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SUBMISSION FOR YOUTH JUSTICE AND CHILD WELLBEING REFORM

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Send to: youthjusticereform@humanrights.gov.au

Throughout this submission, I have tried to remain within the scope of my practice as Youth Justice Mental Health Clinician. I will focus my submission on issues pertaining to the Mental Health needs of this cohort, and how this interacts with systemic barriers. I am unable to comment on factors of a legal scope, such as sentencing and bail requirements, although these are a part of this picture.
I have also limited my response to the first two questions, as I feel unable to comment on the broader questions without further research, and these fall outside of my day-to-day experiences, which is where I feel best placed to contribute.
I have answered to the best of my knowledge, and following a little research, but am happy to be challenged on statistics/specifics quoted within this submission.

Questions:

What factors contribute to children's and young people's involvement in youth justice systems in Australia?

KEY POINTS

Mental Health Factors:

- **Poor Mental Health**

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- **Poor access to appropriate Mental Health Care in a timely manner**
- **A culture of risk aversion in mainstream Mental Health Service**
- **Limited options in terms of forensic Mental Health services to young people who are not sentenced**
- **Limited access to and funding for culturally appropriate supports**

Out of Home Care Factors:

- **Inappropriate out of home care options**
- **Lack of early intervention**
- **Established pathways from OOHC to Youth Justice**

Mental Health

As stated by Rice et al (2023), puberty marks the peak period of both onset of mental disorders, as well as peak period of criminal offending (Simon M. Rice et al., 2023). “The relationship between mental illness and offending varies by disorder, with externalising disorders (e.g. conduct disorder) being directly linked to offending, while internalising disorders (e.g. depression) may contribute to offending indirectly by reducing access to protective factors such as social support and simultaneously increasing exposure to risk factors such as antisocial peers” (Simon M. Rice et al., 2023, p. 2).
Despite the high prevalence of mental health disorders in this cohort, and the (complex and NOT causative) interaction between mental ill health and offending, many of this cohort face barriers to accessing mental health care in community. Whilst there are existing programs, to address this gap, such as the Youth Justice Mental Health Initiative/Program in Victoria (Forensicare, 2023), coordinated by Forensicare, this is limited to six dedicated clinical positions statewide.
While programs such as this provide referral pathways into mainstream mental health services, there are significant barriers. Some of these barriers relate to social determinants “such as unstable housing/accommodation…poverty, lack of transport…and experiences of racism” (Simon M. Rice et al., 2023). However, systemic barriers to youth justice involved young people accessing mental health care also include lack of training and education of Mental Health services around how to work with this cohort, as well as “high risk” ratings on intake scales, and **a culture of risk aversion within mental health services**. Specifically, I have had youth justice clients seeking counselling around the death of a baby, denied counselling at their local Headspace service explicitly because of their offending history, despite a Youth Justice Mental Health Clinician reiterating their low risk rating (they were using drugs at time of offending and were no longer using and had not for several months).

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This attitude of risk aversion and inflexibility by services, disproportionately affects marginalised communities (more on this later).
Another factor contributing to children and young people's involvement in youth justice systems, particularly in relation to recidivism of criminal and otherwise problematic behaviour, is that "access to specialised forensic youth mental health services is often limited or non-existent, especially for young people who are identified as being at increased risk of offending, but who have not yet been charged or convicted (Fraser et al., 2014)" (Simon M. Rice et al., 2023, p. 3). I have, for example, known a young male client exhibiting problematic sexualised behaviour, to the extent that he lost housing, and was exited from two rehabilitation facilities, however because he was on bail for the charges, there were very **limited options in terms of specialist, forensic counselling** specific to his needs.
Another barrier to accessing preventative mental health services is the lack of access to culturally appropriate care. There is consistent data reflecting disproportionately high rates of Youth Justice involvement of Aboriginal and Torres Strait Islander children and young people nationally (The Commonwealth, 2022). In Victoria, for example, incarceration rates were 6.3 x times the rates of non-Indigenous young people in 2020-2021 (Sentencing Advisory Council, 2023). Despite this, programs such as the Youth Justice Mental Health Program only have capacity for a single Youth Justice Mental Health Clinician, specific to Aboriginal referrals statewide. In addition to this, due to workforce issues, there have been challenges in employing an Aboriginal Mental Health Clinician in this role, and there is **no current funding for an Aboriginal Mental Health Worker** to support the non-Indigenous clinician in the role, something which is consistently outlined as best practice where an Aboriginal Clinician is unavailable (Nola Purdie, Pat Dudgeon, & Roz Walker, 2014).

