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Therapeutic Support Panel for Children and Young People 2025 Report

Presented by
Michael Pettersson MLA
Minister for Children, Youth and Families
October 2025

THERAPEUTIC SUPPORT PANEL FOR CHILDREN AND YOUNG PEOPLE 2025 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 Families
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 2025 Report*.

This report fulfils the Panel'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
26 September 2025

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Tables and figures

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
HCSD	Health and Community Services Directorate
CYF	Child Youth and Family Services, including child safety, intake, family response and engagement and family preservation
DCJ	Department of Communities and Justice (NSW), government agency including child protection
ISRP	Integrated Service Response Program
ITO	Intensive Therapy Order
ITP	Intensive Therapy Place
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 Support Team
TST	Therapeutic Support Team

Preface

The ACT continues to lead the way in Australia in raising the minimum age of criminal responsibility (MACR). This was a two-staged process, commencing with a minimum age of 12 years in November 2023 and increasing it to 14 years on 1 July 2025. This report reflects on the first phase. While the minimum age was 12 years of age during the time addressed in this report, the phased approach allowed us to work with older children and young people (up to 18 years) to develop our processes and models of practice and to prepare for the age to be raised to 14 years. This also allowed for a smooth transition on 1 July 2025.

This first phase, with the age raised to 12 years, unfolded much as expected. As outlined in the research that informed these reforms, there was a relatively small number of children under the age of 12 engaging in, or at risk of engaging in, significantly harmful behaviours. Moreover, as expected, these children had a complex array of unmet needs that caused or contributed to these behaviours. Identifying and responding to these needs led to positive changes in their behaviour and lives.

The most notable and important first outcomes include successfully engaging with and developing a rapport with the children and young people and better understanding the underlying causes of the behaviours to inform how we can better support them. Again, as outlined in the research, our clients have complex needs and histories of adversity; they truly are some of the most vulnerable members of our community. By better understanding the conditions of their lives we not only match them with supports but it helps people see them as more than just their behaviour.

Many of the children at the heart of these reforms have struggled to find some sense of control of their lives—lives that can appear and feel out of control. Under adverse conditions, they develop ways of coping that helped them survive, but these behaviours often described as maladaptive, over time expose both themselves and others to risk of harm. The need for some sense of control or agency, of an ability to look after themselves, often undermines or reinforces their vulnerability, putting them at further risk. However, despite these often-habituated responses and strategies, we have seen these children and young people create stable attachments with safe adults and reflect on their lives. While some maintain a facade of bravado and defiant independence, they often start to engage in positive pro-social activities and supports. We see positive shifts in their behaviour and in their identity.

Success and change are non-linear. The complexity of their lives does not disappear, so we expect and plan for relapse and challenges. We support the children, young people and their families to function in an imperfect world and learn to deal with less-than-ideal conditions. This can be a complex, long-term process that is not a single or simple event, referral, assessment or plan. Rather, it is a process and journey that unfolds over time. Yet, despite this, I am often surprised at the positive changes we see in the children and young people with whom we work; many of them seem so responsive to the introduction of positive changes to their lives.

In the last six months since the last report, the Therapeutic Support Panel for Children and Young People has consolidated its workforce, further strengthened relationships with key stakeholders and continued to develop and improve our practice and processes. The Panel and the Therapeutic Support Team continue to grow and develop, strengthening how they function. However, this will continue to be an ongoing evolution and change as we endeavour to continually improve our practice.

These reforms involve developing a new system of supports and building knowledge and capability across the ACT. Key stakeholders have responded to the changes and embraced the opportunity to

provide alternative supports. ACT Policing have become our largest referrer and meet with us regularly to help identify children and young people that they and the community are concerned about. Services in the community appear keen to adapt their practice and find ways to respond to the needs of our cohort. However, given the early stage we are at, we will need to continue to monitor and identify areas for growth, change, and support within the community. While it remains too early to make unequivocal recommendations, emerging themes have developed into hypotheses of changes that we need to explore further to provide more robust findings that identify viable recommendations for the ACT context.

The ACT community and government are to be commended for following the research and supporting the development of an alternative response. I remain optimistic at the early signs of success and positive reception from the community to embrace a therapeutic approach to support our most vulnerable children and young people.

Dr Justin Barker
Chair of the Therapeutic Support Panel
September 2025

Introduction

On 1 July 2025, the ACT became the first jurisdiction in Australia to raise the minimum age of criminal responsibility (MACR) to 14. The cornerstone of these reforms has been the establishment of the Therapeutic Support Panel for Children and Young People (TSP), which commenced operations in late March 2024 after amendments to the *Children and Young Person Act (2008)*. The TSP is a statutory body that delivers, oversees and coordinates therapeutic supports for children and young people at risk of, or engaging in, serious harmful behaviours.

The TSP has both an operational and systemic role. It coordinates and provides supports to children, young people and their families to address the unmet needs and the underlying causes of harmful behaviours. This alternative approach aims to reduce harms and improve positive outcomes including enhanced community safety. The TSP also monitors and oversees the patterns of needs and identifies gaps in supports and services at a systemic level.

At the time of writing this report in July 2025, the TSP has been operational for around 16 months. While we have been working with children and young people aged under 18 years since commencing this program of supports, we are expecting that things will continue to change. Increased awareness and knowledge of the raising of the MACR may lead to an increase in referrals for children and young people under 14 years of age.

Due to the timing of commencement of the TSP, this report was written only 6 months after the 2024 report. During this time, we have continued to see ongoing improvement in how the services, system and supports can work together to response to the needs of the children and young people referred to the TSP. While still in development and needing to identify and respond to emerging areas that need to be strengthened or gaps that need to be filled, we strive to create a service response that never stops developing and undergoing continuous improvement. This endeavour requires ongoing reflection, communication, and willingness to adapt.

This report provides an update on the implementation of the Therapeutic Support Panel as it moves into its second year of operation. It begins with an overview of referrals and active clients, to examine the demand, needs of the target population and the degree to which the TSP is working with the intended target population. The report then provides an outline of the preliminary outcomes, followed by key systemic issues that have emerged, noting recommendations and ways forward. Finally, we discuss stakeholder engagement, which continues to be a key part of addressing the needs of complex clients.

Components of the Therapeutic Support Panel

There are three overlapping components that work together to fulfill the functions of the TSP: the Chair of the TSP, the Panel itself and the Therapeutic Support Team.

Chair of the Therapeutic Support Panel

The Chair manages and oversees the legislated functions of the TSP, including both the Panel and the Therapeutic Support 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 Health and Community Services Directorate (HCSD) about the operations of the TSP. The Chair's role is both operational – overseeing and coordinating the support provided to children, young people, and families referred to the TSP – and systemic – driving change by 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.

The Therapeutic Support Panel

The Panel supports the functioning of the broader elements of the 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, assisting 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 (ITO) should be made.

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

The Panel consists of the Chair (as described above) and other members appointed by the Minister for Children, Youth and Families. It 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
- 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 the TSP.

The current members of the Panel are:

- Dr Justin Barker (chair)
- Victoria Bradley
- Selina Walker
- David Witham
- Dr Bronwen Phillips
- Dee-Ann Brown

- Lisa Dempsey
- Zakia Patel
- Dr Alison Gerard
- Cara Jacobs
- Dr Hayley Passmore

The Therapeutic Support Team

The TST operationalise and deliver the supports provided to children, young people, and families referred to the TSP. This includes:

- receiving and responding to referrals
- intake and screening
- assessments
- developing therapeutic support plans
- case coordination
- casework
- individual advocacy
- referrals
- transition planning
- collaborating with and supporting key stakeholders.

