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***Council of Attorneys-
General – Age of Criminal
Responsibility Working
Group review***

***Danila Dilba Health
Service
Submission***

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Executive Summary

Danila Dilba Health Service (**DDHS**) supports the position adopted by the national campaign group for raising the age of criminal responsibility,¹ which advocates that the laws that dictate the age of criminal responsibility in all states, territories and the Commonwealth need to be reformed in line with the following principles:

1. The minimum age of criminal responsibility must be raised to at least 14 years.
2. There must be no 'carve outs' to this legislation, even for serious offences.
3. *Doli incapax* fails to safeguard children, is applied inconsistently and results in discriminatory practices. Once the age of criminal responsibility is raised to 14 years, *Doli incapax* would cease to be relevant and therefore be redundant.
 - a. Prevention, early intervention, and diversionary responses linked to culturally-safe and trauma-responsive services including education, health and community services should be prioritised and expanded.
 - b. In Aboriginal and Torres Strait Islander communities, the planning, design and implementation of prevention, early intervention and diversionary responses should be community-led.

In addition to this, building on international research and evidence about the damaging effects of detention for young people, our submission advocates that no child under 16 should be held in detention, except in the most exceptional circumstances. We emphasise that we must work towards policy and systems reform that would support incremental increases in the minimum age of criminal responsibility and detention, in line with evidence-based practice in many countries around the world, as set out in the table at **Annexure A**.

In advancing our position that the minimum age of criminal responsibility (**MACR**) must be raised to at least 14, we point to the multitude of recent evidence that suggests that a child's brain is structurally differently to that of a mature adult, particularly in the area devoted to behaviour regulation and decision making.² We also emphasise that the dysregulation of behaviour during adolescence can be significantly exacerbated if a young person has suffered from trauma and neglect from an early age, as have many young people in the NT, and is further compounded by experiences in youth detention.³

Finally our submission draws on our experience working with young people in the justice system and our research about the evidence about 'what works' in working with these young people and preventing reoffending. In particular we discuss the importance of comprehensive and culturally appropriate assessment, and appropriately tailored intervention to improve young people's long term outcomes and overall community safety.

¹ This includes the National Aboriginal & Torres Strait Islander Legal Services, Law Council of Australia, Australian Medical Association; Change the Record; Amnesty International; Human Rights Law Centre; Royal Australian College of Physicians.

² Judge Andrew Becroft, 'From Little Things, Big Things Grow: Emerging Youth Justice Themes in the South Pacific', paper presented at Australasian Youth Justice Conference: Changing Trajectories of Offending and Reoffending, Canberra, 20 May 2013.

³ Frank Oberklaid, 'Early Childhood Development: The Building Blocks of an Equitable, Successful and Prosperous Society', paper presented at Early Years Conference: 'Today's Children – Tomorrow's Future', Cairns, 4 August 2016.

Introduction

DDHS was established in 1991 as an Aboriginal community controlled organisation. Our aim is to improve the physical, mental, spiritual, cultural and social wellbeing of Biluru (and Torres Strait Islander) people in the Yilli Rreung (greater Darwin) region. DDHS is primarily funded by the Australian Government through the Department of Health. We provide services from eight locations, reaching more than 12,000 people, approximately 70 per cent of the Aboriginal population residing in the Darwin/Palmerston region. We employ over 180 people (over 60 per cent are Aboriginal and Torres Strait Islander).

Comprehensive primary health care encompasses the range of health care generally offered by general practice but extends beyond that to provide specialist and allied health services; health promotion and education; care coordination for clients with complex health needs; social emotional wellbeing (**SEWB**) and alcohol other drugs (**AOD**) services. DDHS delivers a range of services that interface with or are targeted at children and young people at-risk of becoming or currently involved in the criminal justice system. These are:

- A collaborative assessment and planning clinic for children with behaviour and development problems (**The ABCD Clinic**). FASD diagnosis is part of the ABCD collaborative service model;
- A Youth Social Emotional Wellbeing service to build capability and skills of parents and children. The parenting program “growing kids up” is being developed to build strength for parents by providing them with the skills to more helpfully manage the often difficult experiences of adolescence and early-adolescence.
- Youth support services, including an afterhours program of pro-social activities for young people at risk of involvement in the criminal justice system and youth social support team based six-days a week at the Don Dale Youth Detention Centre (Don Dale), to provide social emotional wellbeing services and programs to children in youth detention; and
- We will soon begin delivery of primary health care services to children in detention through a clinic at Don Dale including comprehensive health assessments.
- We will also soon begin delivering Community Youth Diversion in the Greater Darwin Region for young people who have committed a divertible offence and are referred by the police or the courts.

We note that the terms of reference of this review focus on the rationale and capacity of Australian jurisdictions to raise the Minimum Age of Criminal Responsibility (**MACR**). DDHS submits the above service delivery experience has given DDHS a level of expertise on this issue that will be valuable to the Working Group’s review.

