



Australian Centre for
Child Protection



***Report on Secure Care Models for Young
People at Risk of Harm***

**Report to the SA Child Protection
Systems Royal Commission**

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Australian Centre for
Child Protection

BACKGROUND

Both the Layton Commission of Inquiry and the Mullighan Royal Commission recommended that consideration be given to the establishment of a secure residential care facility in South Australia. The Mullighan Inquiry in particular focussed on the use of such a facility as a short term 'circuit breaker' for young people who are engaging in behaviour that is such a risk to themselves that as a last resort they ought to be detained for a short period of time in a therapeutic facility. The South Australian Child Protection Systems Royal Commission requested a review of the evidence and practice regarding therapeutic use of secure care for children within the child protection system. The following issues are under consideration:

- What research is available and what does it tell us?
- Do secure care options exist in Australia and if so:
 - What features of this model protect children's rights versus the need for adequate treatment and care?
 - What are the referral criteria?
 - What length of time is considered for admission?
 - Where does the power to commit a young person sit?
 - What features of the model make it therapeutic?

This report will outline the evidence and practice with reference to the concerns outlined above.

SECURE CARE IN THE AUSTRALIAN OUT OF HOME CARE SECTOR

Many service providers in the Out-of-Home-Care sector support the use of secure care if used as part of a therapeutic case plan. For example, Mercy Family Services (Queensland) argue that therapeutic secure care allows young people to be:

'... contained for their own safety until they can be stabilised to the extent that they are able to be placed in less intensive placements such as therapeutic residential care service, general residential care or even supported-independent living programs' (Mercy Family Services, 2012, p.47).

Supporters of the judicious use of secure care argue that it has the potential not only to protect a child from harmful behaviour and self-harm, but also to protect other children from unnecessary distress. In a submission to the Carmody Inquiry, Mercy Family Services (2012) state:

‘In keeping with the well-known Pareto (80/20) principle which states that for many events, roughly 80% of the effects come from 20% of the causes, it is the continued placement of children and young people with such extreme needs in placement settings simply unable to adequately care and support them (such as specialist foster care, general residential care and event therapeutic residential services) that lead to significant problems across the out-of-home care system. ... Multiple placement disruption and breakdown, contagion and vicarious trauma (which is the situation where other children and young people in the placement are impacted by the often distressing behaviours of others), and the inevitable complaints from neighbours and the involvement of police’ (p.47-48).

HOW IS SECURE CARE USED IN SOUTH AUSTRALIA

At present, secure care can only be provided by the Youth Justice Directorate within the Department of Communities and Social Inclusion, or Child and Adolescent Mental Health services, under the Women’s and Children’s Health Network.

Youth Justice Services

At 30 June 2015, there were 2,690 children and young people under the guardianship of the SA Minister for Education and Child Development. In the period 1 July 2014 to 30 June 2015, 827 admissions were made to the Adelaide Youth Training Centre (Secure Care Facility) which involved 426 individual young people. Seventy-eight percent of children were under a guardianship order. At present, youth justice services are the only option for placement of children who are acting out, exhibiting extreme behaviours that place themselves or others at risk, and that cannot be contained in other ways. Adelaide Youth Training Centre (AYTC) is a government service designed to provide a safe and secure environment for young

people in custody. AYTC has two Centres, a three unit (36-bed) facility for boys aged 10–14 on remand and detention warrants and young people on police custody; and a five unit (60 bed) facility for girls aged 10 to 18. According to the Department of Communities and Social Inclusion website, this unit also provides services to young men 15 and over on remand and detention warrants. <https://www.dcsi.sa.gov.au/contact/youth-justice-contacts>

Mental Health Services

If a child is experiencing the early stages of a psychotic illness, suffering severe mental disorder (including depression) with a suicidal component; or experiencing complex and coexisting disorders requiring multiple assessments and specialised care, they may be admitted to Boylan Ward. Boylan Ward is South Australia’s only inpatient psychiatric ward for young people up to 17 years. Anecdotal reports suggest that the needs of children exhibiting risky and harmful behaviour are not accommodated by this secure mental health service.

Other jurisdictions have developed alternatives to youth justice and mental health responses for children in care. This report will provide a description of these models (pages 8-24), and a summary of the key features (pages 24-28). Prior to describing models of secure care, an overview and summary of the research evidence will be presented (pages 4-8).

WHAT DOES THE AVAILABLE LITERATURE TELL US?

The international literature provides some insight into factors that might contribute to best practice for young people in South Australia. The bulk of the published research relates to secure care in the context of youth offending (Souverin et al., 2013; Harder et al., 2012). Outcomes tend to be measured by behavioural rather than social outcomes (e.g., recidivism versus well-being). Studies do not routinely report the guardianship status of children accessing the service. This limits somewhat the utility of this research for informing the development of secure care for young people at risk of harm for children with complex needs not associated with offending. Nonetheless, there are some key messages from this

literature that may be useful in considering what is important for young people in secure settings.

First, young people in secure care are likely to have significant mental health concerns and cognitive impairment. Children in foster care and residential care have significantly higher mental health issues than comparable children (Ford et al., 2007; Meltzer et al., 2004). Children who are placed in residential care are often placed as a 'last resort' and their mental health and behavioural needs are even greater (Ford et al., 2007; McLean & Winsor, in prep). Research shows extremely high levels of mental health and social needs amongst children admitted to secure care. For example, in a study of 514 youth in European secure care, 65% of children were found to have more than one psychiatric diagnosis; 99% had externalising behaviour problems, 89% had internalised mental health problems (suicide attempts and self-harm), 66% had substance use issues, and 40% had 'sexually inappropriate' behaviour (e.g., victims of sexual exploitation and prostitution). Almost all (99%) had grown up in troubled or single parent families in violent or abusive environments. A third were not attending school or working and 3% were homeless (see Souverin et al., 2013).

