26 October 2016

The Hon Justice Margaret White AO
Chair
Office of the Royal Commission
PO Box 4215
KINGSTON ACT 2604

Email: childdetentionNT@royalcommission.gov.au

Dear Justice White

Re: Royal Commission into the Protection and Detention of Children in the Northern Territory

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to contribute to the Royal Commission into the Protection and Detention of Children in the Northern Territory (the Royal Commission). The RANZCP strongly supports the purposes of the Royal Commission to investigate failings in the youth detention and child protection systems in the Northern Territory as well as recommendations for their improvement.

Like many others, the RANZCP was deeply concerned at the footage of the Don Dale Youth Detention Centre that prompted the establishment of the Royal Commission. Given the significant link between trauma in childhood and future psychiatric and social problems, the RANZCP advocates for attitudes and practices within both the youth detention and child protection systems that are guided by compassion and founded on a commitment to ensure that supportive, caring and non-traumatising early experiences are provided for all children and young people. The RANZCP further advocates for the adequate provision of developmentally appropriate mental health care to children and young people in youth detention, with at least equivalence to best-practice community standards.

The RANZCP represents around 3700 psychiatrists in Australia, many of whom have specific interest and expertise directly relevant to this inquiry. In developing this submission, the RANZCP has worked closely with its expert committees and members, to ensure that the recommendations made reflect clinical excellence, community experience and insight. This includes consultation with the RANZCP Faculty of Forensic Psychiatry and Faculty of Child and Adolescent Psychiatry, as well as our Northern Territory Branch and the RANZCP’s Aboriginal and Torres Strait Islander Mental Health Committee (which includes consumer and carer membership). The recommendations contained within this submission are therefore based on the expertise and clinical experience of our committees and members, including pre-eminent child and adolescent, and forensic psychiatrists.
Please see the attached submission which we hope will be of assistance in the inquiry. If you would like to discuss any of the issues raised in the submission, please contact Rosie Forster, Senior Department Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely

[Signature]

Professor Malcolm Hopwood
President

Ref: 0499o
maximising opportunities for recovery
About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 5000 members, including around 3700 fully qualified psychiatrists and almost 1200 members who are training to qualify as psychiatrists. Psychiatrists are prominent among clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey to recovery. The RANZCP is guided on policy issues by a range of expert committees whose membership is made up of leading psychiatrists with relevant expertise, and consumer, carer and community representatives.

Executive summary

There is a significant body of evidence documenting the links between mental health issues and incarceration, as well as between childhood trauma and future psychosocial problems. Without adequate levels of developmentally appropriate mental health services, at-risk children and young people face significant obstacles in their paths to recovery and staff in youth detention centres face significant difficulties in managing children and young people in their care. It is therefore critical that children and young people known to child protection services and/or the juvenile justice system are provided with meaningful treatments and interventions.

The RANZCP affirms the significant benefits of a justice reinvestment approach to criminal justice involving measures to decrease rates of incarceration and recidivism by investing in services in the community. The value of a justice reinvestment approach lies in its potential to direct resources away from prison building and into community building, thereby strengthening and empowering communities to help people at risk of developing mental health issues and reduce offending.

Mental health is the third largest burden of disease in Australia and yet perhaps the most underfunded of all diseases in terms of that burden. Mental health funding in the Northern Territory is among the lowest of all jurisdictions with the Northern Territory scoring the lowest on most measures of resourcing including the availability of both inpatient beds and community residential placements as well as staff. Furthermore, there is no youth- or adolescent-specific forensic mental health service in the NT at all and existing child and adolescent mental health services do not have capacity to provide sufficient in-reach services to youth detention centres.

Early intervention strategies targeting the mental health of children and young people, particularly those who have experienced significant trauma and adversity, reduce the likelihood of adverse outcomes in relation to future offending. Thus, the development and implementation of early intervention strategies for the prevention of psychiatric disorders associated with increased incarceration rates is critical in efforts to reduce offending and guide juvenile offenders towards recovery and rehabilitation.

The RANZCP therefore advocates for the increased provision of mental health services to children and young people known to the child protection and juvenile justice systems, as well as for attitudes and practices within both systems that are guided by compassion and founded on a commitment to ensure that supportive, caring, and non-traumatising early experiences are provided for all children and young people in our care.
Summary of key recommendations

It is the RANZCP’s position that the detention of children should only occur as a last resort, for the shortest possible period of time and with the decision informed by the best interests of the child. When/if detention does occur, the RANZCP recommends:

- the development of long-term strategies aimed at reducing, and where possible, eliminating the use of seclusion and restraint on children and young people in detention facilities
- adequate facilities and freedoms provided to secluded detainees including:
  - consistent and unobstructed access to drinking water
  - respect for privacy when showering and toileting
  - facilities for hand washing in cells with toilets
  - temperature control
- the establishment of protocols pertaining to crisis intervention which:
  - are specific to children and young people, taking into consideration their developmental needs
  - cover the need for seclusion and restraint to be used only as a last resort
  - include mechanisms to ensure a high level of accountability when using seclusion and restraint, including the monitoring of critical incidents
  - include reference to negotiation and de-escalation techniques as well as the proper use of PART (Predict, Assess & Respond to Challenging/Aggressive Behaviour)
  - are incorporated into staff training arrangements
- the development of strategies to ensure that youth detention facilities are founded on trauma-informed approaches to treatment and rehabilitation
- improved education and training of staff in youth detention facilities around the mental health needs of children and young people, including appropriate responses to threats or actual instances of self-harm
- the inclusion of relevant facts about past harmful practices, and evidence of their ongoing impact, in the core training curriculum of youth detention staff members, including how to be sensitive when dealing with individuals affected by harmful practices in the past, and to understand the consequences of traumatic memories in the present
- improved education and training of staff in youth detention facilities around cultural competency including specific training in Aboriginal and Torres Strait Islander cultural competency and trauma-informed care, including the effects of transgenerational trauma on the developmental and mental health of Aboriginal and Torres Strait Islander children and young people
- increased support of youth detention staff members to ensure they are psychologically equipped to deal with crisis situations and other workplace hazards
- investment in a Youth Forensic Mental Health Service to meet the treatment needs of children and young people in detention as well as the educational needs of staff employed by youth detention centres
• provision of in-reach mental health and drug and alcohol services, delivered by local child and adolescent mental health services, that are trauma-informed and include screening to assess the mental health, drug and alcohol and developmental needs of children and young people in detention

• policies guaranteeing equivalence of health care for those with mental illness in the criminal justice system, taking into account the higher prevalence of mental disorder amongst individuals in custody when compared to the general community

• implementation of the recommendations made by the Children’s Commissioner and the Department of Correctional Services’ Vita report

• review of the functioning of official visitors, as enshrined in Part 9 of the Youth Justice Act.

With regard to child protection services, the RANZCP recommends:

• age-appropriate screening and assessment of mental health concerns and risk factors in all children and young people known to child protection services, including children entering out-of-home care, with reference to the New Orleans Model which has demonstrated effectiveness internationally

• mechanisms to ensure that recommendations arising out of the mental health assessments of children and young people known to child protection services can be implemented, ideally via referral to age-appropriate, evidence-based clinical interventions grounded in trauma-informed and culturally appropriate approaches to care

• the provision of systematic and mandatory training for out-of-home care service providers and foster carers from point of entry into the residential care sector delivered by experienced facilitators, incorporating:
  o information on the particular vulnerabilities of children in out-of-home care
  o information on healthy developmental stages
  o attachment theory and practice
  o background to the psychopathology experienced by children in out-of-home care
  o an overview of the compounding effects of neurological, psychological, emotional, behavioural and relational sequelae and how this relates to the provision of care
  o the reparative parenting training model
  o empowerment to set developmentally appropriate limits on the movement and affiliations of young people in out-of-home care
  o information on problem sexual behaviour

• regular, ongoing supervision for out-of-home care service providers and foster carers

• improved education and training of staff in child protection agencies around cultural competency and cultural responsiveness, including the effects of transgenerational trauma on the developmental and mental health of Aboriginal and Torres Strait Islander children and young people
approaches that promote the preservation of ties between Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) children and young people and their communities and cultures

the use of professional interpreters where there are language barriers

strengthening the implementation of the Aboriginal and Torres Strait Islander Child Placement Principles through:
  o increased recruitment of Aboriginal and Torres Strait Islander carers and support for their skill development
  o additional investment in developing Aboriginal and Torres Strait Islander leadership and participation in decision-making and monitoring processes
  o improved linkages between communities and government including improved communication and education regarding the intent of the Principles.

