Raising the Minimum Age of Criminal Responsibility

AFI Response to Discussion Paper

About Advocacy for Inclusion

Advocacy for Inclusion incorporating People with Disabilities ACT is a leading independent organisation providing dedicated individual and self-advocacy services and training, information and resources in the ACT. We deliver reputable national systemic advocacy informed by our extensive experience in individual advocacy and community and government consultation.

As a Disabled People's Organisation, the majority of our organisation, including our Board of Management, staff and members, are people with disabilities. Advocacy for Inclusion speaks with the authority of lived experience and is strongly committed to advancing opportunities for the insights, experiences and opinions of people with disabilities to be heard and acknowledged.

Advocacy for Inclusion operates under a human rights framework. We uphold the principles of the United Nations *Convention on the Rights of Persons with Disabilities* and strive to promote and advance the human rights and inclusion of people with disabilities in the community. Advocacy for Inclusion is a declared public authority under the *Human Rights Act 2004.*

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Advocacy for Inclusion acknowledges the Aboriginal and Torres Strait Islander peoples as Traditional Custodians of the lands where we live, learn and work.

We respect and celebrate diversity of individuals, including those amongst the lesbian, gay, bisexual, trans, and intersex communities and we value and promote inclusion and diversity in our communities.

Introduction

Advocacy for Inclusion (AFI) strongly welcomes and supports the ACT Government's commitment to raise the minimum age of criminal responsibility. We strongly support raising the age to *at least* 14 years old, with no exemptions and no carve outs.

This submission will focus in the majority on responding to the questions raised in 'Section two: An alternative model to the youth justice system' of the *ACT Government Discussion Paper Raising the minimum age of criminal responsibility* (Discussion Paper).[1] AFI wishes to highlight the significance of this discussion as a disability issue, and the necessity of ensuring disability perspectives and considerations are included in the development of an alternative model. We emphasise the importance of early support in the community and recognise the significant opportunities which are provided to better identify and respond to the needs of children at risk of contact with the youth justice system. We also wish to highlight important considerations which must not be overlooked in the development of an alternative model, chiefly regarding mandatory engagement and specific accommodation options, to successfully meet the needs of this cohort.

The prevalence of disability and mental ill health in youth justice

The 'appallingly high'[2] prevalence of mental health disorders and cognitive disabilities within youth justice systems means that it is critical that considerations of disability and mental health underpin and frame all levels of discussion of raising the minimum age of criminal responsibility.

Although Australia does not collect comprehensive national data on the prevalence of mental health conditions and cognitive disability of children and young people within the youth justice system, research collected from States and Territories, inspectorates, academics and non-government organisations has indicated a high prevalence.[3] It is also commonly recognised from within Australian youth justice systems that 'most young people who come through the system have 'a mild issue or impairment or disability'.'[4] However the prevalence and significance of intersections of disability, mental health and complex support needs of young people within youth justice are 'conspicuously under-researched and under-theorised.'[5]

This is certainly the case in the Australian Capital Territory (ACT), where even young people detained in the youth justice system are not adequately screened for disability, and sufficient data

[1] ACT Government *Discussion Paper Raising the minimum age of criminal responsibility* Justice and Community Safety Directorate and Community Services Directorate.
[2] Baldry, E. et al, *Cruel and unusual punishment': an inter-jurisdictional study of the criminalisation of young people with complex support needs* (2018) Journal of Youth Studies, 21:5, 636-652, DOI: 10.1080/13676261.2017.1406072, p 644.
[3] Ibid, p 637.
[4] Ibid, p 640.
[5] Ibid, p 637.

is not collected on the prevalence of disability among detainees.[6] Despite this, comparative evidence from other states and nationally indicates that the high prevalence of mental health conditions and disability within youth justice is an extensive and entrenched problem.

Research from New South Wales (NSW) has found that rates of psychological disorders in young people in custody range from 83% to 88%.[7] While limited research has been conducted, the high prevalence of cognitive disabilities in young people in youth justice systems is also evident, with studies suggesting that 18% of young people in custody in NSW have cognitive functioning in the low-range (IQ < 70),[8] while 39% to 46% fall into the borderline range of cognitive functioning (IQ 70–79).[9] This is significantly higher than estimations of the national prevalence of intellectual disability in children of 4.3%.[10]

Studies also show that young people in contact with youth justice systems have higher levels of speech and language impairments, acquired brain injury, attention deficit hyperactivity disorder (ADHD) and fetal alcohol spectrum disorder (FASD).[11] Cognitive impairments and associated conditions such as FASD may characteristically include "poor impulse control, developmental delay, poor memory, difficulties with abstract concepts and difficulties with planning and following through on goals."[12] (While it will not be addressed further in this submission the prevalence of, and failure to adequately assess, cognitive impairment may have significant implications for concepts such as *doli incapax*.)[13]

The high rate of co-occurrence of multiple impairments within these conditions must also be noted. Children with cognitive disabilities experience higher rates of additional developmental disorders such as autism spectrum disorder (ASD) and ADHD,[14] and it is estimated that 40% also present with mental ill health.[15] Adding to the complexity of support needs of this cohort, children with such conditions are also much more likely to present with associated behavioural problems, experience bullying, and engage in harmful drug and alcohol use.[16] However it is important to note

