Royal Commission into Victoria's Mental Health System

# WITNESS STATEMENT OF DR CLAIRE GASKIN

I, Dr Claire Gaskin, forensic adolescent psychiatrist, of University of New South Wales, 38 Botany Street, Randwick, New South Wales 2052, say as follows:

## Background

### *Qualifications and background*

1 I am currently employed as Clinical Director and Consultant Psychiatrist in Child and Adolescent Psychiatry at South Eastern Sydney Local Health District and as a Conjoint Senior Lecturer at University of New South Wales in the School of Psychiatry.

2 I qualified in medicine from St George's Hospital Medical School, University of London, in 1991. I then trained in psychiatry and became a Member of the Royal College of Psychiatrists in 1998. I completed Advanced (Specialist Registrar) training at the Maudsley Hospital in both Child and Adolescent and Forensic Psychiatry.

3 I previously worked as Consultant in specialist adolescent forensic services. From 2003 to 2006, I worked in the United Kingdom as a Consultant Adolescent Forensic Psychiatrist at Ardenleigh, Adolescent medium secure unit (**MSU**) in the Birmingham and Solihull Mental Health Trust. I also worked at The Lowther Adolescent MSU in St Andrews Healthcare Northampton.

4 From 2006 to 2016 I worked in New South Wales (**NSW**) with what is now called Justice Health and the Forensic Mental Health Network (**Justice Health**). Justice Health look after the mental health of people when they are in custody, in the courts and in the community. I assisted with developing a range of mental health services to young people in the community and custody, alongside other agencies, forming the Justice Health Adolescent Court and Community Team (**JH-ACCT**).

5 I have collaborated on projects to enhance provision of mental health care to the offender population, including the production of a World Health Organisation Manual to aid the management of mental health disorders in the prison setting.

6 Attached to this statement and marked 'CG-1 is a copy of my CV.

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

*Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.*

## Mental illness and offending

### *The nature of offences committed by children and young people living with mental illness*

8 In general, young people in NSW with mental health issues commit the same sorts of offences as young people without mental health issues. The experience in NSW is consistent with international and domestic literature.

9 Most people who commit violent offences are not mentally ill. There is, however, a small but statistically significant association between severe mental illness and violent offending.[1] Evidence in the youth population is anecdotally similar but as so few young people commit very serious violent offences, the statistical evidence is less compelling.

**Apprehended violence orders**

10 In the 10 years I was at Justice Health, I was not aware of any significant increase in violent offending noted across NSW amongst young people with or without mental illness. However, following the introduction of apprehended violence orders (**AVOs**), which were introduced to address the issue of domestic violence and protect victims, we saw an increase in young people coming into contact with the criminal justice system as a result of breaching AVOs and therefore being charged with violence offences. These young people may or may not have had a mental health issue, but very often had difficult family circumstances, or were placed in care settings. An AVO would be breached as a result of family or care-based incidents and the young person would be arrested and placed in custody, often being charged with associated property damage offences.

11 Whilst I was at Justice Health, the JH-ACCT carried out an audit of the numbers of young people who had come to court on breaches of AVOs since the legislation was introduced, in order to secure funding for a diversion program. I recall that we found that the numbers had significantly increased in the two years prior.

12 In response to this, and as a result of receiving Got It! Funding in NSW,[2] we attempted to set up a specific diversion program for family-based intervention in adolescents with conduct issues. This program was targeted at the time the AVO was issued - before it became a criminal matter due to a breach. As this was a voluntary program, we had limited success in engaging young people and families.

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[1] Hodgins, S (2008) "Criminality among persons with severe mental illness" in Soothill, K, Dolan M & Rogers P (Eds) Handbook of Forensic Mental Health. Willan Publishing.

[2] See NSW Ministry of Health, 'Getting On Track In Time – *Got It!*' <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/got-it-guidelines.pdf> [accessed 24 June 2020].

13 The program has now been adjusted so that youth aged 11-14 are identified at high school, when they are presenting with aggression and violence. The program seeks to improve attachments and family functioning and address a number of issues related to anxiety, depression, substance use and trauma. The young person has an assessment to identify any mental health issues and contributing significant issues within the family setting and these are then targeted through the Adolescent Got it! Team, part of the JH-ACCT. This teen program, run in collaboration with the Department of Education, has been operational for about a year and is trying to intervene early and prevent young people coming into contact with the criminal justice system.

### *Experiences of young offenders living with mental illness as victims of crime*

14 There is a recently published paper which examines a young person's contact with the police as a victim and subsequent contact as a person of interest or witness. One of the co-authors is Kimberlie Dean, the Professor of Psychiatry at Justice Health. The paper considers the data from a longitudinal, population-based sample of 91,631 young people in NSW. The study found that contact with the police as a victim was associated with an eight-and-a-half times greater likelihood of contact with the police as a person of interest and an almost seven times likelihood of contract with police as a witness.[3] The results of this study align with my own experience.

15 Justice Health and Juvenile Justice have conducted health surveys for young people in custody in NSW three times since 2003, called the Young People in Custody Health Survey (**YPICHS**). Justice Health and Juvenile Justice are separate entities but work closely and collaboratively on this survey. Juvenile Justice are responsible for the care of young people in custody and in the community who have committed offences and for pre-sentence reports. Justice Health is a health organisation that is responsible for their healthcare, not their justice needs.

16 In the most recent survey (in 2015), 60% of the total number of young people in custody at a point in time were interviewed.[4] A number of young people were excluded from the survey because they were too unwell (mentally ill) and could not adequately engage or consent. In that survey, 68% of the young people who agreed to be interviewed indicated that they had experienced some sort of childhood abuse, neglect or sexual abuse.[5] Further, 20-30% of young people across the surveys of 2009 and 2015 said they had been assaulted within the last 12 months, a significant number by a peer.[6] The evidence

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[3] Whitten et al, 'Children's contact with police as a victim, person of interest and witness in New South Wales, Australia' (2020) *Australian & New Zealand Journal of Criminology* 1, p 9. https://journals.sagepub.com/doi/pdf/10.1177/0004865819890894.

[4] Justice Health & Forensic Mental health Network and Juvenile Justice NSW, *2015 Young People in Custody Health Survey: Full Report* (November 2017) xx, 74.

[5] Ibid, 74.

[6] Ibid, 41. See also Justice Health & Forensic Mental health Network and Juvenile Justice NSW, *2009 Young People in Custody Health Survey: Full Report* (March 2011).

from these surveys appears to support the association between being an offender and a victim.

