

PeakCare Queensland Inc.

Discussion Paper

Secure Care - Needed or Not?

March 2013



CONTENT

| | |
|---|-----------|
| Background | 2 |
| Views and opinions raised with the Commission | 3 |
| Core concerns of the Commission | 5 |
| Purposes of this paper | 6 |
| Parts of the paper | 7 |
| | |
| Part One: What United Nations rules and conventions say | 8 |
| Rules for the Protection of Juveniles Deprived of their Liberty | 8 |
| Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) | 9 |
| Convention on the Rights of the Child | 9 |
| Key elements of the Covenant and Rules | 10 |
| | |
| Part Two: A ‘snapshot’ of secure care provided elsewhere | 11 |
| New South Wales – Therapeutic secure care | 11 |
| Victoria – Secure welfare services | 12 |
| Western Australia – Secure care arrangement | 13 |
| Scotland – Secure care estate | 14 |
| England – Secure accommodation network | 15 |
| | |
| Part Three: Past, present and proposed reasons for detaining Queensland children | 16 |
| The circumstances under which Queensland children can currently be detained | 17 |
| Detention of children on arrest or sentence for a criminal offence | 17 |
| Detention for the assessment and/or treatment of mental illness | 18 |
| Other circumstances under which children may be detained | 19 |
| The relationship between secure care and youth detention | 20 |
| The relationship between secure care and secure mental health services | 26 |
| The role and purpose (if any) to be served by secure care | 31 |
| | |
| Part Four: Other major consideration factors | 36 |
| Who should determine children’s admission and length of stay in secure care and what (if any) restrictions should apply to their admission or length of stay? | 36 |
| What avenues and rights of review and appeal should be made available to children who are detained in secure care? | 38 |
| How many and where should secure care facilities be located in Queensland? | 39 |
| How ‘secure’ is ‘secure’? | 41 |
| How restrictive should secure care practices and procedures be? | 44 |
| What programs and services should be provided for resident children? | 46 |
| How is cultural safety to be promoted? | 47 |
| What are the costs of providing secure care? | 48 |
| | |
| References | 50 |



BACKGROUND

On 1st July 2012, the Queensland Child Protection Commission of Inquiry (the Commission) was established for purposes of making recommendations for ‘charting a new roadmap for child protection over the next decade’. The Honourable Tim Carmody SC was appointed as Commissioner and charged with the responsibility of providing a report with recommendations to the Premier by 30th April 2013. The due date for this report has recently been extended to 30th June 2013.

Witnesses appearing at public hearings of the inquiry as well as written submissions lodged by individuals and organisations have raised the introduction of a ‘secure care’ option for children¹ in Queensland as a matter for consideration by the Commission. The topic also receives attention in the Commission’s *February 2013 Discussion Paper* which notes that the Commission has “heard evidence relating to the establishment of a therapeutic secure care model of placement, or a ‘containment model’” (Queensland Child Protection Commission of Inquiry, 2013, p135).

For the purposes of this discussion, secure care is broadly defined as a form of congregate care in a setting from which children are not permitted to leave at will. In various jurisdictions where secure care exists as an option, a more precise and fuller description may be used to define the particular model and approach to secure care that has been adopted locally.

Reflective of the diversity of models and approaches to secure care that have been adopted, the views and opinions that have been submitted to the Commission vary widely in relation to their presentations of a rationale for a secure care placement option. Subsequently, similarly wide variations exist in the opinions being offered about the purposes of secure care, its functions and ‘fit’ within the range of other systems, service and placement responses that may be accessed by Queensland children.

Factors that appear to have prompted interested parties to raise the need for a secure care option include:

- an opinion that some children need to be contained within a secure care setting, but do not meet the criteria for detention under the *Mental Health Act 2000* or incarceration within a youth detention centre either on arrest or sentence for a criminal offence in accordance with provisions of the *Youth Justice Act 1992* and moreover, in the opinion of some, would not be appropriately contained within either of these settings
- an observation that, even when the criteria for detention under the *Mental Health Act 2000* may be met, the current infrastructure of ‘acute’ in-patient units within Queensland is not appropriately designed to provide the long-term placements and treatment that these children require, and
- a view that the suite of kinship, foster and intensive foster care services and residential and therapeutic residential care services that currently exists in Queensland is inadequate in

¹ The terms ‘child’ and ‘children’ have been used to refer to persons aged 0 to 17 years. Where specifically referring to older children in their teenage years, the terms ‘adolescent child/ren’ or ‘young person/people’ have been used.

being able to deliver the intensity of therapeutic care needed for some children due to, at least in part, an inability of these services to ‘contain’ these children through the use of various security measures.

Views and opinions raised with the Commission

Within written submissions and/or evidence verbally provided to the Commission, most proponents of secure care generally refer to multiple purposes that may be served in having this option introduced, but ascribe significantly different ‘weightings’ to each purpose.

For example, most in their presentation of information to the Commission argue that secure care is needed to contain and curtail the behaviours of some children in order to prevent these behaviours causing harm to themselves and/ or others. However in relation to the ways in which secure care is intended to achieve this aim, significant differences exist in the amount of emphasis placed on the ‘disciplinary’ and/ or ‘punitive’ purposes of secure care in preventing children from ‘absconding’ and in managing ‘unruly, defiant and criminal behaviour’. In response to ways in which secure care was being described during some of the public hearings, dialogue that transpired with two witnesses led Commissioner Carmody to summarise the purpose of secure care as “something between residential care and (youth) detention”² and “a step between a youth detention centre and a residential care facility”³.

In contrast with this description, some written submissions have given greater emphasis to the ‘therapeutic’ purpose of secure care. In these instances, it is argued that the containment of some children is necessary to ensure, coercively if necessary, their access to various programs and interventions aimed at addressing their “emotional, psychological and educational/learning needs”⁴. Their containment is viewed as necessary for therapeutic strategies to “gain traction”⁵ without disruption caused by a child’s refusal to attend or absconding from the premises in which these strategies are being delivered. Proponents of this approach warn against secure care being perceived as performing the functions of a “quasi-correctional centre” and the adoption of a “punishment mindset” in preference to a “treatment mindset”⁶. The argument is presented that secure care can serve a role in preventing children proceeding on a “trajectory towards long-term incarceration in the adult prison system”⁷.

In contrast with the description of secure care falling somewhere in between residential care and youth detention which implies that residential care per se has, at least, some level of punitive or

² Transcript, Peter Waugh, 4 October 2012, Beenleigh (p19: line 34)

³ Transcript, Antoine Payet, 3 October 2012, Beenleigh (p23: line 3)

⁴ Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)

⁵ Submission of Mercy Family Services, December 2012 (p50)

⁶ Submission of Mercy Family Services, December 2012 (p50)

⁷ Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)

disciplinary purpose associated with it, Commissioner Carmody summarised this approach as “detention for therapeutic purposes rather than for punitive reasons”⁸.

In line with these contrasting approaches, some appear to conceptualise the containment of a child as an emergent measure that should be strictly time-limited by regulation for purposes of intermittently serving as an ‘adjunct’ to other longer term therapeutic programs, placement and support services that are being provided to the child. Others appear to perceive the containment aspect as ongoing and integral to the long-term care of a child within a residential setting. Where the latter view is held, preferences stated in relation to the length of secure care placements range from “12 to 24 months or more”⁹ through to open-ended periods of time “informed by assessment, rather than a blanket regulation”¹⁰.

Whilst not explicitly stated within written submissions, it appears that the children for whom secure care is presented as a possible option represent a sub-set of children who are in the guardianship of the ‘chief executive’¹¹ (i.e. it has not been suggested that secure care also be made available for the detention of children who are not in the guardianship of the chief executive, which is unlike other settings such as youth detention centres and mental health facilities in which children are currently detained).

It is noted that to the best of PeakCare’s knowledge, no written submissions have been made to the Commission as yet that oppose the introduction of a secure care option, which is not to suggest that this opinion is not held by a number of parties with an interest in this matter. It is also noted however that one witness, when questioned about the need for “facilities whereby both therapeutic services as well as some restrictive practices were applied... (for)... some young people who have discipline problems” indicated her lack of support for a “punitive response... (that)... represents an escalation to containment” when we cannot be satisfied that the types of therapeutic services exist that are better able to effectively address and respond to the reasons for the behaviours of these children¹².

Another witness expressed concerns about “the comparison being made to (youth) detention and whether young people have the ability to understand that they’re not in secure care because they’ve necessarily committed an offence” and whether secure care would be “institutionalising young people in another way”¹³.

⁸ Transcript, Peter Waugh, 4 October 2012, Beenleigh (p21: line 9)

⁹ Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)

¹⁰ Submission of Mercy Family Services, December 2012 (p51)

¹¹ The term ‘chief executive’ has been used in the same manner in which it is used in the *Child Protection Act 1999* (i.e. it refers to the Director-General of the Department of Communities, Child Safety and Disability Services).

¹² Transcript, Natalie Lewis, 16 January 2013, Brisbane (p61: line 7)

¹³ Transcript, Marissa Sherry, 7 February 2013, Brisbane (p50: line 11)

During testimony by Ms Margaret Allison, Director-General of the Department¹⁴ within one of the concluding hearings of the inquiry, Ms Allison expressed reservations about returning to practices of the past where there was a “blurring between what we now call youth detention centres and secure care facilities”. Ms Allison stated that her strong reservations about secure care are also based on her longstanding concerns about the “paucity of mental health services for young adolescents ... (and) ... great deal of difficulty of getting access to mental health services for adolescents manifesting extreme behaviours”¹⁵.

Core concerns of the Commission

Central to the concerns of the current inquiry, as stated by Commissioner Carmody, is assessing the extent to which the State should exercise legislated authority in “interfering with family privacy and autonomy”. Commissioner Carmody stated, “It can only do that on clear and transparent grounds that the community is willing to permit that’s consistent with contemporary values that are shared and you can only act, if you’re the State, in accordance with the law”¹⁶.

Notwithstanding the wide variations in the views and opinions submitted to the Commission about the purpose of secure care and the means and processes for its delivery, a key element that is inherent within all of the proposals is the need for an extension of the legislated authority held by the State to intrude not only on the autonomy of families, but also the civil rights and liberties of some children.

As detailed within other parts of this paper, the authority held by the State to ‘contain’ individuals, either adults or children, through the imposition of either ‘static’¹⁷ and/ or ‘dynamic’ security measures¹⁸ is strictly restricted by laws to a limited number of circumstances. In relation to most of these circumstances, the relevant laws apply additional restrictions concerning the length of time (if any) and conditions under which a child can be detained in recognition of the lesser levels of maturity and greater vulnerability of children compared to adults.

The importance ascribed by law to the personal liberty of individuals is reflected in Queensland’s Criminal Code which states that any person who unlawfully confines or detains another in any place against the person’s will, or otherwise unlawfully deprives another of the other person’s liberty is guilty of a misdemeanour (s.355). The maximum penalty for the offence of deprivation of liberty is three years imprisonment. As defined by the Australian Defence Lawyers Alliance, “Deprivation of liberty simply means taking away the free choice of a person to move about as he or she wants”

¹⁴ The term ‘Department’ has been used to refer to the Queensland Government agency responsible for administering the Child Protection Act 1999

¹⁵ Transcript, Margaret Allison, 26 February 2013, Brisbane (P105: line 7)

¹⁶ Transcript, Natalie Lewis, 16 January 2013, Brisbane (p7: line 24)

¹⁷ For the purposes of this discussion, ‘static’ security measures are defined as buildings or other physical structures, property or ‘electronic’ equipment intended to detect, prevent and/or impede a person’s egress from a designated location

¹⁸ For the purposes of this discussion, ‘dynamic’ security measures are defined as person-related activities such as surveillance, supervision and /or actions taken to physically restrain or obstruct a person’s egress from or movements within a designated location

(2013). Beyond keeping a person in confinement through use of force or physical restraint, the deprivation of liberty extends to using threats as a means of compelling a person to remain in a place against their will.

The significance of extending State authority to intrude upon a child's liberty that their placement in secure care would entail must not be understated, especially when it is being proposed that this authority would apply exclusively to children (i.e. an adult in similar circumstances would not be made subject to this same level of intrusion).

