Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR ADAM DEACON

I, Dr Adam Jon Deacon (MBBS, BMed Sci, MP, FRANZCP, Advanced Certificate Forensic Psychiatry, Advanced Certificate Child & Adolescent Psychiatry), Child and Adolescent Consultant Psychiatrist at Alfred Health, of 55 Commercial Road Melbourne, in the state of Victoria, say as follows:

1 I am providing evidence to the Royal Commission in my personal capacity rather than on behalf of Alfred Health.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND AND QUALIFICATIONS

3 I have been working as a forensic psychiatrist since 2005. During that time, I have worked in both the public and private mental health system.

4 I am currently employed as a Child & Adolescent Psychiatrist at Alfred Health leading the Youth Forensic Specialist Service.

5 I have previously worked in forensic mental health centres including:

(a) the Victorian Institute of Forensic Mental Health (**Forensicare**) from 2004 to 2018;

(b) Barwon Prison from 2005 to 2010;

(c) Melbourne Assessment Prison in 2005;

(d) Malmsbury Youth Justice Centre from 2005 to 2013; and

(e) Parkville Youth Justice Centre from 2013 to 2016.

6 Attached to this statement and marked 'AD-1' is a copy of my curriculum vitae.

MENTAL ILLNESS AND OFFENDING

The nature of offences committed by children and adolescents

7 A disproportionately large percentage of children and adolescents who commit offences that warrant police involvement and become involved in the youth justice system come

from disadvantaged backgrounds or have experienced trauma, abuse and neglect. Disadvantaged children are also disproportionately represented among the children who exhibit behaviours of concern that lead them to the attention of a child forensic mental health service.

8 The behaviour that these children and adolescents display is varied, but in general, they will engage in offending behaviour that reflects the endeavour to meet some of their unmet needs. For some, this may be the basic need for food or shelter. Others may lack a sense of safety, security and connection. These children and adolescents may seek validation and acceptance from other children and adolescents who are similarly inclined to engage in offending behaviour. All of these unmet needs can become drivers for offending behaviour.

9 There are also children and adolescents who may engage in more targeted behaviour for specific secondary gain or in the context of complex mental health presentations. For example, this may include children and adolescents with emerging personality disorders or psychotic disorders. These complex presentations may lead to them engaging in a spectrum of behaviours, which could range in seriousness from being a public nuisance to expressing urges to commit a serious violent offence.

Nature of violent offences committed

10 The nature of the offences committed by children and adolescents can be extraordinarily broad, but a significant proportion of children and adolescents will engage in interpersonal violence of varying severity. Violence can relate to person or property.

11 Interpersonal violence can be directed towards peers, family and random people. The severity of interpersonal violence tends to correlate with age, although there are exceptional circumstances whereby younger adolescents engage in serious violent acts. Interpersonal violence commonly occurs in groups of youth and weapons are increasingly commonplace. There are a myriad of circumstances that lead to violence being used by an adolescent to manage their situation. It is more common for violent adolescents to come from disadvantaged backgrounds where violence has been directly observed and they are commonly victims of violence themselves.

Prevalence of offending and violent offending

12 The Australian Bureau of Statistics publishes statistics on youth crime rates. Crime committed by youth (aged 10-17) approximates 13% of all crime with youth constituting

approximately 11% of the population. In 2016-17, Victoria had the second lowest rate of youth crime compared to other states and territories, with the ACT having the lowest rate.[1]

13 The Crime Statistics Agency confirmed the rate of youth crime in Victoria increased by 7% in 2019 with males aged 15-19 the most represented group of alleged offenders for crimes against a person, which includes assaults, sexual offences, homicides, robberies and stalking.[2] A rise in family violence has also been observed. This may be due both to an increased rate of incidents, but also an increased rate of reporting to police.

14 Violent youth tend to have co-occurring problems such as victimisation, substance abuse, school failure and emerging associated mental health problems. There is considerable continuity from childhood aggression to youth violence. Violence from an early age predicts a large percentage of violent offences committed by youth. Violent youth commonly have problems with executive function and impulse control, low intelligence, poor parenting practices or an absence of positive parental influences, peer delinquency and lower socio-economic conditions.

Effect of age and/or substance use on the types of offences committed

15 The Youth Forensic Specialist Service (**YFSS**) is for children and adolescents aged between 10 to 21 years. The service sees a small number of 10 to 14 year olds, however the majority of the individuals we see are 14 to 21 year olds.