The work of the TST is underpinned by a therapeutic approach that aims to have a healing effect by addressing unmet needs, treating the underlying causes of behaviour and achieving positive outcomes and growth, rather than just address harmful behaviours (Barker 2024). The TST consists of a Team Leader and three Therapeutic Case Managers. The TST and the Chair have weekly assessment meetings to review referrals, allocate work, evaluate intake and screening and provide group reflection and support for practice.

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 *the 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. The TSP includes the Chair of the Therapeutic Support Panel (*the Chair*), the Therapeutic Support Panel (*the Panel*), and the Therapeutic Support Team (*TST*).

Operations of the TSP

For the TSP, *therapeutic support* refers to approaches that have a healing effect: treating the underlying causes and 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 their families need support to create safe, stable predictable conditions in their lives that enable them to build a sense of belonging, self-worth and 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.

For further details on the model of practice see *Therapeutic Support Panel for Children and Young People 2024 Report* (Barker 2024).

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: accept referral; active monitoring and referred on and closed at intake. All decisions made regarding referrals are reviewed at the weekly assessment meetings and 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 (see Appendix 1 for detailed description). 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 three primary typologies of support for accepted clients:

- lead worker
- collaborative care – on orders
- 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.

In addition to these typologies of support, the TSP also provides 'active monitoring' for children and young people who are considered to already have supports and services that match their needs. This is often assessed by meeting with professionals and/or care teams. However, TSP may deem it prudent to continue to monitor children and young people to see if their needs are being addressed or if the risk of harm increases.

Therapeutic Support Panel: descriptive statistics

The children and young people who are referred to the TSP often have complex needs and require different types of support. This case file analysis, uses deidentified and aggregated descriptive statistics to show the main features and characteristics of all the children and young people who have been referred to the TSP since it was established in March 2024. It will focus on those children and young people who became what we call 'active clients'.

Although we cannot make any generalisations or predictions based on the current case file analysis, we can look for patterns or trends to see whether these were what we expected to find based on past research. We need to be especially careful about predicting future demands on the TSP because the age of criminal responsibility was recently increased from 12 to 14 years on 1 July 2025. It is likely this age increase will see a rise in the number of young people, especially those aged 12 to 14 years, referred to the TSP.

The data below were captured on 30 June 2025 and include data since the beginning of TSP on 27 March 2024, when the minimum age of criminal responsibility was 12 years.

Confidentiality

The identity of a child or young person who has been referred to the TSP will not be disclosed in this report. Because the ACT is a small community, and given the low numbers of children and young people referred to the TSP, when there is a small number of individuals in a category (e.g. referral source), there is a risk that the individual(s) can be identified. Therefore, where the number in a category is less than 5 and the individual may be identified, the symbol * is used instead. The * means there is a small number present, but the exact number will not be shown. In some categories, numbers less than five cannot lead to an individual being identified and the numbers are included. Further data may be suppressed to stop calculating or cross referencing of the numbers that risk identifying individual children and young people, but the suppressed numbers will still be included in the totals. While some case numbers in this report will need to be suppressed, future reports using larger case numbers may show recurring themes and allow us to discuss more issues and in further detail.

Due to the small sample size and limited time that the TSP has been operational, the descriptive statistics provided cannot be regarded as representative or used to infer future client profiles. We should expect statistical anomalies will misrepresent and bias the data. Therefore, these data should be used with caution to represent the scale and nature of the issues facing the TSP and MACR more broadly. Where possible we have provided some narrative to help understand the statistics presented.

Referrals received

The TSP had received a total of 93 referrals as of 30 June 2025. The main referrer to TSP was ACT Policing (26.9%) followed by family/community/other (24.7%) and CYF (22.6%). Further details can be seen in Table 1.

Table 1: Number of referrals to the Therapeutic Support Panel by source

Referral source	Number (%)
ACT Policing	25 (26.9)
Family/community/other	23 (24.7)
Child, Youth and Family Services	21 (22.6)
Education	10 (10.8)

Public Advocate	*
Children's courts	*
ACT Health/CAMHS	*
SYRS	*
ISRP	*
IAS	*
TOTAL	**93**

Figure 1 shows the rate of accepted referrals. For the first half of 2025, the TSP received an average of 7.2 referrals per month, which is a slight increase from the 2024 average of 5.0 for the 10 months the TSP was operational. Over the 16 months of operation, there was an average of 5.8 referrals per month.

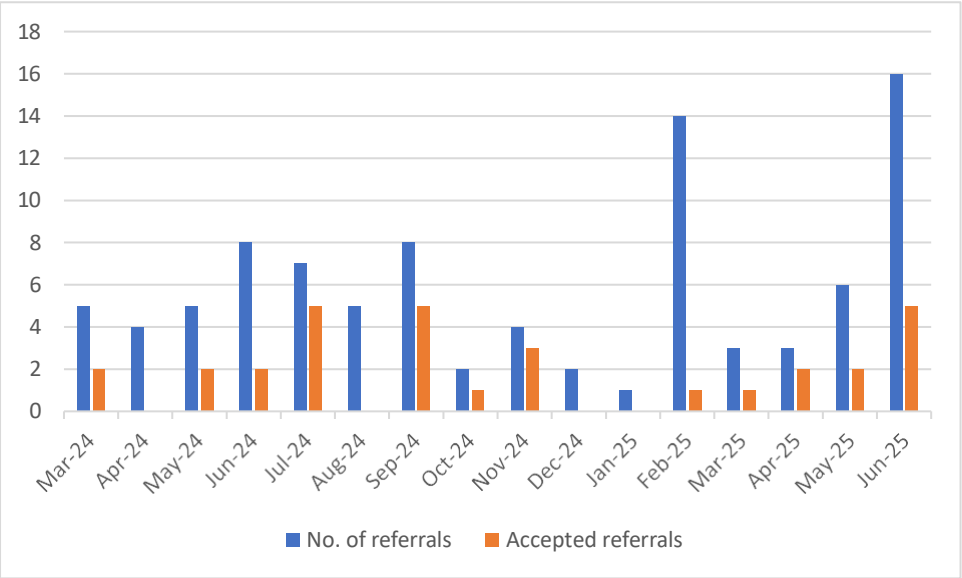

Figure 1: Rate of referrals to TSP

When the MACR rose to 14 years on 1 July 2025, there was increased visibility of the TSP in the media and more discussion with key referrers, particularly, ACT Policing. This increase in public profile may have led to the spike in referrals for June 2025 that, although not captured in these data, continued into July and August 2025. We will keep monitoring the number of referrals since raising the MACR to better understand the scope of referrals and demands being placed on the TSP. As such, with the existing data, it is difficult to predict future demands on the TSP, and the associated service landscape.

The increase in February may be due to children returning to school. As TSP was not in operation until March 2024 and this is the first return-to-school referral period, this assumption can be tested in the 2026 report.

