2013 National Youth Health Conference

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Judge D J Reynolds
President, Children's Court of Western Australia

MENTAL HEALTH AND YOUTH JUSTICE

I wish to acknowledge the traditional owners of this land, the Wajdjuk clan of the Noongar people, and pay my respects to their elders past and present.

At the outset of my presentation, I also wish to give due recognition and thanks to all of the health workers who give high level expert care to the children in our community and who give it in such a professional and caring way. In particular, I wish to recognise those who deliver mental health services. My presentation will focus on the mental health of children in the criminal justice system.

I am pleased to say that I think that there is an increasing appreciation within our community, and also within government, of the need to give much greater attention and resources to the mental health of our children. That said, there is of course a long way to go and we must continue to increase our investment in this area. One way of judging how morally strong a community is, is to look at how well it supports its children in being able to hope and reach their full potential.

The Children's Court of Western Australia deals with all charges brought against children for criminal offences, including the most serious offences of personal violence, robberies, burglaries, car stealings and sexual offences to the less serious kinds for which no detention can be imposed such as disorderly conduct and simple traffic offences.

Often, children appear before the Court for a multiple number of offences.

The prevalence of mental health problems is greater for people in the justice system than it is in the general population. It is my experience and that of the experienced magistrates of the Court, that many children appearing before the Court are more mentally damaged than ever before. In many cases seriously so and at a very young age.

Based on the contents of pre-sentence reports, most of the children who have appeared before me for serious offences have not had any mental health assessment prior to entering the criminal justice system. In my view, that highlights the need for more to be done on early identification and intervention in relation to mental health.

The commencement age of criminal responsibility in Western Australia, and elsewhere in Australia is 10 years. Given the medical research on brain development, early intervention is the key, and so intervention before 10 years of age is clearly desirable. Even where early assessments are made it may be difficult to distinguish between the existence of a sub-threshold level of a developing illness and behavioural issues.

WA Police statistics show that children less than 10 years of age are committing serious offences, e.g. burglaries. However, no charges can be made in such cases.

Entry into the criminal justice system should not be the catalyst for a first time mental health assessment and intervention. There needs to be a system in place for collaboration of government agencies and community for early identification of potential health problems, both physical and mental health, of children in our community. Absenteeism from school, contact with WA Police, involvement of child protection for the child or siblings, reports of potential abuse by professionals and community members, call outs to WA Police and the existence of violence restraining order applications in relation to domestic violence, are all factors, which if considered collectively, could reliably flag the need for early assessment and intervention.

Many children who enter the criminal justice system make an upward progression from less serious offending to more serious offending. That pattern shows that prevention and diversion requires assessment and intervention when children are charged for the first time. However, that is not always the way. In recent times I have had to deal with children who have come before the Court charged with top end offences, e.g. attempted murder and also burglary involving offences of personal violence and unlawful sexual penetration, and who had no or very little prior record, and who clearly had mental health problems. I mention those last examples to show the need for early identification, assessment and intervention in the community before a Court ever becomes involved.

I now wish to talk about children in detention and mental health.

Western Australia is geographically very large. However, for many years until October 2012, there were only two detention centres in the State, both located in Perth. One was for children sentenced to detention, namely Banksia Hill Detention Centre (BHDC). The other was for children who were refused bail and remanded in custody before their charges were finally dealt with, namely Rangeview Remand Centre (RRC). In October last year RRC was closed and all of the remand detainees were transferred into BHDC.

On 20 January 2013 a large number of children were involved in a riot at BHDC.

Before I talk about the riot, I wish to mention some comments I made in a case decided in March 2012, about ten months before the riot. It reflects the culture at BHDC at the time and leads into my comments on the riot.