The significance of this matter appears to be appreciated by the Commission. During a public hearing when it was suggested that use of the term 'detention' within the previously noted description of secure care as 'detention for therapeutic purposes rather than punishment' may be 'problematic', Commissioner Carmody responded by saying that "we have got to stop beating around the bush. I think that this is part of the problem. People don't say what they mean"¹⁹. This sets up a clear challenge to not be euphemistic in describing secure care and under-playing the fact that secure care entails children being deprived of their liberty. Understating the significance of this aspect of secure care belies the gravity of the process to be undertaken by the Commission in weighing up any perceived benefits to children that might possibly arise from the introduction of secure care with the increased level of authority that would need to be vested in the State to allow for this level of intrusion into the civil rights and liberties of some children.

Beyond reaching a determination about whether or not this level of intrusion can be justified, in the event that a decision is made that secure care is warranted, consideration must also be given to the manner and conditions under which it is to be provided. This would require clarity being achieved about the purpose of secure care, the circumstances in which it may be used (and not used), and the means and processes to be employed in governing and administering its delivery.

Purposes of this paper

The purposes of the paper are to:

- identify and methodically explore the issues that need to be taken into account in considering the introduction of a secure care option for Queensland children in State care
- serve as a catalyst for further discussion and debate amongst PeakCare's member agencies, supporters and other interest groups about this important matter
- collect and collate the range of views and opinions formed by these parties based on their own research, practice experience and knowledge, and
- provide this information to the Commission, thereby adding to the body of knowledge being considered in its inquiry.

¹⁹ Transcript, Peter Waugh, 4 October 2012, Beenleigh (p21: line 9)

Parts of the paper

To assist in ‘tracking through’ and focussing on the various elements of this matter, the paper is presented in four parts:

- Part 1 summarises aspects of various United Nations conventions and rules relevant to this discussion
- Part 2 provides a ‘snapshot’ of the various forms of secure care provided in other Australian jurisdictions and elsewhere
- Part 3 identifies the past, present and proposed reasons for detaining Queensland children in State care and what role, if any, secure care might serve in comparison with other system and service responses, and
- Part 4 lists and describes other major consideration factors that it is suggested need to be taken into account in weighing up the possible benefits and detriments of introducing a secure care option within Queensland and, in the event that secure care is introduced within Queensland, the manner and conditions under which it should be delivered.

At intervals throughout Parts 3 and 4 of the paper, opportunity is provided for comments to be entered into the paper either by individuals or representatives of organisations, or in response to facilitated group discussions of PeakCare members and supporters.



Part One:

WHAT UNITED NATIONS RULES AND CONVENTIONS SAY

Some United Nations conventions and rules serve as a useful reference point in considering the introduction of secure care. The following summarises key elements of the conventions and rules relevant to this discussion.

Rules for the Protection of Juveniles Deprived of their Liberty

The scope and application of these Rules

The *Rules for the Protection of Juveniles Deprived of their Liberty* sets out rules that apply to all types and forms of facilities in which children are deprived of their liberty. While Section III of the *Rules* apply specifically to children on arrest or sentence for a criminal offence, the remaining four sections apply to youth detention facilities (i.e. facilities used to detain children on arrest or sentence) as well as all other types of facilities and settings in which children are detained (Rule 15).

For the purpose of the *Rules*, 'deprivation of liberty' is defined as any form of detention or imprisonment or the placement of a child in a public or private custodial setting, from which the child is not permitted to leave at will, by order of any judicial, administrative or other public authority (Rule 11(a)).

A 'juvenile' is defined by the *Rules* as a person under the age of 18 (Rule 11(a)).

As a 'fundamental perspective', the *Rules* stipulate that the deprivation of a child's liberty should be "a disposition of last resort and for the minimum necessary period and should be limited to exceptional cases" (Rule 2).

The management of facilities (Section IV)

Section IV of the *Rules* sets out requirements in relation to the management of facilities in which children are detained including:

- the collection and use of all legal and medical records and records of any disciplinary proceedings undertaken in respect of individual children
- processes to be observed in managing the admission, registration, movements and transfers of children from one facility to another
- the classification and placement of children in facilities that are best suited to their particular needs
- children's access to:
 - education, vocational training and/or work
 - recreation
 - opportunities to observe and practise their religious and spiritual beliefs
 - adequate medical care including, where a child is suffering from a mental illness, treatment within a specialised institution under independent medical management
 - regular and frequent visits with family and legal counsel as well as contact with the 'wider community'
 - services that facilitate their return to the community, and
 - complaints processes and independent authorities that are empowered to regularly inspect and report on the facilities in which children are detained.

Section IV also addresses practices concerning the use of physical restraint and force, limiting their use to 'exceptional cases' explicitly authorised and specified by law and regulation wherein the physical restraint or force is used to prevent self-injury, injuries to others or serious destruction of property. Corporal punishment is prohibited as is 'placement in a dark cell, closed or solitary confinement'. This section stipulates that children are to be informed of alleged infractions and provided opportunities to present their defence and appeal to an impartial authority.



Personnel (Section V)

Section V of the *Rules* sets out requirements in relation to ensuring that the personnel employed to work within facilities where children are detained:

- are qualified and include a sufficient number of educators, vocational trainers, counsellors, social workers, psychiatrists and psychologists
- are appointed as professional officers with adequate remuneration to attract and retain suitable men and women, and
- receive training in child psychology, child welfare and human rights.

Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules)

Whilst predominantly addressing ways in which children should be dealt with and treated during any involvement they may have with a youth justice system, the *Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules)* nevertheless provide some guidance regarding the detention of children generally (i.e. not only those who have been arrested or sentenced for a crime). Specifically, Rule 3.1 states that the provisions of the *Beijing Rules* shall be applied not only to juvenile offenders but also to juveniles who may be proceeded against for any specific behaviour that would not be punishable if committed by an adult (i.e. 'status offences').

Rules 17.1 (c) and (d) state that:

- (c) restrictions on the personal liberty of a child shall be imposed only after careful consideration and shall be limited to the possible minimum, and
- (d) the deprivation of a child's liberty shall not be imposed unless the child is adjudicated of a serious act involving violence against another person or due to their persistence in committing other serious offences and there is no other appropriate response.

Rule 17 implies that strictly punitive approaches are not appropriate in dealing with children. While recognising that 'just desert' and 'retributive' sanctions might be considered to have some merit in cases of severe offending, "such considerations should always be outweighed by the interest of safeguarding the well-being and the future of the young person".

In keeping with the rationale underpinning Rule 17, Rule 19.1 states that the placement of a child in an institution shall always be a disposition of last resort and for the minimum necessary period.

Convention on the Rights of the Child

The *Convention on the Rights of the Child* is a human rights treaty setting out the civil, political, economic, social, health and cultural rights of children. The *Convention* defines a child as any human being under the age of 18, unless the age of majority is attained earlier under a state's own domestic legislation.

Article 3(1) requires countries that are signatories to the *Convention* (such as Australia) to ensure that the best interests of the child are the primary consideration in all actions concerning children.

Specifically in relation to actions taken that deprive children of their liberty, Articles 37(b) and (d) declare that:

- (b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.
- (d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent independent and impartial authority, and to a prompt decision on any such action.



Key elements of the Covenant and Rules

Read together, there are five key elements contained with the *Convention on the Rights of the Child*, the *Beijing Rules* and the *Rules for the Protection of Juveniles Deprived of their Liberty* that are especially relevant to this discussion:

1. The deprivation of a child's liberty and their detention for whatever reason must be a **measure of last resort**.
2. The deprivation of a child's liberty and their detention must be for the **shortest appropriate period of time**.
3. No child shall be detained **unlawfully or arbitrarily**.
4. Every detained child has the **right to challenge** the legality of their detention before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.
5. The **best interests of the child** must be the primary consideration and over-ride all other considerations that may be relevant to the deprivation of their liberty and detention.

The principles that detention of children should be a last resort option used for the shortest appropriate period of time read with the 'best interests of the child' principle indicates that there is an obligation to explore all possible alternatives to secure care prior to depriving a child of their liberty and to do so with the best interests of the child given paramount consideration.

Beyond serving as a useful framework for considering the question of whether or not children should be detained within secure care and under what (if any) circumstances this detention should occur, specific articles and rules contained with the *Convention on the Rights of the Child*, the *Beijing Rules* and *Rules for the Protection of Juveniles Deprived of their Liberty* also establish the manner and conditions under which secure care should be provided if it were to be introduced to Queensland. Further reference to these articles and rules is made in Part 4 of this paper.



Part Two:

A 'SNAPSHOT' OF SECURE CARE PROVIDED ELSEWHERE

Other Australian jurisdictions that have for some time made use of a secure care option for children are Victoria, Western Australia and New South Wales and more recently, a range of secure care responses for adults and children has been commenced in the Northern Territory. Secure care has also been considered by South Australia but not proceeded with in that state.

The following provides a 'snapshot' of secure care provided in other Australian jurisdictions as well as England and Scotland. The descriptions provided illustrate some areas of commonality along with significant variations in the approaches taken by various jurisdictions.

New South Wales – Therapeutic secure care

Target group

The target group is children aged 12 to 17 years in out-of-home care who require intensive care and support, which can only be effectively provided in a secure therapeutic environment to protect them from extreme risk taking or life threatening behaviour such as serious or life threatening self-harming behaviour, serious risk taking behaviour that leads to severe abuse and exploitation, particularly sexual exploitation, drug or substance abuse that leads to severe harm or risk of death. The child must be case managed by the New South Wales Department of Communities (i.e. not a non-government organisation). If case management has already been transferred to a non-government organisation (as per the New South Wales system that allows for the transfer of case management responsibility to a non-government organisation), the arrangements concerning the child's admission and ongoing case management are negotiated with the Department.

Stated purpose

Therapeutic secure care is a placement option to keep children safe while their behavioural, emotional, educational and mental and physical and health needs are assessed, their case plans are reviewed and linkages to appropriate support services and treatment are established or enhanced. Usually the child presents in a state of crisis with multiple challenging behaviours and may have been resistant to previous treatment interventions. The intention is to reduce the serious risk to the child arising from their behaviour to the extent that it can be effectively managed in a community setting and return the child to a less restrictive community placement, such as therapeutic residential care, intensive foster care, supported independent living, relative or kinship care or family restoration, as quickly and safely as possible.

Referral process

A referral is commenced through a case conference that makes a recommendation about whether to apply for a therapeutic secure care order in the Supreme Court. The Director-General must approve seeking a therapeutic secure care order. If the child is Aboriginal, an Aboriginal case worker must be involved in the case conference and other legislated provisions about consulting with family or community must be adhered to. If the child is from a culturally and linguistically diverse (CALD) background, CALD background input or a culturally appropriate person must inform the case conference. For refugee or asylum seeker children with a history of detention and/ or refugee related trauma, refugee health specialist input is required.

Length of stay

The length of stay is determined by the New South Wales Supreme Court.



Authority

The decision about the order is made by the New South Wales Supreme Court, reflecting the seriousness of detaining a child involuntarily and the exceptional circumstances leading to such a decision being made. The court only makes interim therapeutic secure care orders. The court sets the review dates for each matter and provides instruction to the Department on what information must be provided at the next review (i.e. a court case management model).

Miscellaneous

There is one facility, Sherwood House in south west Sydney, which was established in February 2009 and is managed by the New South Wales Department. It has capacity for a maximum of 4 residents (though the 2010-11 annual report of the Department states that it provides placements for up to 5 young people) and offers a range of educational and recreational spaces and facilities including space to meet with family and significant others. The house operates from a 'therapeutic philosophy' and has a 1:2 staff to child ratio. Direct care staff facilitate behavioural change and other interventions are delivered by a range of mental health, education and medical professionals. Community visitors monitor children's welfare while placed in the facility. Children are advised about their rights relating to their detention.

Victoria – Secure welfare services

Target group

The target group is children aged 10 to 17 years who are at substantial and immediate risk of harm and the only suitable option to ensure the child's safety and wellbeing (i.e. a significant crisis for the child, not for the protection of others or property) is to restrict the child's freedom of movement within the community by placement at a secure welfare service. Children under 10 years can be placed in exceptional circumstances. Children are either under a custody or guardianship order to the State or under an interim accommodation order (IAO).

