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Raising the minimum age of criminal responsibility

RACP submission to the ACT government discussion paper on raising the minimum age of criminal responsibility

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand, including 327 and 144 in the ACT. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

RACP response to ACT government's Minimum Age of Criminal Responsibility discussion paper

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to respond to the Australian Capital Territory (ACT) Government's Discussion Paper regarding the age of criminal responsibility. The RACP is pleased to provide feedback that will inform the ACT Government's approach to the complex legal and system-level questions that lie at the heart of this important reform.

This submission will respond to Section 1: 'Threshold issues for raising the Minimum Age of Criminal Responsibility' and Section 2: 'An alternative model to the youth justice system' of the discussion paper. As the RACP is a medical organisation, we will not be responding to the sections focused on the legal implications of changing the minimum age of criminal responsibility (MACR).

The RACP strongly supports raising the minimum age of criminal responsibility to 14 years of age. Children aged 10-13 years in contact with the criminal justice system are physically and neurodevelopmentally vulnerable and the majority have experienced trauma, abuse or neglect. They need appropriate and wholistic healthcare, education and protection from further harm. Incarceration adds to their trauma and increases the risk of reoffending and poorer outcomes.

General comments

Children who interact with the criminal justice system and the child protection system have complex health and social needs. Many inequities start at, or before, conception, continue in early childhood and increase along a clear social gradient. The greater a child's disadvantage, the worse their health, development and well-being. These gaps widen as children progress across the life trajectory resulting in adverse adult health, educational and vocational outcomes, with increased subsequent premature mortality and morbidity. This can have an intergenerational effect with inequity passed on to the next generation.[1] A child's health and wellbeing can also be impacted by historical trauma from earlier generations. Poor access to services compounds inequities. Intensive early support and interventions are needed to prevent inequities rather than responding to crises as they happen.

Article 24 of the United Nations Convention on the Rights of the Child (CROC), calls for the right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.[2] This inalienable right applies to all children, including those at risk of contact with the criminal justice system.

RACP feedback on Section 1: Threshold issues for raising the Minimum Age of Criminal Responsibility

The RACP strongly supports raising the minimum age of criminal responsibility to 14 years of age. A range of problematic behaviours in 10 to 13 year old age children that are currently criminal under existing Australian law are better understood as behaviours within the expected range in the typical neurodevelopment of 10 to 13 year olds (typically actions that reflect poor impulse control, poorly developed capacity to plan and foresee consequences such as minor shoplifting or accepting transport in a stolen vehicle)[3]. Young children with problematic behaviour, and their families, need appropriate healthcare and protection. Involvement in the youth justice system is not an appropriate response to problematic behaviour. It further damages and disadvantages already traumatised and vulnerable children. It is inappropriate for 10 to 13 year olds to be in the youth justice system. Alternative approaches to managing problematic behaviour are likely to be less

[1] The Royal Australasian College of Physicians. Inequities in Child Health statement, 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/racp-inequities-in-child-health-position-statement.pdf?sfvrsn=6ceb0b1a_6

[2] UN General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577

[3] Johnson, Sara B. et al. Adolescent Maturity and the Brain: The Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy Journal of Adolescent Health, Volume 45, Issue 3, 216 - 221

damaging to young children, and evidence shows incarceration in this age group does not deter future offending[4].

The brain of 10-13 year olds is still immature and many executive functions have not yet developed. Functional neuro-imaging indicates that the pre-frontal cortex of the brain, the part of the brain that controls "executive functions" (that is impulse control, planning and weighing up long term consequences of one's actions), is not fully developed until around 25 years of age[5]. Impulse control, the ability to plan and foresee the consequences of one's actions is vastly less developed in a 10 year old than an adult[6]. As such, when faced with a choice of jumping into a stolen car with peers, or being left on the side of the road alone, it is highly conceivable that a 10 year old may jump into the stolen car, and thus become an accessory to a crime, without having planned this or thought through the consequences.