The case concerned a sentenced 17 year old aboriginal detainee at BHDC, who the Department wanted by my order, permission to transfer him to an adult prison because of his poor behaviour in BHDC. When I decided the case I made the following comments:

> '…the individual management regime for the respondent was in my view very oppressive and did not seem to contain any program component individually tailored to address his particular behaviours, his psychological needs, and his social development, as I think it should have and as the name of the regime would suggest.
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> …

The evidence shows that a purpose for removing the respondent from the general population and putting him in a cell alone and with little or nothing for mental stimulation, is to enable him to reflect on his poor behaviour and decide to change or improve it. This approach ignores the professional opinion of Dr [-] that the respondent has demonstrated limited reflective capacity, has a concrete cognitive style, and has poor emotional skills. In my view it also ignores the respondent's background of exposure to neglect, rejection, abuse and violence. As a result of that history, the respondent has no personal experience of positive behaviours that he would need to have in order to meaningfully reflect on his poor behaviour. The oppressive conditions of both the regression management regime and the individual management regime have the real potential to exacerbate already serious existing mental health problems for many young detainees. That is particularly so when the detainee is subjected to such conditions for a lengthy period of time. It seems to me that this has likely happened in the respondents case.

On this point, I think that it is relevant to note the opinion of Ms [-] that the respondent has elevated levels of depressive symptoms and possibly has dysthymic disorder. Some of the respondent's behaviours consistent with that diagnosis include him preferring to sit in the dark, not exercising in the yard when he could do so, and his ongoing disruptive behaviour due to feelings of anger and pervasive irritability.

In my view, the oppressive conditions of the regression management regime and the individual management regime imposed on the respondent at BHDC really amount to psychological punishment. Indeed, the lengthy time of both of them, singularly and in combination, really amounts to psychological subjugation. In my view they seek compliance at too high a cost. When imposed too frequently and over lengthy periods of time they are cruel and inhumane. Further, in a detention setting where positive relationships and trust between detainees and staff are important, they would be counter productive.

> Seeking real behavioural change is more than just seeking compliance and creating fear of punishment.
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> …
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> Even staff being friendly to the respondent would likely be outweighed by the harshness of the conditions of the regime he was under over such a lengthy period of time.

At the time of the riot on 20 January 2013, there were 219 detainees in BHDC. In the early hours of the morning of 21 January 2013, 73 male detainees were transferred from BHDC to a unit in a nearby adult prison, Hakea Prison.

As undesirable as that move was, it was nevertheless lawful because it was necessitated by such a sudden emergency which put so many cells and a large proportion of BHDC out of operation.

On 7 and 8 February 2013, a total of 89 male detainees were transferred from BHDC to Hakea to join the balance of the 73 who were still in custody at Hakea at the time. Following that further transition, there were 165 detainees at Hakea and 35 detainees at BHDC. About 30 detainees were charged with unlawful damage arising from the riot. No youth custodial officer working at BHDC at the time was threatened or injured in the riot.

A multiple number of factors in combination caused or contributed to the riot. They included, poor planning in the amalgamation of sentenced and remand detainees, long

term high levels of staff shortages leading to lengthy and frequent lock-downs of children in their cells, a clash of cultures of BHDC staff and RRC staff, no or very few programs, little activity by detainees, harsh and regressive management regimes, no meaningful system of rewards for good behaviour, no air conditioning in cells and it being January in the heat of summer, and no structure for the young detainees to have a voice on their needs and how they were treated.

Following the riot, from 21 January 2013 to 12 February 2013 all of the detainees at BHDC and Hakea were subjected to 23 or 24 hour lock-downs each day. Whether or not a detainee was actually involved in the riot did not matter. Many of the children had mental health problems. One of them that was on remand at the time and who I later sentenced, had a diagnosed bipolar disorder. During this time the detainees had no visits from family or ready access to psychological services. When detainees were moved about both Centres, they were handcuffed. They were subjected to strip searches when moving in and out of the Centres to go to Court, even though they were continuously in custody.