Northern Territory Context

Over-representation of Aboriginal young people in the system

Aboriginal and Torres Strait Islander young people are vastly over-represented in the criminal justice system. Throughout 2019, at all times nearly one hundred percent of young people in detention were Aboriginal.⁴ The young people in detention in the NT come from diverse cultural, linguistic and regional backgrounds – from urban centres (Darwin, Alice

⁴ <https://www.theguardian.com/australia-news/2019/may/31/system-is-broken-all-children-in-nt-detention-are-aboriginal-officials-say>

Springs, Tennant Creek, Katherine) to more remote communities (Central Australia, Arnhem land, Tiwi Islands, Wadeye etc) where English is often not their first language and where cultural practices and traditional ways of being are the norm.⁵ The majority of these children and young people come from families and communities which are socially and economically disadvantaged and are living in poverty,⁶ and many of the young people in detention are 'crossover kids' from the Child Protection system.

This degree of over-representation in the NT Youth Justice system is a reflection both of underlying risk factors that give rise to offending and re-offending and to the structure and operation of the NT youth justice system. Underlying risk factors include:

- systemic failure to address economic and social disadvantage of Aboriginal people in the Northern Territory which contributes to complex, interrelated risks that impact on many Aboriginal families and children;
- high incidence of health issues associated with disadvantage, such as hearing disorders, foetal alcohol spectrum disorders (FASD), childhood trauma and injury
- pathways into detention and offending – including the significant proportion of youth in detention who have experienced neglect or abuse, and/or have been placed in Out of Home Care (OOHC);
- developmental and behavioural disorders of children who have experienced trauma (factors which contribute to disengagement and subsequent youth offending)
- impact of detention on young people isolated from their families, communities, culture and language.

The system itself compounds over-representation and the likelihood of further offending and detention through:

- The lack of mechanisms for early identification of young people at risk of offending or reoffending;
- The operation of police powers to determine whether to divert from the youth justice system;
- A lack of suitable diversionary programs and alternatives to institutional incarceration;
- The high proportion of children and young people held in detention on remand;
- The inability of the system to direct young people into intervention and treatment programs until after they have been dealt with by the court;
- Failure to provide appropriate treatment and support to children and young people in regard to their health, disabilities, behavioural issues or past trauma.

⁵ Royal Commission Final Report, Chapter 18 'Culture in Detention'.

⁶ The AIHW has identified 'disadvantage in areas of health, education, employment, housing, and social inclusion' as key contributing factors to pathways into child protection systems, which in turn have been linked to a significantly increased risk of youth offending: AIHW, Closing the Gap Clearinghouse Resource sheet 34, Daryl Higgins and Kristin Davis (2014), Law and justice: prevention and early intervention programs for Indigenous youth. See also AIHW (2016), Vulnerable young people: interactions across homelessness, youth justice and child protection, 1 July 2011 – 30 June 2015.

Social determinants of offending

There are clear links between the Social Determinants of Health and their contribution not only to health outcomes but to the likelihood of contact with the child protection system and behaviours associated with offending. These determinants are ‘economic, physical and social conditions that influence the health of individuals, communities and jurisdictions as a whole’ – housing, education, social networks, racism, employment, law enforcement and the legal and custodial system.⁷

The AIHW has also identified ‘disadvantage in areas of health, education, employment, housing, and social inclusion’⁸ as key contributing factors to pathways into child protection systems, which in turn have been linked to a significantly increased risk of youth offending – or, as Higgins and Davis put it, ‘overlapping vulnerabilities’.⁹

A recent study at Banksia Hill Detention Centre in Western Australia (**The Banksia Hill Study**) found that 89 per cent of young offenders have a severe neurodevelopmental impairment, and 39 per cent were diagnosed with FASD.¹⁰ This is the highest prevalence of neurodevelopmental impairment in a custodial context to have been found in the world. Though a similar study has not been undertaken in the NT, it is likely that there is a very high-prevalence of FASD among children in the youth justice system.¹¹

Research has continued to emphasise the need to divert or find alternative arrangements for these youth with FASD and neuro-disability from contact with the justice system, to prevent indefinite entrenchment in the criminal justice system.¹² As we pointed out in our submission to the Royal Commission, timely assessments to diagnose disabilities when risks or vulnerabilities to young people emerge. Comprehensive holistic assessments can help to ensure that individualised support services are identified and provided to address the complex needs of these young people. These will be discussed below.