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[6] ACT Inspector of Correctional Services *Report of a healthy centre review of Bimberi Youth Justice Centre* 2020, p 12.
[7] Baldry, E. et al, above n 2, p 637.
[8] Ibid, p 638.
[9] Other jurisdictions (England and Wales) have recorded 23% of young people in juvenile justice having cognitive functioning in the low-range (IQ < 70) in Baldry, E. et al, above n 2, p 638.
[10] Australian Institute of Health and Welfare *Australia's Children* <https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/children-disabilities> last updated 03 Apr 2020.
[11] Baldry, E. et al, above n 2, p 638.
[12] Commonwealth of Australia, *Effective approaches to prevention, diagnosis and support for Fetal Alcohol Spectrum Disorder* Senate Standing committee Report, March 2021, p 15.
[13] 'It was reported that many young people appearing before the courts have cognitive functioning and reading and writing levels at an age well-below the age of criminal responsibility (10 years of age) in Australia and England and Wales. Many respondents reported that children and young people with cognitive and borderline cognitive impairments have a reduced capacity to understand and comprehend the implications of their offending and to follow, and actively engage with, the legal process' in Baldry, E. et al, above n 2, pp 640-641.
[14] Ibid, p 638.
[15] The Australian & New Zealand Mental Health Association *What About the Mental Health of Kids with Intellectual Disability?* <https://anzmh.asn.au/child-mental-health/mental-health-kids-intellectual-disability/>.
[16] Baldry, E. et al, above n 2, p 638.

that on the whole research has found 'no inherent link between disability and crime', rather it has found 'a strong causal link between disability and incarceration'.[17]

For children with cognitive impairments and mental health conditions engaging with the youth justice system, contact with police often begins at a young age, as both victims and offenders.[18] In this cohort, police contact 'typically' starts in the early teenage years, becomes frequent and continues for many years. Children with multiple co-occurring disabilities or impairments and associated complex support needs often have a significantly lower age of initial contact with police, and are more likely to go on to have a higher number of arrests, custodies and remands, while also being more likely to be convicted of lower level offences.[19] This pattern is very common in young people with 'the trifecta' of cognitive impairment, mental health conditions and contact with youth justice, who have been referred to as 'frequent fliers'.[20]

This description is likely to be very fitting of the small number of children in the ACT who are at the centre of considerations of raising the age of criminal responsibility. Given the age range of 10-14 years of the children captured in these discussions (and accordingly their very young initial contact with the justice system), it is highly likely that these children are experiencing disability and/or mental health conditions, potentially undiagnosed or unidentified, and it is likely that their associated support needs have not been, and are not being adequately supported.

Aboriginal and Torres Strait Islander children in youth justice

Aboriginal and Torres Strait Islander peoples experience higher rates of mental health conditions and cognitive impairment than non-Indigenous Australians.[21] The overrepresentation of Aboriginal and/or Torres Strait Islander children in youth justice systems in Australia has been linked to 'schools and police viewing certain kinds of behaviour through prisms of institutional racism and offending rather than disability.'[22] Aboriginal and/or Torres Strait Islander peoples in particular commonly experience co-occurring conditions as well as further complex support needs that are 'managed by police and justice systems, often from childhood'.[23] Research has also highlighted 'a severe and widespread lack of appropriate early diagnosis and positive culturally responsive support for Indigenous children and adults with cognitive disability' within criminal justice systems.[24]

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[17] McCausland, R. and Baldry, E. *'I feel like I failed him by ringing the police': Criminalising disability in Australia* (2017) Punishment & Society, Vol. 19(3) 290–309, p 293.
[18] Ibid, p 294.
[19] Baldry, E. *Vulnerable young people with complex support needs and the criminal justice system* (2016) South Australia Disability Justice Plan Symposium.
[20] Baldry, E. et al, above n 2, p 641.
[21] McCausland, R. and Baldry, E. above n 17, p 294.
[22] Ibid, p 294.
[23] McCausland, R. and Baldry, E. above n 17, p 292.
[24] Ibid, p 294.

It is important to recognise the different perceptions and experiences of the concept of 'disability' in different communities. This can impact on the cultural appropriateness, accessibility and engagement level of disability services and supports, including concern within Aboriginal and/or Torres Strait Islander communities of the use of Western assessments and criteria, as well as the potential for intervention into families.[25]

It is essential that the ACT Government engages with Aboriginal and/or Torres Strait Islander peoples to support culturally appropriate responses and supports.

In summary, it is inappropriate and inadequate to manage children with disability, mental health concerns and complex support needs through a framework of criminal justice. The overrepresentation of this cohort within youth justice represents both the criminalisation of disability,[26] and the failure to adequately identify and respond to disability needs. The minimum age of criminal responsibility must be raised, and the needs of these children must be through an approach which is consistent with our obligations under international human rights law, particularly the United Nations *Convention on the Rights of Persons with Disabilities* (CRPD), in order 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.'[27]

Principles underpinning the development of an alternative model to a youth justice response

Due to the high prevalence of disability and mental health concerns within young people in the youth justice system, and the significant likelihood that the youngest children in contact with the youth justice system may have multiple disabilities and mental health conditions and associated complex support needs, a disability perspective and considerations of accessibility must be incorporated into every level of discussion and design of an alternative model to a youth justice response.