Stated purpose

The purpose of placement in a secure welfare service is to stabilise the crisis, a single incident or an accumulated risk, by addressing immediate safety issues and keeping the child safe while plans are developed or revised to reduce their risk of harm and return the child to the community as soon as possible. As this placement option involves a restriction of the child's liberty, it may be used only where other placement and support options have been considered and assessed as inadequate in being able to protect the child from significant harm.

Referral process

Depending on the child's legal status, the divisional Child Protection Operations Manager (or designated on call manager outside office hours) or the court may make a decision to place the child at a secure welfare service. For children under a custody or guardianship order to the State, the Secretary must be satisfied that there is a substantial and immediate risk of harm to the child, or if the child is under an IAO or any other court order, the Court must be satisfied that there is a substantial and immediate risk of harm to the child.

Three criteria must be met: (1) placement in a secure welfare service is in the child's best interests (defined by factors relating to the child's stability, development and safety needs), (2) no other available support or placement is adequate to protect the child from significant harm, and (3) a secure welfare service place is available and can meet the child's identified needs. The child is consulted about the placement and if the child is Aboriginal, there must be consultation with an Aboriginal Child Specialist Advice Support Service (ACASS).

Where case management is contracted to a non-government agency, that agency is responsible for procedural tasks relating to the placement.

Length of stay

A child can be placed for a maximum uninterrupted 21 day limit. In exceptional circumstances, there can be an extension not exceeding 21 days. The legal maximum is an uninterrupted period of 42 days.



Authority

Admission to a secure welfare service may occur via either an administrative arrangement approved by the appropriately delegated manager or an interim order (secure care) made by the court.

Right of review

An internal review can be requested by persons affected by the decision (i.e. parent, carer, child) to place or not to place a child in a secure welfare service or about the proposed length of stay. The review outcome is communicated and explained to the child by the next working day (or within 24 hours for a placement of less than 72 hours duration) by the reviewer or a person delegated by the reviewer, and to the care team within 2 business days. Case work decisions can be reviewed by the Victorian Civil and Administrative Tribunal. For a child under an IAO, there are different review provisions.

Miscellaneous

The secure welfare service is a specialist statewide service located in the north and west region. It provides two 10-bed gender specific residential units that are staffed on a rostered 24 hour 'stand up' model. There is an initial health screening within 12 hours for an Aboriginal child and within 24 hours for other children. A case meeting is held within 48 hours (or sooner) of admission with the family, case worker, carers/staff and care team to review the purpose and goals of the placement, transition plans, and roles and responsibilities. The child can be actively involved in planning and goal setting to the extent to which this is in each child's best interests. If the placement is longer than 7 days, the '48 hour meeting' sets review timeframes. There must be a written transition and exit plan. Children are told about their rights relating to their detention.

Western Australia – Secure care arrangement

Target group

The target group is children aged 12 to 17 years:

- who are subject to a short or long term protection order or application, or in the provisional protection and care of the chief executive officer (CEO)
- where there is an immediate and substantial risk of significant harm to themselves, and
- where the broader protection and care network cannot manage or reduce the risks to the child.

The grounds for placement cannot be risk of harm to others.

Stated purpose

As referral is usually precipitated by a significant crisis in a child's life. Secure care is a planned, short term, intensive intervention, the purpose of which is to stabilise the child and keep them safe while reviewing or developing a suitable plan to address the child's needs in readiness for a return to the community. Secure care is the option of last resort where containment is deemed necessary and in keeping with the child's best interests. Secure care is not described as being a residential placement option or a punitive option, but rather as a 'therapeutic care service'.

Referral process

Similar to the Victorian approach, three criteria must be met: (1) placement in secure care is in the child's best interests (defined by factors relating to the child's stability, development and safety needs); (2) no other available support or placement is adequate to protect the child from significant harm; and (3) there has been appropriate consultation undertaken indicating that a secure care placement is available which can meet the child's identified needs. If the child is Aboriginal, there must be consultation with an Aboriginal Practice Leader prior to authorisation of the placement, if possible. If the child is from a CALD background, there must be consultation with a team leader or Senior Practice Development Officer. If there are complex cultural issues, there must be consultation with a Senior Advisor Cultural Diversity, prior to authorisation of the placement, if possible.

Referral is not appropriate if the child's needs are best serviced through admission to a mental health facility or if a youth justice (detention on arrest or sentence) response is required.

Length of stay

A child can be placed for a maximum uninterrupted 21 day limit - the 'secure care period'. In exceptional circumstances, there can be an extension not exceeding 21 days. The legal maximum is an uninterrupted period of 42 days.

Authority

Admission to secure care may occur via either an administrative secure care arrangement made by the CEO (or delegate) or an interim order (secure care) made by the Children's Court.

Right of review

A child, a carer or the child's parents can apply for a 'reconsideration' of the CEO's secure care decision by an 'independent' senior departmental officer regarding the secure care arrangement, the period of the secure care arrangement or an extension of this arrangement. If the person is unhappy with the review outcome, they can apply to the State Administrative Tribunal (SAT) for a review of the decision.

Miscellaneous

There is one statewide Secure Care Centre (Kath French Secure Care Centre) which commenced operating in mid 2011 and is located east of Perth. From January 2013, there are 6 beds, a cost cutting reduction from the previous 9 beds. The child's care team utilises a therapeutic approach and there are in-residence educational, health and recreational services. A child's care plan or provisional care plan must be reviewed not more than 2 working days after admission (secure care initial planning meeting). Staff, service representatives, the child's family and the child participate. Secure care arrangements are subject to inspection and quality assurance through external assessors appointed by the Departmental CEO. Family contact is encouraged and facilitated. Children are told about their rights relating to their detention.

Scotland – Secure care estate

Target group

The target group is children under the age of 16 years who are in need of care and protection for their own safety or who commit offences (i.e. present a risk to others), notwithstanding the acknowledged overlap between the two groups.

Stated purpose

The purpose of secure care is to keep the child safe, 'set boundaries' and re-engage them with support and positive activities.

Miscellaneous

There were more beds than demand in 2009. Scotland now has 106 secure care places spread across seven dedicated secure care units which provide a full curriculum of care, delivering a range of educational, health and behavioural programs for children. The units undertake tailored programs of work to prepare children for their transition back into the community. Because the nature of secure accommodation in Scotland is strongly influenced by being located within services for 'looked-after-children' and the welfare-based children's hearings system, regardless of the protection or offending reasons for their referral to a secure care unit, all children receive a welfare-based service in a child-centred setting. The average cost of a secure placement during 2007-08 was £4,500 per week.



England – Secure accommodation network

Target group

The target group is children aged 10 to 17 years. The child:

- must have a history of absconding and is likely to abscond from anything other than secure accommodation, and
- if the child absconds, is likely to suffer significant harm, or
- if kept in anything other than secure accommodation, is likely to injure themselves or other persons.

Referral process

Secure care is the option of 'last resort' for use after all other options have been comprehensively considered and rejected.

Length of stay

A first application for secure care can be for up to 3 months and 6 months for a subsequent application to keep the child in the accommodation. Courts often prefer to make 28 day orders. As part of making the case to the court, the social worker must present what they envisage for the child beyond that of secure accommodation. No child can be kept by the local authority in a secure unit once the dangers relating to absconding and harm to self or others no longer exist. A court must regularly decide whether or not these dangers have passed. There is provision for emergency placement but for no longer than 72 hours. The legal right to restrict the liberty of a child aged 16 or 17 years without an interim or full care order relies on the voluntary agreement of the child to reside within the unit.

Authority

A secure accommodation welfare order is sought from the Family Proceedings Court to protect a child. In order to seek an order for a welfare placement of a child under 13 years, special permission is first required from the Secretary of State.

Miscellaneous

There are 17 secure care units in England, providing full residential care, educational facilities and healthcare. Some provide 'welfare' and 'youth justice' placements and some specialise in one or the other. Seven of the 17 only provide welfare placements. Most are provided by local authorities with a small number provided by non-government agencies. A very high level of intensive help is offered to each child, with low child to staff ratios. A secure accommodation review is held within 28 days of admission and at least every 3 months thereafter. These involve one local authority person and two others who are independent of the placement and decision making. The purpose of the review is to ascertain whether or not the criteria for restricting the child's liberty continue to be met. Secure care units are subject to in-depth regulation through the Office for Standards in Education, Children's Services and Skills (Ofsted). Ofsted is an independent body responsible for the regulation and inspection of services which care for children and those that provide education and skills for learners of all ages. Ofsted reports directly to Parliament.



Part Three: PAST, PRESENT AND PROPOSED REASONS FOR DETAINING QUEENSLAND CHILDREN

In determining whether a secure care option is needed within Queensland, it would seem necessary to firstly identify those circumstances under which, and for what purposes, Queensland children can already be detained. This includes identifying the legislated restrictions that currently apply to the circumstances under which they can be detained.

This information is regarded as essential in ensuring that the reasons being stated for the introduction of a secure care option:

- are well-informed and able to demonstrate if and in what ways such an option would effectively address a 'gap' in system and service responses to an identifiable group of children
- are not simply being borne out of a frustration with the performance of other service systems or responses in adequately addressing the needs of particular children which may include, where necessary, their detention in a secure facility, and/ or
- represent an expeditious means of undermining or subverting legislated restrictions to the detention of children that may be soundly based in contemporary practice and/ or are being promoted for reasons other than the 'best interests of the child' as required by Article 3.1 of the *Convention on the Rights of the Child*.

Given the significance of depriving a child of their liberty, a determination that secure care is needed should only be concluded if it can be clearly established that:

- all other alternative options have been properly considered in accordance with Article 37(b) of the *Convention on the Rights of the Child*, Rule 17.1 of the *Beijing Rules* and Rule 2 of the *Rules for the Protection of Juveniles Deprived of their Liberty*
- better and more appropriate 'solutions' cannot be found in changes to policy governing other service responses to children and/ or the ways in which these services are being provided
- the detention of children in secure care would not be viewed as unlawful or arbitrary, in keeping with Article 37(b) of the *Convention on the Rights of the Child*, and
- the benefits to certain children that would arise from their detention in secure care outweigh the potential detrimental effects and is congruent with their best interests, in keeping with Article 3(1) of the *Convention on the Rights of the Child*.

In reaching a conclusion, it should be established that:

- there are clearly discernible differences between the reasons for depriving children of their liberty and detaining them in secure care and those that account for their detention in other settings (such as a youth detention centre or mental health facility)



- the profile, characteristics, needs and/ or behaviours of children detained in secure care would differ from those detained in these other settings, and
- the differing purposes of each secure setting (i.e. secure care, youth detention and secure mental health service) would be reflected in their facility designs and location, staffing arrangements and programming.

The circumstances under which Queensland children can currently be detained

The following table summarises the circumstances under which children can currently be lawfully detained within Queensland.

Detention, on arrest or sentence, for a criminal offence

The *Youth Justice Act 1992* sets out the processes that allow for the detention of children, on arrest or sentence, in a youth detention centre. Subject to certain provisions of the *Youth Justice Act 1992*, the *Bail Act 1980* also applies to a court or police officer when making decisions about the granting of bail to a child. When bail is refused, a child may be held in a youth detention centre or a watchhouse pending their transportation by police officers to a youth detention centre.

Schedule I of the *Act* lists a Charter of Youth Justice Principles, one of which states that “a child should be detained in custody for an offence, whether on arrest or sentence, only as a last resort and for the least time that is justified in the circumstances”.

The ages of children to whom the Act applies

The *Youth Justice Act 1992* defines a ‘child’ as being a person aged 17 years or less. However, Queensland’s *Criminal Code* states that children under 10 years of age cannot be regarded as criminally responsible and are therefore excluded from punishment for a criminal offence. Children under the age of 10 are presumed to be *doli incapax*, meaning ‘incapable of wrongdoing’. Children aged 10 to 13 years in principle are also not liable to punishment for criminal offences. However, the *doli incapax* principle can be rebutted for this age group and they can be liable if it is proved they had the capacity to know what they were doing was wrong. Once 17 years of age, a young person is treated as an adult with some exceptions provided for within the *Act*.

Detention Orders

The *Act* sets out the range of unsupervised, supervised and custodial orders that may be made by various courts. Sentencing principles that are included within the *Act* state that a non-custodial order is better than detention in promoting a child’s ability to reintegrate into the community (s.150(b)) and a detention order should be imposed only as a last resort and for the shortest appropriate period (s.150(e)).

