Children's Court of Victoria

Royal Commission into Victoria's Mental Health System:

Children's Court of Victoria Submission

Dated 5 July 2019

Contents

1 Introduction

As a specialist court, the Children's Court of Victoria (the Court) focuses on the rights of children, young people and their families, and other parties before the Court. The Court deals with children, youth and families presenting with often multiple and complex problems. This includes mental health issues frequently evident among many who appear before the Court. The Children's Court sees the impact of a mental health system under extreme pressure, as an increasing number of people seek assistance, but are not able to access the help and treatment services that they need.

The Court welcomes the establishment of the Royal Commission into Victoria's Mental Health System (the Commission), and is pleased to have the opportunity to inform the Commission's work through this submission. It is hoped that the Commission's recommendations lead to fundamental reform to a system that is critical to supporting the mental health and wellbeing of the Victorian community, and in particular the vulnerable children, young people, and their families who come through the Children's Court.

A disproportionate number of young people who come before the Court experience mental health issues.[1] It is the Court's general experience that services to meet their needs are often inadequate or are fragmented. Consultation in the preparation of this submission with judicial officers of the Children's Court highlighted a general experience of significant gaps in access to appropriate mental health support services post-assessment for many Court users in both the Family and Criminal Divisions of the Court, including children, young people and parents.

The Court has a particular interest in the Royal Commission's inquiry into improving mental health outcomes for people – particularly children – who are in contact, or at greater risk of contact with the forensic mental health system and the justice system. The Court offers a unique perspective on these issues, as arising within this specialist jurisdiction. This submission:

- seeks to inform the Commission about the prevalence and impact of mental health issues in the Children's Court jurisdiction (Part 2);
- provides examples of existing evidence-based practices across the Court that lead to better outcomes for children and families experiencing mental health issues (Part 3);
- briefly outlines some comparative international responses (Part 4);
- identifies possible initiatives informed by best practice models, such as solution-focused courts and client-centred practices, which have the potential to better meet the mental health needs of Court users (Part 5).

The Court notes that the Commission intends to issue an interim report followed by a discussion paper in early 2020 and to afford an opportunity for responses to matters raised in the discussion paper. At that point in time, the Children's Court will seek to make further detailed submissions to the Royal Commission on the potential legislative, procedural and other options

[1] Armytage, P. and Ogloff, J., *Youth Justice Review and Strategy: Meeting needs and reducing offending* (2017), Executive Summary, p. 13.

that it suggests could improve the Court's response to the children and young people presenting at Court with complex mental health and related issues.

2 Background

2.1 Mental Health Issues in the Children's Court

2.1.1 Family Division

The Family Division of the Court hears applications relating to:

- the protection and care of children and young persons at risk; and
- applications for intervention orders in cases in which children and adults are family members affected by exposure to family violence or are perpetrators of family violence.

The social impacts of childhood abuse and neglect are complex and long lasting. Adverse impacts on the child can include compromised health and mental health, poor educational engagement and outcomes, difficulties in obtaining employment, alcohol and other drug abuse and addiction issues, difficulties in retaining stable accommodation, and increased risk of criminal behaviour lasting into adult life. In addition to these adverse impacts, there have been numerous studies on the intergenerational cycle of childhood abuse and neglect that point to a high percentage of childhood victims becoming perpetrators later in life.

Recent data published by the Australian Institute of Health and Welfare (AIHW) reveals that numbers of children who were the subject of substantiated notifications in Victoria continues to rise from 11,395 cases in 2013-14 to 17,245 in 2017-18.[2] The links to mental health issues for parents and children before the Family Division of the Court are outlined in this submission.

In recent years, publications on the Victorian child protection system including:

- the Report of the *Protecting Victoria's Vulnerable Children Inquiry*[3] which was established to investigate systemic problems in Victoria's child protection and related services system;
- the '*Always was, always will be Koori Children'* Report produced by the Commission for Children and Young People (CCYP) in its 'Systematic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria' (*Taskforce 1000* Report);[4] and
- the *Roadmap for Reform: Strong families, safe children* which detailed the then strategy for reform of the children, youth and families services system;[5]

[2] Australian Institute of Health and Welfare (AIHW), *Child protection Australia: 2017–18* (2019), p. 69.
[3] Cummins, P., Scott, D. and Scales, B. 2012, *Report of the Protecting Victoria's Vulnerable Children Inquiry*, Victorian Government, Melbourne (Cummins Inquiry report).
[4] Commission for Children and Young People, *Always was, always will be Koori Children* (October 2016).
[5] Department of Health and Human Services, *Roadmap for Reform: Strong families, safe children* (2016).

observed that mental illness is a significant risk factor in contributing to adverse outcomes for Victorian children. In 2016 the *Roadmap for Reform* report noted that mental health issues were referenced in almost 30 per cent of child protection reports.[6] The Cummins Inquiry report noted that estimates based on Australian Bureau of Statistics data suggest that "between 21.7 per cent and 23.5 per cent of children in Victoria (approximately 250,000 children) are living in households where a parent has a mental illness".[7] This is reflected on a broader national scale – the AIHW noting that in 2016, numbers of Australian parents with a mental health issue were at 22.5 per cent for Aboriginal families and 14.6 per cent for non-Aboriginal families, a trend that was largely consistent over the data collected between 2010 and 2016.[8]

After-hours warrants

The Magistrates' Court of Victoria offers a State-wide after-hours service for issuing warrants for children in emergency situations.[9] Recent data collected by a magistrate of the Children's Court whilst undertaking after-hours duty reveals that applications for warrants issued under the *Children, Youth and Families Act 2005* (CYFA) represent two-thirds of the work on after-hours.[10] This data shows that the majority of those warrants (90.2%) are sought and granted pursuant to s598 of the CYFA, where a child subject to a child protection order is absent from their placement, and is almost invariably at significant risk of harm.[11]

For the purposes of the analysis of after-hours emergency care warrants, the term 'mental health' includes self-harm, suicidal ideation, experiencing a psychotic episode, an admission to a psychiatric ward, ADHD, ODD, borderline personality disorder.

An analysis of the data for the period 10-17 November 2018 indicates 75 warrants were issued under s598 of the CYFA. The following table indicates the percentage of applications in which young people experienced mental health issues and/or substance abuse and/or engaged in the commission of criminal offences:

Mental health	58.7%
Substance abuse[12]	82.6%
Criminal offending	38.7%

The equivalent statistics for the after-hours week from 6-13 May 2017 indicates 72 warrants were issued under s598. The relevant data is as follows:

Mental health	50%
Substance abuse[13]	79.2%
Criminal offending	52.8%

[6] Ibid, p. 3.
[7] Cummins Inquiry report, p. 39.
[8] AIHW, *Child protection Australia: 2017–18* (2019).
[9] The after-hours service also deals with other types of emergency applications (e.g. for intervention orders or police search warrants).
[10] Data collected by Magistrate Bowles in a summary of after-hours applications for the period 23-30 March 2019.
[11] Ibid.
[12] In addition to illicit substances, includes alcohol, chroming and non-prescribed medication.
[13] Ibid.

The following *de-identified* case studies are examples of the highly concerning circumstances leading to requests for emergency care warrants to be issued for children, who are often in states of acute mental illness, and the subject of child protection orders.

Case study 1

A 16-year-old female was living with her father under an interim accommodation order, however concerns arose about her associations with a 29-year-old male and that she was at risk of sexual exploitation in exchange for the provision of methylamphetamine (ice). She had previously been diagnosed with a borderline personality disorder and had a short-term admission to a psychiatric unit. She experienced multiple placements in secure welfare without long term improvement in her wellbeing. The day following her exit from secure welfare, she absconded from her placement and a warrant was sought to return her after she was located at the 29-year-old male's address.

Case study 2

A 16-year-old female who was living in residential care subject to a care by Secretary order, had a history of significant mental health concerns including a history of self-harming, complaints of auditory hallucinations to harm others, and suicide attempts. These included attempts to jump from a bridge, overdose on tablets and cutting her wrists. She was on medication for depression and anxiety. Her parents relinquished care of her due to their inability to manage her suicidal intentions and inability to keep her safe. She displayed dysregulated behaviour, had little insight into the risks of her absconding and had a history of drug use, including ice, alcohol and cannabis. She had been placed in secure welfare on at least eight occasions and was previously admitted to the High Dependency Unit in the Adult Acute Unit of a regional hospital. She had recently absconded interstate and was exposed to significant sexual exploitation. A further emergency care warrant was sought to place her in secure welfare.

Case study 2

A 15 ½ year old male living in a therapeutic residential care unit under a family reunification order had a history of mental health issues including self-harm (cutting), historical suicidal thoughts, including stating he is "dead inside". He has been diagnosed with Asperger's Syndrome, and his behaviour is obsessional, impulsive and that he is readily influenced by others. He reports illicit substance use including ice, cannabis and alcohol. He had three secure welfare admissions in 2018 and he consistently absconded from his unit and his whereabouts at times unknown. He also engaged in criminal offending.

Secure welfare service

Further, the numbers of emergency care warrants issued after-hours by the Court over the past five years are continuously increasing.[14] The numbers of emergency care search warrants issued State-wide has increased by 420% between 2003/04 and 2017/18.[15]

The CYFA provides that if there is a substantial and immediate risk of harm to a child, a child may be placed in secure welfare for a period of 21 days.[16] Section 3(1) of the CYFA defines a "secure welfare service" as a secure welfare service established under s44.[17] There are two secure welfare services in Victoria: a 10 bed facility located at Ascot Vale (for boys) and a 10 bed facility at Maribyrnong (for girls).[18] As former Magistrate Peter Power states in his Research Materials:

> "*A secure welfare placement is usually only ordered in a case where a child has a serious psychiatric/psychological condition or a serious drug dependence which places him or her at substantial and immediate risk of harm*."[19]

While the CYFA makes provision for the placement of children at substantial and immediate risk of harm in secure welfare, the reality is that these are limited by the number of beds available for those at-risk children and young people.