AFI highlights that disability perspectives and accessibility considerations have not been adequately included within youth justice or wider mainstream support services in the ACT previously. These systems, and new alternatives, will continue to fail to meet the needs of this cohort if this trend continues.

[25] McCausland, R. and Baldry, E. above n 17, p 292.
[26] Baldry, E. et al, above n 2, p 639.
[27] United Nations *Convention on the Rights of Persons with Disabilities* Art 1.;
Also see McCausland, R. and Baldry, E. above n 17, p 292.

The Social Model of Disability

AFI strongly emphasises the necessity of incorporating the principles of the Social Model of Disability into the development of an alternative model. This distinguishes disability from being solely an individual impairment, to acknowledging the disabling impact of socially constructed discriminatory barriers.[28]

Fundamental consideration of the interaction of disability and mental health on other social structures such as family cohesion, mainstream and specialist supports and services (including Child and Youth Protection Services [CYPS] and out-of-home-care [OOHC]) and interactions with police and justice systems processes is needed to 'better comprehend the dynamic interactions between individuals, institutions and systems that lead to disadvantaged and marginalised young people with disability (and/or complex needs) being funnelled into, around, and often back into, youth justice systems before eventually being discharged into adult prisons.'[29] These interactions and experiences impact on disability needs and behavioural responses and have significant implications for the design of effective response models.[30]

The narrow scope of intervention thresholds

AFI notes with concern the narrow scope indicated in the Discussion Paper of the three main thresholds indicating key points for intervention, starting at 'when crisis occurs'.[31] AFI submits that priority of focus of an alternative model should be before harmful behaviour occurs or reaches crisis point. We recognise the inconsistency of a crisis point focus with the *Early Support by Design* reform highlighted in the *ACT Disability Justice Strategy* to 'shift from a heavy focus on crisis driven responses, where service impacts are less effective in achieving positive intergenerational change, to a system focused on early support'.[32] AFI emphasises that an alternative model must look beyond the usual points which create engagement opportunities for a youth justice response, and instead incorporate community support at a much earlier stage than a crisis point:

> *The way that people with mental and cognitive disability are managed by police, courts and prisons in Australia highlights systemic problems requiring systemic responses. Their over-representation in criminal justice systems cannot be addressed by conceiving of those systems as therapeutic. Criminal justice systems are premised on punishment and risk management rather than on responding to the unmet needs of the high proportion of persons in their care who have mental and cognitive disability and the underlying causes of their offending. As a result, diversionary mechanisms, however well intentioned, are serving to entrench rather than divert. Law reform, adequate resources, education and training for police, lawyers, magistrates and*

[28] Baldry, E. et al, above n 2, p 639.
[29] Ibid.
[30] Ibid, p 641.
[31] ACT Government, above n 1, p 23.
[32] ACT Government *Disability Justice Strategy 2019-2029 A Strategy to Address Unequal Access to Justice in the ACT,* p 39.

> *corrections staff to ensure more equitable access to justice for people with mental and cognitive disability should be a matter of urgent national priority. However, what is fundamentally required is a genuine commitment to providing children and adults with mental and cognitive disability with appropriate holistic support in the community throughout their lives to ensure genuine alternatives to criminalisation.*[33]

Identification of needs of children and young people

Assessment and identification of disability and mental health need is not occurring early enough, or sufficiently in the ACT. As stated previously, even young people detained in the youth justice system are not adequately screened for disability.[34] While the *Healthy Centre Review of Bimberi Youth Justice Centre 2020* highlighted the need for better disability screening (and development of screening is under consideration), AFI highlights the 'cognitive dissonance' of aiming to prevent children with cognitive and mental disability connecting with youth justice, while also potentially only managing the assessment and identification of disability need *within* the youth justice system.[35]

The lack of adequate identification of disability need, and the implications this has on the effective response towards harmful behaviours may have several causes in the ACT, including a lack of disability awareness across mainstream services, and the lack of or inaccessibility of assessment services. However, AFI emphasises that there is significant opportunity in the ACT to increase the capacity of services and systems to better recognise and respond to disability needs. We note that the utilisation of these opportunities could strongly link with a multidisciplinary panel, as discussed in the Discussion Paper.[36]

AFI highlights that a child at risk of contact with the youth justice system is often connected to a number of formal and informal support networks which provide opportunity for identification and response to disability need, including family, education, health, youth services, support services, CYPS and OOHC. Many factors which increase the likelihood of contact with youth justice are well known, including childhood abuse and neglect, OOHC and complex support needs.[37] We highlight that:

> *Many of these factors are identifiable early in life and, potentially at least, there are opportunities for government agencies and related services to mobilise appropriate support for such children, young people and their families. Early recognition of need and the concomitant provision of support through infant health services, early childhood programmes and preschool and school-based interventions (see also Baldry et al. 2015) offer the prospect of positive and preventive outcomes for young people. In cases where these early opportunities are missed, the same young people are invariably criminalised and 'washed-up' into youth justice systems and, unless*

[33] McCausland, R. and Baldry, E. above n 17, p 303.
[34] ACT Inspector of Correctional Services, above n 6, p 12.
[35] Baldry, E. et al, above n 2, p 644.
[36] ACT Government, above n 1, p 21.
[37] Baldry, E. et al, above n 2, p 646.

