Viewpoint

Juvenile Justice System, Juvenile Mental Health, and the Role of MHPs: Challenges and Opportunities

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ABSTRACT

Juvenile justice system (JJS) and the mental health of the juveniles involved in it are intricately related. Children in conflict with the law (CICL) and children in need of care and protection (CINCP) have a higher prevalence of mental health-and substance use related—problems, similarly, juveniles with mental health problems have a higher chance of coming in contact with JJS. Juvenile Justice Act, 2000 (JJ Act), with its latest amendment (2015), emphasizes the developmental well-being, including the psychological well-being of juveniles coming in contact with JJS and their social reintegration and rehabilitation. Mental health professionals (MHPs) can play a significant role in realizing this goal by contributing at all the levels: mental health promotion, preventing juveniles from coming in contact with JJS, treating juveniles in contact with JJS, and subsequent rehabilitation. Being well-versed in this area would also give a clinical and legal edge to the MHPs. Although JJ Act is a child-friendly law, its implementation in the real-world is faced with many practical challenges, which in turn limit or undermine the full legal, social, educational, and health benefits to the juveniles. The current viewpoint is aimed to highlight the important mental health aspects of juveniles involved with JJS with reference to the JJ Act (care and protection of children act, 2015) and the potential role that MHPs can play and discusses important challenges and road ahead.

Key words: *Child mental health, JJ Act (Care and Protection of Children, 2015), juvenile delinquencies, juvenile justice system, mental health professionals*

Being the future of any society and a vulnerable section, children deserve laws that could ensure their developmental well-being. Many children-centric laws do exist in India, such as Child Labour Act (1993),[1] Juvenile Justice Act (JJ Act, 2000), Prohibition of Child Marriage Act (2006),[2] Right of Children to Free and Compulsory Education Act (2009),[3] and Protection of Children From Sexual Offences Act (POCSO, 2012).[4] Among these, JJ Act deals with 'children in need of care and protection (CINCP)' and 'children in conflict with the law (CICL),' i.e., juveniles involved with Juvenile

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Justice System (JJS). Literature suggests that at some juvenile justice contact points, as high as 70% of the youth have a diagnosable mental health problem. The commoner ones include externalizing disorders such as to conduct disorders (40.9–64.7%), attention deficit hyperkinetic disorder (ADHD, 4.1–19.2%) or substance use disorders (40.2–50.4%); and internalizing disorders such as anxiety disorders (30–38%) and mood disorders (7.3–13.9%). Externalizing disorders increase the likelihood of juvenile delinquency, violence, and recidivism.[5-9] In contrast, early identification and intervention are associated with a decreased rate of recidivism and better social integration.[6,10]

Individuals involved in providing care to such juveniles in the observation homes or child care institutions (CCIs) are often untrained and unskilled and lack on-job support from the mental health professionals (MHPs) to recognize and address the psychological needs of such juveniles.[11] This, to a certain extent, also holds true for the members of the justice system board (JJB) and officers of the child police protection unit (CPPU) of the district. This comes as a great challenge on the path of providing holistic and comprehensive care to the juveniles coming in contact with JJS. Therefore, the proactive role of MHPs becomes far more important in training, skill development, and capacity building. Moreover, it is also not uncommon for MHPs to come across such juveniles during their clinical practice or when called as an expert in the court of law.

Despite the existence of the JJ Act in India for more than two decades, the latest amendment for the last four years, and its clinical and legal implications for the MHPs, the literature is scarce from Indian psychiatry. The literature is mostly from social science or legal schools.[11-13] Furthermore, the literature available from the mental health field is skewed towards the mental health of the CICL,[9,14] while the mental health aspects of the CINCP (orphans or adoptees) remain untouched.

This review attempts to highlight the relevant sections of JJ Act (care and protection of children act, 2015), emphasizes mental health aspects of the juveniles involved with JJS and the potential role that MHPs can play, discusses the contentious issues, and also provides some way forward.