History of Out of Home Care

The link between the child protection and criminal justice systems is well established, earning young people who transition from Child Protection services into the Youth Justice system the moniker "Crossover Kids". The details of this relationship are outlined in 3 reports by the Sentencing Advisory Council 2019-2020 (Sentencing Advisory Council, 2019).
According to the Sentencing Advisory Council report from 2019, children who experienced residential care "were about twice as likely as children who were not known to child protection to be sentenced for particular offence types such as property damage (66% versus 29%), bail-related offences (50% versus 22%), drug offences (23% versus 10%), weapons offences (23% versus 10%)" (Sentencing Advisory Council, 2019). Of these children and young people, they were "more likely to be sentenced for drug use than children not known to child protection (37% versus 28%)" (Sentencing Advisory Council, 2019). One of the most

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shocking statistics from these reports is that “of children first sentenced between ages 10-13, 32% had experienced 10+ carers” (Sentencing Advisory Council, 2019). It is well-established that a lack of early secure attachment is likely to have a lifelong impact on factors such as emotion regulation (Nola Purdie et al., 2014), suggesting concerning outcomes for these children, extending beyond Youth Justice involvement.

Aboriginal and Torres Strait Islander children make up a significant portion of children and young people in OOHC. As at 30th June, 2020, 18,900 (5.6%) of all Aboriginal and Torres Strait Islander children were in OOHC. This is 11 x times higher than the rates for non-Indigenous children (The Commonwealth of Australia, 2021). These rates continue to rise (Public Interest Advocacy Centre, 2022). The pathway for Aboriginal and Torres Strait Islander young people from OOHC to Youth Justice is not only specifically implicated in Closing the Gap outcomes 11 and 12 (The Commonwealth, 2023), but is also intrinsically linked to other Closing the Gap outcomes. For example, the 2023 Closing the Gap annual report, states that “progress towards the targets relating to reducing out-of-home-care (Target 12) and family violence (Target 13) will significantly assist in achieving justice outcomes. Progress on targets that focus on First Nations people’s health and wellbeing, housing, education and employment outcomes, will also benefit justice outcomes (The Commonwealth, 2023, p. 88).

In light of this, it is my strong opinion that **any youth justice reform must also consider out-of-home care reform/improvements** as the two cannot be separated.

What needs to be changed so that youth justice and related systems protect the rights and wellbeing of children and young people? What are the barriers to change, and how can these be overcome?

KEY POINTS

- **Poor continuity of care between and within systems/lack of crossover services/intermediate services**
- **Poor information sharing, limited knowledge by workers around obligations to share/necessity.**
- **Limited access to appropriate healthcare services (including Mental Health)/restricted access for community healthcare providers to custodial settings**
- **Continuity of care failures in medication management**
- **Poor workforce capacity**
- **Poor workforce training**
- **Limited culturally appropriate workforce**

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- **Failure to utilise established culturally validated psychometric tools for assessment and treatment**
- **Lack of family inclusive practice/low impetus to provide family inclusive care in time pressed system.**

From my observations, the Youth Justice system in Victoria is failing to meet the Human Rights of children and young people outlined in the United Nations Convention (The United Nations General Assembly, 1989). I could provide examples of systematic breaches of articles 3, 12, 19, 23, 24, 27, 28, 29, 31, 36, 37 and 39. I will address this question in relation to common themes.

Continuity of Care Failures

There are consistent failures of continuity of care arrangements at multiple levels/systems:

1. Across state lines
2. Across catchments (for example, Mental Health Catchments do not align with school, council, Child Protection and Youth Justice catchment areas (at least in Victoria)) (The issue of catchments is addressed in the Royal Commission into Victoria's Mental Health System, (2021)) .
3. Across systems
4. From youth to adult prisons
5. From custody to community
6. Another barrier facing "justice involved young people living in the community…[who] fall through systemic cracks, often magnified by the mismatch between developmental (10-25 years) and legal (<18 years) definitions of this population" (Simon M. Rice et al., 2023).

Mental Health

Specific to Mental Health, this includes barriers to:

Information sharing:

- Across systems *and*
- from Youth Justice to Adult Justice

For example, a young woman who was on a Youth Justice Order was detained in Adult Custody. The Youth Justice Community Mental Health Clinician attempted to access the mental health service in the prison to pass on information around risk of suicide, however was denied contact to both the young person, as well as the treating

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professionals. I believe this is an infringement upon her right to safety, contact with a cultural service (an ACCHO), and adequate access to appropriate healthcare.

- Across systems

For example, a girl I worked with as a preventative client (she was at risk of Youth Justice involvement following a series of thefts, but with no current charges) was expelled from a Catholic school at age 13. I had worked with the school to develop a Behaviour Support Plan, however, the school ultimately decided they did not have funding for adequate supports in the classroom to meet her needs. It was only several months later, in the process of advocating for her, that I was made aware by a new Child Protection worker that she had existing Program for Students with a Disability funding from a year prior-this had not followed her from the public to the Catholic school system, and I had been unable to access this in developing her Behaviour Support Plan. This lack of communication between services infringed upon her right to access additional support, and ultimately, her right to education.

<u>Access to Psychiatric Care</u>

- Access to a psychiatrist

Whilst young people with mental health needs can usually access full and timely psychiatric care in Youth Justice Centres in Victoria, this is not the case once they exit custodial settings, or, if they continue into adult custody.