16 Studies have identified three broad sub-groups of youth offenders.[3] The first group are children who commit offences in their childhood with a peak age of 14 followed by a decline into later adolescence. The second group are children who have not offended in their early teen years with a gradual increase in offending up to age 16. The third group are children who have an early onset of offending and persistence of offending through their adolescence. This third group are commonly the more serious and chronic youth offenders.

17 Youth offenders commonly have extensive drug use histories. Consumption of alcohol and use of cannabis and increasingly methamphetamine is strongly correlated with offending. Many youth offenders commence using drugs and consuming alcohol at a young age, with drug use commonly beginning before, or around the same time, as the onset of offending.

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[1] Australia Bureau of Statistics – 4519.0 – Recorded Crime – offenders 2016-17
[2] Crimes Statistics Agency - Year Ending 31 December 2019
[3] Livingston, M et al. Understanding Juvenile Offending Trajectories, Australian and New Zealand Journal of Criminology 41(3)

18 Drugs and alcohol can significantly impact a young person's cognitive function, emotional control, ability to self-monitor and exercise reasonable judgement. In this context, drug-using youth commonly engage in more serious violent offending when intoxicated.

Effect of intellectual disability or cognitive impairment on the types of offences committed

19 The YFSS assesses many children and adolescents who exhibit behaviour that may not have reached the threshold for entry into the youth and criminal justice systems. An unexpectedly large percentage of the children and adolescents referred to YFSS are on the autism spectrum.

20 A significant portion of children and adolescents in the youth and criminal justice system have cognitive problems, such as intellectual disability, attention deficit hyperactivity disorder (**ADHD**) or speech and language problems. Children with ADHD have severely compromised executive function. This can result in reckless and impulsive risk-taking behaviour.

21 A number of the children with intellectual impairment seen by YFSS have borderline intellectual function. As a result, those children are ineligible for specialised support through intellectual disability services. These are frequently also children and adolescents who often struggle to function within the normal boundaries of the education system and end up falling out of organised activities and sport. They may have low self-esteem, have issues with their identity, be prone to experiencing depression and anxiety and often seek to mask these conditions by using alcohol or other drugs.

22 Intellectual disability and other forms of cognitive impairment, such as milder impairments as a result of foetal alcohol syndrome, can influence the type of offences committed. However, it is more often a relationship with the young person's personal circumstances and related opportunities to commit offences. For example, if a low functioning young person lives in residential care with other similarly low functioning and disadvantaged children, that person may mimic his or her peers' behaviour and adopt offending behaviour that they may not have otherwise developed.

Effect of access to treatment at the time of the offence having any bearing on the types of offences committed

23 Children with identified mental health issues that impact on their behaviour and potential for offending behaviour are less likely to be at risk when engaged in effective treatment programs. Conversely, many youth offenders have undiagnosed mental health problems that directly contribute to their offending behaviour. This subgroup would be at lower risk of engaging in further offending behaviour if their treatment needs were adequately met. Youth with serious mental illness such as psychotic disorders can engage in a range of

idiosyncratic offending behaviour which includes serious interpersonal violence stemming from core psychotic symptoms such as delusions and hallucinations.

Development in research findings on the relationship between youth, mental illness and offending and contemporary Australian research findings on these issues

24 There is consistent international research which shows a correlation between the rates of offending and the prevalence of disorders. In Australia, most of this research has been conducted in New South Wales (**NSW**), but there are also a number of research papers based on research conducted in Victoria and Tasmania.[4]

25 Three surveys in 2003, 2009 and 2015, have been conducted on the prevalence of mental health disorders in children who are in custodial services in NSW.[5] That research showed very high rates of mental health disorders among children in custody in comparison to children who were not in the justice system. Of the participants in the 2015 survey, each had on average 2.5 psychological disorders. 83.3% met the threshold criteria for at least one psychological disorder, and 63.0% for two or more. The population of psychological disorders for young people is estimated to be 13.9%, meaning young people in the NSW justice settings were nearly six times more likely to experience them. 57.8% of young people surveyed were found to meet the threshold for at least one substance related disorder. Nearly 60% of young people in the 2015 survey met the threshold for an attention or behaviour disorder, 11.5 % for a mood disorder, 25% an anxiety disorder, 13.5% had PTSD and 4.2% schizophrenia or another psychotic disorder. Thoughts of self-harm and suicide and attempts to self-harm and suicide were particularly high with many young people identified as more likely to perform serious suicidal acts.