In recognition of the significant links between mental health and juvenile offending, the RANZCP also recommends:

significant investment in prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations

built-in, formal economic evaluations for all trials of prevention and early intervention programs for children and young people to determine whether they have provided value in terms of justice reinvestment

specific attention paid to at-risk groups including the screening of vulnerable children and young people for early identification of mental illness and/or psychosocial difficulties

the development of targeted prevention and early intervention programs for at-risk children and young people, including Aboriginal and Torres Strait Islander peoples.

Further recommendations are provided in the relevant sections of the submission below.
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Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to contribute to the Royal Commission into the Protection and Detention of Children in the Northern Territory (the Royal Commission). In developing this submission, the RANZCP worked closely with its expert members and representatives including the Faculty of Child and Adolescent Psychiatry, Faculty of Forensic Psychiatry, Section of Child and Adolescent Forensic Psychiatry, Section of Youth Mental Health, Aboriginal and Torres Strait Islander Mental Health Committee and the Northern Territory Branch members. The recommendations contained within this submission are based on both the expertise and clinical experience of our members, including pre-eminent child and adolescent, and forensic psychiatrists, as well as the experiences and insights of community members, including members of Aboriginal and Torres Strait Islander communities.

The RANZCP strongly approves of the purposes of the Royal Commission to investigate failings in the youth detention and child protection systems in the Northern Territory. Increasing demands on youth detention systems require appropriate resourcing and management so as to ensure the proper protection and care of detained children and young people. The development of robust protocols and policies in youth detention facilities are especially important now given recent calls in other states to establish behavioural management units similar to the Don Dale Youth Detention Centre (ABC News, 2016). While the RANZCP recognises the geographical scope of the Royal Commission, it also recognises that many of the issues to be discussed, and recommendations to be made, are relevant across the country.

Given the significant links between mental health issues and incarceration, the RANZCP believes that adequate resourcing for mental health care is imperative to stem the tide of youth incarceration. This is true in relation to both youth detention centres and child protection services, where large numbers of at-risk young people may be identified and provided with suitable services to aid them in their recovery and/or rehabilitation. Unfortunately, these systems all too often provide experiences which compound trauma and mental health issues, rather than alleviate them. Given the well-documented connections between childhood trauma and future psychosocial problems, the RANZCP advocates for attitudes and practices within both the youth detention and child protection systems that are guided by compassion and founded on a commitment to ensure that supportive, caring, and non-traumatising early experiences are provided for all children and young people in our care.

The RANZCP further notes the under-resourcing of mental health care in the Northern Territory where mental health funding is among the lowest of all jurisdictions. The Northern Territory scores the lowest on most measures of resourcing including the availability of both inpatient beds and community residential placements as well as staff. Furthermore, there is no youth- or adolescent-specific forensic mental health service in the NT at all and existing child and adolescent mental health services do not have capacity to provide sufficient in-reach services. As such, the RANZCP affirms the significant benefits of a justice reinvestment approach to criminal justice involving measures to decrease rates of incarceration and recidivism by investing in services in the community. The value of a justice reinvestment approach lies in its potential to direct resources away from prison building and into community building, thereby strengthening and empowering communities to help people at risk of developing mental health issues and reduce offending. Early intervention strategies targeting the mental health of children and young people, particularly those who have experienced significant trauma and adversity, reduces the likelihood of adverse outcomes in relation to future offending. Thus, the development and implementation of early intervention strategies for the prevention of psychiatric disorders associated with increased incarceration rates is critical in efforts to reduce offending and guide juvenile offenders towards recovery and rehabilitation.
Youth detention systems

Background

Before examining the particular conditions of youth detention facilities, it is important to note the effects of detention itself on the mental health of children and young people. The removal of a child from their home is a highly stressful experience encompassing the child’s loss of liberty, personal identity and familiar landscape, compounded by the loss of social supports and coping mechanisms including family and friends, school, sports and other activities. Events of this kind will place psychological stresses on any child with at-risk children and young people more vulnerable to the effects of psychological trauma.

Studies of children in immigration detention facilities is telling. Although there are many differences between these population groups, some points nevertheless bear mentioning. A body of evidence exists demonstrating the detrimental effects of immigration detention on the development and mental health of children including the potential of prolonged detention to cause long-term damage to social and emotional functioning (RANZCP, 2014b). While even short periods of detention have been found to impact children’s functioning (Fazel et al., 2012; Dudley et al., 2012), children detained for long periods of time have been found to be at high risk of suffering mental illness and post-traumatic stress symptoms. There is also clear evidence establishing a relationship between the length of detention and the severity/comorbidty of psychiatric disorders (Bull et al., 2012). Detention has also been found to compound distress in children with prior experience of trauma, torture or neglect (Burrell, 2013).

Many children and young people in youth detention centres have prior experiences of trauma which are difficult to address in detention settings where continued exposure to stress is likely to impact adversely on recovery. The protection and strengthening of a child’s attachment relationships is central to promoting healthy development and well-being. Many children and young people who come into contact with the juvenile justice system have already experienced significant disruptions to their attachments, and their relationships with caregivers are often tenuous at the time they enter detention. The separation engendered by detention is likely to further disrupt the abilities of children and young people to maintain their attachment relationships, causing significant psychological harm.

Comprehensive assessment of children in detention should therefore examine the effects of traumatic exposure, the role of environmental deprivation and the availability of parental emotional support in contributing to mental and developmental well-being. Mental health functioning in child and young people in detention should be assessed by child and adolescent psychiatrists or other mental health specialists with appropriate expertise. Where mental illness is identified, it should be managed outside the detention environment whenever possible. Given the significantly higher rates of mental illness, as well as general health problems, among children and young people in the juvenile justice population, all children and young people who enter custody should, at a minimum, receive a screening health assessment upon entry to custody. If mental health concerns are identified, then that person should be offered a comprehensive mental health assessment including referrals for appropriate treatment.

Wherever possible, children and young people who have committed offences should be managed in community settings with primary caregivers to ensure their attachment relationships are not threatened. When this is not possible, there needs to be an assessment of the impact of family separation and the availability of alternate attachment figures. This is particularly significant for Aboriginal and Torres Strait Islander peoples given the complexity of their family relationships arising from systems of kinship.
It is therefore the RANZCP’s position that the detention of children should only occur as a last resort; where it does occur, it should be for the shortest possible period of time and with the decision informed by the best interests of the child. When detention does occur, it is absolutely imperative that children in detention be treated with dignity and respect, and have adequate access to health care and non-clinical support to support their development and, where relevant, recovery. Under the current model of youth detention, however, the RANZCP is concerned that detention is more likely to contribute to adverse mental health outcomes.

The provision of mental health care to children and young people in detention

The need for mental health services within youth detention centres

There is a significant body of evidence which demonstrates that children and young people in detention exhibit higher rates of mental health issues than the general population. While much of the evidence is not specific to the Northern Territory, RANZCP members have expertise and experience to attest to the relevance of national and international data to the situation at hand. Prisoners experiencing mental illness are more vulnerable to other prisoners and pose a higher suicide risk; they also pose a considerable challenge to prison management. Both correctional and health agencies have responsibilities in relation to prisoners but their competing priorities can be difficult to reconcile.

The correlations between mental ill health and incarceration are well documented (White et al., 2016), attesting to the importance of providing appropriate mental health care to detained children and young people with the dual goals of treatment and rehabilitation. Youth incarceration has been found to be associated with increased risks of suicidality and psychiatric disorders including depression, substance use, and behavioural disorders (Barnert et al., 2016; Schuftel and Cocozza, 2006; Casiano et al., 2016). Epidemiological studies in the US indicate that 40–55% of detained adolescents meet the diagnostic criteria for behavioural disorders including conduct disorder and oppositional defiant disorder, 60–70% meet the criteria for non-behavioural mental disorders while 45–50% meet the criteria for a substance abuse disorder (White et al., 2016). Australian studies have found less pronounced but nevertheless significantly above-average rates of mental illness among young people in detention (Kasinathan, 2015).

Furthermore, risk factors for suicidality among children and young people are more prevalent among detained children and young people (National Action Alliance for Suicide Prevention, 2013). The ‘principle of equivalence’ affirms the rights of individuals to access to health care which is appropriate to their needs, regardless of their legal status. As such, it is imperative that children and young people in detention facilities have consistent access to high-quality mental health care to address their individual needs.

Conduct disorder bears particular mention here as it is a common childhood disorder marked by a persistent pattern of disruptive behaviour that infringes upon the rights of others or violates social norms. Young people with conduct disorder may cause serious physical and psychological harm to others and are overrepresented in detention systems. Epidemiological studies show a correlation between those who experience psychiatric disorders in childhood and adulthood with children and young people with conduct disorder at particular risk of developing further mental health problems later in life (Kim-Cohen et al., 2003). Behavioural problems experienced from as early as 3 years of age can be predictive of adult psychiatric problems. Early intervention significantly reduces the psychiatric morbidity experienced in children and young people and may well reduce the prevalence and severity of psychiatric disorders later in life.

