression and anxiety
- young Māori are over-represented amongst young people with mental health and/or AOD problems, and amongst youth who have offended.

Self-harm and suicide risk

Clearly established risk factors for self-harm and suicide include placement in care and protection facilities, exposure to violence, and experience of mental disorder (Beautrais 1998; New Zealand Guidelines Group 1999). Young people who have offended are, therefore, more likely to self-harm and/or attempt suicide than the general population of young people. Evidence also suggests that young females who have offended, particularly those who are of Māori or Pacific ethnicity and those who are detained, can be expected to have higher rates of suicidal ideation than their male counterparts (Werry Centre 2009).

Behavioural and conduct disorders

Conduct disorders are characterised by such behaviours as hostility to others, aggression and rule infractions, defiance of adult authority and violations of social and cultural norms (Ministry of Social Development 2009).

Fonagy et al (2000) found a strong correlation between children with childhood onset conduct disorder and offending. Conduct disorder and other mental health problems also frequently co-occur with offending. Fonagy et al identified that there is a high rate of co-morbidity between conduct disorder and attention deficit hyperactivity disorder (ADHD).

The co-occurrence of conduct disorder and substance abuse is generally reported as common among youth who have offended (Werry Centre 2009).

Alcohol and other drug disorders

AOD disorders are particularly prevalent amongst youth who have offended. They have been consistently found to be much higher amongst detained young people (Skowrya and Cocozza 2007).

Alcohol and other drug and co-existing disorders

There is a high prevalence of co-existing mental health and AOD disorders amongst youth who have offended. A study of nine New South Wales youth detention centres found that 73 percent of the sample had more than one disorder, with the most frequent being conduct disorder and substance abuse (NSW Department of Juvenile Justice 2003).

Intellectual disability

Most young people with an intellectual disability⁶ do not offend. Many of the youth with an intellectual disability who do offend will also have co-existing mental health and AOD problems.

Psycho-social factors may also have a role in the development of an intellectual disability, and in some cases developmental damage can be repaired.

⁶ The IDCC&R Act defines an intellectual disability as a permanent impairment that:

- results in significant sub-average general intelligence as measured by standard psychometric tests generally used by clinicians (indicated by the results of an intelligence quotient being 70 or less (with a confidence level of no less than 95 percent))
- results in significant deficits, as measured by tests generally used by clinicians, in at least two of the following skills: communication, self-care, home living, social skills, use of community services, self direction, health and safety, reading, writing and arithmetic, leisure and work
- becomes apparent before the person turns 18 years.

The small number of youth with an intellectual disability who do offend may be eligible for disability support services, including intervention under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Youth forensic services will work with disability support services, particularly the Regional Intellectual Disability Care agencies, to ensure co-ordination of service provision.

The Ministry of Health's Disability Support Services funds services for people with disabilities, including forensic services for people with disabilities who have offended. The Ministry also funds the Behaviour Support Service for People with Intellectual Disability Presenting Behaviours that Challenge, a national service that is contracted to non-governmental organisations on a regional basis. Approximately 330 people with an intellectual disability receive high-intensity behavioural and residential supports through programmes funded under the Act.

Other health needs

In addition to being more likely to have mental health and/or AOD problems, youth who have offended generally have high needs in other domains of health. In an unpublished 2005 study of residents of the Youth Justice North residence in South Auckland, 70 percent of the residents were reported to have sexual health problems, 16 percent had untreated physical health problems (such as asthma, skin infections, chronic headaches and abdominal pain) and 10 percent had orthopaedic needs (primarily resulting from untreated injuries). Almost the entire cohort had significant oral health care needs and non-existent or incomplete immunisation histories (Newman and O'Brien, unpublished).

More details on prevalence studies are provided in Appendix 2.

Legislative context

The Children, Young Persons, and Their Families Act 1989 (the CYPF Act) is the legal basis for New Zealand's separate justice system for children aged 10 to 13 years and young people aged 14 to 16 years. The Act defines the structure and decision-making processes of the youth justice system.^{7 8}

⁷ An overview of the CYPF Act (About Youth Justice – Overview of Principles and Process) can be found at: <http://www2.justice.govt.nz/youth/about-youth/overview.asp>

⁸ The Children, Young Persons, and Their Families (Youth Court Jurisdiction and Orders) Amendment Act 2010 came into effect on 1 October 2010. Amendments included: extending the length of some Youth Court Orders; giving the Youth Court the power to issue new orders including parenting, mentoring, and drug and alcohol rehabilitation programmes; and extending the jurisdiction of the Youth Court to include 12- and 13-year-olds charged with committing certain serious offences (other than murder and manslaughter).

The other pieces of legislation most relevant to provision of youth forensic services are:

- the Criminal Procedure (Mentally Impaired Persons) Act 2003⁹
- the Mental Health (Compulsory Assessment and Treatment) Act 1992¹⁰
- the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.¹¹

The youth offending demographic

The youth offending demographic comprises three separate age groups:

- children aged 10 to under 13 years are covered by the care and protection provisions of the CYPF Act and, if required, are dealt with in the Family Court; there is a dual pathway for children aged 12 and 13 who are charged with certain serious offences where proceedings may be commenced in the Family Court as a care and protection matter or by criminal proceedings in the Youth Court
- young people aged 14 to 16 years are covered by the youth justice provisions of the CYPF Act and, if charged, are usually dealt with in the Youth Court
- young people aged 17 to under 20 years are covered by the adult criminal justice system.

Children can be held criminally responsible from the age of 10 years for either murder or manslaughter and, if so charged, will be dealt with in the High Court. When children (aged 10 to 13 years) are sentenced to imprisonment by adult courts, they must be transferred to a youth justice residence and detained there until they turn 14, or their sentence is completed (whichever occurs earlier).

Children aged 12 and 13 years may be brought before the Youth Court if they are alleged to have committed an offence(s) (other than murder or manslaughter) for which the maximum penalty available is or includes imprisonment for life or at least 14 years or if they are a previous offender and are alleged to have committed an offence for which the maximum sentence is or includes imprisonment for at least 10 years but less than 14 years. A child is deemed to be a previous offender if they have been the subject of a section 67 declaration in the Family Court, have been convicted in the District or High Court or have had a charge proved against them in the Youth Court.

⁹ An overview of the Criminal Procedure (Mentally Impaired Persons) Act 2003 can be found at: <http://www.justice.govt.nz/publications/publications-archived/2003/guide-to-the-criminal-procedure-mentally-impaired-persons-act-2003/publication>

¹⁰ A guide to the Mental Health (Compulsory Assessment and Treatment) Act 1992 can be found at: [http://www.moh.govt.nz/moh.nsf/pagesmh/2443/\\$File/Chapter2MentalHealthLaw.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/2443/$File/Chapter2MentalHealthLaw.pdf); more detailed guidelines can be found at: [http://www.moh.govt.nz/moh.nsf/pagesmh/4584/\\$File/GuidelinesCAT92.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/4584/$File/GuidelinesCAT92.pdf)

¹¹ A guide to the IDCC&R Act can be found at: [http://www.moh.govt.nz/moh.nsf/0/47B3BFB016FE6B86CC256F08000EC36F/\\$File/idccrguidelines-intellectualdisability.pdf](http://www.moh.govt.nz/moh.nsf/0/47B3BFB016FE6B86CC256F08000EC36F/$File/idccrguidelines-intellectualdisability.pdf)

When children aged 12 or 13 years are brought before the Youth Court they are considered to be 'young persons' for the purposes of the Court. These children are entitled to all the resources available to other young offenders including having a youth advocate appointed by the court and being eligible for section 333 or section 38 assessment¹² and forensic service intervention. If a Youth Court decides that the matter would be more appropriately dealt with under the care and protection provisions of the CYPF Act, it may direct the Police to reconsider the matter or direct that a family group conference (FGC) be held to consider whether the matter should remain in the Youth Court.

Youth aged 14 to 16 years who commit serious offences may be referred to the District or High Court, may be tried and/or sentenced by the adult criminal justice system, and can receive prison sentences.

Jurisdiction is determined by the young person's age at the time of the alleged commission of the offence. Thus youth who commit an offence at the age of 16 years remain the responsibility of the youth justice system (and hence youth forensic services) after their 17th birthday, in relation to the processing of that offence.

Figure 1 below summarises how many youth are at different levels of the justice system, relative to the total of those aged 10 to 16 years in the overall population. Details on Youth Court locations, sitting days and frequency of sittings are provided in Appendix 6. Data on numbers prosecuted are provided in Appendix 7.

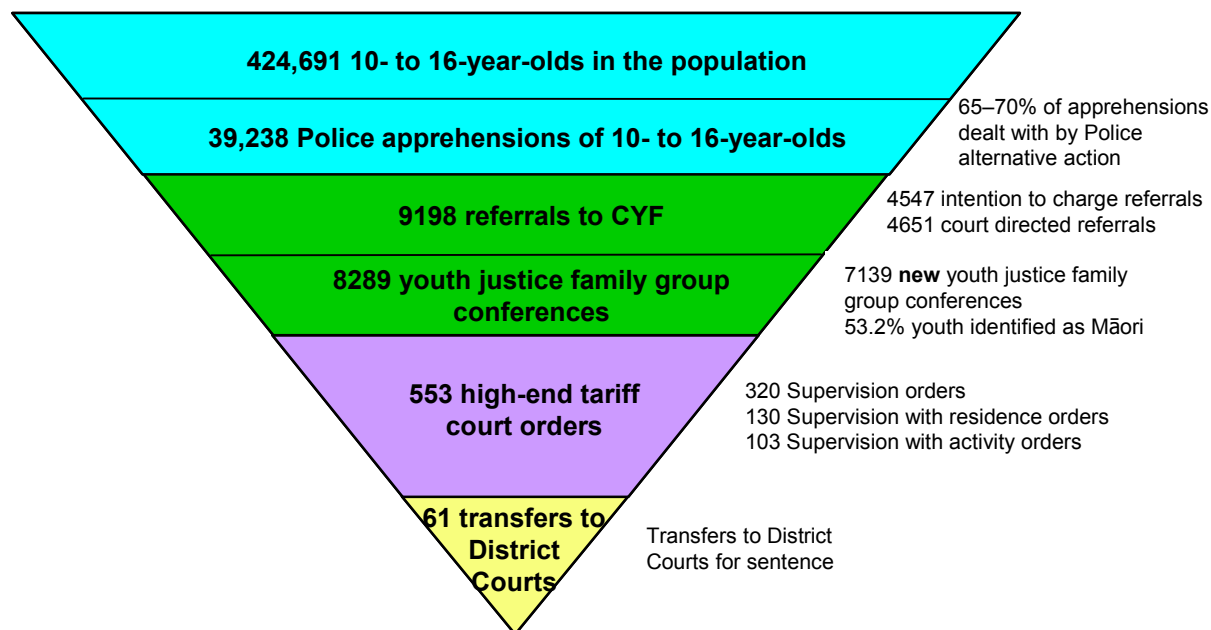
¹² Section 333 of the Children, Young Persons, and Their Families Act 1989 provides that a judge can order medical, psychiatric or psychological reports to assist the court in determining:

- (a) whether the young person is unfit to stand trial within the meaning of [section 4](#) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; or
- (b) if the young person is insane within the meaning of [section 23](#) of the Crimes Act 1961; or
- (c) the type and duration of any order that it is empowered to make.