> *diversionary screening is activated at the very first point of contact with such systems, young futures are blighted.*[38]

Across many services and systems in the ACT there are clear and strong opportunities for earlier intervention to change the trajectory for these children. Various supports and services may be greatly assisted by being able to refer children who are presenting with harmful behaviours or who may be at risk of contact with youth justice to a multidisciplinary panel with the expertise and ability to put appropriate supports in place.

Considerations for a Multidisciplinary Panel

AFI emphasises the importance for a multidisciplinary panel to uphold a Social Model view of disability, and not resort to a Medical Model view of disability, which could simply perpetuate the response and access issues currently experienced by many people with disability in attempting to access support in the ACT (outlined further below).

AFI also highlights the necessity of the panel to include disability awareness and expertise. We note with concern the wording in the Discussion Paper of including on the panel 'Mental health *or* disability' (emphasis added).[39] AFI cautions against the conflation of mental health and disability (particularly cognitive impairment) as these are distinct and require specific and distinct responses and support:

> *The conflation of cognitive impairment and mental health disorders in the criminal justice system is a particular problem (NSW Law Reform Commission 2012, 2013; Sotiri et al., 2012: 46). People with cognitive disability require specific processes and diversionary pathways; responding as if their cognitive impairment is the same as a mental illness is neither effective nor appropriate. Cognitive disabilities are permanent and cannot be 'treated' in the way mental illness may be with pharmaceutical and clinical treatment but people with cognitive disability can be supported to live fulfilling and engaged lives. Nevertheless, people with cognitive disability also frequently suffer from mental health issues, complicating their support needs (Baldry et al., 2013). People with cognitive disability are often seriously disadvantaged by being included in the forensic system because they tend to be treated like someone with mental illness and not someone with cognitive disability. This can result in indefinite or longer detention than had they been sentenced for an offence (Gooding et al., 2016). This is because they may be found unfit to plead or not guilty by reason of mental impairment but may be thought to be a risk to the community, have no other place to go and are not released because they are not seen to improve (Baldry, 2014: 381).*[40]

Further, as will be outlined below, expertise and experience in mental health or disability can also be distinct practices and cannot be conflated, as this can often result in inadequate responses and poorer outcomes.

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[38] Baldry, E. et al, above n 2, p 646.
[39] ACT Government, above n 1, p 21.
[40] McCausland, R. and Baldry, E. above n 17, p 294-295

AFI also emphasises that a multidisciplinary panel will only be as good as the services and supports available to resource it.[41]

Need for improved community support

AFI submits that the high prevalence of children with cognitive disability and mental health conditions is significantly driven by a 'lack of community-based provision and the inadequate nature of support available for children and young people with complex needs.'[42] We emphasise that the improvement and increase of adequate community support for this cohort must be of highest priority in developing an alternative model.

Early support is essential to prevent the escalation of unidentified and unaddressed disability needs and the funnelling of children and young people with disability into acute crisis services and the youth justice system. AFI recommends the prioritisation of increased early disability support in line with the *Early Support by Design* reform under the *ACT Disability Justice Strategy*. This recommendation should also be considered in relation to the ACT's implementation of the *National Disability Strategy* and the recommendations of the final report of *Our Booris, Our Way*.

Additionally, AFI supports the development of a First 1000 Days Strategy in partnership with the community,[43] with inclusion of disability awareness.

Additionally, AFI recommends that existing services are made more accessible and inclusive through improved disability awareness and increasing the capacity of services to better identify and respond to disability needs. We also recommend the provision of additional services to meet demand, including through the creation of new services and the expansion of existing services. Early disability support may include identification and response measures, alongside family, respite and behaviour support.

Improved and increased assessment services are also needed, however these must be reinforced by robust and effective community supports to address need:

> *Those whose disability is recognised and formally diagnosed may receive early intervention and specialist support. Yet all too often, for those from disadvantaged backgrounds in particular, this does not result in timely, appropriate and effective support and can result in stigma, discrimination and negative marginalising treatment by the law. Those whose disability may not be recognised or diagnosed, such as those with borderline intellectual disability, foetal alcohol spectrum disorder or acquired brain injury, are often seen as just poorly behaved and as wilfully offending. Without timely therapeutic support in the community, both groups are set on a trajectory of criminal justice contact.*[44]

[41] Baldry, E. et al, above n 2, p 645.
[42] Ibid.
[43] ACT Government *Parliamentary and Governing Agreement 10th Legislative Assembly for the Australian Capital Territory* (2 November 2020), Appendix 3, 19.5.
[44] McCausland, R. and Baldry, E. above n 17, p 302

The coordination of services must also be improved, through the reduction of siloing of services and improved information sharing to support a coordinated and holistic approach to meeting the needs of this cohort.[45]