Children in both the juvenile justice and the out-of-home care population (foster care, residential care), are more likely to have neuro-disabilities, including Fetal Alcohol Spectrum Disorder (FASD) (McLean & McDougall, 2014; McLean et al., 2014; Parkinson & McLean, 2013a). FASD is a cognitive disability caused by exposure to alcohol before birth. It is estimated that, on average, almost 17% of children in out-of-home care are living with FASD (Lange et al., 2013). This is estimated to be 17-19 times higher than the general population (Lange et al., 2013). FASD affects understanding of language, short term memory, and impulse control, inability to predict the consequences of actions, and often results in intellectual disability (McLean & McDougall, 2014; Parkinson & Mclean, 2013b). It is associated with increase chance of coming into contact with justice services, both as a victim or as an offender. There is growing recognition in the literature that 'invisible' neuro-disabilities are common amongst youth at risk, and that poor insight associated with these difficulties places children at increased risk of becoming a victim or being led into offending behaviour (British Psychological Association, 2015; Parkinson & McLean, 2013a).

Based on this information, we can assume that young people who may be placed in secure care for harmful behaviour directed at themselves or others are likely to have complex needs, including communication disorders, mental health disorders, post-traumatic stress disorder, and may be living with 'invisible' neuro-disabilities such as Fetal Alcohol Spectrum Disorder (FASD), Autistic Spectrum Disorders (ASD), traumatic brain injury, Attention Deficit Hyperactivity Disorder (ADHD) and learning disabilities. Whether young people end up in mental health services or youth justice services may depend on how these difficulties are expressed (in harm to self or harm to others).

Second, the effectiveness of secure care depends on the quality of therapeutic input, on skilled interactions with staff, and on purposeful transition planning. International research demonstrates that secure residential care can lead to modest improvements in behavioural measures (e.g., recidivism) (De Swart et al., 2012; Harder et al., 2012; Souverin et al. 2013). Outcomes appear to improve where there is a clear treatment/therapeutic intervention. This can be achieved by including therapeutic intervention that is matched to need and supported by the literature, when there is good follow up and after care services, and where youth report positive relationship with staff (Souverin et al., 2013; Koehler et al., 2013). Addressing literacy and numeracy difficulties associated with educational engagement as part of the secure care program is also important. Secure care may work best when it is part of a spectrum of options. In particular, outcomes may be related to the quality and continuity of service provision after discharge (James et al., 2013; Souverin et al., 2013). Adopting a welfare oriented approach, as opposed to a judicial (punitive) approach to children's harmful behaviour is believed to be more effective in addressing both criminogenic and social needs (Koehler et al., 2013; Souverin et al., 2013). A welfare-oriented response makes no distinction between offending behaviour and other risk behaviour (Noetic Solutions, 2010; Souverin et al., 2013; PeakCare, 2013).

Third, promising secure youth justice, secure youth mental health and secure youth welfare programs all emphasise the following:

Positive relationship between staff and young people: Staff that adopt a, 'well-being' oriented approach to interactions with young people provide good role modelling and are likely to be more effective than those that adopt a punitive

approach that emphasises compliance. Knowledge about child development, family dynamics, conflict resolution, and responding to challenging behaviour arising from trauma and disability can support this development (De Swart et al., 2012; Harder et al., 2012; Koehler et al., 2013).

Matching therapeutic input to client needs: Evidence based programs for secure care are yet to emerge. There is a sound evidence base, however, for problems that are common in this population (e.g., PTSD, anger management/empathy training). These skills are more easily built into existing programs, depending on the needs of the client group. Skill building, positive behaviour support, communication training and supervision may be more important with young people who have intellectual disability (Cameron, K (2014). For young people who have had strong antisocial role models, anger management, empathy training and problem solving approaches may be more important. Trauma specific interventions may be most relevant in cases of sexual risk-taking behaviour and young people with exposure to complex trauma. Tailored educational support will help address the learning barriers to educational and vocational opportunities (De Swart et al., 2012; James et al., 2013; Souverin et al. 2013).

Services need significant mental health input: Treatment should be administered by mental health professionals who have an understanding of youth risk taking, and who understand the impact of intellectual disability, poor role modelling, adversity and trauma. Where programs rely on youth workers or other paraprofessionals, clinical direction and oversight should be provided by qualified mental health staff (e.g., psychiatrist, psychologist, social workers, speech and language therapists) (Grietens & Hellinckx, 2004; Koehler et al., 2013).

Children must remain engaged with services long enough for them to benefit: Behavioural and therapeutic change of this level takes time. A combination of secure and semi-secure options can facilitate ongoing support and a graduated 'stepped down' transition from secure service (Grietens & Hellinckx, 2004).

Transition planning is critical: Secure care cannot be effective without good transition planning. A range of 'step down' and 'step across' options are needed for

children that can include semi-secure care, youth detention facilities, mental health facilities and outreach, and flexible use of specialised foster placements. Secure care is unlikely to be effective without a range of options that allow a young person to gradually gain more control over their behaviour in a supported way (James et al., 2013).

Taken as a whole, the literature suggests that longer term programs that respond to underlying mental health, disability and social needs, that emphasise skilled interaction and transition planning hold promise for this population of children.

INTERNATIONAL EXAMPLES OF SECURE CARE PROVISION FOR CHILDREN IN CARE

Two examples of systems using secure care were identified in comparable western countries: the Secure Care Estate in Scotland and England's Secure Care Network. These are included as examples of pathways for the provision of secure care.

Scotland

In Scotland residential secure care is provided for children under the age of 16 who either are in need of protection for their own safety or pose a risk to others (including committing an offence) (Noetic Solutions, 2010). The stated aim of secure care is to ensure the safety of the child, to set appropriate boundaries for the child and to re-engage them with positive supports and activities (PeakCare, 2013; Children's Hearings Scotland www.chscotland.gov.uk/)

Secure care is complemented and supported by the Scottish Children's Hearing system which deals with all young people in a similar manner regardless of whether they are victims or offenders. All children at risk are referred to a children's reporter who collates information from multiple agencies and investigates circumstances surrounding the child's problem behaviour. Children's reporters are trained professionals whose job it is to decide whether there are legal 'grounds' and whether a compulsory supervision order is necessary for the child. A children's reporter will talk to significant adults and may also talk with the child to determine if further action is required. If so, the children's reporter will arrange a

Children's Hearing for the child. A Children's Hearing is a legal meeting that involves a panel of trained volunteers, and family or guardians are also present. The hearing can decide that compulsory measures of supervision are needed to help the child and can make a compulsory supervision order. This will have measures attached to it which can include where the child or young person is to live (e.g., with foster carers or a relative, or secure care), or who the child should see and when. Initially developed in response to offending behaviour, hearings are now more commonly used for care and protection issues. Children may be referred to a hearing for reasons of risk by association as well as harm to self and harm against others.