Section 38 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 provides that a judge can order a health assessor to prepare reports to assist the court in determining one or more of the following:

- (a) whether the person is unfit to stand trial
- (b) whether the person is insane within the meaning of [section 23](#) of the Crimes Act 1961
- (c) the type and length of sentence that might be imposed on the person
- (d) the nature of a requirement that the court may impose on the person as part of, or as a condition of, a sentence or order.

Figure 1: Number of youth in different levels of the youth justice system, 2009/10



Source: Child, Youth and Family

Notes:

- 1 The figure for police apprehensions refers to the number of apprehensions rather than the number of individuals. The majority of apprehensions resulted in warnings, cautions and Police alternative actions, such as referral to a Youth Aid programme.
- 2 For more information on New Zealand's youth justice system, see <http://www.courts.govt.nz/youth-justice/system.html>, or <http://www.cyf.govt.nz/youthjustice.htm>.

Role of youth forensic services

The core responsibilities, access criteria and age range of youth forensic services are described in the Mental Health Nationwide Service Framework.¹³ They include:

- triage and assessment of youth who have offended who **may** be severely affected by mental health and/or AOD disorders – in a developmentally and culturally appropriate way
- treatment of youth who have offended who **are** severely affected by mental health and/or AOD disorders – in a developmentally and culturally appropriate way.

Comprehensive youth forensic services include:

- court liaison services
- specialist assessment and treatment services
- habilitation and rehabilitation services for eligible youth with an intellectual disability
- consultation and liaison with other health, mental health, IDCC&R and AOD services and with other agencies

¹³ Information on the Framework can be found at <http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/150>

- mobile in-reach¹⁴ services to CYF youth justice residences and youth units in prisons
- access to secure inpatient beds, if required
- community re-integration planning and facilitation of the transition as appropriate to a CAMHS, a youth or adult AOD service, an adult mental health service, or an adult forensic mental health service.

While specialist in nature, youth forensic services provide a gateway to all other health services for the young people they serve.

Functions and organisation of existing youth forensic services

Forensic mental health services for adults are organised regionally with six service providers operating in: Northern (based in Auckland), Midland (Hamilton), Central (Wellington), Canterbury (Christchurch) and Otago/Southland (Dunedin). Although youth forensic services are currently provided in each of these regions, they are underdeveloped when compared with services for adults and the CAMHS sector. The future development of youth forensic services should continue to follow a regional model. Table 1 shows the availability and key features of existing youth forensic services in New Zealand. A description of existing youth forensic services by region is included in Appendix 3.

¹⁴ 'In-reach' refers to clinical interventions (assessment, risk assessment, treatment, consultation liaison, discharge planning etc) provided by community-based mental health and AOD services in the justice setting in which youth are detained (or to support those working with them).

Table 1: Summary of youth forensic services at 31 March 2010

District Health Board	Regional services	Main provider	Location of regional service	Integrated mental health and AOD approach	C/L to CYF youth justice residence	C/L to prison youth wing	Screening and s 333 reports to Youth Court	Role with FGCs
Northern Region Waitemata Auckland Counties Manukau Northland	Yes	Auckland DHB	Kari Centre, Greenlane Clinical Centre, Auckland	Yes ¹	Yes	No	Yes	Yes
Midland Region Waikato	No	Waikato DHB CAMHS	Hamilton	Partial	No	No	No	No
Bay of Plenty Lakes Taranaki	Yes	Hauora Waikato (Iwi/ NGO provider)	Hamilton Rotorua	Partial	No ²	Yes ³	Yes	Yes
Central Region Capital & Coast Hutt Valley Wairarapa MidCentral Whanganui Hawke's Bay Tairāwhiti	Yes	Te Korowai Whariki	Porirua Hawke's Bay Palmerston North Gisborne	Yes	Yes	Yes	Yes	Yes
Southern Region (1) Canterbury Nelson Marlborough West Coast South Canterbury	No	Canterbury DHB	Christchurch	Yes	Yes	In development; currently led by adult forensic service	Yes	Partial coverage
Southern Region (2) Otago Southland	No	Southern DHB	Dunedin	Yes	No	No	Yes	Yes

Key: AOD = alcohol and other drug; C/L = consultation/liaison; CYF = Child, Youth and Family; FGCs = family group conferences; DHB = District Health Board, CAMHS = child and adolescent mental health service; NGO = non-governmental organisation

Note:

- 1 But only when AOD problems co-exist with mental health problems – not when AOD problems are the only presenting problems.
- 2 In-reach service will commence in youth justice facility in Rotorua in early 2011.
- 3 Weekly in-reach service to Waikeria Prison youth unit, governed by service-level agreement with Corrections Health Service.

Child, Youth and Family residences

There are four youth justice residences operated by Child, Youth and Family. Responsibility for provision of specialist mental health and AOD services in these residences sits with youth forensic services.

Responding to the mental health and/or AOD problems of young people in CYF care and protection residences is the responsibility of CAMHS and youth AOD services, with consultation and liaison support from youth forensic services when needed. Appendix 4 provides a summary of existing CYF residences and admission numbers.

Youth units in prisons¹⁵

Youth units are located in three prison sites: Hawke's Bay, Waikeria and Christchurch. Males under the age of 18, and males aged 18 and 19 years who are deemed vulnerable (using the Prison Youth Vulnerability Scale), are placed in the youth units (remands and those sentenced to a prison term).¹⁶

Identified gaps and issues for youth forensic services

Key stakeholders met in 2007 to discuss how to develop an integrated and comprehensive framework of forensic mental health services for youth who have offended. The meeting emphasised:

- significant gaps within services and lack of a nationally consistent model of care
- the need for workforce development
- the need for greater responsiveness to Māori
- the need for stronger relationships and greater collaboration at the interfaces of youth justice services, forensic services, CAMHS, adult mental health services, other health services, CYF and other social service agencies
- the need for a comprehensive continuum of care spanning court liaison services through to secure inpatient facilities.

¹⁵ See Appendix 5 for a table setting out the name, location and bed capacity of each of the three youth units.

¹⁶ Information on youth units can be found at: <http://www.corrections.govt.nz/about-us/fact-sheets/managing-offenders/youth-unit.html>

Key issues

- Court liaison services. Youth Court judges and current providers identified court liaison services as a key component of current services that needs to be improved, and as a viable place to start the process of improving services for youth.
- AOD disorders. There is anecdotal evidence that existing services do not adequately prioritise the needs of youth with AOD disorders who have offended. It may be that services assume that the needs of this group will be adequately met by CAMHS rather than through involving or providing specialist youth AOD services. Addiction services and mental health services operate separately even though there is a high rate of co-existing AOD and mental health disorders. Youth forensic services need to have the competence to treat mental health and AOD problems in young people while they are in custody.
- Lack of secure youth forensic beds. The health sector has a statutory obligation to provide secure inpatient care and treatment for the most vulnerable young people with intellectual disabilities and/or who are most severely affected by mental illness and addiction and who are involved with the justice system. There are currently no such inpatient services in New Zealand. While each of the youth justice residences identified above is 'secure' in regard to physical containment, none includes a facility to provide 'secure inpatient care'. Such a facility would be specifically designed for the treatment of young people with severe mental health and/or AOD problems, and would have highly skilled clinicians on site 24 hours a day. Regional services have identified the need for a small number of secure youth forensic beds as inpatient and step-down community beds.
- Difference in age ranges between services. Mental health services, AOD services and the justice system differ in the age range they use to define their service provision. Such differences have implications for co-ordination of services across agencies.
- Lack of access to section 333 reports. CAMHS and other health services involved in a young person's ongoing care planning and provision often cannot access section 333 reports previously completed for the court, with the result that critical information is unavailable to inform treatment or the young person is reassessed unnecessarily. Youth forensic services have a role in seeking court approval for access to these reports for ongoing health services.

3 Guideline for Youth Forensic Services

This section defines and describes the essential components of a nationally integrated system of responsive and effective youth forensic services.

Guiding framework

Ten core principles, four cornerstones and six critical intervention points provide a framework for the development of youth forensic services.¹⁷

Principles

1. Access to services to address mental health and/or AOD problems is based on need and ability to benefit.
2. Young people do not have to offend or enter the youth justice system to access mental health and/or AOD services.
3. Young people with mental health and/or AOD disorders are able to access evidence-based treatment in the least restrictive environment that their circumstances allow, balancing individual rights against any matters of public safety.
4. Services are culturally appropriate and responsive to each young person's needs (including appropriateness in regard to culture, age, gender, family and whānau circumstances and sexual identity).
5. Services actively involve whānau and significant others in assessment, care and transition planning, whenever appropriate.
6. Services are person-centred and whānau-focused, meet the developmental needs of young people in a manner that is holistic and integrated, and are delivered in a non-judgemental way.
7. Services work to minimise stigma and discrimination.
8. Multiple systems and stakeholders share responsibility for young people who offend; responding in a collaborative manner.
9. Information collected as part of screening and assessment processes is not used in a way that might jeopardise the interests of the young person.
10. Youth forensic services will be routinely evaluated to assess their effectiveness in meeting desired goals and outcomes.