26 There is developing research into the relationship between use of social media, mental illness and offending. More specifically in my private clinical and forensic work, I have observed over the last five to ten years the potentially profound impact of social media and internet-based content on the attitudes, values and beliefs held by children and adolescents. Exposure to pornography and violent content at critical psychosocial developmental stages can significantly influence children's behaviour and contribute to an array of sexual and violent offending.[6]

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[4] Kinner, S.A., et al., Complex health needs in the youth justice system: a survey of community-based and custodial offenders. J Adolesc Health, 2014, 54(5): p521-6, 2014
Bichel, R. et al, Mental Health of Adolescents in Custody : The use of the Adolescent Psychpathology Scale in a Tasmanian Context, Australian and New Zealand Journal of Psych., 2002, 36:603-609.

[5] 2015 Young People in Custody Health Survey Full Report - Justice Health & Forensic Mental Health Network and Justice Health NSW.

[6] Stanley N. et al, Pornography, Sexual Coercion and Abuse and Sexting in Young Peoples Intimate Relationships: A European Study, Journal of Interpersonal Violence 2019, 33(19)

27 However, although this exposure may lead to a change in behaviour, this does not, in my experience, always represent an increased risk of offending. Children and adolescents are communicating and may post videos and photos on social media of graphic images and make reference to potential violent threats against others. Such conduct may be a form of self-expression, rather than a signal of pending offending. A thorough forensic assessment is required to identify the individual risk.

28 More research is required to analyse the effect of exposure to these forms of violent or pornographic content on children and adolescents psychosocial development.

Reliability of risk and predictive tools in predicting violent offending among children and adolescents

29 I have experience in assessing the reliability of risk and predictive tools to predict violent offending among children and adolescents. However, I consider that there are other professionals with greater academic expertise whom would be better placed to comment on this issue.

30 The Structured Assessment of Violence risk in Youth (**SAVRY**) is the most utilised, reliable and valid violence risk assessment tool. It is used based on the structured professional judgement (**SPJ**) model and assists in guiding a structured means of assessing identified relevant factors and formulating a final professional judgement.

31 Risk assessments and predictive tools exist as an aid to clinical judgement. They are useful to assist clinicians to conduct assessments based on factors that have been proven to be relevant to determining risk of offending among children and adolescents. However, these tools do have deficiencies. The use of risk assessments and predictive tools should be tailored with a comprehensive clinical assessment under the structured professional judgement model. In conducting an assessment, it is important to understand the individual. The recognised risk factors for youth violence are comprehensive, but not necessarily exhaustive, nor inclusive of anomalies such as autism spectrum disorder and complex mental health issues such as psychosis.

32 The SAVRY tool is not validated nor tailored for children and adolescents on the autism spectrum. This is problematic because many children and adolescents in the youth and criminal justice system are on the autism spectrum. Risk assessment tools like the SAVRY are not necessarily helpful in complex cases such as autism spectrum disorder.

TRENDS

The disproportionate representation of young people living with a mental illness in the criminal and youth justice systems

33 To obtain a better understanding of the reason for the disproportionate representation of young people and adults living with mental illness in youth justice system requires consideration of the developmental origins of mental illness.

34 The development of mental illness in children and adolescents in the youth justice system can be partly attributed to early developmental problems. The early infant years stemming to early childhood are critical. Many children who interface with the youth justice system have been deprived of their basic needs.[7] Socio-economic disadvantage is commonplace with many children being placed in out-of-home care from a young age. Parents often have histories of mental illness, substance use issues and criminal backgrounds. Attachment-based deficits and related emotional and behaviour problems typically emerge in early childhood and can extend into marked behaviour problems through childhood and adolescence. Boys are particularly prone to externalising their distress in the form of behaviour disturbance, including interpersonal violence. Whilst girls are not devoid of similar behaviour issues, they are more likely to internalise their distress and engage in self-harm behaviour. Children in the youth justice system have often been neglected, abused and traumatised. Manifestations of these developmental insults in the form of mood disorders, anxiety disorders, including PTSD, cognitive problems, including ADHD or ADHD-like phenomena stemming from PTSD. Substance use to combat distress and deal with psychosocial challenges is commonplace. Extensive drug use, particularly cannabis and methamphetamine, can contribute to the development of psychotic symptoms, and potentially enduring psychotic disorders such as schizophrenia. Children from loving, caring backgrounds are infrequently seen in the youth justice system.

35 In the context of understanding the developmental origins of mental health problems and the interface with the youth justice system, greater investment is required in identifying risk and providing appropriate interventions for high risk parents and children.

36 Child and adolescent mental health services generally cater well to younger children with externalising conditions such as conduct disorders and oppositional defiant disorder (**ODD**). These services can struggle to manage the same children when they reach mid-late adolescence.

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[7] Youth Justice Review and Strategy, Meeting Needs and Reducing Offending, Executive Summary - July 2017, Penny Armytage and Professor James Ogloff.