The detainees in Hakea were gradually returned to BHDC in October 2013. On 23 October 2013 the final group of 46 detainees were transferred from Hakea to BHDC. At the end of 23 October 2013 there were 145 detainees at BHDC, comprised of 134 males and 11 females.

The sad conclusion from all of this, is that over a number of years and by January 2013, the culture in BHDC had changed from one characterised by rehabilitation to one characterised by punishment. A sentence of detention, is of itself punishment. Children are not sent to detention to be punished when they are in there. Two purposes of detention are (1) rehabilitation of the young offender by providing programs in a therapeutic environment, and (2) the protection of the community, by removing the young offender from the community for a period of time, and within that time working on the rehabilitation of the child so that he or she is returned into the community rehabilitated or on the path of rehabilitation.

A detention centre with a culture characterised by punishment does not work. It not only fails to protect the community. It actually makes the community more vulnerable by making already damaged and hardened children, harder again and then returning them back into the community further hardened and more aggressive. A detention centre with a culture characterised by punishment not only fails the children, it also fails the community.

Regrettably, a response to the riot was to harden the estate at BHDC. Thick security grills have been bolted into walls to cover windows, tall fences have been constructed around units containing cells, and razor wire has been placed on top of structures to prevent children from climbing on to or over them.

While staff must be and must feel safe, the downside to all of this hardening of the estate is that it makes the detention centre look and feel like a prison. It also creates a reasonably based sense of distrust in the minds of the young detainees. That is not a good thing for positive relationships between detainees and detention staff.

In my view, rather than hardening estate in this way and to this extent, it would be better to invest in more staff (which is happening), ongoing staff training including training by psychiatrists and psychologists on mental health and behaviour, the provision of programs, including in particular individualised substance abuse programs, and recreational, vocational and life skills programs. The involvement of staff in the delivery of programs is very important because it helps to build relationships and trust between the staff and the young detainees.

A rehabilitative culture in a therapeutic environment best protects staff rather than a punishment culture within an environment which resembles a prison.

It is now about 10 months since the riot. In recent times I am pleased to say that BHDC and the youth justice division of the Department of Corrective Services (DCS) is moving forwards to develop cultures of rehabilitation in a therapeutic environment in the detention space and prevention and diversion in the community space. I also remain optimistic for the future of youth justice in this State because of the resilience and commitment that I see in the staff of DCS, the professionals it contracts, and also the

innovation and commitment within the not for profit sector. I am also pleased to note WA Police becoming active in the area of prevention and diversion.

As at 13 November 2013 there were 159 detainees in custody at BHDC. This total was made up by 67 detainees on remand and 92 detainees serving a sentence. 118 of the 159 detainees were aboriginal. That equates to about 74 percent.

Having given those statistics, I wish to make a comment on them. The gross overrepresentation of aboriginal children in detention is unacceptable. In my view it is the or one of our greatest social challenges. It occupies most of my out of Court time. That said, in my view the reasons or at least the primary reasons for it do not include any failure by the Court to properly apply statutory and common law legal principles, including in particular that detention is the sentence of last resort and should be for the shortest necessary time. The reasons for it also do not include Court processes.

In my view the reasons or at least the primary reasons for such gross overrepresentation are to be found in the family and community environment of the young offender. In the case of young aboriginal offenders some of the underlying causes are historical in nature leading to them being and feeling marginalised and disconnected from the broader community. There is a need for healing. There is a need to help young aboriginal children gain a sense of identity, positive self-esteem, and hope. There is a need to support the empowerment of aboriginal elders and senior aboriginal people. There is a need to include aboriginal people and regard them as the solution. There is a need to support

aboriginal organisations and aboriginal people in designing and delivering culturally appropriate programs for aboriginal children. There is a need to help aboriginal children to be able to engage in economic participation. While aboriginal children live in two worlds and should have the best of both, we all need to walk together.