A court may make a detention order against a child only if the court is satisfied that no other sentence is appropriate in the circumstances after considering all other available sentences (s.208(a)) and taking into account the desirability of not holding a child in detention (s.208(b)). It is required that a court consider a detention order when no other sentence is considered appropriate. This is to ensure that detention is only imposed as a last resort.

Detention orders have fixed release dates. Generally, a statutory period of 70% of any sentence is served in detention with the remainder of the sentence spent in the community under terms and conditions set by the Department of Justice and Attorney-General (s.227(1)). Under special circumstances, a court may order that a minimum of 50% of a detention order is spent in custody (s.227(2)). Non-compliance with the conditions of a supervised release order may result in the child serving the remainder of their sentence in a youth detention centre or receiving a boot camp order (s.246(1)).



A child who is sentenced to detention must serve their period of detention in a youth detention centre (s. 210(1)). Currently, there are two purpose-built and designed youth detention centres in Queensland – the Brisbane Youth Detention Centre at Wacol and the Cleveland Youth Detention Centre at Townsville.

Detention for the assessment and/or treatment of mental illness

The *Mental Health Act 2000* sets out the processes that allow for persons, whether ‘adults or minors’, to be detained for involuntary assessment or treatment of a mental illness (s.4).

For the purposes of administering the *Act*, mental illness is defined as “a condition characterised by a clinically significant disturbance of thought, mood, perception or memory” (s.12(1)). The *Act* further stipulates that an adult or child cannot be considered to have a mental illness merely because they:

- hold or refuse to hold a particular religious, cultural, philosophical or political belief or opinion
- belong to a particular racial or socio-economic group
- have a particular sexual preference
- are engaged in sexual promiscuity or other conduct that may be viewed as immoral or indecent
- take drugs or alcohol or are engaged in antisocial or illegal behavior
- have an intellectual disability
- are or have been involved in family conflict, or
- have previously been treated for a mental illness or been made subject to involuntary assessment or treatment .

The *Act* also states that any power exercised under the *Act* (such as authorising involuntary assessment or treatment) should affect a person’s liberty and rights only if no other less restrictive ways can be used to protect the person’s health and safety or to protect others, and the effect on their liberty and rights are to be the minimum necessary in the circumstances (s.9).

Involuntary assessments

In setting out the processes that enable an involuntary assessment to be undertaken by an authorised doctor, the *Act* allows for a person to be detained in a public hospital or mental health facility for up to 24 hours with provision for this time period to be extended by an authorised doctor to a maximum of 72 hours.

Involuntary Treatment Orders

An Involuntary Treatment Order may be made by an authorised doctor for the treatment of a person’s mental illness without that person’s consent. The Order may be used to authorise community-based treatment or the involuntary detention of the person receiving treatment at a mental health facility. In making an Involuntary Treatment Order, it must be established that:

- there is an imminent risk that the person will harm him or herself or another person, or
- the person is likely to suffer serious mental or physical deterioration, and
- there is no less restrictive way of treating the person, and
- the person lacks the capacity to consent to the treatment or has unreasonably refused treatment (s.14(1))

An Involuntary Treatment Order ends after 72 hours unless it is confirmed by a psychiatrist within that time frame. If confirmed, the Order remains in force until it is revoked by the authorised doctor or the Director of Mental Health, or upon a review by the Mental Health Review Tribunal or appeal of that decision.

Classified patient provisions

The *Mental Health Act 2000* also includes ‘classified patient provisions’ that apply to adults and children who are remanded in custody or serving a period of imprisonment or youth detention. These provisions authorise the person’s detention in an authorised mental health facility for involuntary assessment or treatment.



Provisions that apply exclusively to ‘young patients’

The *Mental Health Act 2000* includes some provisions that apply exclusively to young patients in order to safeguard their best interests. These include:

- stricter time frames for reviews by the Mental Health Review Tribunal of a young patient’s detention in a high security unit (s. 194(1))
- a stipulation that the administrator of a high security unit must not agree to the admission of a young patient for assessment without the approval of the Director of Mental Health (s.53(2)), and
- a requirement that the Director of Mental Health immediately notify the Mental Health Review Tribunal of their approval for, or ordering of, the transfer of an involuntary young patient to a high security unit.

Other circumstances under which children may be detained

Detention of persons with a controlled notifiable condition

The *Public Health Act 2005* allows for chief executive orders of up to 24 hours to be made for purposes of detaining an adult or child in a public health service when:

- it is reasonably suspected that the person has, or may have, a controlled notifiable condition (s.113(1)(a))
- it is reasonably suspected that the person’s condition, or condition and likely behaviour, constitutes an immediate risk to public health (s.113(1)(b)), and
- reasonable attempts have been unsuccessfully made at counselling the person about the condition and its possible effects on the person’s health and on public health (s.113(1)(c)).

Upon application made to a court, a magistrate may make a controlled notification order including:

- an initial examinations order (s.116(1)(a)) during which the person may be detained for up to 72 hours (s.119(1)(b))
- a behavioural order (s.116(1)(a)), or
- a detention order (s.116(1)(a)) for up to 28 days (s.130(1)(a)).

Detention of persons pending processing of their claim for asylum

The Commonwealth *Migration Act 1958* allows for the detention of children, either accompanied or unaccompanied by adults, to be detained pending the processing of their claim for asylum. Most children who are detained are in the company of adults who have overstayed their visas or who are seeking asylum after having arrived in Australia without a visa. While Australian law makes no distinction between the detention of children and adults in these circumstances, Government policy states a preference for children to not be detained in immigration centres. Where children are accommodated in low-security facilities, priority is to be given to promptly accommodating them in community detention allowing them to receive support from non-government organisations and state welfare agencies.

As indicated by the information contained within the above table, Queensland children can only be detained for highly specified purposes enshrined in legislation. Of particular relevance to this discussion are:

- the circumstances under which children are currently detained on arrest or sentence under the *Youth Justice Act 1992* or for purposes relating to their mental health under the *Mental Health Act 2000*, and

- the ways in which, if any, secure care would cater for children in different circumstances and for a different purpose²⁰.

The relationship between secure care and youth detention

In keeping with national trends at the time, proclamation of the *Juvenile Justice Act 1992* (now referred to as the *Youth Justice Act 1992*) represented a shift from ‘welfare model’ principles that were reflected in provisions of the former *Children’s Service Act 1965*, to a ‘justice model’. In essence, the justice model promotes notions that:

- children are primarily responsible for their own behaviours
- courts should be responsible for adjudicating their guilt or innocence, and
- where guilt is established, courts are responsible for ordering a response that is proportionate to the child’s offences and culpability.

Consistent with these notions, key youth justice principles incorporated within Schedule 1 of the *Act* state that “A child who commits an offence should be:

- (a) held accountable and encouraged to accept responsibility for the offending behaviour; and
- (b) dealt with in a way that will give the child the opportunity to develop in responsible, beneficial and acceptable ways”.

Sentencing principles stated within the *Act* also require that there be a “fitting proportion between the sentence and the offence” (Section 150(1)(k)).

Why was there a shift from a welfare model to a justice model?

The shift in philosophy towards a justice model was intended to answer widespread criticisms of the welfare model including:

- the lack of due process and rights accorded to children
- the excessive use of discretionary powers exercised by child welfare bureaucracies
- the incarceration of children in detention centres for non-criminal matters including, in particular, ‘status offending’ (i.e. actions that are considered to be ‘offences’ due to the age of a child such as truancy, running away and promiscuity, for which an adult would not be ‘prosecuted’), and

²⁰ This statement is not intended to be dismissive in any way of the significance of actions taken to detain children with a controlled notifiable condition or those who are detained pending the processing of their claim for asylum or the impact of this detention on the wellbeing of affected children. It is noted that in New South Wales, it is appropriately required that the history of refugee and asylum seeking children’s detention must be taken into account if the placement of these children in therapeutic secure care is being sought.

- the indeterminate ‘sentencing’ of children to detention for periods not proportionate to their offence/s and the vulnerability of children to ‘harsher punishments’ than those imposed upon adults.

Under the *Children's Services Act 1965*, provision existed for a child to be “deemed to be in need of care and control if:

- (a) the child is falling or is likely to fall into a life of vice or crime or addiction to drugs;
- (b) the child is exposed to moral danger; or
- (c) the child is or appears to be uncontrollable”.

Under the *Act*, a child could be committed to a ‘care and control’ order and be detained in a detention centre at the direction of the Director, Department of Children's Services. However, those provisions were repealed in 1992 upon proclamation of the *Juvenile Justice Act 1992*, thereby removing the administrative powers held by the Department to determine whether or not children were placed in detention, and the period for which children could be detained.

In practice, the use of care and control orders to detain children had ceased in practice some time before proclamation of the *Act* in response to longstanding criticisms of the welfare model. As noted by O'Connor in his critique of the newly introduced *Juvenile Justice Act 1992*, “Many reformers were concerned about the harm suffered by children at the hands of bureaucracies acting in children’s ‘best interests’” (1992, p129). Reported findings of the *Commission of Inquiry into Abuse of Children in Queensland Institutions* (1999) about the detention of children under provisions of the *Children's Services Act 1965* noted the injustices that issued from the arbitrary judgements made about the character and circumstances of the child and thus the types of treatment or rehabilitation considered appropriate.

In PeakCare’s preliminary submission to the current inquiry, commentary is provided about the vulnerability of children to moral and cultural constructs that have historically impacted child protection practice including, in particular, the grounds on which some children have been detained:

Somewhat perversely, the danger of a moral or cultural bias influencing child protection policy and practice has also in the past disadvantaged children whose families have a ‘mainstream’ demographic profile. These were the children from ‘good families’ who were too frequently not heard or believed when they complained of being abused or whose behaviours in acting out the trauma of their abuse, were misinterpreted and dealt with in a punitive manner.

Within commentary contained in the 1967 Director’s Annual Report of the Queensland Department of Children’s Services explaining the high numbers of ‘intractable’ girls detained in ‘training homes’, a conclusion was drawn, “The problem involving girls is generally morals, but in a few cases they have been involved in offences”. A developing awareness of sexual abuse and public outcry about the high numbers of children, ‘status offending’ female children in particular, being detained in the Wilson Youth Hospital eventually prompted the establishment of a Commission of Inquiry. The Demack Report that was released in 1976 recommended the use of alternative facilities and services for adolescent girls and emphasised community responsibility and treatment in preference to



their detention. However, the legislated ability to detain ‘uncontrollable’ children on the grounds of being ‘likely to fall into a life of vice’ remained in place until the early 1990s²¹.

As summarised by O’Connor (1992) in his description of the rationale for a shift to a justice model, “The benefits claimed for the justice model are that children are accorded the same legal process rights accorded to adults, intervention is restricted to criminal matters, and sentencing is proportionate to the child’s deeds, rather than needs” (1992, pp129-130).

Is secure care a ‘back to the future’ response?

To the best of PeakCare’s knowledge, no submissions have been made to the Commission recommending that youth detention centres be used as secure care facilities (i.e. it has not been suggested that the same secure facility be used to accommodate children on arrest or sentence for a criminal offence and children who are being detained in secure care). Invariably however, statements pertaining to the use of secure care to detain children for reasons of ‘absconding, unruly, defiant and criminal behaviour’ draw obvious comparisons with past practices in detaining children who were made subject to care and control orders, even if their detention were to take place in a separate facility.

As such, it may be expected that many of the same concerns previously held about the detention of children in accordance with a welfare model will re-emerge including, in particular:

- the opening of an avenue to have children detained without being accorded due process or rights concerning the adjudication of their alleged offences (or indeed, their non-criminal ‘misbehaviour’), and
- the imposition of a ‘penalty’ that deprives children of their liberty that may be disproportionate to their ‘offence’.

Concerns may be especially anticipated in relation to secure care creating the potential for inequitable and arbitrary treatment of some cohorts of children (such as Aboriginal and Torres Strait Islander children who are already grossly over-represented within and at all points of both the child protection and youth justice systems and, as was traditionally the case, adolescent girls). These concerns are borne out of not only Queensland’s own history of detaining children as highlighted by findings of the *Commission of Inquiry into Abuse of Children in Queensland Institutions* (1999), but also emerging trends within other States. For example, analysis of Victorian data has found that female children are more likely to be both admitted and re-admitted into secure care than males.