Action / determinations of referrals

As of 30 June 2025, the TSP had accepted 45 (48.3%) of the 93 referrals as 'active clients' and were still working with 31 active clients, as 14 previously active client cases had been closed. Of the 31 active clients, 17 (54.8%) were determined to need TSP as the 'lead worker'; 9 (29%) were supported as 'collaborative care-on orders'; and 5 (16.1%) were 'collaborative care-in community (no orders)'.

Of the 48 referrals not accepted into the program, 44 (91.6%) were 'referred on and closed' because they had adequate support in the community, they could be matched with more appropriate services, or they were over 18 years of age. Three referrals were placed on 'active monitoring' and one was still to be determined at the time of data collection.

Demographics of referrals

Just over half of the referrals (n=49, 52.7%) were children under 14 years of age, with 13.05 the average age. Just under 1 in 5 (n=17, 18%) were under 12 years. There were more referrals for males (n=55, 59%) than females (n=38, 41%). Approximately 30% of referrals to the TSP were Aboriginal and/or Torres Strait Islander children and young people, and 14% were culturally and linguistically diverse.

Children under 10 years of age

Despite the formation of the TSP being a response to raising the MACR to 14 years, the TSP receives referrals and provides support for children under 10 years of age, which was the MACR prior to these reforms. At the time of this report 7.5% of referrals were for children under 10 years. Having a systematic response for children under 10 is an important part of these reforms that is rarely discussed. These referrals allow us to match these children with appropriate supports and provide early intervention for a cohort that did not previously receive a coordinated response and/or would be vulnerable to criminalisation at a later stage.

Most referrals to the TSP (68.8%) were for children and young people with no current orders in place with Child Safety (care and protection). Just under 30% of referrals were for children and young people with existing orders in place: 19.4% (n=18) were in sole care of the DG; 7.5% (n=7) had shared parental responsibility; and less than 5 were on orders with Department of Communities and Justice (DCJ).

ACT Policing referrals

Throughout the period of this reporting, the TSP met with ACT Policing fortnightly to discuss any emerging issues, provide and receive updates on supports being provided, and to facilitate any referrals where necessary. From June 2025, in preparation for raising the MACR to 14 years, these meetings increased to weekly.

As described earlier, ACT Policing are the leading source of referrals to the TSP, and referrals come through several avenues and communication and awareness of TSP within ACT Policing continues to improve.

At the time these data were captured, 27% of all referrals were sourced from ACT policing (n=25). Of these referrals, 56% were under the age of 14 years (n=14). More than a third (36%) of the referrals (n=9) were Aboriginal and/or Torres Strait Islander children and young people. Of the children referred to the TSP who were under the age of 10 years, 5 of the 7 referrals came from ACT Policing.

More than half (56%) of the police referrals were accepted as active clients. At the time of this report there were 8 current active clients who came from police referrals, 5 of whom were under 14 years of age.

Active clients

Active clients fall under three categories: lead worker, collaborative care – on orders with CYF or collaborative care – in community (CYF). The different client typologies require different forms of

support from the TSP. Different clients also require different amounts of support depending on their needs and the phase or stage of work. The majority of active clients (70.9%) had no Child Safety orders in place upon intake.

The TSP has accepted 45 active clients since March 2024 and is actively working with 31 clients as of 30 June 2025. To ensure the data presented are robust, we have not included incomplete or unconfirmed data in the following analyses.

Demographics of all active clients

Of the 31 active clients, 13 identified as female and 18 identified as male.

The age of children and young people at the time of referral ranged from 8 to 16 years, and the average age at referral was 12.25 years. Table 2 shows the breakdown by age range.

Table 2: Age profile of active clients

Age at referral	Number of active clients
Under 12 years	9
12-13 years	16
14 and over years (over MACR)	6

Table 3 provides the 'current' age profile of active clients (age on 30 June 2025). The age range was 9–17 years with an average of 12.84. At the time these data were captured, 6 (19%) children and young people who were active clients were under the MACR (12 years) and 21 (67%) of active clients were under 14 years of age.

Table 3: Current age of active clients at time of report

Current Age	Number of active clients
Under 12 yrs	6
12-13 years	14
14 and over years (over MACR)	11

The TSP has made an explicit focus on triaging and prioritising clients under 14 years in the lead up to raising the MACR on 1 July 2025. Since our last report at the end of 2024, we have seen an increase in the proportion of active clients under the age of 14 years and a decrease in the average age of active clients, with 25 of the 43 referrals (58%) made since January 2025 being under the age of 14 years.

Aboriginal and Torres Strait Islander Children and Young People

At the time of this report, 38.7% (n=12) of active clients were Aboriginal and/or Torres Strait Islander children and young people, which was higher than the proportion of referrals who identified as Aboriginal and/or Torres Strait Islander. The acceptance rate is consistent with research which documents that Aboriginal and/or Torres Strait Islander peoples, families and communities face more significant levels of marginalisation, criminalisation and disadvantage on account of historical and ongoing policies/practices of colonisation (ALRC, 2018). This research also highlights a lack of culturally safe, proportionate and accessible services to address unmet need and the integral nature of cultural supports to build connection to identity and culture as a source of wellbeing (Krakouer et

al, 2018). The successful engagement of Aboriginal and/or Torres Strait Islander children and young people in the TSP is encouraging, given this engagement is voluntary. The TSP values the contribution of Aboriginal and/or Torres Strait Islander panel members who can provide advice on enhancing the cultural safety of children and young people, families and communities involved in the program.

Culturally and linguistically diverse children and young people

TSP has expertise embedded within its membership upon which advice is sought and used to enhance therapeutic support plans, linking children and young people to culturally appropriate connections, supports and services.

Demographics of active clients under MACR of 14 years

The data for this report were captured on 30 June 2025, just prior to the MACR raising to 14 on 1 July, 2025. As such, the following section outlines data specific to the cohort under 14 years of age. In line with the intentions of the phased approach, we began working with this cohort prior to the raising of the minimum age to provide an initial outline of the likely demand and needs. However, given the timing of this report, we should be cautious about using these data to predict the future demands around responding to children under the new MACR legal framework.

Table 4 shows the age profile of active clients at the time of referral and their age at the time of data collection, or 'current' age.

Table 4: Age profile of Active Clients under 14 years of age

	Active clients under 14 yrs (at referral)	**Active clients currently under 14 yrs (3 July 2025)**
Average age at referral	11.52 yrs	11.95 yrs
Min	8 yrs	9 yrs
Under 12 yrs	n = 9	n = 6
Under 14 yrs*	n = 25*	n = 21*

* Number also includes children until 12 years

For active clients under 14 years of age, TSP are the lead worker for 15 clients, providing collaborative care for four clients on orders with Child Safety, and providing collaborative care for two clients who are not on orders. Fifty-seven percent (n=12) were males and 42.8% (n=9) were females.

Thirty-eight percent (n = 8) of current active clients under 14 years identified as Aboriginal and/or Torres Strait Islander children and young people, and 14.2% (n = 3) identified as culturally and linguistically diverse.

At the time of data collection for this report the TSP were working with 12 children (38.7%) who identified as Aboriginal and /or Torres Strait Islander. Four of these clients were on care orders with Child Safety and were accepted as Collaborative Care clients, working alongside the existing Care Teams. Eight of these twelve children (66%) were under the age of 14 years.