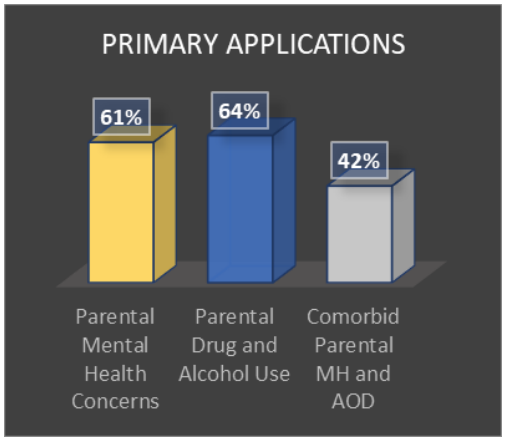
Increases in child protection applications

It is important to recognise that parental or caregiver mental illness alone is not the cause of neglect or abuse of children. However, mental illness left untreated, and in combination with other parental or caregiver risk factors such as drug and alcohol misuse, intellectual disability and socio-economic disadvantage can lead to poor outcomes for children.[20] These risk factors appear to have contributed to a rise in child protection notifications. Over a six-year period the Children's Court has seen a considerable increase (approximately 65%) in the number of child protection applications, both primary and secondary, issued in the Court. In the financial year 2011/12 a total of 11,912 child protection applications were issued. That number increased to 18,133 in the financial year 2016/17.[21]

The table below represents a snapshot of the issues leading to the initiation of child protection applications at Melbourne and Broadmeadows Children's Court over a three-month period to June 2019:

[14] For example, an analysis of data collected by Magistrate Bowles regarding CYFA emergency care warrants issued after-hours shows that in a one-week period in 2013 a total of 33 warrants were issued. Comparatively, in a one-week period in 2018 a total of 88 warrants were issued.
[15] Children's Court of Victoria, former Magistrate Peter Power, Research Materials at [5.27.3].
[16] See, e.g., ss 173(2)(b), 242(5), 263(1)(e) CYFA.
[17] Which enables the Governor in Council to declare by Order in the Government Gazette that a service with lock-up facilities is a secure welfare service under the CYFA.
[18] Children's Court of Victoria, former Magistrate Peter Power, Research Materials at [5.11.3].
[19] Ibid.
[20] Cummins Inquiry Report, pp. 35-39.
[21] Children's Court of Victoria, *2016/17 Annual Report* (2017), p. 4.

Primary Applications – Melbourne and Broadmeadows Children's Courts[22]



Out-of-home care (particularly in residential care facilities)

The *Roadmap for Reform* notes that children in out-of-home care (OOHC) are more likely to exhibit a range of problematic characteristics, including a diagnosed mental health problem, than their peers.[23] Further, children placed in OOHC in residential care facilities, as distinct from out-of-home care with family or foster families, are particularly vulnerable to mental illness. The impact of child abuse and neglect and consequent involvement in the child protection system is a significant risk factor for the mental health of these children. These children often have trauma backgrounds and are frequently subject to placement instability. The Australian Government Productivity Commission *Issues Paper on the Social and Economic Benefits of Improving Mental Health* describes "sharply elevated rates of mental illness among young people that child protection authorities have placed in out-of-home care (OOHC) and young people that have left out of home care" and note that the "prevalence of mental illness is especially high among the 5% of children in OOHC that live in residential care facilities".[24]

Aboriginal children

Aboriginal children and young people are over-represented in the child protection system in Victoria by a factor of six in comparison to the general child population.[25] In addition, Aboriginal children are over-represented in OOHC compared to non-Aboriginal children. For example, analysis of the recent Report on Government Services for Victoria indicates: 88 per 1,000 Aboriginal children in comparison to 4.4 per 1,000 for non-Aboriginal children.[26]

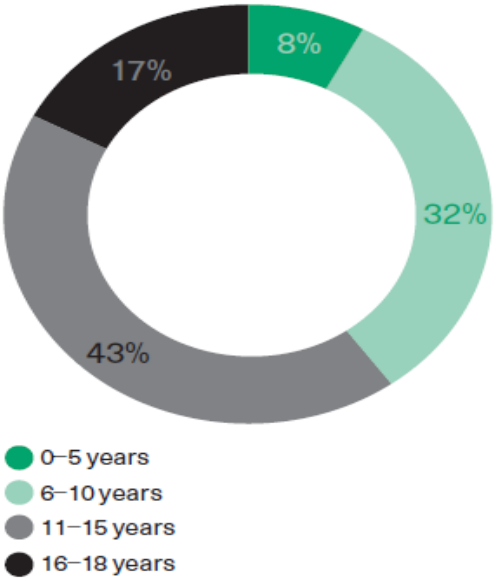
The *Taskforce 1000* inquiry found that "more than 60 per cent of the children reviewed came to the attention of child protection as a result of parental mental health issues in combination with

[22] Data analysis of 129 Primary Applications involving 218 children across Melbourne and Broadmeadows Children's Courts over a three month period to 1 June 2019. Information has been obtained from Child Protection documents accompanying Primary Applications.
[23] DHHS 2016, p.7.
[24] Australian Government, Productivity Commission, Inquiry into Mental Health, *The Social and Economic Benefits of Improving Mental Health – Issues Paper* (2019), p. 24.
[25] DHHS, *Roadmap for reform: Strong families safe children*, Melbourne, April 2016, p.1.
[26] Productivity Commission Report on Government Services 2017-18 for Victoria (2019), Part F, Chapter 16 Child protection service.

other risk factors. For many children this was a barrier to them being able to return home safely".[27] The CCYP in its *Taskforce 1000* Report stated:

> "*The Commission was concerned at not only the prevalence of children with mental health issues (22 per cent of all children reviewed), but also the very young ages of these children. As shown in Figure 18 [as reproduced below], 8 per cent of children with mental health issues were under the age of five.*"[28]

Figure 18: Children with mental health issues reviewed during Taskforce 1000, by age



n = 216
Source: Appendix 1, Table A26.

2.1.2 Criminal Division

The Criminal Division of the Court hears matters relating to criminal offending by children and young persons. It is recognised that young people with mental health needs are significantly over-represented in the criminal justice system. The Youth Parole Board *Annual Report 2017-2018* includes data from a 2017 survey revealing that 53 per cent of the young people detained on remand or on sentence presented with mental health issues and that 30 per cent had a history of self-harm or suicidal ideation.[29] The *Youth Justice Review and Strategy: Meeting needs and reducing offending* notes that more than 50 per cent of young offenders have mental health concerns and further, in Victoria 33 per cent of young offenders in 2015-16 had used a mental health service in contrast to 1.11 per cent of the broader Victorian youth population.[30] It is also noteworthy that the Youth Parole Board imposed the following numbers of special conditions on parole orders during 2017/18: 156 for substance abuse counselling, 63 for general counselling and 67 for psychological counselling.[31]

[27] Taskforce 1000 Report, p. 50.
[28] Ibid, p. 94.
[29] Youth Parole Board, *Annual Report 2017-2018*, p. 15.
[30] Armytage and Ogloff, *Youth Justice Review and Strategy: Part 1* (2017), pp. 156-157.
[31] Youth Parole Board, *Annual Report 2017/18*, p. 6.

A high proportion of the young people appearing before the Criminal Division of the Court experience mental health issues. A key issue of concern for the Court includes assessments that are not "followed through" and that there are "significant gaps in accessing support post-assessment".[32]

Young people in the criminal justice system frequently present with complex needs which encompass a range of comorbidities including mental health issues, alcohol and drug misuse, and cognitive disability.[33] This was a concern that was reiterated and emphasised through consultation with Children's Court Magistrates in support of this submission. Armytage and Ogloff note that a 'higher proportion of young people in youth justice have disabilities than the general public'[34] and cite the following figures from Victoria Legal Aid in relation to their high contact users: 56 per cent of clients have mental health issues, 15 per cent of clients have an intellectual disability and 11 per cent of clients have an acquired brain injury.[35] The co-existence of these conditions requires a service delivery model which can effectively address comorbidities.

The Court supports evidence-based problem-solving approaches similar to those recommended in the Armytage and Ogloff *Youth Justice Review and Strategy* report. This includes risk, needs, responsivity (RNR) approaches that involve assessment to identify who will benefit from interventions (risk), the type of interventions that will address the causal factors of offending (needs) and how to successfully deliver the interventions (responsivity).[36] This approach is particularly appropriate in responding to the criminal behaviour of young offenders as it best addresses the casual factors of a young person's offending including responding to any underlying mental illness.[37]

Aboriginal children

Aboriginal young people, in particular, are over-represented within the youth justice system. The 2016-17 AIHW report on youth justice noted that despite Aboriginal young people in Victoria only making up 2 per cent of those aged 10–17 in the general population, they constituted 18 per cent of those of the same age under youth justice supervision. The report also found Aboriginal young people were 13 times more likely to be in youth detention than non-Aboriginal children.[38]

2.1.3 'Crossover Kids'

A recent study by the Sentencing Advisory Council (SAC) on 'crossover kids', namely those children with experience of both the child protection and criminal justice systems, reveals significant levels of overlap between clients of the two statutory environments. The SAC report reveals that one in three sentenced and diverted children in Victoria had been the subject of a

[32] Issues identified via collective consultation with Children's Court of Victoria Magistrates.
[33] ACT Human Rights Commission 2016, p.11.
[34] Armytage and Ogloff, *Youth Justice Review and Strategy: Part 1* (2017), p. 157.
[35] Ibid 160.
[36] Ibid 12.
[37] Ibid.
[38] AIHW, *Youth justice in Victoria 2016-17* (2018).

child protection report.[39] The SAC research also notes that the younger the child was at first sentence, the greater likelihood that the child had been the subject of a child protection report.[40] This is particularly concerning in relation to the correlation identified between the age when offending commences and higher rates of offending throughout life.[41]

There are high rates of mental health issues in this crossover population. This is unsurprising given the prevalence of mental illness observed amongst the children in both the Family and Criminal Divisions of the Court. Comprehensive research conducted by Monash University in conjunction with the Children's Court, into the characteristics of children that crossover from the Family Division into the Criminal Division shows the complexities and comorbidities in those children. The Monash University report (as yet to be published) notes that 61 per cent of children in the cohort examined in the study experienced mental health problems, 73 per cent engaged in substance misuse and 72 per cent had challenging behaviours.[42] In addition, the study notes that "[a]round half the children (48 per cent) had a diagnosis of intellectual disability, borderline intellectual function, attention deficit hyperactivity disorder/attention deficit disorder… learning or communication disorder ..". Further, twenty-five per cent of these children experienced comorbidity with diagnoses of two or more conditions.[43]

Many of the children involved in both the child protection system and youth justice systems will also have experience of OOHC. As the SAC report notes, trauma can impact healthy brain development and consequently a child's ability to regulate emotions and behaviours. In addition, children in OOHC are likely come into contact with police as a consequence of behaviour that would otherwise be dealt with in a family context.[44]

Aboriginal Children and Families

The Monash University research into crossover kids also identified the over-representation of indigenous children in both the Family and Criminal Divisions of the Children's Court as an issue. The research identified certain key differences facing indigenous communities, including:

- families of indigenous crossover children were "survivors of the impact of European settler colonialism and the stolen generations";
- a higher degree of contact with child protection and the criminal justice system throughout indigenous families and communities; and
- "socio-economic deprivation was pervasive in indigenous communities".[45]

[39] Sentencing Advisory Council, *'Crossover Kids': Vulnerable children in the Youth Justice system. Report 1: Children who are known to Child Protection among sentenced and diverted children in the Victorian Children's Court,* Melbourne (2019), p. xx.
[40] Ibid, p. xxvi.
[41] Armytage and Ogloff, *Youth Justice Review and Strategy: Part 1* (2017), p. 149.
[42] Baidawi, S. and Sheehan, R. forthcoming, *'Cross-over kids': Effective responses to children and young people in the youth justice and statutory Child Protection systems*, Monash University, Melbourne, p. 9.
[43] Ibid, p. 68.
[44] SAC, *'Crossover Kids'* report, p. xxv.
[45] Baidawi and Sheehan, '*Cross-over kids': Effective responses* report (forthcoming), pp. 152-153.