A matter of particular concern is the extent to which the introduction of a secure care option for children displaying ‘absconding, unruly, defiant or criminal behaviour’ may potentially dilute Queensland’s adherence to principles contained within the *Convention on the Rights of the Child*, the *Beijing Rules* and the *Rules for the Protection of Juveniles Deprived of their Liberty*, namely that:

²¹ Submission of PeakCare Queensland, October 2012, p11

- a child’s detention must be a measure of last resort and be for the shortest appropriate period of time
- no child should be detained arbitrarily, and
- every detained child has the right to challenge the legality of their detention before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

These are principles that are generally reflected within the *Youth Justice Act 1992* and which underpinned the shift to a justice model.

Do other jurisdictions establish a clear distinction between youth detention and secure care?

It appears that other Australian jurisdictions have attempted in a number of ways to address concerns about the “blurring between what we now call youth detention centres and secure care facilities” noted in the testimony of Ms Margaret Allison.

Major ways in which distinctions appear to have been drawn between youth detention and secure care include:

- making use of a separate infrastructure of facilities for youth detention and secure care, and
- defining the target population for secure care and establishing ‘admission criteria’ that excludes children for whom a youth justice response is deemed to be more appropriate.

For example, the *Secure Care Background Paper* produced by the Western Australian Department in February 2011 clearly states, “Secure care is not appropriate for children ... who require a juvenile justice response such as detention/ remand facilities” (p2).

Referral guidelines currently used in Western Australia also state that secure care is:

- not for the purpose of ‘punitive detention’
- not to be used as an alternative option for children who are remanded in custody or serving a period of detention, and
- not to be used where risk of harm to others is the only ground for a child’s admission. (In cases of serious incidents involving physical harm to others and criminal offences, these matters are to be referred to the police.)

The distinctions drawn by Australian states between a youth justice response and the use of secure care are not as apparent in some overseas jurisdictions. In Scotland, for example, where 106 secure care placements are provided by seven secure care units, the children who are accommodated within these units include a ‘mix’ of non-offending children in need of protection (i.e. for their own safety) and children who have committed offences (i.e. for the safety of others). In England where there are 17 secure care units, some provide both ‘youth justice’ and ‘welfare’ placements while others specialise in one or the other.



As such, the United Kingdom's approach to secure care may be seen as more reminiscent of Queensland youth detention practices under the *Children's Services Act 1965* operating in accordance with the now abandoned welfare model.

Would secure care be a 'stepping-stone' to imprisonment or provide the diversion some children need?

The written submission of the Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists advocates for the introduction of a 'secure children's home' model similar to that used in the United Kingdom so that children "can receive the help they need before they are on a trajectory towards long-term incarceration in the adult prison system"²². They qualify their argument by stating that the criteria for children's admissions should be based on "risk and welfare, not their offending" and the aims of the placement must be "explicitly therapeutic"²³.

The submission by Mercy Family Services similarly promotes the introduction of a secure care option as a "therapeutic intervention and not punishment" whilst also acknowledging that "the reality of separating offending behaviour from trauma-related child protection interventions is not always possible"²⁴.

Despite efforts which may be made to claim and promote a 'therapeutic' rather than 'punitive' purpose of secure care, it is likely that many children would nevertheless view their detention in secure care as a form of 'punishment'. As speculated by a witness during an inquiry hearing, there may be doubts about "whether young people have the ability to understand that they're not in secure care because they've necessarily committed an offence"²⁵. Some corroboration of this concern may be seen in the testimony of a child in care when he described his 24 hour detention in a mental health facility as an action taken by the police to "punish him" rather than for any therapeutic-related purpose²⁶.

It is noteworthy that consideration of a secure care option is occurring within an environment wherein criticism is already being levelled at some residential care services for relying too heavily on 'police call-outs' to manage the behaviours of children and a subsequent 'overly-punitive' response including the 'over-charging' of children with offences that escalates the potential for their prolonged involvement with the youth justice system. A submission by the Youth Advocacy Centre details concerns about the greater propensity for children, older adolescent children in particular, who are living in residential care to come to the attention of the police and be charged with offences

²² Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)

²³ Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)

²⁴ Submission of Mercy Family Services, December 2012 (p50)

²⁵ Transcript, Marissa Sherry, 7 February 2013, Brisbane (p50: line 13)

²⁶ Transcript de-identified witness, 4 February 2013, Brisbane (p63): line 12)

than children who are living in a “normal family environment”²⁷. A submission by Sisters Inside raises similar concerns about the “increasing criminalisation of children in residential care facilities”²⁸.

The questions to be contemplated are:

- whether secure care would, despite whatever claims may be made in relation to its therapeutic purpose, invariably be perceived by children and others as a ‘step’ towards youth detention which will lead to an increased likelihood of their involvement with both the youth justice and adult criminal justice systems, or
- whether secure care can, through a rigorous application of strategies to maintain an exclusively therapeutic purpose, divert some children from proceeding on this trajectory.

Your comments:

What relationship (if any) should exist between secure care and youth detention? Would secure care become a ‘step towards’ youth detention and increase the likelihood of children’s involvement with the youth justice and adult criminal justice systems, or can it be used to divert some children from proceeding on this trajectory?

²⁷ Submission of Youth Advocacy Centre, October 2012 (p2)

²⁸ Submission of Sisters Inside, July 2012 (p3)



The relationship between secure care and secure mental health services

In advocating to the Commission for the introduction of ‘secure therapeutic facilities’, the Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists puts forward a ‘two-pronged’ argument.

Firstly, the argument is made that the adolescents who are in need of such facilities “generally do not meet the criteria for detention under the *Mental Health Act 2000*”²⁹. The second prong to the argument is based on the current inadequacy of adolescent mental health in-patient units in being able to deliver the services needed by some children. In particular, it is noted that “such in-patient units are designed for acute (short-term, 2 to 3 week) admissions of young people with an acute, treatable mental illness not long-term therapeutic work”. The submission also notes that “even services with capacity for active engagement and intensive follow-up, such as Evolve Therapeutic Services, find them very difficult to locate and engage with” and on the occasions when they are admitted to an in-patient unit, they “cause disruption to the units and to the care of young people with acute mental illness and they often abscond”³⁰.

The submission calls for the “development of a new legislative framework which allows for restrictive care of children at extreme risk”³¹. It is not stated however whether this legislative framework should be incorporated within amendments to the *Mental Health Act 2000* or the *Child Protection Act 1999*. Similarly, in calling for the establishment of secure therapeutic facilities similar to those that exist in the United Kingdom, the submission does not articulate the finer details in respect of ‘who’ would be responsible for the governance, financial resourcing, administration and service delivery of such a facility (i.e. whether it would fall under the ‘umbrella’ of a child protection response or a mental health response or a ‘hybrid’ of both) which are critical to fully understanding the proposition.

Would secure care serve as an additional response to, or a substitute for, the involuntary assessment or treatment of children in a mental health facility?

Other submissions and the testimony of witnesses have also generally been unclear about whether their preferred models for secure care would:

- provide a service response that is distinctly different from, and additional to, the involuntary assessment or treatment of children with a mental illness in a secure mental health facility, or
- serve as a replacement for the assessment or treatment of children with a mental illness in a secure mental health facility.

²⁹ Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)

³⁰ Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)

³¹ Submission of Queensland Branch of the Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists, September 2012 (p23)



The *Rules for the Protection of Juveniles Deprived of their Liberty* however are clear in respect of this matter. Section IV(H)(53) states that “a juvenile who is suffering from mental illness should be treated in a specialised institution under independent medical management” . In an apparent recognition of this requirement, the *Secure Care Background Paper* produced by the Western Australian Department for Child Protection in February 2011 states, “Secure care is not appropriate for children whose needs are best serviced through admission to a mental health facility...” (p2).

Current referral guidelines used within Western Australia state that a secure care arrangement:

- is not appropriate when children are exhibiting behaviours indicating possible mental illness in which case, consultation must be undertaken with a qualified practitioner able to assess the extent of the mental condition, prior to any referral to secure care, and
- where a severe mental illness is suspected, requiring medication or a possible inpatient admission, case referral should always occur to those services specialising in such care and treatment, as a priority.

Within New South Wales and Victoria however, the answer is less clear. In New South Wales for example, children who are eligible for involuntary treatment under the *Mental Health Act 2007* may be admitted to therapeutic secure care for a short duration if necessary. The program guidelines also state however that children with a significant, complex mental health condition who require close psychiatric monitoring and treatment must be carefully assessed when placement in therapeutic secure care is being considered and, if admitted, their treatment is to be provided by health professionals.

To what extent is the paucity of child mental health services in Queensland driving the call for a secure care option?

As previously noted, testimony by Ms Margaret Allison included statements of her reservations concerning the introduction of a secure care option based on her longstanding concerns about the “paucity of mental health services for young adolescents...(and)...great deal of difficulty of getting access to mental health services for adolescents manifesting extreme behaviours”³².

These concerns match with anecdotal reports received by PeakCare from staff of non-government organisations in which dissatisfaction is frequently expressed about the scarcity of specialised mental health services available for children as well as the lack of preparedness by those that do exist to diagnose a mental health condition and/or provide treatment, be that in a secure setting or the community. As noted in the testimony of one witness to the inquiry, “there aren’t a lot of options within the mental health system for young people with those sort of behaviours”³³.

It must be viewed as alarming that the range of facilities currently available within Queensland for the involuntary assessment or treatment of children with a mental illness are confined to inpatient

³² Transcript, Margaret Allison, 26 February 2013, Brisbane (P105: line 28)

³³ Transcript, Greg Wall, 5 February 2013, Brisbane (P40-132: line 10)

beds/ units within hospitals, the Child And Family Therapy Unit at the Royal Children’s Hospital and the Barrett Adolescent Centre. This is compounded by evidence before the Commission indicating that the Barrett Adolescent Centre is under review and will close with no commitment having been made by the State Government, as yet, to replace the Centre. As noted in the testimony of Dr Brett McDermott, Executive Director of the Mater Child and Youth Mental Health Service, “to lose this service would be to lose the place of last therapeutic help for some of our most traumatised Queensland adolescents”³⁴. This is notwithstanding the concerns also stated by Dr McDermott that the Centre which is currently “sitting out by itself under an adult mental health unit which doesn’t understand it” needs reform and would be better located “under the Queensland Children’s Hospital” due to the specialised knowledge and expertise required to deliver child and adolescent mental health services.

The dearth of specialist services and professionals resulting in poor quality assessments and treatment for children in care is a problem also frequently noted by non-government organisations. A complaint commonly made is that assessments undertaken by mental health services usually result in an outcome whereby difficulties being experienced by a child are regarded as ‘behavioural’ rather than an indication of existing or emerging mental health concerns and therefore not warranting of treatment. For example, in response to questioning about the refusal of an admission of a nine-year old girl to a mental health unit, another witness stated that “the hospital does not admit children with behaviours...(despite the)... significant trauma attached to this child and ... extensive history of abuse”³⁵.

In a submission to the Commission lodged by the Youth Affairs Network of Queensland (YANQ), a number of specific concerns are raised about the growing percentage of Queensland children in care who are being diagnosed with attention deficit hyperactivity disorder (ADHD) and being prescribed psychotropic medication³⁶. The YANQ submission refers to information contained with the annual *Views of Young People in Residential Care Queensland* reports produced by the Commission of Children and Young People and Child Guardian indicating increasing rates of ADHD diagnosis and subsequent psychotropic medication use amongst children in care that significantly exceed rates within the general population of children. The YANQ submission postulates that inappropriate diagnosis of ADHD and use of psychotropic medication is taking place in the absence of access to alternative and more effective health and treatment services.

Speaking specifically in relation to the treatment for adolescent depression provided nationally, Dr McDermott within his testimony to the inquiry stated that, “It was very clear that in certain areas expertise around adolescent health was poor, the number of adolescence centres of excellence were not very widespread, understanding of their differences in presentation of depression in adolescence was fairly poor. It’s clearly something that some systems don’t do well. Probably they

³⁴ Transcript, Dr Brett McDermott, 8 November 2012, Brisbane (P58: line 18)

³⁵ Transcript, Michelle Bellamy, 7 February 2013, Brisbane (P71: line 43)

³⁶ Submission of Youth Affairs Network of Queensland, 2012

do best with children in the middle years, and infants and adolescents they do more poorly, as a generalisation³⁷.