⁷ HoRCATSIA, (2011) Doing Time – Time for Doing: Indigenous Youth in the Criminal Justice System, ch.4.3, pp 87-88

⁸ AIHW, Closing the Gap Clearinghouse Resource sheet 1, Daryl J. Higgins (2010), Community development approaches to safety and wellbeing of Indigenous children;

⁹ AIHW, Closing the Gap Clearinghouse Resource sheet 34, Daryl Higgins and Kristin Davis (2014), Law and justice: prevention and early intervention programs for Indigenous youth. See also AIHW (2016), Vulnerable young people: interactions across homelessness, youth justice and child protection, 1 July 2011 – 30 June 2015: <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557799>;

¹⁰ Carol Bower et al, ‘Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia’ BJM Open (19 February 2018) <http://bmjopen.bmj.com/content/8/2/e019605>.

¹¹ Final Report of the Royal Commission into the Protection and Detention of Children in the NT (2017), Chapter 15, 351.

¹² See e.g Harry Blagg, Tamara Zulich and Zoe Bush, ‘Indefinite Detention Meets Colonial Dispossession: Indigenous Youths With Foetal Alcohol Spectrum Disorders in a White Settler Justice System’ (2017) Social and Legal Studies <https://doi.org/10.1177/0964663916676650>

DDHS Position on Raising the Age

Recommendation: Minimum age of criminal responsibility should be raised to at least 14 for all offences including serious offences

Why 14?

The Royal Commission heard substantial evidence regarding the modern understanding of child brain development, prevalence of trauma and neuro disability in young offenders, and the particularly harmful effects of detention for these young people.¹³ The evidence presented suggested a strong association between offending and early life trauma including family violence, physical or emotional abuse and neglect, removal from family or involvement in the care and protection system, all experiences likely to disrupt a child's emotional development.¹⁴ Brain structures that regulate emotion, behaviour and impulsivity are for this reason often less-developed in young offenders who have experienced trauma.¹⁵ These issues are further compounded by experiences in youth detention.¹⁶

Further, a significant amount of evidence from both behavioral science and neuroscience research has led to an understanding that offending behavior among young people is frequently driven by transient developmental influences that change with maturity. Every young person is likely to engage in increased risk-taking, have poor impulse control and poor planning skills by virtue of the physical structures of their still-growing brains.¹⁷ Children's brains are still developing throughout their formative years where they have limited capacity for reflection before action and are unable to fully appreciate the criminal nature of their actions or the life-long consequences of being labelled a criminal.

Understanding the neurobiological consequences of maltreatment and trauma on children, and consequently the underlying characteristics of young offenders is therefore critical to setting an appropriate minimum age of criminal responsibility.

In light of this, the Royal Commission recommended that Section 38(1) of the *Criminal Code Act* (NT) be amended to provide that the age of criminal responsibility be 12 years, and section 83 of the *Youth Justice Act* (NT) be amended to add a qualifying condition to section 83(1)(l) to limit the circumstances in which offenders under 14 can be ordered to serve a period of detention other than where the youth:

- has been convicted of a serious and violent crime against the person;
- presents a serious risk to the community, and
- the sentence is approved by the President of the proposed Children's Court.¹⁸

¹³ Midson, B, 2012, 'Risky Business: Developmental Neuroscience and the Culpability of Young Killers', *Psychiatry, Psychology and Law*, no. 19, vol. 5.

¹⁴ See, Professor John Boulton, Statement to the Royal Commission, 6 October 2016, 56 (ii). P 6

¹⁵ Samantha Buckingham. Legal Studies Paper No. 2016-2017. 'Trauma Informed Juvenile Justice'. 53 *American Criminal L. Rev.* 641. 2016

¹⁶ Frank Oberklaid, 'Early Childhood Development: The Building Blocks of an Equitable, Successful and Prosperous Society', paper presented at Early Years Conference: 'Today's Children – Tomorrow's Future', Cairns, 4 August 2016

¹⁷ Risky Business: Developmental Neuroscience and the Culpability of Young Killers', *Psychiatry, Psychology and Law*, no. 19, vol. 5

¹⁸ Royal Commission, Recommendation 27.1.

The NTG committed to making these changes implementing the Royal Commission's recommendations,¹⁹ and we understood that they would form a part of legislative changes to the *Youth Justice Act* (NT) in 2019.²⁰ However, the NTG has since deferred action until the CAG review has been completed and until uniform action is taken by all states and territories.

DDHS, along with other key stakeholders supported the Royal Commission's position at the time the Final Report was handed down in 2017.²¹ However, since then there have been significant developments in Australia's international treaty obligations, which have caused the Royal Commission's recommendation on this issue to be out of step with these progressed understandings. These developments include The UN Committee on the Rights of the Child (**CRC**) General comment No. 24 (2019) on children's rights in the child justice system (**General Comment No. 24**), which noted that:²²

- Article 40(3) requires state parties to set a minimum age of criminal responsibility;
- Over 50 State Parties have an MACR of 14 years of age;
- Documented evidence in the fields of child development and neuroscience indicates that maturity and the capacity for abstract reasoning is still evolving in children aged 12 to 13 years due to the fact that their frontal cortex is still developing. Therefore, they are unlikely to understand the impact of their actions or to comprehend criminal proceedings;
- States parties are encouraged to take note of recent scientific findings, and to increase their minimum age accordingly, to *at least 14 years of age*.

