WHAT CAN BE DONE?

- *Residential therapeutic treatment options for young people suffering substance abuse/mental illness*

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Magistrate Jennifer Bowles
2014 Churchill Fellow

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To review options for residential therapeutic treatment for young people suffering substance abuse/mental illness

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Signed Jennifer Bowles Date 16 February 2015

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1. INTRODUCTION AND ACKNOWLEDGEMENTS

The children and young people who appear before the Children's Court of Victoria are the most vulnerable in our community. They are before the court because the Department of Human Services (Child Protection) is involved in their lives and/or they have been charged with criminal offences. A significant number of them have drug/alcohol/mental health issues – which adversely impact on their ability to make rational decisions to voluntarily engage in treatment. Rehabilitative opportunities to assist these children and young people are being lost.

I therefore applied for a Churchill Fellowship to gain an understanding of the overseas residential treatment options for children and young people. In particular, I was seeking to ascertain whether mandated treatment (counselling) in a secure, therapeutic, residential facility could assist our young people and if so, what were the essential requirements.

Being awarded a Churchill Fellowship has been one of the highlights in my life. It has been such a privilege. I am so grateful to everyone associated with the Winston Churchill Memorial Trust of Australia for giving me this invaluable opportunity. I have returned with fresh ideas which could assist these troubled young people to get their lives 'back on track' and with a commitment to do whatever I can to see the recommendations I have made implemented.

I am indebted to all of the people I met whilst I was away for giving so generously of their time and sharing their considerable knowledge and experience. I had not anticipated having the opportunity to also speak with any of the young people in the residences. However, in all places there were young people who were interested in discussing the reasons for my visit, expressing their views and sharing details of their very sad lives. To hear them describe their renewed interest in life was a highlight. I greatly appreciate everyone's hospitality and generosity.

I would particularly like to thank and acknowledge my referees, His Honour Judge Paul Grant and Dr Patricia Brown; and also Chief Magistrate Peter Lauritsen, without whose support this project would not have been possible. I also wish to thank the following people for their support and assistance – The Honourable Justice Jennifer Coate, His Honour Judge Peter Couzens, Deputy Chief Magistrate Bob Kumar, Magistrates Peter Power, Greg Levine, Ann Collins, Ros Porter, Belinda Wallington and Tony Parsons, Associate Professor Rosemary Sheehan, Janet Matthew, Dr Pernilla Leviner, Dr Helena Sandahl, Maria Lusby, Emily Holland-Tam, Louise Leone, Elisa Buggy, Katarina Palmgren and Anna McKenzie-McHarg. Heartfelt thanks to 'Greg' and his mum for their commitment, dedication and inspiration.

Thankyou also to my wonderful husband, Frank Dixon, for his love, support, faith and encouragement. I am so fortunate that Frank could accompany me on this journey. He is committed to this project. He accompanied me to the appointments, provided essential logistical support and, most significantly, valuable insights. The shared experience is something we have both truly treasured. Finally, I would also like to acknowledge and thank my family. I have been so fortunate to have a loving and supportive family. My wonderful parents instilled in me strong principles of social justice and compassion, for which I will always be grateful. Every day I am reminded how fortunate I have been when I see the tragic consequences which flow for young people who have not been so fortunate.

Sir Winston Churchill once said "Never never never give up" - for the sake of our vulnerable children and young people, we should never give up!

2. EXECUTIVE SUMMARY

Residential therapeutic treatment options for young people suffering substance abuse/ mental illness

Jennifer Bowles, Magistrate, Children's Court of Victoria, 477 Little Lonsdale St Melbourne [redacted]

As a Magistrate in the Children's Court of Victoria, I see children and young people whose lives are spiralling downwards as a result of the (often cumulative) effect of their drug or alcohol misuse or mental illness or criminality. These young people are amongst the most vulnerable in our society because many of them have been subject to trauma, neglect or abuse. I applied for a Churchill Fellowship because the current voluntary system is not working for many of our most troubled young people. I was aware that, if considered necessary, Sweden has compulsory orders to require young people to receive intensive treatment in secure homes. I wanted to know whether such orders could make a difference.

I visited secure homes and therapeutic community residences in Sweden, Scotland, England and New Zealand. I experienced many highlights, including meeting a vast number of dedicated staff who had the welfare and advancement of young people as their prime objective. I observed the positive results from placing trust in young people in therapeutic community environments in places such as Glebe House in Cambridge and Auckland Youth Odyssey. I was impressed by the homely feel of the 'manors' at Huntercombe's Maidenhead and Stafford Hospitals in England. I was overwhelmed by the support provided by Mr Ola Karlsson Rûhmkorff and the staff at the secure (SiS) facilities in Sweden. Dr Dickon Bevington presented an enlightening model for engaging young people in the community. I am very grateful to Judges Jane McMeeken (Christchurch) and Tony Fitzgerald (Auckland) for allowing me to observe the successful Youth Drug Court and Crossover Court List. Most importantly, I was delighted to be able to talk with young people about their experiences.

The advice I received from numerous experts and practitioners in all countries was that, for some young people, compulsory orders to attend therapeutic residential facilities are necessary in order to ensure these young people are safe and secure, to deal with the addiction, to commence the process of improving their physical and mental health and wellbeing and to reconnect them with education and training. I spoke with some young people who admitted they did not wish to attend such a facility, but having been there, they believed that it was essential for them.

I was able to identify critical elements for successful facilities, including the need for them to be welcoming and therapeutic (not punitive) and well located. High quality staff; effective after-care and transition back into the community; and external scrutiny are vital. I have recommended that residential therapeutic facilities that meet these objectives be established as a matter of urgency. Legislation will be required to enable orders for compulsory assessment and treatment (Youth Therapeutic Orders) to be made in the Children's Court of Victoria. As a result of observations I made in New Zealand, I am also recommending that a Youth Drug Court and a Crossover List (to coordinate the process of dealing with the many young people who are subject to both criminal and child protection proceedings) be established in the Children's Court of Victoria.

I will discuss my report and its recommendations with the Victorian Premier, key Ministers and agencies and seek to present to the recently established Ice Taskforce. I will also distribute the report as widely as possible. I will present the report's findings to my judicial colleagues and at national and international conferences. I look forward to working with others in implementing the recommendations.

3. CHURCHILL FELLOWSHIP PROGRAM

SWEDEN

Date	Location	Organisation/ Institution Visited	People Interviewed
14/10/2014	Stockholm	The Swedish National Board of Institutional Care (SiS)	• Ola Karlsson Rûhmkorff, Head of Business Intelligence
	Stockholm	Stockholm District Court	• Judge Lena Egelin, Head of Division
15/10/2014	Stockholm	Stockholm University	• Associate Professor Pernilla Leviner, Senior Lecturer, Faculty of Law • Associate Professor Tove Pettersson, Head of Department & Senior Lecturer, Department of Criminology
	Stockholm	Stockholm Centre for the Rights of the Child, Faculty of Law, Stockholm University	• Presentation (to mostly academics) on the Children's Court of Victoria and specialist lists of the Court • Hosted by Dr Pernilla Leviner, Deputy Head of the Centre
16/10/2014	Fagersta	Sundbo Youth Institution (SiS)	• Kristin Wahnström, Registered Clinical Psychologist • Karin Olsson, LSU Co-ordinator (sentenced young people) • Anders Erman, Senior Teacher and Careers Advisor
17/10/2014	Stockholm	Stockholm University (off campus)	• Professor Tommy Lundström, Department of Social Work • Professor Marie Sallnäs, Department of Social Work
	Huddinge, Stockholm	Helix Forensic Psychiatric Clinic	• Kaj Forslund, Helix Director • Anette Johansson, Senior Psychiatrist, Director Northern Stockholm Hospitals • Magnus Kristiansson, Forensic Psychiatrist, Head of Clinic
20/10/2014	Uppsala	National Prison Service Parole Office	• Hans Palmetorp, Head of Probation Office • Susanne Williams, Senior Probation Officer
	Uppsala	Bärby (Sirius) Youth Institution (SiS)	• Erik Sandström, Treatment Secretary

Date	Location	Organisation/ Institution Visited	People Interviewed
21/10/2014	Norrköping	Swedish Prison and Probation Service	• Åsa Wallengren, National Coordinator and Project Manager "Young Offenders Violent Offenders" • Malin Karlsson, Researcher - Young Offenders
	Vagnhärad	Lövsta Youth Institution (SiS)	• Annica Pettersson, Manager • Mats Stenius, Assistant Manager
22/10/2014	Stockholm	National Police	• Christina Kiernan, Project Manager, Community Intervention Teams (for Young Offenders), Swedish Police
	Stockholm	Maria Ungdom, City of Stockholm Youth Community/Medical Centre	• Mikael Jeppson, Head Social Youth Emergency Service • Kerstin Öqvist, Social worker

SCOTLAND

Date	Location	Organisation/ Institution Visited	People Visited
24/10/2014	Edinburgh	Mental Welfare Commission	• Margo Fyfe, Nursing Officer • Dougie Seath, Nursing Officer
27/10/2014	Edinburgh	Royal Edinburgh Hospital – Child and Adolescent Mental Health Services	• Cathy Richards, Chair National Lead Clinicians' Group for Children and Young People's Mental Health
	Edinburgh	Office of the Children's Commissioner	• Tam Bailie, Children's Commissioner for Scotland
	Edinburgh	National Children's Hearings Office, Ladywell House	• Boyd McAdam, Chief Executive and National Convenor Children's Hearings Scotland • Fraser Thompson, Performance and Research Officer
28/10/2014	Glasgow	Skye House, Stobhill Hospital	• Jane Fuller, Consultant Psychiatrist • Sean Fitzpatrick, Clinical Nurse
	Glasgow	Glasgow Sheriff Court	• Sheriff Principal Craig Scott • Sheriff Alan Millar
	Bishopton, Glasgow	The Good Shepherd Centre, Bishopton	• Robert Clark, Unit Manager, Head of Strategic Development

Date	Location	Organisation/ Institution Visited	People Visited
29/10/2014	Hamilton	Mental Health Tribunal, Hamilton House	• May Dunsmuir, In-house Convenor with the Mental Health Tribunal for Scotland, President of the Additional Supports Needs Tribunals for Scotland
	Glasgow	James Shields Project	• Lorraine Fraser, Manager • Ros McQuillian, Nurse and Deputy Manager • Martin Kirkwood, Additional Support Addiction Worker
30/10/2014	Hamilton	Mental Health Tribunal, Hamilton House	• Dr Joe Morrow, Tribunal President • Heather Baillie, In-house Convenor • Valerie Mays, Legal Secretary to the Tribunal

ENGLAND

Date	Location	Organisation/ Institution Visited	People Visited
4/11/2014	London	Middle Temple	• Sarah Hankinson, Assistant Students' Officer
	London	Great Ormond St Hospital for Children	• Dr Danya Glaser, Honorary Consultant Child and Adolescent Psychiatrist and Visiting Professor, University College London
	London	Royal Courts of Justice	• The Honourable Mrs Justice Parker, DBE, Family Division, High Court of Justice
5/11/2014	Maidenhead	Huntercombe Maidenhead Hospital	• Iris Cupido, Registered Manager • Sofia Majays, Nurse Consultant • Dr Mark Tattersall, Medical Director and Consultant Psychiatrist • Paul Thompson, Drug and Alcohol Advisor • Ann-Marie Woodham, Senior Social Worker • Nic Rose, Head of Education, Huntercombe Group • Debbie Wade, Healthcare Assistant • Dawn Bailey, Environmental Control Manager • Michelle Hancey, Healthcare

Date	Location	Organisation/ Institution Visited	People Visited
			Assistant • Walker Matsvaire, Family Therapist • Charlotte Nicholds, Account Manager
	Roehampton, London	Huntercombe Hospital, Roehampton	• Iqbal Golamaully, Hospital Manager • Johnson Oshodi, Clinical Services Manager
6/11/2014	Staffordshire	Huntercombe Hospital, Stafford	• Mark Edwards, Registered Manager • Dr Sasha Hvidsten, Psychiatrist
10/11/2014	York	The Retreat	• Dr Dan Anderson, Medical Director and Psychiatrist • Peter Gorbert, Communications and Engagement Officer
11/11/2014	Cambridgeshire	Glebe House	• Peter Clarke, Director • Karen Parish, Assistant Director (Clinical)
	Cambridge	Cambs Children and Adolescent Substance Abuse Service (CASUS) - The Bridge	• Dr Dickon Bevington, Consultant Child and Adolescent Psychiatrist • Verity Beehan, Psychiatric Nurse and Substance Abuse Practitioner

NEW ZEALAND

Date	Location	Organisation/ Institution Visited	People Visited
20/11/2014	Manukau, Auckland	Manukau District Court and Manukau Youth Court	• Judge Tony Fitzgerald
21/11/2014	Auckland	Odyssey Auckland (various sites): -adult facility -school -youth residential -youth outreach	• Pat Williams, Compliance and Quality Manager, Odyssey House trust • Renee Berry, Team Leader, Youth Residential Service • Sherry Cochrane, Head Teacher
24/11/2014	Otane, Hawke's Bay	Te Waireka	• Te Aranga Hakiwai, Service Manager • Jon Fletcher, AOD Clinician • Pam Kupa, Sheeran Clinical Supervisor
26/11/2014	Christchurch	Christchurch District Court	• Judge Jane McMeeken
27/11/2014	Christchurch	Christchurch Youth Drug Court	• Judge Jane McMeeken

Date	Location	Organisation/ Institution Visited	People Visited
28/11/2014	Christchurch	Odyssey Youth Christchurch	• Nigel Loughton, Clinical Director • Debbie Bradshaw, Clinical Coordinator • Jim Merster, Team Leader • John Hannah, Adventure Therapist • Fiona Bell, Youth Worker • Melissa Giles, Youth Worker • Tipane Walker, Teacher
	Christchurch	Youth Specialty Service (YSS)	• Janet Prendergast, Registered Nurse
1/12/2014	Christchurch	Te Oranga Care and Protection Residence	• Michelle Hughes, Residential Manager
	Rolleston, Canterbury Region	Te Puna Wai ō Tuhinapo Youth Justice Residence	• Chris Rewha, Acting Residents' Manager • Cheryl Bok, Team Leader Operations – Girls' Unit • Rachel Maitland, Assistant Principal, Kingsley School • Kate Marriott, Team Leader Operations & Military Camp • Georgia Candler, Youth Worker, Youth Program (out-of-school hours) Manager & Shift Leader

4. WHAT IS THE CRISIS? – THE VICTORIAN CONTEXT

4.1 Greg's story

"What can you do? I am watching my son die before my eyes."

These words were uttered to me by the loving mother of a 17 year old boy when her son was in court one day. Her son Greg[1] had a dependence on alcohol, which resulted in multiple hospital admissions for alcohol poisoning. He also had a dependence on cannabis and he had begun to experience concerning mental health symptoms.

His offending consisted of shop thefts of bottles of vanilla essence[2] which he would then consume. His life was spiralling downwards and reached its lowest ebb when he was ultimately remanded in custody, as his offending (always substance related) had become more serious. Greg promised on a number of occasions to attend a detoxification centre which he did, but he could only remain for an hour or two and then he would leave and relapse and the cycle would commence again.

He has given me permission to reproduce a poem he wrote whilst he was in custody. The following is an extract:

My depression turns to anger from the pain it's brought to me
Is there anyone to blame, or is this how it's meant to be?
I crave for something in the distance, too far for eyes to see
My sense of logic figures that it is a sense of tranquillity…..

I pray for a Saviour to help me conquer my compulsive behaviour
Which keeps leading me into trouble and life threatening danger
I feel weighed down and burdened with responsibility
Having to work on getting better and back to normality.

It seems like it's all too much, after years of such fuss
I'm prepared to give up and declare that I've had enough
If I am to die, please keep in mind that I did try
Tears come to my eyes, at times I've contemplated suicide.

[1] Name has been changed (as has been applied to all young people referred to in this report).
[2] Vanilla essence has a very high alcohol content (approximately 35%).

As this report will demonstrate, many of the young people who appear before the Children's Court have experienced abuse/neglect and have child protection involvement in their lives and do not have a caring mother who attends every court hearing, as Greg's mother did. Nor do they have the literacy skills of Greg, as many have left school when they were very young. However, Greg was able to describe very graphically the lifestyle of many of the young people who appear before the court.

Despite Greg's best intentions, he could not remain at a treatment facility. Victoria's system depends upon a young person voluntarily accessing treatment.

I applied for a Churchill Fellowship because I believed there must be a better way to provide young people with the opportunity to receive treatment for their drug and alcohol and mental health issues.[3] A valuable opportunity to assist them whilst they are young and their rehabilitative prospects are potentially at their greatest was being lost. I wanted to have an answer to the question posed by Greg's mother.

I have been a magistrate for 16.5 years and I have sat in the Children's Court of Victoria for half of my time on the Bench. In our specialist Children's Court I am dealing with young people who have been charged with criminal offences and young people whose families are part of the child protection system.

Despite the best intentions of people and agencies entrusted with the care of these young people, their lives can too often be described as chaotic and deeply troubled.

All of the countries I visited had children and young people with drug/alcohol/mental health issues. Their approaches varied regarding the best ways to assist them. I will first of all outline the current position in Victoria, Australia:

4.2 Youth Custody

Children[4] and young people who commit or it is alleged have committed criminal offences when they were aged 10 to 17 appear in the Children's Court. The focus of the Criminal Division of the Court is on rehabilitation[5] and it is only when there is no other alternative that a young person is sentenced to detention[6] at Parkville Youth Residential Centre (10 - 14 years of age) or Parkville Youth Justice Centre (15 - 17). Parkville[7] is the only secure site for young people who commit criminal offences in Victoria.

The following statistics are of particular relevance to this paper. It relates to children and young people in custody:

[3] Mental health issues include anxiety, depression, self-harm, conduct disorder and schizophrenia. There is generally a reluctance, as young people are still maturing, for a formal diagnosis to be made.
[4] 'Child' is defined in s 3(1) Children Youth and Families Act 2005 (CYFA).
[5] Refer to ss 360 – 362A CYFA. There are many strengths in the Victorian system, for example, the number of young people in custody is the lowest rate of any State or Territory in Australia; *Australian Institute of Health and Welfare Youth Detention Population in Australia* 2014, AIHW, p 30.
[6] Maximum sentences of detention – if under 15, one offence 12 months, more than one offence 2 years; over 15, one offence 2 years, more than one offence, 3 years.
[7] The total number of beds for males and females is 116.