¹⁷ This framework has been adapted from Skowrya and Coccozza's (2007) model and applied to the New Zealand context. The original model was developed for the identification and treatment of young people with mental health needs in contact with the juvenile justice system in the United States.

Cornerstones

Four main issues or cornerstones identify the critical areas for improving the system:

1. collaboration – across the youth justice and mental health and AOD sectors
2. identification – the mental health needs of young people should be systematically identified at all critical stages of youth justice processing
3. diversion – whenever possible, young people with identified mental health and/or AOD needs should be diverted into effective community-based treatment, balancing individual needs against matters of public safety
4. treatment – young people with mental health and/or AOD needs in the youth justice system should have access to effective treatment to meet their needs.

Critical intervention points

The critical intervention points for youth who have offended are:

- apprehension – if arrested and held in a cell (Police or social worker, mental health crisis assessment clinician)
- decision pathway – at the time a decision is made for the young person to appear before the Youth Court or be diverted to another youth justice or care and protection process such as an FGC (Police or social worker, health and education assessor)
- court appearance – at the time a young person appears before a Youth Court and the judge adjudicates on the matter, including consideration of disposition options (court liaison clinician or care co-ordinator appointed under the IDCC&R Act)
- custody – at the time a young person enters a youth justice or care and protection residence or other custodial facility (health provider in facility)
- transition to community – at the time a young person transitions out of a youth justice or care and protection service or other custodial facility and/or transitions out of the youth forensic service (CAMHS or youth forensic clinician and CYF social worker).

Service delivery components

Functions

A comprehensive youth forensic service will provide:

- triage and screening
- referral to other health, mental health, IDCC&R and AOD services
- specialist forensic mental health and AOD assessment
- court liaison services
- specialist interventions to treat mental health and AOD problems including considering the young person's criminogenic needs
- consultation and liaison with other health, mental health and AOD services and other agencies
- mobile in-reach services to CYF youth justice residences and youth units in prisons

- access to secure inpatient beds, if required
- community re-integration planning and facilitation of the transition as appropriate to a CAMHS, a youth or adult AOD service, an adult mental health service or an adult forensic mental health service.

Capability and skills

Youth forensic services should have the following capabilities and skills:

- the capability to accurately screen for, diagnose and implement appropriate interventions (including the capability to complete section 333 and section 38 assessments)
- a comprehensive knowledge of the legislative framework under which the youth justice sector operates, as well as of other relevant legislation
- integrated mental health and AOD assessment and treatment skills
- a multidisciplinary team comprised of appropriately skilled clinical and non-clinical professionals – particularly for providing services in a developmentally and culturally appropriate manner
- close linkages and strong collaborative relationships with CYF, Youth Courts, CAMHS, youth AOD services, paediatrics, primary care, disability support services, general adult mental health services, adult AOD services and adult forensic services
- a comprehensive knowledge of and collaborative relationships with the other agencies and organisations that are involved in meeting the high and complex needs of young people with mental health and/or AOD problems who offend
- support and advice to other agencies and services involved in the youth justice sector (including family group conferences¹⁸ and youth offending teams).¹⁹

Screening and assessment

The terms ‘screening’ and ‘assessment’ are referred to in the literature as separate events in the youth forensic context.

Generally, the term ‘screening’ refers to the screen:

- being applied to every young person at entry into the youth justice system
- focusing on identification of conditions/issues that require an immediate response such as suicide risk and AOD issues, and on the need for more specific information relating to the young person’s mental health.

¹⁸ An FGC is a formal meeting for the young offender, their youth advocate, members of the family group/whānau/hapū/iwi, the enforcement officer and any victims to decide how the young offender can be supported to address their offending and be encouraged to take responsibility for their behaviour. For an overview of family group conferences, see: <http://www.cyf.govt.nz/1254.htm> or <http://www.justice.govt.nz/courts/youth/about-the-youth-court/family-group-conference>.

¹⁹ For more information on youth offending teams, see: <http://www.justice.govt.nz/policy/crime-prevention/youth-justice/youth-offending-teams/>

'Assessment' is defined as being performed selectively with some young people, generally as a result of the outcome of a screen, and is a more thorough review of the young person's mental health. The purpose of assessment is to:

- inform treatment decisions and develop a treatment plan
- perform risk management (including risk of potential behaviour problems) and develop a treatment plan
- assist in community referrals for care (Werry Centre 2009).

The choice of screening or assessment instruments is a clinical decision and is not discussed in this guideline. However, screening or assessment should acknowledge the developmental context and be sensitive and responsive to the culture of the young person who is being assessed. Consideration should be given to the young person's social and family context.

Youth who have offended are more likely to self-harm and/or attempt suicide than the general population of young people, with young females and those who are detained being even more at risk. Therefore, screening and risk assessment need to consider, and be able to detect, current and historical suicidal ideation and self-harm intent.

Ideally, every young person who has offended will undergo screening for mental health and/or AOD problems at the following points during their transition through the youth justice system:

- at the point of apprehension
- during generalist health checks prior to an FGC (if this occurs)
- when the young person comes before the court (if this occurs)
- at the time the young person is admitted to any custodial care (if this occurs)
- at regular intervals when a young person is detained.

A screen at any of these points may identify a need for more detailed assessment and treatment. Youth forensic services will work with eligible children and young people identified at any of these transition points.

Monitoring changes in a young person's needs is a routine part of intervention. There may be changes in the type and nature of the problems that a young person is experiencing, such as in times of stress at the prospect of an FGC, court appearance or placement in a CYF residence and, although supporting a young person through these processes is a CYF responsibility, youth forensic services need to monitor their impact on mental status. In addition, each stage of the youth justice process involves a degree of coercion, which may also affect a young person's mental health.

Screening – at all stages – must be able to detect unmet physical health needs as well as mental health and AOD problems. When screening identifies other health needs, youth forensic services will refer young people to the appropriate services. In the first instance, most physical health needs will be addressed by primary care providers. For young people in CYF residences, services will ideally be provided within the residence as part of collaborative arrangements to provide health services in residences being funded and provided by DHBs.²⁰

As part of their consultation and liaison role, youth forensic services will provide advice and training for professionals from other agencies on the selection and use of screening instruments relevant to the mental health and AOD needs of children and youth who have offended.

The court may order an assessment under section 333 of the Children, Young Persons, and Their Families Act 1989 or under section 38 of the Criminal Procedure (Mentally Impaired Persons) Act 2003. Court-ordered assessments are not funded by Health. The courts fund and may contract with youth forensic services to provide these assessments on a fee-for-service basis. Remuneration received by youth forensic services for services to the courts must be applied exclusively to service provision for this purpose to avoid double dipping.

A multidisciplinary team with multi-skilled clinical and non-clinical professionals – including integration of AOD skills

Evidence on best practice for addressing the mental health and AOD needs of young people who offend consistently shows that the best outcomes are achieved through an integrated, multidisciplinary and multi-skilled approach.

Relative to their non-offending peers, youth who offend are more likely to experience multiple co-existing mental health and AOD problems. Thus a youth forensic service should include both mental health and AOD specialists who are able to assess and treat co-existing disorders. Moreover, while some staff may specialise in a particular area, all staff should have an appropriate level of knowledge of assessing and treating co-existing mental health and AOD problems. Youth forensic services will also provide specialist AOD interventions for youth who present solely with AOD problems.

²⁰ DHBs in collaboration with CYF made a commitment to providing health services for young people (aged 10–16 years) residing in CYF care and protection and youth justice residences from July 2009, according to a nationally agreed service description. Health services comprise personal, mental and population health interventions. Health service provision takes into account youth development, resilience and protective strategies. Key agencies work together to create sustainable health outcomes for these young people while they are in the residence, and to establish a transition plan for ongoing engagement with health services when they leave the residence. Funding has been top-sliced from all DHBs in the 2009/10 Funding Package so that the DHBs that have CYF facilities in their districts can fund and provide the agreed range of services.

Case management model

In addition to having a multidisciplinary team, evidence indicates adopting a 'case management' approach to intervention planning and ongoing treatment is a valuable component of service delivery.

Central to a case management approach is that someone within the multidisciplinary team has a designated responsibility for the care of each service user. In youth forensic services, this role will include responsibility for facilitating access to services that are needed by a young person but are not directly provided by the youth forensic service itself.

Inclusion of family and whānau

Inclusion of family and whānau is a fundamental principle when addressing mental health and/or AOD problems, as part of both planning and treatment. Understanding a person's family history and wider social context is important. However, the history and current context of family circumstances can present multiple, complex challenges. A young person may be estranged from their family. They may have been a victim of abuse, or may have experienced and replicated other behaviours that have been prevalent within the family and whānau. Even in such circumstances youth usually attempt to reconnect with family. It is therefore important that the youth forensic service supports youth to make good decisions and facilitate appropriate family engagement strategies.

Youth forensic services, working closely with Child, Youth and Family (as lead agency with responsibility for the safety and wellbeing of the child or young person), should attempt to (re-)establish an appropriate adult support network for a young person. Ideally, this network should comprise adults within the young person's immediate and/or wider family. When this arrangement is not appropriate, an alternative network of responsible and supportive adults should be sought.

When youth who are receiving mental health and/or AOD services are in custody away from their family and whānau, Child, Youth and Family and youth forensic services (often in conjunction with CAMHS) have a responsibility to ensure that there is ongoing contact with the family and whānau and that, when appropriate, the family and whānau are involved in decisions concerning their young family and whānau member. Section 12 of the IDCC&R Act outlines the principles governing decisions affecting children and young people with intellectual disabilities and their family and whānau.