Referrals to services and supports from TSP

When the TSP identifies an unmet need, we endeavour to link children and young people to the supports and services best able to address the need. The TSP can make *direct referrals* (referrals that come directly from our Therapeutic Support Team) and *indirect referrals*, where we collaborate with others who hold responsibility for the referrals. Indirect referrals include the TSP linking other

providers (such as case managers) to services and supports and helping them navigate the service systems from which the child/young person or family would benefit. We do not record these referrals; however, this service navigation function and individual advocacy is an important part of building the capability of, and improving access to, therapeutic services for children and young people. We know from anecdotal advice that this role by the TSP is highly valued by ACT service providers.

We refer to a wide range of formal services, including government services, non-government services and private providers. Wherever possible, we prioritise accessing government and non-government services. This allows us to provide children and young people with supports as quickly as possible that they can continue to access without any ongoing financial commitment. However, if a government or non-government service does not exist, or is not accessible or available, we refer clients to private services. Some of our cohort with highly complex needs require specialist services with additional clinical expertise. TSP brokerage is utilised to access these services.

Table 5 outlines the service/support type of direct referrals from the TSP between 1 July 2024 and 30 June 2025 and the sector to which they belong.

Table 5: TSP referrals - services/supports and corresponding sector

Service/support type	**Sector**
FFT-YJ -& FFT-CW: family therapy	Community sector, NGO
Be Me (CRS): DFV support	Community sector, NGO
Safe and Connected (CRS): accommodation and family support	Community sector, NGO
Equine Therapy	Private
Music Therapy	Private
Intensive Adolescent Support (IAS, CYF)	CYF (ACT government service)
Forensic Psychology consultations	Private
Cognitive and psychology Assessments	Private
Individual and family therapies	Private, NDIS
Child and Adolescent Mental Health (CAMHS)	Community sector
Functional Capacity Assessment	Private, NDIS
Safer Youth Response – crisis and after-hours support	Community sector, NGO
Individual mentoring – i.e. PCYC, FLIP, etc.	Private
PCYC: P180, P2E, Case management	Community sector
Pro-social activities	Private & community sector
Allied health – medical appointments and support	Private & community sector
Accommodation	Private
Integrated Service Response Program (ISRP) – disability support	HCSD (ACT government service)
Multicultural Hub	Community sector
ACCOs	Community sector
Education: Flexible Education & Targeted Support	Education Directorate
Galilee	Independent Education

Education mentoring	Private
Marymead CatholicCare: AOD and Mental health	Community sector

Presenting issues

These data provide an overview of the presenting issues and factors impacting the lives of current clients. These data give us insight into the complexity of our TSP clients and allow us to compare these with our expectations from prior research.

Informed by the McCausland and Eileen Baldry (2023) social determinants of justice framework, the TSP has identified eight risk factors that have significant associations with criminal justice system contact:

- police contact
- educational engagement
- mental health diagnoses
- confirmed disability
- trauma
- involvement with CYF
- housing status
- alcohol and other drug use.

Under this framework, the more of the determinants you have, the more likely you are to be exposed to the criminal justice system (McCausland and Baldry, 2023: 45).

The below case file analysis is drawn from the 22 active clients for whom we have complete data. At the time of capturing these data we were still collecting data on 9 recently accepted clients.

It is important to note that these data under-represent the scale of the presenting issues. These data are based on formal diagnoses and knowledge of the presenting issues at the time of initial assessment only. As we work with active clients, more factors often emerge.

Police contact

More than 90% of active clients had police involvement before engaging with the TSP. Police contact can refer to any interaction with ACT Policing. This may include a child or young person coming to the attention of police from concerns in the community, police attending an incident or police having ongoing concerns regarding a young person's behaviour and/or safety. This highlights how central ACT Policing are as referrers to the TSP and their role in addressing community safety.

Educational engagement

Almost all (90%) active clients were disengaged from education to some extent (either partially or not attending school at all). Twelve (55%) clients were not attending education at all at intake, and 8 (36%) were partially attending.

Mental health diagnoses

Nine of the 22 (40.9%) active clients had a mental health diagnosis at intake and 13 did not. Those without a diagnosis may, of course, have a mental health issue yet to be identified. This proportion is a slight reduction from the previous report. However, this may be due to the reduction in the average age of active clients and the difficulties of obtaining a formal diagnosis for children and young

people. Barriers to finding a diagnosis include knowledge, availability and accessibility of health services, cost and housing stability, among others.

Disability

Just under half (10; 45.5%) of active clients had a confirmed disability at intake and the rest (12; 54.5%) did not. The two most common diagnoses are Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD). However, there are several clients with suspected disabilities yet to be confirmed at the time of intake.

Trauma

All of the TSP's current clients have experienced trauma, and most have also had complex trauma—exposure to repeated and multiple traumatic, often interrelated events. The trauma histories include domestic and family violence, neglect, parental conflict, physical and emotional abuse, sexual abuse, parental substance misuse, serious/persistent conflict, parental mental health issues and cumulative harm. Family violence continues to be the most common form of trauma experienced by active clients, but abuse can occur in institutions and other settings outside the family. These data do not adequately capture the extent and complexity of the exposure to trauma experienced by the active clients.

Child Youth and Family Services involvement

As noted earlier, 30.1% of all active clients were on care orders with Child Safety at the time of intake. As shown in Table 6, all clients have had some involvement with CYF.

Table 6: CYF involvement for active clients

Current CYF involvement for active clients	No.
Current CYF orders	7
Appraisal	*
Closed involvement	9
Family preservation	*
Child concern reports with no action	*
TOTAL	22

Housing status

Housing status refers to the safety, stability and security of accommodation. Just under half (45%) of active clients were at risk of or were actively experiencing homelessness at the time of initial assessment.

Alcohol and other drug use

The nature and extent of alcohol and other drug use for the children and young people varies. Just under 60% (13/22) of active clients were reportedly engaged in some level of alcohol and/or other drug use.

Complex needs

'Complex needs' refers to individuals with a combination of multiple differing needs (McArthur et al 2021). The interaction between these needs has a compounding effect that creates further challenges for therapy. Active clients continue to show very high rates of complex needs, with an average of 5.27 risk factors meaning they are an acutely vulnerable group of children and young people at extremely high risk of future criminal justice system contact.

Given the limits of the current data—only including formal diagnoses of mental health issues and/or disability at the time of intake, and numerous traumatic experiences and adverse childhood events under the generic category of 'trauma'—it is safe expect these data greatly underrepresent the complexity of the needs of these children, young people, and their families.

Intended target groups

The data on active clients indicate that the TSP are working with the intended target population when we look at high proportion of presenting issues and risk factors.

Research evidence shows that children with complex needs are at increased risk of victimisation and at higher risk of coming into contact with police (McArthur et al., 2021; Baidawi et al. 2023; McLachlan, 2023). Research about the social determinants of justice involvement highlights key factors that increase the likelihood of being involved in the justice system across the life span (McCausland & Baldry 2023). The case data analysis on active clients shows the TSP are working with the intended target group and reinforces the demand for a therapeutic approach to meet the complex needs of our vulnerable children and young people. However, these data capture the needs of the clients as seen at intake only. As we work with our active clients, we identify further needs that were not recognised at intake.