These grounds are set down in section 67(2) of the *Children's Hearings (Scotland) Act 2011* (Children's Hearings Scotland. www.chscotland.gov.uk/).

The grounds include that the child or young person:

- is likely to suffer serious harm to health or development through lack of parental care
- has been the victim of a schedule 1 offence*, is likely to have a close connection with someone who has committed such an offence or is likely to become a member of the same household as another child who has been the victim of a schedule 1 offence
- is or is likely to be exposed to persons whose conduct may mean that the child or young person is abused or harmed or their health, safety or development will be seriously adversely affected
- has or is likely to have, a close connection with a person who has carried out domestic abuse
- has or is likely to have, a close connection with a person who has committed an offence under the *Sexual Offences (Scotland) Act 2009*
- is accommodated by a local authority or is the subject of a permanence order and special measures are needed to support them
- has committed an offence
- is misusing drugs or alcohol

- has behaved in a way that has had or is likely to have, a serious adverse effect on the health, safety or development of themselves or another person
- is beyond the control of parents or carers
- is not attending school regularly without a reasonable excuse
- has been, is being, or is likely to be, forced into a marriage or civil partnership, or is, or is likely to become, a member of the same household as such a child.

* A schedule 1 offence is a physical, emotional or sexual offence against a child. These offences are called 'schedule 1 offences' because they are listed in schedule 1 to the *Criminal Procedure (Scotland) Act 1995*.

English Secure Care Network

The secure care accommodation network in England is aimed at providing care for children aged 10–17. It tends to be used as the option of last resort when all other options have been explored. In order to be placed in secure care, a child must have a history of absconding or be likely to abscond from anything other than secure accommodation. If kept in anything other than a secure placement the child is likely to suffer significant harm or injure themselves or other persons. The statutory social worker must make an application to the Magistrate of the Family Court, for a secure welfare accommodation order, demonstrating the need for secure care and presenting a plan for transitioning out of secure care. Applications can be made for up to three months, although generally 28 day orders are granted initially. There is provision for emergency placement of no longer than 72 hours. A subsequent application may be made for up to six months. The Court must regularly review the evidence regarding absconding and harm to self and others to ensure that these dangers still exist. Children under 13 years may only be placed with special permission from the Secretary of State (Cabinet Minister in charge of the relevant statutory welfare department). In England, secure care units provide residential care, educational facilities and healthcare. Some provide 'welfare' placements, many provide 'youth justice' placements; many are mixed and some specialise in one or the other. Most are provided by the statutory agency, or 'local authority'. Reviews, involving a statutory worker and two independent people are held within 28 days of admission and at least every three months

after that to ensure that the criteria for restriction of the child's liberty are still present. Secure care units are subject to in-depth regulation through the Office for Standards in Education, Children's Services and Skills (Ofsted), which reports directly to Parliament.

WHAT HAS BEEN LEARNED FROM THE INTERNATIONAL EXPERIENCE OF SECURE CARE?

The use of secure care has been subject to debate both in the UK and Scotland where it has been used. Published information is limited and difficult to interpret. In particular, the distinction between evidence and ideology is difficult to discern in the reviews that have been published.

There is general agreement on the need to better match the needs of children with placements and that secure placement tends to be utilised for children with intellectual disability, violent and aggressive behaviour, and for young women at risk of exploitation. There is little guidance, however, about how to do this in the case of children in care. While UK reviews hint at difficulties in combining 'youth justice' and 'welfare' clients in the same secure care home, there does not appear to have been any documentation about what these difficulties might be nor how to resolve them.

At present, despite best intentions, secure homes still seem to be used mostly as a 'last resort' for children with the most challenging behaviour and disrupted placement history. UK reviews have identified a reluctance to use secure care for purposeful early intervention. As one manager described:

'... there still isn't that appetite for actually saying let's use this at the soonest opportunity for this young person as a short-term expense for a long-term gain' (Mooney et al., 2012).

Arguably, this attitude towards secure care may serve to exacerbate, rather than resolve, some young people's issues. In the context of a perceived bias against secure care, any failure to make impacts in a short period of time can be attributed to secure care as a model, rather than the characteristics and complex history of the young people who receive

this support. This serves to reinforce a negative view of secure care (Mooney et al, 2012). To date, there does not appear to have been any research completed that can disentangle these factors.

Published reports call for services to train staff in specialist skills such as working with young people with neuro-developmental compromise and in joint (collaborative case) working (Mooney et al., 2012).

Taken together, discussion of secure care in the international context suggests that secure care may be a necessary and potentially effective option for young people in care. Despite this, it may still be used as a 'last resort' and more research is needed to determine 'what works' and 'when' for this group of vulnerable children.

AUSTRALIAN EXAMPLES OF SECURE CARE PROVISION FOR CHILDREN IN CARE

Secure care models are relatively new in Australia, compared with other western countries. In particular, there is very little literature on secure accommodation options for children in care (Mercy Family Services, 2012).

New South Wales, Victoria, Western Australia and Northern Territory have implemented forms of secure care for children under child protection orders, although these reforms are relatively new. There are variations between jurisdictions in the way that placement in secure care is initiated, in the length of time that secure care can be used for, and in the way that secure care is utilised. No research appears to have yet been conducted about the efficacy of this care option. The parameters of secure care in each jurisdiction will be described and the common features will be then be summarised.

SECURE CARE IN NEW SOUTH WALES

Referral criteria

Therapeutic secure care is specified for children aged between 12 and 17 years who are already living in out-of-home care, but who need more intensive and secure support in order to protect them from behaviour that places either themselves or others at risk.