Inpatient/residential facilities will provide room(s) to accommodate family and whānau. They will also provide access to technologies such as email, teleconferencing and videoconferencing for communication with family and whānau and clinicians involved in transition planning.

If a youth's intervention plan includes a return to family and whānau, the youth forensic service should work with the CAMHS in that location to engage the family and whānau using evidence-based interventions (eg, Functional Family Therapy) to help family and whānau members to change their own behaviour so the young person can return to a supportive environment.²¹

Cultural responsiveness

Māori

In New Zealand, cultural responsiveness is particularly important in youth forensic services as Māori are over-represented among youth who have offended and are affected by mental health and/or AOD problems.

The over-representation of Māori in this vulnerable population suggests that consideration should be given to developing youth forensic services as entirely kaupapa Māori services, especially in areas where young Māori can be expected to be more than three-quarters of those who appear before the Youth Court. Kaupapa Māori services are based on Māori philosophy and spirituality. They take a holistic approach to treatment and recovery, focusing on the total lifespan. Hauora Waikato provides an example of such a service. District Health Boards considering a kaupapa Māori approach to youth forensic service provision should use the Tier 2 Service Descriptions in the Mental Health Nationwide Service Framework for both kaupapa Māori and child and adolescent mental health services.

All regional services should be committed to delivering services through Māori worldview paradigms that integrate the best of forensic psychiatric care and rehabilitation.

Services need to have competency in responding to the specific cultural needs of young Māori and engaging with their whānau. In the short term, an appropriate level of responsiveness would include having cultural advisors within the service, and the ability to access kaumātua and kaupapa Māori CAMHS services. However, over time youth forensic services will need to become more responsive to Māori by recruiting and retaining Māori clinicians.

Other cultures

A significant proportion of young people who have offended identify with Pacific cultures. Over time, youth forensic services will also need to develop their ability to appropriately respond to the needs of Pacific youth.

Being responsive to other cultures within New Zealand's increasingly diverse society also needs to be considered as youth forensic services develop.

²¹ Functional Family Therapy (FFT) is an empirically grounded, well-documented and highly successful family intervention for at-risk and juvenile justice involved youth. For more information, see: <http://www.fftinc.com/>.

Interventions

Youth forensic services will collaborate with other mental health and addiction services to provide an integrated continuum of services. The interventions undertaken by the services will include but not be limited to:

- development of comprehensive treatment and care plans, which help address the young person's criminogenic needs
- development of comprehensive risk management plans that promote and protect the safety of service users, staff and the community, recognising that some service users may present a risk of suicide, self-harm or danger to others
- provision of medication and other treatment in accordance with a documented comprehensive recovery plan with identified goals
- provision of evidence-based psychotherapeutic interventions.

To address re-offending behaviour Functional Family Therapy, as mentioned above, is an intervention that youth forensic services can undertake. The services should refer as appropriate to other providers that specialise in delivering intensive, evidence-based interventions such as Multidimensional Treatment Foster Care or Functional Family Therapy.

Collaboration

The provision of effective youth forensic services is dependent on those involved in service delivery maintaining collaborative relationships with other services and organisations, especially with Child, Youth and Family and the Youth Courts.

Age range and service responsibility

Youth forensic services will cover eligible children and youth from the age of 10 years through to their 18th birthday, or beyond until their 20th birthday if developmentally appropriate. While youth forensic services are getting established, the main priority is provision of services for children and youth under 17 years old in the youth justice system because adult forensic services currently meet the needs of 17- to 19-year-olds in the criminal justice system. As youth forensic services become established, they will work with adult forensic services to plan and put in place a transition towards taking responsibility for youth up until their 18th birthday (and beyond to their 20th birthday if developmentally appropriate) in accordance with the Mental Health Nationwide Service Framework.

Currently, where youth forensic services are not available adult forensic services provide services to young people under 17 years of age. However, a transition to specialist youth forensic service provision is required because adult forensic services may not have clinicians specifically trained in the developmental needs of young people. Further, adult forensic services may not have the youth service networks that are required to work in a systemic way to achieve positive outcomes for young people, and their model of care may not always include working therapeutically with family and whānau or caregivers.

Differences in age ranges used to define service provision in health and the justice system have implications for co-ordination across agencies that need to be considered in youth forensic service development plans.

The United Nations Convention on the Rights of a Child defines a child as anyone up to the age of 18 years. However the CYPF Act and the youth justice system define a child as someone aged 10 to 13 years and a youth as someone aged 14 to 16 years (up to their 17th birthday). CAHMS and youth AOD services cater for children and young people from 0 to 19 years of age (up to their 20th birthday). Adult mental health and AOD services cater for people from 18 years of age (except for adult forensic services, which cater for people from 17 years of age). The two-year overlap provides flexibility to access the service most appropriate to an individual’s developmental needs.

Table 2 shows the respective responsibilities of the principal agencies involved.

Table 2: Responsibilities for responding to the mental health and AOD needs of young people who offend

	10–13 years	14–16 years	17–19 years
Court liaison services	YFS ^{1, 2}	YFS	AFS and YFS ³
Court assessment services eg, s 38 or s 333 assessments	YFS	YFS	AFS and YFS
Specialist forensic assessment	YFS	YFS	AFS and YFS
In-reach to CYF residences and adult prison youth wings	CAMHS ⁴	YFS	AFS and YFS ⁵
Community re-integration planning ^{6, 7}	CAMHS	YFS	AFS and YFS
Community treatment	CAMHS and/or youth AOD	CAMHS and/or youth AOD	CAMHS and/or youth AOD or adult mental health service
Inpatient	CAMHS or paediatric unit	YFS (secure unit)	AFS or YFS secure unit
Consultation and liaison	CAMHS, youth AOD or YFS	YFS	AFS or YFS

Key: YFS = youth forensic services; AFS = adult forensic services; CAMHS = child and adolescent mental health services

Note:

- 1 Court liaison services will not be routinely provided in the Family Court except by prior arrangement.
- 2 When young people aged 10 to 16 years appear in the District or High Court, court liaison services will be provided by AFS, but AFS will refer to YFS when necessary.
- 3 When young people aged 17 to 19 years appear in the District or High Court, court liaison services will be provided by AFS, but AFS will refer to YFS when necessary.
- 4 Children aged 10 to 13 years who are placed in residential care will reside in a CYF care and protection residence (except when they have been charged with murder, manslaughter or certain other serious offences and been sentenced in the Youth Court, District Court or High Court). CAMHS have responsibility for responding to the mental health and/or AOD problems of young people in CYF care and protection residences.
- 5 AFS and YFS need to have agreed mechanisms and protocols that define how they will work together to respond to the needs of young people who are detained in youth wings of adult prisons.
- 6 The forensic service is responsible for planning and arranging transition to CAMHS or adult mental health service, and engaging with other services and agencies as needed.
- 7 Forensic services may provide treatment in the community instead of, or prior to, arranging transition to CAMHS, when this approach is clinically indicated – eg, when the community treatment phase is likely to be short or when specialist forensic expertise is required to meet clinical needs. YFS will provide consultation and liaison support to CAMHS, including specialist forensic (re)assessments after transfer of clinical responsibility.

Collaboration with adult forensic services

Youth forensic services can provide advice to adult forensic services on: developmentally appropriate interventions; other agencies (eg, education and vocational services); and the wider 'youth health network' to support the ongoing recovery of a young person.

Adult forensic services are more developed than youth forensic services. Adult forensic services have knowledge and expertise (eg, medico-legal expertise) that youth forensic services need to access as youth forensic services develop.

Adult forensic services and youth forensic services need to have agreed mechanisms and protocols (eg, memoranda of understanding) to ensure mutual support and to define how they will work together to respond to the needs of 17- to 19-year-olds in a timely and seamless manner.

Court liaison services²²

A youth forensic court liaison clinician will be available at each Youth Court sitting and will be competent at providing brief mental health and AOD screening, assessment and advice for the court and the CYF court officer.²³ Court liaison clinicians will also:

- refer young people to health services when required
- provide mental health and AOD advice and support young people to help them access required health services
- facilitate the completion of relevant formal court reports (predominantly section 333 reports (CYPF Act) and section 38 reports Criminal Procedure (Mentally Impaired Persons) Act 2003 when required).

A memorandum of understanding regarding court liaison services should be established between the DHB youth forensic service and the court. Ministry of Justice courts staff can assist with this process.

In-reach to CYF residences

Children aged from 10 to 13 years who offend can be placed in care and protection residences. Those aged 12 and 13 who are charged with certain serious offences and youth aged 14 to 16 who offend can be placed in youth justice residences. Responding to the mental health and/or AOD needs of eligible children in care and protection residences is the responsibility of CAMHS, with consultation and liaison support from youth forensic services when needed. Youth forensic services are responsible for providing in-reach services to youth justice residences.

²² Appendix 6 provides information on Youth Court locations, sitting days and court liaison provision.

²³ It is important that health advice and referral information is provided to the CYF court officer to facilitate the availability of appropriate information for the FGC and for interagency care planning and co-ordination purposes.

A higher prevalence of mental health and/or AOD problems is consistently reported amongst youth who are detained compared with their peers who are not detained.

CYF residences provide youth with a structured and secure environment in which their needs can be addressed. In-reach services must ensure that a child or young person who resides in a CYF residence has access to a range of developmentally appropriate mental health and AOD services that are similar to those available to a young person with similar needs who is not in that facility. Such services include access to after-hours crisis cover. Wherever practicable, services need to be provided within the residence.

The youth forensic in-reach team will be part of the inter-agency multidisciplinary team (with CYF residence staff and site social workers, the education provider and other health professionals) that undertakes assessment, intervention and transition planning and oversees day-to-day monitoring and management. The youth forensic in-reach team will co-ordinate multidisciplinary treatment plans for young people returning to the residence after discharge from a mental health or youth forensic inpatient admission.

Youth forensic services will also contribute to the development and maintenance of appropriate skills and knowledge amongst the workforce involved in caring for young people with mental health and AOD problems in CYF residences.