Youth Custody[8]

Issues	% of total number of young people in custody
History of alcohol and/or drug misuse	89%
Alcohol and/or drug use related to offending	78%
Victims of abuse, trauma or neglect	60%
Previous child protection history or current child protection involvement	59%
Mental health issues	27%
History of self-harm or suicidal ideation	26%
Parents	13%

Apart from the overwhelming presence of drug and alcohol misuse, these figures confirm the high levels of young offenders who are also or have been part of the child protection system (59%). Considering the number and age of these young people who are already parents, there is a clear risk of perpetuating this intergenerational cycle.

4.3 Child Protection

When there are protective concerns regarding a child or young person, the Department of Human Services may apply to the Children's Court for an order which prescribes where the child must reside.

The options, in order of preference are:

- with a parent[9]
- with a family member
- with a person the young person knows
- out of home care[10]
  - foster care[11]
  - residential care[12]

[8] *Annual Report Youth Parole Board and Youth Residential Board 2013-2014* – (snapshot 9 October 2013), p. 13 (134 males; 4 females).

[9] "A child is only to be removed from the care of his or her parent if there is an unacceptable risk of harm to the child." Children Youth and Families Act 2005 (CYFA) s 10(1)(g).

[10] It is pleasing to note that additional funding has very recently been committed to this area. (The Age 7/2/2015).

[11] "Foster care - children requiring foster care can be of any age (up to 18 years)… children are placed in foster care for a range of reasons, and foster care can occur as a result of a court order, or through a voluntary arrangement between the child's parent and a foster care agency… Foster care agencies, also known as community service organisations, are funded by the Victorian Government." *Foster Care*-Department of Human Services 10 July 2014.

- therapeutic treatment (placement) (10-14 - sexually abusive behaviours)[13]
- lead tenant (16-18 year olds)[14]
- secure welfare service (10-17 year olds).[15]

4.4 Residential Care

The Victorian Auditor General has reported:

> *"There are currently around 500 children in residential care in Victoria. These children are among the most vulnerable in the community. They are in the Out of Home Care (OOHC) system because in most cases the Children's Court has decided they are at significant risk of harm, abuse or neglect from their own families and cannot remain in the home…..*
>
> *Children in residential care have complex needs relating to mental health, cognitive development and social interaction. They are likely to engage in extreme behaviours, such as self-harm, aggressive or sexualised behaviours, substance abuse and other activities that place them, or others, at high risk."*[16]
>
> *"School attendance, health and preparedness for independent living after leaving care are poor. More than 1/3 of children and young people in residential care have experienced over 10 out of home care placements. The number of critical incidents, such as death or severe trauma, is disproportionately high for children in residential care compared with children in other forms of out of home care."*[17]

4.5 Secure Welfare

In the child protection system, there are two secure welfare facilities in Victoria, with a total of 20 beds: Ascot Vale – 10 bed site for males and Maribyrnong – 10 bed site for females. They are closed or locked facilities.

A child or young person aged 10-17 years may be placed in secure welfare if "there is a substantial and immediate risk of harm to the child."[18] The order may be made by the Court or if the Secretary of the Department of Human Services (DHS) is the custodian or guardian, the Secretary may place the child or young person in secure welfare.

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[12] "Residential care is a care placement service for children in the child protection service system. Residential units are operated by Community Service Organisations… short, medium and long term out of home care in community based residential facilities for children and young people aged mainly 12-17 years who are unable to be placed in home based care (such as foster care or kinship care)". *Residential Care*-Department of Human Services 3 July 2013. There are therapeutic residential care units which provide additional specialised support for young people with especially challenging and complex needs.

[13] "Therapeutic treatment (placement) order… allow(s) the child to be placed away from home where this is necessary for the treatment (for sexually abusive behaviours). The placement order will only apply for the duration of the treatment order." *Every Child Every Chance – Children in Need of Therapeutic Treatment*, Department of Human Services p 1.

[14] "Lead tenant is an out of home care placement option providing medium-term accommodation and support to young people aged 16-18 years, who have been placed away from the care of their families by child protection… semi-independent living environment… (with) one or two approved volunteer lead tenant/s." *Department of Human Services Program Requirements for Lead Tenant Services in Victoria* 7 October 2014.

[15] Refer to Section 4.5

[16] *Residential Care Services for Children Victorian Auditor-General Report 2013 – 2014*; p ix.

[17] Ibid; p. xii.

[18] s 263(1)(e) and s 173(2)(b) *Children Youth and Families Act 2005 (CYFA).*

In either case, the criteria must be met and the maximum period must not exceed 21 days.[19] If there are exceptional circumstances, there may be one extension not exceeding 21 days.[20] This extremely short period of time can only provide temporary protection and containment, but cannot begin to effectively address the underlying trauma, abuse or neglect experienced by the young people.

One of the difficulties experienced with the young people who are placed in secure welfare is engaging them in treatment when they return to the community.[21] It means that for some, there is a 'revolving door' in and out of secure welfare. Over the period 1 April 2013 – 16 September 2014, the relevant statistics are as follows:[22]

	First time in secure welfare	Previously in secure welfare
Female	74	100
Male	59	72
	133	**172**

For those people who had previously been placed in secure welfare, the statistics over this 17 month period were as follows:

Number of times previously placed in secure welfare	Female	Male
1	19	28
2	38	29
3	19	9
4	10	2
5	5	0
6	3	1
7	1	1
8	2	0
9	0	2
From 10 to 16	3	0

[19] s 264(2) and s 173(2)(b) *CYFA.*
[20] s 267(2)(c) and s 173(2)(b) *CYFA.*
[21] Information provided by the Secure Services Branch, Department of Health and Human Services: Children and young people who have been in Secure Welfare have a history of trauma. The most common risk factors are sexual abuse; physical abuse; parental substance and alcohol abuse; parental mental health issues; lack of parental skills and capacity; and family violence.
[22] Statistics provided by Manager, Education and Programs, Secure Services, North Division Department of Human Services.

4.6 Missing from care

If a child or young person is absent without lawful excuse from where they have been placed on a court order or by DHS, the Department may apply to the Children's Court for a search warrant[23] which authorises the police and child protection to search any premises where the child or young person is suspected to be.

The applications provide an insight into the chaotic, sad and damaged lives some children and young people in our community are leading.

The following is a typical extract from an Affidavit[24] for a search warrant submitted to the court:

> *"Annie is a thirteen year old female currently placed in a residential unit.*
>
> *Annie has been subject to 8 reports to child protection, the most recent involvement stemming from a report received on the [redacted], shortly after her mother's passing. Annie's father has had limited involvement in her life, having only been released from prison in April 2014.*
>
> *Annie absconds frequently to places and with persons unknown. In the past safe custody warrants have been required to ensure her safe return to placement as attempts to negotiate her voluntary return have been unsuccessful. Annie can remain absent for extended periods of time.*
>
> *Annie is reported to engage in sexualised behaviours such as "sexting", the recipients of which have at times included adult males who have reciprocated. Annie is reported to also form friendships with adult males whom she is at risk of sexual exploitation from.*
>
> *As aforementioned, Annie has experienced significant and recent grief and loss associated with her mother's death in 2013, and a highly disrupted relationship with her father who has recently exited prison.*
>
> *Annie is reported to engage in self harming behaviour. She has difficulty regulating her behaviour and often exhibits minimal insight into the risks associated with her behaviour and persons whom she chooses to associate.*
>
> *Annie is frequently reported to be in the company of an older negative peer group and is reported to engage in substance abuse, primarily ice.*
>
> *Annie has previously been missing for 5 weeks, and was then placed in secure welfare for a further 2 weeks. Annie's behaviours have deteriorated greatly since the time she had been missing for 5 weeks.*
>
> *Annie was placed in secure welfare on [redacted] as there were significant concerns regarding her absconding, negative older peer associations, substance abuse and her mental health. Annie was exited from secure welfare on [redacted] and returned to her residential placement.*

[23] s 598 CYFA.
[24] Names and dates have been changed.

Annie absconded from placement at [redacted] and has not returned. Phone contact has been made with Annie whilst she has been missing, although she has not disclosed her location and advised that she would be returning to placement later.

Given Annie's young age, engagement in high risk activities and her current whereabouts being unknown, there are significant and immediate concerns for her safety."

In 2014 there were 2,625[25] of these search warrants issued by the court. This meant that, on average, at least 50 applications were made to the court per week regarding young people in the child protection system in Victoria who were missing or not at their homes. It is clearly an alarming situation with young people's whereabouts being unknown throughout the day and night and at the same time engaging in risk taking behaviour.

4.7 Mental health/substance abuse and the Courts – treatment options

4.7.1 Compulsory treatment – mental health

Compulsory treatment may currently be ordered for children and young people who meet the criteria prescribed in the *Disability Act 2006*, the *Mental Health Act 2014* and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA). The power to make the orders under the CMIA[26] commenced on 31 October 2014 as a result of the Government accepting the recommendations in the Report of the Victorian Law Reform Commission (VLRC) Review of the CMIA 1997 (June 2014).

The significance of the CMIA is that the VLRC recommended that a specialist youth forensic facility be built in order for treatment to be provided to young people on custodial supervision orders.

"The Commission is of the view that there is a need for a youth forensic unit in Victoria. It is unacceptable that young people with a mental illness, intellectual disability or other cognitive impairment are being detained in custodial facilities that are not appropriate to meeting the needs of this vulnerable group of young people."[27]

[25] 1,701 females and 924 males.

[26] Supervision orders can be made if a child or young person has been charged with a criminal offence and they are 'unfit to stand trial' which means a child or young person who is unable to understand the nature of the charge or unable to enter a plea to the charge or unable to understand the nature of the hearing or unable to follow the course of the hearing or unable to understand the substantial effect of any evidence that may be given in support of the prosecution or unable to give instructions to his or her legal practitioner (s 38K(1) CMIA). In addition, supervision orders can be made if a child or young person has established the defence of mental impairment. 'Mental impairment' means that the child or young person at the time of engaging in the conduct which constitutes the offence did not know the nature and quality of the conduct or that the conduct was wrong (could not reason with a moderate degree of sense and composure about whether the conduct as perceived by reasonable people, was wrong) (s 38ZA(1) CMIA). There are custodial and non-custodial supervision orders.

[27] V*LRC Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (CMIA*) Report June 2014; [6.244] p 215.

Despite the recommendations of the VLRC, a specialist youth forensic facility has not been built. The current position is that, if a custodial supervision order is made, a child or young person would, subject to their current presentation, be placed in the detention facilities at Parkville Youth Justice Centre.

There is an urgent need to provide a secure forensic facility for young people to whom CMIA applies and separate facilities for those who do not meet the CMIA criteria but have drug/alcohol/mental health issues (the young people discussed in this report).

4.7.2 Voluntary treatment

Apart from the very limited situations detailed in section 4.7.1, when a young person is abusing substances or has mental health issues, the treatment model is a voluntary model, that is, in order to access treatment, the young person has to decide that they wish to attend for treatment.

If the young person has committed criminal offences, the Children's Court can require the young person to attend for counselling or treatment by requiring them to follow all lawful directions of Youth Justice or by including treatment and counselling conditions on a court order.

The treatment and counselling conditions could include seeing a drug and alcohol or mental health counsellor or psychiatrist. This would generally involve attending for counselling or therapy once a week for approximately an hour. As Dr Sasha Hvidsten commented, (for the most troubled)…..

"…attending once per week is a drop in the ocean…it isn't going to work."

The young person may be encouraged to enter a detoxification program or to attend a residential program for drug or alcohol use.

Many of these young people are from very disadvantaged backgrounds and are in the care of the Department of Human Services because they cannot live at home (as previously outlined).

There are only 33 adolescent residential detoxification (detox) beds in Victoria.[28] If the young people attend detox, they generally have difficulty remaining for the whole program. Whilst the detox and residential facilities provide very good services, most young people even with the best will in the world, have trouble turning up or remaining at the facility. There are many distractions which impact on them attending, for example, negative peer group influence, dependency on alcohol or substances, mental health issues and the trauma to which they have

[28] Peter Wearne, Director of Services YSAS (Youth Support and Advocacy Service).

been exposed. Such factors adversely affect the ability of the child or young person to make reasoned, rational decisions regarding seeking treatment.[29]

The existing residential treatment programs include Bunjilwarra, Birribi, Windana, Teen Challenge, Hurstbridge Farm and Tandana. My understanding is that they provide excellent support and assistance in a setting for young people with drug, alcohol or mental health issues. My brief visit to Birribi, for example, strongly confirmed this to be the case. Once again, however the young person can leave at any time.

4.8 Dealing with the crystal methamphetamine (ice) scourge – urgent need for a change of approach

The recent establishment of the Ice Taskforce by the Premier of Victoria was a clear reflection of the sense of community and government concern about the growing number of people using ice in Victoria and about its serious physical and mental health impacts on users.

The urgency to change our current approach to treatment for young people is demonstrated by the impact crystal methamphetamine (ice) has when taken. Dr Danny Sullivan, consultant psychiatrist, described some of those effects:

> *"So over time the brains of people who use stimulants (which includes methamphetamine) become depleted of dopamine, and in long term use we see a syndrome which is similar to Parkinson's disease, which of course is a disease where your brain reduces its supply of dopamine, and people have the Parkinsonian face, reduced movement, and the sorts of the effects that we see from Parkinson's disease.*[30]
>
> *"In terms of people who go on to develop problems, we know that that correlates to early use, poly drug use and dosage…. in methamphetamine users, the increase in rate of psychosis is 11 fold. So if you take a population of teenagers, those who don't use methamphetamine and those who do, and you follow them up over time, 11 times the number in the methamphetamine group will have had contact with psychiatric services with a diagnosis of a drug psychosis, a psychosis or schizophrenia."* [31]
>
> *"Ice is the drug which appears to be correlated in the main part with offending."*[32]
>
> *"There have been "devastating amounts of the penetration of this drug into teenage groups, indigenous communities and a range of other areas."*[33]
>
> *"Young people are being recruited by motorcycle gangs because they're effective couriers… organised armed robberies conducted by 15 and 14 year olds in the*

[29] "Research informs us that young people are reluctant to seek professional help for substance use and mental health problems." *Turning Point – Adolescent Pathways to Help Seeking for Substance Use Disorders, November 2010 - October 2012.*

[30] "*Methamphetamine – 'Ice' Psychiatric Perspectives".* Dr Danny Sullivan, Assistant Clinical Director, Victorian Institute of Forensic Mental Health (Forensicare) (currently on extended leave), Presentation at the Magistrates' Court of Victoria Conference 10 October 2014. Transcript page 10.

[31] Ibid; pages 10 and 11.

[32] Ibid; page 12.

[33] Ibid; page 21.

northern suburbs and which they associate again, with pressure from motorcycle gangs ….”[34]

Whilst the process of detoxification from heroin and alcohol is painful and protracted and requires medical support due to the physiological effects, Dr Sullivan states that methamphetamine does not “have a significant withdrawal syndrome.”[35] However, the significance of attending a residential facility can mark a transition and “still has a powerful placebo effect.”[36]

“… if everyone around you is using it then it becomes much harder to cease, and that’s why perhaps that residential rehabilitation, the period of time away from the drugs, might be what’s needed.”[37]

When considering appropriate treatment models to deal specifically with ice, the *Inquiry into Methamphetamine Use (Particularly Ice) in Victoria* identified the need to undertake *“…more research into treatment options for specific groups of people who use methamphetamine, including young people and Aboriginal people…”*[38]

The significant issue which continues to arise is the use of substances by young people appearing before the court, contributing not only to their offending but impacting adversely on their health, their participation at school, their safety and other people’s safety in the community.

The lifestyles these young people are living mean that the chances they will attend or regularly attend treatment (at a time in their lives when early intervention could result in their dependencies not being entrenched) are minimal. Given the complex reasons for their drug and alcohol/mental health issues, the treatment model of receiving one session with a psychologist or counsellor for perhaps one hour each week and then returning to their lives is deeply flawed.

There is an urgent need to address these issues and to consider what we can do to intervene and break the existing, dire situation.

What can be done?

[34] Ibid; page 25.
[35] Ibid; page 28.
[36] Ibid; page 28.
[37] Ibid; page 35.
[38] Volume 2 p 676.

5. WHAT WAS THE PROPOSITION TO BE TESTED?

The proposition I sought to evaluate during my Churchill Fellowship was that **a secure (closed) therapeutic residential facility for young people with drug/alcohol/mental health issues needed to be established in Victoria**. It needed to have the capacity to be a closed facility in order to provide an opportunity for therapeutic work to be provided for those young people who, for whatever reason, would otherwise leave.

However, the first fundamental question I needed to answer was – **could mandated treatment make a difference?** If not, then there would not be a justification for such a facility to be proposed.

The second question I needed to answer was **what legislative changes would be required** which would safeguard the rights of the child and also provide for mandated treatment? I reviewed the rationales behind the legislation in the countries I visited, in which mandated treatment was prescribed.

The third question I needed to answer was **what would be the features of such a facility**, that is, what would be required to provide the optimal service with the greatest prospects of success? In order to answer this question, I selected a variety of different types of adolescent residential facilities in the countries I visited.[39]

The final question was **– what, if any, other observations could I make of overseas innovative approaches and initiatives** from which we could learn in Victoria?

I chose to visit Sweden because orders can be made for young people with drug/alcohol/mental health issues to receive compulsory treatment in secure homes. I wanted to examine the legislative safeguards in Scotland when compulsory orders are made for young people to receive mental health treatment. I was interested in observing innovative models for therapeutic treatment in England. Finally, in New Zealand, I wished to observe youth residential drug and alcohol facilities and the Youth Drug Court. I have summarised the major features of the adolescent residential care facilities in Appendix I.

The facilities I visited for young people can be categorised as follows:

Closed youth care facilities

Country	Facility Name	Location
Sweden	Lövsta	Vagnhärad
	Sirius, Bärby	Uppsala
	Sundbo	Fagersta
Scotland	The Good Shepherd	Bishopton, Glasgow
New Zealand	Te Oranga	Christchurch

[39] I also visited three residential facilities which catered primarily for adults. The rationale for including those facilities was to ascertain whether any learnings could be applied to a facility for young people. Regard could be had, for example, to the impressive interior layout and fittings of Helix Forensic Psychiatric Clinic in Stockholm if a youth forensic unit is to be built.

