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Therapeutic Support Panel for Children and Young People Report 2024

Presented by
Michael Pettersson MLA
Minister for Children, Youth and Family Services
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THERAPEUTIC SUPPORT PANEL FOR CHILDREN AND YOUNG PEOPLE 2024 REPORT

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Acknowledgement

Acknowledgement of Country

The Therapeutic Support Panel for Children and Young People acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

Acknowledgement of lived experience

We acknowledge that we can only provide leadership in systemic reform through valuing, respecting, and drawing upon the lived experience expertise and knowledge of children, young people and families. We acknowledge the individual and collective contributions of those with a lived and living experience of youth justice and law enforcement systems, and those who love, have loved and care for them. Each person's journey is unique and a valued contribution to ACT's commitment to the raising of the minimum age of criminal responsibility reform.

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Therapeutic Support Panel for Children and Young People

LETTER OF TRANSMISSION

Minister for Children, Youth and Family Services
ACT Legislative Assembly
London Circuit CANBERRA ACT 2601

Dear Minister

As Chair of the Therapeutic Support Panel for Children and Young People, I am pleased to present you with the *Therapeutic Support Panel for Children and Young People* 2024 Report.
This report fulfils the Committee's statutory obligations.
I hereby present the report for tabling in the Legislative Assembly.

Yours sincerely,

Dr Justin Barker
Chair of the Therapeutic Support Panel
17 December 2024

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Glossary and Acronyms

ACCO	Aboriginal Community-Controlled Organisations
ACEs	Adverse Childhood Experiences
ACT	Australian Capital Territory
AOD	Alcohol and Other Drugs
CCR	Child Concern Reports
Child Safety	Care and protection system in the ACT
CSD	Community Service Directorate
CYF	Child Youth and Family Services including child safety, intake, family response and engagement and family preservation
ISRP	Integrated Service Response Program
ITO	Intensive Therapy Order
MACR	Minimum age of criminal responsibility
OOHC	Out of home care
The Panel	The multidisciplinary panel (referred to as 'Therapeutic Support Panel' in the legislation)
SYRS	Safer Youth Response Service
TSP	Therapeutic Support Panel for Children and Young People, referring to the whole program of supports, including the Chair of the Panel, the Panel, and the Therapeutic Case Management Team

Foreword

The ACT has led the way in Australia to raise the minimum age of criminal responsibility, by being the first jurisdiction to raise the age to 14-years in 2 stages. It is currently 12-years and will raise to 14-years on 1 July 2025. While the evidence and ethical considerations clearly support raising the age, other jurisdictions have stumbled over uncertainty about alternative service responses and supports for children at risk of harm. Led by research and consultation, the ACT has developed legislation, and the foundations of supports which commenced in 2023. These 2 components – legislation and systems of support – are inextricably linked, interdependent and mutually supportive. Creating a new system presents many challenges. Raising the minimum age of criminal responsibility involves developing a new service response and supporting existing systems and services to adapt. The Therapeutic Support Panel for Children and Young People (TSP) is the centrepiece of creating and leading these changes. TSP has been tasked with shifting the focus of work with children and young people at risk of or engaging in harmful behaviour to one that considers underlying causes and unmet needs, an approach which is ultimately therapeutic and healing. As such, raising the age requires a cultural shift with very real, practical considerations.

TSP commenced operations in late March 2024. While it is still early in the life of TSP and the reforms to raise the minimum age of criminal responsibility, things have started well. It takes time for existing systems and supports to learn about new offerings, establish referral pathways and clarify processes. Moreover, it takes time to develop and refine the model of practice for TSP. The Chair of the Therapeutic Support Panel oversees the multidisciplinary panel (the Panel), after which the TSP gets its name, and a Therapeutic Case Management Team. These components work together to provide services to referred children, young people, their families and community of support, in addition to monitoring how the systems are working to meet the needs of this target group. Individual and systemic advocacy inform each other, always grounded in the endeavour to improve outcomes.

The therapeutic mandate of TSP requires a shift in the way in which children and young people at the heart of these reforms are viewed. To see them as more than their behaviour and to understand them as children and young people shaped by their environment, as a product of conditions of existence and histories that often transcend generations. It requires an absence of blame and a willingness to understand the reasons for the behaviours of which they are not the sole authors, in order to find solutions that have a healing and ameliorative effect.

This report revisits some of the previous research and rationale for raising the age which also informs how we can better meet the needs of these children and young people and keep the community safe. We need to consider unmet needs and their environments. It is hard for any individual to change under the weight of their history and conditions of existence, however, as we often know, these children and young people are capable of significant change when supported by opportunities which are meaningful to them. This reform provides us with the chance to present new opportunities and possible futures.

We have seen positive changes already. Systems, services and supports are rethinking and adapting to the new legislative and practice landscape. The children and young people with whom we work are changing too. This can be a slow and incremental process. Although they are young, many of these children and young people have been shaped by a complex web of adversity and it can be challenging to rethink the dispositions and attributes they have used to survive. As the research consistently suggests, these are some of the most vulnerable children and young people in our community. They have often found ways to meet their primary needs that may be maladaptive but cannot see other viable alternatives. Some have made a virtue out of necessity, investing in identities

that felt like the only option. It takes time for them to trust that things might be different, that they can hope for something else. However, we are seeing change. We expect and plan for relapse, trial and error. We aim to provide a predictable and safe environment that allows for growth, underscored by unconditional positive regard and enthusiasm for the children and young people with whom we are working.

This report comes early in the life of TSP and the reforms of which it is a part. We are limited in what we can state with any rigor due to the dynamic and changing nature of TSP and the current environment. We have taken this inaugural report as an opportunity to provide (a) a brief background and contextual information regarding the needs and profile of the children and young people that are the target group of TSP, and (b) preliminary data regarding the functioning of TSP, our clients to date and a discussion of emerging systemic issues.

It is too early to make strong recommendations or report outputs or outcomes. There is still work to be done as we continue to develop and refine the way in which we work. However, thus far I am optimistic and see promising early signs of success for TSP and the children, young people, and families we work with and for.

Dr Justin Barker
Chair of the Therapeutic Support Panel
December 2024

Structure of this report

This is the inaugural report for the Therapeutic Support Panel for Children and Young People (TSP). TSP commenced on 27th of March 2024. While this timeframe places constraints on what can be meaningfully reported regarding the functioning of TSP and progress towards outcomes, it provides an opportunity to outline the foundational rationale for the intended model, the evidence regarding the intended target group, the degree to which the initial data aligns with previous research and the progress to date.

This Report is presented in two sections. Section One provides a brief overview of the background framing the raising of the age and the development of TSP. This provides context for the intended purpose of TSP as outlined in the legislation. This leads into an explanation of the role of the Therapeutic Support Panel, the elements and functions of TSP and how it operates. This is followed by a synopsis of the rationale and context for raising the minimum age of criminal responsibility and the creation of TSP. This provides an overview of the research regarding the needs of the intended target group of TSP. This overview of the cohort explains the rationale for raising the age and at the same time informs the approach that is taken by TSP. It is important to understand the needs of the children and young people that present to TSP to understand the approach and to frame expectations for change. Section One finishes with addressing what constitutes the therapeutic approach to the work of TSP.

Section Two provides a summary of data collected by TSP and emerging systemic issues. These descriptive statistics provide an overview of the referrals and Active Clients. These data give an indication of the cohort that are referred to TSP. When set against the research outlined in the Section One, this provides preliminary insights into whether TSP is working with the intended cohort and matches the evidence informed model of practice. Some initial observations regarding emerging systemic issues are then outlined, highlighting issues that need to continue to be monitored.

A note on terminology

It is necessary to clarify the terminology used in this report. The *Therapeutic Support Panel for Children and Young People* (referred to as *TSP* throughout this report) is an overarching term that includes the system of services and structures put in place to support children and young people following the introduction of the Justice (Age of Criminal Responsibility) Legislation Amendment Bill 2023. TSP includes the Chair of the Therapeutic Support Panel (*the Chair*), the Therapeutic Support Panel (*the Panel*), and the *Therapeutic Case Management Team*.