Further, The UN CRC's Concluding observations on the Combined Fifth and Sixth Periodic Reports of Australia (**Concluding Observations on Australia**) urged Australia that in order to bring its system into line with the Convention it needed to:

raise the minimum age of criminal responsibility to an internationally accepted level and make it *conform with the upper age of 14 years*, at which *doli incapax* applies. (emphasis added)²³

In light of this clear guidance from the CRC, DDHS, along with other key stakeholders agree that the minimum age of criminal responsibility must be raised to 14 with no exceptions. The evidence which supports this position is now firm; the most appropriate and effective interventions for young people below the age of 14 who are coming into contact with the criminal justice system is one rooted in evidence about adolescent-child brain development, restorative justice and therapeutic practice. As noted in the CRC's most recent general comment on youth justice, young people lacking criminal responsibility 'should not be in the child justice system at all'.

It is important to note the relatively low number of young people under the age of 14 who come into contact with the criminal justice system. Nationally, In 2018-19:²⁴

¹⁹ NT Government, 'Safe Thriving and Connected: Generational change for children and families 2018 – 2023' (April 2018), at 27.

²⁰ *Youth Justice and Related Legislation Amendment Bill 85* (NT) (Commencement 2 March 2020).

²¹ DDHS Submission to the Royal Commission (2017).

²² At [20] – [24]

²³ UNCRRC, Concluding Observations on Australia, CRC/C/AUS/CO/5-6, at [48].

²⁴ Australian Bureau of Statistics – Recorded Crime – Offenders, Australia 2019-19.

- Children under 14 years of age constituted less than 20% of all youth offences recorded by police.
- Almost 40% of those offences are for theft, public order or property damage.

Furthermore, in the NT, the number of young people offending has been stable and has fallen slightly over the last seven years despite a growth in the total population of young people. The numbers of people below the age of 14 who are coming into contact with the criminal justice system is small enough that alternative approaches can (and in fact already are considered), albeit on a case-by-case basis.

Why should the age be raised for all offences including serious offences?

The MACR should be raised to 14 and should be applied uniformly in all circumstances. Relevantly in the General Comment No. 24 the CRC stated:

The Committee is concerned about practices that permit the use of a lower minimum age of criminal responsibility in cases where, for example, the child is accused of committing a serious offence. Such practices are usually created to respond to public pressure and are not based on a rational understanding of children's development. The Committee strongly recommends that States parties abolish such approaches and set one standardized age below which children cannot be held responsible in criminal law, without exception.²⁵

The community demands that young people are held accountable for their offending, particularly where this offending is serious (e.g sexual offences, or serious offences against the person). However evidence and practice from overseas jurisdictions indicates that systems can be setup to provide interventions which adequately safeguard the community whilst providing for young people in an appropriate and meaningful way avoiding criminalisation and its harmful effects. Some of these alternative approaches including in Belgium, Finland, Switzerland and Scotland were discussed in detail in the Final Report of the Royal Commission.²⁶

Scottish Example

In Scotland, where there is no prison service for children under 16, measures taken to raise the minimum age of criminal responsibility included giving police the power to take young people to a 'place of safety', bringing the matters into the care and protection system rather than criminal justice. These matters are primarily dealt with through family group conferences, avoiding much of the harm caused by traditional court processes, resulting in increased compliance with orders by young people and overall reducing re-offending.

Doli Incapax

Where the age of criminal responsibility is raised to 14 and no exceptions are created for offences committed under that age, the presumption of *doli incapax* will no longer be relevant and need not apply.

The Royal Commission discussed issues relating to the doctrine of *Doli Incapax* and its inconsistent application in the NT.²⁷ Legal services gave evidence about the often long delays between when the offence is committed and when the issue of *Doli Incapax* is finally

²⁵ General Comment 24, at [25].

²⁶ Royal Commission, Chapter 27, at p 418-419.

²⁷ Royal Commission Final Report, Chapter 25, p 324.

ventilated in court, in particular where there is an appeal. This is exemplified by the case study set out below. These delays are both a drain on resources, and are deleterious to the rehabilitation of the young person, who, by the time a decision about *Doli Incapax* is finally reached, have often already experienced significant contact with the harmful elements of the system.

Case Study: *KG v Firth* [2019] NTCA 5

KG was 13 year old at the time of the alleged offending. It was common ground that KG suffered from a significant intellectual disability and severe functional impairments and FASD. He had also been raised in dysfunctional and transient home environments and suffered early childhood trauma, including exposure to domestic and sexual violence.²⁸

The matter proceeded to trial in the Youth Justice Court in October 2017. The Court acquitted the young person despite being satisfied that the prosecution had proven all of the elements of the offence.