Adolescent psychiatric hospitals – closed units

Country	Facility Name	Location
Scotland	CAMHS (Child and Mental Health Service) Inpatient Unit, Royal Edinburgh Hospital	Edinburgh
	Skye House, Stobhill Hospital	Glasgow
England	The Huntercombe Hospital Maidenhead	Maidenhead
	The Huntercombe Hospital Stafford	Staffordshire

Adolescent drug and alcohol residential programs

Country	Facility Name	Location
New Zealand	Youth Odyssey	Auckland
	Odyssey House	Christchurch
	Te Waireka	Otane, Hawkes Bay

Adolescent residential program for sexual offenders[40]

Country	Facility Name	Location
England	Glebe House	Cambridgeshire

Adolescent drug and alcohol outreach services

Country	Facility Name	Location
Sweden	Maria Ungdom (Maria Youth Centre)	Stockholm
England	The Bridge	Cambridge

Youth Detention Centre

Country	Facility Name	Location
New Zealand	Te Puna Wai ō Tuhinapo	Christchurch

[40] Refer Appendix II

The adult facilities can be categorised as follows:

Psychiatric hospitals

Country	Facility Name	Location
Sweden	Helix Forensic Psychiatric Clinic	Huddinge, Stockholm
England	The Huntercombe Hospital Roehampton	Roehampton, London
	The Retreat	York

Residence for people who would otherwise be homeless and generally have drug/ alcohol/mental health issues

Country	Facility Name	Location
Scotland	James Shields Project	Glasgow

Adult drug and alcohol residential program

Country	Facility Name	Location
New Zealand	Odyssey	Auckland

The boys' house – Te Waireka

6. WHAT WAS OBSERVED?

6.1 Brief comparison of countries' situations

The major drugs young people are using

Given the concern about ice in Victoria, it was interesting to observe that ice is not the same issue for young people in the countries I visited. Alcohol and in particular, binge drinking, continues to be one of, if not the major concern here and overseas.

	Alcohol	Cannabis	Crystal methamphetamine (ice)[41]	Synthetics[42]
Victoria	✓	✓	✓	
England	✓	✓		✓
Scotland	✓	✓		✓
Sweden	✓	✓		✓
New Zealand	✓	✓		✓

Key comparisons – criminal law

The ages of criminal responsibility vary significantly between the different countries I visited. In part, this reflects the welfare approach adopted in Sweden. However, in Scotland whilst the age of criminal responsibility is the lowest, a welfare approach has also been adopted as the children and young people are usually referred to the Children's Hearings System, which I discuss in Section 6.4.

[41] In the countries I visited, there was some use of crystal methamphetamine, but as it was expensive, especially compared to the synthetics, it was not one of the major drugs being used by their young people. In over 10 years sitting in the Youth Drug Court (NZ), Judge McMeeken had not had any young person appear before her who was using ice. However, she was aware of one young girl who had failed to appear in the Youth Drug Court who was being provided with ice whilst she was working as a prostitute.

[42] This includes substances referred to as synthetic cannabis, 'legal highs' or internet spice. Whilst synthetics have been linked to the deaths of some young people in Australia, it is not as prevalent in Victoria as the other drugs in the chart. Synthetics are difficult to detect in urine screens. "…there is increasing evidence of a burgeoning market in what are euphemistically termed 'legal highs' – a greatly heterogeneous, frequently stimulant-based collection of generally novel substances, about most of which little is known, and which do not fall within the existing legal/illegal classifications of substances": Fonagy, Cottrell, Phillips, Bevington, Glaser and Allison, 2015; Kindle p. 12263.

	Victoria	Sweden	Scotland	England	New Zealand
Age of criminal responsibility	10	15	8 (minimum age of prosecution is 12).[43]	10	10[44]
Definition of a child (criminal law)	10-17	15-17	8-15	10-17	10-16[45]
Are there separate secure facilities for children undergoing sentence and for children in care?	Yes	No[46]	No[47]	No	Yes

Key comparisons – secure facilities (child protection)

The extremely limited period of time young people can be placed in the Victorian 'secure welfare' facilities was addressed in Section 4.5. In all of the countries I visited, these strict restrictions do not apply. The number of secure facilities to which a child or young person could be placed for child protection or welfare purposes is summarised in the following chart.[48] It clearly demonstrates Victoria has a much lower rate of secure welfare beds than Sweden or New Zealand:

	No. of Facilities	No. of Beds	Population (Millions)	Beds per Million
Sweden	24	491	9.65	50.9
New Zealand	4	58	4.5	12.9
Victoria	2	20	5.8	3.5

[43] The Children's Commissioner for Scotland anticipates that the age of criminal responsibility will be raised to 12 years. Very few children are prosecuted in court. A child under 16 cannot be prosecuted except on the instructions of the Lord Advocate. Rather than being prosecuted, offending by young people is generally dealt with in the Children's Hearings System.

[44] (NZ) – 10 and 11 year olds may only be charged with murder and manslaughter. 12 and 13 year olds may only be charged with offences if the offending is very serious or persistent. Generally, children and young people aged 10-14 years do not face prosecution in the youth or adult court – but rather their offending is treated as a welfare issue in the Family Court.

[45] (NZ) – 17 year olds cannot be charged and appear before the Youth Court, but orders made when they were younger can continue until they turn 18 and judicial monitoring can include 17 year olds if a supervision order extends past their 17th birthday.

[46] Those young people who are undergoing sentence in have committed very serious offences eg murder, possibly rape.

[47] However, it is very rare for a child to be prosecuted in Scotland.

[48] It is problematic to identify the beds for welfare purposes only in Scotland and England. The statistics for England, for example, include Wales. Further details regarding Scotland and England are included in sections 6.3 – 6.5.

6.2 Sweden overview

The National Board of Institutional Care - Statens Institutionstyrelse (SiS) is responsible for secure homes. I will refer to them as SiS homes. Due to the fact that the system is very different from Australia and the other countries I visited, I will provide a more detailed summary.

Compulsory youth care is provided by SiS at 24 sites throughout Sweden with a total of 547 beds. They provide for children and young people from the age of 12 to 20 who have been taken into out of home care and placed by social services due to child protection concerns[49] and (at six of the sites) young people who have been sentenced by the District Court for criminal offending (56 beds).

I visited the following units at three SiS sites:

- Sundbo (males) - a unit for 12-16 year olds and the open transition unit (older adolescents)
- Sirius, Bärby (males) - the whole facility - drug and alcohol units (16-21) and the open transition unit
- Lövsta (males and females) - the emergency/assessment unit (12-16).

Appendix I provides a summary of the features of each facility.

For the vast majority of young people in a SiS unit, other out of home care placement options have previously been tried and have not succeeded.[50] These previous options include:

- foster family homes
- residential care homes (HVB homes (state owned) and privately owned residential homes).[51] [52]

The SiS sites consist of both closed and more open units. As the word 'open' indicates, those units provide a greater degree of freedom for the young person. Depending upon risk assessments and progress in treatment, the young people are able to progress, ultimately, to an onsite unit from which they are able to leave each day to attend an off-site school or a job, for example.

In 2013, 25,000 children in Sweden were placed in out of home care by voluntary arrangement and 8,000 children were placed in compulsory care of whom 1,000 were placed in a SiS home.

[49] Whilst on occasions 10 and 11 year olds are placed in a SiS home, they should be able to be located in another facility according to Mr Ola Karlsson Rümkorff due to their youth and the mix of ages. He does not consider it is desirable for children under 12 to be placed in a SiS home.

[50] There are also some young people placed in a SiS unit due to an emergency crisis situation and in those cases there may not have been any previous placement.

[51] There are 800 privately owned residential homes in Sweden; which constitutes 70% of all the residential care homes. They are open homes. Only SiS can operate closed homes.

[52] The private facilities are often located in the countryside. The places are paid for by the municipalities (social services). The facility could include babies of drug affected mothers, young children or adolescents. Concerns were independently raised by Dr Pernilla Leviner, Professor Tove Pettersson, Professor Tommy Lundström and Professor Marie Sallnäs regarding the lack of regulation and scrutiny to which the private facilities were subject. There has been a rapid growth in private institutions.

Child protection

The relevant child protection legislation in Sweden is the *Social Services Act 2001¸ Care of Young Persons Act, 1990* (LVU) and the *Parental Code 1949*. Each of the 290 municipalities throughout Sweden has a social services authority with various responsibilities including child protection.[53]

Concerns regarding the welfare of a child are reported to social services to investigate and if necessary social services is responsible for removing a child from the parents' care. In 60%-70% of the cases, the parents consent to a voluntary placement in care.[54]

Compulsory or involuntary action may be taken by social services to protect children if the deficiencies are shown to be very serious and the child runs a 'tangible risk of harm.'[55]

Applications by social services for out of home care are made to a judge alone and in the Administrative Court. Social services then applies to the SiS for a placement. Orders are reviewed by the court every six months.

In 2013, the reasons for admission were:

- Criminal behaviour – 60%
- Drug abuse – 59%
- Generally destructive behaviour – 70% [56]

The young person will receive counselling whilst in the unit as indicated in Appendix I.

The average stay is 5 months.[57]

Criminal law

As previously stated, the age of criminal responsibility in Sweden is 15 years of age. Young people under 15 will accordingly not be charged with any criminal offence. Instead, for those young people who engage in criminal activity, it is generally the responsibility of social services to investigate and intervene.

> *"…juvenile delinquency, in most cases, is handled by child welfare authorities. For several decades, a community consensus has decreed that delinquency in principle should be addressed with general welfare measures and social work on the individual or family level, or both, not punitive actions in a criminal justice frame."*[58]

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[53] The responsibilities also include welfare support, elderly, disability care and treatment for drug abusers.

[54] Professor Marie Sallnäs. She also noted that for some whilst it is categorised as voluntary, there may not have been any other option.

[55] Dr Pernilla Leviner "*Child Protection under Swedish Law-Legal Duality and Uncertainty*." 2013 European Journal of Social Work page 8 (s 1 Care of Young Persons Act 1990).

[56] Statistics provided by SiS-Mr Ola Karlsson Rûhmkorff 14 October 2014: Girls are over represented – this includes prostitution, for example, or a 15 year old living with older male drug addicts.

[57] Statistics provided by SiS-Mr Ola Karlsson Rûhmkorff 14 October 2014.

[58] "*A Comparison of Out of Home Care for Children and Young People in Australia and Sweden – Worlds Apart?*" Karen Healy, Tommy Lundström and Marie Sallnäs Australian Social Worker Vol. 64 No. 4 December 2011 p 416 at 422, 423 with reference to an earlier study (Ginner Hau 2010; Swärd 1993).

> *"Basically, we regard criminality and problems associated with that as a social problem for young people and not as a justice problem so ours is treatment basically, not punishment. That is what is guiding our system."*[59]

Even for those young people over 15 and under 18 who may be involved in criminal activity, the police and public prosecutor may refer the case to social services rather than have the charges proceed before the court.[60]

When a child is sentenced they are sentenced under the Penal Code. The sentencing options available and the numbers of young people sentenced in 2013 were as follows:[61]

Fine	1067
Youth Service (may include treatment and/or community service)	1322
Suspended sentence	29
Probation	30
SiS Youth Care	30[62]
Imprisonment[63]	4
Forensic Psychiatric Care	2

Judge Egelin confirmed that the young people sentenced to SiS Youth Care have committed the most serious criminal offences which could include murder, manslaughter or rape.

The Penal Code provides "if someone has committed a crime before he or she has turned 18 years old and the court finds that the sentence ought to be imprisonment, the court shall instead order a sentence of closed youth care for a duration specified by the court. This section is nevertheless not applicable if, when considering the accused's age at the time of the prosecution or other circumstance, special reasons exist against closed youth care."[64]

Whilst there are no longer any youth prisons or detention centres in Sweden, as some of the young people have been sentenced for such serious offences, the level of security observed at one of the facilities I visited, the Aspen Unit at Sundbo, was substantial. At that time, there were two young people serving sentences for murder (see photo next page).

[59] Professor Marie Sallnäs 17 October 2014.
[60] Christina Kiernan, Project Manager, Community Intervention Teams (for young offenders) 23 October 2014.
[61] Statistics provided by SiS-Mr Ola Karlsson Rûhmkorff 14 October 2014.
[62] Historically, this figure has been around 100 per year.
[63] As the statistics indicate, and they are consistently very low, there are very few young people who are sentenced to imprisonment in Sweden. If they are, the sentence will be served in a youth unit but in an adult prison.
[64] Penal Code Brottsbalken: 32 Kap. 5: Re surrender of youth to exclusive care. Throughout my visit in Sweden, young people sentenced to a SiS youth care secure facility, were referred to as being sentenced according to LSU.

When a young person is sentenced to SiS Youth Care they are sentenced for a fixed period to remain at a SiS facility. There is no parole system. The sentence range for closed youth care is a minimum of 14 days and a maximum of 4 years. The average stay for those sentenced is 10 months. [65]

Initially, they must commence serving their sentence in a locked unit. Staff continually conduct risk assessments and depending on the level of risk, the young person may serve all of their sentence in a locked unit[66] or may progress to a more open unit at the SiS facility. For the last two years, young people nearing the end of their sentence may be able to attend a nearby city for training or further studies.

On completion of their sentence, they will leave the facility unless social services considers that their circumstances warrant them remaining in care. If so, social services may apply to the Administrative Court for an order that the young person continue to remain in the SiS facility.

SiS Homes

Each facility is divided into a number of smaller units, for example, consisting of 6–8 young people. The Units are divided according to age. There are units for 12–16 year olds and 17–20 year olds.

There are two units which accommodate mixed genders.[67] There are specialist units, for example, for those young people suffering drug and alcohol abuse, sexual offending and violent and aggressive young people.

There is a high staff ratio which includes psychologists, psychiatrists, doctors, nurses and treatment officers. Some of the specialists will be consultants and not on site.

For those with drug and alcohol issues, detoxification can take place on site at SiS units. During the first 8 weeks, a number of assessments are conducted, for example, psychological, cognitive, education, physical and mental health and risk assessments.

The young people will receive compulsory treatment dealing with their needs as identified in an individual treatment plan or as agreed with Social Services.

The majority of young people have struggled at school or left school early. Each facility has a school[68] which is registered and studies are accredited and will be recognised when they leave. The ratios of staff to young people in the facilities are high, for example three staff to one young person. In school they may be one to one or one to two.

[65] Professor Tove Pettersson 15 October 2014.
[66] For example, young people who have committed sexual offences and are in denial may serve the entire sentence in a closed unit.
[67] The unit which I visited at Lövsta had both boys and girls aged 12-16 years. Next year however the boys and girls will be placed in separate units, although they will continue to attend the school together.
[68] At Sirius, the young people are over 16 years of age and not required to attend school. Provision is made for those who wish to attend the school at a nearby SiS facility once per week.

6.3 Overview of Scotland, England and New Zealand

In all of these countries, consistently with Sweden and Victoria, the priority is for children to remain at home, provided it is safe for them to be there. The same unfortunate issues confront their young people also. Secure homes are utilised when children in care cannot be placed in less restrictive homes or when they have been sentenced for criminal offending. Education is a critical element in the secure homes.

In England and Scotland, some of the individual secure homes cater for both children in care and those who have been sentenced. In New Zealand, there are separate secure facilities for young people in out of home care and for those on remand and undergoing sentence. An overview of the key features and procedures for children and young people who offend or are in the child protection system in each country follows:

6.4 Scotland

In 1971 Scotland introduced Children's Hearings[69] which are conducted by a quasi-judicial tribunal constituted by 3 lay volunteer members. There is a review procedure to the Sheriff Court. One of the core principles when Children's Hearings were introduced was that:

> **"whether they require care or have offended, children or young people in trouble have similar needs and those needs should be met through a single system." [70]**

Unless the type of offending involves murder or rape, it is "extremely rare"[71] for a child under 16 to be prosecuted.[72] Once the young person turns 16 years of age they will be subject to the adult criminal justice system.

There are five secure homes in Scotland providing 90 secure care beds for children and young people who have been sentenced or placed there for welfare reasons.

A Children's Hearing has jurisdiction to make a Compulsory Supervision Order (short or long term) which could require the child or young person to be placed in a secure home and receive drug and alcohol counselling or treatment.[73] The orders are reviewed every 12 months.[74]

The criteria for a young person to be admitted to secure care are that:

- the young person has previously absconded and is likely to abscond again, and if the young person were to abscond, it is likely that their physical, mental or moral welfare would be at risk; or
- the young person is likely to engage in self-harming conduct; or
- the young person is likely to cause injury to another person. [75]

[69] Social Work (Scotland) Act 1968.
[70] *Kilbrandon Report 1964 Background to the Children's Hearing System*, Children's Hearings Scotland.
[71] Mr Boyd McAdam, National Children's Hearings Convenor 27 October 2014.
[72] In 2013/2014, of 19,077 children who appeared before the Children's Hearings, 17,476 were child protection and 2,764 were for criminal offending.
[73] Sherriff Alan Miller 28 October 2014.
[74] They could be reviewed more frequently if required.
[75] s 83(6) Children's Hearing (Scotland) Act 2011.

Compulsory orders for treatment for a mental illness may be made under the *Mental Health (Care and Treatment) Scotland Act 2003*. Compulsory orders cannot be made for drug and alcohol abuse under this Act; however if substance abuse is a contributing factor to a psychosis, for example, the substance abuse would be treated. The same situation applies in England.

6.5 England

Secure children's homes cater for children and young people placed by local authorities or courts due to welfare concerns or who have been remanded or sentenced for criminal offending.[76] Children and young people between the ages of 10 and 17 who commit criminal offences are generally dealt with by youth courts[77] and if they are to be detained they are sent to secure centres, not adult prisons.

A child or young person aged 12-17 may be sentenced to a Detention and Training Order[78] which may be served in:

(i) a secure children's home

(ii) a secure training centre[79]

(iii) a young offender institution[80]

Whilst both males and females between the ages of 10 and 17 may be placed in secure children's homes, they generally cater for those children aged 12-14 who have been sentenced and up to 16 years of age for welfare concerns. There are 16 secure children's homes in England and one home in Wales with a total capacity of 298 beds for England and Wales.[81]

Two elements of my visit to England were of particular significance because they both (in different ways) provided outstanding adolescent engagement models - Glebe House (refer Appendix II); and The AMBIT Model, an outreach adolescent drug and alcohol service (refer Appendix VII).

6.6 New Zealand

Family Group Conferences (FGC) are a unique feature of both the child protection and the criminal justice system in New Zealand. The FGC is "a mediated formal meeting between family members and other officials such as social workers and police in regards to the care and protection or criminal offending of a child or adolescent."[82] In the criminal justice jurisdiction,

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[76] From 31/3/2013 – 31/3/2014, 48% were detained or sentenced by the Youth Justice Board, 45% by the Local Authority for child protection and 6% by the Local Authority in a criminal justice context. Department of Education Statistical First Release Children Accommodated in Secure Children's Homes England and Wales, p 4.

[77] If they commit a very serious offence, eg murder or rape, they will be sentenced by the Crown Court.

[78] s 100 *Powers of Criminal Courts (Sentencing) Act 2000*.

[79] There are four secure training centres in England. They are privately operated. Young people aged 12-17 years may be remanded or serve their sentence in a secure training centre. There are 50 to 80 people detained in units of 5-8 people. Education is provided.

[80] There are six Young Offender Institutions in England. They are run by the Prison Service and private companies for young people aged 15-21. Those under 18 are detained in different buildings from the older young people. Young Offender Institutions hold 60 – 400 people, in units of 30 – 60 people.