Limitations: development and implementation of the Therapeutic Support Panel

It is important to note that TSP has been in operation since 27 March 2024. At the time of writing this report this is just over 7 months. TSP is still in a developmental and implementation phase. This involves continual reflection and change in the model of practice, creating and refining processes, guidelines and procedures, and liaising with external stakeholders. Moreover, it also involves recruiting staff, onboarding, increasing awareness of TSP and developing system readiness. All these factors entail ongoing change in many aspects of TSP. As such, it is difficult to make firm conclusions regarding TSP and the implications for raising the minimum age of criminal responsibility at this early stage.

SECTION ONE

This section provides a brief overview of the background framing the raising of the age and the development of TSP in the ACT. This leads into an explanation of the role of the TSP, including the elements and functions of TSP and how it operates. This is followed by a summary of the rationale and context for raising the criminal age of responsibility and the creation of TSP, including an overview of the research regarding the complex needs of the intended target group of TSP. Section One finishes with addressing what constitutes the 'therapeutic approach' of the Panel providing an overview of the intended model of practice for the Case Management Team.

Background

The ACT Government committed to raising the minimum age of criminal responsibility (MACR) in the Parliamentary and Governing Agreement of the 10th Legislative Assembly. In February 2021, the ACT Government commissioned an independent review, led by Professor Morag McArthur (McArthur et al, 2021), which reviewed the service system and outlined implementation requirements for raising the MACR in the ACT. The review found that raising the MACR would help address the risk factors of children and young people that commit crimes and strongly advocated for a therapeutic response model to further address these risk factors. The report also made note that raising the MACR would also help tackle the overrepresentation of Aboriginal and Torres Strait Islander children and young people in the criminal justice system.

In May 2023, the Justice (Age of Criminal Responsibility) Legislation Amendment Bill 2023 (Bill) was introduced in the ACT Legislative Assembly and came into effect in November 2023. The Bill increased the minimum age of criminal responsibility (MACR) to 14 years of age in 2 phases; first to 12 years of age and then to 14 years of age, no more than 2 years later. The minimum age of criminal responsibility was raised to 12 when the Bill commenced and is set to raise to 14 years in July 2025.

The legislation embeds an imperative to take a therapeutic approach to addressing the needs of children and young people at risk of or engaging in harmful behaviours. This approach is in line with the evidence (Baidawi et al., 2023, McLachlan, 2023, McArthur et al., 2021) that highlights that children and young people that use harmful behaviours and are involved in the criminal justice system are "amongst the most vulnerable and least nurtured of all youngsters" (McAra & McVie, 2018). This therapeutic imperative required an alternative response to harmful behaviour and complex needs of children and young people by diverting children and young people from the youth justice system and onto healthier pathways. Central to the alternative response is TSP which will replace the current youth justice statutory response for children and young people under the MACR. However, TSP is also intended to have a broader impact, to improve and strengthen therapeutic responses for children and young people, not just limited to children under the MACR.

In preparation for the new legislation, the Community Services Directorate (CSD) designed TSP and its implementation. The community sector, people with lived experience and the broader community provided valuable insights to inform the Government's reform agenda. CSD drew on this knowledge and developed a service design to make sure children and young people get the help they need earlier in their lives to reduce reoffending, and improve their health and wellbeing, and the safety of the community. This service design drew on the report by MacArthur et al (2021).

The phased approach

The phased approach outlined in the Bill, commencing with a minimum age of 12 years and increasing it to 14 years in July 2025, is a deliberate and planned approach. These 2 phases allow for the development, implementation and refining of the approach and identification of needs prior to raising the age to 14 years. In phase one we are expecting small numbers of children based on past

data and research about who has been involved in the youth justice system (Baidawi et al., 2024, Community Services Directorate, 2021). Phased implementation allows us to start a process of discovery and learning, understanding the needs and circumstances of children and young people in the first phase, understanding the current gaps in the service system, and building evidence about what works and where we may need to invest in the future. It also allows for the refining of the practice model, recruiting and onboarding staff, development of an evaluation plan, preparing systems, services, and the community for raising the age to 14 years.

Role of the Therapeutic Support Panel

The Therapeutic Support Panel (TSP) is a statutory body established by the amendments to the *Children and Young People Act 2008* that delivers, oversees, and coordinates therapeutic supports for children and young people at risk of, or engaging in, serious harmful behaviours. TSP has both an operational and systemic role. TSP coordinates and provides supports to children, young people, and their families to address the unmet needs and the underlying causes of harmful behaviours. This aims to reduce harms and improve positive outcomes including enhanced community safety. TSP also monitors and oversees the patterns of needs, identifies gaps in supports and services at a systemic level. These 2 roles are inextricably linked, allowing for the delivery of services, and enabling ongoing improvement at a systemic and strategic level. TSP is not subject to direction from anyone in relation to the exercise of its functions, however, must comply with any guidelines made by the Minister. The independence of TSP creates an authorising environment through both formal and informal mechanisms that allow TSP to deliver on its intended functions.

TSP is not a crisis service. The intended model, as outlined by McArthur et al. (2021) and developed by CSD, is for a crisis service to work alongside TSP as an integrated service system. The model outlined by McArthur et al intends for the crisis support and ongoing case management to work as a coordinated service system to ensure referral pathways and adequate supports are provided to children and young people that come to the attention of police. The government is trialling new initiatives and pilots to understand and address afterhours crisis support needs for children and young people who come to the attention of police.

Elements and functions of the Therapeutic Support Panel (TSP)

There are 3 overlapping components that work together to fulfill the functions of TSP: (a) The Chair of the Therapeutic Support Panel (the Chair); (b) the Therapeutic Support Panel (the Panel); and the (c) Therapeutic Case Management Team.

(a) The Chair of TSP (The Chair) manages and oversees the functions of TSP, including both the Panel and the Therapeutic Case Management Team. This involves managing and presiding over matters before the Panel, overseeing referrals, initial intake assessments, developing therapy plans, and coordinating the provision of support. The Chair informs the Director-General of the Community Services Directorate about the operations of TSP. The Chair's role is both operational – overseeing and coordinating the support provided to children, young people, and families referred to TSP – and systemic – identifying and informing territory entities about systemic issues that affect children and young people. The Chair is a statutory position appointed by the Minister.

Dr Justin Barker was appointed as inaugural Chair of the Therapeutic support Panel and started in the role in March 2024.

(b) The Therapeutic Support Panel (the Panel) supports the functioning of the broader elements of TSP to coordinate multidisciplinary therapeutic services and supports for referred children and young people and identifies system barriers to improve outcomes for children and young

people at risk of or engaging in harmful behaviour. The Panel has numerous functions including reviewing referrals, assist in assessing therapeutic needs of referred children and young people, developing therapy plans, providing advice on appropriate therapeutic treatment and support, and recommending whether applications for an intensive therapy order should be made.

The Panel meets regularly every two months and holds additional meetings as needed on a case-by-case basis to discuss individual children and young people. At the bi-monthly meetings the Panel reviews all referrals, receive updates on current clients, identify any further panel meetings to further discuss clients, and identify and review any systemic issues that may require further action. This structure allows the Panel to fulfill its functions and transcend the operation and strategic roles.

The Panel consists of the Chair and other members appointed by the Minister for Children, Youth and Families. The Panel must consist of a minimum of 10 and no more than 12 members who have qualifications, experience, and expertise in one or more of the following:

- psychology;
- paediatrics;
- criminology;
- education;
- working with Aboriginal and Torres Strait Islander children and young people;
- working with culturally and linguistically diverse children and young people;
- social work;
- mental health;
- child protection;
- disability; or
- has other qualifications, experience or expertise, or membership of an organisation, relevant to exercising the functions of a panel member; or
- is a police officer nominated by the chief police officer as an officer experienced in working with children and young people and families.