However, the mental health needs of at-risk children and young people in the Northern Territory can be difficult to address prior to their entry into the juvenile justice system considering the relative lack of
mental health funding in the Northern Territory which scores the lowest of all Australian state and territories on most measures of resourcing including the availability of beds and staff. Child and adolescent mental health services in the NT are already overstretched meaning that there is little capacity to reach at-risk children and young people before they come into contact with the juvenile justice system, especially in remote areas including Aboriginal communities. Furthermore, the capacity of these services to provide in-reach treatments to children and young people in detention is limited.

The provision of mental health services within Northern Territory youth detention centres

The RANZCP is concerned about reports it has received regarding the unmet mental health needs of children and young people in detention. Initial screening of children and young people entering detention in the Northern Territory is undertaken by a general health nurse without any specific screening of mental health issues. Detainees then have access to a GP but referrals for psychiatric assessment are usually only made when there is an identified risk, at which point they will be referred to a hospital emergency department for assessment. There is no youth- or adolescent-specific forensic mental health service in the NT and the adult forensic mental health team will only see children and young people in situations of acute risk and with limited provision of treatment. The RANZCP is aware of situations where psychiatrists have made recommendations for the treatment of children and young people in detention which have not been implemented, sometimes many months later. Given the significant prevalence of mental health issues among children and young people in detention, it is critical that detainees have the ability to receive timely interventions delivered in the setting.

Access to mental health care is necessary, not only because of the high prevalence of psychiatric disorder among children and young people in detention, but also due to the increased psychological stresses of the detention setting. This is because even when the diagnostic criteria for a psychiatric disorder are not met, the detention setting still heralds serious implications for the healthy psychosocial development of children and young people in detention. Furthermore, what is often interpreted as delinquent behaviour within detention facilities may in fact be the normal functioning of children who have experienced abuse and/or neglect and thus assumed the responsibility for taking care of themselves (Burrell, 2013). The RANZCP therefore recommends the embedding of mental health assessments into youth detention processes in order to ensure that the varying mental and developmental health needs of detainees are adequately addressed.

Children and young people with conduct disorder and/or other mental health issues which may result in behavioural difficulties do not appear to be receiving adequate treatment in youth detention facilities. The Northern Territory Correctional Services Directive 2.4.5 approves the use of ‘management regimes’ for:

- a prisoner [who] through his/her attitude, conduct and behaviour continually jeopardises the good order and security of a prison, threatens the health and safety of staff, other prisoners or themselves…

(Children’s Commissioner, 2015)

The RANZCP expresses concern that management regimes may be applied to children and young people with conduct disorder without due regard for their health-care needs. Particularly concerning is the implementation of management regimes at the Don Dale Youth Detention Centre utilising long-term seclusion without consultation with case workers or health professionals, as was reported by the Children’s Commissioner (2015). The RANZCP believes that management regimes should not be applied without the appropriate screening of children and young people with behavioural issues for mental disorder.
It should be noted that the National Statement of Principles for Forensic Mental Health states that ‘legislation should not allow coercive treatment for mental illness in a correctional setting’ (AHMC Mental Health Standing Committee, 2006). The principle of equivalence also requires that if involuntary treatment is necessary, it must be performed in hospitals to ensure that proper safeguards apply and vulnerable prisoners are not placed at risk of direct harm. As such, where children and young people in detention centres are diagnosed with conditions requiring intervention but refuse treatment, they should be treated outside of the correctional setting. However, there is no child and adolescent inpatient psychiatric unit in the Northern Territory, meaning that children and young people requiring inpatient care will usually be housed in a paediatric ward or an adult inpatient setting, neither of which are at all suited to the treatment of child and adolescent mental health issues.

It is imperative that children and young people in detention facilities have consistent access to high-quality mental health care including the involvement of child and adolescent mental health services. In recognition of the important role which mental health services have to play in the youth detention system, the National Commission on Correctional Health Care in the USA has released guidelines recommending that youth detention facilities implement behavioural screening within 14 days of intake followed by daily treatment services upon request (Committee on Adolescence, 2011). It is the RANZCP’s position that monitoring by psychiatric professionals should be mandated for all children and young people in detention. Comprehensive assessment of children in detention should examine the roles of environmental deprivation, availability of parental emotional support and traumatic exposure in contributing to a clinical disorder. Psychiatric illnesses in child and adolescent detainees should be assessed by child and adolescent psychiatrists or forensic psychiatrists with adolescent experience. Where possible, identified psychiatric illnesses should be managed outside the detention environment as continued exposure to traumatic stress associated with the detention environment undermines treatment and the possibility for recovery (RANZCP, 2014b).

Recommendations

Pursuant to the evidence above, the RANZCP recommends:

- improved education and training of staff in youth detention facilities around the mental health needs of children and young people, including appropriate responses to threats or actual instances of self-harm
- investment in a Youth Forensic Mental Health Service to meet the treatment needs of children and young people in detention as well as the educational needs of staff employed by youth detention centres
- provision of in-reach mental health and drug and alcohol services, delivered by local child and adolescent mental health services, that are trauma-informed and include screening to assess the mental health, drug and alcohol and developmental needs of children and young people in detention
- policies guaranteeing equivalence of health care for those with mental illness in the criminal justice system, taking into account the higher prevalence of mental disorder amongst individuals in custody when compared to the general community.

Furthermore, the RANZCP recommends:

- mental health screening of all children and young people in detention to assess their mental health, drug and alcohol and developmental needs:
o upon intake
o prior to the implementation of management regimes
o whenever the use of seclusion and restraint are employed
o at regular intervals

- mechanisms that enable children and young people in detention to be diverted from detention centres into appropriate mental health settings if they are in need of involuntary mental health treatment.

Institutional practices and the mental health needs of children and young people in detention

Cruel, inhumane and degrading practices

The RANZCP strongly condemns the use of torture or other cruel, inhumane or degrading treatments or punishments under any context (RANZCP, 2015a) and for any age or racial/ethnic cultural group. The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ratified by Australia in 1989, defines ‘torture’ as:

any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity (UN General Assembly, 1984) (emphasis added).

The RANZCP therefore expresses extreme concern at footage documenting what it considers to be the cruel, inhumane and degrading treatment of children and young people at the Don Dale Youth Detention Centre. Tear gas, or orthochlorobenzalmalononitrile (CS) gas, is a chemical agent and its use on unarmed children and young people is unjustifiable. The lack of adequate attempts at negotiation to resolve the incident on 21 August 2014 without the use of force, as documented by the Children’s Commissioner (2015), is similarly unjustifiable. Subjecting children and young people to these extreme measures without due regard for all alternative methods is not merely equivalent to child abuse, but in fact constitutes severe child abuse, and the RANZCP expresses its disapproval of such actions in the most extreme terms. The rights of all children to be treated with respect for their individual human worth and dignity must not be waived in any circumstance, regardless of an individual’s history of offending or their behaviour while detained.

Seclusion and restraint

The damaging effects of solitary confinement on children and young people is well documented (HRW and ACLU, 2012; Gallagher, 2014). Seclusion not only exacerbates pre-existing mental health conditions but has long been known to even create new ones (HRW and ACLU, 2012; Mitchell and Varley, 1990). Children and young people have fewer coping mechanisms when faced with solitary confinement and have reported adverse effects to seclusion including extreme anxiety, rage, depression, self-harm, suicidal thoughts, suicidal attempts and hallucinations (HRW and ACLU, 2012). Isolation may evoke

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1 Even Don Dale staff have described the treatment as ‘inhumane’ (Children’s Commissioner, 2015).
memories of past traumas, reawaken feelings of fear, powerlessness and loneliness and/or leave children and young people alone with negative thoughts; thus, the use of seclusion may well be traumatising for individuals with prior exposure to trauma (Simkins et al., 2012; Burrell, 2013). In recognition of the developmental vulnerability of children, the United Nations General Assembly forbade the use of seclusion on detained children and young people through adopted resolution 45/113 which clearly states:

All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.

(UN General Assembly, 1990b)

Seclusion and restraint have long been used in mental health-care settings as emergency measures to manage violent behaviour or agitation. Studies have reported substantial deleterious physical and more often psychological effects on both patients and staff (Fisher, 1994) with patients experiencing the use of seclusion and restraint as emotionally unsafe, disempowering and potentially (re)traumatising (Muskett, 2014). Adolescent psychiatric units, unique settings wherein children and young people are frequently held against their will, therefore provide a useful point of comparison regarding the institutional use of seclusion and restraint on children and young people.