Assessment services

Research has found that children and young people engaging with youth justice systems are 'increasingly presenting with multiple disabilities and health problems and, therefore, must be screened for a whole range of conditions'.[46] There is substantial need for a range of specialist services in the ACT, with interstate services often being the only option (and therefore out of reach for many). AFI highlights particular need for mental health services appropriate for children and young people with cognitive disabilities, ASD and other developmental and behavioural disorders. We note the ongoing need for specialist allied health professionals to meet demand for Autism Spectrum Disorder (ASD) assessments,[47] and also note that the Foundation for Alcohol Research and Education (FARE) has repeatedly called for the establishment of a Fetal Alcohol Spectrum Disorder clinic in the ACT.[48] We highlight the lack of progress in the ACT since MLA Elizabeth Kikkert brought a *Bimberi Youth Detention Centre, Screening Practices, Foetal Alcohol Spectrum Disorder* motion, amended and agreed to in 2018, including identifying 'best practice approaches and tools for the diagnosis and treatment of FASD, both in juvenile detention settings and in the community'.[49]

Service access issues

Mainstream services in the ACT are not currently equipped to adequately support many disability needs, and specialist disability services are lacking. AFI strongly encourages initiatives to increase the accessibility of mainstream services, as well as the extension or creation of specialist disability services. Common barriers to accessing services in the ACT for children and young people with disability can include financial constraints and the lack of existing services. Additionally, disability specific accessibility barriers can prevent adequate service and treatment. Of particular concern in the ACT is a lack of disability awareness and specific disability knowledge in health services. This can lead to communication barriers, misunderstandings, increased difficulty implementing

[45] Baldry, E. et al, above n 2, p 646.
[46] Ibid, p 644.
[47] Community Services Directorate *Annual Report 2019-20* (Report, ISSN 2206–9968, 2020), p 94.
[48] Foundation for Alcohol Research and Education *Election commitment sought for Canberra FASD clinic* 9 September 2017 <https://fare.org.au/election-commitment-sought-for-canberra-fasd-clinic/>;
See also Foundation for Alcohol Research and Education *ACT Drug Strategy Action Plan 2018-2021* August 2018, p 21-22.
[49] Legislative Assembly for The Australian Capital Territory *Minutes of Proceedings* (Parliamentary Minutes, No 57, 9 May 2018) <https://www.parliament.act.gov.au/__data/assets/pdf_file/0006/1198311/MoP057F1.pdf>.

management plans, examination difficulties and an increased likelihood of misdiagnosis and diagnostic overshadowing.

Diagnostic overshadowing is a significant concern in identifying and determining disability and/or mental health factors impacting behaviour in children. The presentation of mental health concerns co-occurring with developmental and behavioural disabilities can be atypical, and often missed by mainstream mental health services:

> *Australian research following a cohort of children and adolescents with ID [Intellectual Disability] for 14 years demonstrated that just 10% of those with a mental disorder received intervention. This compares unfavourably with access to mental health supports for the general population which has been estimated to be about 35% over a one year period.*
>
> *Potential barriers to accessing effective mental health care for people with ID in an Australian and NSW context include: a lack of substantial epidemiological data on prevalence of mental illness in people with ID; a lack of data on the interaction between, and distinct roles and responsibilities of disability and mental health services; a lack of training and confidence of mental health professionals; poor understanding by carers, disability and mental health workers of the manifestations of mental disorders in people with ID; a lack of coherent service models and funding for ID mental health services; lack of coordination between services and treating agencies; and a lack of specific inclusion of people with ID in mental health policy.*[50]

Additionally, the co-occurrence of conditions can lead to underdiagnosis, for example recent research has found that "ADHD is a common problem in children with neurological disabilities and may be underdiagnosed due to overshadowing of somatic, physical or syndromal features of the disability."[51]

Siloing of services contributes to misdiagnosis and diagnostic overshadowing in the ACT. For example, Child and Adolescent Mental Health Services (CAMHS) appears unable to provide assessments for ADD/ADHD or ASD,[52] and AFI has been told young people with ASD have been turned away from CAMHS due to their lack of specialist knowledge of ASD. A siloed service approach and lack of information sharing has been identified as contributing to difficulties of adequately identifying disability needs 'as young people often bounce from service to service without important diagnostic and assessment information travelling with them."[53]

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[50] Mental Health Commission of New South Wales *Clinical Services Planning for Adults with Intellectual Disability and Co-occurring Mental Disorders* 2014, <https://www.nswmentalhealthcommission.com.au/sites/default/files/old/assets/File/Intellectual%20Disability%20and%20mental%20disorders%20cover%20page.pdf> p 6.
[51] Hendriksen, J. et al. *Diagnostic overshadowing in a population of children with neurological disabilities: A cross sectional descriptive study on acquired ADHD* (2015) 19(5) European Journal of Paediatric Neurology 10.1016/j.ejpn.2015.04.004.
[52] Health Direct *Child and Adolescent Mental Health Services (CAMHS) – Northside* <https://www.healthdirect.gov.au/australian-health-services/20133970/child-and-adolescent-mental-health-services-camhs---northside/services/belconnen-2617-56-lathlain-street>.
[53] Baldry, E. et al, above n 2, p 644.