Behaviour related to sexual exploitation or substance use meet the criteria for risky behaviour. The service is only offered to children who are case managed by Department of Family and Community Services (FACS: NSW Statutory Department), and not by one of the many non-government service providers. Referrals are accepted by department case managers, from the Intensive Casework Support Services team. Referrals are initiated as the result of a case conference in which it is decided to apply for a therapeutic secure care order in the Supreme Court. The Director of FACS must approve a therapeutic secure care order application.

Therapeutic model and aims

The aim of therapeutic secure care is to keep children safe while their behavioural, emotional, educational, and mental and physical health needs are assessed, their case plans are reviewed and linkages to appropriate support services and treatment are established or enhanced. In using this placement option, serious risk to the child caused by their behaviour is removed, while the drivers of risk behaviour are addressed. The ultimate aim is to manage risk to the extent that a child can be managed in a community setting or other less restrictive placement within the shortest time possible. Additional specialist input is sought for Aboriginal, culturally and linguistically diverse, or refugee children.

Duration of detention

The length of stay is determined by the NSW Supreme Court. Most typically, a one-week order is initially obtained, during which more intensive assessment and evaluation is obtained. If appropriate, an application would then be made for a three-month order. Orders are reviewed every three months by application to the Supreme Court.

Example of how the model is used

Sherwood House is a therapeutic secure care service that draws on a therapeutic model of trauma recovery. It uses a trauma recovery model (ARC: Attachment Regulation and Competency; Blaustein & Kinniburgh, 2010) to inform its practice. The service has provided care almost exclusively to girls since its inception six years ago, although it does accept referrals for boys. Anecdotal reports suggest that other secure care options are utilised for children who may not be suited to this model of care (e.g., children with challenging

behaviour arising from intellectual disability). The average length of stay is around 16 months, and it is uncommon for children to be in the service less than one year.

Strengths of this service model are the requirement for children to be case managed by experienced workers from the statutory department's intensive case management team, and for the relevant worker and the manager of this service to attend regular clinical review meetings. The intake panel comprises senior staff from Sherwood House, senior managers from Intensive Casework Services team, a psychiatrist and where appropriate representation from the statutory department's Indigenous liaison unit, education services and Juvenile Justice. Education services (20 hours per week) are provided either by tutors on site or by one of the education department behaviour exclusion schools. Secure care is provided in one six-bed house and two three-bed cottages situated in the community (12 beds in total). The house is secured by a perimeter fence, but otherwise looks like a normal community setting. The cottages are semi-secure, offering a step down alternative to children as they transition from the unit. All sites offer capacity for containment, via fencing or physical restraint where necessary.

It is important to note that Sherwood House is not the only secure care service that exists in NSW; but it is the most well-known model in that state and offers a clear conceptual model. Other services offering secure care appear to use two-bedroom community houses, with capacity to lock doors where necessary. Anecdotally, the reported success of Sherwood House may be due to its clear referral criteria and treatment model (Fahey, personal communication). Children who are not suited to a trauma-informed therapeutic recovery model (e.g., by reason of intellectual disability) are accommodated by different secure care services. It is difficult to determine how many children are subject to secure care, as apart from Sherwood House, secure care tends to be provided in parallel with conventional residential homes, where the capacity to provide secure containment is achieved via physical barriers (locked doors) and physical restraint, rather than high perimeter fencing. This allows services greater flexibility in which clients they can accept.

Further Information

NSW Department of Human Services. (2010). Out of home care service model: Therapeutic secure care programs. Sydney: Out of Home Care Policy Planning Division: Community Services.

SECURE CARE IN VICTORIA

Referral criteria

In Victoria, secure care is available for children aged 10 to 17 years who are at substantial and immediate risk of harm. It is also necessary to demonstrate that the only suitable option to ensure the child's safety and well-being 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. There must be a significant crisis for the child (i.e., this option is not to be used for the protection of property). Children must be under a custody or guardianship order or under an interim accommodation order.

Therapeutic model and aims

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 transition the child to the community as soon as possible. Care is provided to young people in one of two locked gender-specific facilities.

Depending on the child's legal status, the divisional Child Protection Operations Manager or the court may make a decision to place the child at a secure welfare service, depending on the child's legal status. In the case of children under guardianship of the Minister, the Secretary, Department of Human Services, must approve an application and be satisfied that there is substantial and immediate risk of harm to the child. The following criteria must be demonstrated: (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 (PeakCare, 2013). Placement of Aboriginal children must include consultation with the Aboriginal Child Specialist Advice Support Service. In Victoria, case management may be contracted to non-government organisations (intensive case management support) and in that case, the NGO is responsible for leading an application to the Court (PeakCare, 2013)

Duration of detention

Secure Welfare placements are expressly used for short-term containment of risk and are time limited (21 days with the option of another 21 days in exceptional circumstances). 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 insufficient to protect the child from significant harm (Mercy Family Services, 2012; PeakCare, 2013). In exceptional circumstances, there can be an extension to the placement, but the maximum period allowed in total must not exceed 42 days.

An internal review can be requested by persons affected by the decision (i.e., child, parent, carer) to place or not to place a child in a secure welfare service or about the proposed length of stay. The review outcome is explained to the child within the next working day.

Example of how the model is used

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 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 involved in planning and goal setting to the extent to which this is in each child's best interests and children are informed of their rights relating to detention, review and complaints.

In the case of a young child (aged 10–15) exhibiting sexual abusive behaviours, there is provision under the *Children, Youth and Families Act 2005* (CYFA) that allows for application to the Court for a therapeutic placement order. A therapeutic placement order must be

accompanied by an application for a therapeutic treatment order and can only remain in place as long as the therapeutic treatment plan is active. This provides a means for children to be compelled to attend treatment, including secure care, where this might not otherwise occur (due to limited family engagement or recognition of the problem) and avoids the need to rely on criminal prosecution (Department for Human Services (DHS), 2007). Therapeutic treatment orders can be made for a maximum of one year, with capacity for a one-off extension up to a further one year. Although this option is not exclusively applied to children under guardianship, anecdotal reports suggest that this is often the case, providing a means to intervene with problematic sexual behaviour in this population of children.

Further Information

Department for Human Services (2007). Children in need of therapeutic treatment: Therapeutic treatment orders. Melbourne: Government of Victoria.