In mental health-care settings, seclusion and restraint should only ever be used as a safety measure of last resort where all other interventions have been tried or considered and excluded. Under these circumstances, seclusion and restraint should be used within approved protocols by properly trained professional staff in an appropriate environment for safe management of the patient. Seclusion and restraint should not be used as a substitute for inadequate resources (such as lack of trained staff or accommodation) nor as a method of punishment. However they are still deployed for these purposes far too often, albeit ineffectively. Seclusion and restraint are thus being phased out in many psychiatric inpatient settings, either completely or except in the most extreme circumstances.

The RANZCP expresses concern at allegations of the inappropriate use of seclusion and restraint at the Don Dale Youth Detention Centre. A report from the Children’s Commissioner investigating these allegations evidenced a patterned use of seclusion as a method of punishment compounded by:

- inhumane and unhygienic conditions within the secluded area
- lengthy stays without clarification from staff regarding the length of time to be spent in seclusion
- the non-termination of seclusion after the resolution of behavioural issues which led to its use in the first instance
- a lack of monitoring and supervision of children and young people in seclusion (Children’s Commissioner, 2015).

Use of seclusion in this manner is unlikely to resolve behavioural issues; instead, it serves to reinforce the sense of mistrust experienced by children and young people who have experienced trauma. The RANZCP expresses further concern at allegations regarding the indiscriminate use of restraint measures, including handcuffs and ‘spit hoods’, on children and young people. As experiences in mental health care have demonstrated, seclusion and restraint should be minimised and eliminated wherever possible. Their indiscriminate and systematic use is cause for very serious concern with regard to the developmental and mental well-being of the children and young people involved.

With the emergence of trauma-informed care, there is increasing recognition of the need to reduce coercive practices including restraint and seclusion. All Australian jurisdictions have introduced laws,
policies or guidelines focusing on reducing seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint. In 2005, Australian health ministers endorsed the National Safety Priorities in Mental Health: a National plan for reducing harm which identified four priority areas for national action including ‘reducing use of, and where possible eliminating, restraint and seclusion’ (National Mental Health Working Group, 2005). The RANZCP is also committed to reducing, and where possible eliminating, the use of seclusion and restraint in mental health-care settings (RANZCP, 2016b). Reduction of seclusion and restraint is certainly possible, as demonstrated by studies such as those in the United States which have reduced use considerably without additional resources (Huckshorn, 2005). The RANZCP would strongly encourage organisations in relevant settings including the criminal justice system to consider the significant harm caused by seclusion and restraint and make all reasonable attempts to minimise and, where possible, eliminate the use of seclusion and restraint on children and young people in detention facilities.

Trauma-informed care in youth detention facilities

While it may sometimes be necessary for the protection of the individual and/or the community, detention of children is in contravention of responsibilities under the United Nations Convention on the Rights of the Child, ratified by Australia in 1990, when it is not aligned with the following:

- Article 3(1): the best interests of the child must be a primary consideration in all actions concerning children
- Article 37(a),(c): children in detention have the right to be treated with humanity and respect for the inherent dignity of the person
- Article 6(2), 39: children have the right to enjoy, to the maximum extent possible, development and recovery from past trauma.

Trauma-informed approaches to care are fundamental to best-practice mental health care and their relevance within the criminal justice system is becoming increasingly recognised. A trauma-informed approach to youth detention is based first and foremost on an understanding that juvenile offending is best addressed throughout treatment and rehabilitation. The assumption that punitive measures deter children and young people from criminality has been largely refuted by scientific studies and evaluations of juvenile corrections systems (Burrell, 2013). As such the RANZCP supports a trauma-informed model replacing the deterrence model to ensure that the youth detention system has adequate supports to facilitate the recovery and rehabilitation of children and young people in its care.

The Children’s Commissioner’s investigation into the Don Dale Youth Detention Centre uncovered a number of failings with regard to the provision of trauma-informed care. As centres of rehabilitation, youth detention systems should have robust programs to ensure adequate health care, education and recreation for all detained children and young people. Reports of the Don Dale facility lacking a ‘comprehensive structured day, which includes elements of work, programming, recreation, cleanliness, hygiene and schooling’ (Vita, 2015; also see Children’s Commissioner, 2015) is therefore concerning.

According to the Children’s Commissioner (2015), ‘there is no formal process in place to inform the young people of their right to contact and make a complaint to Children’s Commissioner’. Even when an individual is knowledgeable about their rights and acts upon them, their communication may not be anonymous. Without assuring children and young people in detention of their safety, feelings of insecurity are likely to aggravate psychosocial difficulties. Many children and young people in detention who have suffered trauma have only had experiences of adults failing to protect them and so have an
inherent mistrust of caregivers; thus, it is imperative that the detention setting provide a counterpoint to that for rehabilitation to occur.

The physical environment is further cause for concern. Notwithstanding appropriate requirements for control and safety, detention centres should cultivate an environment of safety to facilitate the healthy development of detained young people and children. Descriptions of the Behavioural Management Unit at the Don Dale Youth Detention Centre attest to the need to drastically improve the physical environments in youth detention:

The cells do not have any air-conditioning, or fans. There are no facilities for the young persons to access drinking water, nor are there any facilities for hand washing after using the toilet, or before eating meals. There are no windows which allow direct natural light, or ventilation…There is a shower [in the exercise yard] partially enclosed by a three-quarter height wall in the corner, and a water tap. The shower is not private, as persons in some of the cells can see directly into the shower (particularly, cells 5, 4 and 3)...

People behave differently when they are placed in foreign environments and the use of unsettling jail-like environments in youth detention centres are likely to create feelings of insecurity and unsafety in children and young people who are detained there. This will, in turn, disrupt their healthy development and prevent the meeting of their psychosocial needs.

Appropriate staff training is required to ensure that staff possess adequate knowledge and skills to follow a trauma-informed approach to their work. For example, the RANZCP supports the use of Predict, Assess & Respond to Challenging/Aggressive Behaviour (PART) to help with de-escalation, particularly noting its utility for the minimisation of seclusion and restraint. In health-care settings, appropriate staff training regarding the early warning signs of aggression, including how to use structured violence risk assessments, has been shown to result in reductions in violence and the use of seclusion and restraint (Kasinathan et al., 2015). As such, the RANZCP strongly recommends the further development of risk assessment protocols within the context of youth detention facilities.

Increasingly, criminal justice reformists are advocating for community-based treatments and other alternatives to incarceration in the hope of avoiding the institutional retraumatisation of juvenile offenders within detention facilities. Where community-based treatments are not possible, detention facilities would do well to be informed by Burrell's (2015) comprehensive overview of trauma-informed approaches to care in youth detention facilities. Recommended mechanisms include front door screening and orientation, institutional values, staff training, behavioural intervention techniques and adjustments in physical environment to reduce potential exposures to trauma. Burrell also elucidates several key elements in a trauma-informed approach to youth detention including that:

Staff are sensitive and alert to whether a young person is in distress, and appropriate steps are taken to address concerns.

Youth are informed that their needs will be recognized; for example, that ‘safe zone’ signs are posted to help LGBTQ youth feel more at ease, and youth are informed of non-discrimination policies.

Interviews about sensitive information occur in private areas.

Youth are informed about safety in the facility, for example, how gang issues are handled, what protections there are to assure safety, and how to confidentially report any problems.

Searches are no more intrusive than needed for intake…

Youth are screened for trauma, and further assessment occurs where needed.

Youth receive all of the information they need about their rights and the institutional rules in a form they can understand.
Youth receive information about how to register complaints or to speak confidentially to someone who can help them if problems arise.

Particular mention is made of the importance of avoiding the unnecessary use of force, including seclusion and restraint, the utilisation of positive behaviour management methods and the adaptation of the physical environment to creating a trauma-informed environment of care. The RANZCP supports all efforts to create safer environments for detained children and young people and would welcome any further efforts to ensure a trauma-informed approach is taken with regard to the management of children and young people in detention facilities.

Recommendations
Pursuant to the evidence above, the RANZCP recommends:

- adequate facilities and freedoms provided to secluded detainees including:
  - consistent and unobstructed access to drinking water
  - respect for privacy when showering and toileting
  - facilities for hand washing in cells with toilets
  - temperature control

- the development of long-term strategies aimed at reducing, and where possible, eliminating the use of seclusion and restraint on children and young people in detention facilities

- the establishment of protocols pertaining to crisis intervention which:
  - are specific to children and young people, taking into consideration their developmental needs
  - cover the need for seclusion and restraint to be used only a last resort
  - include mechanisms to ensure a high level of accountability when using seclusion and restraint, including the monitoring of critical incidents
  - include reference to negotiation and de-escalation techniques as well as the proper use of PART
  - are incorporated into staff training arrangements

- the development of strategies to ensure that youth detention facilities are founded on trauma-informed approaches to treatment and rehabilitation.