METHODOLOGY

Literature was searched with the help of academic search engines such as PubMed and Google Scholar' using search terms such as"Juvenile delinquency OR juvenile justice system" AND "Mental health OR Mental health professionals." A total of 93 results were obtained; however, only seven articles were

available from India, including one full-text article obtained by contacting the author,[14] one book,[15] and one document.[16] Gray literature was searched by visiting government departments (Ministry of Women and Child Development, National Commission on Protection of Rights of the Children [NCPCR], and Integrated Child Protection Scheme [ICPS]) and legal agencies' websites. The review narratively highlights and discusses the evolution of the JJ Act of India, the JJS from the mental health perspective of juveniles, challenges in bridging the gap between the mental health need of the juvenile involved with JJS, and the opportunities and road ahead.

RESULTS

Juvenile Justice System and evolution of the Juvenile Justice Act of India

India enacted the JJ Act for the first time in 1986. It prohibited the sentencing to prison of any CICL under any circumstances.[16] India, being a signatory of the United Nations Convention (1992) for the rights of the child,[17] ratified the treaty by passing the JJ Act (Care and Protection of Children) in 2000, incorporating the international standards to deal with CICL and CINCP.[18] The Act ensures proper care, protection, and treatment to the children by catering to their development needs and by adopting a child-friendly approach in the adjudication and disposition of matters in the best interest of children. Further, it mandated the ultimate rehabilitation of such children through various institutions established under this enactment.

The Act underwent amendments in 2006, 2010, and 2015. The major changes have been described below:

Highlights of the amendments of JJ Act (2006)

This amendment makes a provision that "if a child who commits an offense while being juvenile and

apprehended after the cessation of juvenility, the child should be treated as a juvenile" (considering their physical and mental immaturity at the time of committing an offence). It entrusts the state governments to review (on a six-monthly basis) the number of the pending cases under JJ Act, expedite the process of trials, constitute an adoption center in each district, and establish child protection unit in each district and hold the unit accountable for the implementation of the Act in each district and also encourages the adoption of CINCP and promotes it as a rehabilitative measure.[19]

Highlights of the amendments of JJ Act (2010)

This amendment omits the provision from the Act that ruled for the "separate treatment of juveniles or children suffering from leprosy, sexually transmitted disease, hepatitis B, tuberculosis, or children with unsound minds." It regulates the power of the competent authority of the special homes to move a child from special homes to a special facility like a mental health institution.[20]

Highlights of the amendments of JJ Act (2015)

Some of the major amendments and relevant aspect of of the Act are as follows:[21]

The Act defines the CINCP as one "who is mentally ill or mentally or physically challenged or suffering from a terminal disease and having no support system (parents or guardians) if found so by the Juvenile Justice Board (Board) or the Child Welfare Committee (CWC)."

Furthermore, the Act describes the principles to be followed while dealing with juveniles involved with JJS. It includes treating children with dignity and rights, maintaining their privacy and confidentiality during the various processes of juvenile justice, ensuring their safety, considering institutionalization as the last resort only, focussing on restoration, and keeping a non-stigmatizing attitude towards them.

The Act also describes the structure and qualifications for the members of the Juvenile Justice Board (JJB). The Act mandates that the non-magistrate board members (two in number) should have experience (of at least seven years) in the field of health, education, or welfare activities pertaining to children or be a practicing professional with a degree in child psychology, psychiatry, sociology, or law.

One of the important amendments in the Act is with regard to the procedure to be followed in case a heinous offense is alleged to have been committed by a child of age <16 years. As per the amendment, a preliminary assessment with regard to the mental and physical capacity of the juvenile should be conducted to determine the juvenile's ability to understand the consequences of the offense and the circumstances in which he/she allegedly committed the offense. If the board finds (the board may take the assistance of mental health or other experts) that the child had the capacity to commit a heinous offense, it may order to conduct a trial on the child as an adult.

The Act also mandates that no person shall be appointed as a member of the Child Welfare Committee (CWC) unless such person has been actively involved in health, education, or welfare activities pertaining to children for at least seven years or is a practicing professional with a degree in child psychology or psychiatry, law, social work, sociology, or human development.