How large is the ‘gap’ between the ‘demand’ for specialised child mental health services and their ‘supply’?

There is a lack of Queensland-specific research about the prevalence of mental health conditions amongst children in care that might be used to measure the ‘gap’ between the ‘demand’ for specialised mental health services and their ‘supply’. However, research undertaken in other states provides an indication of ‘un-met’ demand at a national level and it may be surmised that this is similar to the situation that exists within Queensland. This research includes:

- a study of 347 children in care within New South Wales reporting high levels of poor mental health including trauma-related anxiety and self-injury (Tarren-Sweeney & Hazell, 2006)
- a study of 364 children from four States with a history of placement instability in care which found evidence of these children experiencing high levels of psycho-social disorders including clinical anxiety and depression (Osborn et al, 2008)
- a survey of 60 young people leaving care in Victoria which found that 50% sought help from a mental health professional after leaving care and almost two-thirds were diagnosed with a form of physical, mental or intellectual disability or illness (Raman et al, 2005), and
- a study of 41 care leavers in New South Wales which found that 71%, within four to five years of leaving care, had contemplated or acted on suicidal thoughts reflected in self-harm or risk-taking behaviour and nearly 50% had attempted suicide (Cashmore & Paxman, 2007).

A feature story recently published in the Weekend Australian magazine also gives cause for concern about the prevalence of mental health issues amongst Queensland children for whom there are inadequate and insufficient service responses. Within this article, the Director of the Brisbane Youth Detention Centre is quoted as having said, “They found that 70 per cent of the boys coming in here have some diagnosable mental health issues... (and)... ninety per cent of the girls have a diagnosable mental health issue. In the community, a lot of these young people go unassessed, untreated, unhelped” (2013).

In light of the likelihood that significant numbers of the boys and girls spoken of were children who are or were in the guardianship of the chief executive for child protection reasons, the Director’s comments strongly suggest that these children did not commence receiving the mental health treatment they needed until they were incarcerated within a youth detention centre. It must be viewed as extremely concerning these services were not made available to them prior to their detention and begs the question to be asked how many of these children may have been diverted from involvement in criminal offending and subsequent incarceration in a youth detention centre had adequate mental health services and support been made available to them. It similarly begs the question how much is the identification of a need for a secure care option being driven by a lack of

³⁷ Transcript, Dr Brett McDermott, 8 November 2012, Brisbane (P55: line 46)

accessible mental health services delivered at much earlier stages of difficulties being experienced in the lives of some children.

Your comments:

What relationship (if any) should exist between secure care and secure mental health services? Should secure care be seen as a different and added response to, or as a substitute for, the involuntary assessment and/ or treatment of children in a secure mental health facility? To what extent is the call for a secure care option being driven by a lack of accessible mental health services?



The role and purpose (if any) to be served by secure care

The past twenty-five years have seen significant changes in the circumstances under which Queensland children can be detained and the purposes associated with their detention. Shifts away from a welfare model to a justice model resulted in a cessation of the practice of detaining children deemed to be ‘uncontrollable’ or ‘likely to fall into a life of vice and crime or addiction to drugs’. In parallel with these developments, changes were also occurring in the field of mental health treatment and care. Movement away from institutionalisation and the often degrading and inhumane ‘excesses’ of the ‘medical model’ impacted the treatment and care received by both children and adults.

In line with these developments, the Sir Leslie Wilson Youth Hospital which had been used since 1961 to accommodate a ‘mix’ of children who had broken the law along with those deemed to be emotionally disturbed or simply ‘trouble-makers’ was transferred from the control of the Department of Health to the Department of Children’s Services in 1983 and re-named the Sir Leslie Wilson Youth Centre. The centre was re-named again in 1993 when it became the Sir Leslie Wilson Youth Detention Centre before eventually closing in 2001 after its urgent de-commissioning had been recommended by the 1999 *Commission of Inquiry into Abuse of Children in Queensland Institutions*.

The developments that occurred within both Queensland’s youth justice and child mental health systems reflected similar changes that were taking place nationally and internationally, evidenced by the adoption of the detention as a last resort principle stated within the United Nations *Convention on the Rights of the Child*, the *Beijing Rules* and the *Rules for the Protection of Juveniles Deprived of their Liberty* with this principle evident in both Queensland’s *Youth Justice Act 1992* and *Mental Health Act 2000*.

These developments, whilst laudable in their ‘tightening up’ of the grounds on which children could be detained, also had the effect of exposing a ‘gap’ in the capacity of the ‘system’ to deal with the needs and demands of a small cohort of children. These are the children who, due to their displays of extreme and often life-threatening behaviours previously found themselves being made subject to a ‘care and control order’ and placed in a youth detention centre or in some instances, a mental health facility or, in respect of those children who were placed in the Sir Leslie Wilson Youth Hospital, a combination of the two.

In effect, the child protection system was left to ‘fill the gap’ with inadequate service responses at its disposal or thought given to what these responses might be. It may be argued that the exposure of this gap has been exacerbated by growing numbers of children displaying complex behaviours over recent years along with increases in the extremity of their needs.

In part, it may be seen that the Department has attempted to fill this gap through its funding of ‘therapeutic residentials’. However, as observed by the Action Centre for Therapeutic Care (ACTCare) in its submission to the Commission, “Relationship between the therapeutic residentials and the Department of Communities, Child Safety are not yet stable in every region, which means that inappropriate referrals are sometimes made. Until Departmental personnel understand that the

therapeutic residentials are not set up to be treatment centres, or psychiatric inpatient centres, they will continue to refer some of the very high risk young people who have significant mental health, criminal and substance use problems... Therapeutic residential staff are not trained psychiatric or substance use clinicians, and will struggle to contain and form relationships with this group of young people”³⁸.

The ACTCare submission provides opinion about difficulties experienced by Queensland non-government organisations in properly setting up therapeutic residential care including:

- a lack of adequately trained staff able to provide a therapeutic response, particularly Aboriginal and Torres Strait Islander residential care workers
- lack of a pool of trained managers, team leaders and clinicians/ therapists who understand therapeutic care models and are able to lead good practice
- poor pay rates within the non-government sector, especially for managers and clinicians, in comparison with the government sector, and
- organisational frameworks that are not completely compatible with the provision of therapeutic care including, for example, poor provisions for training, supervision and team meetings.

Use of secure care to ‘fill the gap’ in other jurisdictions

With other States also seeming to be struggling with a similar cohort of children, some (Western Australia, New South Wales and Victoria) have introduced secure care in an apparent attempt to ‘fill the gap’ in the range of service options available to these children.

Unlike the United Kingdom’s approach to secure care where there is largely a ‘blending’ of ‘youth justice’ and ‘welfare-related’ purposes which is reflected in the profile and characteristics of the children who are placed in their facilities, Australian States are making clear distinctions between youth detention and their models of secure care through the establishment of a separate infrastructure of facilities and admission criteria that excludes children for whom a youth justice response is deemed to be more appropriate. To varying extents, the program descriptions published by other States similarly create some level of delineation between secure care and the involuntary assessment or treatment of children in secure mental health facilities.

Generally, it may be regarded that the secure care models of Western Australia, New South Wales and Victoria serve a role in removing ‘pressure’ from the child protection system (residential care services delivered by the non-government sector, in particular) in providing care for a small cohort of children whilst also ensuring that pressure is maintained on the youth justice and mental health systems to properly fulfil their roles in respect of children for whom they exercise responsibilities.

Within the program descriptions of these other States, emphasis is placed on the purpose of secure care in keeping children safe. For example, the New South Wales Department of Human Services

³⁸ Submission of Action Centre for Therapeutic Care, 28 September 2012, (p10)

states that “the defining feature of the target group is behaviour which places the children or young person’s life at extreme risk of harm. It is serious risk of harm to self, rather than overall levels of assessed need, which places a child or young person in the target group for secure care”.

In accordance with the New South Wales program description, entry into secure care is restricted to children whose behaviours are so extreme that they cannot be managed in a less restrictive setting. These behaviours may include:

- serious or life threatening self-harming behaviour
- serious risk-taking behaviour that leads to severe abuse and exploitation, particularly sexual exploitation, and/ or
- drug or substance abuse that lead to severe harm or risk of death.

The Victorian program description similarly emphasises that secure care is to be used “only when children or young people are at extreme risk and existing community services cannot manage the risk”. Admission is likely to be precipitated by a significant crisis.

As such, the children for whom secure care may be an option should not be regarded as an homogenous group in relation to their profile or characteristics. The feature they have in common is simply that they are, for whatever reason, at risk of death or severe harm and in need of an immediate response to prevent this from occurring.

In other words and in keeping with Commissioner Carmody’s request to ‘not beat around the bush’, the primary purpose of secure care within these States is about ‘keeping some children alive’ or, at least, safe from severe injury or harm when no other alternative means exist to do so.

In keeping with the criteria for admission set by these States, it would seem highly unlikely that ‘absconding, unruly, defiant or criminal behaviour’ and/ or the existence of a known or suspected mental health condition would be seen as sufficient to allow for a child’s admission to secure care unless it could be clearly demonstrated that the child’s behaviours were severely harming them or placing them at imminent serious or life-threatening risk.

Secure care, then what?

Beyond this primary purpose of keeping some children ‘alive and safe’, it may be seen that additional ‘secondary purposes’ have been added to the program descriptions developed by each State to ensure that secure care is not simply about providing a ‘hiatus’ during which time a child may be kept safe through their ‘containment’, but then free to resume their ‘at-risk’ behaviours upon their discharge. As commented upon by a witness during questioning about the suitability of a secure care option for a particular child, “I’m not really sure how this young person would actually benefit long term in a secure facility, because then what would happen? ... I don’t think it’s a long-term solution for young people, because somewhere along the line they’re going to be back into the

community unless you're planning to keep them for the next 60 years in some sort of secure facility, but I doubt that"³⁹.

Beyond the full range of individualised therapeutic, educational/ vocational, recreational and cultural safety programs and services that need to be provided to children whilst residing in secure care, "a key message from research is that more needs to be done to ensure integration of secure care services - both at the point of step down from secure into community support and at step up to secure care provision, where community support and intervention are unable to meet need" (Giller, 2006). This is viewed as critically important in ensuring that children are not unnecessarily placed in secure care and can be effectively transitioned from secure care services to less intensive out-of-home care and support services that are able to meet their needs.

It is noteworthy that following the establishment of a secure care service in New South Wales, a linked step down program had to be developed to allow gradual progress and the continuity of program elements (Fahey and Hardman, 2010).

Is secure care compatible with principles of 'detention as a last resort' and the 'best interests of the child'?

The right to personal freedom is viewed as a fundamental human right that is to be protected. While laws are in place that strictly limit and govern the circumstances under which adults may be deprived of their liberty, the detention of children receives particular attention in international law. The principle of detention as a measure of last resort and for the shortest appropriate period of time that features with the United Nations *Convention on the Rights of the Child*, the *Beijing Rules* and the *Rules for the Protection of Juveniles Deprived of their Liberty* amounts to, in effect, a recognition by the international community that the deprivation of a child's liberty is rarely in their best interests.

Adherence to the principle of detention as a last resort does not mean that children should never be detained under any circumstances. It does mean however that there is an obligation to fully consider and explore alternatives to a child's detention with the best interests of the child remaining the over-riding and paramount consideration factor.

In wrestling with the question of whether or not secure care serves the best interests of some children, New South Wales, Victoria and Western Australia have apparently determined that it does in extenuating circumstances where children would otherwise be at imminent risk of death or severe harm.

This is not the conclusion reached by South Australia. During that State's consideration of the need for 'safe keeping services', South Australia's Guardian for Children and Young People formed the view that the government should not proceed with introducing the legislation and facilities for 'safe keeping for children' (2008). The reasons stated for this conclusion being reached included:

³⁹ Transcript, Kristina Farrell, 5 February 2013, Brisbane (P74: lines 39-41; p75: lines 3-7)

- firstly, a failure to be convinced, in the absence of other intensive therapeutic residential services, that it is necessary to detain children in order to engage them with an intensive service, and
- secondly, the high likelihood for abuse of the purpose of the legal orders and facility because there is limited access to community-based therapeutic services and over demand on the alternative care system.