The Panel must represent diversity of experience and expertise from these identified fields. Moreover, the Minister must appoint at least one person to represent Aboriginal and Torres Strait Islander people, and one panel member who is an Aboriginal and/or Torres Strait Islander. There are currently 3 Aboriginal and/or Torres Strait Islander members on TSP.

The current members of the Panel include:

- Dr Justin Barker (chair)
- Victoria Bradley
- Selina Walker
- David Witham
- Dee-Ann Brown
- Cara Jacobs
- Dr Bronwen Phillips
- Zakia Patel
- Dr Alison Gerard
- Dr Hayley Passmore
- Lisa Dempsey

There are also 4 Government appointed positions from Community Services Directorate (CSD), Education Directorate, ACT Health, and ACT Policing.

(c) The Therapeutic Case Management Team operationalise and deliver the supports provided to children, young people, and families referred to TSP. This includes receiving referrals, intake, assessments, developing therapy plans, case coordination, casework, individual advocacy, referrals, transition planning, and collaborating with and supporting key stakeholders. Their work is underpinned by a therapeutic approach aiming to have a healing effect, addressing unmet needs, treating the underlying causes of behaviour, and aiming to not just address harmful behaviours but achieve positive outcomes and growth.

The Therapeutic Case Management Team is intended to consist of a Team Leader and Three Therapeutic Case Managers. Since February 2024 two Therapeutic Case Managers were assigned to these roles. From November 2024 a Team Leader commenced. We expect a full team to be in place in the beginning of 2025.

Operations of TSP

TSP works with children, young people, and their families to address unmet needs that cause and contribute to harmful behaviour. We aim to divert children from criminal legal responses and systems and create lasting positive outcomes by receiving referrals and evaluating the needs of referred children and young people to determine the most effective and timely therapeutic response. This process aims to reduce the future likelihood of high-risk harmful behaviour.

TSP plays a crucial role in driving systemic change towards a more therapeutic, trauma-informed, and holistic service system, that diverts all children and young people from traditional and often-punitive service responses, such as the criminal justice system. By identifying the challenges faced by referred children and young people, TSP advocates for individual changes in therapy plans and broader system changes in the annual report to the Minister. Further, the Chair may report to the Director-General about the operations of TSP and may inform a territory entity about systemic issues that affect children and young people who are the subject of referrals, in a more frequent manner.

For TSP, *therapeutic support* refers to approaches that have a healing effect; treating the underlying causes; aiming for positive outcomes and growth. We consider the whole person and their conditions of existence – their environment, history, ecosystem of support and community, and individual traits. These children, young people and families need support to create safe, stable, predictable conditions in their lives that enable them to build a sense of belonging, self-worth, accomplishment, and a positive identity and value.

Therapeutic support can be a long-term process that addresses trauma, vulnerability, disability, and other complex issues at the root of children and young people's concerning or harmful behaviour. TSP is not a crisis service. Our Case Management Team can provide case management support including case coordination, casework, referrals, advocacy, and assessments.

Referrals to the Therapeutic Support Panel

TSP can receive requests for support and to evaluate the needs of a child or young person from referring entities. A child or young person may be referred to TSP for assessment and support where the referring entity believes on reasonable grounds that a child or young person:

a) has a genuine need for therapeutic support services; and
b) is at risk of engaging in or has engaged in
    a. harm to themselves or someone else; or
    b. serious damage to property or the environment or

c. cruelty to an animal; or
d. any other serious or destructive behaviour.

Harmful conduct, in the Act, refers to behaviours or conduct engaged in by a child or young person that leads to significant risk of significant harm to the child or young person or someone else.

Initial assessments are conducted on all referrals to decide what action is to be taken. Following the initial assessment there are three possible actions: (1) accept referral (2) Active Monitoring, and (3) referred on and closed at intake. All decisions made regarding referrals are reviewed by the Panel at bi-monthly meetings.

Accepted referrals – typologies of support

Different client typologies were developed to address the varying levels of support needed, based on the existing services and resources already present in the lives of the children and young people. Some clients had numerous services and systems involved in their lives, while others had very few or none. Moreover, it was important to differentiate between the clients under care orders with CYF and those with supports in the community, not on care orders. As such we have identified 3 typologies of support for accepted clients: 'lead worker'; 'collaborative care – on orders'; and, 'collaborative care – in the community'. In all instances we work with the existing ecosystem of support and people in the lives of the children and young people. It is essential to understand the role of the community and their networks and work with them. Our collaborative care typologies acknowledge the existing services and supports and our need to fit into this.

Lead worker

Some of the accepted clients have very few or no services and supports involved at the time of referral. Sometimes these clients sat outside of the inclusion criteria of services and systems, falling short of being able to access supports. These children and young people required TSP Case Management Team to take the lead and conduct all the elements of case management, including:

- Engagement
- Assessment
- Develop therapy plans
- Case coordination: Identify roles, responsibilities, delegation, and mechanisms for accountability and timeframe
- Case work: implementing actions in the case plan/therapy plan
- Individual advocacy
- Monitoring and reviewing
- Transition to exiting
- Follow-up and post exit communication

Collaborative care – on orders

Research has identified the strong overlap between children in the care and protection system and the youth justice system, often referred to as the 'crossover kids' (Baidawi & Sheehan 2019). This cohort are expected to constitute a large proportion of the children and young people based on previous research and scoping. Working alongside CYF is an important feature of this typology, acknowledging the existing care team, plans and supports. Consequently, the involvement of TSP does not need to include all the elements of the Lead Worker role. TSP often provides an advisory or critical friend role for the existing care team. However, the Therapeutic Case Management Team can be involved in any of the other elements of support on a case-by-case basis.

Collaborative Care – in the community (not on orders)

Collaborative care with children and young people in the community differs from those involved with CYF due to access to different resources and supports, and parental responsibility still sitting with the parents or carers. These clients already have established care teams where a service or support is already leading the case management. The role of TSP varies for these clients and can include all the elements of practice outlined in the Lead Worker role.

Active Monitoring

When children and young people are referred to TSP, they may be considered to already have the supports and services that match their needs. This is often assessed by meeting with professionals and/or care team meetings. However, TSP may deem it prudent to continue to monitor if their needs are being addressed or if the risk of harm increases. These children and young people are placed on Active Monitoring, which means TSP will continue to pro-actively monitor their situation and progress with the supports.

Referred on and closed at intake

Some referrals do not meet the inclusion criteria of TSP. This may be due to being older than 18 years of age, or not being at risk of harm or using harmful behaviour. However, these children and young people may still have unmet needs. In these instances, we provide advice and referral on to other services and supports that match the child or young person's needs. This may involve chairing a professionals meeting with current or potential services to ensure the needs of the child or young person are being matched to the right services.

Therapy Plans

These children, young people and families require intentional, purposeful, explicit plans that are applied with consistency, predictability and are coordinated and unified in their aim. Without a coordinated response from the system around them there is no reason to think anything will change in a positive direction. The aims, or intended outcomes need to be explicit and linked to plans that are actionable.

The Chair, with the assistance of the Panel and the Therapeutic Case Management Team, can prepare and support the development of therapy plans for clients. Therapy Plans aim to reduce the likelihood of the child or young person engaging in harmful conduct in the future by addressing their unmet needs. Therapy plans can be developed by other services and supports who have parental responsibility or leading the case management for a child or young person. This is often the case with 'collaborative care clients' – where we work with others in collaboration to support the needs of a child or young person.

Intensive Therapy Orders (ITO)

TSP has several roles relating to Intensive Therapy Orders (ITOs). An ITO is a mechanism outlined in legislation that provides a means to direct a child or young person to undergo either or both assessment or treatment in alignment with their therapy plan. This measure is intended to facilitate children and young people receiving treatment when they are at significant risk of significant harm arising from their conduct. It enables children and young people who are resisting participation in therapeutic supports and are risk of significant harm to be supported and safe.