The marginalisation of Aboriginal people, combined with intergenerational trauma, grief and loss, has serious and ongoing consequences for the mental health of these young people. In 2016 it was reported that 64 per cent of Aboriginal young people in the criminal justice system were also child protection clients, compared with 49 per cent of non-Aboriginal clients.[46]

3 Children's Court: Specialist Services, Processes and Lists

This section of the Court's submission focuses on specific legislative provisions, specialist lists and Court-based initiatives that have been developed to better respond to the particular needs of Court users. The Court considers that these may be of assistance in informing future reforms and processes to improve the Court-based responses available to children, young people and families experiencing mental health issues.

3.1 Legislative Provisions

Therapeutic Treatment Orders – Referrals to the Secretary of DHHS

The Therapeutic Treatment Order (TTO) is an innovative legislative response to children displaying sexually abusive behaviours that aims to divert children into evidence-based therapeutic interventions. From the commencement of the TTO regime until 28 March 2019 applications for TTOs were restricted to children aged 10-14 at the date the order was made. From 29 March 2019 the TTO framework has been extended to include children aged 15-17 on the recommendation of the Royal Commission into Family Violence.[47] The Court considers that the TTO legislative framework, which results in the discharge of criminal charges upon completion of the therapeutic treatment program, has the potential to provide guidance for future legislative schemes to address offending behaviours by children that arise in the context of underlying mental health concerns.

Section 349(2) of the CYFA states if a child appears in the Criminal Division of the Court as an accused and the Court considers there are grounds for the making of an application for a TTO, it may refer the matter for investigation by the Secretary of DHHS.[48] If the Criminal Division makes such a referral the Secretary must refer the matter to the Therapeutic Treatment Board (TTB) for advice.[49] The Secretary must consider (but is not bound by) any advice received from the TTB before applying for a TTO under s245(7) CYFA. The Secretary may apply for a TTO where satisfied on reasonable grounds that the child is in need of therapeutic treatment.[50] A TTO may be ordered by the Family Division of the Court pursuant to ss248-250 of the CYFA, requiring a child to participate in an appropriate treatment program to address sexually abusive behaviours.

If a TTO has been made in respect of a child who is an accused in related criminal proceedings, s352 of the CYFA requires the Court to adjourn the criminal proceedings at least until the end of the TTO. If a TTO has been made in respect of a child, the Court may require the Secretary

[46] See DHHS citation in Armytage and Ogloff, *Youth Justice Review and Strategy: Part 1* (2017), p. 174.
[47] Royal Commission into Family Violence Recommendation 34; *Justice Legislation Amendment (Family Violence Protection and Other Matters) Act 2018* amendments.
[48] Section 349(1) CYFA gives a similar power to the Criminal Division of the Court to make a referral to Child Protection if there is prima facie evidence that an accused in criminal proceedings is in need of protection.
[49] CYFA s245(4).
[50] CYFA s246(1).

to report to the Criminal Division at the time/s specified by the Court, on the child's progress and attendance at the therapeutic treatment program.[51] If the Criminal Division is satisfied that a child accused has attended and participated in a therapeutic treatment program s354(4) requires it to discharge the child without any further hearing of the related criminal proceedings. Section 354(4) has been interpreted to mean the child's attendance and participation in a therapeutic treatment program until it has been completed, as inclusive of any extended TTO period. As Judge Grant noted in *Victoria Police v HW* [2010] VChC 1 (at [18]):

> "*If, as in this case, the TTO has been extended for a period, the appropriate order on the associated criminal proceedings is to adjourn those proceedings for a period that is not less than the period of extension of the order. Accordingly, I adjourn these proceedings to the same date as the return of the TTO*, …"

Ultimately if the Court is satisfied that the treatment has been effective the child will no longer face charges and the child avoids the stigma of a finding of guilt and the possibility of a criminal conviction.

Between 2007/08 and 2017/18 the Court has made 231 TTOs the aim of which has been to ensure the child receives effective treatment to address the underlying sexually abusive behaviours. The Court may also, pursuant to ss252-254 of the CYFA, make a Therapeutic Treatment (Placement) Order (TTPO) to ensure the child receives the treatment to meet their sexually abusive behaviours. Over that same period, the Court made 14 TTPOs. At a time when the Court's ability to make these orders was restricted to children aged 10-14 at the date of the order, the Court notes that the overwhelming majority of orders made involved therapeutic treatment being provided to the child in the community.

TTOs operate within a legislative framework that enables investigation and reporting and where appropriate, treatment and placement of young people. This is an example of how the Court has been enabled through legislation to modify its procedures to ensure that children's behaviours are addressed through effective therapeutic intervention, both mandated and oversighted by the Court.

Diversion

Diversion is recognised as an effective process to respond to early offending through effective short-term responses. The Children's Court Youth Diversion service (CCYD) operates in Children's Courts across Victoria and is governed by Division 3A of Part 5.2 of the CYFA. Diversion provides an opportunity for eligible children and young people appearing before the Children's Court to address the underlying causes of their offending and engage with support services assessed as required without the stigma of a conviction or a finding of guilt for a criminal offence. Importantly, CCYD is an opportunity to intervene early in the potential trajectory of offending behaviour and prevent the child or young person from deeper involvement in the criminal justice system. A report exploring "criminal justice response to mental health conditions, cognitive disability, drug and alcohol disorders, and childhood trauma" by the ACT Children and Young People Commissioner stated that:

[51] CYFA s352A.

> *"Whether priority is placed upon community safety and reducing recidivism, or upon improving the health and rehabilitation of the offender (or both), evidence is increasingly showing that it is appropriate to consider diversion and support programs for people with mental health conditions and cognitive disability".*[52]

Findings from several studies indicate that a young offender who participates in a diversion program is far less likely to reoffend than a young person whose case is determined in court and who is subsequently incarcerated.[53] Research also indicates that rates of offending usually peak in late adolescence and decline in early adulthood. As most young people grow out of offending, diversion and early intervention play an important part in avoiding the criminogenic effects of incarceration.[54]

The Youth Diversion program offers an opportunity for assessment and intervention for young people with mental health/cognitive problems who might otherwise not receive the support they require to live a pro-social life. From a broader perspective, Armytage and Ogloff note that Victoria has a strong diversionary approach to offending, given that of those in contact with police, few go on to formal involvement with the courts and youth justice system.[55]

Mental Impairment and Fitness to be Tried

In 2012 the Victorian Law Reform Commission (VLRC) reviewed the *Crimes (Mental Impairment and Unfitness to be Tried Act) 1997* (CMIA) and made recommendations for legislative reform including the extension of the law in the Children's Court. The VLRC noted that at the time the lack of powers under the CMIA resulted in the "unjust and ineffective operation" of the legislation and that was "inconsistent with its underlying principles".[56] The VLRC noted that a specialised approach was required to remedy the gap in the application of the CMIA in the Children's Court, and to "provide an appropriate response to young accused under the CMIA who face multiple layers of vulnerability, including mental conditions, development issues and trauma in connection with offending behaviour".[57] During the consultation it was noted by the VLRC that:

> *"… there was consistent support for the extension of the CMIA to ensure that young people whose vulnerability is heightened by the fact of mental illness, intellectual disability or other cognitive impairment could be kept within the specialist jurisdiction of that court as far as possible. A strong theme in this regard was the need for this to occur within a specialised approach in the Children's Court, supported by necessary programs, facilities and services.*"[58]

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[52] Roy, A., McGill, B. & Fenn, L. *Children & Young People with Complex Needs in the ACT Youth Justice System*, Office of the ACT Children & Young People Commissioner, ACT Human Rights Commission, March 2016, p. 19.
[53] K. Richards & L. Renshaw (2013) 'Bail and remand for young people in Australia: A national research project', Australian Institute of Criminology, Research and Public Policy Series No. 125, p. 2; L. Jordan & J. Farrell (2013) op. cit., p. 420, quoting T. Allard et al. (2010) 'Police diversion of young offenders and Indigenous overrepresentation', Trends & Issues in Crime and Criminal Justice, No. 390, Australian Institute of Criminology, Canberra; T. Cunningham (2007) 'Pre-court diversion in the Northern Territory: Impact on juvenile offending', Trends & Issues in Criminal Justice, No. 339, Australian Institute of Criminology, p. 6.
[54] P. Power (2015) 'Research Materials: Chapter 11 Sentencing', Children's Court of Victoria, [11.1.16].
[55] Armytage and Ogloff, *Youth Justice Review and Strategy: Part 1* (2017), p. 154.
[56] VLRC, Review of the CMIA, p. xxix.
[57] Ibid.
[58] Ibid 28.

Despite the reference to "necessary programs, facilities and services" in the VLRC report, the CMIA legislative framework was extended to the Children's Court without the facilities, programs and services intended by the VLRC to underpin an effective response for these vulnerable children.

The CMIA was amended in 2014 to empower the Children's Court to deal with the issue of a child's fitness to be tried and the defence of mental impairment. This amendment recognises the vulnerability of a child suffering mental health problems, albeit at the extreme end, and that the ordinary court processes are not appropriate in such cases. The legislation recognises that in certain instances, cognitive deficits or mental illness may impact the child or young person to the extent that they should not be found criminally responsible for their actions. If a child's fitness to stand trial is raised as an issue the Court will request a psychological report from the Children's Court Clinic. There have been 40 young people referred to the Children's Court Clinic for assessments since the amendment commenced in 2014 and 23 have been found to be unfit, mentally impaired, or both. It should be noted that the Act does not define 'mental impairment' and based on case law it may include mental illness, intellectual disability and other cognitive impairments, such as brain injuries.

The CMIA is another example of legislative processes that have been articulated to meet particular vulnerabilities. The Court notes that in its experience the majority of the CMIA cases involve children and young people with intellectual disability, autism and ADHD.

