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10 November 2021

Ms Corrine McMillan MP
Chair, Community Support and Services Committee
Parliament House
George Street
BRISBANE QUEENSLAND 4000

Via Email: CSSC@parliament.qld.gov.au

Dear Ms McMillan

Support for the Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021

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

The RACP Queensland Regional Committee welcomes the opportunity to contact the Community Support and Services Committee regarding the Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021 (the Bill). The Queensland Regional Committee strongly supports the Bill to raise the age of criminal responsibility to 14 years of age in line with medical evidence.

The RACP has provided a submission to the Community Support and Services Committee in support of the Bill. The submission outlines the medical evidence supporting raising the age and alternative frameworks to youth justice, including advocating for multidisciplinary wrap around services for young people with complex needs. As representatives of Queensland physicians and trainees, we wish to confirm our support for the submission and acknowledge local support for the Bill. Our committee identified this issue as a priority in our election statement prior to the 2020 election, and the RACP has also made this issue a national priority for College advocacy.

Queensland based physicians and paediatricians are available to provide expert testimony in support of the Bill should the Community Support and Services Committee or other parliamentary groups wish to discuss the views of the Queensland Regional Committee.

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For enquiries related to this correspondence or the RACP submission on the Bill, please contact Beth Wilson, Senior Policy and Advocacy Officer [redacted].

Yours sincerely

Professor Nick Buckmaster
Chair, RACP Queensland Regional Committee

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Submission on the Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021

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About The Royal Australasian College of Physicians (RACP)

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RACP submission on the Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021

Introduction

The RACP welcomes the opportunity to provide a submission to the Queensland Parliamentary Community Support and Services Committee regarding the Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021 (Bill).

The RACP strongly supports the Bill to raise the age of criminal responsibility to 14 years of age. The Royal Australasian College of Physicians (RACP), alongside many peak medical bodies including the Australian Medical Association and the Australian Indigenous Doctors' Association, recommends that the minimum age of criminal responsibility be raised to at least 14 years of age. The RACP has been advocating for this change to occur across Australia since 2016.

Medical reasons in favour of raising the age of criminal responsibility to 14 years of age

Children aged 10 to 13 years old in the youth justice system are physically and neurodevelopmentally vulnerable. Most children in the youth justice system have significant additional neurodevelopmental delays. Children aged 10 to 13 years old in juvenile detention have higher rates of pre-existing psycho-social trauma which demands a different response to behavioural issues than older children.[1]

A range of problematic behaviours in 10 to 13 year old age children that are currently criminal under existing Australian law are better understood as behaviours within the expected range in the typical neurodevelopment of 10 to 13 year olds with significant trauma histories (typically actions that reflect poor impulse control, poorly developed capacity to plan and foresee consequences such as minor shoplifting or accepting transport in a stolen vehicle).[2]

Given the high rate of neurodevelopmental delay experienced by children in juvenile detention, including conditions such as Fetal Alcohol Spectrum Disorder (FASD) and delayed language development, these behaviours often reflect the developmental age of the child, which may be several years below their chronological age. Judging criminal responsibility on the basis of a chronological age is inappropriate for children who may have a much lower developmental age due to a number of medical and developmental conditions described in the following sections.

Young children who exhibit problematic behaviour as a result of their neurodevelopmental conditions, and their families, need appropriate healthcare and protection. Involvement in the youth justice system is not an appropriate response to addressing problematic behaviour that stems from these conditions. It further damages and disadvantages already traumatised and vulnerable children.