Rationale and context of the Therapeutic Support Panel

There is extensive and robust evidence informing the raising of the minimum age of criminal responsibility. This evidence informs the rationale for raising the age and, furthermore, directs and

informs the approach that is needed to meaningfully improve the lives of these children and young people and to enhance community safety and wellbeing. The following section provides an overview of the research outlining the needs of the children and young people that are likely to be referred to TSP. This research does 2 things; it allows us to compare the expected cohort with those that are referred to TSP to ensure we are targeting and delivering support to the intended population group (see 'Section Two'); and, it informs the development of the model of practice and what constitutes our therapeutic practice (see 'Model of Practice' below).

Complex needs, trauma and developmental considerations

> "The majority of children who commit offences have histories of abuse, abandonment and bereavement compounded by learning difficulties and disabilities which have all been inadequately addressed" (UK Children Commissioner 2011)

Research highlights that children and young people do not have the brain development to form criminal intent or participate fully in the criminal justice system. The research suggests that children under 14 years of age do not have the cognitive capacity to understand the behaviour they are engaging in. Neuroscientific research confirms that the cognitive capacity of children and young people to make decisions is limited, due to underdeveloped consequential thinking, emotional regulation, abstract reasoning, and executive function. Moreover, the children that are using harmful behaviours are even less likely to have developed these cognitive and social functions, given the range of factors or determinants that have led them to these behaviours. Children who use harmful behaviours that have previously been criminalised have complex needs (McArthur et al., 2021).

Research highlights that children involved in the justice system disproportionately suffer from high levels of victimisation and are faced with high intensity of social adversity which even further impacts on their capability to be held criminally responsible. The range of factors that shape the behaviours of children and young people that present with harmful or concerning behaviours often compound, accumulating more disadvantage and risk factors over time. This compounding of vulnerabilities and risk factors highlights the need for early intervention. It also demonstrates a clear need for case management that can assist in navigating complicated systems to address these needs.

The research addressing the complex needs of children and young people who come into contact with the justice system highlight the following vulnerabilities and risk factors:

- High levels of trauma and adverse childhood experiences (ACEs)
- Disabilities (including neuro-disability, developmental impairment, FASD, & ABI)
- Disconnection from educational
- Unstable and unsafe housing
- Poor mental health and physical health
- Engaged in alcohol and other drug (AOD) abuse
- Exposed to family conflict and violence
- Child abuse, neglect, child protection and out-of-home care involvement

The presence of these vulnerabilities is often further complicated by the absence of protective factors, positive life experiences, and participation in pro-social activities.

The vulnerabilities and risks outlined above are well evidenced and overlap with research examining the impact and role of criminogenic factors, social determinants, and adverse childhood experiences (ACEs) that adversely impact children and young people, shaping their development and life trajectories. It is particularly notable to outline the impact of adverse childhood experiences (ACEs) and trauma on the development of children and the conditions that increase the likelihood of

involvement in harmful behaviours. The way these experiences and life events can impact on cognitive and social development further demonstrates the logic and rationale for raising the MACR and informs the approaches that meet their needs and increase community safety.

Adverse Childhood Experiences (ACEs) and Trauma

Children who have been involved in the justice system disproportionately suffer from high levels of victimisation and high intensity of social adversity which impacts on their capability to be held criminally responsible. A significant proportion of children who offend have a history of adversity and trauma (Baglivio et al, 2014; Malvaso, Day, Casey, & Corrado, 2017; Malvaso, Delfabbro, Day, & Nobles, 2018; Malvaso et al., 2022).

Longitudinal studies have demonstrated the relationship between criminal offending behaviour and the impact of adverse childhood experiences (ACEs) in terms of developmental trauma. ACEs is a term coined by Felitti et al in 1998 to describe the cumulative effects of both maltreatment (physical, sexual and emotional abuse, and physical and emotional neglect) and household dysfunction (parental separation, domestic violence, mental illness, substance abuse and incarceration) before the age of 18 (Malvaso et al. 2022). There is consistent evidence demonstrating that children and young people who have experienced a higher number of ACEs are more likely to engage in serious, violent and chronic offending (Fox et al. 2015). Children's developmental age is significantly influenced by trauma. Children who have faced numerous ACEs are likely to have a developmental age lower than their chronological age (McLachlan, 2023). Developmental trauma can lead to impaired neurological development and functioning, poor emotional regulation, antisocial attitudes and behaviours, and unstable attachment (Farrington, Ttofi, & Piquero, 2016; Sampson & Lamb, 2003; Craig, Piquero, Farrington, & Ttofti, 2017; Malvaso et al., 2017, 2018, 2022).

Key developmental differences in cognitive and social functioning

Early childhood adversity changes the brain in very specific ways to cope with abuse and neglect (Teicher & Samson, 2016). Childhood adversity not only results in psychological and emotional harm, it changes the brain's structure. The following provides an overview of the key developmental differences in cognitive and social functioning that have been identified for children who have experienced adversity.

Emotional dysregulation: This refers to children who experience difficulty registering, responding and regulating emotions (Kezelman & Stavropoulos, 2019). This can involve children struggling to suppress or having excessive emotional responses. Children who have experienced maltreatment demonstrate increased neural activity during emotional regulation tasks, suggesting that these tasks take more effort. Consequently, these children often need support to develop self-regulation skills. Difficulty regulating emotions can include dysregulated anger (Malvaso et al., 2017) and impulsivity (Shin et al., 2018; van der Kolk, 1987).

Diminished social reward: Children who experience early adversity can respond differently to rewarding events and activities. Social rewards and goal-directed behaviours play an important role in social learning. There is often blunted neural responsiveness in the anticipation of social rewards for children who have faced maltreatment. This can lead to less motivation and engagement with socially rewarding relationships and inhibit experiencing positive and rewarding interactions. This developmental difference can lay the foundation for the development of addiction and depression later in life (McCrory et al., 2017).

Difficulty with executive functioning: Executive functioning refers to brain functions that are involved in metacognitive and behavioural control, including organising and planning, responding

flexibly to changing circumstances, and consequential thinking (anticipating the consequences of actions). Skills linked to executive function are involved in focusing, monitoring attention and learning. Impaired executive functioning can lead to children struggling in unpredictable and unstructured environments and having difficulty with transitions and change. As a result, they often need support from others to develop executive skills.

Enhanced threat bias: Children exposed to early adversity can develop a sensitivity to and over-react to everyday situations and events, which is seen at a neural response level but presents as an automatic 'threat bias.' The threat bias can trigger a cascade of 'fight or flight' survival responses. The enhanced bias can lead to perceiving and responding to benign or innocuous events as threatening and dangerous. This may lead to the development of anxiety disorders and avoidance behaviours (McCrory et al., 2017). Early childhood perceptions that the world is a dangerous place can affect social interactions later in life and activate fear response by people and places that bear little resemblance to the context of maltreatment (Fox & Shonkoff, 2012). Providing physical and emotional safety to children is foundational to enabling positive change through reducing the need for constant vigilance and scanning for threats.

Unstable attachment: Unstable attachment is associated with ACEs, (Miller & Klockner, 2019). Insecurely attached individuals tend to make choices in their relationships that bring out negative outcomes they fear the most and even expect. For people with an unstable attachment the blueprint for social interactions has not been set to expect stable, secure, positive interactions, but to anticipate rejection, danger, uncertainty, undermining the formation of new relationship. This is set against a longing and drive to have connection and sense of belonging, often linking them to other peers with similar life experiences that can reinforce this relationship instability. Developing secure attachment is crucial for addressing unmet needs of children who have experienced trauma and maltreatment.