17 Anecdotally, and from the examination of crime statistics, it can be seen that young people who offend often offend in their own neighbourhoods, with and against other young people. Reliable reports of the patterns of offending, and how they develop over time, can often be difficult to ascertain. However, much of the information available and the subjective reports of young offenders indicates that community prevalence of offending is a key factor to address on release from custody, as is the experience of trauma.[7]

## Changes over time

### *Disproportionate representation of young people and adults with mental illness in Victoria's criminal justice system*

18 It is well documented in domestic and international literature that adults living with mental illness are disproportionately represented in the criminal justice system[8]. In my role as an adolescent forensic psychiatrist, it was obvious to me that young people with mental health issues are overrepresented in custody.

19 For instance, the Australian Child and Adolescent Survey of Mental Health and Wellbeing Survey, for children aged 4–17, was conducted for the second time in 2013–14 (also referred to as the 'Young Minds Matter' survey).[9] This indicated that around 1 in 7 (13.9%) of children and adolescents aged 4–17 years met criteria for a mental health disorder in the previous 12 months.[10] Attention Deficit Hyperactivity Disorder (ADHD) was the most common mental disorder (7.4% of all children and adolescents), followed by Anxiety disorders (6.9%), major depressive disorder (2.8%) and conduct disorder (2.1%).[11]

20 The YPICHS in 2015 showed that 83% of young people in custody who participated in the survey met the criteria for a mental health disorder.[12] Although a significant number of those met criteria for a conduct disorder, substance-use disorder or another externalising behaviour disorder, the rate of serious mental illness was also high. For

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[7] Justice Health & Forensic Mental health Network and Juvenile Justice NSW, *2015 Young People in Custody Health Survey: Full Report* (November 2017) Chapter 7.
[8] Butler, T., Andrews, G., Allnutt, S., Sakashita, C., Smith, N. E., & Basson, J. (2006). Mental disorders in Australian prisoners: a comparison with a community sample. Australian and New Zealand Journal of Psychiatry, 40(3), 272-276.
[9] See Telethon Kids Institute (2015) *Young Minds Matter: the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Survey User's Guide*. Centre for Child Health Research, University of Western Australia: Perth, Australia, ISBN 978-1-74052-336-3.
[10] Ibid.
[11] Ibid.
[12] Justice Health & Forensic Mental health Network and Juvenile Justice NSW, *2015 Young People in Custody Health Survey: Full Report* (November 2017) 65.

instance, the rate of psychosis was five times what you would expect to see in the general population. There was also a significantly increased prevalence of mood and anxiety disorders compared to the general population, with most disorders appearing at least three to five times more prevalent than what you would see in the general population.

21 International studies have also demonstrated markedly higher rates of mental illness and disorder in young offender populations in custody.[13]

**Women in custody**

22 Women in custody across all age groups present with particular challenges. While there are not many women in secure mental health care, they often present with complex and specific mental health needs. Their average length of stay is longer than males.

23 Women in secure mental health care are likely to have more than one diagnosis, a history of violence against them and sexual abuse and trauma, experience loss and separation (related to children) and have difficulty forming and maintaining relationships.[14] Similarly, young women who are violent to others and come to the attention of mental health services whilst in custody have been shown to have similar profiles, being at increased risk of mental illness and to have experienced abuse.[15] In my experience, young women who are repeatedly placed in custody often have complex presentations, including significant PTSD, borderline personality disorder structure and self-harming behaviours.

## *Reducing recidivism for young people living with mental illness in the criminal justice system*

24 One follow-up study completed in NSW and published in 2015 found that recidivism (as in returning to custody having reoffended) in young people with severe mental illness, was associated with poor follow-up of their illness in the community.[16] Young people who had follow-up with someone connecting them to services in the community and active case management were far less likely to return to custody and if they did, it was often at a much later point than those who received minimal follow-up. Further, if a young person

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[13] Linda A Teplin 1, Leah J Welty, Karen M Abram, Mina K Dulcan, Jason J Washburn "A Prevalence and Persistence of Psychiatric Disorders in Youth After Detention: A Prospective Longitudinal Study". Arch Gen Psychiatry 2012 Oct; 69(10):1031-43.

[14] Short, J., Earthrowl, M., Miller, B., Aitchison, R., Renfree, A., Davies, M.,Joines, R. (2009) Report of the National Working Party for Standards of Care for Women in Secure Mental Health Services, New Zealand. NZ Forensic Psychiatry Advisory Group

[15] Anne Jasperhttps://www.sciencedirect.com/science/article/abs/pii/S0140197198901774 - !, Carly Smith, Susan Bailey, 'One hundred girls in care referred to an adolescent forensic mental health service' (1998) 21(5) *Journal of Adolescence* 555-568.

[16] John Kasinathan, 'Predictors of rapid reincarceration in mentally ill young offenders' (2015) 23(5) *Australian Psychiatry* 550 https://journals.sagepub.com/doi/pdf/10.1177/1039856215597532. Dr John Kasinathan, who is currently the clinical director of Justice Health, conducted an audit of 51 patients that he had treated whilst working at Frank Baxter which is a fairly busy juvenile justice centre on the central coast and they have longer stay patients there or custodial detainees.

with a severe mental illness had been treated for a significant period of time in custody, with medication and psychotherapy, they were more likely to remain in the community for longer, compared to those that had only been treated briefly.[17]

25 Another factor that increased recidivism was exposure to significant psychosocial issues when returning home – for example, if they had parents with mental illness, with substance use issues, or who are abusive. Additionally, homelessness and lack of support were key factors in determining the likelihood of recidivism.

26 Magistrates in NSW have been concerned about this for a long time, seeing the same young people coming back through the Courts, due to unstable accommodation. To address the issue, a joint program was set up between Housing, Juvenile Justice, Justice Health and the Children's Court, with Magistrates requesting that these agencies work together to try to improve the stability of accommodation and support for young people not able to return home. A number of Community Managed Organisations have now stepped into this space and are offering longer-term stable accommodation to young people with offending histories and ongoing mental health needs (for example, Kurinda Adolescent Service).

## Best practice in youth forensic mental health treatment

### *Provision of mental health services provided to young people in custody*

27 The provision of mental health services for young people in custody is managed by NSW, through Justice Health. This ensures access to equitable health services for young people in contact with the criminal justice system and ensures that these services meet NSW policy and governance requirements.

28 When I worked at Justice Health, the system was organised so that when a young person came into custody, they were placed on a clinic list and asked to participate in a health assessment with a general nurse employed by Justice Health but working in the Juvenile Justice centre. Advice was sought through the after-hours nurse manager for Justice Health by Juvenile Justice staff for urgent health issues. Urgent after-hours health assessments were undertaken by transporting young people to a local ED as necessary.