There are many examples of policies to recognise the physical, neurocognitive and emotional vulnerabilities of children between the ages to 10 to 13 years and to protect children physically and emotionally. People under 18 generally cannot marry in Australia, exemptions to this age limit can be sought (by judicial hearing) for one person under 18 but not, in any circumstance, under 16. Facebook requires users to be 13 years of age, Qantas considers children travelling under 12 years of age as unaccompanied minors. Current Australian laws that allow 10 year old children to be incarcerated seem to be incongruous in this regard.

RACP feedback on Section 2: An alternative model to the youth justice system

3. Are these the appropriate principles to underpin the development of an alternative model to a youth justice response? Are there alternatives or other principles that should be included?

The RACP is broadly supportive of the outlined principles that underpin the development of an alternative model to a youth justice approach. As Aboriginal and Torres Strait Islander children currently have higher rates of interaction with the youth justice system, culturally appropriate models of care and principles should underpin any systems and programs.[7]

The RACP recommends considering the principles on which the Medical Specialist Access Framework is based when developing the health elements of an alternative model for youth justice. These principles in practice align with the discussion paper's principles. The Principles in Practice include: Indigenous Leadership, Culturally Safe and Equitable, Person-Centred and Family Orientated, Flexibility, Sustainable and Feasible, Integration and Continuity of Care, Quality and Accountability. The key principles identified by the Indigenous Health sector can be used to underpin an alternative model of youth justice. The principles should be considered as both a guide and a standard for service delivery organisations and providers.[8]
The RACP recommends the principle of self-determination as an underpinning principle: provide opportunities for children and young people to have a voice and contribute to the development of policies and services for their benefit.[9]

Other principles that we recommend be considered include;

1. Interagency collaboration- particularly involving health, education, disability and child protection systems and characterised by supportive governance and funding models.
2. Provision of sustained, comprehensive, flexible and culturally sensitive case management or coordination is essential to support engagement and collaboration.
3. Meaningful outcomes should be identified, measured and reported that might include educational attainments/engagement, identification and treatment of health, developmental or cognitive conditions.

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[4] Specifically, "the imposition of a custodial sentence had no effect on the risk of reoffending." McGrath, A., & Weatherburn, D. (2012). The effect of custodial penalties on juvenile reoffending. Australian & New Zealand Journal of Criminology, 45(1), 26–44. https://doi.org/10.1177/0004865811432585.

[5] Johnson, Sara B. et al. Adolescent Maturity and the Brain: The Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy Journal of Adolescent Health, Volume 45, Issue 3, 216 - 221

[6] Ibid.

[7] Child, Family and Community Institute Australia, Child protection and Aboriginal and Torres Strait Islander Children 2020 https://aifs.gov.au/cfca/publications/child-protection-and-aboriginal-and-torres-strait-islander-children#footnote-001

[8] The Royal Australasian College of Physicians, Medical Specialist Access Framework 2018 www.racp.edu.au/msaf

[9] The Royal Australasian College of Physicians, The role of paediatricians in the provision of mental health services to children and young people, 2016 https://www.racp.edu.au/docs/default-source/advocacy-library/racp---the-role-of-paediatricians-in-the-provision-of-mental-health-services-to-children-and-young-people.pdf

4. What universal or secondary services should be introduced and what existing services should be expanded – or alternatively are there any services that could be re-oriented or repurposed - to better support this cohort?

The RACP recommends increasing access to preventative, early intervention, trauma informed and integrated multidisciplinary programs. It is crucial that programs are wraparound services, not delivered in silos. The RACP statement on the role of paediatricians in the provision of mental health services to children and young people recommends ensuring that models of care effectively integrate paediatric and young people's health services with mental health services for those at risk or diagnosed with mental health problems. Wraparound programs may include access to primary care health professionals, specialist paediatric services, mental health services, social workers, school support and family support. All programs must be culturally safe for children and their families.

There is an established link between children in Out of Home Care (OoHC) and juvenile incarceration, the younger children are incarcerated, the more likely they are to be known to child protection (e.g. to have experienced psycho-social trauma).[10] For this reason, the RACP recommends preventative health focused solutions for children who have interreacted with the child protection system and children with complex health and social issues. Children who experience or are at risk of trauma, mental health issues, developmental issues, interaction with the child protection system and incarceration have greater need for health services. Addressing health inequities using a strengths based approach can both prevent long term health issues and potentially reduce interaction with the criminal justice system.