These are the things that should be focused on and talked about and actioned. Not so much about the Court and Court processes. Of course, all of these comments on inclusion of aboriginal organisations and aboriginal people apply not just in the detention space, but also importantly in the prevention and diversion space in the community.

As mentioned, many of the children sentenced to detention have serious mental health problems. A lot of them have post traumatic stress disorder. A lot of them also have conduct disorder, i.e. they behave in an antisocial way and have an issue with authority. Some have an induced psychosis as a result of polysubstance drug abuse. Many have learning and language difficulties. Some have organic brain damage. I think that it would be fair to say that many have undiagnosed FASD.

Many children also suffer from depression and anxiety. Contributing factors include socioeconomic factors, environmental factors within family and extended family, including neglect, abuse, unresolved trauma, domestic violence, abandonment and rejection, and unstable or no accommodation. Substance abuse is both a symptom and a cause and can overlay all of those things.

You no doubt get the point. Children in detention have complex and high needs. Children in detention need to be treated as individuals. Different children with different problems or a different mix of problems need to be treated differently. One size will not fit all. Being a teenager is difficult enough without having to cope with mental health problems.

About half of the children in detention are there for serious personal violence offences. In their cases, substance abuse contributes to aggression. Unfortunately binge drinking has become a feature of our society. Alcohol remains the most commonly abused substance contributing to most personal violence offences. The aggression can be worse if cannabis and/or methalamphetamine are added to the mix, but alcohol by itself can be bad enough.

At the moment, while we have some substance abuse programs in detention, they are somewhat generic and do not adequately target the particular individual. It is essential to deal with any substance abuse problem in order to clear the way to get at all of the mental health issues that it overlays.

The mental health professionals at BHDC consist of 6.8 full time equivalent psychologists, a mental health nurse and a visiting psychiatrist. I can attest from the reports I read and from my visits to BHDC that they are all highly professional and committed to the care of the children they counsel and treat. While they clearly all work well together, it seems to me that there are some intra and inter Departmental policy

positions on information sharing that should be changed for the best interests of the children and the community.

As I understand it, there is a separate health section within DCS, and then there is also DCS separate from the Department of Health. At BHDC, as I understand it, the psychologists on the one hand and the mental health nurse and psychiatrist on the other, need to and do keep separate files, and each does not get to see the information on the file of the other for the same child. This has become an issue with the LINKS program, which is a mental health program which supports the Court and which I will mention later.

Can I make two observations from my position on all of that. First, I would like to see health for children separate from health for adults within DCS. Secondly, in the context of mental health within BHDC, I would like to see a multi-disciplinary team approach with everyone working together under a formal arrangement and with robust information sharing. For example, a psychologist should know whether or not a child that he or she is working with is on any medication, and if so, which medication and what for.

I appreciate the need for confidentiality in the broader scheme of things, but in my view there needs to be a disclaimer or exception in the context of a place like BHDC and youth justice. The basis of the disclaimer would be that where clinicians are trying to manage behaviour for the health and rehabilitation of the child and the safety of the community, then information should be allowed to be freely shared in the attempt to achieve those

objectives. The greater the amount of information available for consideration the greater the quality of decisions. Surely information sharing is better than running the risk of compromising a child's prospects of rehabilitation with a potential consequence that the child may reoffend and end up back in detention.

We do not have a secure facility in Western Australia for the observation and treatment of children with a psychiatric or suspected psychiatric disorder. The Court is very reluctant to send children to an adult facility. In my view a forensic mental health hospital with about a dozen or so beds, the number dependant on expert advice, should be located within BHDC.

In my view, the responses to children and young people who offend, responses in both the detention and the community settings, are too individualistic in nature. Of course we need to work with the individual, but it should be done in combination with family and also community. This applies generally, including in relation to mental health. In combination with that, there needs to be an holistic approach. Otherwise, there would likely be no change in the environmental factors which are causative of the mental health problems, and in turn the offending, in the first place, and the child would likely end up back in detention.