37 When children with externalising conditions reach mid to late adolescence their behaviour can become more seriously violent. The behaviour can also be perceived and responded to differently. Aggressive behaviour as a six year old can be understood to be a feature of ODD. The same type of behaviour in later adolescence can constitute an offence and lead to police intervention. Fundamentally, the behaviour of the child remains similar but the consequences change significantly as the person reaches mid-adolescence.

38 Once police become involved or youth justice intervention has occurred, Child and Adolescent Mental Health Services (**CAMHS**) and Child and Youth Mental Health Services (**CYMHS**) may not consider the adolescent to be a suitable candidate for their service.

39 Likewise, many clinicians do not have the confidence, or do not perceive that it is within their clinical remit, to treat children and adolescents with complex needs that includes offending behaviour. A mental health system that excludes children and adolescents, ironically in the context of complexity, is a cultural issue that can result in many children and adolescents unable to obtain the therapeutic help they require.

40 YFSS seeks to bridge the gap in services for these children and adolescents. Originally, our clinical remit was to provide a primary consultation service to CAMHS and CYMHS in the southern metro parts of Victoria, and secondary consultation for CYMHS services in eastern metro and eastern rural Victoria, for children with emerging or formed forensic issues under their care. However, we have found that the existing demand from CAMHS and CYMHS has required YFSS to operate outside these service guidelines on a discretional basis. Our resources are limited to one part-time psychiatrist and one full-time psychologist.

41 The YFSS model was intended to be similar to that of Forensicare’s community forensic mental health service in a modified form. That is, consultation to CAMHS or CYMHS services in relation to children exhibiting problem behaviours and upskilling clinicians to become more confident in treating these children. Clinicians who have not worked in forensic settings often lack confidence, familiarity and clinical skills in assessing and managing these complex children. YFSS operates solely as a hub that provides consultation services to CYMHS and CAMHS. Ideally we would also be able to provide direct treatment and case management in particularly difficult cases that warrant specific forensic expertise. Case management could be challenging if it was to operate as a stand-alone service given geographical barriers, so a conjoint case management model in cooperation with the primary service provider would likely be the necessary model.

42 We are also currently undertaking a pilot involving children and adolescents who are not currently managed by a CAMHS or CYMHS by accepting direct referral from the DHHS, Youth Justice and VFTAC.

43 YFSS has experienced challenges given we are a consultation-only service. In instances where YFSS has determined that a child or adolescent is high risk, and has advised the referral service of our assessment, we do not have control over whether these children are subsequently discharged in spite of our recommendations.

The effect of passage of more stringent criminal and sentencing laws over the past ten years

44 Whilst it may not be appropriate for a psychiatrist to provide an opinion on the evolution of sentencing laws and whether they are appropriate, it is important to appreciate that youth justice settings currently provide limited opportunity for genuine rehabilitation, and instead potentially aggravate existing risk factors for recidivism. Coalescing children together can lead to a sharing of attitudes and adopting of new behaviour that did not exist prior to that interface. There appears to be growing concern that youth justice settings lend to a gathering of like-minded youth less deterred from re-offending and provide the opportunity to develop offending by promoting ideas and plans.

Community attitudes

45 The community has a primary need for safety and security. Youth offenders jeopardise these primary needs. There has been a groundswell of momentum that frames youth offenders as dangerous and worthy of harsh punishment, rather than being balanced with the understanding that youth offenders are objectively the most disadvantaged children in the community with complex unmet needs. Shifting community attitudes from a strictly punitive stance to a more empathetic and compassionate position is challenging. Unfortunately political and media influences have been very significant in shaping public perception and propagated the adoption of a harsher and punitive stance. Shifting attitudes and promoting greater understanding and empathy requires a collective and strategic approach led by government and supported through media channels.

Impact of trends and changes in criminal justice law and policy

46 In 2014, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* in Victoria was extended to the Children's Court of Victoria following the Victorian Law Reform Commission Review in 2013. Unfortunately, youth justice and mental health systems were not equipped and resourced to provide a suitable service to children found unfit to stand trial and/or not guilty by reason of mental impairment. There is a need for the development of an adolescent forensic hospital and community programs specifically

tailored to cater to the complex needs of this cohort of children equivalent to established systems in the adult sector where comparable orders are well established.[8]

47 I do not have the specific expertise to provide an opinion on approaches to diversion, bail and parole law. Orygen may be able to provide an informed opinion regarding mental health services available to young people on remand and sentenced in custodial settings and whether their criminogenic needs can be met whilst remanded.