Furthermore, the RANZCP recommends:

- adequate resourcing to ensure youth detention facilities have appropriate infrastructure to complement a trauma-informed approach

- ratification of the Optional Protocol to the Convention against Torture.

The importance of cultural competency in the care of children and young people in detention

Young Aboriginal and Torres Strait Islander people are more likely than other ethnicities to be incarcerated in NT detention centres with one report from the Australian Institute of Health and Welfare
(2013) finding 89–100% of detained young people were from this group. Aboriginal and Torres Strait Islander people also suffer from high levels of psychiatric morbidity and mortality as well as high levels of drug and alcohol disorders and compromised well-being, far in excess of non-Indigenous Australians. There are complex social and historical reasons for this including transgenerational trauma from decades of maltreatment compounded by individual traumatic exposures during childhood and lacks in schooling, employment and cultural self-determination.

Youth detention centres therefore require clinically and culturally competent services to cater for the complex support needs of Aboriginal and Torres Strait Islander young people under their care. There is, however, an alarming lack of culturally appropriate mental health care, as well as drug and alcohol services, available to Aboriginal and Torres Strait Islander people in custody (Shepherd and Phillips, 2016; Baldry et al., 2015). Promising health initiatives have tended to suffer from a lack of long-term funding, support and appropriate evaluations (Dudgeon et al., 2014) as well as a lack of an overarching system delivery framework (Jones and Day, 2011). At the same time, education and training initiatives within the youth detention system have suffered from similar deficiencies compounded by impractical teachings and inconsistent implementations (Shepherd and Phillips, 2016).

In working with Aboriginal and Torres Strait Islander peoples, it is imperative to acknowledge the effects of transgenerational trauma. This necessitates the training of staff who are otherwise unlikely to possess the knowledge required. Beyond a mere lack of understanding, however, there is still an alarming level of outright discrimination which continues to impact Aboriginal and Torres Strait Islander peoples both within and outside of the criminal justice system. The lack of respect that such attitudes engender facilitate environments in which harmful practices may occur. It is therefore imperative that efforts to prevent the harm of children and young people in detention facilities address the issue of racism to ensure that Aboriginal and Torres Strait Islander children and young people are no more likely to encounter harmful practices than their non-Indigenous counterparts.

It should not be assumed that ethical and clinical models derived from western individualistic viewpoints can be automatically applied to Aboriginal and Torres Strait Islander individuals and communities. Nor should we assume we have a mandate to automatically apply such models. Within mental health care, the RANZCP recognises the need for models with a broader understanding of the mental health of Aboriginal and Torres Strait Islander communities which involves a holistic construct of social, emotional, cultural and spiritual well-being. The RANZCP therefore supports attempts within the psychiatric profession to reconceptualise models of care that are culturally appropriate and would encourage similar attempts in related areas. Jones and Day (2011) provide a useful analysis of the requirements for the development of culturally competent mental health services within the criminal justice system which is worth further examination. More efforts and resources are also required to enhance effective and empathic communication between non-Indigenous professionals and Aboriginal and Torres Strait Islander people.

The RANZCP’s Principles and Guidelines for Aboriginal and Torres Strait Islander Mental Health (2014c) contains a number of requirements for psychiatrists and psychiatry trainees working with Aboriginal and Torres Strait Islander peoples. A number of these requirements are just as relevant for staff, including managerial staff, working with Aboriginal and Torres Strait Islander children and young people in detention, including that they:

- always treat Aboriginal and Torres Strait Islander people with courtesy and dignity
- recognise that social injustice, racism and mainstream hostility and ignorance are still causing serious suffering, mental ill health and drug and alcohol disorders for Aboriginal and Torres Strait Islander people, at rates far in excess of those found in non-Indigenous Australian communities
• understand the tragic impact which attitudes and policies of the mainstream Australian community have had on the mental health and social and emotional well-being of Aboriginal and Torres Strait Islander peoples and take this into consideration when working with Aboriginal and Torres Strait Islander people

• recognise that working with Aboriginal and Torres Strait Islander peoples requires special expertise and understanding which is available within Aboriginal and Torres Strait Islander communities, including specific cultural competence and trauma-informed care skills

• treat Aboriginal and Torres Strait Islander workers as respected colleagues with special knowledge which can be essential for the appropriate treatment for Aboriginal and Torres Strait Islander people

• make every effort to ensure that language used does not present a barrier to full understanding and sharing of information and, wherever possible or appropriate, make use of Aboriginal and Torres Strait Islander health professionals, mental health workers, interpreters and/or confidantes to facilitate communication

• understand and respect cultural traditions as they affect verbal and non-verbal communication.

Recommendations

Pursuant to the evidence above, the RANZCP recommends:

• improved education and training of staff in youth detention facilities around cultural competency including specific training in Aboriginal and Torres Strait Islander cultural competency and trauma-informed care, including the effects of transgenerational trauma on the developmental and mental health of Aboriginal and Torres Strait Islander children and young people.

Furthermore, the RANZCP recommends:

• the establishment of principles and guidelines for the detention of Aboriginal and Torres Strait Islander children and young people and the embedding of these within organisational frameworks

• improved training, qualification, supervision and mentoring of sufficient Aboriginal and Torres Strait Islander professionals including mental health clinical professionals and mental health workers to work closely with children and young people in detention as well as staff members

• greater collaboration with Aboriginal and Torres Strait Islander communities, and Aboriginal Community Controlled Health Services in particular, to facilitate the systematic accommodation of Aboriginal and Torres Strait Islander worldviews in decision-making processes regarding resource allocation, diversity employment, cultural competency training and program implementation and evaluation

• the development of targeted services in youth detention facilities to meet the health needs of Aboriginal and Torres Strait Islander children and young people.
Governance structures to safeguard the mental health of children and young people in detention

Oversight mechanisms

The RANZCP recognises that certain institutions create environments where there is an increased risk of child abuse. There are many examples in Australia and internationally of comparable institutions in which a lack of external independent security and monitoring has enabled extensive abuse to have occurred. A number of governance issues have already been identified with reference to the Don Dale Youth Detention Centre including:

- deficiencies in staff training
- poor communication
- incomplete or non-existent policies and procedures (Vita, 2015; Children’s Commissioner, 2015).

The RANZCP supports the recommendations made in both the Vita and Children’s Commissioner reports, especially with regard to governance and oversight. To reduce the risk of maltreatment being repeated in youth detention facilities, increased governance mechanisms are required.

Appropriate policies, procedures, standards and management practices must be developed with a broad range of goals in mind including rehabilitation, the avoidance of trauma, the treatment of mental health issues and the assurance of the human rights of detainees. Some useful language can be found in various United Nations instruments. The principle of equivalence, which affirms the rights of individuals to access health care which is appropriate to their needs, regardless of their legal status, is stated and reaffirmed in the Basic Principles for the Treatment of Prisoners (1990), the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991), and the Convention on the Rights of Persons with Disabilities (2009). In order to comply with this principle, prisoners suffering from mental illness must have access to the same quality of service or treatment as their non-offender counterparts.

There are a variety of mechanisms to ensure transparency and accountability which could be advantageous for the improvement of conditions within youth detention facilities. For example, a robust complaints mechanism is required as well as independent monitoring of the conditions and circumstances in which children are detained, conducted by relevant experts, under a cyclical process of continuous improvement. This should be complemented by regular reporting so that standards and protocols regarding the protection and provision of appropriate services to children and young people in detention centres can be developed. The RANZCP notes that official visitors, whose role is enshrined in Part 9 of the Youth Justice Act, should be fulfilling this function to some degree. However, there continue to be situations in which harm can occur.

Working with behaviourally disturbed and disadvantaged young people will inevitably have a psychological impact on staff and supervisory and governance systems need to be more cognisant of this. Workplace trauma increases the risk of psychological damage to staff, thereby increasing the risk of punitive responses. Governance structures in youth detention facilities should therefore include improved screening processes during recruitment processes to ensure that staff have the appropriate attitudes and personality traits for managing at-risk children and young people in the detention environment. Then improved education and support of staff are required to ensure hired workers are psychologically equipped to deal with crisis situations. Governance systems should provide a foundation for a fundamental change in workplace culture to ensure that staff are able to perform their roles with attitudes guided by compassion and founded on a commitment to ensure that supportive, caring, and non-traumatising early experiences are provided for children and young people in their care.
System reform: lessons from psychiatric history

There are some important lessons to be learned from the history of psychiatry which are directly relevant to the treatment of children and young people in detention facilities. In the past, a great deal of harm was caused to individuals within the mental health system due to certain historical mental health practices which were ineffective, distressing to experience, without an evidence base and/or used inappropriately (RANZCP, 2014a). Although there are many differences between harmful mental health practices used in the past and the current failings of the youth detention system, the success of the psychiatric profession in identifying and countering the root causes of systemic deficiencies provides an important example of how extensive system reform can be undertaken to ensure the protection of individual human rights within those systems.