29 Routine health assessments took place up to 8pm at night in the larger centres as staffing allowed but in the smaller regional centres, the clinic staff would only be present for daytime hours. The young person completed a health questionnaire in regard to their previous history and discussed any current health issues, including mental health. If they had any current symptomology and required a General Practitioner (**GP**) to see them, they would be booked in to see a visiting medical officer (**VMO**) GP. The VMO GPs were

[17] John Kasinathan, 'Predictors of rapid reincarceration in mentally ill young offenders' (2015) 23(5) *Australian Psychiatry* 550, p 553 https://journals.sagepub.com/doi/pdf/10.1177/1039856215597532.

employed by Justice Health and contracted for between four to eight hours a week, depending on the size and needs of the centre.

30 The questionnaire had a number of mental health screening questions within it, taken from the Children's Schizophrenia Affective Disorder Schedule (**K-SADS**) and the YPICHS. The questionnaire also added some additional questions addressing contact with health services and mental health services in the past, any hospital admissions, family history and trauma exposure. Questions about trauma were asked with best practice in trauma-informed care (as per NSW Health policy) in mind, with appropriate support provided to young people.

31 If anything was flagged on the K-SADS, or a young person had a past history of mental health issues, they were referred to the specialist clinical nurse consultant (**CNC**) who had training in drug and alcohol and mental health care. They would review the young person for an in-depth drug and alcohol and mental health assessment and then discuss the review with the psychiatrist for that centre.

32 Each centre also had VMO forensic psychiatrists employed by Justice Health. Each of the clinics had a psychiatry clinic weekly to monthly (depending on size) and consultation to the CNCs was available every weekday and through the after-hours line at weekends.

33 If the nursing staff flagged a mental health or a physical health issue, but the young person was discharged before being seen by a CNC or psychiatrist, they were referred to the Community Integration Team (**CIT**) for follow-up (discussed from paragraph 37).

34 For the most seriously unwell young people in custody, the Forensic Hospital (run by Justice Health) has a six bed Adolescent Unit, which can take girls and boys up to the age of 18. The majority of young people there are transferred from the Juvenile Justice centres for treatment of serious mental illness. A small number each year are young people who are found not guilty by reason of mental illness or are unfit to plead as they have an intellectual disability and are appropriate for hospital treatment. Young people transferred from Juvenile Justice for treatment can be transferred back or released from the hospital if this is appropriate to their ongoing care and supervision. That is a really good partnership developed over time between Justice Health and Juvenile Justice.

35 This system was really dependent on a strong partnership between Justice Health and Juvenile Justice staff and management. During my time at Justice Health, we found that the better the relationships were with Juvenile Justice psychologists, the better we were able to jointly manage young people. Juvenile Justice staff provide all the specialist programs, like the sex offending programs and specific violence programs. Treatment of these young people requires good communication between services.

36 One barrier to the provision of mental health services to young people in custody in NSW was the fact that the services were delivered by a Network that provides services to both adults and adolescents. There are significant differences in the adult offender cohort and this is particularly evident when reviewing the number of detainees and the rapidity of turnover. The adult custody cohort have more people on opioid replacement therapy, for example. We found it challenging working within a health system that is not specifically adolescent based and where adolescents make up such a small number of the total number of people in custody (approximately 450 of 12,000).[18]

**Transition support**

37 The Justice Health Community Integration Team (**JH-CIT**) was funded by the NSW Government following the presentation of evidence that intregrated, specialist health follow-up both reduced recidivism and improved health outcomes. There were a number of projects: a pilot project that ran originally in regional NSW (Dubbo) targeting young people released from the Orana Juvenile Justice Centre; and the audit of follow-up of young people leaving Frank Baxter Juvenile Justice Centre cited above at paragraph 11. There was also recognition in NSW that young people were less likely to return to a custodial setting if they were connected to supports upon release from custody.

38 JH-CIT clinicians provide a pre- and post-release program offering a continuum of care to recently released adolescents, with an emerging or serious mental illness and/or problematic drug and alcohol use or dependence.

39 Justice Health now has 11 CIT positions across NSW who work with young people for three to six months to engage them with external community services of various types including health resources, education and housing. This helps to support young people as they transition out of the custodial setting.

40 The success of the program has been evaluated a couple of times. It was evaluated externally within the NSW Government setting because it was a government funded program. The review showed that it actually improved health outcomes, reduced the recidivism rates and improved wellbeing for young people leaving custody.[19]

41 I understand there is a similar program in New Zealand which is partly where the idea came from. In the UK they have youth offending teams (**YOTs**). These consist of staff from the local health authority (care of children), the police, Juvenile Justice, health and education, who all collaborate and work together to address the health, housing,

[18] See NSW Bureau of Crime Statistics and Research, 'Custody Statistics' <https://www.bocsar.nsw.gov.au/Pages/bocsar_custody_stats/bocsar_custody_stats.aspx> accessed 24 June 2020.

[19] See NSW Government Agency for Clinical Innovation, 'Community Integration Team: At Risk Youth Mental Health' <https://www.aci.health.nsw.gov.au/ie/projects/community-integration-team> (Accessed 24 June 2020).

education and other needs of young people to prevent them going into custody. They are also involved in the supervision of young people on Intensive Supervision Programs for young people as an alternative to custody.

42 The UK YOTs program was evaluated in 2017 and the evaluation showed good outcomes, even for severe offenders.[20] The offenders benefited from intensive surveillance in the community with supportive agencies working with them to engage them in meaningful, positive activity and provide health care, and mental health care to them.

43 There is not much literature regarding services to young people appearing at court and their mental health needs outside of programs in the US, which is a very different jurisdiction. One study done in Manchester about 20 years ago showed significant needs in that population.[21] That evidence helped to fund the earlier version of the YOTs in the UK.

**Court diversion**

44 Many young offenders are only committing summary offences, such as breaching AVOs, and other low-level offences (as discussed from paragraph 10), but have a number of associated mental health and psychosocial issues contributing to reoffending. Those young offenders are the ones who may benefit most from connection with appropriate services in the community, including mental health treatment and substance use services. They are a group of offenders likely to be quickly returned to the community from custody as they pose limited risk to the public and most are not eligible for specific juvenile justice supervision. They often have issues amenable to intervention if services work together to address them, as demonstrated by the YOT program in the UK, which has demonstrated a significant reduction in the number of young people placed in custody.