[81] Department of Education *Statistical First Release Children Accommodated in Secure Children's Homes at 31/3/14 England and Wales*; pp 1&6.

[82] Wikipedia 10 February 2015.

compliance with a FGC Plan may result in the matter not proceeding in the Youth Court or, if it does proceed, compliance may result in a discharge.[83]

In New Zealand, child protection matters are heard in the Family Court. If a young person is unable to reside at home due to protective concerns, the placement options in order of priority are:

- foster care
- family homes (maximum of seven young people, professional foster carers)
- supervised group homes (staff on a roster 24/7)
- secure residence.[84]

If a young person 10-13 commits a criminal offence[85] their case is heard in the Family Court. It is dealt with as a welfare concern. For those aged 14-16, their cases are dealt with in the Youth Court unless the offending is so serious that it is transferred to the District or High Court.

The most serious order which can be imposed is a supervision with residence order. This is a detention order to be served in a secure youth justice centre. The minimum sentence of detention is 3 months and the maximum is 6 months. Upon release, the young person must be supervised in the community for not less than 6 months and not more than 12 months.[86]

The secure residences in New Zealand are:

	No. of residences	No. of beds
Child Protection	4	58
Youth Justice	5	140
Other	1[87]	12

I visited two secure facilities in New Zealand, Te Oranga (child protection) and Te Puna Wai (youth justice).

There were a number of initiatives which I observed in New Zealand, namely the 'Crossover List' in Manukau and the Youth Drug Court in Christchurch; both of which I am recommending be introduced in Victoria (refer sections 11.1 and 11.2 of this report).

[83] s. 282 *Children Young Persons and Their Families Act 1989*.
[84] Michelle Hughes, Te Oranga 1 December 2014.
[85] Except for murder and manslaughter.
[86] The young person may serve two-thirds of the sentence in detention. s 311 Children Young Persons and Their Families Act 1989.
[87] Te Poutama Arahi – for young people displaying sexually abusive behaviour.

7. CAN MANDATED TREATMENT BE EFFECTIVE?

7.1 Compulsory versus voluntary

As this report has established, the current voluntary system is not working for many young people.

It would be naïve to suggest, in light of the deeply entrenched issues that so many of these young people have, that any type of intervention would solve their problems and be 100% successful. However, an improved intervention represents the possibility that, as many of the experts have explained to me, even if not successful at first, they can 'sow a seed'[88] in treatment and provide the opportunity for the young person to reflect and to make informed decisions about their futures.

Given the seriously troubled and deeply traumatised nature of the young people we are seeking to support, it is very difficult to determine relative levels of success. SiS reviewed the young people placed in secure homes and their research has established that one third of them moved on to live productive lives.

Some practitioners with whom I spoke identified 'success' as sometimes reducing the seriousness of offending. Importantly, some young people spoke about the fact that they may not have still been alive if intervention had not taken place.

It was necessary to determine whether mandated treatment can be effective. I spoke to many young people and experienced practitioners. Whilst some people felt that treatment needed to be voluntary, **the overwhelming views were that mandated treatment can work as effectively as voluntary treatment. In both cases, ongoing support is essential.**

In this section, I will leave it to a sample of those with whom I spoke to express their views about voluntary[89] and mandated treatment:

Young People:

> *"I didn't want to come here. But I couldn't do it on my own. I'm really scared to think of what could have happened if I hadn't come here… I could have died."*
> Peter, 18, Sundbo

> *"It was hard when I first came because it was so different to the life I was leading. But everyone was so supportive when I came here that it made me want to stay. I felt safe and I hadn't felt safe for a long time. My life was all about scoring. I couldn't live at home and whenever I saw my mum we fought - mainly about drugs. Since I have been at Odyssey one of the highlights is seeing my mum each week. Our relationship is so*

[88] Hans Palmetorp, Susanne Williams and staff at the James Shields Project.

[89] The word 'voluntary' is difficult to define in this context because the young person may be otherwise facing a term in detention or may be in a 'voluntary' facility because their parents required it.

much better. She told me she was proud of me." Melanie, 17, Youth Odyssey Auckland

"When I entered Odyssey House, I couldn't believe that I would only be able to have things that were necessities and not what I liked or wanted or I was used to having. Initially I did not think I could cope without my phone, Facebook, makeup, my hair straightener. I could not imagine waking up each day living with a bunch of strangers and not wearing makeup. But then it wasn't so bad. I realised it was great not having to worry about Facebook and my phone. I realised such things were a burden. When I didn't have those things I was able to get back to who I really am. I feel for the first time like the girl I used to be - the real me and I can laugh at the things I used to laugh at. I am happy again." Tara, 16, Youth Odyssey Auckland

"Even if I'd been sent here, it would mean I'd have a chance to make a difference". Lavinia, 16, Te Waireka

"We're just kids – you guys are the adults. We're teenagers, we're rebellious, we don't like to admit it. You're wiser and isn't it up to you to know what's best for us." Tara, 16, Youth Odyssey Auckland

Professionals:

Sweden

"Some of the youth actually think that it might be helpful for them because they know they have to be there. The staff would say it gives them time to actually work with them. One thing with secure (accommodation) is that you can get a lot of treatment and not have breakdowns in treatment ...breakdowns in treatment are very bad for youth."[90]

"It does happen, even though it's very rare, that boys volunteer to come here. It could for example be when they feel that they can't control their drug abuse anymore. But still it's very rare. I would also say that it's very rare that the boys want to stay at our place. I would rather say that many of our boys are very resistant when they first come to Sundbo, but after a period of time they often come to be much more comfortable with our place as well as being able to enjoy at least parts of it because they make friends here; the staff genuinely care for them; they feel safe; they don't have the worries they have outside; and they feel healthy and meals are provided."[91]

(Compulsory v voluntary) *"I think it's both. It's not black and white because (for example) we told a guy 'you need to talk about your alcohol abuse if you want to move forward'. From the beginning it's 'no, I do not have a problem', but with the right person, a lot of things happened with him, so he understood he has this problem. Because it was compulsory, he had to confront it."*[92]

[90] Professor Tove Pettersson 15 October 2014.
[91] Kristin Wahnström, Sundbo 16 October 2014.
[92] Karin Olsson, Sundbo 16 October 2014.

> *"They're put here by force. They don't want to be here....there is a turning point....when you can see your drug use and behaviour in some kind of mirror. You can see it from a distance and you can realise that this is not good for me when you have perspective and you can see what you have done: what it means for your parents…what it means for you and your girlfriend...if I continue, this is going to be the end of my life."*[93]

(Compulsory treatment) *"For a time (and it is a relatively short time) in a young boy or girl's life, I think it's good to have this opportunity because otherwise it's too late."*[94]

> *"For a long time, we considered treatment had to be voluntary...but here, they studied groups, one mandatory and the other voluntary and they couldn't see any difference. If you are already in a closed institution you could make them go through treatment and it might work as well as if they said they want it and especially young people who change their mind all the time.....their ability to make decisions is affected by drugs and they are so young."*[95]

(Compulsory) *"Absolutely...sometimes they require a closed facility because nothing else is working (eg one boy who is drunk every day and refuses assistance)."*[96]

Scotland

> *"When the young people first arrive, generally they will say they don't want to be here, they hate it - within one or two days there is a shift - the staff look after them, they are away from poverty and for some being homeless."*[97]

"(Compulsory?) "I think especially for the younger kids because I think they don't see themselves in 10 or 15 years' time being an addict that's begging in the streets. That's because it's always 'That won't happen to me', so I think for some kids things have to be compulsory. Something that might start off compulsory does not end up that way for them because the thought process changes during that (the treatment). It might be that they resisted it at the start because you're putting the order on them and saying it's compulsory for you to do that, but I think from there to what interventions you're then implementing, whether it's a treatment centre they've gone into or a program that you're running, they're in that centre because they really need it."[98]

> *"When I worked with addictions previously, we did have people coming to us when it was compulsory for them to be there, but over time they wanted to be there because they liked what they were seeing; they liked*

[93] Anders Ermann, Sundbo 16 October 2014.
[94] Annica Pettersson, Lövsta 21 October 2014.
[95] Åsa Wallengren, Swedish Prison and Probation Service, National Coordinator and Project Manager, "Young Offenders Violent Offenders" 21 October 2014.
[96] Mikael Jeppson, City of Stockholm, Social Youth Emergency Service 22 October 2014.
[97] Robert Clark, The Good Shepherd 28 October 2014.
[98] Lorraine Fraser, James Shields Project 29 October 2014.

how they then started feeling; and having a bit of time out, especially some young kids whose families are chaotic as well. So what choice, really, would they have if you were not making things compulsory for them?"[99]

England

"It seems to me – I think it's a false dichotomy between mandated treatment vs voluntary treatment. The Mental Health Act requires the least restrictive possible response. If you can get away with voluntary without mandating, that's great, but where there's absolutely no volunteerism and there's risks to self and other people, the situation is very clear that you can't keep harming other people and their property."[100]

(Question of mandatory orders to contain young people) *"They'd be better off if it is more like a secure children's home set up with access to psychological therapies. Not all of them will take it up, but it would be in a safe environment - that's better than having people just roaming about."*[101]

New Zealand

"There is not really any difference between those who volunteer and those who are here as part of a court order in terms of how effectively people engage in treatment."[102]

"I think that coercion and compulsion can work. We certainly coerce these kids in a sense in that they know they run the risk of youth detention or even adult gaol. Some young people have to be totally secure...There's certainly, in my view, a place for compulsion. I can always lock people away, but I can't always put them in rehab."[103]

"The research indicates there is not very much, if any, difference in the results between voluntary and compulsory. Once there, it's about the exposure to some of the thinking and reflection that goes on and that's the most important thing."[104]

Victoria

"*There's a lot of discussion about whether mandated drug treatment, the sort of things that you (as judicial officers) have the power to do, is more effective than voluntary. I think it's a fallacious argument. If you've got someone in front of you and you could impose a sentence, which is going*

[99] Lorraine Fraser, James Shields Project 29 October 2014.
[100] Dr Dickon Bevington 11 November 2014.
[101] Dr Mark Tattersall, Huntercombe Hospitals 5 November 2014.
[102] Pat Williams, Odyssey Auckland 21 October 2014.
[103] Judge Jane McMeeken 27 October 2014.
[104] Chris Rewha, Te Puna Wai 1 December, 2014. Nigel Laughton, Odyssey Youth Christchurch, shared this view.

to reduce the likelihood that they use methamphetamines, then why would you not? Why would you not do that?"[105]

7.2 Institutions – never again?

It is acknowledged that whenever reference is made to a secure residential facility for children and young people, the first response of some or perhaps many, will be "Do you want to institutionalise these kids again?" The word "institution" has become synonymous with the abuse of children and young people, with the outside world being "locked out" and with nobody protecting the vulnerable children or young people from within.

In addition to the physical, sexual and emotional abuse for which many institutions have become infamous, there are other potential negative consequences of institutional care which have been identified by Mr Nils Åkesson, Research and Development Director, SiS, Stockholm:

- young people being separated from the normal maturation process;
- family ties are temporarily cut or weakened;
- the obstruction of the development of social skills;
- negative peer influences;
- possible interruption to education;
- responsibility for everyday life is limited;
- compulsory care is in itself offensive.[106]

He also identified in the same presentation the potential advantages of institutional care:

- offering shelter in a situation of chaos and anxiety;
- putting a halt to destructive behaviour, such as drug abuse;
- inhibiting young people from developing antisocial norms and behaviours "out there";
- compensatory schooling, health care and social training activities of daily life;
- influencing the young people all day, every day, building alliances between the staff and the young people.

The Royal Commission into Institutional Responses to Child Sexual Abuse has published its Interim Report. It has described horrendous, almost unimaginable abuse to which the most vulnerable children and young people were subjected. In my view, however, much has been learnt from these evil practices.

There is undoubtedly a requirement for transparency, accountability, scrutiny and oversight. In addition to judicial oversight, there would be a vital role for such organisations as the Commission for Children and Young People. The Commission has been described as playing "an important role in overseeing and improving accountability of services for children's health and

[105] Dr Danny Sullivan; op cit. p 30.
[106] SiS – Presentation by Nils Åkesson: *The History of Swedish Youth Care*.

wellbeing and provide a strong voice for children."[107] There will be court oversight. **There must be a commitment to ensure the past mistakes are not repeated.**

I have considered all of the possible treatment options instead of requiring a young person to be placed in a secure residential facility. However**,** my Churchill Fellowship observations have confirmed my initial view and in fact, strengthened my resolve that with the safeguards in place, for some children and young people who for whatever reason cannot or will not, access voluntary services, it is the only possible option.

I have purposely used the word 'therapeutic' to describe the residence and it is not a matter of semantics. The facility cannot be and cannot be seen to be a punitive response. For many young people appearing before me in the Children's Court that is their perception of secure welfare. When they are told they are going to be placed in secure welfare, they will say "please don't lock me up. I'll be good."

If young people feel they are being warehoused or sent to the proposed facility for punishment, they will disengage as it will reinforce for them that they exist on the margins of our community and that they do not have any value. As Dr Bevington observes:

> ***There is ample evidence that it (treatment) doesn't work in a draconian lock up punitive environment.***

Using the correct language will be important:

> **"Terminology, language is important – it needs not to be punitive ….if you have a dialogue with them in an open and articulate manner, they are going to understand it's beneficial for them."**
>
> Dr Dan Anderson, Medical Director, The Retreat

The first words spoken to the young person at the residence on arrival and the way they are treated from the outset, will be crucial, particularly given that he or she will be a troubled young person. One young person at Glebe House highlighted that being able to wear his clothes and have photographs of his family were for him one of the most significant differences between Glebe House and serving a sentence in custody.

The culture of the residence needs to result in the word on the street being that it is a positive, caring place where young people feel safe; they may not wish to go there initially, but they are able to see the benefits.

The first 'institution' to which every child and young person belongs is the family. The family nurtures the child and young person and provides guidance and support; a sense of self; and a sense of safety and security in which the child and young person can grow and develop. In such an environment, children and young people understand almost subliminally that they are cared about and valued and that they matter. It is those values which need to be reinforced and replicated as far as possible in a therapeutic facility. Based upon many of the facilities I visited, I believe it is possible to achieve this objective.

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[107] *Commission for Children and Young People Annual Report 2013-2014* at page 40 (referring to Victoria's Vulnerable Children Strategy May 2013).

8. THE PROPOSED MODEL

As a result of my Churchill Fellowship, the model I am proposing to assist in addressing my core concern is:

1. The young person appears before the Children's Court of Victoria and has substance abuse/mental health issues.
2. The Children's Court receives an assessment report confirming that the young person requires intensive support to address these issues.
3. The Children's Court determines that a Youth Therapeutic Order should be made.
4. The Youth Therapeutic Order places the young person in a secure therapeutic community facility in order to detoxify, if necessary, and to engage in treatment (eg CBT,[108] DBT[109]) with appropriately qualified and committed staff. There would be intensive individual and group counselling.
5. There would be judicial oversight regarding the progress in treatment of the young person.
6. The young person would attend a school on site, providing access to education and training.
7. There would be a transition to an open therapeutic community residence, which would ideally be on the same site as the closed facility. The clinicians would work with the young people at both residences, to ensure continuity.
8. There would be a well-resourced transition plan for the young person to return to the community. This could include:
    - outreach from the residential facility;
    - a clinician with whom the young person has established a rapport, prior to entering the facility and who continued that rapport whilst the young person was in the facility; and
    - a house, off site, with some support, with the aim that the young person would fully engage in the community.
9. The Court would have regard to the progress of the young person, when determining an appropriate sentence or child protection order.

[108] Cognitive Behaviour Therapy.
[109] Dialectical Behaviour Therapy.

9. WHAT LEGISLATIVE CHANGES WILL BE REQUIRED?

Legislative amendments would be required to the Children, Youth and Families Act 2005 in order for the Children's Court to have the power to place a young person in a therapeutic residential facility as I have described.

I am proposing that the Youth Therapeutic Orders be for a period of six months (allowing time for adequate levels of protection and intervention), subject to judicial oversight and other checks and balances. Applications could be made to vary, revoke or extend the order. Rights of appeal should also be provided.

The placement in a closed facility involves a restraint on a young person's liberty. There are fundamental human rights as detailed in the *U.N. Convention on the Rights of the Child* and *The Charter of Human Rights and Responsibilities Act 2006* (Vic). Appendices III and IV summarise a number of key matters which are relevant when considering the principle of proportionality: competing interests of a person's liberty and their need for treatment.

As I have previously indicated, Victoria already has legislation – the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, the *Disability Act 2006* and the *Mental Health Act 2014* – which prescribe procedures whereby orders may be made for young people to compulsorily receive treatment. There are a number of statutory safeguards included in these Acts, for example, rights of appeal and a complaints procedure.

Young people would be legally represented and there would be judicial oversight and possibly a role for the Commission for Children and Young People and/or other independent bodies.

Ms Valerie Mays, Legal Secretary to the Mental Health Tribunal for Scotland[110] stated in relation to compulsory treatment orders:

> *"The Tribunal would see proceedings before it as an important part of the care and treatment which will eventually, hopefully, lead them (the patient) on the road to recovery. So it's not actually a bad thing… it's something that's needed at that particular point in time because they meet the statutory criteria, but there are all the layers of protection… It is a principle of reciprocity – a 2 way street – if detained, the patient has to get something out of it. Appropriate treatment for a mental disorder is not about just being detained and things being done to you."*

The purpose of a young person being placed on a Youth Therapeutic Order in Victoria would be for them to receive the intensive support and treatment they require, including effectively dealing with the underlying causes of their drug/alcohol/mental health issues. The proposed Youth Therapeutic Order would be able to be made for children and young people in both the Family (child protection) and Criminal Divisions of the court.[111] Whilst I acknowledge the concerns of a young person in child protection being potentially tainted by those who have been charged with criminal offences, for the following reasons it is recommended that the Youth Therapeutic Order should be able to be made in both Divisions:

1. I have highlighted the significant crossover of young people in both Divisions.

[110] The Tribunal has the power to make compulsory treatment orders to detain people (including children and young people) who have a mental illness for treatment.
[111] The Carney Report 1984 identified compelling reasons to establish separate Family and Criminal Divisions of the Court.

2. The use of drugs and alcohol, albeit a health concern, also constitutes offending.

3. It would be contrary to public policy for a young person in the Family Division to be required to commit an offence in order to be eligible to be placed in the facility.