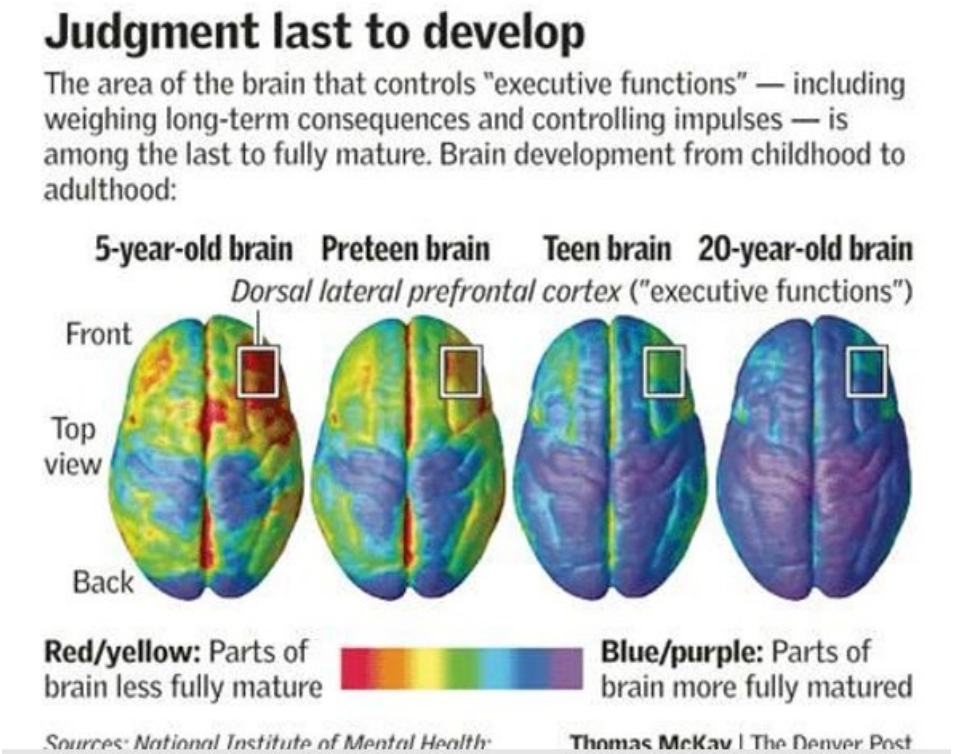
Evidence:

Normal neurocognitive development of children

Functional neuro-imaging indicates that the pre-frontal cortex of the brain, the part of the brain that controls executive functions (e.g. impulse control, planning and weighing up long term consequences of one's actions), is not fully developed until around 25 years of age.[3]

Impulse control, the ability to plan and foresee the consequences of one's actions is vastly less developed in a 10 year old than an adult.[4] As such, when faced with a choice of jumping into a stolen car with peers or being left on the side of the road alone, it is highly conceivable that a 10 year old may jump into the stolen car, and thus become an accessory to a crime, without having planned this or be able to process through the potential consequences.

Figure 1[5]



The neurocognitive profile of children in the youth justice system is different from their peers

It is important to note that the narrative above relates to the vulnerability of all children due to "normal and expected" childhood growth and development.

There is now clear evidence that children in the youth justice system in Australia have high rates of additional neurocognitive impairment, trauma and mental health issues.[6] These issues markedly increase their vulnerability. Additionally, these children much more likely to be disengaged from the education system.

Neurocognitive impairment in children in the youth justice system

There is strong evidence that children in youth detention in Australian have a very different neurodevelopmental and mental health profile compared to children who are not in custody.

A large multidisciplinary study of 99 young people aged between 10–17 years 11 months and sentenced to detention in the only youth detention centre in Western Australia, from May 2015 to December 2016[7], showed: Of 99 children in detention in that state; 89% had at least one severe neurodevelopmental impairment.[8] This included 36 children who were diagnosed with FASD.[9]

These impairments included:

FASD Intellectual Disability
ADHD Trauma / Attachment
Depression Anxiety
Learning Difficulties Speech and Language Disorders

Notably, the majority of children diagnosed with neurodevelopmental disorders had not been previously identified until the study occurred, highlighting the need for appropriate screening and assessment within 24 hours of detention.[10]

These findings highlight that many, if not most, incarcerated children with a chronological age of 10 years are likely to have a functional age younger than 10 years of age, further impacting their decision-making abilities.

Physical vulnerability: growth and pubertal development

Normal childhood growth

Figure 2 below depicts standard child growth charts (height and weight) for boys and girls. The tips of the arrows mark the average heights for boys and girls at 10, 12, 14 and 16 years.