It also framed law with regard to the procedure to be followed in relation to CINCP. The Act mandates that any individual (including doctor) or organization (including nursing homes or hospital) who/that finds a CINCP shall, within 24 hours (excluding the time necessary for the journey), give the information to the child-line services, the nearest police station, a CWC, or the CPPU, or hand over the child to a CCI registered under this Act. Non-compliance with the rule is liable for punishment (with imprisonment up to six months, fine of ten thousand rupees, or both).

Moreover, the Act states that the juveniles should be provided rehabilitation and reintegration services by institutions registered under this Act. It also mandates that the institutions should provide mental health interventions, including counseling specific to the needs of the child.

One of the important parts of the Act is the one which talks in detail about adoption and the procedure to be followed. It rules that adoption shall be resorted to for ensuring the right to family for the orphan, abandoned, or surrendered children.

One of the relevant aspects from the health providers' perspective is the prohibition of disclosure of the identity of the children registered under juvenile justice law. Any person found to be in contravention of this is liable for punishment (with imprisonment for a term that may extend to six months, a fine that may extend to two lakh rupees, or both).

Lastly, it describes the provisions for moving a child from special homes to treatment centers for mental illness or substances use related problematic behaviors.

Important mental health aspects of the juveniles involved with JJS and the potential role of MHPs

The mental health of the CICL and their delinquent behaviors are interrelated. This could be attributed to their shared biopsychosocial vulnerabilities or one condition exacerbating the other.[22,23] Non-addressal of these interrelated factors leads to subsequent recidivism and poor functional outcomes.[24] Hence, addressing the mental health needs of such juveniles is of utmost importance. It cannot be overemphasized that MHPs can contribute significantly in preventive, therapeutic, and rehabilitative fronts apart from their advisory role in JJS. Fortunately, JJ Act (2015 amendment) has given due weightage to this aspect and mandated no social worker to be appointed in the JJ Board or the CWC until one has experience in education or is a practicing professional with a degree in child psychology, psychiatry, sociology, or law.

The JJ Act (2015 amendment) rules that a preliminary assessment should be ordered for the mental and physical capacity of the juvenile aged 16-18 years alleged to have committed a heinous crime. The Board may take the assistance of experienced psychologists or psychosocial workers or other experts. Literature suggests that adolescents aged >14 years (Vs. <14 years) coming in contact with the law have more mental health issues.[25] Because MHPs are frequently called as an expert in such cases, their role becomes crucial, especially when such incidents get highlighted in the media and the legal procedure is likely to get influenced by various agencies (e.g., Nirbhaya's case, 2012).

The Act mandates that confidentiality should be maintained while dealing with juveniles in contact or likely to come in contact with JJS, to avoid litigation. This is in sync with the latest Mental Healthcare Act (MHCA, 2017), which also emphasizes maintaining the confidentiality and autonomy of a person with mental illness.[26] Since MHPs are frequently involved in assessing mental health and providing care to juveniles involved with JJS, exercising confidentiality is of paramount importance to avoid untoward legal complications.

Rehabilitative and re-integrative services form the core of the JJ Act. It mandates the registered childcare institutions to have mental health care facilities and referral facilities to mental health and de-addiction centers. The MHPs providing care to such juveniles are expected to prepare a comprehensive plan for ensuring quality and continuity of care.

The adoption rule of the JJ Act (amendment, 2015) gives weightage to the emotional needs and wishes of the child deemed fit for adoption. Adopted children are at a heightened risk for problematic externalizing behavior, neuroses, social incompetence, and poor educational performance (vs. non-adopted counterparts).[27-30] Some of these problems are related to early childhood and pre-adoption institutionalization-related stressors.[30] Hence, addressing mental health issues at both the pre- and post-adoption stages are important, and the role of MHPs in this context cannot be overemphasized.

The Act also rules that as and when required, a juvenile can be moved to a mental health facility (including de-addiction centers) for the necessary treatment. However, the MHCA 2017 rules that any person with age <18 years should be treated as minor and be admitted with a nominated representative, forming the advance directives for the child.[31] With two parallel acts in force, the MHPs should remain updated about the laws because they have clinical and legal implications. Formulating a comprehensive post-discharge plan is important to ensure continuity of care at the CCI or at the community, to minimize the worsening of psychological/behavioral problems and re-institutionalization.