45 There are a number of Juvenile Justice diversion programs, including substance use programs, but no programs targeting mental health. If someone is recognised as having a mental health issue in custody and they have an ongoing treatment needs, that young person will be referred to the appropriate Child and Adolescent Mental Health Service (**CAMHS**) in the community when they leave custody. Since 2013, they may also receive support from the JH-CIT. However, in NSW it was recognised (before the advent of the CIT) that one point of potential intervention was at the Children's Court. In 2005, with the

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[20] Inspectorate of Probation, United Kingdom Government, 'The Work of Youth Offending Teams to Protect the *Public* (Report, 2017)
Public' <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2017/10/The-Work-of-Youth-Offending-Teams-to-Protect-the-Public_reportfinal.pdf.
> (accessed 1 June 2020).

[21] M.Dolan, J. Holloway, S..Bailey, C.Smith, 'Health status of juvenile offenders. A survey of young offenders appearing before the juvenile courts' (1999) 22(1) *Journal of Adolescence* 137-144.

support of the NSW Children's Magistrate's, Justice Health was successful in being awarded funding to start the JH-ACCT in order to set up a Court Diversion service.

46 One of the issues recognised in the setting up of the JH-ACCT was that many young people are spending only short, but often repeated,periods of time in custody. The average length of stay in custody in NSW is currently around seven days, but the median is two days or even as short as a day. This makes planning and follow up difficult if mental health issues are present.[22] Court diversion would enable more young people to benefit from treatment in the community and reduce the workload in custody.

47 The Court Diversion program in NSW works on a referral basis and is dependent on the legal practitioner, Juvenile Justice worker, Magistrate, or sometimes the young person themselves, asking for an assessment. Despite the success of the ACCT in identifying young people at court and attempting diversion, Justice Health statistics and data from activity in custody indicated that there was still a significant proportion of young people coming into custody with mental health issues who had not been referred to teams. In response to this, in 2012 Justice Health ran a small study (with unpublished data) at Campbelltown and Surrey Hills Children's Courts. A psychiatrist and CNC sat at those courts for one month in an attempt to see all the young people who attended and carry out a comprehensive assessment similar to that in the YPICHS if they consented. The aim was to discover what groups of young people were not being referred for assessment and whether there was any way of screening them without breaching consent and confidentiality.

48 During this study, the clinicians identified significant numbers of young people who had current mental health needs that were not referred for assessment to the court teams. From my recollection, about 5% to 10% were felt to need immediate treatment for their mental health, some needed admission and there were a number that had significant histories of self-harm. There was also a significant amount of unmet physical health need in this population such as asthma, epilepsy, hearing loss and untreated infections. This study was delivered to the Executive as part of a plan to expand services and work more collaboratively with the Magistrates in identifying young people for diversion.

49 I am currently involved in a large linkage study (a collaboration between UNSW and Justice Health) reviewing the outcomes of the young people and adults seen by the court diversion teams in NSW. For the study, we collaborated with the NSW Bureau of Crime Statistics and Research (**BOCSAR**) and Juvenile Justice (now part of the NSW Department of Communities and Justice). BOCSAR retain all the information regarding

[22] NSW Bureau of Crime Statistics and Research, 'NSW Custody Statistics: Quarterly Update March 2020' <https://www.bocsar.nsw.gov.au/Publications/custody/NSW_Custody_Statistics_Mar2020.pdf> p 13 (accessed 24 June 2020).

court appearances and outcomes, including sentencing for all age groups appearing before the courts. The initial study of the adult population has identified factors associated with initial successful diversion for offenders with mental illness at local courts in NSW as well as outcomes in health, mental health and offending.[23]

50 In the study, we looked at all the young people referred to our court diversion program from 2007-2015 and considered whether they were eligible for diversion under the *Mental Health (Forensic Provisions) Act 1990* (NSW) ss 32 or 33 and how many received this outcome.

51 The study indicates that about 85% of young people seen at the Children's Court (referred) who had committed summary offences were eligible for diversion, having been identified as having a mental health disorder that might be treatable in the community. However, far fewer were actually diverted due to a number of issues including differing opinions as to best disposal at Court, a lack of appropriate services in the community to provide treatment or concerns about the young person's offending history.

52 The first paper in the study of the young people referred for diversion is in the final stages of review before publication. Currently, based on preliminary findings, we have identified that under half of those identified as being eligible for diversion received this outcome.[24]

53 In the preliminary analysis of our unpublished data, we have also found two statistically significant findings in terms of diversion, indicating that a young person was less likely to be diverted if they were Aboriginal and less likely to be diverted if female. Both of these findings need further review and to be confirmed; they will be a focus of the study going forward.

**Trauma-informed practice**

54 Over time, there have been steps taken towards ensuring trauma-informed practice in all Justice Health settings, including Juvenile Justice centres where Justice Health staff work. There are some limitations to the application of trauma-informed practice in Juvenile Justice settings, the courts or police cells, but Justice Health follow best practice as advised by NSW policy in this area.

55 Justice Health provided all staff with education regarding the origins of offending and the associations including attachment and other related theories when I was there. Children

[23] Yin-Lan Soon, Natasha Rae, Daria Korobanova, Calum Smith, Claire Gaskin, Carolynn Dixon, David Greenberg & Kimberlie Dean, 'Mentally ill offenders eligible for diversion at local court in New South Wales (NSW), Australia: factors associated with initially successful diversion' (2018) 29(5) *The Journal of Forensic Psychiatry & Psychology* 705-716, DOI: 10.1080/14789949.2018.1508487. See also Justice Health & Forensic Mental health Network and Juvenile Justice NSW, 2009 Young People in Custody Health Survey: Full Report (March 2011).

[24] Our preliminary findings are awaiting review.

in the juvenile justice system have many significant trauma markers with high levels of children in out of home care[25] and or who have experienced a parent being in custody.[26] At the time that I was leaving Justice Health, a lot of work was underway to upskill the care staff (who are called Youth Workers in Juvenile Justice) in trauma-informed practice. Despite attempts to manage young people without the use of restrictive practices (seclusion or restraint) sometimes young people with very serious behavioural issues have to be isolated to keep themselves and others safe. Juvenile Justice and Justice Health work collaboratively to ensure these issues are reviewed frequently and that young people with significant mental health issues are managed in the least restrictive way and receive regular review and intervention.

**Therapeutic support**

56 Both Justice Health and Juvenile Justice are cognisant of the need to provide therapeutic support to young people when they come into custody. Juvenile Justice try to house the younger detainees together and keep the female offenders separate from male offenders. They have also run a number of staffing education programs to upskill youth workers in caring for young people and run individual and group therapeutic programs. Education is also available in every centre, run by the NSW Department of Education.

57 I think, however, that it would be beneficial if there was greater opportunity and funding to provide specialist therapeutic inputs for young people when they were in custody. When I was at Justice Health, we did not have therapists working in Justice Health, and Juvenile Justice staff focused on reducing reoffending.