On appeal to the Supreme Court (*R v KG* [2018] NTSC 68) the intermediate Appeal Judge upheld the appeal. The case was then appealed to the Court of Appeal, which in 2019, the overturned the decision, upholding the Trial Judge's decision that the doctrine of *Doli Incapax* applied.

This case, which took over two years to resolve, demonstrates the often protracted process of determining a question of *Doli Incapax*, which is a complicated legal concept. In the intervening period, whilst this complicated legal question is considered, a young person may have had repeated contact with police, have spent time in police watch houses and/or on remand in detention facilities. This often occurs in the absence of an evidence based and more appropriate intervention that could address the social determinants of a young person's offending behaviour. The criminal justice system itself, is what inflicts harm on young people, particularly Aboriginal and Torres Strait Islander Youth. The evidence of the harms caused by this interaction is clear:

- The Royal Commission noted the harm caused to children by time in custody²⁹
- The Australian Medical Association has noted in particular the negative impacts imprisonment has on the health of Aboriginal and Torres Strait Islander peoples.³⁰
- youth imprisonment is associated with higher risks of suicide and depression;³¹
- the earlier in a child's life that contact begins with the criminal justice system, the greater the likelihood of further enmeshment in that system.³²

²⁸ *KG v Firth* [2019] NTCA 5 at p 2.

²⁹ Commonwealth, Royal Commission into the Protection and Detention of Children in the Northern Territory, Final Report (November 2017), Volume 1, Chapter 27, 28.

³⁰ Australian Medical Association (2012) "The justice system and public health", available at <https://ama.com.au/position-statement/health-and-criminal-justice-system-2012>.

³¹ Commonwealth, Report of the Royal Commission and Board of Inquiry into the protection and detention of children in the Northern Territory, (November 2017).

³² Sentencing Advisory Council, Reoffending by Children and Young People in Victoria, (December 2016), 26

Effective responses for Under 14 year olds

Culturally appropriate comprehensive assessment and early intervention

Children and young people who come into contact with the youth justice system have complex and overlapping vulnerabilities and needs, which are not being addressed, as outlined above. In our submission to the Royal Commission we noted that in the NT, there is no coherent, comprehensive process to assess the needs of vulnerable children and their families.³³ Our submission noted that decision makers (Police, Courts and Government Departments) and service providers working with these children often do not have enough information to make decisions that will ensure that a child or young person gets the supports and responses they need.

Evidence demonstrates that early assessment and intervention is important to long term outcomes and to ensure access to appropriate services.³⁴ Looking at the beginning of a person's life, factors which contribute to becoming involved in the youth justice system are also factors which impact negatively on health outcomes. This overlap and close links between health, disability and contact with justice and child protection have led to DDHS becoming involved in service provision and advocacy in this area.

International Best Practice – Tuituia Assessment Process

Comprehensive, holistic, culturally appropriate assessment is a key part of the New Zealand approach that has delivered positive results. New Zealand has developed a tool called Tuituia which is based on detailed work to develop and validate measures across domains that are important in directing action to support, service and hold young people and families accountable.³⁵ Through this process, every child or young person's needs, strengths and risks need to be assessed at an early point of contact with child protection or youth justice.

The assessment will:

- identify risks affecting the child or young person that make them more vulnerable to abuse and neglect, or more likely to have conduct problems, offending, and poor life outcomes;
- Identify the strengths and resources available to the child or young person within family and community;
- Look at the hopes and dreams of the child or young person.

Such an assessment allows the system to respond in ways that reduce risks of abuse and neglect and reduce the likelihood of conduct problems and offending continuing. It is undertaken or updated at various decision points during the child or young person's contact with the system. If a child or young person has further or ongoing contact with the system, the assessment will remain with them and can be updated if circumstances change.

DDHS ABCD Assessment Process

Building on evidence about the need for early assessment and intervention to improve long term outcomes for vulnerable children and families, over the past few years DDHS has

³³ DDHS Submission to the Royal Commission, p 38.

³⁴ INSERT

³⁵ <https://practice.mvcot.govt.nz/policy/assessment-and-decision-making/resources/understanding-the-tuituia-domains-kaitiaki-mokopuna.html>

worked in partnership with the Top End Health Service (**TEHS**) Paediatric Department to improve specialist services for Aboriginal and Torres Strait Islander children in the Darwin/Palmerston region. In February 2019, with the assistance of NT Department of Health funding,³⁶ and funding as part of a research project with PATCHES Paediatrics,³⁷ DDHS established an Assessment of Behaviour and Child Development Clinic (**ABCD Clinic**) to support families and children with learning, behavioural and development issues.