It is evident that unresolved neurological, psychological, and behavioural symptoms or manifestations of trauma and adverse childhood experiences can be associated with harmful behaviour that has historically been criminalised (McLachlan, 2023). Furthermore, contact with the youth justice system tends to be criminogenic and traumatic (Baidawi & Sheehan, 2019; Lansdell, Saunders, & Eriksson, 2022). Developmental trauma is often compounded when children are criminalised and locked up (McLachlan 2023). This is set against research that has found that punitive responses to children who offend result in higher levels of criminality and less punitive responses reduce recidivism (Fowler & Kurlychek, 2018).

Current conditions of existence

It is not only the historical or past experiences of adversity that shape and determine the behaviours of children and young people. Their current conditions of existence often create environments that foster maladaptive coping strategies, ways of trying to survive in uncertainty, chaos and instability. It is important to note and consider how the current conditions of existence impact on and shape the behaviours of the child or young person and influence their expectations of change. Unstable and insecure accommodation and unpredictable environments have a profound impact on the capability to participate in therapeutic supports. It is imperative that therapeutic support includes creating environments that allow for change, creating safe, predictable and secure environments.

Model of Practice: what makes this approach 'therapeutic'?

When considering the behaviours and presenting symptoms of the children and young people outlined above, it is essential that TSP be therapeutic (McArthur 2021) – looking at and addressing

the underlying causes of the behaviours to bring about positive change. For TSP 'therapeutic' refers to approaches that have a healing or ameliorative effect. As a result, TSP takes a broad understanding of what it means to be therapeutic. There are a range of evidence informed approaches and interventions that address the presenting behaviours and underlying issues of this cohort. TSP, supported by the Therapeutic Case Management Team, will be drawing on a range of approaches that support desistance – the reduction in harmful behaviours – by addressing the underlying causes of the children and young people's behaviours in therapeutic, trauma-informed and holistic ways.

There are many common elements to the evidence informed approaches to working with the target group of TSP. The model of practice for TSP and the Therapeutic Case Management Team is informed by Positive Youth Development, Positive Psychology, Trauma Informed Practice, Dialectical Behavioural Therapy, Circles of Courage, Advantaged Thinking, and Family Systems Theory. Below is a list of some of the key elements of practice that inform the model of practice for TSP and Therapeutic Case Management Team:

- unconditional positive regard and enthusiasm for the child or young person;
- accepting, non-judgmental and non-blaming approach that can help them develop an understanding and reframe their behaviour and life story;
- build trust, rapport, modelling a secure attachment;
- foster secure and safe attachments within their ecosystem of support;
- validate emotions and experiences to develop an understanding of their behaviours and life;
- develop a sense of safety, stability and security;
- link them to people and activities that can foster positive emotions;
- develop pro-social relationships and networks;
- provide a sense of empowerment, mastery and competence;
- engage in activities that allow for psycho-social and cognitive development;
- allow choice and agency in decisions to build an internal locus of control and self-efficacy;
- create a sense of meaning, value and accomplishment;
- create opportunities to contribute to community and support others;
- involvement with parents, family, community, and culture;
- limit and structure contact with anti-social peers, managing risk but supporting interpersonal effectiveness;
- provide youth with the tools and skills, including; mindfulness, distress tolerance, emotional regulation;
- create an environment that can enables behaviour change, adopting a different identity and view of the future.

The children and young people who are referred to TSP lack access to 'things they value or need', such as a sense of belonging, connection, validation, sense of safety, peer relationships, agency and control. As a result, they find other behaviours and practices to try and achieve these goals and get access to these valued resources (Barker 2012, 2013, 2014, 2016). Children and young people who exhibit harmful behaviours have developed behaviours that serve a function, fulfilling specific needs or purposes within their life circumstances. It is important to understand the function of these behaviours, identify the need that they are trying to meet and present realistic and viable alternative ways for them to meet their needs. This includes finding alternative behaviours placing them in environments that foster and nurture successfully adopting new behaviours and, ultimately, a

different identity. It is unrealistic to expect these children and young people to just generate change, given the developmental and environmental limits. Instead, we must surround them with people and conditions that allow them to adapt and adopt new ways of being. However, this can be a slow process, and we should expect and plan for relapse, remaining vigilant in achieving our therapeutic goals.

SECTION TWO

This section provides a summary of data collected by TSP and an overview of systemic issues. These descriptive statistics provide an outline of the referrals and Active Clients. These data give an indication of the cohort that are being referred to TSP. When set against the research outlined in Section One, these data provide preliminary insight into whether TSP is working with the intended cohort. Section Two concludes with a consideration of the emerging systemic issues.

Therapeutic Support Panel: descriptive statistics

The data below covers the period of 27th March to 29th October 2024. The following provides deidentified, aggregated, descriptive statistics to analyse the main features and characteristics of the sample of referrals and clients. This allows us to examine trends and patterns of data and see how this aligns with the expectations and the intentions of TSP informed by previous research. This data does not allow us to make any generalisations or inferences to make predictions to a larger population group. Furthermore, due to TSP being in a developmental and implementation phase and the limited sample size, these data and findings should be considered with caution.

Confidentiality

The identity of a child or young person who has been referred to TSP will not be disclosed in this report. Given the small number of children and young people referred to TSP, there will at times be only small numbers of individuals that appear in a particular data category (e.g. referral source). The ACT is a small community, and individuals may be identified through the reporting of these low numbers. Therefore, where the number in a category is less than 5 and the individual may be identified, the symbol * is used to indicate presence of a number but not how many. In some categories numbers less than five cannot lead to an individual being identified and the numbers remain. Further data may be suppressed to prevent calculation of figures or cross reference to risk identifying of individuals. The suppressed numbers will remain included in total figures. Moreover, this report cannot use case studies or presenting details of any instances due to the identifiability of the data. Over time, recurring themes will allow us to discuss issues at a higher level of abstraction.

Due to the sample size and limited time the Therapeutic Support Panel has been operational, the descriptive statistics provided cannot be regarded as representative or used to infer future client profiles. We should expect statistical anomalies to misrepresent and bias the data. Therefore, this data should be used with caution to represent the scale and nature of the issues facing TSP and MACR more broadly.

Referrals received

This section presents data on the children and young people that were referred to TSP. It provides insights into the number and sources of referrals, and a snapshot of the demographics or profile of the referrals.

TSP has received a total of 45 referrals as of 29 October 2024. The largest number of referrals have been received from CYF (n=20), followed by ACT Policing (n=10) and Education (n=6). Table 1 shows the number referrals from different sources that are greater the five.

Referral source	Total
Child, Youth and Family Services	19
ACT Policing	10
Public Advocate	*
Education	6
CAMHS	*
SYRS	*
ISRP	*
Family/community	5
TOTAL	**45**

Table 1: number of referrals by source

Table 2 shows the number of referrals from March to October 2024 by month. To date there has been a relatively steady number of referrals. As can be expected with a new service, it takes time for external agencies and the community to became aware of the service, to clarify the referral pathway and to develop their own internal processes to enable referrals. As such, for March and April referrals only came from CYF, the Public Advocate and Integrated Service Response Program (ISRP). The first referrals from ACT Policing were received in May after it had clarified its internal processes. Similarly, referrals from Education were first received from June.

	March	April	May	June	July	Aug	Sept	Oct	TOTAL
No. of referrals	5	5	5	7	8	5	8	2	45

Table 2: number of referrals by month

Action / determinations of referrals

Table 3 outlines what course of action was taken with the referrals that have been received. As of 29 October, TSP was actively working with 24 clients, 10 had been 'referred on and closed at intake', 8 were in 'Active Monitoring', and 3 were still being screened through the intake process.

Client type following intake	Total
TSP lead worker	7
Collaborative Care – on orders with CYF	10
Collaborative Care – in community (no orders)	7
TOTAL ACTIVE CLIENTS	**24**
Active Monitoring	8
Closed and referred at intake	10
Intake assessment (TBD)	3
	45

Table 3: action taken with referrals

The referrals that were 'closed and referred at intake' were assessed to have adequate support in the community, able to be matched with more appropriate services, or did not meet the inclusion criteria by virtue of age (over 18 years of age). Referrals that were put into 'Active Monitoring' were assessed as requiring ongoing monitoring to see if their needs were being met or if the situation had changed and required further action.