Queensland’s exploration of the role and purpose of secure care necessitates wrestling with the following questions:

- whether the deprivation of a child’s rights to liberty and their detention in secure care can be justified as being in their best interests
- under what circumstances (if any) this justification can be found
- what safeguards must be in place to ensure that the principle of detention as a last resort and for the shortest appropriate time is maintained
- what alternatives must first be fully explored and considered before resorting to depriving children of their liberty, and
- in the event that it is determined that secure care can be justified, what role and purpose would it serve within Queensland and for whom would it be provided.

Your comments:

(In response to any of the above questions)



Part Four:

OTHER MAJOR CONSIDERATION FACTORS

This part of the discussion paper lists and briefly describes other factors that warrant consideration in:

- weighing up the perceived benefits (if any) of secure care with the possible detriments of its introduction within Queensland, and
- in the event that secure care is introduced, identifying the means and processes for its management and delivery.

Who should determine children’s admission and length of stay in secure care and what (if any) restrictions should apply to their admission or length of stay?

Article 3(1) of the *Convention on the Rights of the Child* requires that individualised decisions be made about the detention of children that take account of each child’s best interests as the paramount agenda. This decision-making should not be limited to the question of whether or not a child needs to be detained however. The best interests of each child must also be given paramount consideration in relation to decisions made about the length of a child’s detention and the manner in which they are to be detained.

Article 37(b) states that no child shall be deprived of his or her liberty unlawfully or arbitrarily. In order for Queensland children to be detained in secure care, legislated provisions would need to be proclaimed stipulating the circumstances under which they may be detained (separate to those that allow for their detention in a youth detention centre or mental health facility) and procedures in law established pertaining to all matters relevant to ensuring that their detention is lawful.

Beyond ensuring that the detention of children in secure care is ‘lawful’, Article 37(b) sets the additional requirement that children are not detained ‘arbitrarily’. Despite a child’s detention in secure care being lawful under ‘domestic law’, it may nevertheless be viewed as arbitrary if tested against principles of ‘international law’. For example, a child’s detention in secure care whilst lawful may still be assessed as arbitrary if:

- there are elements of injustice or inappropriateness concerning the child’s detention
- the child’s detention is seen to be unreasonable or unnecessary in their particular circumstances, or
- the child’s detention is not a proportionate means of achieving the legitimate aims of secure care as stated in law.

Additionally, whilst a child’s admission to secure care may not be viewed as arbitrary, their continued stay in secure care may become arbitrary if the grounds for their initial detention cease to exist or over time, becomes a disproportionate response that is no longer consistent with the stated



goals of a secure care placement. This is especially relevant when consideration is given to the principle of detention as a measure of last resort incorporating the requirement that detention should also be for the shortest appropriate period.

Other Australian States that make use of a secure care option employ different structures, decision-making processes and means for addressing the above matters including, in particular, those concerning a child's initial admission and length of stay in secure care. For example, in Victoria and Western Australia, a child's length of stay in secure care is limited to 21 days with provision for this to be extended for a further 21 days. Depending on a child's legal status, delegated senior Departmental Officers may authorise a child's admission to secure care or an interim order (secure care) may be made by a court if the court is satisfied that there is a substantial and immediate risk of harm to the child. Three criteria must be met in determining that a child is eligible for placement in secure care: firstly, the placement must be deemed to be in the child's best interests as defined by factors concerning their stability, development and safety needs; secondly, no other placement or support will adequately protect the child from significant harm; and thirdly, a secure care placement is available and able to meet the child's needs.

In reflecting the significance of detaining a child involuntarily and the exceptional circumstances that would lead to such an action occurring, in New South Wales the Supreme Court is charged with the responsibility of determining whether or not a 'therapeutic secure care order' is made. The Supreme Court makes interim therapeutic secure care orders only, sets review dates and issues instructions to the Department about the information to be provided at the next review.

In the United Kingdom, courts are also the decision-makers about a child's admission to secure care. In England, Wales and Scotland, the length of stay varies with an average length of stay amounting to three to four months. Despite the role played by courts, a Scottish study (Walker et al, 2005) found that decision-making was a dynamic process in which the response to each child was shaped by four characteristics of the local context. These were:

- ease of access to secure placements
- availability of 'alternative' resources which offer intensive support
- views about the role of secure accommodation, and
- practice in and attitudes towards risk management.

Together these inter-related considerations have shaped each local authority's use of secure care. Though each authority claimed to be using secure accommodation as a 'last resort', thresholds across authorities were different because of local variation in resources and perceptions of secure placements' potential benefits or harm.

Your comments:

If secure care were to be introduced into Queensland, who should determine children's admission and length of stay, and what (if any) restrictions should apply to their admission or length of stay?

What avenues and rights of review and appeal should be made available to children who are detained in secure care?

Article 37(d) of the *Convention on the Rights of the Child* states that children who are deprived of their liberty have the right to challenge the legality of their detention before a court or other competent, independent and impartial authority. Article 37(d) also states that children have the right to promptly access legal and other appropriate assistance for this purpose. For reasons previously discussed, the right to a prompt review of the legality of a child's detention should not be limited to a review of its 'lawfulness', but also allow for a review of its 'arbitrariness'.

All Australian jurisdictions providing secure care have appeal and review processes in place. In New South Wales, these are judicially based. In Victoria and Western Australia, persons affected by a decision (i.e. a parent, carer or child) may first request an 'internal' review. Decisions that can be reviewed include those that have been made in relation to the approval or non-approval of a child's placement in secure care or the initial or extended length of the placement. In certain circumstances, parties within Victoria may have casework decisions reviewed by the Victorian Civil and Administrative Tribunal and Western Australians may similarly access their State Administrative Tribunal.



Your comments:

What rights and avenues of review and appeal should be made available to children and others such as the child's parents or carers?

How many and where should secure care facilities be located in Queensland?

The *Rules for the Protection of Juveniles Deprived of their Liberty* state that “The number of juveniles detained in closed facilities should be small enough to enable individualised treatment. Detention facilities for juveniles should be decentralised and of such size as to facilitate access and contact between the juveniles and their families. Small-scale detention facilities should be established and integrated into the social, economic and cultural environment of the community” (Rule 30).

Within New South Wales, there is one secure care facility, Sherwood House, that is located in south west Sydney. Sherwood House can accommodate a maximum of four children aged 10 to 17 years.

In Victoria, two 10-bed gender specific residential units are located in the north and west region of the State for children aged 10 to 17 years.

The Kath French Secure Care Centre is located east of Perth in Western Australia and from January 2013, has been able to accommodate up to six children aged 12 to 17 years. Prior to this year, the Centre had a nine bed capacity.

Considering Queensland’s geography, there would be particular challenges in selecting an appropriate location (or locations) for one or more secure care facilities, especially if a facility was intended to provide a State-wide service. Particular challenges would be created in relation to:

- arrangements for transporting children from, and returning them to, their home communities, and
- maintaining children's connections with their family, community and culture.

These challenges would apply in respect of children’s initial admissions into secure care as well as their re-admissions were they to occur.

Your comments:

If secure care were to be introduced into Queensland, how many facilities should be established and where should they be located? What bed-capacity should each facility have and should they be gender-specific and/or restricted to a specified age group? What arrangements would need to be made for the transportation of children from, and returning them to, their home communities? What arrangements would need to be put in place to maintain children’s connections with their family, community and culture?



How 'secure' is 'secure'?

The term 'secure' does not represent an 'absolute' concept. Security is best thought of in terms of a continuum ranging from a low or minimum security level through to a level defined as high or maximum. When the term 'secure' is applied to a particular setting however, the general public often holds an expectation that the security is 'absolute' and escapes are viewed as indications of deficiencies in the facility design and/ or the incompetence of the facility's administrators or staff. It is noteworthy that over the past 25 years, there has been a dramatically decreased public tolerance of escapes from youth detention centres that has been met with a corresponding increase in security measures.

In line with the level of security assigned to a particular setting, contemporary security design is less about creating an impenetrable physical barrier to 'escape' and is much more about a mix of static and dynamic security measures that both:

- reduce the desire of those who are detained to escape, and
- in the event that an escape is attempted, prolong the time needed for detained persons to successfully bring this about, thereby maximising the response time available for attending staff to intervene and thwart the attempt.

Generally, a higher level of security will be accompanied by a higher level of threat to the physical safety of those who attempt to escape. In relation to secure facilities that are specifically designed to accommodate children in comparison with those that detain adults, there is a much higher level of public expectation that children who attempt to escape will not be placed at risk of incurring significant physical injury or death. There are also significant differences between the behaviours of children and those of adults who are detained that must be catered for within the design of both static and dynamic security strategies. For example, children tend to be far more impulsive, agile, persistent and dangerously foolhardy in their attempts to escape than adults. They are less likely than adults however to engage in complex planning of an escape or to receive assistance to escape from external parties.

In keeping with contemporary security design, major emphasis is usually placed on securing the perimeter of facilities that are used to detain children which enables less reliance to be placed on their confinement within rooms or buildings. The static security features of the design are generally not overt (e.g. perimeter fences are usually 'sunk' below the line of eyesight from within the grounds or buildings) to reduce the sense of confinement.

Beyond the level of requirements set for a secure facility in obstructing escapes, the design must also take into account levels of risk to the safety and well-being of those who are detained based on an understanding that the act of confining a person and depriving them of their liberty can, in and of itself, either exacerbate pre-existing risk factors or introduce new ones. This includes, in particular, debilitating psychological effects, increased suicidal ideation and increased displays of violent behaviour that may be self-directed and/ or directed at others.

A review of the literature (Children’s Guardian, 2002; Guardian for Children and Young People (2008); Scottish Institute for Residential Care, 2009; Walker at al, 2005) indicates limited consideration of the negative impact of secure care on children. However, some of the factors identified include:

- isolating and institutionalising effects on children
- labelling of children as ‘bad’ or ‘sick’
- diminishing of children’s sense of control over their feelings and behaviour
- escalation of self-harming behaviours or behaviours that harm others, and
- exacerbation of previous experiences of being detained.

A skilfully applied mix of static and dynamic security measures is required to ameliorate and manage these impacts as far as possible. Given that the usual purpose of secure care to ‘keep children safe’, it is especially important to ‘get this mix right’ in order to ensure that the act of containing a child in secure care does not, in fact, exacerbate or add risks to the child’s physical and psychological safety (i.e. that secure care does not turn into a ‘solution that becomes the problem’).

Consideration of these factors is apparent within New South Wales’ secure care program description (2010) which states that “The physical environment of a therapeutic secure facility should maximise its primary functions of safety, therapy and security. It is important that while achieving safety and security, through close 24 hour supervision in a secure environment and removing objects to minimise opportunities for self-harm where necessary, a therapeutic secure care facility also focuses on the child or young person’s sense of well-being”.

A decision to introduce secure care into Queensland would similarly require that detailed consideration be given to the purpose of the facility in order to ensure that its security design and strategies properly reflect this purpose and the facility’s operational philosophies and practices. The decision-making that occurs about this matter should also take account of public expectations and ways in which these expectations can be managed. Particular consideration would also need to be given to the impact of confinement on Aboriginal and Torres Strait Islander children, children with culturally and linguistically diverse backgrounds and those who have previously experienced detention when seeking asylum. As previously noted, other States have measures in place to consult with designated persons with expertise in relation to the best interests and needs of these children when referrals to secure care are being considered.

As asked by Commissioner Carmody during a public hearing of the inquiry, “What would it (a secure care facility) look like on the ground? Would it have chain wire around it with razor wire on the top or would it have guards with guns? What would it have, shrubs?”⁴⁰

⁴⁰ Transcript, Paul Glass, 6 February 2013, Brisbane (P51: line 42)

Your comments:

If secure care were to be introduced into Queensland, what would it look like 'on the ground'? What is the nature and level of security that should be attached to the facility?



How restrictive should secure care practices and procedures be?

Secure care is not simply a 'place' in which children are accommodated and contained. Within a facility of this type, practices and procedures must be developed to manage the safety and security of children during the course of their daily living and interactions with each other as well as staff members and others. This requires consideration of any 'restrictive practices' that may be used in response to 'unsafe' behaviours of resident children.