These assessment processes are complex and multidisciplinary and, involve ruling out vision and hearing problems, neuropsychological assessment, as well as assessment by paediatricians, OT, physios and speech pathologists. For our clients, given the impact of trauma and overlapping vulnerabilities the ABCD Clinic is holistic, and aims to strengthen through continuity and developing trusting relationships. The existing service aims to:

- Support Aboriginal families, children and carers to establish diagnoses, and support plan for children with development and behaviour difficulties including FASD;
- Strengthen capacity of specialist and primary health care staff in assessment and planning for children with development and behaviour difficulties;
- Engage children and their families in primary health care and specialist follow up and to identify children who are eligible for NDIS funded services;
- Improve access to allied health services for DDHS child clients.

The collaborative model brings together the expertise of DDHS staff with knowledge of community and primary health care, paediatricians and registrars with an interest, knowledge and skill in development, behaviour, assessment and management. FASD assessment is also an integral part of the ABCD assessment process, particularly given the implication that a FASD diagnosis can have on availability of supports, particularly through the NDIS.

Our ABCD Clinic strives to ensure holistic engagement, assessment and case coordination, building on relationships of trust to assist families to navigate complex referral pathways and systems. This involves assisting children and families to access all relevant assessments and supports to meet their child's complex and overlapping needs (e.g vision, hearing, impact of trauma and other developmental concerns) as well as assisting with other challenges like accessing safe accommodation.

Case Study

Leanne*, a DDHS client, is the carer for her three grandchildren. One of the children was suspected of having autism, one was suspected of having ADHD, and all three had a history of trauma and suspected in-utero alcohol exposure. The children all came into Leanne's care with foetal incontinence, difficulty learning and regulating behaviour. At this time Territory Families were also involved as the school had made reports of concern regarding the children and were particularly concerned about the children's behaviour. Leanne was terrified of losing the children, whom she loved and cared for dearly.

At this time the family came to the attention of the ABCD Clinic project officer through a referral from Leanne's regular DDHS clinic. Given the complexity of the case, it was decided that it was necessary to convene a case conference to develop an assessment and

³⁶ Arising out of the NT FASD Strategy.

³⁷ A nationally funded research and service development project, with a vision of building a private public assessment and planning service with sites across Australian. Funding for this research helped support an additional DDHS child health project officer position.

treatment plan. Through engagement with her local clinic, Leanne was supported to keep the assessment process on track, including referrals for hearing, vision and other relevant assessments. The children were engaged with several support services, including occupational therapy and play therapy to help address their complex trauma.

Working across the DDHS services, a social worker from our SEWB team was also engaged to assist Leanne with a range of other challenges, for example arranging furniture for the house.

*This is an actual client. Name changed for privacy reasons.

Assessments of functional capacity and FASD are particularly important as they can help clients to gain access to relevant supports, including through the NDIS. At DDHS this process has been strengthened through our health-justice partnership with the Northern Territory Legal Aid Commission, through which we are able to work collaboratively to assist children, parents and carers to navigate the complex legal and other processes.

In his evidence to the Royal Commission, Dr James Fitzpatrick discussed the importance of ensuring access to multidisciplinary assessments to determine functional capacity. He noted at [20] that:

The neuropsychologist is in a good position to establish the functional implications of a child's unique profile to inform psychoeducation and facilitate a better understanding of the child's functioning, with the opportunity for ongoing review and assessment as the child develops. Such assessments are typically multi-faceted, and require an understanding of the complex neuropsychological, clinical, forensic and educational implications of neurodevelopmental conditions, often within a cross-cultural context.³⁸

Our experience working with vulnerable children, young people and their families, highlights the importance of taking a child wellbeing and development focussed approach. Investment in comprehensive and culturally appropriate assessment, and appropriately tailored intervention, can help to improve young people's long term outcomes.

Culturally strengthening diversion programs

Aboriginal young people are vastly over represented in Australian youth justice systems, particularly in the NT, where in 2019, at almost all times 100 per cent of children in detention were Aboriginal. As outlined above, this overrepresentation is caused by the complex and overlapping social determinants: pervasive disadvantage, poverty, overcrowding, poor parenting, mental health issues, and substance misuse and family and community violence.³⁹

As such, DDHS firmly believes that we must adopt a public health framework, which looks at these social determinants of youth offending and empowers all agencies and services working with children and families to provide better universal and targeted universal programs to ensure that all children have an upbringing that is safe, respected and free from harm. In this way, shifting the focus and resourcing to prevention and early intervention will see fewer young people, particularly those below that age of 14 that come into contact with the criminal justice system.

³⁸ Dr James Fitzpatrick, Evidence presented to the Royal Commission into the Protection and Detention of Children in the NT (2017), at [20].

³⁹ Royal Commission, Volume 3A, p 197.

Where young people below the age of criminal responsibility are coming into contact with the criminal justice system, holistic interventions, focussed on child wellbeing and development, are likely to have the best results. For Aboriginal children, it is clear that the most effective responses are those that are designed and delivered by Aboriginal communities, recognising and utilising the young person's language and culture as a source of strength.