Challenges in bridging the mental health needs a gap of the juvenile involved with JJS

JJ Act has an inherent flaw as it attempts to address the rights of CICL and CINCP within the same system.[11] This brings about an ambiguity among the personnel involved with JJS (including CPPU) in the absence of a clear distinction between the two similar populations with different needs. It is not uncommon for juveniles with intellectual disabilities or mental illnesses to get detained and placed in observation homes. It only adds to the suffering of the CINCP. Hence, a better understanding and a different approach for CINCP should prevail.

Although the Act rules that the basic needs of the children involved with JJS (including their mental health needs) should be ensured, it seems far from achieving in the real world. Lack of understanding about child psychology (normal childhood or deviant behavior) and skills among the CPPU, social workers, and staff of the CCIs are important limiting factors.[11,14] In the absence of access to training or required skills, staffs of CCIs tend to resort to harsh behavior and punitive actions as a form of corrective measures.[11,14] Hence, orientation and on-job training to the staff of the CCIs are important.

Poor budget allocation to the institutes/non-government organizations (NGOs) running CCIs is another important limiting factor as they receive a meager grant.[11] However, in its revised scheme, integrated child protection scheme (ICPS) has increased the budget to

Rs 2,000 per child per month, but its implementation and impact in the real world are yet to be seen.[32]

Though JJ Act rules that registered CCIs should have basic mental health facilities, including specific need-based counseling, many institutions run without regular qualified MHPs, and the available MHPs are either volunteers or associated with the NGOs providing supplementary services like health, recreation, etc.[11,14,16] More so, the practice of continuity of care post-discharge hardly exists. A research conducted by the National Commission for Protection of Child Rights (NCPCR) (2018) in the national capital region (NCR) highlighted that children in child-care homes face many mental traumas in the form of bullying by the seniors, sexual abuse, overcrowding; their foods have unspecified nutritive value, they lack tutors for education and dedicated MHPs to assess their mental health needs.[16] This mandates periodic monitoring of the child-care homes registered or unregistered under the JJS. Though ICPS has taken steps in this line, its outcomes are yet to be seen.

There is a growing incidence of juveniles from Lesbian, Gay, Bisexual, and Transgender (LGBT) communities or with gender identity issues coming in contact with JJS in India.[11] Western literature suggests that the mental health needs of such juveniles are often overlooked, despite them suffering the bullying of the senior inmates and humiliations by the staffs of the institution and being at heightened risk of mental health problems.[33] Data are scarce from India in this regard, but this should not preclude us from exploring and addressing these aspects. MHPs can definitely play a major role in this regard in terms of training, clinical care, and research.

Realization of the holistic care and rehabilitation of the juveniles involved with JJS becomes challenging, as it requires coordination among different agencies such as legal, health, social justice, and educational systems, which at times may have varying and competing goals. Hence, establishing coordination and sensitizing them about the biopsychosocial aspects of juvenile delinquent behaviors could, to a certain extent, bridge this gap[7,11,13] and help in leveraging the available resources. The role of MHPs in this regard cannot be overemphasized.

Stigma is another major hurdle, as the community often considers such juveniles as 'wicked,' 'threatening,' or of 'bad character'[34] and prejudice d them based on their socio-economic status and ethnicity.[11] This leads to marginalization and they getting deprived of the much needed social support and re-integration.[35] Moreover, exaggerated negative portrayal of such juveniles in public media further adds to their stress and worsens their psychological and behavioral problems.[36]

Although JJ Act mandates the maintenance of confidentiality, its violation is not uncommon in our country. MHPs can play a vital role in spreading awareness in the community and advocate for responsible reporting by media; this would help in reducing stigma, thereby preventing psychological and behavioral problems among juveniles and facilitating their rehabilitation.

Lack of awareness about the mental health issues and treatment options also deprive juveniles of early intervention. Western literature suggests that juveniles involved in delinquent behavior or with mental health issues (and their family members) often think that the problems would self-resolve or remain unsure about the treatment.[37] This results in a delay in seeking help till the time such juveniles come in contact with the JJS. Hence, mental health promotion (primary prevention), early identification, and intervention (secondary prevention) become imperative.