The RANZCP acknowledges that continuous improvement in psychiatry and mental health care requires recognition of harm caused by past practices. This necessitates acknowledgement of their ongoing impact and recognition of the obligation of the psychiatric community to learn from the past, and commit to using these lessons to improve current and future mental health care. The RANZCP recognises the imperative of utilising root cause analysis to look beyond the immediate details of individual events in order to find contextual and contributory factors that allowed the development of situations where harm could occur. Many of the root factors implicated in reviews of adverse events in mental health care are still in existence and have the potential to cause harmful effects in the future. Careers and professional attitudes shaped during the ‘institutional’ era of psychiatry may yet persist in individuals and the RANZCP actively encourages its members to beware of such attitudes. The youth detention system may find it beneficial to look further at the developments and reforms undertaken in the mental health care sector.

Recommendations

Pursuant to the evidence above, the RANZCP recommends:

- implementation of the recommendations made by the Children’s Commissioner and the Department of Correctional Services’ Vita report
- review of the functioning of official visitors, as enshrined in Part 9 of the Youth Justice Act
- the inclusion of relevant facts about past harmful practices, and evidence of their ongoing impact, in the core training curriculum of youth detention staff members, including how to be sensitive when dealing with individuals affected by harmful practices in the past, and to understand the consequences of traumatic memories in the present
- increased support of youth detention staff members to ensure they are psychologically equipped to deal with crisis situations and other workplace hazards.

Furthermore, the RANZCP recommends:

- thorough screening of potential staff members for suitability, perhaps via consultation with people with relevant expertise in staff recruitment
- the establishment of continuous improvement processes to ensure that appropriate protocols and policies are designed to prevent the development of situations where harm can occur
- the development of appropriate standards within the youth detention system which:
  - are in line with the Youth Justice Act and the UN Convention of the Rights of the Child
are based on a broad range of goals including best-practice service delivery, trauma-informed care, rehabilitation, treatment and the assurance of human rights

- mechanisms to ensure transparency and accountability including a complaints mechanism and independent monitoring of the conditions and circumstances in which children are detained, conducted regularly and continuously, by relevant experts

- consideration of the utility and feasibility of an accreditation system based on the standards and monitoring mechanisms outlined above

- the establishment of dialogue and partnerships with community members who may have important insights to offer, and who may continue to feel the impact of harmful practices for many years to come after their containment

- the facilitation of a culture within youth detention systems where staff members are expected to show leadership, empathy, and understanding regarding past harmful practices, to openly discuss and acknowledge the past without fear of retribution, and to support healing initiatives

- consideration of the policies, procedures, standards and management practices of health services at which children and young people are provided psychiatric care as inpatients on an involuntary basis as a foundation for corresponding rules and practices within youth detention facilities.

Child protection systems

Background

The link between trauma in childhood and future psychosocial problems is so well-documented that it is practically an axiom of contemporary psychiatric knowledge. Children exposed to dysfunctional family situations can develop behavioural difficulties stemming from the unpredictability of their world leading to a lack of verbal and conceptual understanding of the interaction between their inner world and surroundings. These children may experience other people as sources of terror or gratification rather than fellow human beings and potential allies which may lead to further problems in social settings (Streeck-Fischer and van der Kolk, 2000). Insecure attachment during infancy can manifest as conduct disorder, aggression, anxiety and mood disorders, hyperactivity, antisocial behaviour, vulnerability to stress, difficulty regulating negative emotions, learning problems and displays of hostility or oppositional behaviour as the infant moves through childhood (RANZCP, 2014d). Adverse childhood experiences including family violence are known to be highly co-occurring and strongly associated with the onset of psychiatric disorders (Haliburn, 2014) with children and young people with experiences of trauma more likely to resort to physical conflict and self-medication in attempts to increase feelings of security (Burrell, 2013; Vuong et al., 2009).

Early childhood is the period of greatest vulnerability to stress-related changes to the brain. The majority of neurological development associated with language, values and complex cognitive and emotional functioning are determined in these early years of life. Infants who are exposed to family violence will be exposed to dysfunctional relationships, inconsistent attachment dynamics and interactions characterised by negative affect and inconsistent meaning making. Infants who experience extremes of abuse or neglect are at risk of failure to thrive, reduced brain size, impaired development and ongoing mental health issues. These factors can have significant implications for the way infants make sense of the world around them and develop the core sense of themselves (RANZCP, 2015d). Infants as young as 4
months old who have been exposed to these environments have been found to engage in more negative patterns of interaction and explore the inanimate environment less avidly (Tronick and Beeghly, 2011). For many children who have experienced family violence, support and treatment from universal primary care services such as general practitioners and school programs will be enough to address the sequelae of trauma. For others, mental health outcomes may be more deleterious and require the attention of specialist services (RANZCP, 2015d).

The role of child protection systems with regard to mental health care

The mental health needs of children in dysfunctional family situations

Child protection agencies are integral in the identification and intervention of at-risk children and young people. Children face multiple barriers to asking for help independently of their caregivers, including fear that they will not be believed, assuming the abuse is normal, wishing to protect the perpetrator, being threatened with reprisals if they tell, experiencing disbelief and confusion about what is happening to them, lack of linguistic ability to describe what is happening or a feeling of being responsible (RACGP, 2014). Furthermore, some programs require the consent or involvement of a caregiver which is not always possible.

It is therefore imperative that child protection systems include a focus on early identification and intervention of at-risk children and young people encompassing mandatory reporting obligations and the initiation of support strategies for those children. A range of evidence-based interventions are available to treat at-risk children and young people, most of which involve working to achieve safety within relationships, providing psychoeducation, treating the effects of trauma and then developing healthy behavioural, emotional and relationship functioning. These evidence-based interventions can work across a spectrum, from early intervention with asymptomatic children exposed to recent violence through to complex interventions in children with high levels of traumatic symptoms and dysfunctions in complex family situations. In situations of family violence, it is also important to ensure the child’s mother has access to holistic services to support the family’s access to safe accommodation, counselling, education, employment and legal services. The importance of securing these things cannot be overstated in supporting families to rebuild and recover.

Interagency collaboration is essential when addressing psychosocial problems in children and young people. Osofsky and Lieberman (2011) describe a systems-of-care approach encompassing judicial, legal, child welfare, mental health, health care, child care, early intervention systems and family resource centres. The focus of this approach is on ensuring that children and families receive consistent, timely and appropriate referrals, follow up and support. Assessment and early intervention lead to appropriate treatment at the earliest possible juncture. The importance of collaboration is increasingly being recognised, with mechanisms for cross-sector collaboration such as Risk Assessment Management Panels (RAMPs) being established in Victoria to enable the family court, police and schools to, for example, communicate better (Plunkett, 2014). It is essential that child protection services maximise their collaboration with medical and mental health professionals and include them in approaches to decision-making regarding the well-being of at-risk children and young people.

Unfortunately, child protection services in the Northern Territory are overstretched. They have limited capacity to provide family support and a very high threshold for intervention. While the evidence base has been established for a number of treatments and interventions, access to these remains limited for the majority of at-risk children and young people. Thus, with the well-documented links between mental health and incarceration serious obstacles remain to stemming the tide of juvenile offending, most
notably of which is the diminished capacity of child protection services to adequately identify and treat at-risk children and young people.

The mental health needs of children in out-of-home care

The mental health needs of children in out-of-home care (OOHC) is a pressing concern deserving of increased attention. With the number of children and young people in OOHC continuing to rise, Australia now leads the world in the number of juveniles removed from their families (Fitzpatrick, 2016). Children and young people in OOHC are a highly vulnerable group with increased physical, mental and social health needs yet often limited access to services and support. As a consequence of their exposure and experiences both prior to entering care and within the care system, they are more likely to have significant, often unrecognised and unmet health needs, increased rates of developmental difficulties and less consistent access to health services that may directly increase the risk of incarceration (Council on Foster Care, 2012). The RANZCP therefore supports the National Clinical Assessment Framework for Children and Young People in Out-of-Home Care (Department of Health, 2011) which was developed to improve health outcomes and urges adherence to the National Framework for Protecting Australia’s Children 2009 (Department of Social Services, 2011).

The RANZCP has further developed a number of documents relating to the mental health needs of children in OOHC including:

- The mental health care needs of children in out-of-home care (March 2015)
- Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse’s consultation paper on out-of-home care (April 2016)
- Submission to the Senate Standing Committees on Community Affairs inquiry into out of home care (October 2014)
- Child Protection Legislative Reform discussion paper (March 2013)
- The mental health care needs of children in out-of-home care: A report from the expert working committee of the Faculty of Child and Adolescent Psychiatry (June 2008)

The RANZCP is committed to advocating for the adequate care and protection, including comprehensive health and developmental assessment, early intervention, psychosocial treatment and relational support for children and young people in OOHC in order to assist them to achieve their full potential as healthy adults (RANZCP, 2015b).