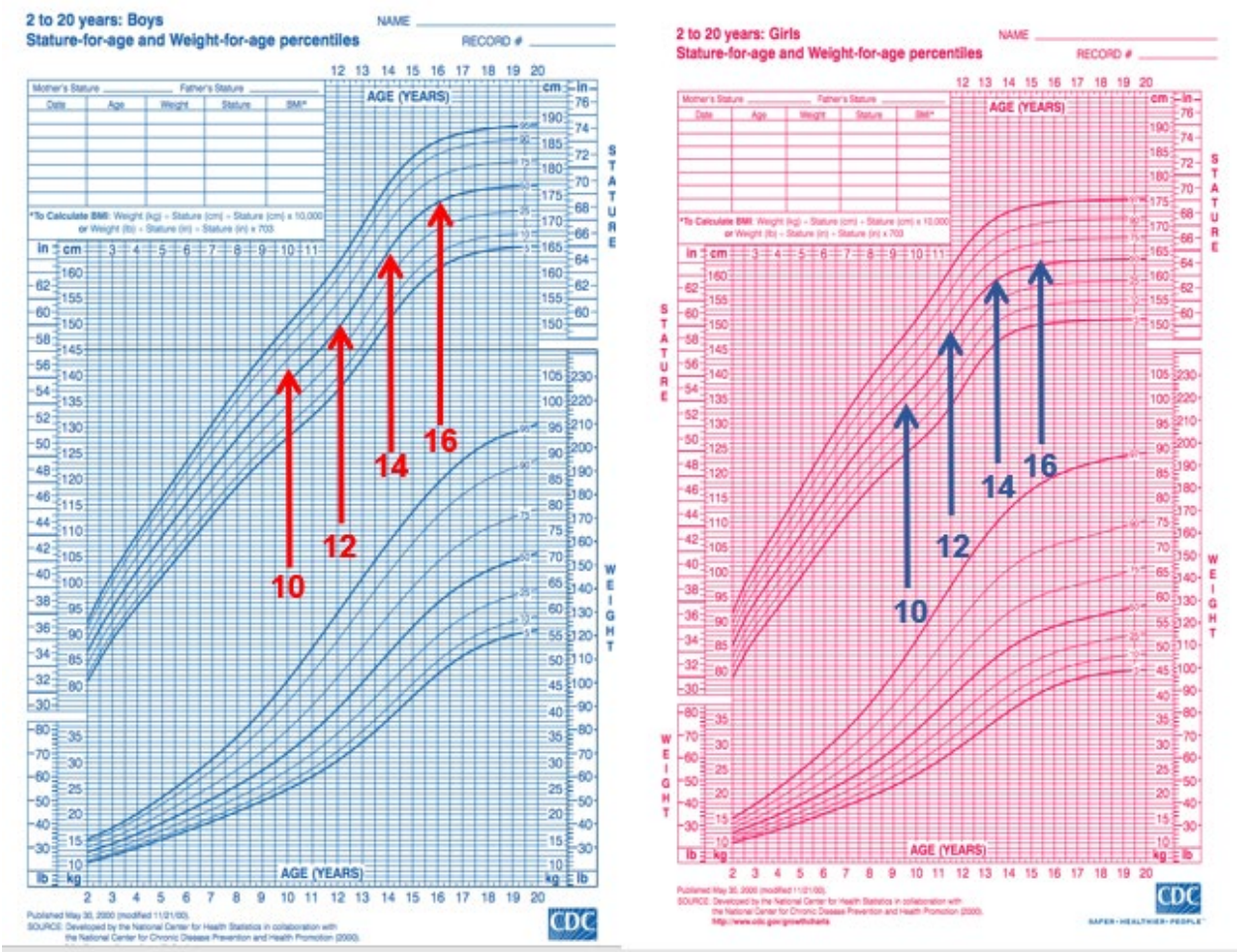
An average 10-year-old boy is 138 cm tall, with some boys still being as short as 125 cm at the age of 10 years. 10-year-old boys weigh on average 31 kg with some still weighing as little as 23 kg.

An average 10-year-old girl is 138 cm tall, with some girls still being as short as 125 cm at the age of 10 years. 10-year-old girls weigh on average 32 kg with some weighing as little as 22 kg.

The current minimum age of criminal responsibly is such that children this small can be incarcerated.

It is clear from growth charts that on average boys do not reach full adult height till around 16 years and on average girls do not reach full adult height till around 15 years.

Figure 2
Growth Charts: Boys and Girls (Centres for Disease Control)



Variations in normal pubertal development

Photograph 1 highlights the range of pubertal development commonly seen in the 10 to 13-year-old age group. The girl in the middle was 10 years old, the taller of the boys on the right was 12 years old, and the shorter boy on the left was 13 years old when this photograph was taken.

All three children photographed in Figure 1 were old enough to be arrested, held in adult police cells, brought before a magistrate and incarcerated at the time this photograph was taken.

The current minimum age of criminal responsibility is such the small and physically vulnerable children can enter the youth justice system.

Photograph 1

* All persons in this photograph are now adults and have consented for this photograph to be used.