Section IV of the *Rules for the Protection of Juveniles Deprived of their Liberty* state that the use of physical restraint and force in respect of detained children should be limited to exceptional cases explicitly authorised and specified by law and regulation wherein the physical restraint or force is used to prevent self-injury, injuries to others or serious destruction of property. Corporal punishment is prohibited as is placement in a dark cell, closed or solitary confinement.

In Queensland, the Department's Positive Behaviour Support policy provides general guidance on managing the behaviour of children in care and specific guidance on the use of restrictive practices which are referred to within the policy as 'reactive responses'.

The policy states that:

“When responding to unsafe behaviour of children and young people, carers and direct staff may be required to intervene with reasonable force to protect the child, oneself and others from injury or harm.

Reactive responses are defined as immediate responses where reasonable force is necessary to respond to a child or young person's behaviour to ensure the safety of those involved while avoiding potential escalation of the behaviour. Reactive responses may include:

- *Temporary physical restraint of a child or young person to prevent an injury or accident. This involves restricting the child or young person's freedom of physical movement to ensure their immediate safety or the safety of others. Physical restraint is the holding of any body part and should only continue so long as it is necessary for the child or young person to no longer be at risk of significant immediate harm to themselves or others.*
- *Removal of illegal or harmful objects that may be used to harm self or others.*
- *Relocation of a child or young person to another area that provides safety.*

Reactive responses may only be used where there is a high risk of immediate harm to the child or others should intervention be withheld”.

The policy also lists 'prohibited practices' and stipulates reporting requirements in respect of any incidents involving use of a reactive response.

New South Wales' secure care program description highlights the importance of written procedures and staff training on crisis management. It states that training should include understanding crises, crisis communication, early identification and de-escalation of potential crisis situations, use of safe, appropriate physical restraint and isolation during a crisis and assisting the child in recovering from a crisis.



Your comments:

If secure care were to be introduced into Queensland, is the current Positive Behaviour Support policy and its approach to the use of reactive responses appropriate for a secure care service? Are the reporting requirements in relation to incidents involving the use of reactive responses as stated within the policy suitable for a secure care service? What minimum qualifications and/or training requirements (if any) should be established to support staff in responding to the behaviours of resident children and the use of reactive responses?



What programs and services should be provided to resident children?

Section IV of the *Rules for the Protection of Juveniles Deprived of their Liberty* sets out requirements in relation to children's access to:

- education, vocational training and work (Section IV E)
- recreation (Section IV F)
- opportunities to observe and practise their religious and spiritual beliefs (Section IV G)
- adequate medical care (Section IV H)
- regular and frequent visits with family and legal counsel and contact with the wider community (Section IV J), and
- services that facilitate their return to the community (Section IV N).

Section V of the *Rules* sets out requirements in relation to ensuring that the personnel employed to work within facilities where children are detained:

- are qualified and include a sufficient number of educators, vocational trainers, counsellors, social workers, psychiatrists and psychologists
- are appointed as professional officers with adequate remuneration to attract and retain suitable men and women, and
- receive training in child psychology, child welfare and human rights.

Other States' secure care program descriptions indicate that a range of program and services are provided that generally match those listed above with arrangements in place for the delivery of these programs and services by a 'multi-disciplinary' team of personnel.

Your comments:

If secure care were to be introduced into Queensland, what is the range of programs and services that should be provided to resident children? What range of occupational groups would be required to deliver these programs and services?

How is cultural safety to be promoted?

Services provided for Aboriginal and Torres Strait Islander children need to reflect an understanding of, and respect for, their culture including the importance of maintaining connections with family, community and culture. Consideration of the placement of Aboriginal and Torres Strait Islander children in secure care must incorporate the findings of the *Royal Commission into Aboriginal Deaths in Custody*.

Similarly, the needs of children from culturally and linguistically diverse backgrounds and impact of secure care must also be considered. Such children or their family members may have previously been subject to state intervention and, in some instances, may have been detained and tortured.

In both instances, consideration needs to be given to how representatives of the relevant communities and cultural services are involved in making decisions about whether secure care is appropriate and, if so, how the potential impact of secure care may be ameliorated.

Your comments:

If secure care were to be introduced into Queensland, what measures would need to be taken to ensure the cultural safety of children?



What are the costs of providing secure care?

From information presented to the Commission by the Department⁴¹, the following is a summary of the expenditure of other States on secure care:

- New South Wales expends around \$2.6M on a secure care facility that accommodates up to six children which equates to a cost of around \$433,000 per child per annum. Taking into account the usual occupancy rate of only four children at a time, the 'actual' expenditure amounts to approximately \$650,000 per child per annum.
- Western Australian has a total budget allocation of \$13.7M for two secure care facilities. These facilities were originally intended to accommodate up to ten children at a cost of around \$688,000 per child per annum. Due to a lower than expected demand, bed capacity of the facilities has recently been reduced to six in total which, it is anticipated has increased the child per annum costs.
- The Northern Territory government has budgeted \$4M to be expended on two facilities each accommodating four children at cost approximating \$0.5M per child per annum.

The above-listed amounts do not include the non-recurrent capital costs of constructing the facilities.

Your comments:

⁴¹ Transcript, Margaret Allison, 26 February 2013, Brisbane (P107: line 17)



Concluding comments

Please enter any concluding comments you may wish to make in response to issues raised within this paper or other matters that you think are of importance to this discussion.

Your comments:



REFERENCES

- Australian Defence Lawyers Alliance. (2013) Retrieved from http://www.australiancriminallawyers.com.au/web/page/qld_law_deprivation_of_liberty
- Cashmore, J. & Paxman, M. (2007) *Longitudinal Study of Wards Leaving Care: Four to Five Years On*. Social Policy Research Centre, Sydney.
- Children's Guardian (2002) *Is there a place for secure care in the provision of services for children and young people?* Author, Sydney.
- Commission for Children and Young People and Child Guardian. (2009) *Views of Young People in Residential Care Queensland*. Retrieved from http://www.ccypcg.qld.gov.au/resources/publications/views/ViewsYPResidentialCare_2009.html
- Dalton, Trent (2013) Little Girl Lost, Weekend Australian Magazine. Retrieved from <http://www.theaustralian.com.au/news/features/little-girl-lost/story-e6frg8h6-1226564961262>
- Department for Child Protection. (2011) Secure Care Background Paper. Perth. Retrieved from <http://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/SecureCareBackgroundPaper2011.pdf>
- Department for Child Protection. (2011) *Kath French Secure Care Centre, Practice Guidelines*. Author, Perth.
- Department of Children and Families (2010) *Enhancing Care and Support Services for Young People and Adults with High Risk Behaviours. Consultation Paper*. Author, Darwin.
- Department of Children and Families (2012) *Public Release of the Care and Protection of Children (Therapeutic Orders) Amendment Bill 2012*. Author, Darwin.
- Department of Human Services, Community Services (2010) *Out of Home Care Service Model, Therapeutic Secure Care Programs*. Author, Sydney.
- Department of Human Services (2012) *Placement in secure welfare services, Child Protection Manual*. Author, Victoria
- Fahey, L, & Hardman, B. (2010) *Therapeutic Secure Welfare NSW*. National Therapeutic Residential Care Workshop. Melbourne. Retrieved from http://www.dhs.vic.gov.au/_data/assets/pdf_file/0006/587715/workshop-c5-therapeutic-secure-welfare-nsw-2010.pdf
- Guardian for Children and Young People (2008) *Safe Keeping Orders in South Australia: Discussion Paper*. Author, Adelaide.
- Giller, H. (2006) Is Secure Care Fair. *Community Care*, Sep 14-Sep 20, 1640.
- Mooney, A., Statham, J., Knight, A. & Holmes, L. (2012) *Understanding the Market for Secure Children's Homes. Summary report. A rapid response study for the Department of Education*. Childhood Wellbeing Research Centre, London.



O'Connor, I. (1992) *Issues in juvenile justice in Queensland: new laws, old visions*. Retrieved from http://www.aic.gov.au/media_library/publications/proceedings/22/oconner.pdf

Osborn, A., Delfabbro, P. & Barber, J. (2008) The psychosocial functioning and family background of children experiencing significant placement instability in Australian out-of-home care, *Children and Youth Services Review*, 30, 847-860.

Queensland the Commission of Inquiry into Abuse of Children in Queensland Institutions (1999) *Report of the Commission of Inquiry into Abuse of Children in Queensland Institutions (Forde Inquiry)*. The Inquiry, Brisbane.

Raman, S, Inder, B. & Forbes, C. (2005) *Investing for Success: The economics of supporting young people leaving care*. Centre for Excellence in Child and Family Welfare, Melbourne.
Scottish Institute for Residential Child Care (2009) *Securing Our Future: A Way Forward for Scotland's Secure Care Estate*. Author, Glasgow.

Tarren-Sweeney, M, & Hazell, P. (2006) Mental health of children in foster and kinship care in New South Wales, Australia, *Journal of Paediatrics and Child Health*, 42, 89-97.

United Nations, *Convention on the Rights of the Child*, Retrieved from <http://www2.ohchr.org/english/law/pdf/crc.pdf>

United Nations, *Rules for the Protection of Juveniles Deprived of their Liberty*, Retrieved from <http://www.wwda.org.au/juven1.pdf>

United Nations, *Standard Minimum Rules for the Administration of Juvenile Justice* (the Beijing Rules), retrieved from <http://www2.ohchr.org/english/law/pdf/beijingrules.pdf>

Walker, M., Barclay, A., Hunter, L., Kendrick, A., Malloch, M., Hill, M. & McIvor, G. (2005) *Secure Accommodation in Scotland: Its Role and Relationship with 'Alternative' Services*. Scottish Executive. Edinburgh.

Queensland Child Protection Commission of Inquiry transcripts of hearings

Allison, Margaret, 26 February 2013, Brisbane, retrieved from http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0019/176023/2013-02-26-QCPCI-Day-45-Brisbane.pdf

Bellamy, Michelle, 7 February 2013, Brisbane, Retrieved from http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0009/174978/2013-02-07-QCPCI-Day-43-Brisbane.pdf

Farrell, Kristina, 5 February 2013, Brisbane, Retrieved from http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0005/174425/2013-02-05-QCPCI-Day-41-Brisbane.pdf

Glass, Paul, 6 February 2013, Brisbane, retrieved from http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0006/174723/2013-02-06-QCPCI-Day-42-Brisbane.pdf



Lewis, Natalie, 16 January 2013, Brisbane, retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0018/172440/Day-37-16-January-2013,-Brisbane.pdf,

McDermott, Dr Brett, 8 November 2012, Brisbane, Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0011/167870/2012-11-08-QCPCI-Day-33-Brisbane.pdf

Payet, Antoine, 3 October 2012, Beenleigh, Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0005/163823/2012-10-03-QCPCI-Day-21-Beenleigh.pdf

Sherry, Marissa, 7 February 2013, Brisbane, Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0009/174978/2013-02-07-QCPCI-Day-43-Brisbane.pdf_p42-59

Waugh, Peter, 4 October 2012, Beenleigh, Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0010/163846/2012-10-04-QCPCI-Day-22-Beenleigh.pdf

Wall, Greg, 5 February 2013, Brisbane, Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0005/174425/2013-02-05-QCPCI-Day-40-Brisbane.pdf

Submissions to the Queensland Child Protection Commission of Inquiry

ACTCare Kids, Downey, Laurel (2012), Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0011/163928/ACTCare_Cairns_Downey_Laurel_Submission.PDF

Mercy Family Services (2012), retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0005/170762/Mercy_Family_Services_Submission.pdf

PeakCare Queensland (2012), Retrieved from
<http://peakcare.org.au/files/cms/files/PeakCaresubmission231012%5B1%5D.pdf>

Royal Australian and New Zealand College of Psychiatrists Faculty of Child and Adolescent Psychiatry, Queensland Branch (2012), retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0019/163441/Faculty_of_Child_and_Adolescent_Psychiatry_Qld_Branch_Royal_Australian_and_New_Zealand_College_of_Psychiatrists.PDF

Sisters Inside (2012), Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0017/160505/Sisters_Inside_Kilroy_Debbie.pdf



Youth Advocacy Centre (2012), Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0007/164950/Youth_Advocacy_Centre_Wight_Janet.pdf

Youth Affairs Network of Queensland (2012), Retrieved from
http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0009/171864/YANQ-1.pdf