4. Mr Peter Clarke, Director of Glebe House, provided the following insight:

> *"It is generally useful… [to have the mixture of young people who enter the program via criminal justice and those who enter via the care system]. Monocultures often act to support the institutionalised aspects of the culture (eg. the staff v lads dynamic of the secure estate). It also highlights the somewhat random responses to offending within criminal justice systems. It is common for two young people to sit in the same group with similar profiles and very different responses (one with no record and one with a high tariff response)."*

5. Ms Renee Berry[112] who was a Team Leader at Youth Odyssey Auckland responded to the question – "Is there a mixture of young people from the Youth Court and child protection? If so, do you think there are any positives or shortcomings in having a mix?"

> *"Yes and the mix is imperative. From some of the research (and experience) we have learnt that groups of kids (eg. Youth Court/court ordered) come with typical traits or diagnoses. If we take court ordered young people, for example, we have seen that they often come with diagnoses of Conduct Disorder (CD). If we had an entire residential facility full of young people with conduct disorder, it would be chaos! The literature also clearly states that this scenario limits change for those with CD… What I have learnt is that the house/staff can work with and accommodate one or two people with active psychosis, one or two kids with CD, one or two girls with borderline personality traits, one or two highly institutionalised young people, multiple high functioning young people…"*

One of the key differences to some of the secure homes in Sweden, Scotland and England, would be that a young person could not be sentenced to the therapeutic residential facility. The rationale being that it would introduce a punitive environment, that is, one of punishment. However, a young person could be bailed to the facility on the Youth Therapeutic Order and this would assist in providing a motivation for them to address their drug, alcohol and mental health needs. When sentencing, the Court would have regard to the extent of engagement in treatment. It may result, for example, in the young person not being sentenced to detention.

The fact that the facility has the capacity to be closed, may also result in some young people in the community voluntarily engaging in treatment, when perhaps they otherwise may not.

I propose that a multidisciplinary Steering Committee be established as soon as is practicable in order to consider and make recommendations regarding all of the elements outlined in Sections 9 and 10 of this report.

[112] Masters in Psychology. Previous experience in establishing a Young Adult Program at Odyssey House (17-24 year olds) and project management in crisis youth mental health.

10. WHAT DO EFFECTIVE RESIDENTIAL THERAPEUTIC TREATMENT FACILITIES TO ADDRESS THE PROPOSED MODEL LOOK LIKE?

As a result of visiting the numerous residential programs, I propose the following critical elements need to be addressed to maximise the opportunities for the model to succeed:

1. Committed and high quality staff;
2. Assessment;
3. Location of the facilities;
4. The nature of the onsite buildings (both secure and open elements);
5. A therapeutic community model;
6. A 'step down' facility as part of the transition;
7. Support for the young person after leaving the residential facilities;
8. Democratic principles;
9. Culture;
10. Education;
11. Professional development and support for the staff;
12. External scrutiny.

10.1 Committed and high quality staff

The most critical requirement for a successful residential program is the quality of the staff. The essential qualities which they need to possess (in addition to relevant professional qualifications) are that they:

- relate well to the young people
- care and can show they care
- can instil trust
- have empathy
- can inspire and motivate
- are nurturing
- can provide positive reinforcement
- are excellent role models
- are able to set boundaries
- are professional
- are patient
- are forgiving
- require accountability from the young people
- treat the young people with respect and dignity.

These qualities apply to all of the staff at the residence. Dr Mark Tattersall, Medical Director and Consultant Psychiatrist at Huntercombe Maidenhead observed that everyone in the team has a role. He referred to a young person forming an appropriate relationship with a cleaner, a person who is not threatening and a consistent person who takes care of them. At Te Oranga, there were kitchen staff who have been working there for a number of years and spoke with obvious enjoyment and satisfaction regarding working with the young people.

A number of the young people referred to the benefit of having some staff who have previously had dependency issues as they had "walked in their shoes" and had an in depth understanding of what they were feeling. Odyssey House (Auckland-Youth) refers to these staff as 'interns'.

Renee Berry stated as follows –

> *"Odyssey has a commitment to having what we call 'interns'. They are people who have completed the programme (at least 2 years prior) and are employed in support worker/intern roles. Odyssey supports the interns to undertake relevant study and full time employment….a fabulous intern can be an amazing asset… a real life model for our kids and can give great perspective to the staff. Interns require quite specific support and encounter challenges not shared by other staff. Odyssey has supports specific to our interns including a peer group for staff who have received treatment (not necessarily within Odyssey). There is a forum where they can address/talk through and receive peer supervision around their specific challenges."*

There were some reservations raised by others, but all acknowledged the potential benefits, provided there were stringent guidelines and criteria.[113]

10.2 Assessment

In addition to the assessment that will be required to be made before the Children's Court can determine whether a Youth Therapeutic Order is appropriate, regular assessment of each young person will be required in the treatment facility. All of the treatment services I visited have a detailed assessment conducted when the young person enters the residence (for example, ADAD[114] in the SiS homes). Risk assessments are also regularly conducted, progress in treatment is reviewed and there are regular care plan meetings conducted. The ongoing onsite risk assessments determine the level of security required for each young person. Some (particularly just following arrival) require 24-hour 1:1 monitoring. As the level of risk is seen to reduce, then the relative level of security in accommodation would progressively decrease.

10.3 Location of the facilities

Appendix V provides an analysis of the different sites and settings of the residential facilities I visited**.** As this analysis indicates, there are advantages and disadvantages of all visited sites. In view of the urgent need throughout Victoria, ideally a number of therapeutic residential facilities should be established in Melbourne and throughout the major regional centres of

[113] For example, Erik Sandström, James Shields Project management and Pat Williams.

[114] Adolescent Drug Abuse Diagnosis (questionnaire prepared and managed by the Belmont Centre for Comprehensive Treatment, Philadelphia, USA) is a comprehensive assessment tool that can be effectively utilised for mental health and other wellbeing issues in addition to substance abuse analysis.

Victoria. This would meet the demand in the regions and enable critical after care to be provided near to young people's homes.

However, due to the fact that there are currently no dedicated therapeutic treatment facilities of the type I am recommending in Victoria, if the initial decision was to develop one such facility, it should be in an accessible location in or near metropolitan Melbourne due to its centrality and proximity to the majority of family members and appropriately trained professionals. On the basis of my conversations and observations, the ideal number of children or young people per secure unit is 8-12. There may be more than one secure unit on the site. Subject to the management decisions that need to be made by the service provider, consideration should be given to mixed-gender units where practicable as they reflect everyday life.

In determining a location, serious regard should be given to any available, suitable homes with a 'homely feel' that can be made secure as in my view they provide the optimal setting for a young person (see Section 10.4). The possible presence of drug dealers has to be managed.

Provision should be made for siting open 'step-down' units or bungalows (or open elements in the main building) onsite so that the young people can develop independent living skills before leaving (refer Section 10.6).

Other possible siting considerations include:

- If the State Government is intending to establish a youth forensic facility as per the recommendation of the VLRC (refer Section 4.7.1), consideration could be given as to whether the therapeutic residential facility should be located on the same site. The competing factors to be evaluated would be the benefits of having suitably trained and experienced professionals readily accessible versus the stigma that may be attached to a forensic facility detracting from the therapeutic, non-punitive culture that must be established at the proposed new facility.
- Ascertaining the views of ORYGEN Mental Health regarding the links which could be established with Headspace services; or considering enhanced links with hospitals as applies to the Maria Ungdom adolescent service in Stockholm.

10.4 The nature of the buildings

Whilst it is fully appreciated that the therapeutic facility needs to be secure, the most homely and inviting facilities and in my view, the most appropriate for young people were those that were either located in a home, such as Odyssey House Auckland (young person's and adult facilities) or made one feel at home. These photographs highlight the 'feel' of being in a home:

Odyssey Youth, Auckland

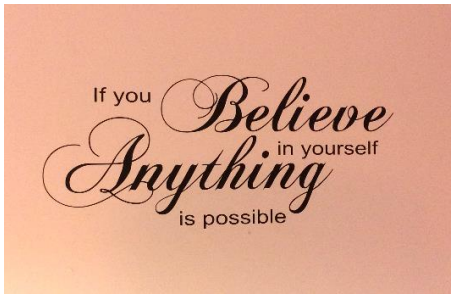
Huntercombe Maidenhead

I had not anticipated feeling that way in a hospital and yet the Huntercombe Hospitals at Maidenhead and Stafford each had a closed unit which felt like a home and yet were secure. Whilst a young person at risk of self-harm or harm to others may need to reside in very secure surroundings, it remains important that from the beginning the young person feels welcome.

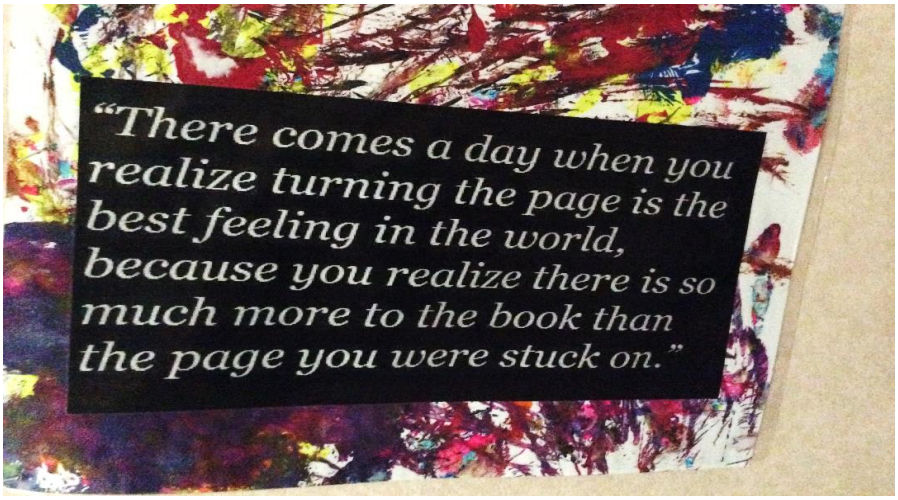
Some of the purpose-built facilities felt like a home in the lounge and kitchen areas but felt like an institution in the bedroom areas, with the bedrooms being located on either side of a central corridor. One exception was a specially built home, away from the main residence at Odyssey, Auckland (adults). It was the residence for mothers and their babies. It was very well designed and felt like a home.[115]

In addition to schools (referred to in Section 10.10), quality recreational facilities are essential.

One of the other features in the residences which the young people said they appreciated were inspirational messages on the walls emphasising hope.[116]



James Shields Project



Te Waireka

10.5 A therapeutic community model

One definition of a 'therapeutic community' is:

"…a participative group-based approach to long-term mental illness, personality disorders and drug addiction….it includes group psychotherapy as well as practical activities."[117]

Key elements of any group approach are honesty and trust. The relationship of the staff towards the young people in encouraging this approach is vital. Young people identify very quickly the

[115] The family residences at Odyssey House, Lower Plenty, Melbourne are also extremely well designed.
[116] Such messages were on the walls at The Huntercombe Hospitals, Maidenhead and Stafford, Te Waireka, Te Oranga, James Shields Project, The Good Shepherd and Glebe House.
[117] Wikipedia 6 February 2015.

genuineness and commitment or otherwise of the staff. Whilst I only visited each of the facilities for on average half a day, it was apparent that save for one member of staff with whom I spoke, they were all committed and it was further demonstrated by the young people responding appropriately to them. [118]

A young girl at Lövsta, for example, approached one of the teachers for a cuddle in our presence. Her father had died and her mother had been admitted to a psychiatric facility. Whilst some of the facilities had a 'no touching' policy, in this case the response was appropriate. When I subsequently spoke to her about being at Lövsta, she said "I am not the one to ask. I like being here." The easy going and yet respectful relationship of the young men at Sundbo with Ms Kristin Wahnström, the clinical psychologist, meant that they were listening intently and seemed to be taking 'onboard' what she had to say. Her commitment to her job and genuine desire to help the young men was outstanding.

The dynamic of 'one big family' at Glebe House, in which there was an excellent relationship between the staff and the young men was self-evident. The staff ate lunch with them. There was banter and an easy going style and yet when there was a need for accountability, everyone was 'on the same page'.

Glebe House had also introduced a unique staff roster. In order to minimise the disruption of shift changeovers, the shifts commence and conclude on a "rolling basis". This means, for example, that there is an almost seamless transfer, so that one staff member may start at 7.00 am, then another at 7.30 am, then 8.00 am etc. One of the criticisms which is often made in facilities is that different shifts can be disruptive and change the mood in a residence.[119] This was a very positive innovation and again tried to emulate the consistency a young person would experience at home.

Auckland Youth Odyssey was also remarkable. It had a very positive feel to it. The girls I spoke to were very impressive. A number of the people at the facilities spoke about the benefits animals can offer. At the Good Shepherd and Skye House, for example, a dog visits. Dr Fuller indicated that one young person had not communicated with staff since she had been admitted to Skye House, but after interacting with the dog, she began communicating. A dog also visits The Retreat and there is a pets' corner of small animals which are cared for by the patients from one of the wards. At Auckland Youth Odyssey, there is a resident cat.

10.6 'Step-down' facilities as part of transition

There needs to be availability of open 'step down' or transition homes which allow for learning independent living skills onsite and for the young person to continue to access support when they return to the community.

One of the young men in Sweden had left Sundbo to return to his home in Stockholm. Although he had been residing at the open unit on the Sundbo site,[120] once he returned to Stockholm, he described feeling bored. He met up with his peers again and he relapsed. He supported the concept of a further 'step down' facility, for example, in Stockholm, which could have assisted him.

[118] On the day I visited Huntercombe Stafford, a staff member was leaving and a number of the girls were upset.
[119] This problem had been identified at Te Oranga and meetings had been conducted in an attempt to maintain consistent approaches between the shifts.
[120] Sundbo (Fagersta) is 173 kilometres from Stockholm.

Despite the efforts made, living in a therapeutic residential facility can never precisely replicate living in the community. The therapeutic community provides both peer and professional support. There are staff 24/7, drugs are not immediately accessible and it is a safe and secure environment. It is therefore not surprising that many of the young people expressed feelings of anxiety about ultimately returning to the community. They were concerned about relapsing and where they were going to live.

Appendix VI provides a more detailed analysis of the 'step-down' facilities associated with the services I visited.

10.7 Support for the young person after leaving the residential facility

Given the level of chaos and trauma many of the young people requiring this level of intervention have experienced, and the serious risk of relapse into harmful substance misuse/ harm to self or others/serious criminality, long- term support is a critical element:

"If you are investing in residential facilities whether mandated to be there or not; if there isn't commensurate investment in what you do with these young people afterwards, you are wasting your time and even possibly making it worse because the young person will think nothing will work. 'I've been to the top, money has been spent on me and I'm in the same position as before I went away.'"[121]

One of the constant themes which emerged during the Fellowship was the significance of building a relationship of trust with the young person. This theme is further explored in examining a particular model of community support (AMBIT) in Appendix VII of this report.

For those children and young people who have participated in residential therapeutic treatment, this relationship of trust could be with a person with whom the young person had worked prior to entering the residence or someone in the residence. What is significant is that there is continuity in the relationship and that the young person can feel comfortable in communicating with them (such as calling them if there is a crisis) and that this person of trust is on hand to provide positive reinforcement, such as celebrating the young person's achievements.

When the young people are in The Good Shepherd they prepare a transition list. They list the staff members with whom they would like to have contact when they leave. Those staff will follow up with them when they return to the community and the young person can call them. The day I visited, one of the staff members had driven two hours to see one of the young people in the community. There is a more formalised process in place if the Local Authorities purchase a transition package.

Glebe House has identified transitioning back into the community as a major challenge. They had been providing support (for example, the young men could telephone Glebe House and there could be some contact with staff in the community) but distance was an issue. In response to the challenge, Glebe House is about to introduce a Circles of Support and Accountability project for their young people when they leave. It is a transition package, free of charge for a period of 18 months from when the young person returns to the community.

[121] Dr Dickon Bevington, 11 November, 2014.

At Youth Odyssey Auckland there is a separate residence (Fraser Unit - pictured) at which initial assessments are conducted. This is the same residence where young people are able to return for ongoing counselling when they leave the program.

10.8 Democratic principles

Whilst therapeutic communities have rules, this does not mean that there cannot be contributions and suggestions made by the young people. I observed various examples in a number of the residences I visited. This is a distinction from traditional institutions of the past.

Te Oranga

- The young person attends the multi-agency meetings;
- Young people appoint a facilitator (one of the young people) to conduct Youth Council Meetings. At the meetings, suggestions are made and raised with the staff (for example, trip to an indoor swimming pool or barbecues on site once every three weeks).

Glebe House

- the daily Group Meetings enable young people to discuss what is happening at Glebe House;
- one of the young people chairs the Group Meetings;
- each young person chooses in which of three rooms he would like to have the 1:1 counselling;
- young people are on the interview panel for the selection of all staff.

The Good Shepherd

- "Blue Sky Thinking Day"- at which all of the young people and all of the staff, including cooks etc, meet to discuss innovations and processes to be incorporated into a master plan;
- young people plan the activities for the unit for each evening (for example, pizza, DVD, dance instructor, beautician).

Te Puna Wai

It was interesting to note that even at Te Puna Wai, a youth detention centre to which young people are remanded or sentenced and which is therefore usually regarded as punitive, the young people have an opportunity to have input into the everyday life of the centre:

- A Youth Council meets every three weeks. Two representatives then attend a meeting with management and put forward the suggestions. One young person wore a suit to the meeting with management. It occurs in an area of the detention centre the young people are not normally allowed to enter.

- There is a newsletter every two to four weeks. It requires at least two contributions by the young people, for example, poems and stories.

- The young people wanted to raise money for two charities for homeless teenage mothers - Holly House and the Home and Family Foundation. They made jewellery and art work to sell and the proceeds were presented to the charities.

- Young people have made suggestions on improving the procedure on admission, which have been acted on.

10.9 Culture

The relevance and significance of culture was particularly apparent at Te Oranga and Te Waireka. Whilst the young people do not have to be Māori or indigenous to the Pacific Islands to attend the program at Te Waireka, when I visited that was the case.

The program at Te Waireka incorporates the fundamental significance of the individual, the family (whanau) and the wider community and the spiritual significance of the land, the mountains and the sea; and adopts a holistic healing approach to drug and alcohol use.

One of the significant features at Te Waireka is the sweat lodge. There are hot irons and hot stones. The young people enter the lodge. It is dark. They sit in a circle. The head clinician commences by sharing his emotional journey. The heat and darkness lower people's defences. There is no judgment. What is said in the lodge remains there. It is an emotional detoxification and the first session is held in the first week of the program. It assists in the bonding of the group also.

The girl who showed me around the property, Lavinia, said:

"For four years I have been putting up a wall and I came in here and the wall collapsed in minutes."