In other words priority support should be provided to children who have been in out of home care, or who have experienced trauma, mental health or developmental issues to prevent later interactions with the justice system.

In addition, access to preventative, integrated multidisciplinary programs should be available to all children regardless of location, socio-economic status or living circumstances. There is now clear evidence that children in the youth justice system in Australia (both above and below 14) have high rates of additional neurocognitive impairment, trauma and mental health issues.[111] These issues markedly increase their vulnerability. Additionally, these children are much more likely to be disengaged from the education system.

Providing access to multidisciplinary health care to children who are in the child protection system or are at risk of coming into contact with the child protection system, aims to reduce the number of children in the justice system. This aligns with the discussion paper comment on the need to improve access to early supports and options for therapeutic care. Comprehensive health services are needed to address child health inequities and potentially reduce the number of children coming into contact with the criminal justice system. In response to the ACT increase in the age of criminal responsible, age specific programs for 10–13-year-olds will be necessary whilst acknowledging that the developmental age may be lower than the chronological age of this cohort. Access to appropriate health care is just one domain required to provide support to children with complex needs. Other domains that should be considered include providing appropriate housing, education and family supports.

The RACP recommends increasing health service capacity through providing strong and truly universal child health and education services that deliver the right care to children for their health and development.[12]

To provide the best possible care, we recommend that services that care for children take an evidence-based approach to addressing child health inequity through:

- Use of programs that have been proven to be effective by high quality research and that have a clear evidence base in promotion of resilience in high risk young people.
- Regular evaluation of services to ensure that program implementation is of high quality and appropriately targeted, and results in increased access, quality and affordability; and

[10] Abram KM, Teplin LA, et al. Posttraumatic Stress Disorder and trauma in youth in juvenile detention. Archives of General Psychiatry, 2004. 61. 403–410

[11] Bower C, Watkins RE, Mutch RC, et al Fetal alcohol spectrum disorder and youth justice: a prevalence study among young people sentenced to detention in Western Australia BMJ Open 2018

[12] The Royal Australasian College of Physicians. Inequities in Child Health statement, 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/racp-inequities-in-child-health-position-statement.pdf?sfvrsn=6ceb0b1a_6

- Providing adequate funding for high-quality evaluations of the evidence used to design service provision.[13]

Services can be supported by developing and implementing equitable health, education, employment, housing, early childhood and welfare policies.[14]

5. How should the Government/community service providers identify and respond to the needs of children and young people before harmful behaviour/crisis occurs?

As per the response to question 4, the RACP recommends providing multidisciplinary support to children in and at risk of entering the child protection system, as children in child protection system may be at a higher risk of entering the criminal justice system.

6. What service and supports are needed to respond to children and young people under the MACR at crisis points including options for accommodation and emergency supports? How could these options support the needs of the child, while also ensuring the safety of the community?

Access to culturally safe paediatric and mental health services is vital for children experiencing crisis. For more information regarding paediatricians providing mental health care to children, please access the RACP statement on the role of paediatricians in the provision of mental health services to children and young people.[15]

7. How should children and young people under the MACR be supported after crisis points?

After crisis, the RACP recommends ongoing access to both multidisciplinary and interagency care. Additional support should be provided as needed. Sustained involvement of key members of the treating team and other members of the multidisciplinary team is vital to retain the approach on prevention and early intervention. Many of the risk factors experienced by these children and their families are long standing and may require long term intervention to effectively support the child. Anticipation of such crisis points should be included in the treatment plan, with appropriate strategies to reduce their impact and consequence identified.

Identifying the strengths in the child, in their family and in their community can serve to build resilience for these crises and for the day to day challenges the child may experience. This may be specific talents, a caring and committed member of the extended family or a deeper connection with their culture and history,

[13] Ibid
[14] Ibid
[15] The Royal Australasian College of Physicians, The role of paediatricians in the provision of mental health services to children and young people, 2016 https://www.racp.edu.au/docs/default-source/advocacy-library/racp---the-role-of-paediatricians-in-the-provision-of-mental-health-services-to-children-and-young-people.pdf