Demographics of referrals

The following data provides an overview of the demographics of all clients referred to TSP. It is important to note that at the time these data were captured the minimum age of criminal responsibility was 12 years of age. There were less than 5 referrals for children under 12 years of age. Just under 50% of referrals have been for children and young people under 14 years of age.

	All referrals
Average age at referral	13.47
Max age	16 yrs
Min	8 yrs
Under 12 yrs	n = *
Under 14 yrs	n = 22
Over 14 yrs	n = 23

Table 4: age profile of referrals

Gender	Total
Female	21
Male	24
Other	0
	45

Table 5: gender of referrals

Across the months the number of referrals for males and females has varied. In the first initial months there were significantly higher numbers of females. This has evened out over time and may be linked to the referral sources diversifying over time.

Culture / Ethnicity	Total
Aboriginal and/or Torres Strait Islander	14
Culturally and Linguistically Diverse	9
TBC	2

Table 6: cultural background/ethnicity identity of referrals

Approximately 30% of referrals to TSP are for Aboriginal and/or Torres Strait Islanders children and young people and 20% are identified as culturally and linguistically diverse.

Active Clients

TSP has accepted 24 clients as Active Clients as of 29th October 2024. This section provides an overview of demographics of TSP clients and the presenting issues.

The following data has categories that are yet to be confirmed (TBC). To ensure the data presented is robust, we have not included incomplete or unconfirmed data.

Demographics of Active Clients

These data provide an overview of demographics information of the current clients accepted into TSP.

Age at referral	All Active Clients
Average age at referral	13.12
Max age	16 yrs
Min	8 yrs
Under 12 yrs	n = *
Under 14 yrs (including those under 12 yrs)	n = 13
Over 14 yrs	n = 11

Table 7: age profile of Active Clients

Less than 5 (20%) children and young people that are Active Clients are under the MACR. Thirteen children and young people under 14 years of age are Active Clients, which is 55% of this age cohort that were referred.

Gender	No.
Female	13
Male	11
Other	0

Table 8: gender of Active Clients

Culture / Ethnicity	No.
Aboriginal and/or Torres Strait Islander	10
Culturally and Linguistically Diverse	5

Table 9: cultural background/ethnicity identity of Active Clients

At the time of this report there is approximately 41% Aboriginal and Torres Strait Islanders as Active Clients.

Client Typology

Active Clients fall under three categories: Lead worker; Collaborative Care – on orders with CYF; and, Collaborative Care – in community (CYF) (for further details of the nature of the client types see Section One).

Client type following intake	No.
Lead worker	7
Collaborative care – on orders with CYF	10
Collaborative care – in community (no orders)	7
TOTAL ACTIVE CLIENTS	24

Table 10: client typology of Active Clients

The different client typologies require different forms of support from TSP. Moreover, different clients require a different amount of support depending on their support needs and the phase or stage of work. It will be important to continue to monitor this data to ascertain what is a sustainable and effective case load.

Presenting issues

These data provide an overview of the presenting issues and factors impacting the lives of current clients. These data can provide us with some insight into the complexity of TSP clients and see if they fit our expectations of the cohort based on previous research.

Eight key factors or domains are addressed below; (1) Police contact, (2) educational engagement, (3) mental health diagnosis, (4) confirmed disability, (5) trauma, (6) involvement with CYF, (7) housing status, and (8) alcohol and other drug use. Each of these domains represents a risk factor or vulnerability. There is a focus in this report on risk factors and vulnerabilities with an eye to examining if the risk profile and complexity of the client group aligns with the expectations of the cohort outlined in previous research – those at significant risk of significant harm. It is important to note that this emphasis on risk factors does not reflect the approach that TSP takes in its practice with children, young people and their families.

Police contact

More than 85% of the Active Clients had contact with the police prior to their involvement with TSP. Less than 5 of the clients had no police involvement. All the clients that had no prior police involvement were under 13 years of age. Police contact can refer to any interaction with ACT Policing. This may include a child or young person who has come to the attention of police due to concerns in the community, police attending to an incident, or where police have ongoing concerns regarding a young person's behaviour.

Educational Engagement

Less than 5 of TSP clients were regularly attending education. Eleven of the clients were not attending school at intake. Approximately 70% of Active Clients were disengaged from education (either partial or not attended school).

Attending	*
Partial attendance	6
Not attending	11
TBC	*

Table 11: educational engagement for Active Clients

Mental Health Diagnosis

Half of the current clients have a mental health diagnosis. This does not suggest that they are receiving treatment for their condition. Moreover, those without a diagnosis may, of course, have a mental health issue that has not been diagnosed.

Current mental health diagnosis	12
No diagnosis	12

Table 12: mental health diagnosis fort Active Clients

Disability

This table outlines the number of clients with confirmed disability. 45% of the clients had a confirmed disability. It should be acknowledged that there are several clients with suspected disabilities that are yet to be confirmed.

Confirmed disability	11
No confirmed disability	13

Table 13: confirmed disability for Active Clients

Trauma

All the current clients have experienced trauma. Most clients have *complex* trauma – exposure to repeated and multiple traumatic, often interrelated events. The trauma histories include family violence, neglect, parental conflict, physical and emotional abuse, sexual abuse, parental substance misuse, serious/persistent family conflict, parental mental health issues, and cumulative harm. Notably, it has been confirmed that 20 of the 24 Active Clients have experienced family violence.

The complex histories of exposure to trauma at referral aligns with the previous research regarding the links between criminal justice involvement and adverse childhood experiences. However, our cohort to date have higher rates of significant trauma than expected. This may be explained by the high rates of referral from CYF and police. As we start to receive more early intervention referrals and more referrals from the community and education we may see an increase in clients with less complex trauma.

Child Youth and Family Services involvement

Table 14 outlines the CYF involvement for Active Clients at the time of intake assessment. As can be seen, all the clients have had some involvement with CYF, varying from: Child Concern Reports (CCR) with no further involvement; involved in family preservation response following an appraisal; closed involvement (including previous appraisals or orders), undergoing appraisal following CCR, or under current child protection orders.

Current CYF involvement for Active Clients	**No.**
Current Child Protection orders	6
Appraisal	6
Closed involvement	10
Family preservation	*
CCR with no action	*

Table 14: CYF involvement for Active Clients

Housing status

These data provide an overview of the housing status of current clients at the time of intake assessment. Housing status refers to the safety, stability, and security of accommodation.

Housing status	No.
Residing in safe, secure, and stable accommodation	13
At risk of homelessness (ongoing conflict and insecure accommodation)	*
Unstable/homeless (no safe, stable or secure accommodation)	8
TBC	*

Table 15: housing stability, security and safety

Approximately 45% of the Active Clients were at risk of or experiencing homelessness at the time of the initial intake assessment.

Alcohol and Other Drug Use

This table presents the rates of alcohol and other drug use. The nature and extent of the drug use for the children and young people varies.

Alcohol and other drug use	No.
Yes	16
No	8

Table 16: alcohol and other drug use

Complexity

When considering multiple, often interactive, risk factors or vulnerabilities TSP clients are complex and complicated. Examining the 8 risk factors/vulnerabilities addressed above the current clients have on average 5.58 of these risk factors/vulnerabilities. The most frequent number of vulnerabilities, the mode, and the median are both 6. While the rigour of this analysis should be viewed with caution, this indicates that the clients accepted into TSP are facing high levels of vulnerability. Considering this only includes formal diagnosis of mental health issues and/or disability and puts numerous traumatic experiences and adverse childhood events under the generic category of ‘trauma’ it is safe to infer that this data underrepresents the complexity of the needs of these children, young people, and families.

To what extent is TSP Working with the intended Target Group?