3.2 Children's Court Clinic and other service providers

The importance of high-quality and timely assessments to identify mental health concerns is widely accepted as a fundamental element of best practice.

The Children's Court Clinic

The Children's Court Clinic (the Clinic) services the Family and Criminal Divisions of the Children's Court of Victoria. The Clinic operates as an independent body that is continued and maintained by the Secretary to the Department of Justice and Community Safety pursuant to s546 of the CYFA.

The Clinic consists of a large team comprising of clinical and forensic psychologists, and a small number of neuropsychologists and consultant psychiatrists who are all highly skilled and trained professionals that have specialist knowledge in the areas of child protection and youth offending. Approximately 11 clinical staff are in-house staff and approximately 20 clinicians provide assessments on a fee for service basis.

The functions of the Clinic are to make clinical assessments of children and provide other clinical assessments and recommendations in relation to children, youth and families. These expert clinical assessments assist the Court in its decision-making in both the Criminal and Family Divisions of the Court.

In the Family Division, s560 of the CYFA provides that the Court may seek a report from the Children's Court Clinic to enable it to determine a proceeding. In the Criminal Division s358 of the CYFA provides that if the Court finds a child guilty of an offence the Court may, in

considering sentence, take into account certain reports/materials including a pre-sentence report prepared by the Clinic. In the Criminal Division, the Clinic provides expert opinions on the criminal presentations of young people charged with criminal offending and assessments of children between the age of 10-13 as to their capacity to form the requisite criminal intent.

The following is a *de-identified* case study of a child protection matter that was referred to the Children's Court Clinic for assessment and recommendations to be made to the Court given the mental health presentation of both parents and the impact on the wellbeing of their children.

Case study

Three children aged 6, 4 and 2 years old. Their parents both have mental health problems and were involved in a 9-year relationship marked by domestic violence and drug use, with the children being exposed to their violence. The father is diagnosed with schizophrenia and has been subject to treatment under the *Mental Health Act* since 2016. When mentally unwell, the father has threatened to kill the children and their mother, sparking police involvement. He lacks insight into his mental health and takes no ownership of his aggressive behaviour and is non-compliant with treatment. The children's mother also presents with psychotic symptoms, low level cognitive functioning and has limited protective capacity and shows poor judgement in keeping her children safe. The exposure of the children to their parents' poor mental health and their father's violence and disorganised home environment, has resulted in the children presenting with disorganised attachments to their parents. They are currently in a stable foster care placement. Attempts at reunification and services attempting to provide parents with support is ongoing.

Furthermore, there is provision in the CYFA for the Clinic to provide clinical services.[59] However, the Clinic's capacity to do so is limited given the high demand for Court assessments.[60] Clinic data from the last five years indicates that the Clinic has received on average 620 referrals per year with referrals increasing from 520 in 2013-2014 to 663 in 2018-2019.

The Court is also concerned that although assessments are undertaken by the specialist clinicians of the Clinic, the degree to which those recommendations are effectively implemented under orders of the Court, either in the Family Division or Criminal Division, are subject to the resourcing of other agencies. A mechanism for the forensic assessment process to better link to mainstream mental health services would be strongly supported by the Court.

Mental Health Advice and Response Service

The Children's Court Mental Health Advice and Response Service (MHARS) is a specialist mental health service that is delivered by Orygen Youth Health at the Melbourne Children's Court. The MHARS Clinician provides mental health assessments for young people appearing before the Children's Court who present with suicidality, acute mental health concerns and/or distress while awaiting their court appearance in the Criminal Division and for children in

[59] Section 546(2)(c) CYFA

[60] Funding for the provision of the Children's Court Clinic has not increased since 2013 despite a more than 35 per cent increase in the Court's Family Division caseload over the same time period.

secure welfare in the Family Division. The MHARS Clinician also advises the Court as to whether mental health concerns are present or whether factors related to mental health may have a bearing on the proceedings; and where possible the clinician also facilitates timely access to appropriate treatment and mental health support services.

MHARS commenced its operations in mid-2019 and has been modelled on the existing MHARS in the Magistrates' Court of Victoria. It is currently being trialled at the Melbourne Children's Court with the view to explore expansion across all Children's Courts in Victoria.

Court Support Coordinator

The Children's Court has three Court Support Coordinators located at Melbourne, Moorabbin and Broadmeadows Children's Courts. The Court Support Coordinator positions are committed to strengthening support services for all court users by providing assistance and support to children, young people and their families attending Court.

The primary focus of the Court Support Coordinator is the provision of information and support to court users on the day of the court hearing to assist them in navigating the court process (particularly self-represented litigants). The emphasis of this role is not case management but rather to provide at-Court assistance to Court users to alleviate levels of distress and anxiety felt while attending the court. This service provides critical support to vulnerable court users particularly those attending at Court, mentally unwell or with cognitive deficits for whom the Court environment and processes can often be daunting and confusing. Court Support Coordinators also facilitate referrals to a range of services including mental health services and they also develop and maintain linkages with community support organisations and treatment agencies.

3.3 Support Services and Treatment – Criminal Division

Effective responses to offending behaviour that meet the individual needs of young people, including those with mental health needs, requires a tailored case management approach with appropriate resourcing and service collaboration. The following specialist lists and Court-based support services are intended to provide more effective Court responses to the particular needs of young people appearing in the Court's Criminal Division.

Children's Court Youth Diversion service (CCYD)

Research suggests that diverting young people from the criminal justice system can reduce the likelihood of further offending and improve community safety and outcomes for children and young people with mental health conditions.[61]

The CCYD generally targets children and young people charged with low-level offences with little or no criminal history who would otherwise be sentenced to an outcome not requiring supervision with youth justice services. A diversion order may contain a range of conditions for

[61] Children's Court of Victoria, *2016/17 Annual Report*, p. 7.

the child or young person. Conditions are underpinned by the principles of diversion and targeted to promote reparation of harm caused by the offence/s.[62]

CCYD coordinators manage risks identified through assessment and by engaging supports to promote the completion of a diversion activity. The interventions build on and strengthen a young person's existing relationships and interests, engaging them in the context of their family or carer and their community to promote positive change.[63]

Fast Track Remand Court

The Fast Track Remand Court (FTRC) is an initiative of the Children's Court that aims to expedite the hearing of criminal charges of children on remand. The FTRC commenced as a pilot at Melbourne in 2016. The FTRC is also supported by specialist services from Victoria Police, Victoria Legal Aid, Youth Justice, and the Children's Court Clinic. The FTRC aims to ensure consistency of magistrates in the management of the complex proceedings that have resulted in the remand of a child.

The FTRC is located in the Melbourne Children's Court and is dedicated to hearing all matters in the Melbourne, Sunshine and Moorabbin catchment areas, where young people are remanded in custody. The objective of the FTRC is to deal with matters more quickly, providing better outcomes for young people by reducing delays with a view to enabling earlier access to rehabilitation programs and easing pressure on the youth detention system.

The FTRC has significantly increased the efficiency of the system of remand for young people in Victoria as evidenced by:

- 24 per cent reduction in the length of time young people from Melbourne, Sunshine and Moorabbin spend on remand (from 62 to 47 days)

- halving the percentage of young people spending more than three months on remand (reduced from 42 per cent of young people being remanded for longer than 3 months to 24 per cent).

An additional clinician in the Children's Court Clinic was funded to provide a dedicated resource for the FTRC. The FTRC Clinician has ensured FTRC timeframes are being met. The role of the dedicated FTRC Clinician is to provide timely assessment reports and recommendations to assist the Court in the management of the more serious and complex criminal charges faced by children held on remand. This service ensures an efficient response to the high prevalence of mental health issues for children detained or on remand.[64]

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[62] Children's Court of Victoria website: https://www.childrenscourt.vic.gov.au/jurisdictions/criminal/youth-diversion, accessed 28 June 2019.
[63] Children's Court of Victoria website: https://www.childrenscourt.vic.gov.au/jurisdictions/criminal/youth-diversion, accessed 28 June 2019.
[64] Youth Parole Board, *Annual Report 2017/18*: "The results of an annual survey of 226 young people involved with Youth Justice in 2017 looked at 209 males and 17 females detained on sentence and remand on 1 December 2017. The survey shows:

- 53 % presented with mental health issues
- 30 % had a history of self-harm or suicidal ideation
- 41 % presented with cognitive difficulties that affect their daily functioning

Children's Koori Court

The Children's Koori Court is another example of a tailored response that has been articulated to the needs of the Koori community, with cultural connections and community involvement.

> "*The importance of cultural safety in the provision of services to Aboriginal people cannot be under-estimated. A culturally safe system is one in which people feel safe, where there is no challenge or need for the denial of their identity, and where their needs are met. A culturally-responsive system is one in which non-Aboriginal people take responsibility to understand the importance of culture, country and community to Aboriginal health, wellbeing and safety, by working with Aboriginal communities to design and deliver culturally-responsive services.*"[65]

In October 2003, the Aboriginal Justice Forum determined that the then Department of Justice and the Department of Human Services should work towards developing a Children's Koori Court. A state-wide reference group was established that included broad representation from the Department of Justice, Youth Justice (then a division of DHS), the Children's Court, Aboriginal agencies and the Regional Aboriginal Justice Advisory Committees. The reference group commenced meeting in mid-2004 and in October of that year the AJF endorsed Melbourne as the site for the first Children's Koori Court. The next 12 months were spent establishing the court, which commenced sitting in October 2005.

The Children's Koori Court has the objective of "ensuring greater participation of the Aboriginal community in the sentencing process of the Children's Court through the role to be played in that process by the Aboriginal elder or respected person and others so as to assist in achieving more culturally appropriate sentences for young Aboriginal persons".[66] The legislation establishing the court requires proceedings to be conducted in a way that is comprehensible to the defendant, the defendant's family and any member of the Aboriginal community present in the court.[67] The legislation allows the court to consider any oral statement made to it by an Aboriginal elder or respected person and inform itself in any way it thinks fit.[68]

Courtrooms used for Koori Courts have been adapted for the court's particular processes. Aboriginal artworks are on the walls and the Australian, Aboriginal and the Torres Strait Islander flags displayed. The courts are "smoked" in accordance with custom and tradition prior to the first sitting. The "sentencing conversation" takes place at an oval bar table in the body of the courtroom. The judge sits at the table with two elders or respected persons. In addition, the Koori Court officer, the prosecutor, the Koori Youth Justice worker, the defence lawyer, the defendant and family members will also sit at the table. If there is a particular worker involved with the defendant, that worker may also sit at the table. Other family members, support persons and community members are present in the courtroom.