Continuity of mental health care and rehabilitation in the community is a crucial aspect for the juveniles involved with the JJS. The socio-cultural milieu of the CICL reinforces their delinquent behavior and exacerbates their mental health problems. Lack of community participation hampers their social reintegration and rehabilitation and increases the frequency of institutionalization and recidivism.[12] Literature suggests that community-based and family-focused interventions (e.g. multisystemic therapy) have favorable mental health outcomes and significantly reduce the rate of juvenile delinquencies.[38] The NCPCR, through ICPS, has taken certain steps such as the provision of open shelter homes and family counseling, but its field level implementation and outcome need to be ascertained.[32]

Opportunities and the road ahead

A standardized curriculum should be developed for the personnel working with a juvenile in contact with JJS in the child care homes (or at the CPPU) and that should include: orientation about child psychology and the different psychological needs of the CICL and CINCP, skill development in identifying and addressing psychological issues of the juveniles, and on-job-training by the MHPs.

A simple, comprehensive screening tool should be developed to screen for mental health disorders (including substance use problems) among all the juveniles at their entry point and which can be applied by even non-MHPs with minimal training.

Capacity building of the CCIs should be ensured by appointing MHPs (including child psychologists and social workers) on a regular basis. Further, regular

auditing of the CCIs for the availability of MHPs, quality-checking of the mental health services, and setting accountability for the concerned authority running the institution should be done. This could ensure the availability of the professional workforce. Moreover, increasing fund allocation to the CCIs would be a promising step in this direction.

Entry-level counseling for the juveniles coming in contact with CCIs should be made mandatory. The counseling should include the rationale behind keeping them in the institute, kinds of situations (e.g. possibility of bullying by the senior inmates) they might face during their stay, and who should be the contact person in case of any mental/physical stress.

Training of the juveniles by the peer trainers (ex-residents of the juvenile homes), in line with peer education practiced in substance use treatment programs, could be another novel and viable option. Because the peers often share similar socio-cultural backgrounds, juveniles may be more comfortable interacting with and learning skills from them.

Job- and livelihood-oriented vocational training (vs. outdated vocational trainings) tailored to the interest and skill of the juveniles should be undertaken. Formal bridge courses, digital learning, and technology-driven skill development would be more effective in this context. Sponsored schemes (under Pradhan Mantri Kaushal Vikas Yojana) and involving professional organizations/NGOs could be welcome initiatives.

The preventive strategy should be strengthened for at-risk populations: school dropouts, first-time offenders, and juveniles with externalizing disorders. Community participation and involvement of NGOs in collaboration with MHPs could not be over-emphasized in this regard.

Inter-sectoral coordination among various agencies should be encouraged. Awareness about child psychology and socio-cultural determinants of delinquent behavior and mental health problems can play a pivotal role in changing the attitude of various stakeholders and thereby would facilitate social reintegration and rehabilitation of such juveniles.

More research work from India, including addressing ethical challenges in researching this vulnerable section, is required to identify the magnitude of mental health problems among the juveniles in contact with JJS and to develop potential interventions.

Post-discharge community re-integration can be ensured by community involvement, public–private partnership, and sponsorship schemes; taking various stakeholders (health, education, and law and order) onboard, and by including family members, if available, of such juveniles.

CONCLUSIONS

This work highlights that the JJS and mental health of the juveniles are intricately related. MHPs can play a key role in the promotion of mental health, prevention of mental illness, and thereby, subsequent contact with JJS, therapeutic intervention at the JJS level, and social rehabilitation. Becoming well-versed with the JJ Act (and its amendment) and acting judiciously would give a clinical and legal edge to the MHPs. There are many challenges in ensuring the psychological well-being of the CICL and CINCP. An attitudinal change among the concerned personnel of JJS and their skill-based approach towards juveniles and participation by the community and other stakeholders in liaison with MHPs are the key steps in this direction.

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Conflicts of interest
There are no conflicts of interest.

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