The gap in mental health services for young people with moderate mental illness in the ACT is well known.[54] There is currently also a lack of services providing adequate behaviour support for people with disability in the ACT. AFI supports appropriate initiatives to address mental health needs, including those of people with cognitive disabilities and ASD, and effective behaviour support (including carer information and support) for children and young people presenting with challenging behaviour associated with disability.

A further concern is that children and young people presenting with harmful behaviour 'are often turned away from health and welfare services as a consequence of their 'disruptive' behaviour. Accordingly, they have a higher than normal public presence/profile and are often left to the police to 'manage".[55] Even National Disability Insurance Scheme (NDIS) service providers can refuse service to someone presenting with challenging behaviours. The result is that people who require complex support are often excluded from support services.

For further information on current accessibility barriers experienced by children and young people with disability in health services in the ACT see AFI's *Submission to the Standing Committee on Health and Community Wellbeing Review of ACT health programs for children and young people*.[56]

Improvement of existing systems

Existing systems and services in the ACT such as education, youth services and OOHC provide significant opportunity for improved responses. For example, children who interact with police are often 'overrepresented amongst those excluded from school'.[57] The ACT has confirmed that it has a 'higher representation of students with a disability among suspended students'.[58] The ACT Civil and Administrative Tribunal has also highlighted problematic use of suspension against children with disability.[59] Additionally, AFI notes the strong correlation between OOHC and contact with the youth justice system, and the need for significant improvement in the identification and response to disability need in OOHC, particularly in behaviour management and response.[60]

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[54] ACT Government, Office for Mental Health and Wellbeing *Review of Children and Young People in the ACT* March 2020, p 22.
[55] Ibid, p 641.
[56] Available at <https://www.advocacyforinclusion.org/review-of-act-health-programs-for-children-and-young-people/>.
[57] Baldry, E. et al, above n 2, p 641.
[58] (Note these statistics are not released publicly) Lindell, J. *Suspension rate up by a third in ACT public schools* 24 January 2021 <https://www.canberratimes.com.au/story/7096933/suspension-rate-spikes-across-act-public-schools/>.

[59] '"Surely a decision-maker would hesitate to impose a suspension ... if it appears probable that the behaviour prompting the suspension is in part a manifestation of one of the child's underlying disabilities," ACAT said.' in Bushnell, I. *ACAT sets aside suspension of Year 2 student with disabilities* 7 January 2021 <https://the-riotact.com/acat-sets-aside-suspension-of-year-2-student-with-disabilities/430744>.
For further information see also Advocacy for Inclusion's *Submission to the Inquiry into the Management of ACT School Infrastructure by the Standing Committee on Education and Community Inclusion* available at <https://www.advocacyforinclusion.org/submission-to-the-inquiry-into-the-management-of-act-school-infrastructure-by-the-standing-committee-on-education-and-community-inclusion/>.
[60] Baldry, E. et al, above n 2, p 642;
See also Campo, M. & Commerford, J. *Supporting young people leaving out-of-home care* Child Family Community Australia CFCA Paper No. 41, 2016, p 10.

Prioritising early support, through greater disability awareness and improved response to already well-known circumstances which increase risk of contact with police and the youth justice system could lead to improved identification of disability need and earlier intervention.

Reliance on the National Disability Insurance Scheme

AFI cautions against overreliance in the ACT upon the NDIS to provide support for people with disability, following the loss or reduction of wider community supports in the rollout of the NDIS. Only a small minority of people with disability gain access to the NDIS. Additionally, children and young people in the cohort being discussed face additional barriers to gaining access to the NDIS, particularly for support of a mental health condition. The NDIS requirement for 'permanence' is harder for young people to meet as the NDIA considers factors such as length of time of the impairment and potential development with age. Mental health practice is often hesitant to diagnose permanence of a condition, especially in children and young people,[61] making it very difficult for young people to be found eligible. The lack of identification of disability, and lack of access to assessment services in the ACT also has implications for the ability of children and young people to gain access to NDIS support.

Emergency supports at crisis points

AFI again highlights the necessity of adequate provision of supports in the community to prevent escalations to crisis.

Presentation at Emergency Departments

Children with disability and mental health conditions often have a high reliance on acute services such as emergency departments (EDs),[62] which arises due to a lack of adequate early support services and the failure of existing services to meet their needs. In AFI's experience, people with disability may make frequent presentations to EDs due to their needs not being met by community supports. Research reflects this, indicating that admission rates are higher for people with

[61] 'Generally, treating health professionals have been reluctant to confirm that someone has a likely to be permanent impairment as a result of their mental health condition before the age of 25. If you are supporting someone under 25 to collect information for their access request, the evidence has to be very clear around treatment options explored and that there are no future treatments that are likely to remedy the impairment.' in *Frequently Asked Questions (FAQs) For mental health professionals supporting people applying for the NDIS* <https://www.ideas.org.au/images/resources/facts/FAQs_-_NDIS_Access.pdf> pp 7-8.
'When interpreting evidence against the likely permanence of impairment requirement, the NDIA considers how long the person has had the impairment, and to what extent treatment options have been explored (noting that the impairment may alleviate with age-appropriate development).' in *Accessing the NDIS, A Guide for Mental Health Professionals* August 2017.
[62] Drainoni, M. et al. *Cross-Disability Experiences of Barriers to Health-Care Access: Consumer Perspectives* 17(2) Journal of Disability Policy Studies, 2006, p 102.