Children in OOHC often present with complex psychopathology related to prior experiences with carers, exposure to perinatal risk (for example, maternal drug use during pregnancy), insecure, disorganised and disrupted attachment relationships and the cumulative effects of childhood maltreatment including traumatic exposures. Australian and international studies show a high prevalence of emotional and behavioural disorders in the fostered population. Developmental delays are also common, including speech and language cognitive development and gross and fine motor skills problems (Chambers et al. 2010; Nathanson and Tzioumi 2007). These can confound both the child’s capacity for communication and the carer’s expectations about, and responses to, the child. Recent research from Monash University in Victoria has demonstrated that around 50% of community and custodial young male offenders over the last decade have a clinically significant yet undiagnosed oral language (talking and listening) disorder (Snow, 2013). These factors add to the complexity of assessment and intervention.

The high rates of psychosocial and developmental difficulties seen in children in OOHC warrant special attention and priority access to comprehensive health and developmental assessments including multi-
disciplined mental health care. Interventions should address their complex health, psychosocial and developmental needs within the context of their placement and the care system. Interventions need to be comprehensive and include a systematic approach that takes into account the length of time the child has been in the current placement, the capacity of current carers to support and care for the child and the adequacy of the system of services and support around the placement.

OOHC placements should occur according to a stepped care approach wherein each decision is made according to the assessed needs of the individual. Therapeutic residential care potentially heralds many benefits and deserves further development (for an in-depth survey of therapeutic residential care, see McLean et al., 2011). Services should have the capacity to collaborate and liaise across all the major aspects of the child’s life including schools, care-givers and mental health services. In order to ensure this is feasible, child protection services need to be resourced at a level that allows them to work flexibly and collaboratively, to share information, liaise with mental health professionals and school staff, and assist in making necessary adjustments at home, school or elsewhere as required. For example, Queensland’s Evolve Interagency Services provides a model for services that are able to ‘wrap around’ the child, and therefore tailor the approach to the child’s specific needs.

Young people aged 16 years and over in OOHC are particularly vulnerable as they face having services cut back ahead of their transition into independent, adult life. This group may nevertheless require ongoing supports to assist them to bridge the gap between the OOHC environment and adulthood. Just as young people leaving the family home will often continue to receive support and care from their parents, there needs to be safeguards to ensure that young people leaving OOHC are not suddenly left without supports.

Support for out-of-home service providers and foster carers

Children who enter OOHC have often already experienced significant trauma and disrupted attachment, many of whom have been placed in OOHC in order to protect them from abuse. Reports of abuse in OOHC environments are therefore particularly concerning as suffering subsequent abuse in an environment intended to offer protection can have devastating effects for the victim, including increased vulnerability to psychiatric disturbance, impaired development and relational risk (Dozier and Linhiem 2006).

It is therefore essential that comprehensive mechanisms are in place to avoid this situation occurring. The task for carers can be difficult, as the infant or child’s behaviour may appear contradictory, apprehensive and/or frankly rejecting or avoidant (Smyke and Breidenstine 2009). Depending on the child’s age and prior experience, considerable time and effort may be required for the child to have the experience of comfort and protection with an available caregiver. Supporting and working with carers is therefore essential when safeguarding the development of children and young people in OOHC.

Recommendations

Pursuant to the evidence above, the RANZCP recommends:

- age-appropriate screening and assessment of mental health concerns and risk factors in all children and young people known to child protection services, including children entering OOHC, with reference to the New Orleans Model which has demonstrated effectiveness internationally (Minnis et al., 2010)
• mechanisms to ensure that recommendations arising out of the mental health assessments of children and young people known to child protection services can be implemented, ideally via referral to age-appropriate, evidence-based clinical interventions grounded in trauma-informed and culturally appropriate approaches to care

• the provision of systematic and mandatory training for OOHC service providers and foster carers from point of entry into the residential care sector delivered by experienced facilitators, incorporating:
  - information on the particular vulnerabilities of children in OOHC
  - information on healthy developmental stages
  - attachment theory and practice
  - background to the psychopathology experienced by children in OOHC
  - an overview of the compounding effects of neurological, psychological, emotional, behavioural and relational sequelae and how this relates to the provision of care
  - the reparative parenting training model
  - empowerment to set developmentally appropriate limits on the movement and affiliations of young people in OOHC
  - information on problem sexual behaviour.

• regular, ongoing supervision for OOHC service providers and foster carers

Furthermore, the RANZCP recommends:

• a transition framework based on continuity of care for young people in OOHC aged 16 years and over, with reference to the New Zealand Ministry of Health’s Transition Planning and Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and Other Drug Services (2014) for an example of an effective framework for transition planning

• mechanisms to support interagency collaboration to implement effective systems of care based on holistic approaches to child protection which aim to secure the safety, stability and healing capacity for the family unit via coordination, case management and care planning to integrate a range of health, education, legal, accommodation, welfare and other agencies

• support for research into the health and mental health needs of children in OOHC in order to:
  - inform policies and practices
  - provide evidence for psychological and pharmacological treatments of their complex psychopathology

• investment into monitoring, evaluation and research into child outcomes including:
  - identification of safe, accessible, relevant, culturally appropriate and cost-effective approaches to mental health care for children in OOHC
  - longitudinal research into the development of a framework for therapeutic residential care.
The importance of cultural competency in child protection systems

Child rearing practices are strongly influenced by culture and values. Family dynamics unfamiliar to the prevailing culture may be wrongly interpreted as harmful or dysfunctional if assessments are not undertaken with sensitivity. The RANZCP specifically notes the need to be culturally competent when working with Aboriginal and Torres Strait Islander children and young people in OOHC. Aboriginal and Torres Strait Islander children are over 10 times more likely to be in OOHC than non-Indigenous children in the Northern Territory (SCRGSP, 2014) while Aboriginal and Torres Strait Islander women and girls are 31 times more likely to be hospitalised due to family violence related assaults than their non-Indigenous counterparts according to national figures (COAG, 2010). There are complex social and historical reasons for this including the ongoing impact of the Stolen Generations (Fernandez and Atwool, 2013). The experiences of Aboriginal and Torres Strait Islander children and young people need to be understood in the context of the historical and transgenerational trauma experienced by this population.

Evidence shows that the Stolen Generations policies have led to higher rates of incarceration, physical and mental ill health, substance misuse, self-harm, suicide and mortality in Aboriginal and Torres Strait Islander communities (HREOC, 1997). Many Aboriginal and Torres Strait Islander children who were removed from their families experienced severe and protracted trauma including deprivation of attachment figures and culture, confinement, physical abuse, exploitation, and sexual abuse. Removal of Aboriginal and Torres Strait Islander children continues at unacceptably high rates (RANZCP, 2015c). Thus, the impacts of these experiences are likely to continue reverberating across generations in years to come.

The cultural needs of Aboriginal and Torres Strait Islander children and adolescents in OOHC must be addressed with assessments and care arrangements taking into account different approaches to child rearing, family composition and care responsibilities. The value of collaborating with Aboriginal and Torres Strait Islander communities to illuminate these issues cannot be underestimated. Aboriginal and Torres Strait Islander mental health workers should be incorporated into all aspects of the mental health care supports delivered to Aboriginal and Torres Strait Islander children and young people in OOHC. This includes the development of programs, policy and services, consultations on cultural safety, and direct service delivery. Aboriginal and Torres Strait Islander mental health workers should be supported to apply for appropriate positions, and should be remunerated for their work at a level at least commensurate with non-Indigenous healthcare providers (RANZCP, 2016a).

Furthermore, professional interpreters should be used in any situation where there is doubt around the person’s English skills, particularly with regard to their capacity to describe complex or sensitive information about health and other issues. Family or friends should not be used as interpreters as this can lead to misunderstandings and breaches of privacy.

Recommendations

Pursuant to the evidence above, the RANZCP recommends:

- improved education and training of staff in child protection agencies around cultural competency and cultural responsiveness, including the effects of transgenerational trauma on the developmental and mental health of Aboriginal and Torres Strait Islander children and young people
- approaches that promote the preservation of ties between Aboriginal and Torres Strait Islander and CALD children and young people and their communities and cultures
• the use of professional interpreters where there are language barriers
• strengthening the implementation of the Aboriginal and Torres Strait Islander Child Placement Principles through:
  o increased recruitment of Aboriginal and Torres Strait Islander carers and support for their skill development
  o additional investment in developing Aboriginal and Torres Strait Islander leadership and participation in decision-making and monitoring processes
  o improved linkages between communities and government including improved communication and education regarding the intent of the Principles.