## Suicide and self-harm

### *Reducing suicide and self-harm in the youth forensic mental health system*

58 Self-harm is a problem amongst young offenders, as it as it is in the community, with significant increases in the past few years amongst young people noted in studies across Australia.[27] There are definitely things that could be done better in custody in managing and addressing self-harm. Teaching key skills to young people who self-harm, such as those taught in Dialectical Behaviour Therapy[28] would be useful. There are also some really good programs from the UK such as the "first night in custody" program which helps a young person to understand things like the process of detention, what they will have

[25] Justice Health & Forensic Mental health Network and Juvenile Justice NSW, *2015 Young People in Custody Health Survey: Full Report* (November 2017) xx.
[26] Ibid 18.
[27] See, eg Orygen Youth Services, 'Research Bulletin: Self-harm and young people' <https://www.orygen.org.au/Research/Research-Areas/Suicide-Prevention/Research-Bulletin-Self-Harm-and-Young-People> (accessed 30 June 2020).
[28] Marsha M. Linehan, Jill H. Rathus and Alec L. Miller, *Dialectical Behavior Therapy with Suicidal Adolescents* (Guilford Press, 2007).

access to and who to call if distressed.[29] The young person is separated initially in a smaller, less busy area of the detention centre and staff provide higher levels of observation, as the first 24 hours have been shown to be a period of risk. Younger offenders in the UK are often placed in Local Authority Secure Children's Homes (LASCHs) where young people up to 14 years of age are placed in smaller, social work run care settings.

59 I am not aware of any suicides of young people in juvenile justice centres in NSW over the period I have worked here (since 2006). I think this may be because Juvenile Justice are cognisant of the need to address behaviour as a constellation of issues and see self-harm as a symptom. Having access to beds at the Forensic Hospital since 2008 has also helped by enabling transfer of unwell and high-risk adolescents from Juvenile Justice custody to a safe and secure mental health facility, for a prolonged period of assessment, and to consider safety planning and treatment.

60 Juvenile Justice provide observation when requested of young people directly and via camera and have safe areas. Justice Health have the ability to recommend transfer to local hospitals under Section 55 of the *Mental Health (Forensic Provisions) Act* if needed. They can also request a hospital assessment under Section 33 if a young person was felt to present with risk related to mental health issues at Court, as can a Magistrate directly. Good working relationships with the local (LHD) staff are key in this.

61 Juvenile Justice staff in NSW also undertake mental health first aid training. That has been really successful; it has helped the youth workers have a greater understanding of what to do rather than being concerned that their response to mental illness and distress will make things worse.

## Comorbid alcohol or other drugs (AOD) and mental health

### *Managing the treatment and support needs of young offenders with comorbid AOD issues*

62 Most young offenders in custody smoke cigarettes and cannabis and use alcohol. The YPICHS surveys indicate that the majority of the young people admitted using cannabis and smoking cigarettes.[30] Some of them had been smoking since they were eight. Smoking is often forgotten as a drug of abuse but it is significantly associated with poor outcomes in mental illness, especially psychosis. Justice Health has a well-managed tobacco cessation program where young people are encouraged to see a specialist

[29] See National Offender Management Service, 'Early Days in Custody: Reception In, First Night in Custody, And Induction to Custody' <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2015/psi-07-2015-pi-06-2015-early-days-custody.pdf> (accessed 24 June 2020).
[30] Justice Health & Forensic Mental health Network and Juvenile Justice NSW, *2015 Young People in Custody Health Survey: Full Report* (November 2017) 56, 62.

tobacco cessation worker and work with them around how they will give up tobacco in the community.

63 There also appears to be a connection between methamphetamine use and youth offending from the anecdotal evidence, although I am not aware of any specific research and this is not my area of expertise. When we did our last custody survey in 2015, ICE use was present but not a huge problem. Anecdotally, from my work in the community currently with CAMHS teams, young people with a history of contact with the juvenile justice setting appear to be using ICE more frequently than those without such a history (but the numbers are small).

64 Justice Health has dual trained mental health/AOD CNCs. This was introduced after recognition that most young people needed input from dual trained and aware clinicians. Funding was provided for specialist CNCs for all the centres with this dual accreditation. Now, the CNCs have the opportunity to undertake supervision and training program with the Justice Health Drug and Alcohol Service.

65 All our GPs have a detailed knowledge of AOD issues and are trained and supervised to prescribe opiate replacement if needed and manage detox from alcohol and other drugs as required.

66 NSW Health has identified a gap in the community in terms of adolescent substance use programs, which are limited.

## Responding to young offenders with very complex needs

### *How NSW services meet the needs of young offenders with serious mental illnesses and complex needs*

67 I have discussed the diversion of young offenders with serious mental illnesses and complex needs from court, if they are able to be diverted (paragraph 44). The Magistrates will often allow for diversion into community treatment even if it is not through the process of the *Mental Health (Forensic Provisions) Act* – it might just be on bail initially, for example.

68 The Justice Health team works closely with the CAMHS teams and the CIT (if engaged) to support the engagement of a young person with the appropriate mental health team in the community. They have good relationships with the local CAMHS teams, particularly in regional areas. Justice Health court clinicians spend time visiting teams and getting to know staff which works well in building relationships. They work hard to get treatment packages in place for those young people with mental illness.

69 One area of frustration can be the use of Section 33 of the *Mental Health (Forensic Provisions) Act*. Under the Act, a Magistrate can order a person to hospital for assessment. The Court clinician (if present) will recommend this to the Magistrate if they feel treatment is needed in that setting. However, when the person gets to the hospital, the hospital staff often disregard the assessment, which can be frustrating to experienced clinicians. This is often because staff at the hospital feel custody is a treatment setting, which of course it is not. Treatment cannot be enforced in custody and ensuring safety can be extremely difficult.

70 Forensic Community Treatment Orders (**Forensic CTO**) give Justice Health the option to treat people in custody and the opportunity to transfer people back from the hospital for instance to custody and maintain their treatment. These are useful as they allow treatment with medication whilst in custody, which can prevent deterioration.

## Compulsory treatment

### *Use of compulsory treatment for mentally ill youth offenders*

71 Compulsory treatment under the *Mental Health Act* is only applicable through a Forensic CTO. Emergency treatment can be given and transfer to hospital in all other situations. Within the custodial setting, Justice Health would never enforce mental health treatment unless in the circumstances of the Forensic CTO.

72 Having the forensic adolescent unit has been pivotal, because managing a young person in custody, when all concerned know transfer to that setting can be facilitated if required, is less difficult for staff.