Sharing of information will be in accordance with the provisions of the Health Information Privacy Code. Existing protocols between CYF and local DHBs define mechanisms for collaboration in CYF residences.

Appendix 4 provides a table of the CYF care and protection and youth justice residences in New Zealand and admission numbers for each one.

In-reach to youth units in adult prisons

In-reach to youth units in adult prisons is functionally similar to in-reach to CYF residences but will need to be provided in collaboration with adult forensic in-reach teams.

Appendix 5 provides a table setting out the name, location and bed capacity of each of the three youth units.

Access to services provided by CAMHS and youth AOD services

Only a small proportion of the young people who come into contact with the youth justice system and are severely affected by mental health and/or AOD problems will be detained in an inpatient facility or CYF residence. For the majority, their needs will be addressed in the community through the provision of a range of evidence-based interventions by CAMHS.²⁴

²⁴ New Zealand has a relatively well-developed system of child and adolescent mental health services that provide a range of specialist, developmentally appropriate interventions for young people.

Youth forensic services will undertake specialist forensic assessments (when needed) and will work closely to support CAMHS when they are working with youth residing in the community who have offended. Seamless referral to CAMHS will also be important for facilitating the successful community re-integration of youth who have been detained.

Consultation and liaison support is particularly critical for CAMHS in the regions when they are working with family and whānau or caregivers to whom the young person will return at the re-integration stage. When the family and whānau live in a different centre from their child or young person, the youth forensic service will need to provide consultation and liaison support to the local CAMHS so they can engage therapeutically with the family and whānau. Each CAMHS should consider establishing a designated role for maintaining a collaborative relationship with its 'hub' regional youth forensic service (ie, a 'youth forensic liaison' responsibility).

The future development of youth forensic services will require collegial and collaborative relationships between regional youth forensic services and the CAMHS sector (which may include a need to share or second some senior CAMHS personnel to facilitate the development of youth forensic services).

Collaboration with youth alcohol and other drug services

Youth forensic services have a core responsibility to assess and treat youth who have offended and are affected by AOD disorders. This responsibility is not limited to only those who are affected by **co-existing** mental health and AOD disorders.

Identifying and addressing AOD problems in young people requires specialist skills. Successfully engaging with young people affected by AOD problems is dependent on operating within the context of youth culture(s) and being responsive to the developmental needs of young people.

AOD services for young people in New Zealand are, in general, underdeveloped compared with their CAMHS counterparts, as are the relationships between CAMHS and the youth AOD services that do exist. Nonetheless, in order to provide appropriate interventions to address AOD problems, youth forensic services need to work with existing AOD services to:

- identify AOD problems and ensure youth who have offended have access to appropriate interventions
- build their own capacity to identify problems and provide specialist AOD interventions as part of developing a youth forensic service that addresses AOD problems in an integrated way
- make referrals to specialist youth AOD services when appropriate, especially at the point of a young person's transition back to the community.

Interface with primary care services

Up to one-third of young people in CYF residential care are not enrolled in a primary health organisation and may not have a regular general practitioner. Youth forensic services will work with CYF to ensure these young people have access to primary health care. Youth forensic services will also co-ordinate access to other health services as required, in collaboration with CYF, including during the transition back to community-based services. CYF, when acting *in loco parentis*, is responsible for meeting costs not routinely met by Health (such as user part charges, etc).

Consultation and liaison services to disability and IDCC&R services

The Ministry of Health currently contracts Waitemata, Waikato, Capital and Coast, Canterbury and Southern DHBs to provide specialist disability services for 'care recipients' detained under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and for 'civil clients' with high and complex disability needs who live in specialist supported accommodation services in the community.

A two-way flow between youth forensic services and specialist high and complex disability services will be essential to respond to the needs of both client groups, and particularly those who have one or more mental health and/or AOD problems and a co-existing intellectual disability. Regional youth forensic services will require agreed mechanisms and protocols (memoranda of understanding) with disability services that define court liaison processes, referral pathways and collaboration processes.

Support and advice to other agencies and services involved in the youth justice sector

Youth forensic services have expertise that will be helpful to other agencies involved with youth who offend. A wide range of agencies, organisations and individuals is involved in the youth justice sector, including:

- Police Youth Aid officers/workers
- youth offending teams²⁵
- providers of health and education assessments (prior to youth justice FGCs)
- CYF social workers and youth justice co-ordinators (and other frontline CYF staff)
- CYF residential services
- education providers and Group Special Education
- professionals involved in FGCs
- Youth and District Court personnel.

Youth forensic services are expected to provide support and advice to these organisations and services, which may include educating them through the provision of information and/or training.

²⁵ Wherever possible, youth forensic services should participate in local youth offending teams.

Access to inpatient beds

Youth forensic services need to be able provide access to suitable secure inpatient services. Inpatient admissions may be necessary to enable a full assessment of a young person's needs and/or as part of initial stabilisation and treatment of acute symptoms. In New Zealand consideration must be given to the constraints of providing highly specialised and resource-intensive inpatient services to a small number of young people across relatively large geographical areas.

There are two feasible options for the development of secure inpatient services for youth in New Zealand, namely inpatient units attached to:

1. adult forensic inpatient services
2. child and adolescent mental health inpatient services.

Of these two options, the Ministry of Health considers the second to be more appropriate. The Ministry will work with DHBs and existing forensic services on an approach to developing youth forensic inpatient services that best meet the needs of the youth offending population in each region.

The *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998) provides some guidance on the number of youth forensic inpatient beds that may be needed in New Zealand. The *Blueprint* suggests that 0.4 secure inpatient beds per 100,000 people (total population) would be needed for children and adolescents. Based on this estimate and 2008/09 population data, Table 3 indicates the number of beds that may be needed across New Zealand's four regions.

Table 3: *Blueprint* indication of number of secure child and adolescent mental health inpatient beds needed in New Zealand (based on 2008/09 population projections)

Region	2008/09 population	2008/09 <i>Blueprint</i> target
Northern	1,605,745	6.4
Midland	822,643	3.3
Central	850,875	3.4
Southern	1,017,005	4.0
Total	4,296,268	17.1

However, the information in Table 3 should not be taken to mean that, for example, an inpatient unit with 3.3 beds needs to be established in the Midland region. Other factors, particularly clinical (and financial) sustainability, need to be taken into account in regard to the development of youth forensic inpatient services. An inpatient unit with fewer than six beds is unlikely to be clinically or financially viable.

Budget 2009 provided for the development of improved secure services under the IDCC&R Act. Such improvements included the development of inpatient services for youth with an intellectual disability who have offended. Initial indications are that, in addition to the mental health beds (Table 3), approximately six dedicated IDCC&R secure beds for young people may be needed across the country. Consideration should also be given to the need for additional community residential beds for this group. Given the high rates of co-existing mental health and/or AOD problems in young people with an intellectual disability, the development of inpatient facilities for youth should therefore proceed in collaboration with IDCC&R services, including through exploring opportunities for co-location of inpatient services.

A key consideration in the development of inpatient services must be the United Nations Convention on the Rights of the Child, particularly section 37(c) which relates to the separation of vulnerable young people (under the age of 18) from adults. Adhering to evidence-based design of inpatient facilities for young people will also be essential in the development of these services. This design may involve developing youth forensic 'pods'.²⁶

Many young people in youth forensic inpatient facilities will require access to education so all such facilities will need to link in to the appropriate regional health school.

The Ministry of Justice estimates that the Youth Court will deal with an additional 60 children aged 12 and 13 years per year from October 2010 as a result of the Children, Young Persons, and Their Families (Youth Court Jurisdiction and Orders) Act 2010.

Taking the above factors into account, establishing secure youth forensic inpatient facilities in two or three regional centres such as Auckland or Hamilton, Wellington and Christchurch may be the most appropriate path forward. However, these services will need to be developed through a collaborative, staged process that is co-ordinated and agreed across the regions. The Ministry of Health will facilitate this process initially.

Community re-integration

From the outset of intervention planning and implementation, youth forensic services will collaborate with other agencies to plan for the full re-integration of a young person who has offended into their community. Consideration of the young person's family and whānau circumstances and their social networks is particularly important when planning for community re-integration. Youth forensic services and CAMHS must work with Child, Youth and Family (lead agency for re-integration) and the family and whānau because returning young people to a community in which their family situation is unchanged and where they re-engage with anti-social peer networks is likely to lead to re-offending (and relapse of problems).

²⁶ A 'pod' is a small unit (one or two beds) with access to separate secure facilities that is designed to enable flexible configuration to ensure the physical separation of:

- youth from adult offenders, or youth of different ages and developmental stages
- youth with intellectual disabilities from other young people (when appropriate)
- young males from young females.

Preparing a young person for community re-integration will include working with CYF and other agencies to link with primary health services, vocational/employment skills training providers and/or education services. Youth Transition Services, Work and Income and the Department of Corrections Prisoner Re-integration Teams will be important partner agencies. Successful community re-integration of youth who have been detained will depend on seamless referrals from youth forensic services to the CAMHS in the community to which they return.

Regional organisation of forensic services

All DHBs need to be able to provide access to the range of youth forensic mental health and AOD services described in this document. Achieving this level of access requires a regional approach to service provision.

Larger DHBs will provide regional specialist youth forensic services within their provider arm services. In a regional approach, these services will have responsibility for provision of clinical supervision, training and consultation and liaison services to clinicians in smaller DHBs in a 'hub and spoke' model.²⁷

Workforce requirements

Importance of suitably qualified staff

Youth forensic services require staff with qualifications and expertise in identifying, diagnosing and responding to the needs of youth who are severely affected by mental health and/or AOD problems or an intellectual disability, using developmentally appropriate interventions. Youth forensic services need to have staff with specialist skills in addressing AOD problems **within** the service. That is, all youth forensic clinicians need to be competent in responding to **both** mental health **and** AOD problems.

Youth forensic clinicians also need to have a detailed understanding of the legislative framework within which they work and be skilled at collaborating with other services in the youth justice system.

