**From:** [redacted]
**To:**
**Subject:** Submission from Alfred Health YFSS - Dr Adam Deacon
**Date:** Tuesday, 9 April 2024 3:25:23 PM



Children's Rights Team,

Thank you for seeking an opinion regarding service models for children interfacing with the juvenile justice system.

I have worked as a Consultant Child & Adolescent Forensic Psychiatrist for nearly 20 years, including in youth justice centres in Victoria and Tasmania. I have also been the clinical lead in the Alfred Health - Youth Forensic Specialist Service (YFSS) for the last five years. YFSS provides an advisory and consultation (secondary and primary) service. We accept referrals from Child & Youth Mental Health Services, Department of Fairness, Families and Housing (Child Protection) and Youth Justice. We have also accepted a limited number of referrals from schools. We cater to children aged 10-21 presenting with a range of problem behaviours, including: aggression/violence, threats. stalking, fire lighting, animal cruelty and sexualised behaviours.

There are a number of consistent challenges working with this increasingly complex cohort of young people.

I like to think about young people at risk of engaging in problem behaviours as those who have been disadvantaged and limited in opportunities to meet their developmental needs (psychological, social, education, family, health). Taking it from an *unmet needs* perspective, rather than necessarily trying to determine a clear mental health diagnosis, tends to be more helpful in order to formulate an understanding and management plan tailored to the specific needs of the young person.

When a young person engages in problem behaviours, it is akin to an iceberg that has emerged from under the ocean's surface. We can see what has occurred, but we have little or no immediate understanding as to why it has occurred. The iceberg emerges for different reasons and in different contexts. The young person can be haphazardly identified at different times and come to the attention of different services initially assigned to take responsibility for case coordination and management. These services can include schools, Child Protection, mental health services, GP, paediatrician and Youth Justice. Each service provider has their own perspective and associated blind spots. The same child will receive a different

response depending on the service provider.

Each service has variable capacity and competencies in assessing the child (and family) to create a formulation that assists in understanding why the child is engaging in the problem behaviour, and what interventions need to be considered to attend to the specific unmet needs of the child.

Mental health services too commonly look for reasons to exclude young people from their service model; ironically often due to their problem behaviours being considered 'too serious' or 'too complex'. There is also an unfortunate push towards narrowing inclusion criteria to 'serious mental illness', rather than a range of complex behaviours typically stemming from a constellation of attachment-based problems, complex trauma, intellectual limitations, learning disorders, speech and language disorders, neurodiversity, substance use and an array of mental health problems equating to Axis 1 diagnoses. Mental health services usually provide time limited intervention that depends on the child and family's voluntary engagement. If they decline to engage then they were often promptly discharged.

Child Protection will similarly become involved depending on a range of criteria. Cases often close when there are no clear indications for further support.

Youth Justice are only able to stay involved depending on whether the young person is on an Order than mandates involvement. Young people often find themselves in and out of Youth Justice case management.

Schools are often left helpless with young people who engage in problem behaviours at school. They are not equipped to assess the young person's complex presentation and formulate a management plan. Schools are dependent on external services, including mental health, Child Protection and Youth Justice to provide direction. Young people who engage in problem behaviours at school are often expelled and placed at risk of complete disengagement. School in clearly vital for all young people, but particularly for this cohort with specific and complex needs. These young people are often not suited to mainstream schools. Their education needs may be better met in alternative education settings, including TAFE.

In my opinion, a centralized service integrating mental health, schools, CP and YJ needs to be established to remove the unhelpful siloed service systems we currently have. This independent service provider needs to be given the authority to assess the young person and formulate an agreed plan to ensure the young person's unmet developmental needs are addressed. Case formulation and care coordination is a unique skill set that needs to be led by experienced forensic mental health clinicians.  Ideally the young person would be case managed until there are clear

signs of significant improvement and stabilisation.

I would also suggest earlier intervention to be an arm to the new service model. Early intervention is understood to mean different things to different people and organisations. Identifying young people presenting with early warning signs of problem behaviours is necessary. This typically emerges in late primary school and transitioning to secondary school. If we were able to readily identify young people in this age bracket it would inevitably result in enormous benefits to the young person.

Regards

Dr Adam Deacon