Aboriginal children and young people are overrepresented in both the criminal justice system and in child protection in Victoria. The following information regarding Aboriginal and non Aboriginal children and young people continues to be alarming:

"*At current levels, the rate of Aboriginal child removal in Victoria exceeds that at any time since white settlement.*"[122]

- 13 times more likely than non Aboriginal children and young people to be in detention;[123]
- 16 times more likely to be in out of home care;[124]
- 9 times more likely to have a child protection concern substantiated;[125]
- one in 11 Aboriginal children experienced an out of care placement; as compared with one in 164 non Aboriginal children or young people;[126] and
- *"Two thirds of Aboriginal children in the Youth Justice system have graduated from out of home care, and it is understood that two thirds of those in adult prisons have graduated from youth justice*."[127]

In light of the above statistics and the over representation of Aboriginal young people using substances, regard should be given to the needs of young Aboriginal people and the possible establishment of an appropriate secure cultural residential facility. I am aware that YSAS, for example, has specific periods of time when detoxification is provided in a cultural context. There is also the voluntary program at Bunjilwarra in Bittern. The location of such a facility would be critical and would require consultation with relevant communities. Similar to the approach taken at Te Waireka, the *Inquiry into the Supply and Use of Methamphetamines, Particularly Ice in Victoria 2014* (Vol 1 p 270) identified the need for "*Aboriginal specific holistic healing centres to adequately cater for the specific cultural needs of Aboriginal communities with regard to substance abuse including methamphetamine."*

Puawai-Te-Ao Cultural Centre
Te Oranga

[122] *Commission for Children and Young People Annual Report 2013-2014* p. 37
[123] Ibid; p. 17
[124] Ibid; p. 37
[125] Ibid; p. 37
[126] Ibid; p. 37 referring to Report on Government Services, 2012 (in 2011/2012).
[127] Ibid; p. 6 – Andrew Jackomos PSM Commissioner for Aboriginal Children and Young People.

10.10 Education

There was a school on site[128] at all of the adolescent facilities I visited, save for those detailed in the footnote below.[129]

Apart from the young people being required by law to attend school, it was one of the significant ways to assist in the transition back to the community and represents a significant protective and rehabilitative factor.

The schools were very impressive. They were registered, the teachers were accredited and the attainment of certain levels or examination results were recognised in schools when they returned to the community. The commitment of many of the teachers was readily apparent.

"Many of the young people have not been at school before coming to Lövsta. The teachers are very welcoming and relate well to the students. Instead of the young people seeing themselves on the streets using drugs, they learn what it is like to be a student again. It's very important for them to leave thinking 'I am a student. I'm supposed to be at school, not on the street'."

Annica Pettersson, Manager, Lövsta.

"Enabling students to feel they can succeed in school is our number one mission....sometimes the lessons are secondary to the 'you can do it' objective."

Sherry Cochrane, Head Teacher, Odyssey Auckland.

One feature at Odyssey Youth Auckland was that the school was located nearby on the adult's site. This meant that the young people went in a mini-bus to school each day. Renee Berry noted that this replicated life in the community when people travel to go to school.

The ratios of students per staff member were low. For many of the young people who had left school early, this was a major opportunity to assist them. For other young people who were high achievers, for example, young people at Huntercombe Maidenhead and Skye House, there was the opportunity to sit exams for 'A' and 'O' levels.

[128] At Odyssey Youth Auckland, the young people travel a short distance to the school which is located on the adult site. They do not mix with the adults, however, as the young people attend in the morning and the adults in the afternoon.
[129] Te Waireka is an 8 week program. The young people do not attend school. Whilst some of the young men at Sirius attended school, Sirius caters for mainly young people over 16. They are not required by law to attend school. The focus is on drug and alcohol counselling. The school is located nearby at Bärby, the major SiS location. The young men at Sundbo (17-19) did not attend school.

The teachers at the facilities liaised with the classroom teachers at the schools the young people attended or would be attending. Further support was also provided by Skye House. An occupational therapist would accompany the young person and sit with them at school when they returned to the community. At The Good Shepherd there was also a focus on vocational training, for example, hairdressing and a commercial kitchen for training to be a chef.

The salon – The Good Shepherd

Whilst The Retreat is primarily an adult psychiatric hospital, it is interesting to note a recent innovation which has been introduced. It is the Recovery College. It is located within one of the hospital buildings. It is based on an education model instead of a clinical model and is designed to give the patient the skills to manage their own mental illness by educating them about it. The aim is to demonstrate there is an end in sight to their stay as an inpatient and to enable them to obtain the skills to be an active participant in their own recovery not only whilst they are in hospital, but when they are in the community.

10.11 Professional development and support for staff

The professionalism and dedication of the staff is pivotal to the success of a residential program. In many of the facilities priority is given to ensuring that the clinical staff are familiar with up to date research developments. SiS, for example, has allocated $4.5 Million AUD each year for research and development. Academics from universities and colleges apply to the Scientific Council for grants to conduct research.[130]

In addition it is important for staff, given the nature of the work and the trauma to which the young people with whom they are working have been exposed, that they receive supervision and that they remain motivated. Mr Erik Sandström at Sirius referred to the "emotional investment" of staff members. Dr Mark Tattersall highlighted that professional development and support was a priority at Huntercombe Maidenhead and was one reason why it was possible to retain the highly qualified staff. Mr Mark Edwards at Huntercombe Stafford also referred to regular training for staff, debriefing led by a consultant and exploring a group counselling service.

[130] Professor Tove Petterson's research was funded by SiS. The research is independent.

At The Retreat the hospital funds therapeutic supervision for the staff. The staff are involved in the governance structure, there are anonymous staff surveys and there is an open door policy with the medical director.

10.12 External scrutiny – the checks and balances

It is essential whenever there is a residential facility which may include children or young people who are mandated to attend for treatment, that there is transparency and accountability. There must be external scrutiny. There must be records maintained and there must be government oversight.

At many of the facilities I visited, there were signs on the walls advising young people of their rights to contact regulatory government organisations and the contact details.

Un/announced visits to the facilities were part of the regime, for example, Inspection by the Social Service and Healthcare Board and Ombudsman for Children in Sweden; the Care Inspectorate for Social Care and the Mental Welfare Commission in Scotland; and the Care Quality Commission in England.

I visited Scotland's Mental Welfare Commission.[131] It is an independent organisation ensuring all people with a mental health issue have access to the care and treatment they should have. In October 2014 it published a visit and monitoring report: "Visits to young people in secure care settings" in which they spoke to young people with mental health issues residing in secure care. The visits were conducted jointly with the Care Inspectorate.

External scrutiny will be a vital element of establishing the proposed new facilities.

10.13 At what cost?

Whenever proposals are made to establish new services, the inevitable (and very reasonable) question is 'what is the cost?' There are many factors beyond the scope of this report to be taken into account when responding to this question (such as whether facilities exist or new facilities are required and the number of young people to be initially accommodated).

There is no doubt that the establishment and ongoing operations of therapeutic treatment facilities and effective after-care will require significant resources. However, regard must be had to the opportunity cost – both economic and human. These young people will lead the most damaged lives and be the most resource intensive unless their needs can be addressed now. Future economic costs include the health costs associated with psychiatric illness; welfare benefits; crime investigation; and imprisonment. Significantly, there is also the impact on victims of crime and community safety.

In addition, there is the cumulative cost of the destruction of their ability to be proper parents, creating the grave risk of perpetuating this intergenerational vicious cycle.

During my Fellowship, I received many comments on cost eg – "*The cost is hugely more expensive in the long term…it costs £150,000 per person now or £1.2 Million in 15 years*."[132]

[131] I was very impressed with the role and mandate of the Commission.
[132] Paul Thompson, Drug and Alcohol Advisor, Huntercombe Maidenhead Hospital.

11. WHAT ELSE CAN WE LEARN FROM THE OVERSEAS OBSERVATIONS?

11.1 The Youth Drug Court

One of the highlights of my Churchill Fellowship was the opportunity to discuss the Youth Drug Court in Christchurch with the presiding judge, Her Honour Judge McMeeken and to observe a sitting of the Court. I also attended the Drug Court meeting held before court.

The Youth Drug Court was established in March 2002 by His Honour Judge Walker. The court began as a pilot. It is now a permanent list which sits once a fortnight in Christchurch. In order to be admitted into the program a young person (14-16 years of age) "must be a serious offender, in terms of type of offence or number of offences and must have a moderate to severe dependence on a substance, which is contributing to their offending."[133] The process by which a young person comes into the Youth Drug Court is depicted in the diagram on the next page.

Judge Walker identified the following strengths of the Court:

- single judicial officer
- coordinated inter-disciplinary team
- availability of treatment
- dialogue between judicial officer and young person
- accountability of the young person. [134]

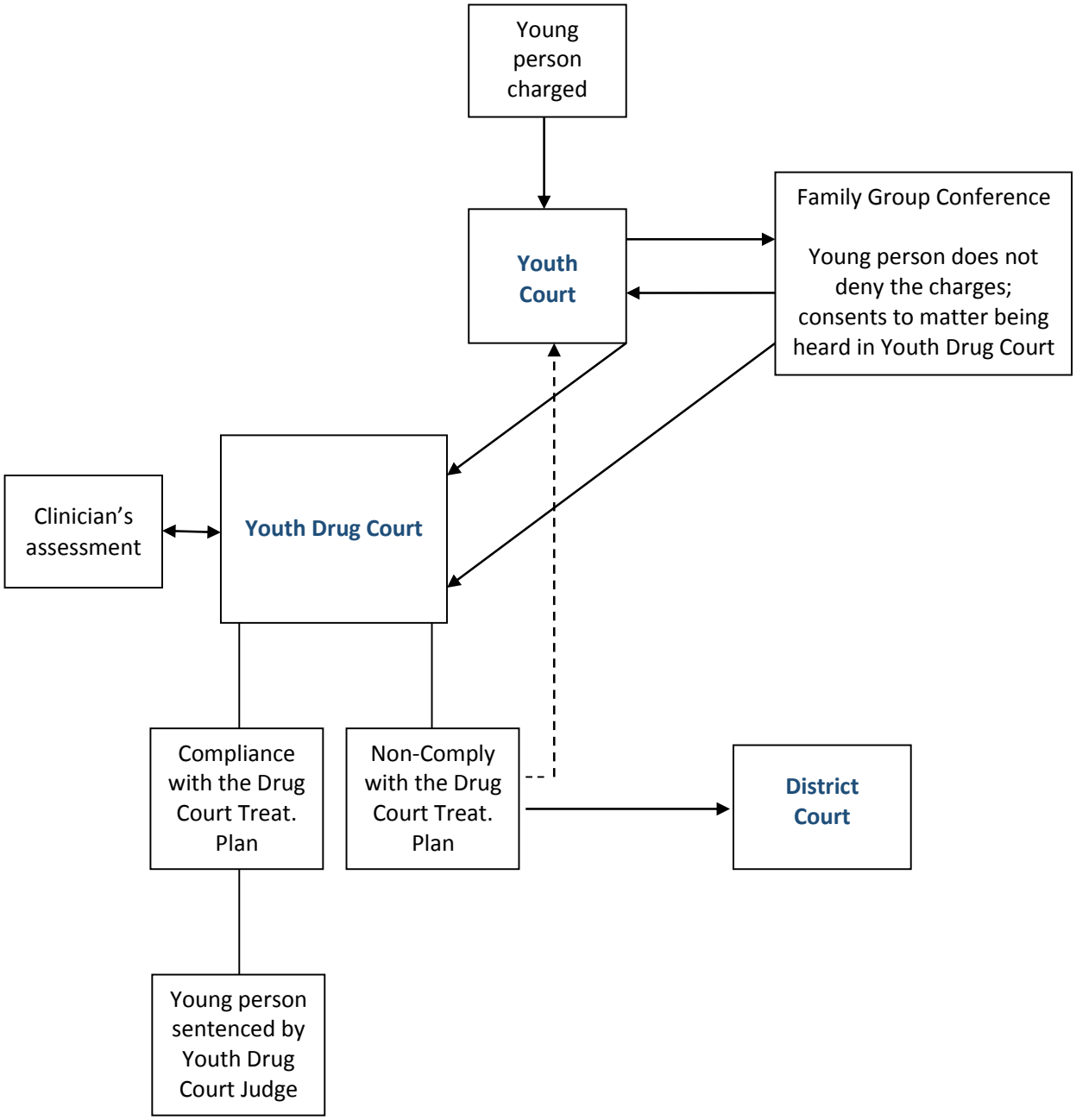
The meeting is attended by all members of the 'Drug Court Team', together with the solicitor for the young person appearing before the Court. The young person does not attend the pre court meeting.

The team consists of the Judge,[135] social worker, police prosecutor, youth justice coordinator, drug treatment clinician, Ministry of Education representative and the court registrar assigned to the Drug Court.

The Youth Drug Court social worker prepares a progress report regarding all of the young people in the list. It is circulated prior to the meeting and provides the foundation for discussing the current situation. The report includes details of the drug dependency which resulted in the young person being accepted onto the program and the treatment plan.

[133] Judge McMeeken 27 November 2014.
[134] *Drug Project/What is the Youth Drug Court?* Internal Court Briefing Notes, Judge John Walker.
[135] The Judge chairs the meeting before Drug Court but does not attend the meeting conducted in the alternate week.

The process by which a young person comes into the Youth Drug Court



An example of a Drug Court Treatment Plan is as follows:-

1. That James be accepted into Youth Drug Court.

2. That James continues to attend his alternative education course and be supported in doing so.

3. That a mentor be engaged to work with James.

4. That James is to see his case manager at Youth Speciality Service (YSS) regularly to monitor his alcohol and drug use and to provide alcohol and drug counselling.

The progress report also includes an update regarding such matters as whether the young person has attended appointments; progress regarding education or vocational training; any difficulties contacting the young person; and discussions regarding a young person's progress at Odyssey House, if applicable.

There are very frank discussions conducted at the meeting. Concerns may be raised by the police prosecutor.

The team has been a stable team. It demonstrates what can be achieved when senior representatives who have relevant practical experience support the specialist court. The seniority enables decisions to be made. For example, one young person had been accepted into a training program and required an exemption from attending school from the Department of Education. The representative from the Education Department was able to confirm what was required and that the exemption would be granted. The significance for everyone, but particularly for the young person, was that there was certainty attached to a plan. Decisions could be made without delay and everyone was supportive of the common goal.

A detailed report of my observations of the Court is found at Appendix VIII.

When the Youth Drug Court was a pilot, an evaluation was conducted. The highlights as described by young people who had appeared before the court were:

- the support they received to assist them with their problems
- how the judge treated them
- opportunity for a second chance regarding opportunities for employment, travel and not having a 'proved' outcome on their criminal record.
- treatment resulted in a reduction in their alcohol and drug use and offending
- assisted in obtaining employment
- met people in the same situation
- did not have to go to Youth Court or District Court.[136]

The report also referred to one family member of a young person who appeared before the court and noted the significance of the relationships formed with the Youth Drug Court team.

[136] *Process Evaluation of the Christchurch Youth Drug Court Pilot* – Dr Sue Carswell Ministry of Justice 2004 [9.6.1] page 133. *A further evaluation in 2006 Christchurch Youth Drug Court Pilot: One year follow up study*, W. Searle and P. Spier Ministry of Justice 2006 confirmed that whilst the sample was small, those who completed the Youth Drug Court requirements had lower reoffending rates than those who did not. (p13).

> *"The young generation, their life is to do with the relationships they have. It is huge. That is one of the major things in their life. If they have got positive influences in their life then they have more of a chance of lifting up their standard if they want to lift the standard. That person can say I am cool but I don't do that. To me, that is the biggest thing."*[137]

11.2 The Crossover List

I was also very fortunate to have the opportunity to sit with His Honour Judge Tony Fitzgerald at the Manukau District Court when he presided over the Crossover List.

"Crossover" refers to those children and young people in the criminal justice system who also have concurrent child protection proceedings and in New Zealand, this applies to 73% of the young people charged with criminal offences.[138]

The List is conducted by the Judge in the Youth Court (criminal court). The child protection proceedings and the criminal charges are both before the court.

The aim of the Crossover List is:

> *"..to ensure that, for all such young people, appropriate information regarding them is obtained from the Family Court to help inform decisions and plans made in the Youth Court and, that there is co-ordination of what is happening for them in both courts."*[139]

It was developed because of shortcomings having been identified. The Children's Court of Victoria experiences similar difficulties.

Judge Fitzgerald summarised the benefits:

> *"The personal history and current circumstances of such young people will be very relevant in the Youth Court which is required to ensure that a young person's needs are acknowledged and underlying causes of their offending addressed".*

The police prosecutor and senior representatives from Children, Youth and Families (Child Protection) sit at the table in court. The Children, Youth and Families representatives have laptops to ensure that the most up to date information is available.

Establishing the List was potentially more problematic in New Zealand as the criminal matters and child protection matters are heard in two different courts. Whilst in Victoria the proceedings are heard in different Divisions, they are both in the Children's Court. There are fundamental and very significant reasons for the Family and Criminal Divisions being separate. However, when a young person is before the Court in both Divisions, there are advantages for the young person if 'everyone is on the same page'.

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[137] Op cit; [9.6.2] p.133.
[138] 'The Crossover List' Judge Tony Fitzgerald. I have previously referred to the statistic in Victoria for those in custody (59%) and the statistic would be higher in respect of all those involved in both systems.
[139] Judge Tony Fitzgerald 20 November 2014.

In Manukau, the young person who has criminal charges is identified as a person who also has child protection proceedings, generally by one of the court officers. The charges are adjourned to the Crossover List and a Family Group Conference is conducted in the interim.

The observations I made which highlighted the benefits of the list included:

- the Children, Youth and Families (CYF) representative could assist during a bail application, regarding the suitability of a particular address;
- the CYF representative could advise the court of the proposed future planning regarding where the young person was going to reside;
- an appeal had been instituted on behalf of one young person and it was before the High Court (regarding a guardianship issue). It was not in the young person's best interests to finalise the criminal charges prior to the appeal being determined.

The reasons for the establishment of the list apply equally in Victoria. There have previously been discussions regarding a DHS Child Protection practitioner being located in the Criminal Division of the Children's Court of Victoria at Melbourne. The list, however, would have the added benefit of reducing the number of court events concerning a young person.

Ideally, it may also result in the young person having one lawyer appearing on their behalf in respect of both the child protection and criminal matters. Currently that is a major difficulty and frequently impacts on relevant information being available to the court (that is, the child protection and criminal matters are not listed on the same day and the child protection worker and the lawyer in the child protection matters are not at court when the criminal charges are listed).

The need for better coordination of effort between child protection and youth justice systems has also been recently recognised by the Youth Parole Board and Youth Residential Board Victoria:[140]

> *"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."*

In my view, the establishment of a Crossover List would be an innovative response to this, unfortunately all too frequent occurrence, of young people having matters in both Divisions of the Court.

[140] *Youth Parole Board and Youth Residential Board Victoria Annual Report 2013 2014*, p. 13.