The open exchange of information that occurs within the Koori Court gives the judicial officer a sound understanding of the young person's circumstances, the context of the offending and the

[65] Burra Lotjpa Dunguludja - Aboriginal Justice Agreement Phase 4 2019.
[66] Judge Paul Grant, Children's Koori Court paper, Prato conference (2009).
[67] CYFA s517.
[68] CYFA s520.

prospects for rehabilitation. The sentencing decision is a fully informed one. Where necessary, the court endeavours to coordinate support services to assist an offender with their rehabilitation.

Children's Koori Courts currently operate at Melbourne, Heidelberg, Dandenong, Mildura, Latrobe Valley (Morwell), Bairnsdale, Warrnambool, Portland, Hamilton, Geelong, Swan Hill and Shepparton. Funding was provided through the AJA4 package for further expansion to three additional venues of the Children's Court over the next three years.

The Children's Court is planning to engage the Koori Caucus and community in a project to review the existing Children's Koori Court model to look for ways to strengthen self-determination, and consider whether the role of the Children's Koori Court Officer might be enhanced.

The Children's Koori Court affords an example of the significant benefits of community involvement in providing services and culturally appropriate supports to assist in the rehabilitation of young Koori offenders.

3.4 Support Services and Treatment – Family Division

Family Drug Treatment Court (FDTC)

The FDTC has been developed as a Court-based response to provide intensive therapeutic and judicial support to parents whose children have been removed because of parental drug and alcohol issues. The FDTC model could inform an articulated court model to better support parents whose children have been removed from their care due to the impact of parental mental health issues on the wellbeing of their children. It is important to note the strong correlation between mental health concerns and drug and alcohol addiction.

In the context of this submission, an analysis of the presentation of participants in the FDTC reiterated that 75 per cent of FDTC participants (75 individuals in a sample of 100 participants) had one or more mental health diagnoses, with anxiety and/or mood disorders the most commonly recorded. Of these participants, 38 were referred by the FDTC to specialist mental health treatment, 20 for mental health support through a GP, and eight to counselling with a clinical psychologist.

The FDTC has been operating since 2014 at the Children's Court in Broadmeadows, and is the first of its kind in Australia. The FDTC is a judicially monitored, therapeutic 12-month program conducted in a highly supportive non-adversarial environment. The program engages parents whose children have been taken into care due to the parent's substance misuse or dependence, and uses intensive case coordination and therapeutic intervention to address issues of substance misuse, mental health, and housing with the aim of achieving permanent, sustainable family reunification of parents and their children. The FDTC has been the subject of two independent evaluations, both of which found that the FDTC is both more effective, and more cost-effective, than traditional court processes in responding to parents presenting to court with complex support needs.

In 1994, the first Family Drug Treatment Court was established in the USA to create an environment where a child's safety and rights could be protected during a time where parents could access mental health, addiction and other support services within the court setting. FDTCs were established to reduce child maltreatment by treating the underlying drug abuse problem through the collaborative efforts of the court, child protection and welfare agencies as well as other services including drug treatment services. Broadly the aims of FDTCs are to:

1. promote behavioural change rather than compliance with the child protection system;

2. focus on the future rather than apportioning blame and focusing on the past;

3. recognise the importance of procedural justice by affirming individuals are competent and equal, provide them with a voice and treat them with dignity and care; and,

4. incorporate judicial involvement in proceedings as well as participation of all parties and encourage self-determination and individual choice.[69]

Since commencing in May 2014, the FDTC at Broadmeadows has provided treatment and support to 131 parents (with related child protection applications affecting 189 children). Of the 131 participants inducted into the FDTC to date, 31 per cent have achieved reunification with their children, while an additional 21 per cent have seen alternate permanent care arrangements made for their children resulting in finalisation of Children's Court matters and the withdrawal of child protection involvement. Combined, this equates to 52 per cent of the program's inductee's children (97 children based on average number of children per participant of 1.4) who have achieved ongoing stability following parental participation in FDTC.

Outcomes from the two independent evaluations of the FDTC conducted by Health Outcomes International in 2017 and Swinburne University's Centre for Forensic Behavioural Science in 2018 demonstrate that:

- Participants in the FDTC are between 1.6 and 2.5 times more likely to achieve reunification than a matched comparison sample in the mainstream court alone.

- 72.2 per cent of FDTC participants who maintain engagement with the program for greater than 6 months achieve reunification, compared with only 43.3 per cent in the mainstream court system.

- FDTC participants who are exited from the FDTC program following a 6-month engagement achieve reunification at a proportionately higher rate (66.7 per cent) than mainstream court users (43.3 per cent).

- For FDTC participants, the average length of time to final order (reunification) is 1.1 years compared with 3.5 years for mainstream court processes.

[69] De Bortoli L, Luebbers S, Riacchi M and Mastromanno B (2018). *The Family Drug Treatment Court - An Evaluation Report*. Report prepared by the Centre for Forensic Behavioural Science for Court Services Victoria.

- FDTC outcomes are more sustainable than those in mainstream court, with FDTC participants 2.2 times less likely than mainstream court users to have a substantiated report to child protection in the post-court period. [70]

The FDTC adopts a solution-focused, non-adversarial approach that is based upon communication and collaboration between Magistrates, clinicians and participants. The FDTC Magistrate plays a pivotal role which enables them to maintain a supportive and highly communicative relationship with clients via frequent review meetings. The FDTC provides parents with intensive holistic support and facilitates access to a range of support services to assist them in overcoming their drug addiction. It draws upon psychological and legal frameworks that focus upon creating a caring and supportive environment as an agent of therapeutic change that targets unique characteristics of clients enabling these changes to be sustained over time. Whilst the focus of the FDTC intervention is addressing alcohol and/or drug addiction, the model and approach is also highly effective at supporting participants with identifying, accessing, and maintaining mental health treatment and support.

Case study

Ms J* was referred to the Family Drug Treatment Program (FDTC) by Child Protection.

Ms J was a 36-year old woman whose primary reason for the removal of her two children (both under the age of 15 years) was illicit substance use. The two children were placed in out of home care with their paternal grandmother.

At the time of assessment Ms J reported a history of addictions to a range of substances including alcohol, tobacco, diet pills, methamphetamines, cannabis and prescription opioids since her early teenage years. Ms J had previously had some alcohol and other drug counselling, which she said did not help her, and one unsuccessful attempt at completing a residential detoxification program.

Ms J was a single mother having separated from the children's father due to family violence perpetrated against her. Ms J presented as extremely anxious, resulting in her becoming quickly overwhelmed. She had many wounds to her face and arms from picking her skin which she attributed to her "obsessional compulsive behaviour". Although Ms J had a regular General Practitioner (GP), who on two occasions had prescribed medication for anxiety and depression, Ms J had discontinued treatment, and had never had a specialist mental health assessment. She had chronic pain in her hip from a past injury. Ms J was homeless at the time of referral. Ms J had 29 outstanding fines and 12 outstanding warrants. She also had driving infringements before the Magistrates Court.

Ms J came to the program with a determination to cease her substance use, in the hope that this would result in her being able to have her children returned to her. Once Ms J was accepted onto the FDTC program a range of supports were put in place in a staged and planned way so as to not overwhelm her. Although Ms J may have had access to these

[70] De Bortoli L, Luebbers S, Riacchi M and Mastromanno B (2018). *The Family Drug Treatment Court - An Evaluation Report*. Report prepared by the Centre for Forensic Behavioural Science for Court Services Victoria.

* Not her real name.

services, it is highly unlikely that she would have been able to benefit from them without the coordination, advocacy and support that the FDTC provided.

Ms J completed the standard program requirements of weekly attendance at court and three times weekly substance screens, and this was reduced over time as she successfully moved through the program. Ms J was referred for drug and alcohol counselling which she completed. She was referred to transitional housing, and once this was secured, she was allocated a housing worker who assisted her to maintain her lease and work towards securing permanent accommodation. A referral was made to a psychiatrist, for mental health treatment, and a psychologist for trauma and grief counselling. Both worked with Ms J's GP to coordinate her mental health supports. She attended Narcotics Anonymous, through which she secured a sponsor. She accepted the support of a peer mentor and participated in a peer support group for FDTC parents. She was referred to an orthopaedic surgeon and pain clinic. Ms J successfully completed a residential detoxification program and a community rehabilitation program. Ms J completed two parenting courses while in the program. She accessed specialised trauma-sensitive yoga. Ms J was assisted to secure a Disability Support Pension and was supported by a financial counsellor. She was assisted to access legal advice leading to a resolution to both her infringement and driving matters.

Due to her engagement with, and completion of, the FDTC program, Ms J's two children were returned to her. She continues to work on her psychological and addiction issues but has supports in place to assist with this. Ms J has established an amicable relationship with the father of her children. She has joined an employment agency who are funding a training course for her, and she is working towards becoming a (paid) peer support mentor, with the intent of supporting other parents in the FDTC.

The range of services put in place, the majority of which were not funded directly by the FDTC, are intended to be a circuit breaker, to then allow her to develop new skills, to be able to cope with any further issues that she may have to face in the future.

To be eligible for referral to the FDTC, a prospective participant must:

a) Have a child/children residing out of their care predominantly due to concerns relating to substance use, and the youngest child must be aged under 3 years;

OR

b) Have a child/children of any age residing out of their care predominantly due to concerns relating to substance use, where the duration of the out of parental care placement does not exceed 6 months.

The prospective participant must consent to the referral being made, and be actively seeking to have their child/children returned to their care. At present the FDTC is only available in two Children's Court locations, Broadmeadows and Shepparton, although the Children's Court Statement of Priorities 2019-21 identifies the Court's longer-term plans to expand the availability of Specialist Children's Court services state wide which includes the availability of the FDTC.

The FDTC program consists of three phases that participants move through as their recovery progresses. In the first phase, participants must attend Court each week to meet with the Magistrate and their FDTC team to discuss their recovery goals and their support needs, in addition to providing supervised urine drug screens three times per week. In the second phase, participants are only required to attend Court once per fortnight and provide supervised urine drug screens twice per week, while in the third and final phase, Court attendance is expected once per month and supervised urine drug screens occur once per week.

FDTC participants are allocated their own FDTC Clinical Case Manager who will guide the development of a Family Recovery Plan that identifies treatment strategies to address substance misuse, as well as addressing any needs associated with mental and physical health, housing, parenting, family violence and child safety, stability, and development. The FDTC works in a collaborative manner with a range of external support services to attempt to meet these needs.