Trends and changes in recidivism rates for young people living with mental illness in the criminal justice system

48 The NSW mental health youth justice survey has consistently demonstrated that young people in the criminal justice system have substantially higher rates of mental illness that comparative age-matched community samples. There is a direct correlation between recidivism and persistent poorly managed or untreated mental illness.

Challenges to building workforce capabilities

49 Forensic youth mental health is a highly specialised area. There are very few child youth forensic psychiatrists and psychologists in Australia. I estimate that there are less than 10 clinicians in Australia and New Zealand who have completed both adolescent psychiatry and forensic psychiatry training programs.

50 There are limited opportunities for training psychiatrists and psychologists to gain experience in adolescent forensic mental health. YFSS recently applied for federal funding for a registrar position under the Specialist Training Position program and was unsuccessful.

51 In 2005 when I began as a psychiatrist, forensic speciality training was still in its infancy. All psychiatrists must complete six months of child and adolescent psychiatry training. However, the completion of forensic training is optional. There are different training programs for adolescent psychiatry and forensic psychiatry. A psychiatrist planning to be an adolescent forensic psychiatrist needs to complete both training programs.

52 The United Kingdom offers a dual track child and adolescent forensic psychiatry program that requires three years to complete rather than four. In the United Kingdom, registrar training positions are available in adolescent forensic psychiatry. In Victoria, a forensic psychiatry registrar position is available at Orygen.

[8] The Extension of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 to the Children's Court: Opportunities and Shortfalls, Katinka Morton, Adam Deacon and Danny Sullivan; Psychiatry, Psychology & Law, pages 375-384, Vol 26, 2019 - Issue 3

53 A significant barrier to the development of child and adolescent forensic psychiatrists is the lack of a dual track program. I am aware that many clinicians who are interested in adolescent forensic psychiatry have felt that they did not have the energy to complete both training programs. To work as a youth forensic psychiatrist requires clinical skills derived from both programs. In my opinion, you need to have a richness of experience in forensic work and a healthy understanding of developmental influences on youth to undertake adolescent forensic psychiatry. A psychiatrist can work in forensic youth settings without completing both programs, but it is not preferable.

YOUTH FORENSIC MENTAL HEALTH

Ability of the youth forensic mental health system to adequately service the needs of young people living with mental illness

54 Orygen provide clinical services to children detained in youth justice settings, including Parkville and Malmsbury. Orygen also provide a community forensic mental health service very similar to the Alfred Health based YFSS model.

55 I am unable to comment on the current capacity of Orygen to meet the service needs of youth in juvenile justice settings. YFSS has been able to effectively respond to the referrals received, but I am aware that many children with complex mental health and forensic needs are not currently being referred given they are not CYMHS case managed.

Need for a specialist youth forensic mental health service

56 YFSS is an established youth forensic mental health service but in its early stages of development. Ideally we would be better resourced with more expert staff and have the capability to provide a case management model akin to that provided at Forensicare with their community programs, including the Problem Behaviour Program. Many young people with forensic and mental health issues are remarkably complex and difficult to engage. These young people are less likely to be willing and able to attend clinics for appointments. An outreach model whereby the young people are seen in their community and place of residence is often necessary and more fruitful. Having the flexibility to provide an outreach service would be a very helpful addition to the current YFSS model.

57 In addition, currently young people requiring court appointed assessments and reports attend the Children’s Court Clinic. This is a separate service to YFSS but Orygen have recently appointed a much needed court liaison clinician based at the Children’s Court in Melbourne. Developing close ties with the Children’s Courts, including a court liaison clinician in all Children’s Courts would be a helpful addition. Accessing Children’s Court psychiatric and psychological reports has historically been difficult and potentially a problem for clinicians involved in the ongoing management of the young person. It is

unhelpful for young people to be comprehensively assessed if the relevant information is not readily available for clinicians to use in management.

Best practice in the delivery of youth forensic mental health care: Victoria and other jurisdictions

58 I am familiar with the youth forensic mental health systems operating in NSW, Tasmania and Queensland. The Queensland youth forensic mental health service is perhaps the most advanced and integrated care model.

59 Together with Dr Paul Denborough, Clinical Director of Alfred Child and Youth Mental Health Service, I visited Queensland in 2018 to learn about their youth forensic mental health service. I believe that an integrated model, such as the model currently operating in Queensland, would be the ideal model.

60 A recurring issue I have experienced in my years of clinical practice in Victoria is the difficulty in accessing the criminal reports of children and adolescents who have come into contact with the justice system. By comparison, this information is more readily accessible in Queensland.