SECURE CARE IN WESTERN AUSTRALIA

Referral criteria

In Western Australia, placement of children aged between 12 and 17 in secure care is permitted for children who are under short or long term care of the Department for Child Protection, or subject to provisional protection arrangements in that state. The criteria specify that there needs to be immediate and substantial risk of significant harm to the child. An additional criterion is that risks to the child cannot be managed or reduced by the child's available care and protection network. A child may not be placed due to posing a risk to others, nor can they be placed if there are clear mental health concerns.

In order for a placement to be approved, the following must be demonstrated: (1) placement in secure care is in the child's best interests (stability, development and safety needs); (2) no other available support or placement is deemed adequate to protect the child from significant harm; and (3) there has been consultation with secure care staff that establishes that placement in secure care can indeed meet the child's identified needs. For children of culturally and linguistically diverse, and Aboriginal backgrounds, consultation must occur with Senior Practitioners or Senior Advisor Cultural Diversity and Aboriginal

Practice Leaders respectively. Legislation specifically states that referral is 'not appropriate if the child's needs are best serviced through admission to a mental health facility' or if a youth justice response is required. Admission to secure care may occur via either an administrative secure care arrangement made by the CEO of the Department for Child Protection (or delegate) or via an interim order (secure care) made by the Children's Court.

Therapeutic model and aims

Secure care is a planned, short term, intensive intervention, the purpose of which is to stabilise the child during a significant crisis in their life 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 (PeakCare, 2013; Department for Child Protection, 2011b). The service is conceived of as reflecting:

'... best practice therapeutic services and provide some of Western Australia's most vulnerable young people with their best opportunity to stabilise and begin to address the complex problems and behaviours that prevent them from maintaining longer term placements and transitioning to more independent living' (Department for Child Protection, 2011b, p.1).

It is viewed as the option of last resort where containment is deemed both 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'. The background paper produced by the department states that children's needs:

'will be addressed through a collaborative approach between the Department and relevant key partner agencies within secure care. The Department will provide these care arrangements in a secure residential setting that will focus on intensive therapeutic intervention. It will not simply detain the child' (p.2).

Administratively and conceptually, the secure care unit in Western Australia is guided by the Department's *Residential Care Conceptual and Operational Framework*, which claims to provide an evidence-based therapeutic approach (Sanctuary Model) that creates a culture of healing and begins to address children's trauma (Department for Child Protection, 2009, 2011 c).

According to the Department's background paper (2011b) Secure Care aims to:

- be evidence-based and reflect best practice
- be provided by a therapeutic care team and based on multi-agency involvement in the young person's life
- be subject to inspection and quality assurance through external assessors appointed by the CEO
- provide intensive interventions with a focus on support and stabilisation
- involve the minimum length of stay necessary to stabilise a young person whilst identifying alternative plans for the young person's exit from secure care
- provide educational, health and recreation services in-residence
- include ongoing support from the child's care team including Child Protection Workers, birth family, carers and significant others as well as other government, non-government and specialist service providers as part of the secure care program
- include a transition process to alternative care that will be developed through intensive collaboration in planning for service provision and follow-up with other government and non-government agencies.

Duration of Detention

A child can be placed for a maximum uninterrupted 21 day limit – the 'secure care period'. In keeping with Victoria's model, there is provision for an extension not exceeding 21 days in exceptional circumstances. The legal maximum is an uninterrupted period of 42 days (Department for Child Protection, 2011d). There is provision for children or their caregivers to apply for 'reconsideration' by an independent senior department officer in circumstances where the placement or length of placement is contested. If this process is unsatisfactory there is provision to apply to the State Administrative Tribunal for review. The service is also subject to independent assessment by assessors appointed by the department.

Example of how the model is used

Western Australia has only one state-wide secure care centre (Kath French Secure Care Centre). This unit originally had nine beds but was reduced to six beds in 2013 (Mercy Family Services, 2012). It commenced operating in 2011 and is located east of Perth. Policy and procedures for this unit are publically available. The children's care team utilises a

therapeutic approach and there are in-residence educational, health and recreational services (Department for Child Protection, 2009; 2011b; PeakCare, 2013). A collaborative approach is taken to care planning – staff, children’s family, and the child participate in care planning in conjunction with relevant external services. Care plans are subject to review (within two working days of admission). Practice guidelines are publically available (Department for Child Protection, 2011a).

Further Information:

Department for Child Protection (2011a). Kath French Secure Care Centre: Practice Guidelines. Perth: Government of Western Australia.

Department for Child Protection (2011b). Secure Care Background Paper. Perth: Government of Western Australia.

Department for Child Protection (2009c). Residential Care Conceptual and Operational Framework. Perth: Government of Western Australia.

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SECURE CARE IN NORTHERN TERRITORY

Referral criteria

The CEO of the Department for Children and Families can apply to the court for a therapeutic residential order or therapeutic assessment order under the Care and Protection of Children (Therapeutic Orders) Amendment Bill (2012). Any person who is the subject of an application for these orders must be represented by a legal practitioner for any Court proceedings and to be available to the young people for the duration of the order.

However the Court may, because of emergency or other unusual circumstances, waive the representational requirement (Department of Children and Families, 2012a,b).

A therapeutic residential order can be made if accompanied by a therapeutic treatment plan prepared by the CEO. This plan must include details of the treatment to be provided to the child and the plan that is proposed for the further assessment and treatment of the child after the order expires. Once the child is in secure care, the CEO is required to report to the court on the child's progress every three months. The therapeutic residential order must end not later than six months from the day the child enters secure care. If granted, the order lapses if the child is not taken to a secure facility within 28 days.

The CEO may also apply for therapeutic assessment order, which enables a child to be involuntarily placed in a (secure) approved treatment facility. This facility is co-located within hospital mental health services. This order can be in place for 14 days and can only be approved if an authorised psychiatric practitioner is satisfied that the criteria for application are met.