FDTC participants are expected to attend some core support programs, in addition to being able to choose to attend others. Programs and supports currently offered include parenting skill development, cooking and nutrition, yoga and mindfulness, safe and healthy relationships, and peer mentorship. As identified in the Swinburne evaluation of the FDTC, parental engagement is known to play a role in enhancing outcomes in child welfare more generally, as well as contributing to sustainable family reunification within the FDTC setting[71]. Specifically, providing services to parents that are personally relevant strengthens their connection to those services, improves engagement and motivates participation[72].

Another key feature of the FDTC approach is the role it plays in promoting and supporting collaboration between support services towards a common goal. Effective collaboration between individuals and agencies has been identified as important for enhancing the effectiveness of the FDTC, as it improves the quality of relapse support available to parents as well as the ability of the Court to coordinate relevant resources and provide consistent advice to parents. For parents, collaboration has a therapeutic effect that is important and connects them to a supportive and multi-disciplinary team, an experience that many have never had despite sometimes multiple and complex service system involvement previously. The FDTC also plays a role in ensuring the accountability of the service system through the regular monitoring hearings, making use of the authority of the court to encourage relevant services to engage with participants and provide them with the level of support they require.

As part of the FDTC model, the Self-Help Addiction Resource Centre (SHARC) is funded to provide peer mentors for program participants. Peer mentors who have lived experience of successful recovery from addiction, including a number of mentors who have successfully graduated from the FDTC program, offer currently engaged parents advice and support related to their own experiences. Parents reported that their sustained involvement with the Court was strongly influenced by having a mentor who had been through the process to share their experiences, validating the challenges, and reinforcing the value of engagement with the program.

[71] De Bortoli L, Luebbers S, Riacchi M and Mastromanno B (2018). The Family Drug Treatment Court - An Evaluation Report. Report prepared by the Centre for Forensic Behavioural Science for Court Services Victoria.
[72] Ibid.

Program participants were interviewed as part of the Swinburne evaluation to seek their views and experiences of the FDTC. Mostly, participants described the elements of the therapeutic approach, particularly those associated with procedural justice and fairness. These included the court hearing their voices and offering care and support. Some examples of the feedback include:

> *"I like that I can be honest without people getting mad at me"* (Participant 3).
>
> *"Pushing us to be drug free but not in a heavy-handed approach"* (Participant 6).

Participants recognised the personal nature of the support offered at the FDTC:

> *"It feels like everyone cares and is trying their best to help"* (Participant 2).

"No matter what the situation, the case manager is there to help. Even it is it not drug-related, the court is very supportive of your needs. I feel like the court advocated on my behalf, and I loved being able to call my case worker for resources and support. It felt that they were there for you" (Participant 7).

> "*They give support rather than judgement. I'm a recovering drug user, need support, not judging, they don't judge… If you miss screens, they understand and support, not just punish. They know what you are doing, what is happening, because you see them regularly. They know me more, so they know when it is a real fuck up and when it is just life*" (Participant 9).

Active judicial involvement plays an important part of therapeutic jurisprudence processes. Participants had many positive comments about the Magistrate's approach and it formed a central part of the overall positive perception experienced by the participants:

> *"It is easy going, and it is good to sit across from the judge and not feel judged. It feels like the judge is on your level, so it is less intimidating"* (Participant 1).
> *"I like how we sit around a table with the judge and have a chance to speak"* (Participant 2).
>
> *"It is nice to have the judge in front of you, it is more helpful"* (Participant 4).
>
> *"They were very supportive and never blamed or judged or put you down"* (Participant 8).
>
> *"She gives support, guidance, activities, it is helpful. The support is to help you and make you do it. I don't feel nervous anymore coming in, they want to help me get better"* (Participant 9).

Marram-Ngala Ganbu

Marram-Ngala Ganbu, meaning "We are one" in Woiwurrung language,[73] is a Koori Family Hearing Day that aims to improve outcomes for Koori children involved in child protection proceedings by better promoting the involvement of Aboriginal families, community and community controlled organisations in a modified and culturally appropriate Court process. Research establishes that connection to culture is a protective factor for Aboriginal children, particularly those at risk of suicide.[74]

The establishment of a pilot Koori list in the Family Division of the Children's Court of Victoria was a recommendation made by the *Protecting Victoria's Vulnerable Children Inquiry* in 2012. This recommendation followed the identification of the need for such an initiative by the Aboriginal Justice Forum (AJF23) in March 2009 given the high rates of removal of Aboriginal children from their families.

The Broadmeadows Children's Court was opened in October 2015 and seeks to trial innovative processes to improve outcomes for children and families involved in child protection proceedings in the Family Division of the Court. In July 2016, the Broadmeadows Children's Court established a pilot Koori Family Hearing Day, to be known as Marram-Ngala Ganbu. The program was officially launched in August 2016.

The Koori Family Hearing Day aims to:

- improve outcomes for Koori children involved in child protection proceedings;
- improve the participation of Koori families and communities in child protection proceedings;
- enable decision-making to be informed by an improved cultural understanding;
- encourage culturally appropriate processes to assist in decision-making reflective of the community to which the Koori child belongs;
- improve adherence to the Aboriginal Child Placement Principles set out in the CYFA;
- promote the provision of cultural support for Koori children (consistent with the cultural plans for children in out of home care) that maintain and develop the child's identity and connection to community and culture;
- provide court processes that enable Koori children, parents and others to participate fully in the proceedings in a manner that respects their cultural identity and needs in accordance with s522 of the CYFA; and
- provide court processes that promote cooperative relationships in accordance with s215B CYFA.

[73] The Wurundjeri Tribe, Land & Compensation Cultural Heritage Council Inc. has provided the name Marram-Ngala Ganbu as an appropriate name for the Koori Family Hearing Day.
[74] Professor P.Dudgeon et al, *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report, 'Solutions that work: what the evidence and our people tell us'*, University of Western Australia, November 2016, p 22.

Marram-Ngala Ganbu provides an informal atmosphere and allows greater participation by family members, Aboriginal community members and organisations in the Court process to improve Court outcomes for Aboriginal Children.

A Koori Family Support Officer coordinates the Marram-Ngala Ganbu list and assists family members in obtaining legal representation and understanding the court process. The Koori Family Support Officer can also assist in referrals to culturally appropriate support services, including mental health services as required.

The Magistrate sits at the bar table with all participants, not at the bench. Marram-Ngala Ganbu provides a safe space for families to work collaboratively with Child Protection to keep children safe and connected to their culture. The Courtroom is replete in Aboriginal art and symbols, including a possum skin cloak covering the bar table, a coolamon, paintings, a shield, and an Acknowledgement of Country. The Aboriginal flag, and Torres Strait Islander flag are also prominently displayed.

Since January 2016, 350 Aboriginal families have participated in the program. Marram-Ngala Ganbu sits once a week and now lists eight mentions and two conciliation conferences each sitting day. On average, Aboriginal families make up 22.3% of the families appearing in the Family Division at Broadmeadows Children's Court per month.

3.5 Family Violence

The Royal Commission into Family Violence (RCFV) identified mental illness as one of the key contributing factors of family violence and emphasized its severe long-term effects on children and young people that sometimes result in behavioral and mental health problems.[75] The Court's own submission to the Royal Commission noted the prevalence of family violence by stating:

> *"… it is estimated that in approximately 94 per cent of child protection applications, protective concerns in relation to vulnerable children have their genesis in family violence."*[76]

A key finding and recommendation of the RCFV was that the Melbourne Children's Court establish dedicated family violence applicant and respondent worker positions to assist young people and their families in situations where adolescents are using violence in the home.[77] The Court obtained funding as part of the 2017/18 financial budget and a Family Violence Applicant and Respondent Support Service (FVARSS) commenced operation at the Melbourne Children's Court in July 2018. The role of the applicant support worker is to provide support to family members affected by young people using violence in the home. The respondent support worker provides support to adolescents using family violence in the home who are attending the Court as a respondent to a family violence intervention order application. Both the applicant and respondent support workers perform risk assessment and safety planning functions and

[75] Royal Commission into Family Violence, *Final Report, Summary and Recommendations*, March 2016 pp22 and 23
[76] Magistrates' Court of Victoria & Children's Court of Victoria, Submission to the Royal Commission into Family Violence, p 3
[77] Royal Commission into Family Violence, *Final Report, Summary and Recommendations*, March 2016, Recommendation 126 p. 79.

importantly link young people and families to available services in the community including mental health services.[78]

3.6 Docketing in the Family Division

In 2010 the Children's Court made submissions to the VLRC inquiry into aspects of Victoria's child protection system on the adoption of less adversarial trial processes and approaches in the Court, such as the "Less Adversarial Trial" (LAT) model in the Family Court as established by Division 12A of Part VII of the *Family Law Act 1975* (Cth).[79] In 2012, the Protecting Victoria's Vulnerable Children Inquiry chaired by the Honourable Philip Cummins recommended that the LAT Family Court model should be adapted for inclusion in the CYFA.[80] The *Children, Youth and Families Amendment Act 2013* inserted s215B into the CYFA to introduce LAT principles into the Children's Court. Section 215(1) of the CYFA should be read in conjunction with the Court's expanded case management powers in s215B.

Section 215B of the CYFA provides that the Court (Family Division) may:

- consider the needs of the child and the impact that the proceeding may have on the child;
- conduct proceedings in a manner that promotes cooperative relationships;
- query with any person connected with the proceeding whether that person considers that the child (or any other person connected with the proceeding) has been or is at risk of being subjected to abuse, neglect or family violence;
- actively direct, control and manage proceedings;
- narrow the issues in dispute;
- determine the order in which issues are decided;
- give directions or make orders about the timing of steps;
- in deciding whether a particular step should be taken, consider whether the likely benefits justify the costs of taking the step;
- make appropriate use of technology (e.g. videoconferencing);
- deal with as many aspects of the matter on a single occasion as possible;
- deal with the matter without requiring the parties to attend Court, where possible;
- do any other thing that the Court thinks fit.

In the Children's Court, two structures for the exercise of a Magistrate's case management powers under s215B of the CYFA are:

- case docketing, where one Magistrate manages a case until its conclusion;[81] and

[78] Children's Court of Victoria website *Intervention Orders*: https://www.childrenscourt.vic.gov.au/jurisdictions/intervention-orders/family-violence-support-services accessed 3 July 2019.
[79] See VLRC, Protection Applications in the Children's Court, 2010, 90-91; Children's Court, Response to the VLRC Review of Victoria's Child Protection Legislative Arrangements, 2010, 28-31, 76-77; *DOHS v Ms B & Ms G* [2008] VChC 1, 26-27.
[80] Cummins Inquiry report, Chapter 15: Realigning court processes to meet the needs of children and young people, 2012, p. 385.
[81] However in the event that a case goes to trial it will not necessarily be heard by the docketing Magistrate.