In the NT, significant work has already begun, both within Government and in the NGO, Social Services and Aboriginal Community Controlled sector to prepare to deliver more effective interventions to young people and affect a transition to a higher age of criminal responsibility. As part of this DDHS has taken an active role in both advocating for, and developing a holistic and comprehensive model of intervention that can be applied without criminal justice system involvement. For example as part of our Community Youth Diversion program, DDHS will accept referrals for 8-10 year olds. We have worked with our in-house team of child specialist psychologists to develop an adapted restorative process that will provide an evidence based intervention to curb offending behaviour and address underlying factors that may be causing this.

DDHS is developing a culturally safe and locally relevant Youth Diversion service that will target the holistic needs of young people and provide an intervention which can occur entirely outside of the criminal justice system. Central to this model is an understanding that:

- young people coming into contact with the Criminal Justice System and their associated behaviour, particularly those under the age of 14, is primarily a function of the care that the young person has received in early childhood;
- a disproportionately high number of young people in this cohort have been the subject of trauma, abuse and neglect, some from an early age. This trauma affects child brain development, particularly the ability to regulate and respond to stress.
- A significant majority of young people in detention suffer from neuro-developmental impairments and disabilities with a significant number suffering from Fetal Alcohol Spectrum Disorder.

In light of this understanding, the service that DDHS has developed includes the following key, evidence based elements that will drive better outcomes for young people and the community avoiding harmful contact with the criminal justice system.

- Holistic and comprehensive assessment of the young person and their family across several domains undertaken by culturally appropriate and qualified staff.
- Where relevant, follow-on assessments as part of our paediatric clinic to assist with diagnosis and treatment of potential neuro-cognitive disability including Fetal Alcohol Spectrum Disorder, which can unlock access to more supports through the NDIS.
- Restorative Justice Conferencing involving the victim and/or the family, the outcomes of which are guided by restorative principles aimed at helping a young person to understand the harm they have caused and to, where appropriate, repair that harm in a way that can be understood by a developing or damaged brain.
- Access to programs and activities, participation in which can either be linked or unlinked to an outcome of a restorative conference. These programs and activities are aimed at connecting young people with culture, family and country as guided by the evidence of how these three elements form protective factors

against youth offending and are a pathway to resilience for young people across several health and welfare domains.⁴⁰

- A wide and diverse range of internal and external referral pathways, including case-by-case work with key stakeholders to ensure a young person is in a safe and supportive environment and that their developmental needs are being met across several domains including; physical and mental health, education, culture and family.

Attached at **Annexure B** is a diagram that sets out this model.

⁴⁰ Harry Blag and Tamara Tulich 'Diversionary pathways for Aboriginal Youth with Fetal Alcohol Spectrum disorder' (August 2018).

DDHS Position on Minimum Age of Detention

Recommendation: Detention should be used as a genuine measure of last resort for all young people under 18; and there should be a legislated minimum age of 16.

The CRC has provided clear advice that State parties should also legislate a minimum age of detention:

The Committee recommends that no child be deprived of liberty, unless there are genuine public safety or public health concerns, and encourages State parties to fix an age limit below which children may not legally be deprived of their liberty, such as 16 years of age.⁴¹

The table set out at **Annexure A** demonstrates that several countries around the world have set a higher minimum age of detention, some as high as 18. In our view, the detention of children must be an absolute measure of last resort, for example where the offending is so serious that there is no viable alternative. As outlined above, in light of the damaging effects of detention for the vast majority of children coming into the youth justice system, detention is not the appropriate response. This is particularly so in the context of the NT, where a period in detention often causes a young person to be taken far away from home (sometimes thousands of kilometres) away from family, support networks and cultural support.

The Report of the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment, notes:

16. Children deprived of their liberty are at a heightened risk of violence, abuse and acts of torture or cruel, inhumane or degrading treatment or punishment. Even very short periods of detention can undermine a child's psychological and physical well-being and compromise cognitive development. Children deprived of liberty are at a heightened risk of suffering depression and anxiety, and frequently exhibit symptoms consistent with post-traumatic stress disorder. Reports on the effects of depriving children of liberty have found higher rates of suicide and self-harm, mental disorder and developmental problems.⁴²

Moreover, detaining a young person in the NT is expensive: in 2017-18 the average cost per day, per young person subject to detention in the NT was approximately \$2000.⁴³ On the contrary, the average cost per day, per young person subject to community-based supervision in the NT was approximately \$500.⁴⁴

⁴¹ General Comment 24, at [89].

⁴² The Report of the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment (5 March 2015) A/HRC/28/68 at <https://www.refworld.org/docid/550824454.html>

⁴³ Productivity Commission, Report on Government Services 2019 'Community Services: Youth Justice' Figure 17.10 at <https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/youth-justice/rogs-2019-partf-chapter17.pdf>

⁴⁴ Ibid, Figure 17.9.