Previous research has indicated that the expected target group – children who use harmful behaviours that have previously been criminalised – have complex needs and experience high levels of victimisation and social adversity (McArthur et al., 2021; Baidawi et al. 2023; McLachlan, 2023). The research addressing the complex needs of children and young people who come into contact with the justice system highlight the following vulnerabilities and risk factors:

- High levels of trauma and adverse childhood experiences
- Disabilities (including neuro-disability, developmental impairment, FASD, & ABI)
- Disconnection from educational
- Unstable and unsafe housing
- Poor mental health and physical health
- Engaged in AOD abuse
- Exposed to family conflict, and violence
- Child abuse, neglect, child protection and out-of-home care involvement

The data on Active Clients indicates that TSP are working with the intended target population when we look at vulnerabilities and risk factors.

Children and young people involved in Care and Protection: 'Cross-over kids'

Previous research has indicated that many of the children and young people who came to the attention of police and the justice system for harmful behaviours are also involved in the care and protection system. These children and young people are often referred to as the 'cross-over kids' (Baidawi, & Sheehan, 2019) due to their involvement in two statutory systems. While the chain of causation is unclear, McFarlane suggests that once involved with police or brought before a court, children in OOHC are subject to differential treatment, with more onerous and complex bail conditions and high levels of surveillance that can lead to an increased risk of bail denials, breaches and custodial episodes (McFarlane 2015).

At the time of capturing the data for this report, 44% of the referrals have come from CYF. All the accepted clients have had some previous involvement with the care and protection system, varying from Child Concern Reports with no further action through to clients on current child protection orders (see Table 14). 25% of the Active Clients were on current child protection orders and 25% were being appraised at the time of referral. These data are in line with rates expected based on previous research.

It will continue to be important for TSP to work collaboratively with CYF and continue to clarify the different roles and how to best meet the needs of the children and young people with whom we work.

Aboriginal and Torres Strait Islander children and young people

Previous research has indicted that the Aboriginal and/or Torres Strait Islander population has been overrepresented in the juvenile justice systems (McArthur et al., 2021; Baidawi et al., 2023). As such, TSP are expecting a similar overrepresentation. At the time of this report 41% (n=10) of the Active Clients are Aboriginal and/or Torres Strait islander and approximately 30% (n=14) of referrals to TSP.

TSP will continue to develop relationships with ACCOs and the Aboriginal and Torres Strait Islander community to identify ways TSP can meet the needs of the community by drawing on the cultural expertise and lived experience of the Aboriginal and/or Torres Strait Islander members. We will prioritise cultural safety and provide culturally appropriate and respectful support and services to

Aboriginal and Torres Strait Islander children, young people and their families, kin and communities through a range of considerations, guided by community and alongside ACCOs wherever possible. It is necessary for TSP to build and maintain relationships with the Aboriginal and Torres Strait communities in the ACT and surrounding areas to provide opportunities to seek their expertise, knowledge, skills and advice. To become a culturally competent service will require an ongoing effort. Most importantly, we aim to demonstrate respect through the actions of TSP.

Systemic issues

The following section briefly addresses some of the emerging systemic issues. Due to the early stage of development and implementation it is difficult to be unequivocal about findings and recommendations. As such, the system issues discussed below are preliminary and highlight emerging issues.

Intensive Therapy Orders (ITO)

Due to reasons of confidentiality and privacy we are unable to talk about the operations of the ITO. However, it has been identified that the ACT will need to strongly consider the development of a therapeutic facility or a Therapeutic Protection Place. The existence of a safe 'home like' accommodation that is therapeutic in its design will be important to enable the use of ITOs for the safety and wellbeing of the children and young people and the community. While research in this area is in its infancy, we need safe therapeutic accommodation that learns from previous examples and research (Bowles 2014a & 2014b; Crowe 2024).

Engagement and service readiness

Due to the past experiences of the TSP target group, the children, young people and families with whom we work, often express and demonstrate reservation in engaging with support services. This cohort are often considered as 'hard to reach' or 'hard to engage', however this characterisation misrepresents the issues and problematises or blames the children and young people rather than the systems and services. As addressed in Section One, the TSP target group have often experienced adversity and trauma that has led to enhanced threat bias. The perception of threat often extends to and includes services and supports. This is often exacerbated by past service experiences, and perceptions that they may be let down or dealt with in a punitive manner. As such, the TSP emphasises the need to create service readiness and having a dedicated engagement phase in our work.

Service readiness refers to flexibly responding to the needs of the child or young person, as well as building the child or young person's readiness. This involves active efforts to engage and develop trust and rapport. Developing trust and rapport can take a significant amount of time and is achieved through being predicable, consistent, flexible, and by listening and responding. It is also paramount that the TSP explicitly reiterate our role – to address the unmet needs of the children and young people referred to us. Achieving this necessitates understanding the child or young person's perspective, their wishes and needs. Hence, the first phase of support is Engagement and Readiness, where the aim is to develop a relationship with the child or young person, clarify expectations, and begin to build a sense of hope for change and motivation.

Education

Disengagement from education is a key vulnerability for our clients, consistent with previous research. Approximately 70% of our clients were disengaged from education, with either partial or no attendance. There are limited resources and capacity restraints of existing programs to currently create individualised education engagement opportunities for children and young people that cannot

be catered for within existing flexible education options due to a range of complex factors. It will be important to explore how we can support the development and increase the capacity of education to meet the needs of our cohort.

Alcohol and other drug services

There is currently a gap in alcohol and other drug (AOD) supports for the children and young people that come to the attention of TSP. AOD misuse is common amongst the target group of TSP, however, it is hard to find outreach-based support for children under 14 years of age. We need a proactive, outreach-based support that can provide services to children, young people and their families in the community to meet their AOD needs.

Disability

Based on previous research it is predicted that many of the clients of TSP will be living with disability. Current data shows 45% of Active Clients have a confirmed disability, however this is likely an underestimation. There is a paucity of supports and assessment that can be used to identify and respond to the needs of TSP clients. This is further complicated by the shifting landscape of the disability sector and NDIS. There is a lack of clarity regarding the future of supports for children and young people living with disability. Moreover, there are specific areas of concern, such as foetal alcohol spectrum disorder (FASD) and autism spectrum disorder (ASD) which lack adequate service response and supports.

Autism spectrum disorder (ASD) is a very common diagnosis and often identified as a potential issue impacting the lives of the children and young people that come before TSP. Numerous clients present with symptoms that have been or could be identified as ASD but also overlap with the impact of developmental trauma. As a result, there can be a lack of clarity regarding the diagnosis and therefore the domain or field of responsibility and, in turn, provision of support and resources.

Mental Health

While 50% of the Active Clients have a diagnosed mental health issue(s), several other children and young people are suspected of having mental health issues. However, the symptomology of trauma, ASD and mental health issues overlap, with presenting behaviours able to be attributed to a range of diagnoses or explanations. It is not unusual for TSP clients to have a multitude of diagnoses. The diagnoses can inform who is responsible for the provision of support and resources. It can also determine the eligibility of support or access to treatment. Navigating these systems has a very tangible impact on the lives of our clients.

The inaccessibility and gaps in the mental health system in the ACT for children and young people are well documented (Office of Mental Health and Wellbeing et al 2022). However, for the cohort supported by TSP, these gaps are even more pronounced. The overlap between symptoms of trauma and mental health issues continue to create a barrier to the access of support. Moreover, the children and young people that present to TSP are often resistance to support. However, mental health services need to develop service responses that meet the needs of this cohort. This aligns with the commitment and intention of creating a stepped model of care - a person-centred, evidence-based approach to mental health care that matches the intensity of services to the individual's needs. Furthermore, consideration of the social determinants of health – the non-medical factors that influence health outcomes and address the conditions of existence more broadly – and social prescribing – identifying people’s non-medical health needs and connecting them with relevant community services – would logically entail either providing different services or working collaboratively with other sectors.