²⁷ The 'hub and spoke' model was originally developed in the freight movements and logistics industry. It has been adapted to health service provision to help specialist clinicians in larger regional centres (hubs) provide clinical support to clinicians in generic secondary services in smaller provincial centres (spokes). The model involves the establishment of formal and informal relationships between each hub and its associated spokes, with regular structured supervision and training combined with ad hoc consultation and liaison support as required. The hub and spoke model is most effective when an individual in the spoke service has a dedicated co-ordination role, often in conjunction with a local 'virtual team' (including in some cases primary care clinicians or professionals from other agencies). Team members often have a clinical interest and experience in the specialty. Successful New Zealand applications include oncology, eating disorders, and adult forensic mental health services.

Successfully responding to the needs of young people is dependent, to a significant extent, on engaging with each young person and with their family and whānau, and keeping them engaged. Clinicians in youth forensic services require specific skills in understanding youth culture(s) and engaging with young people in developmentally appropriate ways.

Responsiveness to Māori

All staff involved in youth forensic services in New Zealand need to have competency in responding to the specific cultural needs of young Māori and engaging with their whānau. These skills include competence to work within a whānau ora framework. Youth forensic services will need to develop strategies for achieving greater responsiveness to Māori by employing kaumātua and by recruiting, training and retaining Māori clinicians.

Ongoing skill development

Developing and maintaining the competencies needed to provide a youth forensic service is an ongoing process. Youth forensic services therefore need to enable their staff to continue to develop their skills as a part of 'business as usual'. Fulfilling this need includes ensuring that clinicians have opportunities to access appropriate training and professional development programmes and events.

Developing the skills of other services

Youth forensic services have a responsibility to impart their skills and knowledge to other individuals and organisations that operate in the youth justice system. To deliver on this responsibility, staff require supervisory and adult education skills.

Research

During the development of this document, the following areas have been identified as priorities for research:

- epidemiology – a robust study of the prevalence of mental health and AOD problems amongst youth who offend in New Zealand
- workforce – to identify skill gaps and inform recruitment and retention strategies
- 'what works' – an evidence base that establishes what works in the specific context of New Zealand, especially in regard to:
 - working with Māori
 - working with young people who are estranged from family and whānau (and when re-integration with family may be inappropriate, such as when there is a history of abuse)
 - working with young people from other cultures (particularly Pacific and Asian cultures).

Responsibility for workforce development and research

Responsibility for workforce development and research does not rest solely with youth forensic services. The Ministry of Health and Health Workforce New Zealand have a role in leading workforce development and research for the child and adolescent mental health and addiction sector.

4 Youth Forensic Forum

During the development of this guidance document, many stakeholders suggested that a national youth forensic forum should be formed. Consideration needs to be given to the relationship between the proposed youth forensic forum and existing adult forensic meetings.

Purpose of a youth forensic forum

A youth forensic forum would encourage stakeholders within the forensic, mental health and AOD sectors to work together and share their knowledge and experiences, and to foster collaboration.

The forum would encourage national discussion of aspects of prevention, early intervention, education and treatment of young people. The forum would promote the development and use of nationally consistent evidence-based, best practice interventions within youth forensic services.

Effective communication across levels of care, across specialities and professional groups, and among clinicians, managers and funders could be facilitated by the use of information technology (including video conferencing), especially when participants are separated by considerable geographical distances.

The forum would provide a vehicle for discussion, planning and co-ordination across regions for training and other workforce development activities.

It could also provide a vehicle for an interface at a national level with other agencies in the youth justice system.

The forum could strengthen and develop the 'hub and spoke' model and network.

Appendix 1: Background to the Development of this Document

In 2006 the lack of youth forensic services was identified by the Ministry of Health and DHBs in *Te Kōkiri* (Minister of Health 2006). In February 2007 the Ministry convened a meeting of key stakeholders from the youth justice and care and protection sectors (including representatives from the Ministries of Social Development and Justice; Child, Youth and Family; Department of Corrections; and Police; and a Youth Court judge) and from the health sector (clinicians, managers and funders from forensic mental health services, CAMHS and youth AOD services) to consider how to develop an integrated and comprehensive framework of forensic mental health services for youth. The meeting emphasised:

- significant gaps within services at that time
- the need for workforce development
- the need for greater responsiveness to Māori
- the need for stronger relationships and greater collaboration at the interfaces of youth justice services, forensic services, CAMHS, adult mental health services, other health services, CYF, the Youth Courts and other social service agencies
- the need for a comprehensive approach in both community-based (outpatient) and residential (secure) care facilities.

During 2007 and 2008 the Werry Centre for Child and Adolescent Mental Health²⁸ undertook two literature reviews to establish an evidence base to inform the development of this guidance document and youth forensic services.

Instrumental in the development of this guidance document for the development of youth forensic services was the completion of the *Review of Forensic Mental Health Services: Future directions* (Ministry of Health 2010). Its purpose was to review and update *Services for People with Mental Illness in the Justice System: Framework for forensic mental health services* (also known as the *Forensic Framework*; Ministry of Health 2001). More specifically, *Future directions* sought to:

- present an accurate picture of the current range of forensic mental health services
- identify and analyse issues of national significance, as well as those that were region-specific
- clarify and reach agreement within the sector on the future funding and planning of regional forensic mental health services.

Future directions identified the lack of youth forensic services as an issue of national significance. A draft of *Future directions* was released to key stakeholders in June 2007. In response to this draft, five-year plans were developed for the four regional forensic services. The Ministry is working to clarify the priorities and funding pathway for forensic services as part of clarifying priorities within overall mental health funding.

²⁸ See <http://www.werrycentre.org.nz/>.

Other initiatives and developments include:

- participation by relevant CAMHS managers and clinicians in each of the 33 youth offending teams
- a reference group of key stakeholders to inform and guide the development of this document²⁹
- inter-agency work, led by the Ministry of Social Development, on conduct problems
- participation by government agencies in the Youth Justice Interagency Group
- roll-out of health and education assessments for youth prior to their first youth justice family group conference
- development of the Christchurch Youth Drug Court
- establishment of the Auckland Youth Court's Intensive Monitoring Group
- implementation of evidence-based programmes such as Functional Family Therapy, Multi-Systemic Therapy, Triple P and Incredible Years parenting programmes and family-inclusive practice
- implementation of the Fresh Start Alcohol and Other Drug Rehabilitation Programmes as part of the Fresh Start Initiative for Youth Justice
- the Children, Young Persons, and Their Families (Youth Courts Jurisdiction and Orders) Amendment Act 2010, which came into effect on 1 October 2010.

²⁹ Appendix 8 identifies the members of that reference group and other key stakeholders who have contributed to the development of this document.

Appendix 2: The Evidence Base

The Werry Centre for Child and Adolescent Health Workforce Development³⁰ undertook two literature reviews to help establish an evidence base to inform the content of this document:

- *Intersectoral Workforces Working with Young People who have Offended and Experience Mental Health/AOD Issues: Workforce training needs* (Werry Centre 2008)
- *A Literature Review: Mental health and alcohol and other drug screening, assessment and treatment for youth justice populations* (Werry Centre 2009).³¹

In addition, the following documents provided useful information:

- *Promoting Mental Health for Children Held in Secure Settings: A framework for commissioning services* (Department of Health (UK) 2007)
- *Blueprint for Change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system* (Skowyrza and Coccozza 2007)
- *The Mental Health Needs of Young Offenders: Forging paths toward reintegration and rehabilitation* (Kessler and Kraus 2007)
- 'Practice parameter for the assessment and treatment of youth in juvenile detention and correctional facilities' (Penn and Thomas et al 2005)
- *Conduct Problems Best Practice Report 2009: Report by the Advisory Group on Conduct Problems* (Ministry of Social Development 2009).

Prevalence studies

International studies have repeatedly reported prevalence rates of mental health and/or AOD disorders of between 40 and 60 percent amongst youth who have offended. The authors of an American study of more than 1400 youth who had offended asserted that at least 20 percent of their sample experience disorders 'so severe that their ability to function is significantly impaired' (Skowyrza and Coccozza 2007, p vii). Multiple international studies of detained youth have reported a prevalence of mental health and/or AOD disorders of more than 60 percent to in excess of 80 percent. A 2003 study of nine juvenile detention centres in New South Wales found that 88 percent of a sample of 242 remanded or sentenced youth reported mild to severe symptoms of a clinical disorder (NSW Department of Juvenile Justice 2003).

International studies indicate that the prevalence of mental health and/or AOD disorders in the general population of young people is between 20 and 30 percent.

³⁰ The Werry Centre website (<http://www.werrycentre.org.nz>) is a New Zealand source of information on evidence-based best practice for working with young people.

³¹ Full copies of the reviews are available from <http://www.werrycentre.org.nz>.

AOD and co-existing disorders

In New Zealand, the Dunedin Multidisciplinary Health and Development Study (DMHDS) and the Christchurch Health and Development Study (CHDS) have provided data on the prevalence of mental disorders amongst young people. The DMHDS found: at 15 years of age, 22 percent of the study cohort had one or more disorders (McGee et al 1990); and at 18 years, 36.6 percent had one or more disorders (Feehan et al 1994). The CHDS found: at 15 years of age, 25 percent of the study cohort had one or more disorders (Fergusson and Horwood 2001); and at 18 years, 42 percent had one or more disorders (Fergusson et al 2003).

AOD disorders are particularly prevalent amongst youth who have offended. Skowrya and Coccozza (2007) found that 46 percent of their sample met criteria for an AOD disorder. Prevalence of AOD disorder has been consistently found to be much higher amongst detained youth. The existence of a high prevalence of co-existing mental health and AOD disorders is widely recognised. In particular, the co-occurrence of conduct disorder and substance abuse is generally reported as the most frequent combination amongst youth who have offended.