In order for a therapeutic assessment or therapeutic residential order to be made, the Court must be satisfied that the young person is likely to cause serious harm to themselves or someone else because of their pattern of aggressive, irresponsible or high risk behaviour. In addition, previous attempts to carry out an assessment, or provide treatment and care must have been unsuccessful; and there can be no less restrictive means available to ensure the young person receives treatment and care. There is also a requirement that the long term well-being of the young person is likely to be enhanced by assessment, treatment and care. The young person must be under the age of 18 years throughout the period of the order.

Therapeutic model and aims

The services aim to meet the needs of a small cohort of young people who, because of their patterns of aggressive, irresponsible or high risk behaviour, are likely to cause serious harm to themselves or others, and who require full-time secure care and therapeutic services (Department of Children and Families, 2012a).

The approved treatment facility (short term secure care) is co-located within mental health inpatient services (hospital ward). This results in increased capacity for secure containment of children, access to qualified mental health staff, while minimising operational costs.

It is unclear to what extent Therapeutic Secure Care (medium term) housing has been developed to date in the Northern Territory. Two secure homes for children were identified in this review: Yirra House in Darwin and Kwiyrnpe House in Alice Springs. These houses are administered by the Department of Children and Families, and each houses eight children. Department documents indicate that these houses deliver therapeutic services that are informed by trauma and attachment theory, and neuro-developmental perspectives and relational theory, and in which harmful and challenging behaviours are viewed as a consequence of changes in brain functioning arising from trauma experienced by the young person (Department of Children and Families, 2012c).

According to the departments' briefing paper (2012a):

'The Secure Care Service is one element of a therapeutic service, care and support system that the Department of Children and Families is developing over the next 12 months for young people with complex needs and high risk patterns of behaviour. Once developed there will be less restrictive options than Secure Care for young people to receive therapeutic services and care as either an alternative to secure care or as a less restrictive step down option. The Therapeutic Care Services will be supported by Specialist Services and Community Support Programs. ... This system will significantly strengthen and enhance the current service system' (p.1).

This appears to indicate an intention to develop a 'continuum' of therapeutic options to support secure care, but it is unclear the extent to which these developments have occurred to date.

The NT Department of Health website indicates that Department of Children and Families houses are co-located with adult Disability Services secure houses in a larger secured complex, in which adults with harmful behaviour are housed on the same site, but in separated quarters. The care of children is the responsibility of the Department of Children and Families, whereas the care of adults is the responsibility of Aged Care and Disability

Services. Children and adults are unable to communicate with each other. It appears, therefore that these units may be used for young people with complex and challenging behaviour associated with disability, although this is not explicitly stated. While the child and adult services are physically co-located on the same site, the buildings have been designed to ensure client separation, with separate accommodation, outdoor and living areas for children and for adult clients. The design reflects the intent for the child and adult services to operate independently from one another. The rationale for co-location of a child and adult secure medium stay unit is that it makes optimal use of available resources and staff expertise while minimising costs.

See: http://health.nt.gov.au/Secure_Care_Facilities_and_Services/index.aspx

Duration of Detention

The therapeutic residential order must end not later than six months from the day the child enters secure care. If granted, the order lapses if the child is not taken to a secure facility within 28 days.

The therapeutic assessment order can be in place for 14 days. This may be renewed for a further 14 days upon application to the court. No further extension is permitted. If a therapeutic assessment order is granted it will cease if the child is not placed in an approved treatment facility within 28 days. Once admitted under a therapeutic assessment order, an authorised psychiatric practitioner must examine the child not less than once every 48 hours while in the approved treatment facility.

A review authority may enter and inspect a secure care facility and its records at any time without notice. The review authority (one or more individuals) is appointed by the CEO of the Department of Children and Families. The review authority reports initially to the CEO. The CEO is required to submit the review authority's report, together with a written response, to the NT Children's Commissioner.

Further Information:

Department of Children and Families (2012a) Public Release of the Care and Protection of Children (Therapeutic Orders) Amendment Bill 2012: Briefing Paper. Darwin. Northern Territory Government.

Department of Children and Families (2012b) Secure Care Services for Young People: Fact Sheet. Darwin. Northern Territory Government.

Department of Children and Families (2012c) Secure care therapeutic framework (Appendix B). Darwin: Northern Territory Government.

KEY CONSIDERATIONS REGARDING SECURE CARE: SUMMARY

This review has identified several models of secure care operating within Australia and in comparable countries overseas. There is some variability in the administration of these models and in the legislation supporting their operation. The key points will now be summarised, with a view to addressing the questions raised by the Child Protection Systems Royal Commission.

WHAT FEATURES PROTECT CHILDREN'S RIGHTS TO FREEDOM VERSUS THE RIGHT FOR ADEQUATE TREATMENT AND CARE?

The secure detention of young people for their own well-being highlights tensions between the child's right to freedom and self-determination, and the need for state parties to take appropriate steps to protect a child from danger and to aid the psychological recovery of affected children.

The rights of children who are detained are summarised in documents such as The UN Rules for the Protection of Juveniles Deprived of their Liberty (JDL): the 'Havana Rules' (1990), the UN Minimum Rules for the Administration of Juvenile Justice: the 'Beijing Rules' (1985), and the UN Convention on the Rights of the Child: UNCRC (1989). In 2014, the Australian Commissioners and Guardians Group drew on these documents to develop a model 'Charter of Rights for Children and Young People in the Justice System'. A copy of this Charter is

included in Appendix A. Amongst other rights, this charter emphasises a child's individual right:

'To receive help for your mental health if you need it, and to be transferred to a mental health facility for treatment if required' (Beijing 26.2, JDL 53)

'To get help if you have problems with drugs or alcohol' (JDL 54)

'To have special care and protection if you are vulnerable or have special needs' (JDL 27, 28)

'To participate in activities and programs that help your rehabilitation' (JDL 12)

'To continue your education, or to do training to learn useful skills for work' (JDL 38)

Against this backdrop, there are also societal expectations for the care of children. The UN Convention on the rights of the Child (1989) states that state parties shall:

'... take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment, which fosters the health, self-respect and dignity of the child' (UNCRC, 1989, Article 39).