## Restrictive practices

### *Ways to address aggression in custody and reducing the use of seclusion and restraint*

73 If a young person in custody experiences aggression as an apparent consequence of a mental illness, then it would be appropriate to transfer them out of the custodial setting and into hospital where they can receive treatment. It can, however, be difficult to get a timely transfer and in these cases, Justice Health work with Juvenile Justice to reduce time in isolation, try to enhance behavioural management approaches and try to adjust the environment to make it conducive to reduced aggression.

74 Internationally, the best outcomes in custody have come from humanising and individualised approaches to care. Young people are often traumatised, untrusting and scared and treating them positively as an individual, instead of sticking with enforced general rules and regulations, often best addresses the individual needs. Each

individual's circumstances and what their triggers might be needs to be ascertained and a good management plan put in place that involves the young person.

75 Juvenile Justice need to prioritise training for youth workers and key staff, particularly in de-escalation and trauma-informed care. In this way, seclusion and restraint in hospital will be used less. There is a need for good procedural management, good supervision of staff and therapeutic support to the staff to ensure an effective, caring and competent workforce.

76 There has been a lot of work on hostility perception in young offenders in the US and other jurisdictions. The work has shown that young people with histories of violent offending tend to see hostility in neutral situations (hostile intent).[31] Specific work can help to neutralise this reactionary response and reduce aggressive outbursts. I am not aware of the extent to which this has been studied in Australia, but in my view it is an area that could be utilised more in Juvenile Justice settings and in young offender programs.

77 Youth workers need to be provided adequate training in attachment, trauma response and hostility bias. When I worked in the UK, for example, I worked in the youth offender wing of Holloway, which is a women's prison, following a spate of suicides and self-harm incidents. Staff were not confided in by the young women because they wore uniforms and were seen as 'screws' and not therapeutic workers. Most of my work did not involve seeing young people, it involved working with staff. I engaged them in education and an understanding of the reasons for these behaviours in this population and how best to offer trauma-informed support and engage the young women effectively.

78 Young people who have a mental illness also need to be involved in their own treatment decisions. Very often if you give young people the choice, they may choose to go off their medications but a few weeks later they might come back and say "*actually, I think it's better when I'm on my medication*". This does not always happen, but it's about building a therapeutic relationship and giving a voice to those who have felt disempowered for generations often.

## Workforce

### *The characteristics of contemporary best professional practice in mental health treatment, care and support of young people in the justice system*

79 It is best practice to keep people as close to home as possible and keep them connected to their community, even in custody. One issue that young people with mental health problems report is feeling like they do not have a purpose, goal or role in the community.

[31] See, eg, Schönenberg, M., Jusyte, A, Investigation of the hostile attribution bias toward ambiguous facial cues in antisocial violent offenders (2014) 264 *European Archives of Psychiatry and Clinical Neuroscience* 61–69.

This is compounded by adolescence, where young people already struggle with a sense of belonging. Being in a dehumanising situation in custody does not help to engender a sense of purpose or goal other than wanting to get out of custody.

80 If the workforce is connected to the community where the young person lives, that can help to connect and support young people. From the worker's perspective, they see that the young person lives in their community and therefore see the young person as someone they want to support to be a positive member of that community. This gives the workforce and community a shared goal for the rehabilitation of that young person.

81 My understanding is that in New Zealand, there is a plan to have smaller Juvenile Justice type settings that are more like secure houses with smaller numbers of people. These houses will be closer to the community that the young person comes from so they can involve the community to help manage the young people's movement out of the centre once they're released and any ongoing community programs.

82 Although there are some great programs in NSW, maintaining connections to a young person's local community can be challenging. At Frank Baxter on the Central Coast, they have innovative programs such as guide dog training and surf life-saving and CPR training that they provide to some young offenders that are on longer sentences for violent offences. These create really good connections with the local community. However, many of the young people will move away when released, breaking that positive connection with the community.

83 In order to address reoffending there is a need to build a community for those young people who do not have stability. Many young offenders do not need to be in custody but are there because they are homeless or lack community support. A lack of access to a stable home environment, access to drugs and alcohol, lack of attachment and lack of purpose and goals drives offending. Education and community engagement are key. Engaging the indigenous community through leadership and cultural connectedness is a key challenge.

**Culturally diverse workforce**

84 Juvenile Justice I believe have a diverse employment policy and try to ensure that they employ staff from a diverse range of cultural backgrounds. They employ specialist Aboriginal and Torres Strait Islander (**ATSI**) youth workers in all settings. In NSW, ATSI young people are extremely overrepresented in the criminal justice system, particularly in certain parts of our State. At the Acmena Youth Justice Centre in Grafton, about 90% of the young people can be from an ATSI background at any one time, so they always try to make sure they have a high number of ATSI workers.

85 Employing health workers from ATSI cultures has been a target in NSW and a number of the CIT positions in Justice Health are specified ATSI positions. Trainee programs exist and there are a number of specific targeted educational programs to encourage health and youth worker staff from ATSI backgrounds into this area.

86 I think that there are some things that NSW can take from the Victorian process. Malmsbury Youth Justice Centre, for example, has a cultural program for discharge and I think it would be good to increase our ability to do this type of work in NSW. We also need more peer staff, particularly those with a lived experience of both mental health and detention if possible, to work with Juvenile Justice and Justice Health.

**Peer support**

87 We need to focus on mentoring, and employing rehabilitated young offenders who have gone through the program with a lived experience of mental illness into our services. Achieving a significant peer workforce would be really powerful.

88 Australia has been relatively slow in developing a youth mental health peer workforce – we are only just starting to see positions in all our inpatient adolescent units now. The aim is to have the peer support worker working alongside the mental health teams and supported through their own management systems, as well as being provided excellent supervision to ensure safe and supported care delivery.

89 Employing peer workers in the JH-ACCT and the custodial clinic setting would be an excellent addition to the care staff. Young people could really identify with peer workers and see a reason to improve behaviour. They need to be involved in running therapeutic groups, rehabilitation groups and supporting people in their transition back to the community.

*sign here* ►

*print name* Dr Claire Gaskin

*date* 1 July 2020

Royal Commission into
Victoria's Mental Health System

# ATTACHMENT CG-1

This is the attachment marked 'CG-1' referred to in the witness statement of Claire Gaskin dated 1 July 2020.