Involvement in child protection as a pathway to involvement the youth justice system

The report "Crossover Kids: Vulnerable Children in The Youth Justice System" published by the Sentencing Advisory Council of Victoria, clearly highlights the significant over-representation of children in the child protection/out of home care systems in the youth justice system.[11]

Of particular relevance to the issue of raising the minimum age of criminal responsibility, the report clearly highlights that the younger children are at first sentence, the more likely they are to be known to child protection (e.g. to have experienced psycho-social trauma).[12]

Of the 438 children aged 10 to 13 years at age of first sentence or diversion:

- 1 in 2 were the subject of a report to child protection
- 1 in 3 were the subject of a child protection order

- 1 in 3 experienced out-of-home care
- 1 in 4 experienced residential care[13]

Links between trauma and youth justice

There is now extensive evidence that exposure to childhood trauma disrupts the development of normal neural pathways in a child's brain.[14] This disruption to the development of normal neural pathways often results in: learning difficulties, a lack of self-regulatory skills, being in a persistent heightened state, and/or dissociation due to misreading of cues and being quickly triggered into a fear response. This often presents as aggression and disobedience. [15]

Research suggests that the behavioural difficulties of many children in care are underpinned by cognitive vulnerabilities related to exposure to adverse and traumatic events in childhood.[16] The behavioural difficulties of children in care can bring these children into contract with the youth justice system.

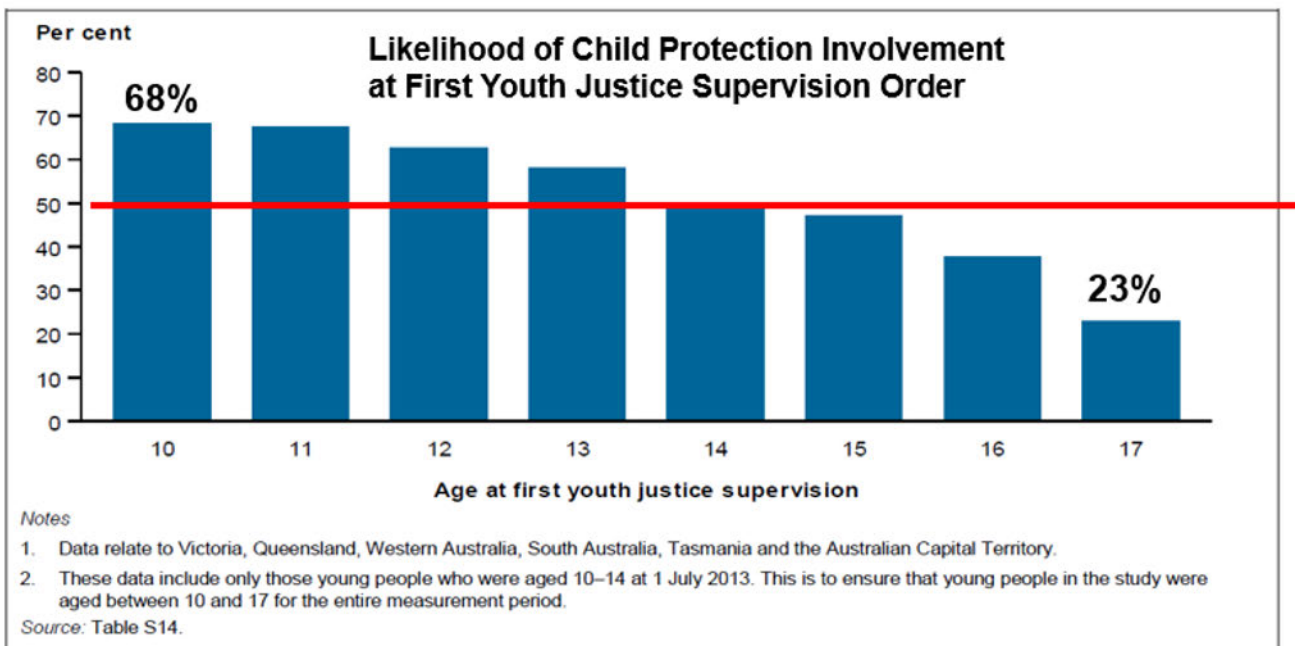
Children who are placed in out-of-home care (OOHC) experience higher levels of behavioural and mental health issues than children from similar backgrounds who are not in placed in care.[17] Green et al identified that children who were placed in out of home care during early childhood were 5 times as likely to develop a mental disorder during middle childhood.[18]

Involvement of the children in the child protection and OOHC system can be considered a proxy indicator for trauma, as most children in the child protection system have experienced some form of physical or mental health trauma,[19] and many have experienced high levels of adverse childhood experiences (ACEs). In practical terms, this almost always means that a child has either been at risk of, or been exposed to, trauma so severe that government authorities have considered it necessary to remove them from their home

When considering the minimum age of criminal responsibility, it is important to note that the younger the child enters the youth justice system, the greater the likelihood that they have been exposed to trauma (using child protection as a proxy).