Children and young people involved in care and protection: 'cross-over kids' or 'dual-system' involvement

Most young people involved with child protection do not have contact with the criminal justice system. Yet, research shows that many of the children and young people who came to the attention of police and the justice system for harmful behaviours were 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) or 'dual-system youth' (Baidawi and Ball, 2023) due to their involvement in two statutory systems. This terminology may no longer be appropriate since the minimum age of criminal responsibility was raised and this cohort are no longer engaged by the youth justice system. However, it remains relevant that children involved in the care and protection system are at an increased risk of anti-social, harmful, or risky behaviour and possible interaction with police, often at an earlier age than their peers (Baidawi and Ball, 2023). Previous studies of dual-involved children have found nearly half have a neurodisability and have experienced more pronounced cumulative maltreatment and adversity than children and young people without dual involvement (Baidawi and Piquero, 2020).

While the number of referrals from CYF have reduced since October 2024, the TSP continues to receive referrals for children involved with CYF from alternative sources. At the time of capturing the data for this report, just under 30% of referrals to the TSP were for children and young people with existing orders in place. Similarly, 29% of all active clients had orders with child safety at intake. A further 40% of active clients were undergoing appraisal with child safety at the time of intake. The remaining children and young people had some form of previous involvement with child safety (CCR, closed involvement or family preservation).

Involvement with child safety and the experiences that led to this involvement continue to be linked with high incidents of harmful and concerning behaviours. As such, it will be important for the TSP and CYF to keep working together, identifying and responding to these behaviours in a trauma-informed way.

Aboriginal and/or Torres Strait Islander children and young people

Aboriginal and/or Torres Strait Islander people continue to be overrepresented in the criminal justice system (Cunneen et al., 2025; McArthur et al., 2021; Baidawi et al., 2023) due to numerous structural factors and drivers and the ongoing effect of colonisation. It is also clear that the routine justice response fails to address these needs and causes further cumulative harm to our Aboriginal and/or Torres Strait Islander children and young people, their families and entire community.

The TSP continues to see a proportionately higher number of referrals for Aboriginal and/or Torres Strait Islander children and young people (30% of referrals, 38.7% of active clients and almost two in five active clients under 14 years of age). This means the TSP accepts a higher proportion of Aboriginal and/or Torres Strait Islander children and young people than non-Indigenous children, indicating that they have a higher proportion of unmet needs.

The TSP prioritise trauma-informed and culturally safe principles, connecting Aboriginal and/or Torres Strait islander children and young people to community and culture through formal and informal supports. While it is difficult to see such high rates of referrals for Aboriginal and/or Torres Strait Islander children and young people, it is positive to see high rates of engagement and retention through voluntary participation. At the time of writing this report, 83% of the TSP Aboriginal and/or Torres Strait islander active clients had engaged with ACCOs and two-thirds (66%) were connected to community and culture though informal supports linked to family, kin and other community members and programs. The TSP encourage engagement with community and culture and are led by the children, young people and families, respecting how, when and with whom they want to engage.

Preliminary outcomes

The TSP aims to achieve a range of positive changes in the short, medium and long term. The short- and medium-term outcomes are the direct results of the program on the participants and stakeholders. The long-term outcomes and ultimate goals of the program are positive impacts on the broader community.

The long-term goals of the TSP include improved safety and wellbeing of children and young people at risk of engaging in harmful behaviour, fewer incidents of harmful or criminal behaviour in the future, and improved community safety. To reach these long-term goals, we start with incremental achievements in the short and medium term. The short-term outcomes are the initial focus, and they provide the necessary foundations for positive results in the future.

It is important to note that change can take considerable time, patience and persistence. As with all complex social issues, progress is rarely linear. The program will need persistent monitoring and adaptation as our clients respond in differing ways, sometimes resisting change. Therefore, all outcomes should be seen as incremental, uncertain in the short-term and requiring regular reflective practice.

Client outcomes – children and young people

Client outcomes are the specific changes that are expected to occur in the target population (children and young people) as a result of being in the program. In other words, our intended outcomes focus on the effects the program has on the children and young people who become active clients of the TSP. The outcomes involve changes in knowledge, attitudes, beliefs, behaviours or skills.

Given the recent raising of the MACR and potential changes to our cohort, the TSP is working to identify any standardised and validated measure of outcomes we can use across our diverse group of active clients. In the meantime, we use observable changes to identify successes with client data. The limited sample size and need to maintain confidentiality means we will show relatively high-level outcomes, recurrent themes and observed results.

The TSP aims to use prevention-based positive youth development methods to foster competence and success when young people face life's challenges. These aims align with the TSP's foundations of positive youth development and therapeutic approaches. As a result, we emphasise intellectual, social and emotional development as goals. To help children and young people achieve their potential, they need safety and support. This requires us to better understand their individual needs and identify their individual strengths and challenges.

The first effects of the TSP happen in the program's *engagement and readiness phase*. Signs of success for our children and young people include a sense of safety and support, improved engagement with the program, improved trust and rapport and improved motivation. The logical first outcomes of the TSP are to successfully engage with the child or young person and develop trust and rapport. This can also be described as *developing a therapeutic alliance*. Any positive future changes start with increasing the chid or young person's engagement with therapeutic and constructive supports.

Early signs of success in the engagement phase are improved involvement and engagement with the TSP and improved trust and rapport. This includes attending appointments, active participation in the program, contacting staff and answering calls. At the time of this report, TSP staff have successfully engaged 93% of active clients, with the remaining 7% still in the early stages of engagement and readiness phase. Successful engagement can take substantial time and persistence given that the target group of the TSP often lack trust of adults and institutions. Many clients ask TSP staff to attend appointments with them to provide support and ask TSP staff for help. This improved help seeking is a result of the trust and rapport between staff and client. It enables therapeutically informed conversations that allow children and young people to explore their feelings, actions and the conditions of their lives. These conversations, embedded in everyday interactions, form a central part of the therapeutic approach, where each interaction with the child or young person is seen as a therapeutic opportunity.

After engaging the children and young people, the TSP often facilitates assessments to identify unmet needs that help in designing appropriate supports and therapeutic plans. The TSP uses private, government and NGO services to link active clients with specialist consultations and assessments to understand their mental health, any neurodiversity or cognitive impairment, functional capacity and the impacts of trauma. This increase in knowledge is not a change we see in the young person themselves but is a vital step towards addressing their needs, developing therapeutic support plans and preparing for future success. An indicator of improved understanding of the client's needs is the increased access to assessments and formal diagnoses for active clients. At the time of this report, the TSP has enabled 20 forensic psychology consultations for 14 clients and 7 specialist cognitive and psychology assessments. It has also facilitated functional capacity assessments.

Improved hope for the future often emerges as the young person is encouraged to think and plan for a future, expressing their hopes and goals. These goals can be concrete or abstract that, through conversations, can become grounded and seen as viable plans by the young person. Increased future hope has been seen to improve attitudes and behaviours in the short term. Some of our clients have

begun expressing interest in particular careers while others have explicitly noted they want to change their behaviour 'to become a better person'. Each of these indicate signs of positive progress for the children and young people.

Improved safety and stability in the young person's conditions of existence is pivotal to success. Upon entry into the program, many children and young people were living in insecure conditions with fractured or unstable attachment to carers and/or family, often lacking trust in other people. These conditions make it difficult for the individual to achieve other outcomes. Initially we need to recognise the main factors contributing to their current instability. Identifying areas for change and creating plans is the first measure of success. The second is implementing these plans and ultimately creating long-term stability and security. Improved safety and stability for active clients can lead to de-escalating harmful behaviours, reduced externalising behaviours and improved parent/carer and child relationships through supports to the family, respite and referrals to family therapy (FFT-YJ). This can involve reassessing living arrangements to reduce conflict, improve attachments and support the young person at home.