# CURRICULUM VITAE


## Dr Claire Teresa Gaskin

**MB BS MRCPsych FRANZCP**

**Child and Adolescent Forensic Psychiatrist**

**Senior Staff Specialist**

**Clinical Director, Child and Youth Mental Health, South East Sydney LHD**

**Conjoint Senior Lecturer, University of New South Wales**

**Email: claire.gaskin@health.nsw.gov.au**


## Professional Registrations

Registered with the Medical Board of Australia through the Australian Health Professionals Registration Authority as a Specialist Medical Practitioner (MED 0001200781)

Registered as a Medical Practitioner with the General Medical Council (UK) (Membership no: 3477362)

Member of the Specialist Register of the United Kingdom as a Dual Specialist in Forensic and Child & Adolescent Psychiatry (since October 2003)

Member of Royal College of Psychiatrists UK

(Member of Child and Adolescent and Forensic Faculties)

Fellow of Royal Australian and New Zealand College of Psychiatrists since 2007

(Member of Faculty of Child and Adolescent Psychiatry and Section of Forensic Psychiatry)

## Undergraduate Education

St. George's Hospital Medical School (University of London) Tooting, London, SW17 (1986-1991)

Bachelor of Medicine and Bachelor of Surgery, MB BS (1991)

Kate Charles Prize in Obstetrics and Gynaecology

Certificate of Merit in Obstetrics and Gynaecology

University of London distinction viva in Obstetrics and Gynaecology

Other activities: Member of medical school management committee

**Current Employment**

***April 2018- current***

**Clinical Director Child and Youth Mental Health, Consultant Child & Adolescent Psychiatrist Sutherland CAMHS**

**South Eastern Sydney LHD, NSW**

I was recruited as the medical lead in child, adolescent and youth mental health services in the District. I am a member of the Mental Health Executive and, in addition to providing direct clinical services at Sutherland CAMHS and advising on complex cases across the District, I am involved in service development, innovation and clinical governance; focusing on safe, effective and efficient service delivery across all District sites with a focus on improving the patient journey for children and young people with mental health difficulties.

***April 2016- current***

**VMO Adolescent Forensic Psychiatrist, Murrumbidgee LHD & Western LHD**

These are both sessional contracted positions. I provide clinical services to the CAMHS teams in the regions including clinical review, assessment and treatment of children and young people aged 0-25 and their families. 4

**Previous Consultant Employment**

***April 2016- April 2018***

**Consultant Child & Adolescent Psychiatrist Consultation-liaison psychiatry,**

**Sydney Children's Hospital, SCHN, NSW**

I had responsibility for the delivery of mental health consultation, assessment and treatment services to children and their families who were patients of the hospital, or attended the emergency department. I led the multidisciplinary team and was involved in service development, audit, clinical governance and research.

***May 2006-March 2016***

**Clinical Director Adolescent Mental Health,**

**Justice Health & Forensic Mental Health Network, NSW, Australia**

Justice Health and the Forensic Mental Health Network is a specialist network responsible for providing health care to juvenile detainees and adult inmates in New South Wales and a range of mental health services to selected clients in the community through the Adult Community Forensic Service, the Statewide Court Liaison Service and the Adolescent Court and Community (JH-ACCT) and Community Integration Teams (CIT) teams. The Network also provides care to patients in the high secure Forensic Hospital at Malabar. This facility includes a 6-bedded adolescent unit.

I was recruited as the clinical lead for the development of the child & adolescent mental health services in JH in 2006. In addition to providing direct clinical services, line managing all the Staff Specialist and VMO Psychiatrists in the adolescent mental health team and providing clinical leadership to adolescent mental health staff, I was involved, over the ten years I was in this position, in the development of community, hospital and detention services, focusing on safe, effective and

efficient service delivery across all the Justice Health service sites in NSW. The focus on improving the patient journey for young people who have mental health difficulties and are in contact with the criminal justice system, led to the development of a number of services, including: the Justice Health- Adolescent Court and Community Team (JH-ACCT); the Community Integration team (CIT) and the Austinmer Adolescent Unit on the Forensic Hospital site at Malabar (a 6-bedded, mixed gender unit, catering for young people with serious mental illness that require admission to a high-secure hospital for treatment under the Mental Health Acts of NSW).

As the Clinical Director Adolescent Mental Health (CDAMH), I was involved in the development and maintenance of working relationships with key partner agencies such as Attorney Generals (Juvenile Justice), FaCS and DET. This required regular liaison with colleagues in the LHD CAMH and youth mental health services and with the Ministry, through submissions to MH-Children and Young people and other peak bodies. I also represented adolescent mental health at senior managerial meetings within JH contributing to projects in Adolescent Health (AH), the Network and at State level as required. This involved input into the development of new services and initiatives, implementation of evidence based best practice, involvement in safety and risk review, and policy & procedure development.

***July 2004-May 2006***

**Consultant Adolescent Forensic Psychiatrist, Lowther Unit, Adolescent Directorate**

**St Andrew's Hospital, Northampton, UK**

The Adolescent Directorate formed part of the St Andrew's Group of Hospitals in the UK, a Charitable Trust. I was one of four Consultant Psychiatrists in the Lowther Unit, a 60-bedded, mixed gender, medium secure inpatient adolescent service with an age range at admission of 13-19 years.

I was the Responsible Medical Officer (Consultant Psychiatrist) for up to 20 young people with a variety of psychiatric disorders who required hospital care in a secure setting, due to the risks they posed to themselves and/or others. The young people presented a range of complex difficulties including severe psychotic disorders, complex post-traumatic stress disorder and severe personality disturbances. They were all detained under civil or forensic sections of the Mental Health Act (England and Wales 1983).

I led a multidisciplinary team and worked with partner agencies particularly Local Authorities (child protection services, social welfare and out of home care) and Department of Education to ensure holistic, family and client centred treatment. I also provided Expert Witness assessments for the Courts in the adolescent forensic field, usually related to criminal matters. These were often requested by the Courts in complex and difficult cases involving issues such as; Fitness to Plead, diversion to mental health treatment and Insanity defences in young offenders.

***Oct 2003-June 2004***

**Consultant Adolescent Forensic Psychiatrist, Birmingham Forensic Child and Adolescent Mental Health Service (Forensic CAMHS), Birmingham, UK**

Ardenleigh is a medium secure inpatient facility with 20 beds for the Forensic Child and Adolescent Service on a site shared with the West Midlands Forensic Service for Women. I worked with two consultant colleagues, each providing inpatient care for up to 8 young people in the adolescent facility.

The position also led the multidisciplinary team which provided both inpatient care and specialist assessment and management advice to other agencies such as Youth Offending Teams for young people with mental disorder who were presenting risk to others. I provided weekly clinical input to a Young Offenders Institution (Swinfen Hall, Lichfield), a rehabilitation prison for younger offenders with a large population of young sex offenders. I also provided weekly clinics and mental health support to a Local Authority Secure Children's Home (secure out of home care).