disability who present with "conditions that could have been prevented through appropriately individualised preventative health care or early disease management."[63]
It is not uncommon for parents and carers of children and young people with disability and mental health concerns to present in EDs with their child as a last resort, or even for youth and other support services to contact emergency after having exhausted all other options during a crisis. EDs and acute mental health services in the ACT are ill-suited to cater to children and young people, especially those with cognitive disability, and presentation to EDs can lead to restrictive practices, isolation, sedation and additional trauma. Many recommendations have been made regarding the need to improve the sensory environments and responses to mental health presentations in hospitals.[64]

Police response

> *Police management of highly disadvantaged young people and adults with mental and cognitive disability has served to criminalise them, and courts, criminal justice diversion and therapeutic approaches have failed to stem their flow into and return to prisons. The entrenched discrimination and disadvantage experienced by marginalised and racialised people with mental and cognitive disability… require reconstruction of the way people with disability who are at risk of criminalisation are understood and responded to, in line with international human rights principles.*[65]

A police response is not an adequate response to children and young people with disability or mental health in a non-criminal crisis.[66] In the ACT young people have raised concerns about 'how the police have treated them/themselves/friends when in a state of mental health crisis,' as 'ACT Police have been reported to exacerbate mental health crises in some instances, rather than calm them.'[67] Police responses to young people experiencing mental health crisis raise further concerns of vulnerability, early contact with the criminal justice system, criminalisation and stigmatisation. AFI supports the increased use of PACER and welcomes the development of a police best practice guide for engaging with people with disability. However, as 'ongoing negative interactions and inadequate police responses to disability-related behaviours have the effect of propelling young people deeper into the youth justice system'[68] AFI recommends that all attempts should be made to prevent formal police responses to children with disability and mental health as much as possible.

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[63] Hull, E. *Preventable hospitalisation rates 4.5 times higher for people with intellectual disabilities, research reveals* (15 June 2021) *ABC News* <https://www.abc.net.au/news/2021-06-14/people-with-intellectual-disabilities-hospitalisation-research/100209410>.
[64] Productivity Commission *Inquiry Report Mental Health Volume 2* (Inquiry Report, No. 95, 30 June 2020), p 603.
[65] McCausland, R. and Baldry, E. above n 17, p 303
[66] Office of Police Integrity, Victoria, *Policing People Who Appear To Be Mentally Ill*, Parliamentary paper, session 2010-12, no. 190 p. 15.
[67] Youth Interact, Youth Advisory Council, ACT Government, *Our Voice Our Impact 2018 ACT Youth Assembly Report* (2018) p. 12.
[68] Baldry, E. et al, above n 2, pp 641-642.

Emergency accommodation

AFI supports 'Ruby's Reunification Program' through the Youth Coalition of the ACT, which supports young people to reunite with families and be diverted away from homelessness, and additional initiatives which prevent an alternative to detention and youth justice settings. AFI emphasises the importance of such programs to be accessible to young people with cognitive disability and mental health needs in order to effectively support this cohort, and highlight the opportunity of the design of new services to ensure they are fundamentally accessible in design and practice.

Additional considerations may be given to increasing the availability of respite facilities for both children with disabilities and their families, with a focus on provision of best practice behaviour support.

Mandatory engagement

AFI cautions against the adoption of a Medical Model approach towards disability needs in the mandating of 'treatment' or therapies:

> *Steele et al. (2016) have raised particular concerns about the way that the medical model of disability, which focuses on disability as an internal, individual pathology, contributes to the marginalisation of people with disability in the criminal justice system, notably by providing a legitimate basis for the legal and social regulation of people with disability in the name of therapeutic interventions. This speaks to the problem raised by Baldry (2010) that diversionary programmes tend to be embedded in a concept of individual responsibility and choice around offending that can be counterproductive for people with mental and cognitive disability, as it presumes they can simply choose to stop offending. Failure to meet the eligibility criteria of a diversion programme or to complete it for whatever reason is considered as failure of the individual rather than a result of systemic factors, ill-conceived programme design or punitive administration (McCausland, 2015: 203).*[69]

In considering non-compliance or failure to engage with services, potential barriers of accessibility and systemic discrimination must be explored as a priority, as perceived 'non-compliance' may be the result of failure to identify and adequately respond to disability. Obligations intended to be therapeutic 'may in reality be entrenching people with mental and cognitive disability in the criminal justice system.'[70] AFI recommends addressing systemic barriers as a first priority, above developing new mandatory requirements to ensure existing failing processes are not simply incorporated into an 'alternative' model and perpetuated.

Specific therapeutic accommodation

AFI cautions against the creation of alternative 'therapeutic accommodation' which could exist in actual fact as a prison by another name. We acknowledge that such an option could be created from an intention to provide services which are not available in the community:

[69] McCausland, R. and Baldry, E. above n 17, p 296.
[70] Ibid, p 295-296.