This tension is difficult to resolve in the absence of a clear evidence base for either residential care or secure care. This is not uncommon, however, in the complex area of child protection, where research knowledge about effective practice is underdeveloped (Australian Human Rights Commission, 2015)

Arguably, the ability to address the rights detailed above depends on developing a service that has a clear model of practice, matched to young people's needs, and supported by sufficient staff with expertise to address the factors that brought the child to the service in the first place. In essence, admission to secure care should afford the opportunity to access highly skilled mental health, health, educational and community service expertise, and a range of (postcare) options.

A range of mechanisms were identified in this review that could enhance ‘best interest’ decision making. Across the various secure care models identified in this report, children’s rights are primarily protected through regular review, use of shared decision making (panels) and high level oversight. Critical points in the decision making and clinical pathway for children involve panels (e.g., in Scotland and NSW during referral and during treatment). In the Northern Territory a child who is the subject of an application must be represented by a legal practitioner for any court proceeding and be available to the young person for the duration of the order.

The requirement to submit and comply with a treatment plan as part of the application and review process can also safeguard against poor practice (e.g., England, Northern Territory). Regular reviews by an appropriate Court (e.g., England every three months) can provide accountability for practice decisions and timelines of progress. Additionally, high level oversight (e.g., CEOs of statutory agencies; reporting to Parliament (e.g., England) and Children’s Commissioners (e.g., Northern Territory)), is required in some jurisdictions. This can be a means to further safeguard against poor practice.

Oversight and complaints pathways may be improved, ‘uncoupling’ the appointment of ‘independent’ reviewers or review panels from the statutory authority administering the service, and providing an independent pathway for complaints and access to facilities by independent advocates without notice (e.g., independent visitor programs).

The location of secure care services also warrants careful consideration. Co-location of vulnerable adults and children could be a high risk situation should measures taken to ensure separation of these groups fail for some reason.

In summary, jurisdictions have various mechanisms for ensuring external accountability, independent scrutiny and for managing complaints. Such mechanisms can act to ensure the therapeutic relevance of secure care.

What are the referral criteria for admission to secure care?

There is some consistency between jurisdictions in the conditions under which an application for placement in secure welfare can be made. Primary criteria include risk and

potential risk of harm to the child and risk of harm to others. This suggests that the characteristics of young people that might benefit from secure care are broadly recognised.

Risk of harm to the child

In all the models identified in this review, placement in secure care is permitted on grounds of *substantial and significant risk* to the child. That is, the child's best interests are served due to need of protection for their own safety. In the Northern Territory this is stated slightly differently, where the criteria state that a child 'is likely to cause harm to self ... because of their pattern of aggressive, irresponsible or high risk behaviour'. In some jurisdictions this explicitly includes sexual exploitation (NSW, Scotland), and substance misuse (NSW, Scotland) and repeated absconding (England). In Scotland, the grounds for calling a children's hearing are very broad and include risk by association with an adult known to have committed a criminal assault against a child and risk posed by forced cohabitation with an adult (e.g., coercion to marry).

Harm to others

In some jurisdictions, an application for secure care may be permitted on the grounds that a child is causing harm to others. This is explicitly stated in Scotland and NSW. The Victorian criteria include a child engaging in sexually harmful behaviour. In the Northern Territory, the criteria include that 'the child is likely to cause harm to themselves or someone else because of their pattern of aggressive, irresponsible or high risk behaviour.' Western Australia does not apply this criterion.

No other effective supports

In Victoria the criteria require that no other available support or placement can be available that is adequate to protect the child from significant harm. Western Australia requires that a child's needs cannot be managed by the available care and protection network. The Northern Territory states that 'previous attempts to carry out an assessment, or provide treatment and care must have been unsuccessful', and there can be no 'less restrictive means available to ensure the young person receives treatment and care'. There is also a requirement that the long term well-being of the young person is likely to be enhanced by assessment, treatment and care.

Exclusion criteria

Victoria explicitly states that property damage cannot be grounds for admission to secure care. In Western Australia an application for placement cannot be made if it is considered appropriate if 'the child's needs would be better serviced through admission to a mental health facility' or if a youth justice response is required. In the Northern Territory the young person must be under the age of 18 throughout the period of the order.

What length of time is considered for admission?

In England, an order for placement in secure care may be made for up to three months initially, although an order of 28 days is more usual. There is provision to make a subsequent application to the Court for up to six months.

In NSW the duration of the initial order is determined by the Supreme Court. It is usual practice to obtain a seven-day order initially to allow for adequate assessment and to make further application to the Court. If satisfied, the Court would then grant a three-month order. Further applications to the Court must be made every three months to satisfy the Court that the criteria for secure care continue to be relevant.

In Victoria a secure welfare placement may be granted for a maximum of 21 days. There is provision to apply for another 21 days in exceptional circumstances. Therapeutic treatment orders (associated with therapeutic placement orders) can be granted for maximum of one year, with provision for a one-off extension of one year. In keeping with Victoria, Western Australia allows for a maximum uninterrupted 21 day period in secure care. There is also provision for an extension not exceeding 21 days in exceptional circumstances.

In the Northern Territory, a therapeutic assessment order, specifying placement in an approved treatment facility, can be granted for 14 days. No further extension is permitted. The therapeutic assessment order will cease if the child is not placed in an approved treatment facility within 28 days, and can only be approved if an authorised psychiatric practitioner is satisfied that the application meets the relevant criteria. A therapeutic residential order is a longer term order, but must end not later than six months from the

day the child enters secure care. This order also lapses if the child does not taken to a secure facility within 28 days.

Where does the power to commit a young person sit?

In New South Wales, an application is made to the Supreme Court; as the child must be in the care of the Family and Community Services (FACS), the Director of FACS must approve the application. In Victoria, the decision to place a child in secure care may be made by the Court or the Divisional Child Protection Operational Manager (Department of Human Services), depending upon the order sought and the legal status of the child, who must be under some form of guardianship order. In Western Australia admission to secure care may occur either via an administrative secure care arrangement made by the CEO of the Department for Child Protection or via an interim order made by the Children’s Court. In Northern Territory, the CEO of the Department for Children and Families can make an application to the court for a therapeutic treatment order if accompanied by a treatment plan. In the event that the CEO wishes to apply for a therapeutic assessment order, this must be accompanied by the assessment of an authorised psychiatric practitioner.