- the dual directions hearing process in the Court, which gives the parties the opportunity to identity issues in dispute and the Magistrate to give directions on the timing of steps in the proceeding.

Docketing (the concept of 'one child, one magistrate') was introduced as a pilot in the Court's Family Division at Broadmeadows in October 2015. From January 2017 docketing was expanded to all child protection proceedings in metropolitan Melbourne. Docketing is an example of an innovative approach to case management in a specialist jurisdiction that brings advantages including:

- the consistency of having a magistrate with knowledge of the case and the child's circumstances;
- improved inter-agency collaboration and involvement; and
- earlier resolution of child protection cases with fewer court events.[82]

4 International Responses

Solution-focused Courts

Informed by therapeutic jurisprudence, solution-focused courts operate in adult criminal, youth and family jurisdictions and can reduce crime and social harm, improve community safety and enhance the legitimacy of the justice system.[83] Solution-focused courts typically operate within existing court buildings and matters are heard by a Judge or Magistrate, however the focus is on rehabilitation and behaviour change.[84] They are specialist courts which work with people in the community to address a problem, such as drug addiction or family violence. Key components of solution-focused courts include specialised assessment, coordinated case management and judicial monitoring.[85] Evidence indicates that not only do solution-focused courts reduce reoffending and improve community safety, they are significantly more cost-effective than traditional methods of responding to criminal behaviour.

Youth Mental Health Courts

Youth Mental Health Courts (YMHCs), which operate widely in the United States and Canada, are a specific example of a solution-focused court that aims to divert young people with mental illness away from the traditional justice system and into treatment by adopting a more collaborative and less adversarial approach.[86] YMHCs utilise a multi-disciplinary team approach and lead to better outcomes for youth and may reduce rates of offending. Research supports that they are an effective alternative to detention and psychiatric facilities.[87]

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[82] Children's Court of Victoria, *Annual Report 2016/17*, p. 4.
[83] Centre for Justice Innovation, *Problem-solving courts: A delivery plan*, London, United Kingdom, p. 3.
[84] Ibid.
[85] Ibid, pp. 16-17
[86] Evidence Exchange Network for Mental Health and Addictions, *Rapid Review: What factors make Youth Mental Health Courts successful at serving youth with mental illness?*, p. 1.
[87] Ibid.

'Crossover' Approaches

One of the fundamental principles of these approaches is that children and young people who commit offences, and who also need care and protection, are supported through the same system and managed by a multi-disciplinary care team.

In New Zealand, child protection matters as well as criminal matters committed by children aged 10 – 13 are heard in the Family Court and criminal proceedings involving young people aged 14 – 16 are heard in the Youth Court.[88] Despite the existence of two systems, Family Group Conferences are available to both jurisdictions which offer a forum where family members and relevant professionals can meet and discuss the care and protection concerns and/or the criminal proceedings of a young person.[89]

5 Possible Solutions

5.1 Criminal Division

Whilst the Court supports problem solving approaches that address the causal factors of offending, it is important to recognise that a "one size fits all approach will never provide an effective solution for young people in terms of rehabilitation and avoidance of recidivism."[90]

Therapeutic programs that address mental health needs along with other criminogenic factors, are one response to this policy problem.[91] The Court supports case management approaches that provide an opportunity to intervene with youth in a manner consistent with their developmental and treatment needs.[92] This type of approach can be broadly applied across the Criminal Division of the Court.

5.1.1 Diversion

The *2018 Children's Court Youth Diversion Annual Report* reported more than half of all diversions matters ordered (57%) were for young people with a diagnosed mental illness (anxiety, depression, bipolar, schizophrenia, post-traumatic stress disorder).[93] In addition to this, approximately one in ten young people subject to diversion orders were diagnosed with one or more cognitive impairments (such as an acquired brain injury, autism, intellectual impairment or borderline intellectual impairment)[94] and 53 per cent of all diversion matters included plans with health and wellbeing interventions.[95]

[88] Planning meetings comprise an important element of the NZ model and have been adopted in Victoria in the YCO legislation.
[89] Bowles, J., Churchill Report, pp. 32-33.
[90] Submission from the What Can Be Done Steering Committee to the Youth Justice Review, March 2017, p. 1.
[91] Cuellar, A, McReynolds, L, Wasserman, G, A Cure for Crime: Can Mental Health Treatment Reduce Crime Among Youth (2006), p. 198.
[92] Ibid, p. 199.
[93] Department of Justice and Community Safety, Annual Report, 1 January 2018 to 31 December 2018, p 14.
[94] Ibid, p. 15.
[95] Ibid, p. 17.

Whilst Armytage and Ogloff found Victoria has a strong diversionary approach to offending (see section 3.1.1)[96] a recent evaluation of the CCYD found that effective diversion was dependent upon a number of core principles including:

- matching risk level to diversion option;
- that diversion operates according to evidence-based frameworks and protocols;
- that diversion addresses multiple needs;
- that diversion provides tailored interventions;
- that the diversion plan includes the family; and
- that the diversion program is staffed by highly qualified and well-trained staff.[97]

The evaluation found that the CCYD was often described as an "in out" model in reference to the prescribed 16-week timeframe for orders[98] and as a result diversion plans often only touched the surface of the complex needs of the young people subject to orders and the diversion period did not:

- provide opportunity to adequately address the core underlying needs of the young person;[99]or
- allow adequate time for case workers to get young people connected to services.[100]

Most importantly, the evaluation also found that one of the core challenges to effective operation of the CCYD "*related to the necessity of having sufficient service capacity in place and available to meet these identified needs in a timely fashion. It was apparent that these services were not available, both in metropolitan and regional areas.*"[101] This was particularly evident in the context of mental health where one legal practitioner stated:

> *"…we have kids that haven't been to school since Grade 6 because they've been kicked out and no one's ever done anything. I mean, you know, it's just appalling…. the child and mental health system could be a bit more responsive… they're going to struggle to even get an appointment in eight weeks…"*[102]

Whilst the CCYD provides excellent outcomes it is clear that there is a need for streamlined access to support services and specifically in the area of mental health given the prevalence of mental health issues presenting in young people's diversion matters.

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[96] Armytage and Ogloff, *Youth Justice Review and Strategy- Meeting needs and reducing offending* (2017), p. 154.
[97] Professor Thomas Stewart & Dr Marg Liddell and Dr Diana Johns, *Final Report, Evaluation of the Youth Diversion Pilot (YDPP: Stage 3)* (unpublished) 16 December 2016, p 5 (YDPP Evaluation Report).
[98] CYFA s 365D.
[99] YDPP Evaluation Report, 6.
[100] Ibid.
[101] Ibid.
[102] Ibid 94.

5.2 Family Division

5.2.1 Family Recovery Court (FDTC with expanded eligibility criteria)

The evaluations of the FDTC demonstrate that adopting a solution-focused approach in the Family Division of the Children's Court of Victoria provides an individualised, integrated and flexible court response that focuses on the needs of children and families to promote recovery and engender long-term sustainable change. Around 75 percent of the parents who have been through the FDTC have at least one diagnosed mental health condition and the complexity of this co-morbidity requires intensive support over a sustained period of time if recovery is to occur and stability and safety for children is to be achieved.

Whilst the majority of solution-focused therapeutic court models focus on a specific issue (drug addiction, mental health, family violence, homelessness) as a criteria for entry or referral, they all face issues of comorbidity and complexity of need, because of the high rates of comorbidity in their target populations. The common characteristics of solution-focused or problem-solving court approaches tend to result in the court being better placed to deal with comorbidity and complexity than mainstream or traditional adversarial court models. For these reasons the Children's Court of Victoria is currently examining ways to broaden the scope of the FDTC to include other vulnerable cohorts, who also present with more intensive support needs and who might benefit from a structured judicially monitored program response. This includes parents with mental health needs and parents with intellectual disability or cognitive impairment. The key elements of the FDTC model that make it well-adapted as a court response for people experiencing mental illness include:

- Access to Specialist Assessment and Planning;
- Specialised court proceedings;
- Evidence-led programming.

Access to Specialist Assessment and Planning

Solution focused courts such as the FDTC offer specialist assessment capability. In the case of the FDTC, each participant is allocated a clinical case manager with expertise in the Alcohol and Other Drug service system to assist them to develop a Family Recovery Plan (FRP). Where indicated the FDTC brokers specialist assessment including mental health assessment, neuropsychological assessment and other psychological and functional assessments. Whilst the FRP is primarily focused on identifying services to support the participant in her or his recovery from addiction, it is person-centred and addresses all of the relevant areas of need for the participant.

Specialised court proceedings

Solution-focussed courts generally offer participants settings that are more conducive to a therapeutic, supportive environment than the traditional courtroom experience. In the case of the FDTC all hearings are held around an oval-shaped bar table, with everyone, including the magistrate, at the table. For the review hearings there are generally no lawyers present and the hearing is conducted by way of conversation and in a manner that is directed towards promoting therapeutic outcomes. Trauma-informed practices ensure processes that are characterised by

empowerment, safety, respect and collaboration and are an important element of the FDTC approach. When participants feel safer and heard, they are more willing to trust the advice and support they receive and adhere to the court's directions.

Evidence-led programming

Once a parent has been inducted into the program, a Family Recovery Plan is developed. The plan articulates needs, goals and tasks that chart a participant's recovery and progress through the program. The purposes of Family Recovery Plans are to provide:

1. clarity and a sense of purpose for participants;

2. clarity regarding roles and responsibilities of the Clinical Case Manager and other case managers/members of the care team; and

3. the FDTC Magistrate with a point of reference for discussion in Progress Review Hearings and with respect to decision making around phase progression.

Throughout the program, participants progress through structured phases which involve attending a range of treatment and case management services as required. Services accessed by participants may include residential treatment, mental health counselling, drug and alcohol counselling, parenting programs, housing services and drug screen testing.

Coordinated case management

Each FDTC participant is allocated a clinical case manager. Problem-solving courts tend to have coordinators who manage the contributions of multiple agencies. They ensure information is available to the court on progress and compliance with testing requirements. Prior to every FDTC hearing day the team of professionals attached to the court meet with the magistrate to discuss progress under the FRP and prepare for the hearing. Thus when a participant comes to court, key activities are traversed, key messages reinforced and the participant has sense of the team all working together towards the participant's success.

Judicial monitoring

In solution-focused courts, judicial monitoring is used to monitor progress towards recovery and compliance with the program requirements. Participants are brought back to court regularly and in front of the same judicial officer. Unlike criminal solution-focused courts, sanctions, other than natural consequences, are not used in the FDTC to guide behaviour. Instead, rewards are used to motivate compliance and encourage progress towards recovery, the FDTC model involves a structured regime of recognition and incentives that are able to be applied swiftly to strongly reinforce positive behaviour. The nature of the recognition varies and is tailored to suit the particular individual but can include simple things such as congratulating progress publicly in court to more formal recognition, including graduation ceremonies. On a larger scale the overall incentive to participate in the FDTC is for parent participants to achieve reunification with their children.