Community engagement

Recommendation: Community engagement and awareness campaigns should be embedded throughout reform processes to educate wider community about evidence-based, best practice reforms to youth justice

In order for the NT's youth justice system to be effectively reformed in line with national and international standards of child wellbeing, it is essential that a government-led community education and awareness campaign is embedded alongside this process of incremental reform.

In light of retrospective amendments to the *Youth Justice Act*⁴⁵ which, effectively back flipped on amendments passed less than a year earlier to implement some of the Royal Commission's recommendations,⁴⁶ it is clear that there must be community understanding and engagement in the legislative reform process to ensure broad support for the changes. There is strong evidence within the local context, notwithstanding the breadth of international evidence about the need for community education to build a strong foundation for reform through coordinated community engagement, education and awareness building.⁴⁷

If and when the wider community becomes aware of the social determinants of youth offending, and understands the evidence available from a broad range of contexts around the world regarding improvements to community safety that can be attributed to raising the age of criminal responsibility, effective and sustained reform can be implemented to ensure a best-practice, child-wellbeing centred approach to youth justice in the Northern Territory.

⁴⁵ *Youth Justice Amendment Bill* (Serial 84).

⁴⁶ *Youth Justice Amendment Bill* (Serial 48).

⁴⁷ See Marsha Weissman et al 'Moving Beyond Prisons: Lessons from New York City's Implementation of Close to Home' (February 2019) at <https://justicelab.columbia.edu/news/moving-beyond-youth-prisons-lessons-new-york-citys-implementation-close-home>

Annexure A – Comparison of Minimum Age of Criminal Responsibility and Minimum Age of Detention in other Jurisdictions

Country	Minimum Age of Criminal Responsibility	Minimum Age for Detention	Special Conditions (*)
<i>Albania</i>	14	N/A	
<i>Armenia</i>	16 and 14*	N/A	For specific offences
<i>Austria</i>	14	N/A	
<i>Azerbaijan</i>	16 and 14*	14	For specific offences
<i>Belarus</i>	16 and 14*	N/A	For specific offences
<i>Bosnia and Herzegovina</i>	14	N/A	
<i>Brazil</i>	18	18*	May be subject to socio-educational measures over 12, and other measures under 12
<i>Bulgaria</i>	14*	N/A	May be subject to educational measures in the case of socially dangerous acts
<i>Cambodia</i>	14	N/A	Under 14 can still be subject to education, surveillance and protection/assistance measures
<i>China (Mainland)</i>	16 and 14*	18**	*for specific offences if 'discernment' can be proven **under 18 may be subject to shelter and rehabilitation by the government if necessary
<i>Croatia</i>	14*	N/A	Offenders under 14 are dealt with by the Centre for Social Welfare
<i>Cyprus</i>	14	N/A	
<i>Czech Republic</i>	15	N/A	
<i>Denmark</i>	15	N/A	
<i>Finland</i>	15*	N/A	Offenders under 15 are contained within the Child Welfare Act
<i>Georgia</i>	14	N/A	
<i>Germany</i>	14	N/A	
<i>Greece</i>	15	8-13*	Can only be subject to educational/ therapeutic measures
<i>Hungary</i>	14 and 12*	N/A	For specific offences and if 'discernment' can be proven

<i>Iceland</i>	15	N/A	
<i>Italy</i>	14 and 14-17*	N/A	If 'discernment' can be proven
<i>Japan</i>	14	11*	Can be committed to Juvenile Training Schools
<i>Kazakhstan</i>	14	N/A	
<i>Kyrgyzstan</i>	16 and 14*	N/A	For specific offences
<i>Lithuania</i>	16 and 14*	N/A	For specific offences
<i>Luxembourg</i>	18 and 16*	N/A	For specific offences
<i>Mongolia</i>	16 and 14*	N/A	For specific offences
<i>Montenegro</i>	14	N/A	
<i>Norway</i>	15	N/A	
<i>Peru</i>	18	18*	Under 18 may be subject to socio-educative measures under 14 may be subject to protective measures
<i>Poland</i>	17 and 15*	N/A	For specific offences
<i>Portugal</i>	16	12	
<i>Romania</i>	14 and 14-16*	N/A	If 'discernment' can be proven
<i>Russia</i>	16 and 14*	N/A	For specific offences
<i>Serbia</i>	14	N/A	
<i>Slovakia</i>	14 and 15*	N/A	For sexual abuse cases
<i>Slovenia</i>	14	N/A	Under 14 can be committed to juvenile institutions (specific age not stated)
<i>Spain</i>	14	N/A	
<i>Sweden</i>	15	N/A	
<i>Tajikistan</i>	16 and 14*	N/A	For specific offences
<i>Timor-Leste</i>	16	N/A	For specific offences
<i>Ukraine</i>	16 and 14*	N/A	For specific offences
<i>Uruguay</i>	18	18*	May be subject to socio-educative measures from 13

Annexure B – DDHS / YWCA Diversion Process