Furthermore, the RANZCP recommends:
• therapeutic and culturally sensitive treatment, advocacy and support services delivered to children and young people known to child protection services who are from Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse backgrounds with services to be informed by an awareness of transgenerational trauma and the influence of culture on the aetiology and manifestation of mental health problems, delivered by Aboriginal and Torres Strait Islander mental health workers wherever possible and appropriate
• the support and proper remuneration of Aboriginal and Torres Strait Islander mental health workers engaged in relevant programs
• greater collaboration with Aboriginal and Torres Strait Islander communities to facilitate the systematic accommodation of Aboriginal and Torres Strait Islander worldviews in decision-making processes regarding resource allocation, diversity employment, cultural competency training and program implementation and evaluation.

A justice reinvestment approach

Background

The RANZCP believes in the value of a justice reinvestment approach to criminal justice involving measures to decrease rates of incarceration by investing in services in the community to improve mental health, prevent entry into prison, and to reduce recidivism. The value of a justice reinvestment approach lies in its potential to direct resources away from prison building and into community building, thereby strengthening and empowering communities to help individuals living with mental illness and psychosocial difficulties. Especially among children and young people, the development and implementation of early intervention strategies for the prevention of psychiatric disorders associated with increased incarceration rates is imperative to addressing adverse outcomes. While some of the following observations may lie outside the scope of the Royal Commission, the RANZCP offers these insights with the view that child protection systems bear a responsibility to advocate for at-risk children and young people under their purview, and that this advocacy should be undertaken with the values of a justice reinvestment approach in mind.

The concept of justice reinvestment focuses on several key tenets, one of which is early intervention. By redirecting funding from the prison system into community-based initiatives, early intervention becomes possible and a cohort of at-risk people may be deterred from crime. Research demonstrates that first
symptoms of behavioural problems typically precede a mental, emotional or behavioural disorder by 2 to 4 years (O’Connell et al., 2009) and that early therapeutic intervention can be highly effective at limiting the severity and/or progression of problems (Hazell, 2000). As set out in the RANZCP’s Faculty of Child and Adolescent Psychiatry’s report *Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning Strategies for Australia and New Zealand* (2010), the RANZCP strongly advocates for improved prevention and early intervention programs to promote the mental health and well-being of children through partnerships between mental health, maternal and child health services and child protection agencies, as well as schools and other related organisations. This includes programs that:

- aim to prevent or intervene early in the development of aggressive behaviour and conduct disorder
- target at-risk children, particularly children in OOHC, those living in dysfunctional family environments and children who have not been helped by less intensive interventions
- coordinate parenting support and evidence-based parenting programs with particular focus on at-risk groups, including the early and effective treatment of maternal depression and other psychiatric illnesses, together with programs which enhance the parent–infant relationship.

**Mental health and recidivism**

The provision of mental health care is critical to reducing recidivism rates. With Australian studies demonstrating reconviction rates of detained children and young people of up to 71% after 2 years (Kasinathan, 2015), and adult jail term rates of 49% after 7 years (Lynch et al., 2003), decreasing recidivism should be a priority for youth detention systems. Mental illnesses, including conduct and substance abuse disorders, have been linked with higher rates of recidivism in a number of studies (Kasinathan, 2015; Gordon et al., 2012; Ryan et al.; 2013; Myner et al., 1998). With conduct disorder as a recognised antecedent of schizophrenia (Hodgins et al., 2007), it is no surprise that detained young people also exhibit high rates of schizophrenia (Gosden et al., 2005); in turn, schizophrenia and related disorders also act as predictors of recidivism (Kasinathan, 2015). Reasons for the relationship between mental ill health and recidivism may include impairments in cognition, including attention and memory deficits, and poor insight (Kasinathan, 2015). Other factors which have been found to be correlated with recidivism include substance abuse, younger age, being of a minority race, having prior offences, frequent contact with the juvenile justice system and family problems including instability, abuse and neglect (Kasinathan, 2015; Aalsma, 2015; White et al., 2016). However, not all research findings are corroborative and further research is needed to clarify the findings of various studies.

Recidivism rates have been found to be responsive to treatment for mental health issues (White et al., 2016; Kasinathan, 2015; Morgan et al., 2012). Three treatments in particular have emerged as effective treatments for detained children and young people, each demonstrating strong empirical evidence for reduced recidivism sustained for at least 1 year and replicability at multiple test sites as well as improvements in psychological and social functioning. Multisystemic therapy, functional family therapy and multidimensional treatment foster care all address key risk factors including social, familial and academic functioning, operate within community settings so as to identify and ameliorate issues within their natural environments, and include support for retention (Henggeler and Schoenwald, 2011). Effective treatment, including access to treatment for alcohol and substance dependence, criminogenic needs, psychosocial rehabilitation and pre-release planning, is the best method to decrease recidivism in mentally ill offenders and is essential for any meaningful attempt to rehabilitate young offenders.
At-risk groups

There are a number of groups in the community that have higher rates of mental ill health and an increased risk of imprisonment. For example, there are known links between incarceration, social adversity and poor mental health for Indigenous people (Kimina et al., 2012). Due to the complex interactions between physical, mental and social well-being, it is vital that the overall health and well-being of Aboriginal and Torres Strait Islander peoples is improved so that the mental health and social functioning of individuals can be improved; this in turn should lead to lower rates of incarceration.

Drug and alcohol use during pregnancy is known to increase the risk of Fetal Alcohol Syndrome (FAS) which is related to specific types of brain damage which can leave individuals susceptible to involvement in criminal activity. As a result of such brain damage, FAS sufferers often have:

- a lack of impulse control
- trouble identifying future consequences of their current behaviour
- difficulty planning and connecting cause and effect
- difficulty empathising with others and taking responsibility for their actions
- difficulty delaying gratification or making good judgments
- a tendency toward explosive episodes
- vulnerability to social influences such as peer pressure.

Research conducted in Canada and the USA shows that children with FAS are 19 times more likely to end up in prison than those who are not affected. Similarly, Canadian research has found that more than one fifth of young offenders are behaviourally impaired due to prenatal alcohol consumption (Kyskan and Moore, 2005). By directly linking parents to drug and alcohol services, child protection services may reduce the number of people who will be diagnosed with FAS, potentially having an impact on imprisonment rates.

Conduct disorder is a common childhood disorder marked by a pattern of repetitive behaviour wherein the rights of others or social norms are violated. Symptoms include verbal and physical aggression, cruel behaviour toward people and pets, destructive behaviour, lying, truancy, vandalism, and stealing. Young people with conduct disorder are at a greatly increased risk of incarceration, injury, mental illness, substance abuse, and death by homicide and suicide (RANZCP, 2010; Barnert et al., 2016). Most research for prevention and early intervention in conduct disorder has focused on reducing conduct difficulties through parent training programs. However, there has also been some limited research focusing on early intervention services that deal with emotional and/or conduct problems in community settings. Programs demonstrated as being effective for conduct disorder include:

- The Nurse Home Visitation program was found to be effective in reducing adolescent delinquency. This is a targeted individual home visiting program delivered over 2 years to low income, unmarried, first-time mothers and includes 60 x 90-minute home visits from pregnancy to age 2 years with a 15-year follow-up (Bayer et al., 2009).
- A Family Check-Up in pre-school age children found that positive and proactive parenting skills correlated with changes in child disruptive behaviour.

The expansion of pre-school check-up programs could also help identify signs of language and communication disorders that can lead to problems later in life. Given that around 50% of community and custodial young male offenders have a clinically significant yet undiagnosed oral language (talking
and listening) disorder, these unrecognised deficits may masquerade as rudeness or indifference, thus further disadvantaging the young person. Language difficulties may also compromise a young person’s understanding of legal process such as bail conditions (Snow, 2013). Addressing conduct and communication difficulties in children could herald important long-term benefits for the psychosocial functioning of individuals involved as well as for the health and safety of their families and communities.

Justice reinvestment initiatives have the potential to improve mental health outcomes and lower the risk of imprisonment for at-risk groups. An approach to criminal justice which emphasises building stronger communities could therefore help to safeguard the healthy development of at-risk children and young people, thereby reducing rates of criminality among targeted groups and relieving youth detention systems of would-be detainees.

Recommendations

Pursuant to the evidence above, the RANZCP recommends:

- significant investment in prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations
- built-in, formal economic evaluations for all trials of prevention and early intervention programs for children and young people to determine whether they have provided value in terms of justice reinvestment
- specific attention paid to at-risk groups including the screening of vulnerable children for early identification of mental illness and/or psychosocial difficulties
- the development of targeted prevention and early intervention programs for at-risk children and young people, including Aboriginal and Torres Strait Islander peoples.
References