Figure 3 illustrates data collated by the Australian Institute of Health and Welfare, it shows that over two-thirds (68.3%) of children aged 10 years at the time of their first youth justice supervision, had also received child protection services at some stage in the 4-year period. It is not until the age of 15 years that the rate falls below fifty percent.[20]

Figure 3 Young people who had been in detention and who had also received child protection services, by age, 1 July 2013 – 30 June 2017[21]



Links between detention and poor health outcomes for children
Young people who have been in contact with the youth justice system have poorer health outcomes. The higher burden of morbidity and mortality is a result of "elevated rates of mental illness, cognitive disability, substance use, infectious disease, and non-communicable conditions".[22] Young people who leave the youth justice system have significantly increased risk of preventable death, primarily from suicide, transport accidents or accidental drug causes.[23] This further supports the need to raise the age of criminal responsibility to avoid young people engaging with a system that is associated with poorer health outcomes. The alternative models and frameworks section below provides an overview of the necessary services to provide young people with complex needs with appropriate assessment, treatment and support.

Links between educational disengagement and youth justice
There is well documented evidence that children in the youth justice system have much higher rates of exclusion and disengagement from the formal education system. Data from Queensland shows that of children in the youth justice system, seventy percent are not attending regularly and more than thirty percent are not even enrolled.[24] In Victoria, of 181 children in a Custodial Setting, 145 incidents of school expulsion were noted in one year.[25]

Alternative models and frameworks to youth justice

The RACP acknowledges the alternative services for young people mentioned in the explanatory note associated with the Bill, the RACP encourages the Queensland Parliament to consider the recommendations in the report 'Review of the service system and implementation requirements for raising the minimum age of criminal responsibility in the Australian Capital Territory (ACT)'.[26] This report provides a clear overview of a roadmap to providing appropriate services to children aged 10-13 years old when the ACT raises the age of criminal responsibility and offers solutions such as the 'Multidisciplinary Therapeutic Panel, a collaborative forum to make service delivery decisions for children with complex and challenging needs'.[27]

Principles informing the development of alternative models:
When developing alternative models and frameworks to youth justice, the RACP recommends considering the principles on which the Medical Specialist Access Framework is based to inform the health elements of an alternative model for youth justice. The Principles in Practice include: Indigenous Leadership, Culturally Safe and Equitable, Person-Centred and Family Orientated, Flexibility, Sustainable and Feasible, Integration and Continuity of Care, Quality and Accountability. The key principles identified by the Indigenous Health sector can be used to underpin an alternative model of youth justice. The principles should be considered as both a guide and a standard for service delivery organisations and providers.[28] The RACP recommends the principle of self-determination as an underpinning principle: provide opportunities for children and young people to have a voice and contribute to the development of policies and services for their benefit.[29]

Other principles that we recommend be considered include;

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

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

As previously mentioned, there is an established link between children in Out of Home Care (OoHC) and juvenile incarceration, the younger children are incarcerated, the more likely they are to be known to child protection (e.g. to have experienced psycho-social trauma).[30] For this reason, the RACP recommends preventative health focused solutions for children who have interreacted with the child protection system and children with complex health and social issues. Children who experience or are at risk of trauma, mental health issues, developmental issues, interaction with the child protection system and incarceration have greater need for health services. Addressing health inequities using a strengths based approach can both prevent long term health issues and potentially reduce interaction with the criminal justice system.

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

In addition, access to preventative, integrated multidisciplinary programs should be available to all children regardless of location, socio-economic status or living circumstances. There is now clear evidence that children in the youth justice system in Australia (both above and below 14) have high rates of additional neurocognitive impairment, trauma and mental health issues.[31,32] These issues markedly increase their vulnerability. Additionally, these children are much more likely to be disengaged from the education system.

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

The RACP recommends increasing health service capacity through providing strong and truly universal child health and education services that deliver the right care to children for their health and development.[33]

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

- Use of programs that have been proven to be effective by high quality research and that have a clear evidence base in promotion of resilience in high risk young people.
- Regular evaluation of services to ensure that program implementation is of high quality and appropriately targeted, and results in increased access, quality and affordability; and
- Providing adequate funding for high-quality evaluations of the evidence used to design service provision.[34]

Services can be supported by developing and implementing equitable health, education, employment, housing, early childhood and welfare policies.[35]

Conclusion

The medical evidence is clear, the age of criminal responsibility should be raised to at least 14 years of age. The RACP strongly supports the Bill and encourages the Queensland Parliament to legislate raising the age of criminal responsibility in line with medical evidence.

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