12. CONCLUSIONS

In summary:

- **the current system is not working for large numbers of children and young people with drug/alcohol/mental health issues;**
- **opportunities are being missed to help those who are not volunteering to access existing services;**
- **secure treatment facilities are necessary, with the opportunity to transition to open facilities;**
- **punitive institutions of the past will not work – they must be welfare based;**
- **the provision of secure residential therapeutic facilities will not deliver perfect results, but will provide an opportunity for young people to access treatment and turn their lives around;**
- **the new services will require substantial ongoing resources, given the need for high ratios of qualified staff; education and training; and effective after-care;**
- **Judicial oversight and further independent scrutiny will be required.**

13. RECOMMENDATIONS

13.1 To establish secure therapeutic residential treatment facilities for young people with significant drug/alcohol/mental health issues.

13.2 To ensure effective after-care and transition arrangements for young people attending the therapeutic facilities.

13.3 To legislate to enable Youth Therapeutic Orders to be made in the Children's Court of Victoria.

13.4 To form a multidisciplinary Steering Committee to advise on and plan for the implementation of Recommendations 13.1, 13.2 and 13.3.

13.5 To establish a Youth Drug Court within the Children's Court of Victoria.

13.6 To establish a cross-over list in the Children's Court of Victoria.

14. APPENDICES

Appendix I – Major features of the adolescent residential facilities visited

SiS Secure Homes – Sweden

	Sundbo	**Sirius**	**Lövsta**
Location	Near Fagersta, 173 kms NW of Stockholm	Outskirts of Uppsala (regional city)	Vagnhärad, 66 kms SW of Stockholm
No. of young persons/ ages	41 males; 16-21	22 males; 16-21	34 (mixed – some segregated units); 12-20
LSU (criminal)/ LVU (welfare)	Both	LVU only	LVU only
No. of residential buildings onsite	6 (includes 1 open unit)	1 building (4 units; including 1 open)	4 (includes 1 open)
Specialisation of unit(s) visited	Closed unit (12-16) & open unit	The four drug and alcohol units and the open unit	Assessment (investigation) and emergency unit; 6 people (mixed: 12-16)
Treatments/ program	Minnesota 12-step; CBT;[141] ART;[142] ACT;[143] DBT;[144] individual psychological therapy; and motivational interviewing	12-step; CBT; individual drug and alcohol counselling; motivational interviewing	ART; individual treatment plan; motivational interviewing; family counselling
Staff	Over 100 f/t; some p/t	44 on this site; 153 over 2 sites	100
Professions/ qualifications	Psychiatrists (consulting); psychologists; social workers; behavioural therapists; treatment assistants	Psychiatrists & psychologists (consulting); AOD[145] clinicians; treatment assistants; treatment secretary	Psychiatrist (consulting); psychologist; nurses

[141] Cognitive Behaviour Therapy.
[142] Aggression Replacement Training.
[143] Acceptance and Commitment Therapy.
[144] Dialectical Behaviour Therapy.
[145] Alcohol and other Drugs.

	Sundbo	Sirius	Lövsta
School	12 teachers – most units have own classroom	School attendance not mandatory (age); unit 2 school counsellor; unit 3 offsite school once per week	12 teachers – school onsite
Other activities	Gymnasium; climbing wall; fishing (lake onsite); skiing; ice skating; AA[146] & NA[147] meetings in town	Attend AA/ NA in town; walks outside (shops etc); outdoor sports court; physical training	Fishing and activities on the lake; indoor sports centre
Open house/ transition	Open unit onsite; 2 apartments 100kms away near fire station	Open unit- up to 5 people	1 unit onsite
Challenges	Distance from families; unaccompanied refugees; major psychiatric or intellectual disability issues	Some leave before full program completed	High demand for beds; unaccompanied refugees

Adolescent hospitals/residential facilities – Scotland and England[148]

	Skye House	Good Shepherd	Huntercombe Maidenhead	Huntercombe Stafford
Capacity	24	27	60 – eating disorders; psychiatric ICU; step-down unit	39 – eating disorders; psychiatric ICU; assessment & treatment unit
Age	12-17 (mixed)	12-18 (mixed)	12-18 (mixed)	12-19 (mixed)
Sentenced/ welfare/ MH Act	2/3 voluntary; 1/3 compulsory (MH Act)[149]	Sentenced and welfare	Voluntary and MH Act	Voluntary and MH Act
Education	Onsite school	Full onsite curriculum and training	Onsite school	Classroom for each unit

[146] Alcoholics Anonymous.
[147] Narcotics Anonymous.
[148] Glebe House is detailed in Appendix II.
[149] Mental Health legislation.

	Skye House	Good Shepherd	Huntercombe Maidenhead	Huntercombe Stafford
Professional staff	Doctors; psychiatrists; nurses; occupational, family and speech therapists; mental health officer; dietician	Psychiatrists and psychologist (consultant); nurse; and access to CAMHS[150] 12 staff per unit	Psychiatrist (consultant); psychologists; associated specialists; family therapists; dietician; OT assistants; nurses	Psychiatrists (consultant); psychologists; doctors; nurses; occupational, sports, art and family therapists; dietician; social workers
Treatment	CBT, DBT, emotional regulation	CBT, anger management, AOD, PALS,[151] holistic therapies	CBT, DBT, AOD	CBT, DBT, AOD
Transition	Open unit	Onsite cottage; telephone contact and home visits	Step-down unit; 2 residential homes (Wales)	Open unit in community

Adolescent Residential Facilities – New Zealand

	Odyssey Auckland	Te Waireka	Odyssey Christchurch	Te Oranga
Capacity	9	17	9 residential; 9 day program	10
Age	14-17 (mixed)	14-19 (mixed)	14-18 (mixed)	9-17 (mixed)
Voluntary/ crim. court/ welfare	Voluntary and crim. court referral	Voluntary and crim. court referral	Voluntary and crim. court referral	Welfare
Education	School at adult Odyssey site	No school – 8 week program	Onsite school	Onsite school
Professional staff	Psychiatrist (consultant); psychologist; nurse; social workers	AOD clinicians; nurse; youth workers;	AOD supervisor; youth workers; adventure therapist	Psychiatrist (consultant); youth workers; residential social workers

[150] Child and Adolescent Mental Health Service.
[151] Program for Adolescents in Life Skills.

	Odyssey Auckland	Te Waireka	Odyssey Christchurch	Te Oranga
Treatment	CBT, DBT	Combination of Māori and western approaches to wellbeing (influenced by work of Sir Mason Durie); importance of family (whanau)	Motivational interviewing, strengths-based practice, therapeutic community model, individual counselling	Containment model, with CBT incorporated
Transition	Separate outreach house	Invite family to spend 2 days during program; some maintain contact with staff	School day program; YSS contact (AOD outreach health service)	Transfer to care in community

Huntercombe Maidenhead

Appendix II – Glebe House

I was particularly impressed with the therapeutic approach implemented at Glebe House, Cambridgeshire, England. I have therefore chosen to present it as a specific Case Study. In my view, it represents what can be achieved when a therapeutic community is established.

Glebe House was established in 1965 as a therapeutic community for males aged 16-18 who have sexually offended. There is accommodation for 16 males. Ms Karen Parish, Assistant Director (Clinical), who has worked at Glebe House for 8 years, considers the optimal number to be 14. It was set up by a Quaker Probation Officer who was concerned by the lack of an appropriate residential placement for young male offenders. Glebe House is operated by a charitable trust. The trustees are Quakers.

The young men are referred to Glebe House by a Local Authority (Child Protection)[152] or as a result of their criminal offending. There are approximately half in each category. The tariffs for sentences in England for sexual offending by young people are comparatively high. For example, indeterminate sentences can be imposed and a custodial sentence of more than one year requires the young person to be placed on the Sex Offenders' Register for a minimum of 2 years. Some of the young men are on parole and have been paroled to Glebe House. A small infraction (for example, criminal damage) can result in them being returned to custody.

Social Services pay for the placements at Glebe House.[153]

There is an assessment conducted before the young person comes to Glebe House to determine their suitability. In this case, the young men have to want to come. However, such factors as being paroled to Glebe House instead of remaining in custody can impact upon their "consent". The young people sign an agreement when they enter the program which includes an agreement to participate in treatment and confidentiality.

When a young person arrives at Glebe House, a risk assessment is conducted. Almost without exception, the young person's self-assessment indicates they do not pose a risk of reoffending. However, the professional assessment generally assesses them at high risk. After approximately 6 months, the self-assessment of their risk almost invariably corresponds with the clinician's assessment. The assessments are constantly reviewed.

The program is for a minimum of 2 years. It takes approximately 6 months according to Ms Parish for them to settle in and expose their vulnerability and over one year to work therapeutically. Approximately 85% of the young people complete the program.

There are no locks and no perimeter 'walls'. Responsibility is vested in the young people. Absconding is not an issue. Ms Parish could only recall one young man seeking to abscond and he got to the front gate and came back.[154]

[152] There are occasionally referrals from the Health Department.

[153] Youth Justice only pays whilst a young person is in custody.

[154] The property is relatively isolated. It is in a very small town in a rural setting. It is 24 kms from the nearest city and approximately 13 kms from the nearest train line.

When I arrived the lounge/games room was a "hive of activity". It was as if I had arrived at someone's home and their teenage son had a number of friends visiting. Some of the young men were playing pool, others were watching the game of pool. Some were working in the kitchen and some wanted to sit down and speak to me. It was a noisy, relaxed and homely environment. The morning group session had finished and they were waiting for or preparing lunch for everyone.

The young people select the chores they wish to do, for example, cooking with the kitchen staff. They set the tables and all the staff and young people eat together. There was much discussion over lunch. The young men were polite and respectful, saying for example, "Excuse me" when seeking to speak to a staff member with whom I was speaking.

I was shown around the property by Ms Parish and one of the residents, 'Stephen'. Stephen is one of three resident chairmen, a position of trust and responsibility which has to be earned. There is a 3 month probationary period. One of their responsibilities is to chair the three group meetings which are conducted each day.

There is a significant range in the cognitive functioning of the young men, from 70 to 125. There is a school on site. The ages and capabilities of the young men clearly vary greatly. For some, adult education pathways are pursued. There are computers in the classroom, an art room and a multi-purpose room.

There is also a workshop which includes a woodwork room. There is a woodwork/trade teacher to assist the young people. If a young person has damaged a cupboard, for example, he will be required to repair it.

There is a large hall with a stage, in which two of the three group meetings each day are conducted. I was invited by the young men to observe the group meeting which took place whilst I visited. The staff attend each meeting. There is an agenda and everyone sits in a circle. Each person tells the group what they will be doing after the meeting. Some of the young men asked different staff members if they could catch up with them and the staff member would indicate if that was possible.

It was a difficult meeting during which the central issue discussed was whether one of the young men was going to remain in the program. During the discussion, it was apparent how supportive the therapeutic community is. The young men and staff offered support and understanding but also required accountability from and to each other. It was understood that for each young man's actions there could be ramifications for others.

The transition within Glebe House consists of young people on arrival having a bedroom upstairs, then progressing to a bed-sit and then, for some, to independent living in the bungalow situated approximately 40 metres from the main residence. The three young people in the bungalow at the time I visited were aged 18. Whilst they sleep in the bungalow, they continue to participate in all of the Glebe House program activities. All of the young men can see and walk past the bungalow and it acts as an incentive to be able to reside there.

The young men are encouraged to have input into how the therapeutic community operates regarding activities for themselves. In addition, they are required to identify and evaluate risk in

relation to activities suggested. Stephen resides in the bungalow. He and one of the other 18 year old residents wanted to go to a nightclub. They provided a written submission to staff which identified how they would address risk factors such as planning transport, money, how to engage with the opposite sex, alcohol etc. Having discussed the trip with one of the staff members, they decided they were not ready to go.

They had also requested that they wanted to have pizza and alcohol one night in their unit. Once again, they had to identify what triggers or risks could result if they had alcohol. They subsequently enjoyed sharing a bottle of wine.

When Stephen took us around the property, whilst there was a staff member present, he held the keys to the large hall, for example, which was not in use at the time.

There is a special room for young people when they feel anxious or distressed or would like some quiet time. It is dark, there is a bean bag, soft toys, lava lamp and other sensory objects. A young person can select music or sit in silence. It is especially utilised by those with learning difficulties.

The staff attempt to sit back and let the young men resolve issues, for example, one young man has difficulty coping with losing when playing billiards.

The young men earn £7.50 a week, an additional £2 if they are in the recycling team and additional £2.50 as a probationary chairman or £5 as a chairman.

Glebe House is a democratic community. One clear example is that young people are on the interview panel for all staff to be employed. This included when interviews were conducted for the appointment of the Director of Glebe House. It is apparent that the young people are treated with respect and that they know the staff care and in turn they respond positively.

Glebe House has made genuine attempts to be a good citizen in the rural community, for example, maintaining the garden at the local church. It has been accepted by the community, which is an outstanding achievement. At the annual Guy Fawkes celebration last year, 700 people from the community attended at Glebe House to celebrate. Due to the size of the tiny surrounding rural villages, this meant people from far and wide attended. Any money raised was donated to a charity decided on by the young men. This celebration has become an annual event.

Staff

There are 54 staff plus 5 consultants at Glebe House. The staff are very experienced. They have 1013 years of relevant experience between them. They include psychologists, those with experience in the criminal justice system, social workers, teachers, psychotherapists and youth workers.

The commitment of the staff was inspiring. They are passionate about the young people and the program. Everyone in the therapeutic community, young people and staff are accountable to each other. There are rules and if a rule is broken, it impacts on the trust the other members of the community have towards that person and potentially undermines the whole community. As previously indicated, this was demonstrated at the Group Meeting I attended.

Accountability was the central theme - accountability to themselves, to their peers, to the staff, to the local community and to the ongoing viability of the program.

Whilst there are no fences and apart from bedrooms being locked at night, there is no security to prevent any of the young people from leaving; the "buy in" to being accountable to everyone including oneself, is very powerful.

The therapies utilised are cognitive behaviour therapy, psychodynamic therapy and a model devised by David Finkelhor who identified 4 preconditions to offending.[155]

Challenges:

- **Transition**

  One of the challenges is to continue to improve the support for the young men when they transition back into the community. Prior to leaving Glebe House, they spend some time, for example weekends, at the residence where they will stay when they leave. There is a key person with whom the young person can liaise once they leave. However, the tyranny of distance can impact on the type of support provided.

  A program (Circle of Support and Accountability) is being developed to extend the support provided leading up to and for 18 months after they leave Glebe House.

- **Mental Health Services**

  The inadequacy of mental health services in the community remains an ongoing concern.

- **Employment**

  Finding employment for the young men when they leave is a great challenge.

Evaluation of the Program at Glebe House

A 12 year longitudinal study was conducted and completed in October 2014.[156]

The study included comparisons between young men during and after they completed the program (ongoing cohort), a group of young men who left the program early (early leaver group) and a comparison group (who had committed similar offences, but had not attended the program).

The significant findings were:

- "… a notable reduction, at departure (of the program), of some very serious problems identified by these young men when they arrived at the Community." (For example, "self-harm, suicidal thoughts, depression, reactions to bereavement and loss… none was in denial about their own previously sexually harmful behaviour").[157]

[155] Refer also to "*Young People who Sexually Abuse: building the evidence base for your practice"* M. Calder (chapter by Peter Clarke) Random House Publishing 2002.
[156] "*Treating Sexually Harmful Teenage Males: A longitudinal evaluation of a therapeutic community*" Boswell Research Fellows University of East Anglia October 2014.
[157] Ibid; pp 3 and 4.

- **"84% (of those who had completed the program) were not subsequently re/convicted, as against 56% of the comparison group,** and that only one person had re/offended sexually and one violently, compared with five each of the comparison group."[158]

- "After leaving Glebe House, the majority of young men who had completed the programme were not in stable employment, but were coping well in other key areas such as accommodation, family relationships and healthy lifestyles, and making the best of their limited circumstances."[159]

- "They (the majority of young men who had completed the programme) had benefited from independence preparation, but would have appreciated more of this. They would also have benefited from ongoing external professional support where this had been absent or ceased prematurely."[160]

- "Not only were most of them (young men who had completed the programme) not re/convicted, as against a considerably higher-convicted comparison group, the majority felt their lives had been turned around by the two or more years they had spent at Glebe House and by the commitment of staff who always had time for them."[161]

[158] Ibid; p 4.
[159] Ibid; p 4.
[160] Ibid; p 4.
[161] Ibid; p 4.

Appendix III – United Nations Convention on the Rights of the Child[162] – extracts

Article 12 – Children[163] have the right to say what they think should happen when adults are making decisions that affect them and to have their opinions taken into account. **Article 16** – Children have the right to privacy. The law should protect them from attacks against their way of life, their good name, their family and their home.	**Article 6** – Children have the right to live a full life. Governments should ensure that children survive and develop healthily. **Article 33** – Governments should provide ways of protecting children from dangerous drugs. **Article 36** – Children should be protected from any activities that could harm their development.

[162] Ratified by Australia 17 December, 1990.
[163] Defined as everyone under 18.

Appendix IV – Charter of Human Rights and Responsibilities Act 2006 (Vic.) – extracts

- **Section 8(2)** – Every person has the right to enjoy his or her human rights without discrimination.
- **Section 8(3)** – Every person is equal before the law and is entitled to the equal protection of the law without discrimination and has the right to equal and effective protection against discrimination.
- **Section 10** – A person must not be – (c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.
- **Section 17(1)** – Families are the fundamental group unit of society and are entitled to be protected by society and the State.
- **Section 21(1)** – Every person has the right to liberty and security.
- **Section 17(2)** – Every child[164] has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.
- **Section 17(3)** – A person must not be deprived of his or her liberty except on grounds, and in accordance with procedures, established by law.
- **Section 22(1)** – All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.
- **Section 25(3)** – A child charged with a criminal offence has the right to a procedure that takes account of his or her age and the desirability of promoting the child's rehabilitation.
- **Section 31** – In exceptional circumstances, Parliament may override the provisions in the Charter.

[164] "means a person under 18 years of age" s 3(1).

Appendix V – Locations and settings of the visited facilities

The residential facilities I visited were located in many different settings ranging from:

- **picturesque rural settings** (eg *Glebe House*, Cambridgeshire, and *Huntercombe Hospital Maidenhead*, England; *Sundbo,* Fagersta and *Lövsta*, Vagnhärad, Sweden; and *Te Waireka*, Hawkes Bay, New Zealand)

Glebe House

Sundbo

- **being on the outskirts of a major city** (eg *The Good Shepherd*, Bishopton, Glasgow, Scotland and *Sirius*, Uppsala, Sweden);

The Good Shepherd

Sirius

- **in an urban environment** (eg *Odyssey*, Auckland and *Odyssey House*, Christchurch);

Odyssey Auckland

Odyssey House (Youth) Christchurch

- **on a large rural-style allotment within an urban area** (eg *The Retreat*, York); and

The Retreat

Skye House

- **in a hospital setting** (eg *Skye House*, Stobhill Hospital, Glasgow, Scotland and *Huntercombe Roehampton Hospital*, England).