I mentioned earlier, that post riot, children in detention initially had no family visits. In my view family visits are essential. Working with family is essential. We should be

assisting family members, and particularly parents and carers, with transport arrangements and as necessary, to visit BHDC and sit down with the child and a psychologist and a caseworker, and together plan and work through a program of therapeutic intervention. It may be necessary to include a child protection worker in some cases. Issues including housing, parental skills, substance abuse, counselling and treatment needs, education, vocational and recreational programs, should all be discussed and actioned. Children and families should be worked with, not worked on.

One of the objectives and principles in the *Young Offenders Act 1994* is to enhance the role of family in the rehabilitation of a young person.

All of this needs to be kept up when the young person returns into the community. That includes support to attend appointments for counselling and treatment for mental health issues. At present the Child and Adolescent Mental Health Service (CAMHS) is over stretched. Waiting lists in some places are 3-8 months. That is unacceptable. CAMHS and other service providers need to be much better resourced. Delays in treatment can result in low level depression or anxiety progressing to a serious disorder. That should not be allowed to happen. It is not in the best interests of the child or the community. Children and families should be linked in with program and service providers in a coordinated and as seamless a way as possible.

In my view we should expand the role of mental health professionals, and particularly psychologists, more into the program space and in the field. That it does not happen, or at least to the extent that I have in mind, is likely a resource issue. As important as reports are, they should be relatively brief and not take up such a large proportion of their time. Mental health professionals have so much to offer in program design, and then if present when programs are delivered, e.g. camps, to observe and advise on behaviours, relationship issues, and any necessary program changes.

Given that rehabilitation of young offenders is very much about behavioural change, it intrigues me that mental health professionals, psychiatrists and psychologists, are not actually involved in senior management decisions in a more direct way. That is particularly so in the detention setting. It seems to me that there is an unhealthy separation between management and psychological services. Psychologists are used too much simply for risk management rather than being actually involved in management decisions, program development, and more therapeutic counselling.

Can I add to all of that, that ideally, the physical infrastructure and regimes within a detention centre should be consistent with and support the therapeutic interventions of the mental health professionals in the Centre. It seems to me that the prospects of children successfully learning how and why to behave in particular ways is far greater in a therapeutic environment rather than a punitive environment. On my assessment, most

children in detention are very resilient and would likely to do well in the right environment with the right supports.

Before ending, I wish to make a few comments about the LINKS program that I referred to earlier. It is a joint initiative in the Children's Court between the Court, the Department of the Attorney General and the Mental Health Commission. The funding has established a specialist mental health service to support the Court.

The overarching aim of the project is to improve and promote the mental health and psychological wellbeing of young people in the Court system through assessments, services, treatment and support for young people and their families.

The objectives for the pilot project are as follows:

1. Providing assistance to the Court in the identification and management of young people with a mental health issue(s) who come before the Court on criminal matters.
2. Improving coordination and communication between criminal justice agencies and mental health service providers through the development of collaborative partnerships.
3. Collating data which indicates the extent of mental health need within the Court.

4. Reduce offending behaviour by providing access to early assessment and early intervention that address both a young persons mental health and psychosocial needs.

The program at the Court involves placing a small clinical mental health team at the Court, operating in partnership with a non-government organisation to deliver community based psychosocial services. The LINKS team is multi-disciplinary and comprised of government and non-government staff.

LINKS offers two types of interventions for a young person: clinical and psychosocial. The two interventions are designed and implemented collaboratively utilising the clinicians' expertise and the non-government service provider's psychosocial expertise. The clinical and psychosocial interventions form part of case management to ensure delivery of an individualised, strength-based and family care intervention.

The project and the professionals involved are already making a positive difference in the lives of children and families. I look forward to its expansion in the years ahead.

Thank you for the opportunity and honour to present to you, and I wish you all the best in your very important work.

Judge D J Reynolds

President of the Children's Court of Western Australia