61 Despite those identified areas for improvement, Victoria is catching up to the northern states in terms of the development of its youth forensic mental health services and systems.

Current plans for reform in youth forensic mental health reform

62 NSW is currently the only state with forensic hospital beds for adolescents. The NSW model is similar to the facility at Thomas Embling Hospital in Victoria which caters to adults. There are, however, currently no equivalent facilities for adolescents in Victoria and this is a real deficiency.

63 In my experience, there is a clear need for vulnerable adolescents with mental illness in youth justice facilities to be separated from other adolescents in a dedicated facility. Ravenhall prison has a dedicated mental health unit for adults but there is no equivalent in youth justice. Due to the lack of dedicated mental health facilities within youth justice facilities, adolescents with mental illness may end up secluded for their own safety, which is often not an ideal environment.

64 I am aware of some advances in the last year to develop a solution to cater to that need, with the initial phases of that solution to be tied to the Orygen inpatient unit, and also discussions in relation to a potential standalone forensic hospital.

Challenges to the youth forensic mental health system over the next ten years

65 The major challenges that will be faced by the youth forensic mental health system over the next ten years will be in establishing an integrated service model and developing a workforce with sufficient skills and experience to work with children and adolescents with forensic backgrounds.

66 My view is that the biggest challenge will be in developing an integrated youth forensic mental health system, such as the model in Queensland. This integrated model must be supported by multi-disciplinary teams that are able to work effectively with forensic patients. A lack of familiarity, exposure and training causes a lack of confidence within many services in treating these children and adolescents because of their behaviour.

67 The second challenge is resourcing. Victoria does not currently have an established dual track program to train registrars in both forensics and youth psychiatry, as discussed at paragraph 49. I assume there are similar challenges for psychologists. There is a compelling argument to establish a dual program to increase the forensic capability of clinicians. Children and adolescents would, in turn, benefit from ingrained forensic expertise across the board.

68 Part of the brief for YFSS is to try and improve the expertise of clinicians and their confidence. YFSS does not currently have the capacity nor resources to implement this on a broad scale. We have made major inroads to developing an education program for clinicians at Swinburne University. The intention was for all interested CYMHS and CAMHS clinicians in Victoria to attend that program, however the impact of COVID-19 has caused delays in the program's implementation.

YOUTH JUSTICE SYSTEM

Delivery of mental health services in the youth justice system

69 I have not worked in a mental health service within the youth justice system for a long period of time. I am only able to comment historically, based upon my experience working at Malmsbury Youth Justice Centre and Parkville Youth Justice Precinct.

70 Youth justice systems should provide a safe, comforting and supportive environment conducive to rehabilitation. These elements are paramount, particularly given the high prevalence of disadvantage, neglect, trauma and associated complex mental health issues in the spectrum of youth detained in custody. If mental health services are to be provided in the youth justice system (whether custodial or in a community setting), it should be done within this environmental paradigm.

71 Youth justice systems have progressively become more custodial and prison-like structurally and operationally. I believe this transition occurred in response to an incident that occurred at Parkville Youth Justice Precinct in 2010 when six boys escaped. This incident led to negative media coverage. A prompt change in organisational culture in youth justice away from a supportive therapeutic environment to a more custodial setting emerged.

72 The delivery of mental health services in the youth justice system could be improved with a change in culture. This will only be achieved if there is a change in perspective at senior leadership and management levels. There has been an erosion of trust between custodial staff and the children in the youth justice system. Whilst there is currently a culture centred on the belief that young offenders need to be equivalently punished in an environment akin to adult prison, this culture will prove very difficult to foster and maintain trusting relationships that facilitate safe engagement and genuine rehabilitation.

Mental health services in the youth justice system

73 Psychologists and psychiatrists provide therapy within the youth justice system. Mental health care plans are not required in custodial settings.

74 I am unaware of any preventative mental health services in the youth justice system. Mental health services have mostly been targeted towards young people presenting with signs of mental health problems through a screening process or when acute mental health issues arise in custody.

75 Acute mental illness is typically treated with a combination of medication and psychotherapies. There are no tailored mental health units in Parkville or Malmsbury Youth Justice units. Young people with serious mental illness can be transferred to a gazetted psychiatric inpatient unit under the Mental Health Act.

Improving linkages between health providers in youth justice settings and youth forensic mental health services to facilitate effective treatment?

76 Orygen provide mental health services in Parkville and Malmsbury Youth Justice. YFSS currently only accepts referrals from CYMHS and CAMHS. Youth released from custody who need mental health care require referral to CYMHS or CAMHS before they can be referred to YFSS. If YFSS was able to provide a case management model in collaboration with CYMHS and CAMHS it could feasibly accept direct referrals from youth justice.