The study of nine New South Wales detention centres noted above (NSW Department of Juvenile Justice 2003) found that 73 percent of the sample had more than one disorder (with the most frequent co-occurrence being conduct disorder and substance abuse). However, a high prevalence of conduct disorder co-existing with disorders other than substance abuse has also been reported. In a six-month cohort of youth in Youth Justice North (South Auckland), assessed by the Centre for Youth Health in 2005, 76 percent had AOD problems and 56 percent had a diagnosable mental illness (Newman and O'Brien 2005). In short, co-existence of mental health and/or AOD disorders is the rule, rather than an exception, amongst youth who have offended.

Fonagy et al (2000) identified that there is also a high rate of co-morbidity between conduct disorder and attention deficit hyperactivity disorder (ADHD), as well as a strong correlation between children with childhood onset conduct disorder and offending. A United Kingdom study found that 6 percent of young boys with conduct disorder went on to become responsible for half of all convictions incurred by the age of 32 years (Farrington and West 1993). Treatment for ADHD and other co-morbid mental disorders is indicated as part of effective intervention.

Young Māori

The CHDS found that half of 18-year-old Māori had one or more disorders. This finding is consistent with results from other studies of the prevalence of mental disorders in New Zealand: that is, the prevalence of mental health and AOD disorders is significantly higher for Māori than it is for non-Māori. There is evidence that young Māori may be twice as likely to experience a mental health disorder as young non-Māori (Ramage et al 2005; Wille 2006). *Te Puāwaiwhero – The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015* (Ministry of Health 2008) emphasises the high prevalence of mental health and AOD disorders, and unmet needs, amongst young Māori and notes that even if Māori were to have similar levels of socioeconomic advantage to others, the disparities in mental health would be reduced but not eliminated.

The CHDS also found that prevalence rates for conduct disorder and substance abuse were, respectively, three and two times higher for Māori than they were for non-Māori. Both the Youth2000 study and its Youth'07 follow-up study (Adolescent Health Research Group 2003, 2008)³² found that Māori school students were much more likely than non-Māori to report symptoms of depression, contemplation of suicide, attempted suicide, and higher use of both alcohol and marijuana.

Young Pacific people

Data on the prevalence of mental health and substance abuse problems experienced by young Pacific people is more limited than is available for young Māori. However, the *Youth2000* study, which included more than 1000 Pacific students, found that Pacific students were more likely to report symptoms of depression than were New Zealand European students. While Pacific students were only slightly more likely to report suicidal ideation than New Zealand European students, Pacific students were much more likely to have attempted suicide than New Zealand European students. While proportionally fewer Pacific students reported current and/or recent “binge” alcohol use than New Zealand European students, the difference was not significant (Mila-Schaaf et al 2008).

Gender differences

There are key differences in the types of mental health disorders experienced by young females who have offended when compared with those experienced by young males who have offended. There is also some evidence that suggests the prevalence of mental health and substance abuse disorders is higher in young females who have offended than it is in young males who have offended (Skowyra and Coccozza 2007), and that detained females are even more likely to have serious mental health disorders than their male peers (Cauffman et al 2007).

Importantly, young females who have offended, particularly those who are detained, are more likely to experience internalising disorders (eg, depression and anxiety), while young males who have offended are more likely to experience externalising (ie, conduct and attentional) disorders (Cauffman et al 2007). Detained young females have also been found to be more likely than young males to have been exposed to trauma and to have experienced physical and/or sexual abuse, and consequently have a higher prevalence of post-traumatic stress disorder than young males who have offended. In addition, Skowyra and Coccozza (2007) found that AOD disorders are more prevalent amongst young females who have offended (55 percent) than young males who have offended (43.2 percent).

³² Youth2007 and Youth'07 were surveys of school students; these surveys are therefore unable to give an indication of the prevalence of mental health and AOD problems of young Māori and Pacific peoples who are disengaged from the education system. (However, a high prevalence of mental health and substance problems amongst young people disengaged from education, though unproven, would be generally assumed.)

As noted above, the co-existence of mental health disorders with AOD disorders, and the co-existence of multiple mental health disorders, occur frequently amongst youth who have offended. However, some studies have reported higher rates of co-existing disorders amongst young females who have offended than amongst young males who have offended (Abram et al 2003).

The Youth2000 and Youth'07 surveys found that young Māori females are more likely than their Māori male peers to have experienced symptoms of depression, had suicidal thoughts and attempted suicide (Adolescent Health Research Group 2003, 2008). Similarly, these two surveys found that Pacific females were more likely than Pacific males to have experienced symptoms of depression, had suicidal thoughts and attempted suicide (Mila-Schaaf et al 2008).

Appendix 3: Functions and Organisation of Existing Youth Forensic Services

Forensic mental health services for adults are organised regionally with six service providers operating in: Northern (based in Auckland), Midland (Hamilton), Central (Wellington), Canterbury (Christchurch) and Otago/Southland (Dunedin). Although youth forensic services are currently provided in each of these regions, they are underdeveloped when compared with services for adults and the child and adolescent mental health service (CAMHS) sector. The future development of youth forensic services should continue to follow a regional model. Table 1 in Section 2 above shows the availability and key features of existing youth forensic services in New Zealand.

Northern Region

A dedicated regional youth forensic service for the northern region is located at the Kari Centre at Auckland DHB's Greenlane Clinical Centre. Its services include:

- Youth Court liaison in some metropolitan Auckland Youth Courts
- section 333 assessments
- triage and consultation services for youth justice personnel
- in-reach assessment and treatment services to youth in the CYF 46-bed Youth Justice North facility (Korowai Manaaki)
- training Korowai Manaaki personnel about mental health and AOD problems.

The Kari Centre's range of youth forensic services does not, however, include secure inpatient beds. No such facility currently exists anywhere in New Zealand.

Specialist youth AOD services are also available in the greater Auckland region.

Midland Region

Youth forensic services in the midland region are predominantly provided by Hauora Waikato, a large iwi-based non-governmental organisation contracted by Waikato and Lakes DHBs. Waikato DHB's CAMHS provides a limited range of forensic services involving consultation and liaison. Hauora Waikato provides youth forensic mental health services to Te Maioha o Parekarangi, the youth justice residential facility in Rotorua. Hauora Waikato provides youth court screening and liaison services, including section 333 assessments, at the Hamilton, Tauranga and Rotorua Youth Courts, and satellite courts across the region. Hauora Waikato also provides a prison in-reach service to the Youth Unit at Waikeria Prison (screening and treatment).

Central Region

The Central Region has a youth forensic service established under the auspices of Te Korowai Whariki. This service currently has nine community full-time equivalent (FTE) staff strategically placed throughout the Central Region as follows: two Youth Court liaison; three youth alcohol and drug clinicians; one psychiatrist; two clinical psychologists; and one Māori mental health clinician. These staff are supported by two FTEs from the adult forensic service.

The service works in Youth Courts, the youth justice facility in Palmerston North, the youth unit at Hawke's Bay Prison, and with young women aged 17 years and under in Arohata Prison. The service provides:

- specialist mental health and intellectual disability screening, advice and triage to the Youth Courts, including alcohol and drug services
- section 333 assessments
- a link with the Central Region's youth mental health and alcohol and other drug services
- a brokerage role with community treatment services and statutory agencies, particularly Child, Youth and Family
- mental health services, including drug and alcohol services, in the Lower North facility and the Central Region's prisons
- treatment and case management for a small group of adolescents with complex mental health needs and high-risk offending behaviour.

Southern Region

Youth forensic services are, in general, not provided as a regional service in the Southern Region (which has two adult regional forensic services in Canterbury and Southern DHBs). However, local youth services are provided in the Canterbury and Dunedin districts, including some CAMHS provision in CYF residences. For example, Southern DHB's CAMHS provides liaison services to the Dunedin Youth Court and Canterbury DHB's Youth Speciality Service provides liaison services to the Christchurch Youth Drug Court.³³ Both Canterbury and Southern DHBs undertake some section 333 assessments.

³³ The Christchurch Youth Drug Court is a programme targeting young offenders appearing in the Youth Court who have been identified as having a moderate to severe alcohol and/or other drug dependency that is linked to their offending.

Appendix 4: Child, Youth and Family Residences

Residence	Location	Beds	Description	Admissions 2009
Whakatakopokai	Manurewa	20	Mixed gender care and protection residence	80
Korowai Manaaki	Manurewa	40	Mixed gender youth justice residence	288
		6	Criminal justice beds	
Te Maioha o Parekarangi	Rotorua	30	Mixed gender youth justice residence	250 ¹
Lower North Youth Justice	Palmerston North	30	Male-only youth justice residence	150
Epuni	Epuni, Wellington	20	Mixed gender care and protection residence	70 ¹
Te Puna Wai o Tuhinapo	Rolleston, Christchurch	40	Mixed gender youth justice residence	250
Te Oranga	Shirley, Christchurch	10	Mixed gender care and protection residence	20
Puketai	Dunedin	8	Mixed gender care and protection residence	47

Note:

1 This figure is an estimate.

Appendix 5: Youth Units in Prisons

Prison	Location	Beds	Description
Hawke's Bay	Hawke's Bay	30	Males under 18 and 18- to 19-year-olds deemed vulnerable
Waikeria	Near Te Awamutu	35	Males under 18 and 18- to 19-year-olds deemed vulnerable
Christchurch	Christchurch	40	Males under 18 and 18- to 19-year-olds deemed vulnerable

Appendix 6: Youth Court Liaison Provision by Youth Court (at 1 September 2010)