Some children and young people feel unsafe in their home or with their carers. As a result, they leave the home and engage in anti-social behaviours in public or place themselves with harmful adults in the community. Through identifying these patterns and creating more stable living arrangements that meet their needs to feel safe and connected, these children and young people remain in the home and develop stronger relationships and supports leading to a decrease in absconding and harmful behaviours.

For some clients we see a reduction in externalising or harmful behaviours quite quickly after engaging them, creating a rapport, identifying needs and implementing changes to increase safety and security. Some clients persist with defiant presentations of bravado—holding onto the need for a sense of control and street credibility that has helped them survive. Even these clients usually show a reduction in harmful behaviour and an increase in pro-social activities. Despite early observable success with some children and young people, other active clients' pathways to a reduction in harmful behaviours take more persistence and continuity of support. Nonetheless, with even the most resistant clients, we see positive signs. It is important to reiterate that we should expect challenges, lapses, relapses and non-linear trajectories given the complex history and conditions of these young people's lives.

Sector/system outcomes

For the TSP to bring about positive change in the lives of children and young people with whom we work, it is necessary for us to encourage and enable changes in the sector and systems that support them. One of the key outcomes in this domain is to improve access to therapeutic supports for children and young people at risk of or engaging in harmful behaviour. This outcome aligns with the aim to improve collaboration with key stakeholders as we increase connections and access to services and supports that were previously hard to find or engage with. Both outcomes can be seen in the increased links for children and young people to services and support through the TSP. The TSP's authorising environment, brokerage funding, and relationships with government and non-government services has facilitated access and reduced barriers to much-needed therapeutic supports for our children and young people.

The TSP aims to increase the focus on the therapeutic needs and outcomes for children and young people. This requires the care teams and support plans to address the therapeutic concerns—to address the underlying causes of the young person's behaviours and to develop approaches to enable change. This is achieved by increasing access to therapeutic assessments and consultations,

which then inform and lend further authority and clarity to the development of support plans and the practice of care teams. We have seen an increase in people seeking the TSP's advice about their practice, accessing consultations and assessments, and using more trauma-informed language and practice regarding children and young people.

A necessary sector/system outcome is the increase in knowledge regarding the TSP to facilitate appropriate and timely referrals for children and young people, as it supports the other changes our program intends to achieve. Success in this domain can be seen by the increase in diversity of referral sources (see Table 1). Notably, 'family, community/other' is our second highest referral source, which indicates an increase in community awareness of the program. However, it is in the steady increase in referrals from ACT Policing that we see our greatest improvement. ACT Policing are a pivotal partner and referral source that enable us to divert young people away from harmful behaviour and its consequences. This increase in awareness and improvement in referral pathways from police are strong indicators of success in this measure. This improvement is in large part due to ACT Policing's proactive efforts to facilitate connections with the TSP.

Systemic issues

The following section draws attention to some key systemic issues and recurring themes. We are still in the early stages of these reforms. Most notably, at the time of writing this report the MACR had only just been raised to 14 years on July 1 2025. The topics below identify emerging issues that need further consideration to understand the scope, scale, and feasibility of the recommendations for the ACT.

Intensive therapy orders and intensive therapy places

The TSP has several roles relating to intensive therapy orders (ITOs). An ITO, outlined in the *Children and Young People Act 2008*, provides a means to direct a child or young person to undergo assessment and/or treatment in alignment with a therapy plan. Some children and young people with complex needs and/or complex trauma, are unable to manage their behaviour (Barker 2024) and require structured/mandated supports to participate meaningfully with their therapy plan to keep themselves and the community safe and achieve therapeutic outcomes. An ITO involves specific structured conditions unique to the child's needs and circumstances and is only used as a last resort.

An ITO can take many forms, including confinement directions, which confine a young person for the purposes of treatment and/or assessment. These directions require a suitable place of confinement or intensive therapy place (ITP) and finding a provider and ensuring it can be appropriately staffed to meet the therapeutic needs of the child. These staff may need specialist training and expertise to make sure the therapeutic intervention works safely and as intended. All these logistics can take time to identify and prepare.

The TSP can recommend an ITO, but it can only be requested by the Director General of the ACT Health and Community Services Directorate (HCSD). The request, with specific conditions and a comprehensive therapy plan, is then assessed by a Magistrate. A Magistrate's order lends gravity and seriousness to the situation. It can provide concise clear directives relating to the child or young person's behaviour, not part of broader care orders, but with a distinct individualised purpose to stabilise the child or young person's behaviour in therapeutic, trauma-informed way.

An ITO application involves a substantial amount of work, including, but not limited to, a therapy plan and consideration of the logistics of a placement. This support work and documentation needs

to be prepared prior to application and can take considerable time given the consultation necessary with key stakeholders, including the child or young person.

If we identify that a child under 14 years needs an urgent response to their harmful behaviour to keep themselves and the community safe, it may be necessary to collate foundational supporting evidence such as a comprehensive therapy plan. This pre-planning can allow for the fast application and execution of an ITO. However, this planning can be impeded by the availability of ITPs, providers and appropriate staff.

One of the main barriers to using ITOs with confinement directions is the availability of ITPs—placements that are designed for therapeutic supports and the safety of both the child or young person and the staff. These places are ideally purpose built, child-friendly environments that simultaneously create safety. To improve the likelihood of a timely and appropriate response when an ITO with confinement directions is issued, facilities that meet the criteria of an ITP need to be identified immediately.

The Panel recommends the ACT government explore the creation of dedicated purpose-built ITPs to enable the effective use of ITOs, ideally purpose-built homes that meet the design needs of a therapeutic place of residence. Simultaneously, existing placements need identification for use as ITPs while planning purpose-built homes. This allows for the urgent use of ITOs with confinement directions while purpose-built options are explored. Once developed, these homes would provide alternatives in the community to meet different children's needs such as location and whether they can reside with others or not.

Clear expectations and guidelines should be given to potential providers regarding the expertise, attributes and training that is needed to deliver an ITO. This allows providers to recruit and train staff prior to the execution of an ITO with confinement directions. Again, this can increase the likelihood of successfully executed ITOs with confinement. While research in this area is relatively recent, we need safe therapeutic accommodation that learns from previous examples and research (Bowles 2014a & 2014b; Crowe 2024).

Fetal Alcohol Spectrum Disorder

Fetal alcohol spectrum disorder (FASD) is a neurodevelopmental condition that can occur in individuals who were exposed to prenatal alcohol exposure. FASD is a lifelong disability involving differences in brain development that can affect a person's behaviour, learning abilities, and overall health (Connor et al. 2000; Streissguth et al., 2004). Individuals with FASD can experience some degree of challenges in their daily living, and need support with motor skills, memory, attention, communication, emotional regulation, decision making and social skills to reach their full potential. Each individual with FASD is unique and has areas of both strengths and challenges, presenting in diverse and unique ways for each individual.