It was apparent that there are advantages and disadvantages in respect of almost all locations. The traditional view of locating a facility in a rural, possibly remote location has the following attractions and difficulties:

- it will be away from negative peers and drug dealers known to the young person;
- it provides an opportunity for the young person to be in a different environment, to reflect on their usual lifestyle;
- if the family is a negative influence, it provides the opportunity to have a break from them;
- it may assist the young person to make disclosures;
- it may reduce the risk of absconding.

However, the converse can also be advanced:

- the young person may feel homesick and the location may reinforce their feelings that they are not part of the community;

- being away from the usual environment is artificial and makes it more difficult to transition when the young person leaves.

Whilst there is no perfect location, a couple of examples highlight certain issues which may arise. I previously referred to the 'homely' feel of one unit of Huntercombe Stafford Hospital, which is a real positive. Its location posed a number of challenges, however. Whilst it was in a rural setting, it was relatively isolated with minimal public transport, which impacted on families being able to visit. The close proximity to the A5 freeway meant that regard needed to be given to the risks of absconding and self-harming.

The Retreat on the other hand had magnificent grounds and was located within the city of York. One of the difficulties, however, was that many patients did not live in York and therefore the continuity of care was an issue when they left.

Huntercombe Stafford

Appendix VI – 'Step-down' homes associated with the visited facilities

As this report recommends, step-down facilities are an essential element of transitioning from a residential treatment facility back into the community. The following is an analysis of some of these step-down facilities.

All of the facilities I visited in Sweden had attempted to assist the young people in transitioning back to the 'real world'. Whilst not all of the young people would have an opportunity to reside in the most open of the units that were on site, for those who could, it represented an opportunity to go to work or to school in the nearest town, to budget, to cook their meals etc. and yet to still have the support of staff on site.

This was also the model adopted at The Retreat, Glebe House and The Good Shepherd.

Open unit Sundbo

Open unit - The Good Shepherd

The young men I spoke to at Sirius who were in the open unit found the security of knowing staff were there, if required, invaluable. In Sundbo, the young men appreciated the opportunity the open house provided to them.

It seems that if the facility is located in a rural setting which is not in the area to which the young person will be returning when they leave, there needs to be a 'step down' facility located in the city to which they will return. This would enable the young person to re-engage in the community but with the security of having a home and staff available to provide additional support and encouragement.

One further example of attempting 'to mirror the real world' was an innovation at Sundbo. The local fire station was going to close due to a funding issue. The National Board of Institutional Care (SiS) entered into an arrangement with the fire station whereby in exchange for the fire station remaining in the town, the young men at Sundbo who are ready to leave could move to one of the two apartments near the fire station. The firemen are regarded as good role models. The young men train with them to maintain fitness and whilst they do not attend incidents where there are deaths involved, they work at the fire station and reside independently in the apartments.

Odyssey Auckland for adults and The Retreat both had access to housing 'off site'. The Retreat has a mixed gender specialist mental health unit in the community (The Retreat Strenshall). In the case of Odyssey, the 'residents' live independently in the community but return at night to Odyssey House to continue to engage and be supported in the program. Ms Pat Williams had inspected a number of homes the day before I met her with one of the residents who was leaving. They had only looked at homes in close proximity to Odyssey in order to maintain that link.

One of the young men at Glebe House was scheduled to leave in February 2015. He was residing in the bungalow and planning for him to leave had been in place for a number of months. When I visited in November 2014, he had just commenced travelling by train to spend one night on the weekend at home with his family and then returning the next day to Glebe House.

The plan was for the number of nights to increase until February 2015 when he would remain in the community full time.

The bungalow – Glebe House

Appendix VII – The AMBIT model and The Bridge outreach service

I visited The Bridge, a community facility and outreach service in Cambridge, England. Dr Dickon Bevington[165] explained the concept of The Bridge and the underpinning model of treatment, known as the AMBIT (Adolescent Mentalization–Based Integrative Treatment) model.

AMBIT is the result of a large collaboration that was co-led by Dr Bevington and Dr Peter Fuggle.[166] He explained that it has been developed to work with young people who are drug dependent and whose lives are chaotic.

"Nearly all have terrible histories of trauma, abuse, neglect, bereavement, maybe major anxiety, emerging psychotic illnesses. The problem for these kids if they had one of those, for example, we know how to treat trauma, bereavement, drugs but the cumulative burden of all of that rubble pushes the flight path down – so it will inevitably hit the trees at the end of the runway. These children very often struggle the most to make helpful relationships, they least know how to say "help me" and they don't have an expectation they will receive treatment."

The model of having a team around the child can work where there is an enlightened family who can help translate to the child what each clinician is telling the child.

However, one young person described having a social worker, drug and alcohol counsellor, psychologist, education support worker and other professionals as follows:

> *"I have to see 6 different people every week, it's like being set upon by a flock of f……. seagulls."*

Whilst the members of the team are well intentioned and it is a 'fine model' for some, Dr Bevington and his colleague considered that a complementary model was needed for the most vulnerable young people.

As Dr Bevington explained, the professionals have their own respective language and their own perspectives, for example, a social worker refers to deprivation and neglect; a drug and alcohol counsellor refers to harm and motivation; and a psychiatrist refers to neurotransmittance. These young people have generally had difficulties forming attachments and yet the young person is being expected to form a relationship with multiple numbers of professionals.

The AMBIT model is premised upon a key worker being the person who works directly and establishes a rapport with the young person. The team of professionals work around the key worker, providing professional expertise and support.

If the key worker is able to build a relationship with the young person then there is a greater likelihood that the young person will feel supported and will seek assistance from the key worker when required.

Dr Bevington explained that a young person will learn from a person who they consider has listened to them and understands what it is like to be them. The key worker needs to engage them in this way. It means that once a week supervision with the young person is not enough. The key worker has to be able to respond, for example, meeting the young person in a park, at

[165] Dr Bevington was named as one of the top 50 innovators in Health in the UK (*Health Services Journal 2014).*
[166] "AMBIT has been described as an "open source approach to the development of effective therapy for hard to reach, socially excluded youth." Dr Bevington. Refer http:ambit.tiddlyspace.com

carparks, the supermarket etc – but all subject to a risk assessment and the key worker always having telephone access to a member of the professional team.

The model requires the key worker to have supervision and professional support to debrief. The situations can be dangerous, for example, the day before I spoke to Ms Verity Beehan (psychiatric nurse and substance abuse practitioner), a young man had called her, being his key worker, seeking assistance because he was wanting to kill himself. She managed to sit with him; talk to him; whilst with him, speak to a member of the team; and convince him to attend hospital. It may be that a second member of the team would accompany the key worker when the risk is very high; or at times the key worker will indicate that they need to make a phone call (loud speaker) to another professional in the young person's presence, in order to seek advice.

One other feature of the program is that whilst the key worker is building a relationship of trust with the young person, they are from the outset also scaffolding any existing relationships around the child. The aim is to ultimately make themselves redundant. The concern is that otherwise young people may be concerned that 'If I let you into my life, maybe you'll never leave.'

There is a culture in the team to respect the expertise of other professionals acknowledging that they all come from a different perspective; for example, the social worker refers to inadequate parenting; the psychologist – mother depressed and child has a conduct disorder; drug and alcohol clinician – cannabis is the problem for the child. From those different perspectives, different treatment recommendations can be made, for example, medication, joining a football team or cognitive behaviour therapy. There is a need for good communication so that all of the members of the multidisciplinary team are on the one page.

The Bridge

Dr Bevington conducts an outreach program utilising the AMBIT model at The Bridge. There are 8 members of the team, including himself, a substance misuse practitioner, a number of nurses and an administrator. One day a week, there is a member of the team writing up notes and always available to support the worker in the field.

The primary outcome sought is to reduce drug use. The secondary outcome is to adjust the young person's attitude to seeking help so that they have a sense of who they can call on.

The young person and key worker text each other. It is not uncommon for contact to be daily. The young person knows when the phone will be switched off and they have an emergency number they can call after hours.

Appendix VIII – Youth Drug Court (Christchurch) – observations of proceedings

As outlined in Section 11.3, I was privileged to be able to observe the Youth Drug Court in Christchurch. The following are my observations and further detail regarding the proceedings:

Court commences at 11.00am which provides an opportunity for the solicitors to speak to their clients before being required in court. There is time certainty, that is, each young person is allocated a specific time and 15 minutes is allocated for each young person's hearing. My initial reaction to observing the daily court list was that in a therapeutic jurisdiction, the allocated time frame seemed very short. However, the value of the pre court meeting was apparent as the members of the team had had the opportunity to raise any issues or highlight any progress and the hearing time is greatly reduced. There were 9 matters listed and all of the young people, except for one (who did not attend at all), were on time.

For almost the entire time the young person appeared in court, the discussions were only between the judge and the young person. The exceptions included, for example when a Youth Justice representative raised concerns that there had been conflict at home, contrary to what the young person was telling the judge; the young person's solicitor elaborated on what his client had said; the police prosecutor praised the progress a young person had made; and such logistical issues as the social worker and Youth Justice worker determining who would drive a young person to a medical appointment.

One of the young men graduated from the program. There was a boy admitted into the program.

One of the most moving experiences was observing Peter's case. The remarkable feature was that despite incredible adversity, he attended court. He was currently homeless and had been living on the streets for 1.5 years. He did not have any means of support and due to complications with his mother not providing his birth certificate, he could not obtain social security benefits. He did not have a mobile phone. He had quite a distance to walk in order to attend court that morning. He was concerned he would be late so he managed to get a message to a friend on Facebook to contact the court to say he was on his way.

The appreciation he had for the support he received from the Drug Court team was palpable.

Peter's drug use had declined from being one of the highest users to one of the lowest. The reason it is possible to be accurate regarding the drug use of a young person in Drug Court is because urine screens are conducted at court by Ms Prendergast, a registered nurse with the Youth Speciality Service.

There is no legislative power prescribing the taking of urine screens. However, young people agree to provide screens when they seek to enter the program. The culture of the solicitors is to encourage their clients to be admitted to Drug Court and they are supportive of screens being taken. The approach of the prosecutor is very important in this context.

When a young person is accepted onto the program, the Judge explains that whilst she wants to see their drug use and offending reduce, above all she requires the young person to be honest. She also explains to them that the screen is used to confirm what they say is happening in their lives, regarding their drug use. A positive screen will not result in charges being laid, such is the support for the court by the prosecution. It will not result in the Judge being angry with them.

It will however, enable a conversation to take place regarding what is happening at that point in time.

The young people can be on the program for 12 months, attending Drug Court fortnightly. It is intensive and requires the young person to be accountable. This is demonstrated not just because of the dialogue which takes place between the Judge and the young person, as distinct from the solicitor speaking on the young person's behalf, but also because of the layout of the court room.

The layout is shown on the next page. The proximity of the young person to the Judge assists in the young person being accountable.

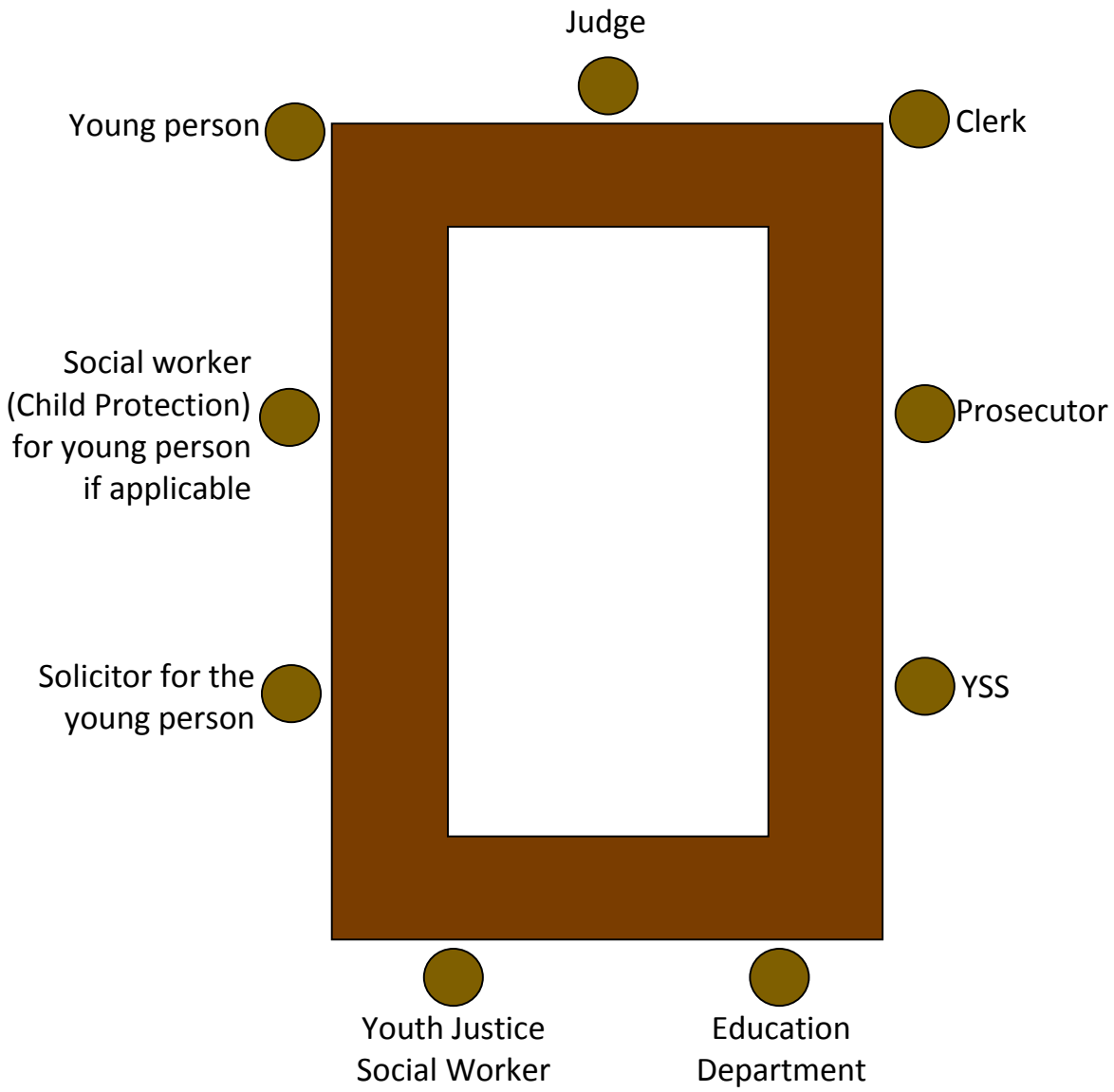
Whilst the traditional courtroom layout in Victoria would not lend itself to the New Zealand format, the critical feature was the proximity of the young person to the judicial officer and this could be accommodated in the Children's Court courtrooms as has been the case during Children's Koori Court hearings.

The discussions were relaxed but the Judge required the young people to be able to explain what their plans were and what was happening in their lives and with their drug use. A couple of the young people described having continued to use and provided reasons as to why that was the case.

Some of the young people were facing custodial sentences if they reoffended. The availability of the residential program at Odyssey House provided an invaluable opportunity for intensive support to be offered.

The boy who was accepted into the Drug Court was about to enter Odyssey House. Judge McMeeken has been presiding in the Drug Court since 2003. She estimated that approximately 25% of the young people in Drug Court at some time during the year will attend a residential rehabilitation treatment program. There has not been a recent evaluation of the Court. Anecdotally, she considered that there was an almost 100% attendance record, which is impressive because the court deals with the "top end" offenders. She also estimated that approximately 80% graduate and that is often a very special occasion.

In imposing an appropriate sentence, regard is had to the extent to which the young person has engaged in treatment and followed the treatment plan. On graduating, the young person may have a without conviction penalty imposed or there may not be any offence proven. If the young person is unable to complete their rehabilitation, they return to the Youth Court for sentence or if the offending is very serious, to the District Court.


Judge
Young person
Clerk
Social worker (Child Protection) for young person if applicable
Prosecutor
Solicitor for the young person
YSS
Youth Justice Social Worker
Education Department

Appendix IX – Consultations conducted and residential facilities visited in Victoria

Name	Organisation
Dr Astrid Birgden	Clinical and Forensic Psychologist, Deakin University
Dr Patricia Brown	Director Children's Court Clinic
Elisa Buggy	Project Manager, Family Drug Treatment Court
Justice Jennifer Coate	Family Court of Australia, Former President of the Children's Court
Judge Peter Couzens	President Children's Court
Deputy Chief Magistrate Michael Daly	Magistrates' Court of Tasmania
Dr Adam Deacon	Clinical Psychiatrist
Dr Carmel Fahey	Clinical Psychologist, Children's Court Clinic
Judge Paul Grant	County Court of Victoria, Former President of the Children's Court
Dr Stefan Gruener	Chief Executive Officer, Odyssey House, Lower Plenty
Lauren Hogan	Senior Teacher (Team Leader), Hurstbridge Farm
Ian Lanyon	Director, Secure Services, Department of Health and Human Services (includes Secure Welfare Services and Youth Justice, Parkville)
Dr Ros Lethbridge	Clinical Psychologist
Professor Patrick McGorry	Professor Youth Mental Health, University of Melbourne, Executive Director of Orygen Youth Health, Board Member Headspace
Associate Professor Richard Newton	Psychiatrist, Medical Director Mental Health, Austin Hospital
Damian Philp	Manager Birribi Residential Rehabilitation, YSAS
Donna Ribton-Turner	Director Clinical Services, Uniting Care Regen
Professor Ann Roche	National Centre for Education and Training on Addiction, South Australia
Dr Helena Sandahl	Clinical Psychologist, Children's Court Clinic
Dr Carl Scuderi	Clinical Psychologist, Children's Court Clinic
Mark Tanti	Acting Manager, Hurstbridge Farm

Peter Wearne	Director of Services, YSAS
Eddie Wilson	Youth Justice Children's Court Advice Officer
Kim Wood	Director, Clinical Programs, Headspace

Facilities visited prior to departing for the Churchill Fellowship[167]

Birribi, Eltham
Headspace, Sunshine
Hurstbridge Farm, Nutfield
Odyssey House, Lower Plenty
Secure Welfare – Ascot Vale and Maribyrnong
Uniting Care Regen, Coburg

[167] I am also very grateful to the representatives of other organisations who offered to meet with me prior to my departure on my Fellowship. I look forward to meeting with them in the near future.

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