Court	Sitting days	Frequency of sittings	No. CL (✓)	CL (✓)	CL on request (✓)
Northland¹					
Dargaville	Wednesday	Monthly			✓
Kaitiāia	Tuesday (usually)	Monthly			✓
Kaikohe	Monday	Monthly			✓
Whangarei	Thursday and Friday (usually)	2 days per fortnight			✓
Auckland					
Auckland	Monday and Thursday	Twice per week		✓	
Manukau ²	Tuesday	Weekly	✓		
	Thursday	Fortnightly	✓		
	Friday	Fortnightly	✓		
North Shore	Wednesday	Fortnightly		✓	
Papakura	Friday	Fortnightly	✓		
Pukekohe	Friday (usually)	Fortnightly	✓		
Waitakere	Tuesday	Weekly		✓	
	Friday (fixtures)	Monthly		✓	
Warkworth	Tuesday and Friday	Fortnightly	✓		
Bay of Plenty					
Opotiki	Thursday	Fortnightly		✓	
Tauranga	Monday	3 times per month		✓	
Whakatane	Friday	Fortnightly		✓	
Waikato					
Hamilton	Wednesday	Weekly		✓	
Rotorua	Tuesday	Fortnightly		✓	
Taupo	Tuesday or Wednesday (usually)	Fortnightly			✓
Te Awamutu	No fixed day (FC day)	Monthly		✓	
Te Kuiti	No fixed day (FC day)	Monthly		✓	
Thames	No fixed day (FC day)	Monthly		✓	
Waihi	No fixed day (FC day)	Fortnightly			✓
Tokoroa	No fixed day (FC day)	Fortnightly		✓	
Huntly	Thursday or Friday	Fortnightly		✓	
Morrinsville	No fixed day (FC day)	Fortnightly	✓		
Gisborne					
Gisborne	Friday	Fortnightly		✓	
Ruatoria	Thursday	Quarterly		✓	
Wairoa	Thursday	Monthly		✓	
Taranaki					
Hawera	Usually Monday or Friday	Fortnightly	✓		
New Plymouth	Wednesday	Fortnightly	✓		

Court	Sitting days	Frequency of sittings	No. CL (✓)	CL (✓)	CL on request (✓)
Hawke's Bay					
Hastings	Tuesday (usually)	Fortnightly		✓	
Napier	No fixed day	Fortnightly		✓	
Waipukurau	Thursday (usually)	Monthly			✓
Wairoa	Thursday	Monthly		✓	
Manawatu/ Whanganui					
Feilding	Rostered judge list days	Monthly		✓	
Levin	Tuesday	Monthly		✓	
Marton	No fixed day	Monthly			✓
Palmerston North	Friday (usually)	Fortnightly		✓	
Dannevirke	Rostered Family Court day	Monthly			✓
Taihape/Ohakune	No fixed day	Monthly (if any)		✓	
Whanganui	Thursday (usually)	Fortnightly		✓	
Taumararui3	Wednesday	Monthly	✓		
Wellington					
Wellington	Tuesday	Weekly		✓	
Porirua	Thursday	Weekly		✓	
Masterton	Wednesday or Thursday	Fortnightly		✓	
Lower Hutt	Wednesday	Weekly		✓	
Upper Hutt	Monday	Fortnightly		✓	
Tasman⁴					
Nelson	Wednesday or Friday (usually)	Fortnightly			✓
Marlborough					
Blenheim	Varies	Fortnightly			✓
West Coast⁵					
Greymouth	Wednesday	Monthly	✓		
Westport	Friday	Monthly	✓		
Canterbury					
Ashburton	Monday (pm)	Fortnightly	✓		
Christchurch	Tuesday and every second Friday (list)	Weekly		✓	
	Thursday (list) 10–11.30 am	Fortnightly		✓	
	Arrests at 9.30 am and 3.45 pm (except on Youth Court list days)	Daily	✓		
	Monday (fixture list)	Monthly	✓		
Rangiora	Thursday	Monthly	✓		
Timaru	Monday (usually)	Fortnightly	✓		
Otago⁶					
Alexandra	Thursday	Monthly	✓		
Balclutha	Wednesday	Monthly	✓		
Dunedin	Monday (usually)	Fortnightly		✓	
Oamaru	Wednesday or Thursday	Fortnightly	✓		
Queenstown	Monday	Fortnightly	✓		

Court	Sitting days	Frequency of sittings	No. CL (✓)	CL (✓)	CL on request (✓)
Southland					
Gore	Wednesday	Six-weekly	✓		
Invercargill	Thursday	Fortnightly	✓		

Key: CL = court liaison; FC = family court

Note:

- 1 Northland DHB typically attends four court sittings per month across the Northland Youth Courts.
- 2 The Auckland DHB Regional Youth Forensic Service plans to commence a court liaison service in Manukau Youth Court in late 2010.
- 3 Taumaranui Youth Court is within the Waikato DHB district and court liaison has not been arranged as yet.
- 4 The Nelson Marlborough DHB plans to commence a regular court liaison service in Nelson and Marlborough Youth Courts in 2011.
- 5 The Canterbury DHB plans to commence a regular court liaison service in Greymouth, Westport, Ashburton, Rangiora and Timaru Youth Courts in 2011.
- 6 Southern DHB plans to commence court liaison services on request in the Alexandra, Balclutha, Queenstown, Gore and Invercargill Youth Courts in early 2011.

Appendix 7: Youth Court Volumes

Number and percentage of young people prosecuted for all offences except non-imprisonable traffic offences by outcome category, and number finalised in the Youth Court, by court region, 2008

Court region	Adult Court				Youth Court				Adult and Youth Court				Total		Finalised in the Youth Court	
	Convicted		Discharge without conviction		Youth Court proved		Section 282 discharge		Not proved		Other		No.	%	No.	%
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%				
Christchurch	10	1.8	0	0.0	181	32.9	262	47.6	96	17.5	1	0.2	550	100.0	532	96.7
Manukau	23	5.1	0	0.0	178	39.5	162	35.9	86	19.1	2	0.4	451	100.0	415	92.0
Wellington	15	4.6	0	0.0	54	16.5	143	43.6	115	35.1	1	0.3	328	100.0	309	94.2
Auckland	16	5.9	0	0.0	54	19.9	124	45.8	77	28.4	0	0.0	271	100.0	247	91.1
Hamilton	17	6.5	1	0.4	81	31.0	123	47.1	39	14.9	0	0.0	261	100.0	238	91.2
Waitakere	11	3.1	0	0.0	61	17.3	201	56.9	80	22.7	0	0.0	353	100.0	338	95.8
Palmerston North	5	2.3	2	0.9	39	18.1	123	57.2	46	21.4	0	0.0	215	100.0	195	90.7
North Shore	2	1.0	2	1.0	51	25.0	81	39.7	68	33.3	0	0.0	204	100.0	190	93.1
Tauranga	15	4.7	0	0.0	103	32.3	154	48.3	47	14.7	0	0.0	319	100.0	285	89.3
Dunedin	7	4.3	0	0.0	35	21.7	90	55.9	29	18.0	0	0.0	161	100.0	151	93.8
Napier	19	9.3	0	0.0	92	45.1	69	33.8	24	11.8	0	0.0	204	100.0	182	89.2
Whangarei	6	2.7	0	0.0	59	26.9	98	44.7	56	25.6	0	0.0	219	100.0	203	92.7
Rotorua	14	5.8	0	0.0	84	35.0	103	42.9	39	16.3	0	0.0	240	100.0	223	92.9
Nelson	0	0.0	1	1.1	45	48.9	34	37.0	12	13.0	0	0.0	92	100.0	84	91.3
New Plymouth	7	4.9	0	0.0	38	26.8	83	58.5	14	9.9	0	0.0	142	100.0	133	93.7
Invercargill	5	3.8	0	0.0	38	29.2	64	49.2	22	16.9	1	0.8	130	100.0	121	93.1
Gisborne	2	1.5	0	0.0	35	26.7	69	52.7	25	19.1	0	0.0	131	100.0	128	97.7
Total	174	4.1	6	0.1	1228	28.8	1983	46.4	875	20.5	5	0.1	4271	100.0	3974	93.0

Source: Ministry of Justice (2010) Child and youth offending statistics, 1992 to 2008

Note:

- 1 The table presents people-based data: that is, the number of people identified by an identifier issued by the Police or the courts. A person is counted once each year. Within a calendar year, the most serious charge (with the most serious outcome or penalty) is used to denote the person.
- 2 The table presents court regions in descending order of the estimated population by court region.

Appendix 8: People Consulted during the Development of this Document

The following people formed an external reference group of key stakeholders to inform and guide the development of this guidance document and were asked to comment on various draft versions.

Dr Sandy Simpson	Clinical Director, Auckland Regional Forensic Service
Nigel Fairley	Clinical Director, Central Regional Forensic Service
Dr Arran Culver	Child and Adolescent Psychiatrist, Hauora Waikato
Dr Elizabeth Myers	Consultant Child and Adolescent Psychiatrist, Auckland Regional Youth Forensic Service and Child and Family Unit, Auckland DHB
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³⁴ John Zonneville was seconded to the Ministry of Health as a senior advisor and led the development of this document in 2008 and early 2009.

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Glossary of Terms and Abbreviations

ADHD	attention deficit hyperactivity disorder
AOD	alcohol and other drug
assessment	in this context, a process conducted for the purpose of informing treatment decisions, developing a treatment plan and performing risk management (including risk of potential behaviour problems) Assessment is performed selectively with some young people, generally results from the outcome of a screen, and is a more thorough review of the young person's mental health
CAMHS	child and adolescent mental health service
CHDS	Christchurch Health and Development Study
CYF	Child, Youth and Family
CYPF Act	Children, Young Persons, and Their Families Act 1989
DHB	District Health Board
DMHDS	Dunedin Multidisciplinary Health and Development Study
FGC	family group conference
FTE	full-time equivalent (staff), an FTE of 1.0 means that the person or people working in a job equivalent to that of one full-time worker
IDCC&R Act	Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
in-reach	clinical interventions (assessment, risk assessment, treatment, consultation liaison, discharge planning etc) provided by community-based mental health and AOD services in the justice setting in which youth are detained (or to support those working with them)
secure inpatient care	a facility specifically designed for the treatment of young people with severe intellectual disability, mental health and/or AOD problems, in a secure setting; it would have highly skilled clinicians on site 24 hours a day
screening	in this context, the screen being applied to every young person at entry into the youth justice system (and at key transition points) and focusing on identification of conditions/issues that require an immediate response such as suicide risk, AOD issues, or the need for more in-depth assessment to obtain specific information relating to the young person's mental health
whānau	extended family
youth forensic services	specialist mental health and AOD services for young people with mental health and/or AOD problems who have offended or are alleged to have offended and are involved in New Zealand's justice system