FASD has been identified as a known and potential factor in the lives of numerous TSP clients. For those clients that are known to have FASD we have seen a lack of knowledge and skills to adequately respond across the community. Moreover, as FASD awareness is low, compounded by a paucity of specialists and assessment skills, children and young people involved in our systems have gone without a diagnosis, resulting in inappropriately responding to their needs. This lack of knowledge and awareness of FASD results in an inadequate understanding of the scale of this issue in the ACT. Furthermore, research highlights that FASD is underdiagnosed across Australia in population groups that come into contact with the justice system.

Children and young people with FASD are often misunderstood and present with behaviours that increase their risk of involvement with youth justice, especially if their complex needs are not recognised (Passmore & Hamilton 2021; Flannigan et al 2018). A study conducted in Banksia Hill Detention Centre in Western Australia found that 36% of young people in detention were diagnosed with FASD and 89% of youth detainees had at least one form of severe neurodevelopmental impairment (Bower et al 2018). Almost none of the young people in the study had been diagnosed prior. These findings suggest that FASD is underdiagnosed across Australian youth detention populations. The identification of FASD can aid in shifting the focus away from punishment to support, to reduce the cycle of involvement with a justice response. FASD is also frequently misdiagnosed or overlooked, with symptomology often attributed to attention-deficit/hyperactivity disorder, autism spectrum disorder or behavioural issues. It has been described as a 'hidden disability' due to the lack of awareness, identification and response. However, early diagnosis and FASD-informed support can improve outcomes.

It is critical that service providers be FASD-informed and capable. This is particularly important for services that work with children that have an increased likelihood of living with FASD. However, it is important that we do not just increase awareness but enable access to assessments and effective supports in line with current evidence. This would require developing a systemic approach to FASD in the ACT. There is currently a paucity of services, supports and skills. While it is essential that the workforce build its capability to work with children and young people who live with FASD, it will require partnership and collaboration with specialist supports (such as allied health professionals and educators) and services.

In 2025, the National Health and Medical Research Council approved new FASD diagnostic guidelines accompanied by an Indigenous Framework, which intends to make assessment and diagnosis more accessible across Australia. While the most recent Australian estimate of FASD prevalence is between 2.91% and 4.44% of the general population (Tang et al. 2025), we currently do not know the extent and scope of FASD in the ACT among children and young people. For us to develop and ascertain the size of this issue and then design a systemic response will require more data collection and collaborating with key stakeholders.

With the development of all new responses to issues that face our community it is essential that we engage with and work alongside the Aboriginal and Torres Strait Islander community. Evidence suggests that we should expect an overrepresentation of the Aboriginal and Torres Strait islander community are affected by FASD, and culturally specific responses are necessary. We aim to consult with the Aboriginal and Torres Strait Islander community in the ACT to identify culturally appropriate and safe ways of addressing FASD. In developing a systemic approach to this issue, we must consider what effectively responding to the communities' needs look likes as a priority.

The TSP will undertake the following actions as the initial steps to supporting FASD-informed approaches:

- consult with Aboriginal and Torres Strait Islander community to develop an understanding of their needs relating specifically to the TSP and more broadly regarding FASD
- consult with key stakeholders to identify existing plans and previous work that has been done to address FASD in the ACT
- build capability to work with children and young people affected by FASD

- identify key stakeholders to facilitate assessments, develop plans and implement the therapeutic response.

Concerning/harmful sexualised behaviour

Over the past year, the TSP has seen numerous children and young people who present with concerning/harmful sexualised behaviours. In the ACT there is currently no clear and established systemic response to address these behaviours. An increase in funding in 2023 for Enhanced Child Health Services (ECHS) situated in Canberra Health Services, created one funded position for this purpose. It is unclear that this is meeting the current demand let alone the expected increase in demand into the future.

The TSP will continue to work with existing services to identify, assess and work with children and young people with concerning/harmful sexualised behaviours. However, it is the Panel's view that the ACT explore the scale of this issue and the viability of introducing a specialised service on a larger scale to address this need. Without a systemic response, children and young people exhibiting these behaviours may not receive appropriate therapeutic support, increasing risk to themselves and others.

In NSW, including Queanbeyan, the service New Street, which is implemented as a health response, has become recognised as an exemplar of an evidence-informed model working to address harmful sexualised behaviour. It involves an interagency approach to supporting eligible young people and their family unit. A 2014 evaluation found the service resulted in positive impacts and significant outcomes for young people and their families, in addition to clear economic benefits for the NSW Government (KPMG, 2014). Based on population size alone, the ACT should consider introducing this model.

Education

Disengagement from education continues to be a key risk factor and vulnerability for the children and young people in our program. Flexible education and targeted support have developed offerings that are proving to be successful in adapting to the needs of the children and young people. However, current resources and capacity constraints mean that demand consistently outstrips what existing programs can provide.

Muliyan continues to deliver an onsite flexible education model that is highly effective for children and young people. For a large proportion of the TSP cohort, Muliyan represents the most appropriate response, providing onsite education that responds to their individual needs. However, its ability to respond at scale is constrained by the physical limits of its premises, and the demand for this program now significantly exceeds capacity. To meet the level of need in the ACT, government could consider investment to bolster and expand Muliyan so that it can operate at a scale proportionate to demand.

Outreach provides a complementary and increasingly vital response, catering predominantly for children and young people in residential care or those who are displaced. As a relatively new education offering, it has demonstrated strong value in providing bespoke, context-specific learning for disengaged students who cannot access onsite programs. The early success of Outreach highlights the importance of continuing to develop, resource and expand this model to ensure that young people in the most complex circumstances are not left without educational engagement.

Together, Muliyan and Outreach form a critical dual response: Muliyan offers structured, high-impact onsite education, and Outreach provides flexible, tailored support in diverse contexts. Both require scaling and resourcing to meet the growing level of need across the Territory.

Stakeholder engagement

The TSP continues to meet and engage with key stakeholders across the community in the knowledge that these relationships are crucial to the success of this initiative. In the eight months since the previous report, much of our engagement has been regarding specific children and young people. We have continued to strengthen relationships with community partners through referrals, collaboration and discussions addressing the needs and supports for the children and young people with whom we work. At this point in the development and implementation of the TSP, two key strategic partnerships require specific mention: ACT Policing and the Aboriginal and Torres Strait Islander community and Aboriginal and Community Controlled Organisations (ACCOs).

ACT Policing

ACT Policing is a key stakeholder in the effective implementation of the MACR reforms and the success of the TSP. ACT Policing have always been, and will continue to be, an integral part of responding to the safety needs and concerns of the community. Like any major reform, raising the MACR has introduced changes to police processes and procedures and has presented new challenges which has made the relationship with the police paramount to the efficacy of the TSP. We have seen concerted efforts and active engagement from ACT Policing to respond to the needs of the community and we also note the difficulties. ACT Policing made the largest number of referrals to the TSP in the financial year. These referrals had a genuine focus on early intervention and prevention as police endeavour to respond innovatively and divert children and young people away from a criminal justice response. ACT Policing have been proactive in identifying opportunities for the TSP to receive referrals and support for children under 10 years of age, recognising the opportunity that TSP presents to work with a cohort that they see in the community with unmet needs and as vulnerable to criminalisation in the future.

Fortnightly meetings with ACT Policing were increased to weekly meetings leading up to the raising of the MACR this year. These meetings enabled us to discuss and address any concerns we had regarding individual children or young people and to identify any recurring themes or broader issues. These regular meetings have also strengthened relationships that allow for ad hoc conversations when needed. The Chair of the Therapeutic Support Panel and the Chief Police Office have regular meetings to identify and discuss any emerging issues and monitor the progress of these reforms. Continuing communication and a positive working relationship with ACT Policing will remain a pivotal component of meeting community needs and expectations with these reforms.