Clarity of process and purpose

A critical aspect of the FDTC model is that time and effort is taken to explain the court process, and associated non-court processes, to participants from the outset. Through the initial assessment process, each individual participant's communication needs are identified and information is then provided in a way that ensures the best possible understanding is achieved. Time is also taken during the regular review hearings to listen and understand what is going on for participants and to problem-solve and plan in a constructive and supportive manner.

Respectful treatment

Solution-focused courts attempt to emphasise that all those engaged in the process treat each other with respect, upholding the worth, autonomy and dignity of each individual. As a result of the focus on outcomes within the FDTC, combined with the forward-looking supportive approach, participants describe the FDTC program as one based upon honesty and compassion and which provides a context of support rather than of blaming and judging.[103]

Voice

The therapeutic context of the FDTC emphasises the magistrate-participant interactions whereas hearings in the mainstream Children's Court of Victoria often lead to more interactions between the Court and legal representatives. Direct communication with the Magistrate is highly valued by participants as they are given 'a voice' in the hearings. The integral involvement of FDTC participants provides them with a sense of empowerment and motivation.

Using evidence to inform innovation

Monitoring data is used alongside other sources of evidence including the perspectives of participants and other stakeholders to inform a process of reflection and innovation. To date the FDTC has been the subject of two independent evaluations and operates within an environment where reflection and innovation are seen as critical to the continued success of the model.

In considering how best to expand the criteria for access to the FDTC approach to incorporate a broader range of complex needs for support, including mental health needs, it will be critical to ensure that a framework similar to the Risk/Needs/Responsivity concept is developed to support the decision by the Court of who is best suited to this type of intensive approach. In this way the Court can be more confident that only those parents who require and are likely to accept intensive support are directed towards a more intensive response.

5.2.2 Supporting Aboriginal Children and Families

The Children's Court recently received funding through the Aboriginal Justice Agreement 4 to expand the Koori Family Hearing Day to Shepparton. This funding will enable a trial of the model in a regional location. Funding was also provided for an independent evaluation of Marram-Ngala Ganbu at Broadmeadows. The Court has engaged Karabeena Consulting and Social Ventures Australia to conduct this evaluation. The project is being overseen by a

[103] De Bortoli L, Luebbers S, Riacchi M and Mastromanno B (2018). *The Family Drug Treatment Court - An Evaluation Report*. Report prepared by the Centre for Forensic Behavioural Science for Court Services Victoria.

Steering Committee convened by the Children's Court of Victoria and includes representation from Government agencies, the Children's Court of Victoria, court workers, and Aboriginal Controlled Community Organisations. The committee is chaired by the Regional Coordinating Magistrate at the Broadmeadows Children's Court and has strong Aboriginal representation.

The Children's Court Statement of Priorities 2019-21 identifies the Court's longer-term plans to expand the availability of a Specialist Children's Court state-wide which includes making the Koori Family Hearing Day available in every Children's Court location.

5.3 Family and Criminal Divisions

5.3.1 Youth Therapeutic Orders

Whilst evidence suggests voluntary community-based treatment of young people, where achievable, is best practice, the capacity of young people with serious substance abuse and mental health issues is often compromised to the extent they are not in a position to make rational decisions about matters that have profound health implications for them.[104] Compulsory orders to attend secure therapeutic residential facilities may ensure a vulnerable cohort of young people with significant substance and mental health issues are safe and secure and well positioned to deal with the myriad of issues they face.[105]

Magistrate Jennifer Bowles, through her research undertaken as part of a Churchill Fellowship in 2014, proposed a model involving compulsory placement of young people suffering significant substance abuse and mental illness in secure residential therapeutic facilities.[106] The proposed model of Youth Therapeutic Orders (YTO) aims to address an existing service delivery gap in the Victorian system. The current system is voluntary, apart from limited circumstances where a court may make orders for a young person's compulsory treatment pursuant to the legislative framework governing a person's mental capacity and fitness to be tried.[107] The YTO proposal seeks to address this gap by providing for a compulsory therapeutic treatment scheme for young people suffering significant substance abuse and mental health issues.

The YTO proposal involves court ordered treatment initially in secure residential facilities and then in on-site step-down residences. The duration of a YTO would depend upon the complexities of the young person and their progress but would be for a period of approximately six months to allow time for adequate levels of protection and intervention. Fundamental to the YTO proposal is the principle that the process and facilities would be therapeutic in nature with specific focus on:

- high quality and appropriately trained staff;
- secure homely environment;

[104] Bowles, J, *What Can Be Done*, (Churchill Fellowship) February 2015, pp 21 & 22.
[105] Submission from the What Can Be Done Steering Committee to the Youth Justice Review, March 2017, p. 1.
[106] Bowles, J, *What Can Be Done*, (Churchill Fellowship) February 2015, p. 42.
[107] See *Disability Act 2006*, *Mental Health Act 2014* and *Crimes (Mental Impairment and Unfitness to be Tried) Act 2014*.

- on-site education and training facilities;
- on-site residential step-down facilities;
- supported community-based transition;
- in-house support services (including mental health) complimented by service continuity for the duration of the order; and
- requisite regulatory oversight.[108]

It is important to recognise that compulsory placement of children in a secure facility restrains a young person's right to liberty as provided by the *Charter of Human Rights and Responsibilities Act 2006* (the Charter).[109] However, as outlined in Magistrate Bowles' Churchill Fellowship report, the purpose of these restrictions is to keep the child alive and well and to rehabilitate the child through the provision of intensive support, combined with court supervision and monitoring. Whilst the YTO is not a sentencing order, it is consistent with the emphasis on the rehabilitation of young people, and may subsequently inform any sentence imposed in accordance with the sentencing principles listed in s362 of the CYFA.[110] Further, the measures and procedures proposed as part of the YTO seek to promote the best interests of children in accordance with s17(2) of the Charter and the principles contained in Articles 6, 33 and 36 of the *United Nations Convention on the Rights of the Child*.

The existence of a mandated court order that seeks to address mental health and substance abuse issues of young people is of great importance, as early intervention with an increased focus on rehabilitation is a major priority for children and young people. YTOs would assist in reducing longer-term costs to the community associated with hospitalisation, health services and community safety.

It is important to note that the YTO proposal is envisaged to apply to children with significant substance abuse and mental health issues appearing in both Divisions of the Court. This approach reflects the fundamental principle that the YTO is a therapeutic response responding to health concerns.

Finally, the executive summary of the Armytage and Ogloff *Youth Justice Review and Strategy* report included the following:

> *Priority access to assessment and treatment should be considered for complex young offenders…. There is also merit in considering a Youth Therapeutic Treatment Order for court-mandated therapeutic treatment for young offenders. This has been proposed to address these deficiencies by Magistrate Bowles and the 'What can be done' Steering Committee*.[111]

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[108] Bowles, J, *What Can Be Done*, (Churchill Fellowship) February 2015, p 45.
[109] *Charter of Human Rights and Responsibilities Act 2006* s17(3).
[110] CYFA. See also Minister Jaala Pulford, Victorian Parliament, Legislative Council, Statement of Compatibility, Children and Justice Legislation Amendment (Youth Justice Reform) Bill 2017, 8 June 2017, p. 3339.
[111] Ogloff and Armytage, *Youth Justice Review and Strategy: Meeting needs and reducing offending*, Executive Summary (2017), p. 14.

In addition, the *Parliamentary Inquiry into Youth Justice Centres in Victoria* included the following recommendation: that the Victorian Government establish a trial program of Youth Therapeutic Orders based on the 'What can be done' model.[112]

5.3.2 'Crossover' Approach

A recent SAC Report,[113] along with a forthcoming Report by Monash University[114] highlight the growing recognition of the need for a joined-up approach across child protection and youth justice systems for children and young people. Furthermore, Armytage and Ogloff noted that there was a lack of service coordination to meet the welfare needs of young offenders in Victoria and identified a need for more focused investment and greater coordination for children and young people involved in youth justice and child protection.[115]

As mentioned above at 2.1.3, the SAC's report reveals that one in three sentenced and diverted children in Victoria had been the subject of a child protection report. The Youth Parole Board and Youth Residential Board Victoria also recognised the need for better coordination of effort between child protection and youth justice systems by stating:

> *"Earlier this year the Child Protection and Youth Justice protocol was revised and updated. The protocol provides a guide to collaborative working practices when a young person is involved with both systems."*[116]

Importantly, the Monash research on crossover kids reported that a mental health diagnosis was evident in 61.2 per cent of all children subject to this study.[117] In addition to this at least 50 per cent of children had a family member with a mental illness and in 16 per cent of cases both parents were identified as having a mental illness.[118]

It is also important to note that the Aboriginal Justice Caucus *Perspectives and Priorities for Self-determination in Youth Justice* identified a need meaningfully to connect Youth Justice and Child Protection services, including the use of family-based models of intervention, thus ensuring information is shared and both systems work with families collaboratively.[119]

The prevalence of young people intersecting with the Criminal and Family Divisions of the Court is undeniable and the reasons to establish a combined case management approach to address the needs of crossover kids are compelling. The Court considers that any reforms or programs responding to the needs of crossover kids and their families should include adequate

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[112] Legal and Social Issues Committee, Parliament of Victoria, Legislative Council, *Inquiry into youth justice centres in Victoria*, March 2018, p 102 (see: recommendation 19).
[113] Sentencing Advisory Council, *'Crossover Kids': Vulnerable Children in the Youth Justice System*, Victorian Government, 2019.
[114] Baidawi and Sheehan, *'Cross-over kids': Effective responses to children and young people in the youth justice and statutory Child Protection systems* (forthcoming).
[115] Ogloff and Armytage, *Youth Justice Review and Strategy: Meeting needs and reducing offending*. Executive Summary (2017), p. 13.
[116] *Youth Parole Board and Youth Residential Board Victoria Annual Report 2013/14*, p. 13.
[117] Baidawi and Sheehan, *'Cross-over kids': Effective responses* report (forthcoming), p. 71.
[118] Ibid, p. 34.
[119] Aboriginal Justice Caucus Perspectives and Priorities for Self-determination in Youth Justice, Summary of Priority Issues – Resulting from Workshops on 10/12/2018, 30/04/2019, 21/05/2019, Priority Issue 9, p. 2.

mental health services that are commensurate with the prevalence of mental health issues experienced by this vulnerable cohort of children and young people.