Collaboration

The target cohort of TSP have complex needs. Notably, the overlapping presentations of trauma, mental health issues, and alcohol and other drug use are very common. While the chain of causality is difficult to unpick, rarely is it easy nor useful to identify one cause or primary presenting issue when developing a therapeutic response. They are often deeply interdependent, and we need to address each of these issues as best we can. However, barriers exist to access services for our cohort. Our clients are often 'hard to engage' and the services are 'hard to access' – with both formal and informal barriers in place. However, these children and young people are arguably some of the most in-need and at-risk children and young people in the community. We need to develop ways of enabling access to support to meet their needs. Currently there appears to be debates between systems from different ideological and professional domains regarding who can or should provide support. While each domain and area of expertise should be respected for their specialised knowledge, the reality of these clients is that their needs are not siloed and the responses need to adapt to these needs, not expect children, young people, and their families to fit into clearly defined categories.

Referral Pathways

The efficacy of any program is contingent on receiving referrals. TSP will continue to work with key stakeholders to increase awareness and improve referral pathways and processes. However, the internal processes of our stakeholders to recognise and authorise referrals can create a barrier to timely referrals. While there is some merit in ensuring that the referring entities outlined in the legislation have done all that they can for these clients before referring them, it is the role and expertise of TSP to assess and support therapeutic approaches are embedded in practice across service systems and supports. It will be important to monitor the flow of referrals and identify any barriers to receive the relevant referrals that will allow TSP to play the key operational and systemic role that it is intended to achieve.

Outputs of the Multi-disciplinary Panel

The Multi-disciplinary Panel (the Panel), after which the Therapeutic Support Panel gets its name, met for the first time on 27 March 2024. The Panel has regular meetings every 2 months and can be called to meet regarding in-depth discussions for individual clients on a case-by-case basis. The format and processes for these meetings continue to evolve and change as we trial different approaches.

The Panel has met 5 times for regular meetings – March, May, July, September, and November. In these meetings all the new referrals and decisions were brought before TSP for review. The Chair and Therapeutic Case Management Team provided an update on Active Clients, with a focus on the clients for whom we need to seek the advice of TSP or to update on previous recommendations and progress. Advice, feedback and questions are provided by the Panel for consideration and actioning by the Chair and Case Management Team.

The Panel also discuss systemic issues, identifying recurring themes, patterns and service/support gaps. This allows the Panel to have both an operational and strategic role, identifying needs and overseeing the supports provided to individuals and the collective need of the community more broadly, facilitating the provision of advice to the government and community.

The Panel has held numerous meetings regarding individual clients. These meetings allow for the Chair and Therapeutic Case Management Team to seek the support and advice regarding an individual child or young person. The Panel is given more detailed information pertaining to the

client to be discussed. Members are given the opportunity to ask questions of the professionals involved, as key stakeholders and members of the care team are invited to participate where safe and appropriate. The Panel can provide advice and support regarding the client. The Panel can make recommendations, including recommending an Intensive Therapy Order (ITO).

Stakeholder Engagement

A key part of creating a functioning and effective service and supports is to ensure we are fitting into and working within the broader service systems and ecosystem. This involves awareness raising and sharing information about our service and approach, making people aware of what we do. It can involve attempting to shift assumptions, address concerns and attitude change. It also includes listening to and negotiating ways of moving forward to meet the needs of the children and young people, and their families we work with and for.

The first eight months of TSP has involved meeting with stakeholders to introduce them to the role of TSP. Some of the key stakeholders we meet with regularly, including ACT Policing, Marymead Catholic Care Canberra & Goulburn as service providers the Safer Youth Response Service pilot, Child Safety, Youth justice, Targeted Support (Education), and Public Advocate and Children and Young Persons Commissioner. Stakeholder engagement requires constant effort to build a system and collaborative relationships. We appreciate the time and advice they generously provide us. Below is a list of external stakeholders who have been engaged and presentations that have been delivered:

- Victims of Crime
- ACT Policing
- ROMART
- Marymead CatholicCare Canberra & Goulburn (MCCG) – Safer Youth Response Service (SYRS)
- Strategic Policy – CSD
- Child Safety – CYF, CSD
- Intensive Adolescent Support Service (IASP)
- Public Advocate & Children and Young People's Commissioner
- Targeted Support - Education
- Catherine Rule – DG CSD
- Youth sector – Youth Coalition of the ACT
- Child and Adolescent Mental Health Alliance Monitoring and evaluation
- Child and Family Reform Ministerial Advisory Council Meeting
- CSD & Community Sector Update Meeting
- Flexible Education
- Restorative Justice Unit
- Melaleuca Place
- Capability Support
- Senior Leaders Forum
- MacKillop Family Services
- Integrated Service Response Program (ISRP)
- NT Children and Young People Advocate
- Disability Justice Community of Practice
- Dr Susan Baidawi & Dr Benjamin Spivak – Monash University
- Dr Hayley Boxall – ANU School of Criminology
- Bimberi Oversight Group

- Security and Emergency Management Division (SEMD)
- Budget Estimates Hearing – Child Youth and Family Services
- Justice Advisory Group Meeting
- NDIS ACT Disability Sector Quarterly Forum
- Strengthening Practice Committee Meeting
- Launch Event – Phase 2 of the Reducing Recidivism by 25% by 2025 (RR25by25) Plan
- 'Help way earlier!' How Australia can transform child justice to improve safety and wellbeing
- ATODA Executive Meeting
- Justice Policy Partnership
- ACT Together
- ANU Sociology/Policy at ANU
- CYF Showcase
- Australasian Youth Justice Conference
- Magistrate Jennifer Bowles
- Carer Wellbeing Joint Committee
- Australasian Youth Justice Administrators (AYJA)

Aboriginal and/or Torres Strait Islander Services and Supports

TSP has met with a range of Aboriginal Community-Controlled Organisations (ACCOs) and other services, supports or mechanisms that promote and aim to address the support needs of the Aboriginal and Torres Strait Islander community. We are grateful for the invaluable expertise and guidance provided by Aboriginal and Torres Strait Islander people, including our Panel members. Their contributions deeply enrich our understanding and approach. Below is a list of services and mechanisms that TSP have met with to date:

- Aboriginal Co-Design Network
- Aboriginal Service Development Branch (ASD)
- Sisters in Spirit Aboriginal Corporation
- Yerrabi Yerwang Child & Family Aboriginal Corporation
- Gugan Gulwan Youth Aboriginal Corporation
- Worldview Foundation
- Yurwan Ghuda
- First Nations Family Response and Engagement Team

CONCLUSION

We are part of creating something new. We are leading the way in Australia to develop an integrated system to raise the minimum age of criminal responsibility to provide some of our most vulnerable children and young people with positive opportunities and to improve community wellbeing. This will involve challenges. However, what we do know is that the previous system did not work, we saw it for ourselves, and we have seen the evidence. While it is still early days, we are travelling in the right direction.

It is clear from the demographic data that the TSP is working with the intended target group – children and young people with complex needs at risk of or engaging in harmful behaviours. While we are still in the developmental and implementation phase of this program, the model of practice that we are progressing matches the needs of this cohort. Positive change is incremental, rarely linear and not without challenges. Nevertheless, we are beginning to see signs of positive change. Change in systems, practice and, most importantly, in the lives of the children and young people with whom we work.

The systems and services we work within are adapting to the new legislative and service environment. We will need to continue to be diligent in building and maintaining relationships with the sector and community. Collaboration is essential. As seen in the research and in the profile of the current children and young people with whom we are working– their lives are complex and are shaped by multiple and interconnected challenges affecting their wellbeing. To address this requires the knowledge, skills and supports across numerous domains to work together and be unified in their purpose whilst also flexible and responsive. This can only be achieved through good communication directed by shared goals. Navigating siloed systems remains a key focus for the TSP.

We are excited moving into 2025. We will continue to develop and refine our approach as to how to meet the needs of the children, young people and families. With the support of and in partnership with community we are progressing towards a positive future for our children and young people, families and the community more broadly.

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