Aboriginal and/or Torres Strait Islander Elders, ACCOs and Community

We acknowledge the strength and resilience of Aboriginal and/or Torres Strait Islander peoples in the ACT and the importance of culture to wellbeing, especially children and young people. The historical and ongoing impacts of colonisation are such that Aboriginal and Torres Strait Islander peoples continue to be over-represented in the criminal justice system and the child protection system. The *Independent Review into the Over-representation of First Nations People in the ACT Criminal Justice System* (Cunneen et al 2025) and their first report (Cunneen et al 2024) provide a detailed exploration of this issue in the ACT, including welcome recommendations for the TSP (Recommendation 6.1). Moreover, addressing the Closing the Gap targets remains the responsibility of all our community. The Productivity Commission's latest report on progress on this target in the

ACT showed that the situation was worsening (Productivity Commission, 2025). It is imperative that we continue to actively build relationships with the Aboriginal and Torres Strait Islander community to inform the supports and approaches undertaken by the TSP. This involvement needs to span the operational and systemic work of the TSP.

The TSP has effectively engaged with and is supporting Aboriginal and Torres Strait Islander children and young people. Around 38.7% of all active clients are Aboriginal and Torres Strait Islander children and young people who are voluntarily engaging in our program. While this engagement rate is a promising indicator, it is essential to continue to build relationships and facilitate connections to culture, country and community.

The TSP make active efforts to prioritise connecting Aboriginal and Torres Strait Islander children and young people accepted into the program to community and culture. It is important that wherever possible, Aboriginal and Torres Strait Islander people and organisations participate in the supports provided to children and young people. This entails supporting referrals and engagement with both formal and informal supports. Formal supports include services and programs specifically for Aboriginal and Torres Strait Islander children and young people and families. Critically, this includes ACCOs and Aboriginal-led programs. Informal supports, alternatively referred to as natural supports, include people in the community. This can include family, kin, friends and community members not being funded or paid. It is important that we create a sustainable ecosystem of support but also that we ensure this is sustainable by providing reciprocal support where we can in the form of remuneration. This diversity of supports is qualitatively different and provides numerous options and opportunities rather than embedding a reliance on formal services which have shown to not be as culturally safe (Cunneen et al 2025).

At the time of writing the report, 83% of our active clients that identify as Aboriginal and Torres Strait Islander were engaged with ACCOs. The remaining 17% had explicitly expressed that they did not want to be involved with ACCOs at this stage. It is important to reiterate that the TSP is child and young person focused, incorporating and hearing their concerns and wishes wherever possible. We actively encourage connection to community and culture but respect the wishes of our clients and their families when this cultural readiness is not present. This will impact how, with whom and when we link children and young people with the community.

Approximately 66% of active clients that identify as Aboriginal and Torres Strait Islander were connected to informal supports in the community. Some clients were not previously connected and/or had ambivalent or strained relationships with family and community.

The ACT Aboriginal and Torres Strait Islander Children and Young People Commissioner, and staff of the Commissioner, provide an important role in advocating for and supporting the community. The TSP have frequent communication and interaction with the Commissioner's team regarding the support for Aboriginal and Torres Strait Islander children and young people. The TSP will continue to make efforts to work alongside and strengthen relationships with the Commissioner's office to inform and support advocacy and improved outcomes for Aboriginal and Torres Strait Islander children, families and the community, including ACCOs.

In the coming year the TSP aims to consult with the Aboriginal and Torres Strait Islander community regarding key areas of support and to build relationships. We recognise that cultivating relationships and developing trust will take time. We also recognise there is a need to identify service and resource gaps to enable and facilitate the support for children and young people by ACCOs wherever

possible and these relationships are integral to our work. It is essential that NGOs and ACCOs are enabled to support children and young people.

Conclusion

The TSP, while still in its infancy, is providing a new response for children and young people in the ACT. This next year will be the first year of operating with a MACR of 14 years. While we worked with this cohort in the lead up to the raising of the age on 1 July 2025, we may see a change in the number and nature of referrals. It will be vital for us to continue to monitor the demand on TSP and the supports in the community we rely on for an integrated and holistic response to meet our clients' needs.

The structure of the TSP with the overlapping components of the Chair, Panel and Therapeutic Support Team has provided a flexible and responsive approach. The authorising environment and independence of the TSP fosters collaboration within and across government and non-government supports. The multi-disciplinary panel provides oversight and accountability and enables a diverse range of perspectives and knowledge to inform the work of the TSP. The ability and willingness of the Panel to provide critical feedback and support has been pivotal to development of this response.

The TSP will continue to identify systemic issues in the service sector and deliver therapeutic services to some of our most vulnerable children and young people, thereby improving outcomes for individuals and the community. This ongoing work involves collaboration with key partners in the community. To meet the needs of the children and young people with whom we work requires a diverse array of skills, expertise and knowledge. It requires engaging with and listening to the community and, most importantly, listening to and observing the needs of the children and young people.

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Appendix 1: Client Typology

Typology	When this occurs	What it looks like
Therapeutic Support Panel has responsibility – convene Panel/sub-Panel		
Lead worker	Where no other agency is providing case coordination, where the family is unwilling/unable to coordinate themselves, or where the children/young person isn't responding to the current case coordination provision and the TSP has formed a reasonable belief that they can add value by stepping into that role.	The Therapeutic Support Panel and Therapeutic Support Team are the lead team on engaging with the client, developing the therapeutic support plan, and providing case management including coordination. The TSP take on responsibility for the child/young person. Sub-Panel convened.
Collaborative Care –in the community	Where an existing care team exists in the child/young person's life,	The Therapeutic Support Panel and Therapeutic Support Team work alongside the existing case management structure, adding value and a different set of skills. Responsibility of care is shared between the TSP and the other case work team. Panel/Sub-Panel convened.
Active Monitoring	Where no consent has been given to engage, but the risk level doesn't require involuntary engagement, but there is concern of escalating behaviours.	The casework team actively pursue consent before taking the client on as a lead or collaborative client. The TSP has responsibility for ensuring the child/young person's situation doesn't worsen. Panel/Sub-Panel convened.
Therapeutic Support Panel does not have responsibility		
Collaborative Care – with orders	Where an existing care team exists in the child/young person's life, and for statutory reasons are required to maintain the lead provision of care.	The Therapeutic Support Panel provide advice and support to the care team but aren't responsible for the client.
Active monitoring – other options	Where, during the intake/assessment stage, the TSP or casework team find alternative supports available to the child/young person which have not yet been exhausted.	The casework team open a file on the client, provide feedback of alternative supports to the referrer, and agree to check in on the child/young person's progress within a specified timeframe. Lines of communication are open so the referrer can contact the casework team in the event that behaviour escalates. The TSP has responsibility for responding when risk of harm is increased.
Referred on and closed	Where the referral does not meet the inclusion criteria or threshold for involvement to the TSP based on considerations such as age, behaviours or other.	The casework team provide feedback to the referrer that the client isn't able to be supported by the TSP, however if the circumstances change, they can provide updated referral. This action should include providing the referrer with information on other services which are more appropriate to support the client. The TSP holds no responsibility for these clients.