What are the therapeutic features of the environment?

There is little publically available information about the characteristics of the current secure care services and what makes them ‘therapeutic’ interventions. All jurisdictions appear to use residential units that place between six and eight young people at a time. In Victoria, there are two secure units – a separate unit for boys and girls. It is unclear whether these units operate at capacity. In NSW, Sherwood House houses six girls, and has two semi-secure community cottages associated with it, enabling 12 young people to access this service. This service has treated only girls for the past few years, although it accepts referrals for boys. In the Northern Territory, there are two secure units, each housing eight children that appear to be co-located with similar secure adult units.

The secure houses in three jurisdictions appear to articulate a model of practice. Sherwood House uses the Attachment, Regulation and Competency model of trauma recovery (Blaustein & Kinninburgh, 2010). Both Northern Territory and Western Australia’s

documents indicate that residential practice in those jurisdictions is informed by Sanctuary model of trauma recovery (Rivard et al., 2005).

Sherwood House employs trained mental health and health clinicians to provide oversight and clinical direction to a pool of casual care staff and security guards. Other models appear to use predominantly youth work staff. In the Northern Territory, the approved treatment facility is located within a secure hospital psychiatric ward, allowing access to highly qualified mental health staff including psychiatric care.

Although several jurisdictions indicate the need for consultation regarding the placement of Aboriginal children or children from other cultural backgrounds, the specific needs of these children do not appear to be incorporated into therapeutic practice, although this may well be the case. Some jurisdictions require the child to be directly case managed by the relevant department (rather than 'outsourced' to an NGO provider). Case management (and 'ownership' of case planning) by experienced department workers with access to critical information and associated legal authority is likely to be important for this group of children in particular. In NSW, the primary secure care provider (Sherwood House) requires that the department's Intensive Case Management team participate in both referral and active case-management.

CONCLUSION

This report identified that several jurisdictions were currently operating secure care models for children under guardianship or other orders. All services that were identified were administered either by the relevant statutory department or in close collaboration between government and private providers. That said, mental health services are often used as part of the 'step down' or 'step across' options for young people in secure care, although they may not be deemed appropriate initially due to children's challenging behaviour (Fahey, personal communication).

There is a paucity of evidence either way regarding the effectiveness and the practice parameters of secure care for children in care, despite anecdotal support for its judicious

use. Therefore, rigorous evaluation by independent research or consultancy body seems warranted with respect to critical factors such as alignment of therapeutic approach with client need, quality of clinical oversight and empirical evidence in favour of the therapeutic model operating and any associated therapies.

Secure care cannot be expected to serve a therapeutic function in the absence of case management that includes clear conceptual model matched to client need, clear case planning, and the availability of a range of post-care options including semi-secure, disability, mental health and youth justice service options. Any secure care service needs to have clearly identified transition pathways as part of the service design (both 'step down' and 'step across' options, based on a child's individual needs).

Finally, it seems important to consider the needs of young people in designing secure care services. While trauma-informed models may be appropriate for some, other children's behavioural challenges may be related to intellectual disability or substance use. Care should be taken to match children's needs with therapeutic interventions that have demonstrated efficacy. This can only be achieved by having a sound understanding of the needs of this group of children and developing supports in response to these needs (Mansell, 2007).

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APPENDIX A: MODEL CHARTER OF RIGHTS FOR CHILDREN & YOUNG PEOPLE DETAINED IN YOUTH JUSTICE FACILITIES

Model Charter of Rights for Children and Young People Detained in Youth Justice Facilities

A model charter of rights for children and young people detained in youth justice facilities

(Australian Children's Commissioners and Guardians)

Based on:

UN Rules for the Protection of Juveniles Deprived of their Liberty: the 'Havana Rules' or JDLs
(1990)

UN Minimum Rules for the Administration of Juvenile Justice: the 'Beijing Rules' (1985)

Convention on the Rights of the Child (1989)

You have the right:

To be treated equally, and not treated unfairly because of your sex, sexuality, race, religion, disability or other status (CRC 2, JDL 4).

To be treated with respect and dignity by staff and to be kept safe while you are in the youth justice centre (JDL 1, 12, 31, 66,87)

To be given a copy of the rules of the centre, and information about your rights and responsibilities, in a language that you can understand (JDL 24)

To see a doctor or nurse whenever you need to, and to receive proper healthcare (JDL 49)

To receive help for your mental health if you need it, and to be transferred to a mental health facility for treatment if required (Beijing 26.2, JDL 53)

To get help if you have problems with drugs or alcohol (JDL 54)

To have special care and protection if you are vulnerable or have special needs (JDL 27,28)

To have regular contact with your family and friends through visits and phone calls (JDL 59,60, 67, CRC 37, Beijing 26.5)

To get help to see a lawyer, and to talk to them privately (JDL 18(a))

To have an interpreter for formal meetings or medical examinations if you are not fluent in English (JDL 6)

To get information and news about what is happening in the world (CRC 17, JDL 62)

To have a say in decisions about your rehabilitation and other issues that affect you (CRC 12)

To participate in activities and programs that help your rehabilitation (JDL 12)

To continue your education, or to do training to learn useful skills for work (JDL 38)

To get exercise every day, and to go outside every day except in bad weather (JDL 47).

To have enough good food (including food that is suitable for your culture or religion, or dietary requirements), and to have drinking water available whenever you need it (JDL 37)

To have clean clothes, and to wear your own clothes if you go out of the centre (JDL 36)

Not to be punished unfairly, and only in accordance with the rules of the centre or the law (JDL 66-71)

Not to have force used against you, or restraints used on you, unless absolutely necessary, and never as a punishment (JDL 63 - 64)

Not to be isolated from other young people unless necessary to keep you or others safe, and never as a punishment (JDL 67)

To practice your religion or express your culture and, whenever possible, to be able to see religious or spiritual advisors (JDL 4 , 48, CRC 30))

If you are Aboriginal or Torres Strait Islander, whenever possible, to participate in cultural activities and celebrations with other Aboriginal or Torres Strait Islander people (CRC 30)

To make a complaint about your treatment to an independent person (like an official visitor) and to be told what happens with your complaint (JDL 75 and 76)