In an ACCHO, there is a waitlist of up to 6 months for forensic or at-risk clients to see a Child and Adolescent psychiatrist. This is a significant amount of time for a young person with, for example, those with ‘prodromal’ psychotic symptoms/considered ‘Ultra High Risk’ (Early Psychosis Guidelines Writing Group and EPPIC National Support Program, 2016).

This often means that the only realistic point of access to a psychiatrist for a young Aboriginal person involved in the Youth Justice system in Victoria, is hospital or custody.

In adult custody, there is similarly a significant waitlist to access psychiatric care.

- Access to medication

In Victoria, upon exit from Youth Justice Centres such as Parkville, young people are discharged with up to 7 x days of medication and no repeat scripts. This is because GP’s in custody will not prescribe for community. They also do not have capacity to fulfil Mental Health Care Plans. This results in a situation in which young people prescribed medication in custody (for example, anti-depressant medication) need to see a GP within a week of exit from custody for this medication to be continued. This

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is complicated further in the case of stimulant medication, which many GP's cannot/refuse to prescribe without oversight from a prescribing psychiatrist. As such, many young people are started on medication in custody that they will be unable to/unrealistically expected to continue into community.

Trauma Informed Care

Rice et. al (2023) note that "justice-involved young people experience an average of three adverse childhood experiences (ACES) (e.g. abuse, neglect, and family dysfunction) prior to their first arrest" (Simon M. Rice et al., 2023, p. 4). This is likely to be higher in Aboriginal and Torres Strait Islander populations (although ACES studies neglect to measure both intergenerational impacts of trauma, and the trauma of cultural dislocation, both of which have a significant impact on First Nations people internationally). Rice et al (2023) emphasise the importance of trauma-informed care when working with justice-involved young people.

Despite this, in my experience, Youth Justice systems are decisively not trauma-informed for several reasons:

Staff training

Despite an emphasis in professional training programs on trauma informed care, many workers (non-professionals) in contact with young people involved in Youth Justice, are working entry level roles (for example, custodial staff, residential carers). Having worked in residential care, I experienced little to no training in trauma-informed care during my time in this role (2+ years), despite working with highly traumatised young people.

There are similar deficits across both professional and non-professional workers in terms of cultural sensitivity, something I would suggest should be considered a part of trauma-informed care. Of particular interest to me in my role is the lack of interest of some staff in Aboriginal and Torres Strait Islander cultural needs, and cultural models of social and emotional wellbeing (Nola Purdie et al., 2014; Roz Walker, 2014; Roz Walker, Clinton Schultz, & Christopher Sonn, 2014). In my observation, this is a particular issue within Forensic mental health, and is evident in the dearth of the use of culturally appropriate and validated psychometrics (a good example is the common use of the HCR-20 as a measure of violence risk assessment).

Staffing capacity/workforce

Staffing capacity in Victorian Youth Justice centres is dire, as outlined in recent news articles (Nick McKenzie, 2023). Similarly, the mental health workforce in Victoria is not enough to meet demand. These deficits are well publicised.

Other workforce deficits I observe as affecting this cohort include:

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- A lack of trained Aboriginal Mental Health Workers and Aboriginal Health Practitioners and a lack of training programs
- A lack of culturally specific/defined roles (as outlined earlier, a single Youth Justice Mental Health Clinician for Aboriginal clients across Victoria)
- A lack of Child and Adolescent Psychiatrists, and in particular, forensically trained
- No gazetted psychiatry hours for Youth Justice clients in community settings

A lack of family-inclusive practice

As VAHS Youth Justice Mental Health Clinician, it is my observation that there is consistently poor practice around family inclusivity, particularly in relation to Aboriginal and Torres Strait Islander families. I have witnessed, in a variety of contexts, a broad range of poor practices, from negligence to blatant disrespect.
It is my observation that workers in various roles, consistently fail to engage with family at time of referral, regularly only engage family at times of crisis and not update family around changes in circumstances (for example, when their child is hospitalised or incarcerated).
I have been contacted by families who were unsure which (adult) prison their child (21yrs) was located at, and had custodial staff tell me that if the young person really wanted to contact their mother, they would have memorised her number (with little regard for the chaotic lives that many of our clients families are faced with, including fleeing domestic violence).

I have observed the failure of the system to adequately acknowledge the trauma of Justice involvement on families, as well as the compounding of intergenerational trauma, when parents are unable to help their young person through these systems, often through which family members have been themselves. I have worked in my practice to facilitate referrals for family members, as well as make an effort to locate and communicate with family members the young person identifies as important (for example, connecting with a father who was incarcerated in an adult prison around his daughter's mental health needs, or arranging an AOD referral for a client's mother), however, there is little impetus to work like this as the system is currently. I believe improved family inclusive practice will require significant cultural change within the Youth Justice and Mental Health systems, and that this is something that ACCHO's and other ACCO's could educate mainstream services on.
Unfortunately, I have run out of time to expand on the above. Should you require further information or specifics in relation to any of the above, please contact me, I would be happy to talk about any of these points further.

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