> *Conceiving of prisons as therapeutic places turns them into sites where people with mental and cognitive disability are 'managed', often returned to as the only 'residential service provider' for many whose behaviour is seen as too complex or difficult to be supported in the community.*[71]

AFI submits that no such service should be designed in the absence of sufficient resourcing of community support. Every effort should be made to provide services which allow children and young people to remain in their homes and communities where possible. Importantly, the decision to place a child with complex support needs arising from disability and/or mental health in specific settings is an indication that social and environmental factors contributing to disability are being ignored and left unaddressed:

> *Rendering some behaviours by persons with disability criminal and then individualising and isolating them makes the determining effects of negative compounding and cumulative factors invisible (Baldry and Dowse, 2013: 224). These factors are embedded in institutional policies and practices and in social and systemic arrangements, sanctioning and perpetuating criminalisation of this group.*[72]

AFI strongly recommends consideration to be given to the findings of the Senate Community Affairs References Committee in *Indefinite detention of people with cognitive and psychiatric impairment in Australia*[73] and the alternative, less restrictive measures which have been recommended including investment in early intervention,[74] improved services for people with cognitive impairment and improved justice reinvestment.[75]

Section 31 (1) of the *Human Rights Act 2004* states that 'International law, and the judgments of foreign and international courts and tribunals, relevant to a human right may be considered in interpreting the human right'.[76] Australia is a party to the United Nations *International Covenant on Civil and Political Rights* and *Convention on the Rights of Persons with Disabilities*.

> Article 9 of the *International Covenant on Civil and Political Rights* states: Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.[77]

> Article 14 of the *Convention on the Rights of Persons with Disabilities* states that people with disabilities, on an equal basis with others: (a) Enjoy the right to liberty and security of person; (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.[78]

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[71] McCausland, R. and Baldry, E. above n 17, p 295-296.
[72] Ibid, p 292.
[73] Senate Community Affairs References Committee *Indefinite detention of people with cognitive and psychiatric impairment in Australia* Commonwealth of Australia, November 2016.
[74] 'The committee strongly supports a move to early intervention in mental health care as a better model of health service delivery.' In Senate Community Affairs References Committee, *above n* 71, p 143.
[75] *Ibid,* p 181.
[76] *Human Rights Act* 2004 s31 (1).
[77] United Nations *International Covenant on Civil and Political Rights* Art. 9.
[78] United Nations *Convention on the Rights of Persons with Disabilities* Art. 14.

Alternative accommodation settings, and the potential for mandated engagement raises significant concerns both about the justice process through which children may face mandated engagement, and the detention of children on the basis of disability.[79] The United Nations *Committee on the Rights of Persons with Disabilities* continues to raise serious concerns about Australia's:

> *(a)Legislative frameworks, policies and practices that result in the arbitrary and indefinite detention and forced treatment of persons with disabilities, and that such frameworks, policies and practices disproportionately affect Aboriginal and Torres Strait Islander persons with disabilities and persons with intellectual or psychosocial disabilities;*
>
> *(b)The ongoing practice of obliging persons with "cognitive and mental impairment" to undergo treatment, including through indefinite detention in psychiatric centres, despite the recommendations contained in the Senate Community Affairs References Committee 2016 report Indefinite Detention of Persons with Cognitive and Psychiatric Impairment in Australia;*
>
> *(c)The commitment of persons with intellectual or psychosocial disabilities to custody, often indefinitely or for terms longer than those imposed in criminal convictions;*
>
> *(d)The absence of data on the number of persons found not guilty due to "cognitive or mental health impairment" indefinitely detained and the number of such persons detained on an annual basis;*[80]

Additionally, proportionality and severity of breaches must be given adequate consideration in the limitation of any human rights. Section 28 ss (1) & (2)(e) of the Human Rights Act state that:

> *(1)Human rights may be subject only to reasonable limits set by laws that can be demonstrably justified in a free and democratic society.*
>
> *(2)In deciding whether a limit is reasonable, all relevant factors must be considered, including the following:*
>
> *(e)any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve.*[81]

AFI submits that deprivation of liberty and mandated residence in specific facilities cannot be considered proportionate while there fails to be adequate investment into less restrictive community support options.

[79] See further Senate Community Affairs References Committee, *above n* 71.
[80] United Nations, Committee on the Rights of Persons with Disabilities *Concluding observations on the combined second and third periodic reports of Australia CRPD/C/AUS/CO/2-3* 15 October 2019 para 27.
[81] *Human Rights Act* 2004 Part 3B, s28(1) & (2).

Conclusion

Raising the minimum age of criminal responsibility in the ACT is a significant consideration for children and young people with disability and mental ill health. It is critical that consideration is given to disability perspectives and that accessibility, inclusion and the human rights of children with disability is prioritised in the development of an alternative approach.

AFI emphasises the importance of codesign with people with disability, including children, in designing effective measures to address the needs of children and young people with disability. We note that the Convention on the Rights of Persons with Disabilities, Article 4 (3) states:

> In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disability, States Parties shall closely consult with and actively involve persons with disability, including children with disability, through their representative organizations.[82]

[82] United Nations *Convention on the Rights of Persons with Disabilities* Art. 4 (3).