MENTAL HEALTH SERVICES - OPERATIONAL CONSIDERATIONS

Strategies to support Area Mental Health Services to expand and improve the delivery of youth forensic mental health services

77 It would be desirable to upskill the forensic capability of staff at Area Mental Health Services to improve their confidence in managing children and adolescents with forensic issues. Victoria is unlikely to be able to train significant numbers of forensic adolescent experts, whether psychiatrists or psychologists. However, we can upskill clinicians to manage adolescent forensic issues more independently. This requires opportunity for clinical exposure to the complexities of forensic cases.

78 A solution would be to develop a training program to offer secondments of staff to the youth forensic service at the Alfred and increase their skills. Supervision of clinicians would enable the integration of forensic work into the generic work of Area Mental Health Services.

79 Forming partnerships between Mindful - Centre for Training and Research in Developmental Health, Forensicare and Swinburne University - Centre of Forensic Behavioural Science could lead to the coordination of a youth forensic education and training program for development of Youth Forensic psychiatrists and psychologists.

80 The establishment of Youth Offending Teams (**YOT**) placed at all CYMHS would cater for the often complex mental health needs of children placed on Youth Justice Community Orders. All children on Youth Justice Community Orders would be directed to the YOTs for a comprehensive assessment with a view to provision of tailored and coordinated systemic and mental health care specific to their unique circumstances.

TRANSITIONS

Risks posed to young people living with mental illness in transitioning between services and how they can be best supported through these transitions

81 When young people are transitioning between services, a challenge arises in managing, integrating and sharing the vast range of information obtained about that individual over time. This information can be lost in the process of youth transitioning between different services.

82 It would make sense to have a structured mechanism to allow information to flow easily between the courts, youth justice facilities, remand centres, prisons and other relevant facilities when young people interface between these services. This is important because young people can become disengaged when they are repeatedly assessed but ineffectively managed.

83 Further, youth services, including CYMHS/CAMHS, Youth Justice, DHHS (including Secure Welfare), Residential Care facilities, support services such as Berry St and McKillop Family Services and Drug & Alcohol Services currently operate as silos without effective integration. It would be preferable for these services to be more collaborative and integrated.

COMPULSORY TREATMENT IN YOUTH JUSTICE FACILITIES

Whether compulsory treatment should be able to be provided within youth justice facilities

84 My understanding is that compulsory treatment of children and adolescents on a youth justice order currently cannot be legally performed in Victoria.

85 As to whether it should be able to be provided, I am only able to provide comment on compulsory treatment in justice settings when I was employed at Forensicare, including Thomas Embling Hospital.

86 There has been steady debate amongst psychiatrists as to whether there should be provision for involuntary administration of medication to an individual in a custody setting. The vast majority of psychiatrists do not support this due to problems with custodial staff interfacing with health staff to manage the patients. However, prisons are often so overwhelmed with seriously mentally ill people that there is insufficient capacity to treat patients in forensic hospital settings. Prisoners who cannot be offered timely treatment could be deprived of necessary medication because they cannot and don't consent to medication being administered in the custodial setting.

87 A temporary solution is to transfer the individual to an 'ultra-acute unit' to allow them to be administered treatment by a clinician, after which they could be sent back to the relevant correctional facility.

88 This is a clear dilemma that highlights the need for creative solutions until a dedicated forensic hospital is established. An obvious risk is that once involuntary treatment is provided in custody it would likely set a precedent for acceptable ongoing practice. My personal view is that involuntary treatment should not be possible in custodial settings if there is an alternative and better option.

Increases in the duration of compulsory treatment among children and young people in area mental health services

89 The duration and rates of compulsory treatment is not my area of expertise. I am aware of data from the Victorian Mental Health Services Annual Report 2018-19 that suggests that there has been an increase in the duration of compulsory treatment of children and young people. This could be interpreted in two ways — either children and adolescents

are being appropriately treated for longer duration, or they are being treated for unnecessarily long periods of time. It is difficult to make a comment without assessing each individual case.

COMPLEX NEEDS

Forensic mental health care system for young people with severe mental illness complex needs

90 Children and adolescents with complex behaviours can be excluded from mental health services. In some instances, these children and adolescents are not properly evaluated or screened by clinicians with insufficient forensic experience.

91 Unfortunately these children and adolescents do not obtain the help that they need. They may end up engaging in offending behaviour, after which they are taken into custody where they are eventually assessed and offered treatment. Hopefully these children and adolescents will no longer fall through the gaps with the forensic services available at YFSS and Orygen.