**Psychiatry Specialist Registrar (Advanced) Training**

***June 1998-Sept 2003***

**Higher Specialist Training in Psychiatry (Advanced training) in Forensic and Child & Adolescent Psychiatry, Maudsley Hospital,**

**South Thames Higher Specialist Training Scheme (London Deanery)**

The specialist registrar dual training was of five years duration and led to accreditation as a specialist after annual reviews and submission of all relevant documentation to the College. The training scheme was evaluated and approved by the Royal College of Psychiatrists and met their requirements for supervision, clinical experience and teaching.

The individual posts were all full-time working in a number of settings including: community, consultation-liaison and inpatient child and adolescent services; community adult forensic service; specialist adolescent forensic community team and adult medium and high secure forensic inpatient services. Throughout the training period I gained a wide experience of preparing reports for criminal matters heard in the Magistrate, Crown and High Courts and gave evidence in court as an expert witness on numerous occasions. I assessed patients and families in relation to complex childcare matters and provided expert witness testimony to the Family and High Courts.

During my training I undertook additional "Special Interest" sessions in: child and adolescent learning disability (Dr Bernard), child and adolescent neuropsychiatry (Dr Heyman) and Addiction Services (Dr Finch). I worked one session per week with the Drug Testing and Treatment Order (DTTO) Service in Camberwell, South London for 6 months; monitoring and prescribing opiate replacement therapy for the clients and monitoring mental illness in those with comorbidity.

I participated in an on-call rota, at a level of 1 in 8, throughout my Specialist Registrar training. This involved assessments of adults, children, adolescents and families who presented out of hours to the Accident and Emergency Departments of two local hospitals or the Emergency Psychiatric Clinic at the Maudsley. Additionally I was responsible for support and advice to the junior staff at four inpatient sites in the region for child and adolescent and forensic psychiatry.

**Psychiatry Registrar Training**

**Sept 1995 – Feb 1998**

**South West Thames Psychiatric Registrar Training Scheme, St. George's**

There was an obligatory six month post in Child and Adolescent Psychiatry and in Consultation Liaison psychiatry during this period and compulsory attendance at an approved weekly teaching course. Appraisal of experience and progress took place every year with the Scheme Organiser. The individual posts covered were general adult, old age, forensic, consultation-liaison and child and adolescent psychiatry working at times in the community and also in inpatient services.

**Non-training positions:**

***July – August 1995:***

**Locum Registrar to Dr. P. Bailey and Dr. M. Tattersall**

**Roselands Resource centre (Day Hospital)**

**Kingston upon Thames**

***Jun 1994–June 1995*:**

**Principal House Officer (Registrar), Paediatrics, A+E and Psychiatry**

**Toowoomba Base Hospital, Queensland, Australia.**

**Psychiatry SHO (basic training)**

***March 1993-June 1994***

**St. George's Psychiatric Training Scheme London (various posts)**

I completed general psychiatry and old age psychiatry posts in South London and Surrey in inpatient and outpatient settings.

**Intern positions**

***Aug 1992 – Feb 1993***

**Senior House Officer to Dr. R. Weeks, Accident and Emergency Department**

**St. Richards Hospital, Chichester**

***Feb 1992 – July 1992***

**Pre- registration House Surgeon (intern) to Mr. Lallemand and Mr. Ross**

**Frimley Park Hospital, Surrey**

***Aug 1991 – Jan 1992***

**Pre-registration House Officer (intern) to Dr. Reed and Dr. Holman**

**St. Richard's Hospital, Chichester**

**Postgraduate Education & Continuing Professional Development**

I am a conjoint senior lecturer at the UNSW in the school of psychiatry and have co-ordinated, written, planned and taught the "Children, Adolescents and Families" module of the Masters in Forensic Mental Health since it was first offered in 2006.

I have a particular interest in trauma and the association with youth offending and have presented widely on this at international forums. In 2013, I co-authored a training handbook in risk of violence assessment and management in adolescents that was endorsed by Prof Susan Bailey (President of the UK Royal College of Psychiatrists). I have a number of joint publications in peer reviewed journals.

I have delivered training for NSW youth mental health clinicians in violence risk management in adolescents, using a structured professional judgement approach to risk that utilises the SAVRY. This training was funded by HETI.

I am a member of a Peer Review Group that meets monthly and am registered with the Royal College of Psychiatrists for Continuing Professional Development and the Royal Australian and New Zealand College of Psychiatrists for CME.

I maintain mandatory training as required. I have attended courses on Clinical Leadership, Time Management, Diversity Awareness and Strategic Development.

I have been trained in the use of a number of diagnostic interviews including: Connors scales, K-SADS, CBCL (Achenbach) Diagnostic Interview Schedule for Social and Communication Disorders (DISCO: Wing and Gould), Autism Diagnostic Interview-Revised Version (ADI-R) and the Autism Diagnostic Observation Schedule (ADOS). I have completed training in TF-CBT. I am trained to use a number of risk assessment tools including the Structured Assessment of Violent Recidivism in Youth (SAVRY-Borum et al), HCR-20, PCL-R and the ERASOR.

***Selected publications***

Kasinathan J; Marsland C; Batterham P; **Gaskin C**; Adams J; Daffern M, 2015, 'Assessing the risk of imminent aggression in mentally ill young offenders', *Australasian Psychiatry*, vol. 23, no. 1, pp. 44 - 48, http://dx.doi.org/10.1177/1039856214563845

Moore E; **Gaskin C**; Indig D, 2015, 'Attempted Suicide, Self-Harm, and Psychological Disorder Among Young Offenders in Custody', *Journal of Correctional Health Care*, vol. 21, no. 3, pp. 243 - 254, http://dx.doi.org/10.1177/1078345815584849

Haysom L; **Gaskin C**; Indig D; Moore E, 2014, 'Intellectual disability in young people in custody in New South Wales, Australia - prevalence and markers', *Journal of Intellectual Disability Research*, http://dx.doi.org/10.1111/jir.12109 9

Moore E; Indig D; **Gaskin C**, 2013, 'Childhood maltreatment and post-traumatic stress disorder among incarcerated young offenders', *Child Abuse and Neglect*, http://dx.doi.org/10.1016/j.chiabu.2013.07.012

**Gaskin C** & Curtis A 2013: *Violence risk assessment and management for youth mental health clinicians,* JH&FMHN Sydney NSW ISBN-13:978-0-646-90232-6

Indig, D., Vecchiato, C., Haysom, L., Beilby, R., Carter, J.,Champion, U., **Gaskin, C.**, Heller, E., Kumar, S., Mamone, N., Muir,P., van den Dolder, P. & Whitton, G. (2011) *2009 NSW Young People in Custody Health Survey: Full Report.*