92 Children placed in Secure Welfare settings frequently have complex forensic mental health issues that ideally require prompt assessment. Children can only be placed in Secure Welfare settings for a maximum one of 21 days. This provides limited opportunity for a thorough forensic mental health assessment to be conducted. It would be preferable for forensic mental health services to have an established relationship with Secure Welfare so the assessments can be conducted in a timely manner. Such an assessment is often required in order to evaluate the young person's risk prior to their discharge.

DISABILITY

Whether forensic mental health services are meeting the needs of young people with a disability

93 I do not have specific expertise in the forensic mental health needs of young people with a disability. My expertise extends from the clinical experience I have gained in assessing the many young people in the youth justice system with mild or borderline intellectual disabilities.

94 There are limited opportunities for clinicians to develop skills in managing young people with forensic issues. Alfred CYMHS has a team of experts specialising in intellectual disability and mental health — The Mental Health Intellectual Disability – Youth (**MHIDI-Y**) Initiative. YFSS provides a consultation service to MHIDI-Y when forensic issues arise.

PREVENTION AND PROMOTION

Mental health prevention and promotion for young people

95 A stronger focus on mental health prevention and promotion for young people would reduce the number of children and adolescents with mental illness who come into contact with the justice system.

96 Preventative measures could be implemented as early as in utero and early infancy. Identifying parents at risk (which in turn, leads to their children being at risk) and allocating resources to support these parents throughout the early stages of their child's life would result in considerable benefit.

97 Ensuring children are retained in schools and alternative education settings is paramount to offset the risk of delinquency. Establishing links between children at risk with positive role models and peer influences is also critical.

The role of structured physical activities play in prevention and promotion programs

98 There are enormous mental health benefits for young people actively engaged in structured sport programs. Organised sporting activities provide children and adolescents with an opportunity to participate in a rewarding activity, enhancing healthy self-esteem and connections to pro-social peers. The most vulnerable children are often not involved in community sport and many disengage at in the critical teen years.

99 There are potential benefits in building linkages between community sport clubs with schools and youth mental health services. Sport clubs recognise that they play an important role in the promotion of mental health, however they require more resources to enable them to support the complex needs of vulnerable young people.

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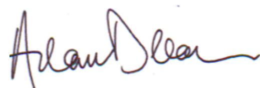

print name Adam Deacon

date 2 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AD-1

This is the attachment marked 'AD-1' referred to in the witness statement of Dr Adam Deacon dated 2 July 2020.

AD-1

DR ADAM DEACON

MBBS BMed Sci MP FRANZCP
Cert. Child & Adolscent Psychiatry
Cert. Forensic Psychiatry
CONSULTANT PSYCHIATRIST

Curriculum Vitae

Qualifications

MBBS BMedSci MP FRANZCP
Cert. Forensic Psych., Cert. Child and Adolescent Psych.

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Education

1985-1988 Melbourne High School

1989-1996 University of Melbourne – Bachelor of Medicine and Surgery

1994/5 Bachelor of Medical Science

1995 Psychiatry 1st Class Honours

2005 Fellow of Australian and New Zealand College of Psychiatry, Master of Psychiatry

2008 Advanced Training Certificate in Child & Adolescent Psychiatry & Advanced Training Certificate in Forensic Psychiatry

DR ADAM DEACON

MBBS BMed Sci MP FRANZCP
Cert. Child & Adolscent Psychiatry
Cert. Forensic Psychiatry
CONSULTANT PSYCHIATRIST

Curriculum Vitae

Employment History

1997 Internship - *Geelong Hospital*

1998/9 Hospital Medical Officer – *Geelong Hospital*

2000 Commenced Psychiatry Training – *Geelong Hospital*

2001-2005 Completed Psychiatry Training, *Austin Hospital*
Advanced Training in Forensic Psychiatry

2005 (May) Fellow of Australian and New Zealand College of Psychiatry

2005-2017 Part-time Consultant Forensic Psychiatrist, *Forensicare*

2005-2006 Part-time Advanced Training in Child and Adolescent Psychiatry, *Austin Hospital*

2007-2020 Part-time Private Practice - Forensic (Family and Criminal), Adolescent / Family and Sport Psychiatry (elite athletes, AFL footballers)

2007-2012 Visiting Adolescent Forensic Psychiatrist - Tasmania

2005-2013 Consultant Forensic Adolescent Psychiatrist - Malmsbury Youth Justice, Parkville Youth Justice

2016-2020 Collingwood Football Club Psychiatrist

2018-2020 Alfred Health – Youth Forensic Specialist Service