Youth Justice Reform Select Committee inquiry into youth justice reform in Queensland

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Submitted by:	Desley BETTENS
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Desley Bettens

Date: 28/11/23

Dear Member/Youth Justice Reform Select Committee,

<u>Re: Community issues of concern which I request be tabled/discussed at Federal Parliamentary level and committee</u> – Townsville (Qld)

The following issues relate to youth crime and youth justice as they are all interlinked and contributing factors to extraneous social issues, particularly 'Justice' services/supports.

I was recently asked by a local member to put my concerns in writing. My concerns are as follows: -

1. <u>Juvenile Crime</u>:-
   a) Anarchy prevails and is exponentially increasing and unfortunately, becoming the new status quo.
   b) Increasing risk to community, possessions, and resources
   c) Increase in community poor morale and lack of faith in establishment or law/legislation/QPS/Judicial system.
   d) Community members, QPS, QAS (First line responders) are NOT safe in their day to day activities.
   e) The Elderly are frightened to leave their home.
   f) Daily cost of living exacerbated by juvenile crime eg security cameras etc needed as a normal need for the family home/business/car security.
   g) Contemporary (Government) response management is a failure.
   h) Response plans do not meet idiosyncratic needs (perpetrator/behaviour).
   i) Informative Wholistic, Comprehensive assessments and management are **not** reliably undertaken nor designed.
   j) Funding is not being maximized to the fullest potential because management/rehabilitation /intervention planning is inadequate nor developed nor delivered by adequately trained/skilled/competent staff.
   k) Efficacy of management plans are not adequately monitored/reviewed.
   l) **Consequences need to be MEANINGFUL. Current remedial practices do not reflect that in any form**.
   m) **Government agencies are reluctant to accept referrals for, or conduct NeuroPsych Assessments based on the 'cost' factor.** This is a false economy because mis managed juveniles/clients frequently develop into further compromised individual's - emotion/mental/physical/medical health and wellbeing and poorly prepared individuals for the future. IT COSTS MORE TO DETAIN A PRISONER OR HOSPITALISE A PATIENT

THAN IT DOES TO CONDUCT A NEUROPSYCH ASSESSMENT IN THE BEGINNING. Please see below, online explanations of NeuroPsych information -

The cost of a neuropsychological assessment in Australia **depends on many factors**[12]. As a guide, the cost of an adult neuropsychology assessment is between $2100 and $3000[1]. However, fees for a neuropsychological assessment can be as low as $600 inclusive of interviews, testing, a written report, and a feedback session, or $300 for concession card holders[3].
https://www.bing.com/ck/a?!&&p=4e6cf5370e80b29cJmltdHM9MTY4NzIxOTIwMCZpZ3VpZD0wZjA0N2JkYS01OWE3LTZiZjItMWVkMy03Njk3NTg5ZDZhYjEmaW5zaWQ9NTYyNQ&ptn=3&hsh=3&fclid=0f047bda-59a7-6bf2-1ed3-7697589d6ab1&psq=cost+of+neuropsychological+assessments+in+Australia&u=a1aHR0cHM6Ly9jbGluaWMucHN5Y2hvbG9neS51cS5lZHUuYXUvbmV1cm9wc3ljaG9sb2dpY2FsLWFzc2Vzc21lbnQ&ntb=1

The purpose of a neuropsychological evaluation is to understand how medical conditions, like HI, or treatments involving the brain or central nervous system affect the person's development, including impacts on cognitive, emotional and behavioral functioning.

Are neuropsychological tests for brain damage?
A neuropsychological assessment consists of a variety of tests designed to measure the damage caused by brain injury. It provides more information about a person's cognitive capabilities than a basic neurological evaluation. A neuropsychologist, who is a psychologist with a Ph. D. or Psy.

How accurate is a neuropsychological test?
What is neuropsychological testing? During the past decade neuropsychological testing has become a very sophisticated science. Currently available tests are highly regarded

What are the two 2 main reasons for conducting a neuropsychological assessment?
The major purposes of a neuropsychology assessment are to assist with questions about:
Integrity of cognitive functions. The evaluation is helpful to determine the presence, nature, and severity of cognitive dysfunction. ...
Differential diagnosis – to confirm or clarify a diagnosis. ...
Treatment planning.

https://sog.net.au/neuropsychological-assessment-what-is-it-and-when-is-it-needed/
https://neurotreatment.com.au/neuropsychological-assessment.aspx

In Conclusion

Juvenile and adult crime is fiscally draining on the federal budget; is increasing already exorbitant funding expenses and causes

insurmountable pain and suffering on the public, individuals, communities, business, environment, tourism and cost of living etc

Contemporary NeuroPsych Assessments cost @ $3000 and incarceration costs @ $1million per head. Doesn't' take a rocket scientist to work out the best deal A!

Comparatively speaking, the nominal cost of a Neuropsych Assessment far out ways the cost of incarceration/hospitalization and is clearly cost effective.

Analogy :-

The health official who waits till a splinter injury turns to gangrene/amputation before they treat the compromised area. EARLY INTERVENTION CONDUCTED BY HIGHLY SKILLED/SPECIFICALLY TRAINED /QUALIFIED PERSONELL minimizes costs in the long run and maximizes the positive potential of a more proactive and functional future for the individual!

My Direct observations/involvement

i) I asked the Team Leader of a Juvenile Corrections organization (Qld Gov), to see the baseline of a mutual client of our services who was incarcerated in Juvenile corrections. The Team Leader advised, none had been conducted and was not a regular part of their 'care'. When I asked how the organization was able to measure the impact of their 'interventions' he was unable to answer me. The reliability and validity of their interventions was not evident nor would have withstood the rigors of a judicial enquiry/investigation.
ii) A number of the clients were very open about Juvenile Corrections being positively reinforcing and a positive part of their life because it was better than being on the streets or being in the damaged family environment and how they would often engage in activities that would ensure their return to Juvenile corrections.
iii) Many of the children showed signs of intellectual compromise, be it environmental/ physical/genetic/social.
iv) General observations regarding contemporary crime appear to reflect protection for the perpetrator and not the victim/s. Victims of crime are rapidly increasing - the correctional/justice outcomes are failing and adding to recidivism. CHANGE NEEDS TO OCCUR IMMEDIATLEY.

Recommendations.

a) Neuro psychological assessment conducted on all youth who require service provision (health / justice) to determine their level of cognitive functioning which would then enable a more effective, idiosyncratic, comprehensive, and effective behavioural management plan opportunity.
b) Ensure the availability of clinical Psychologist who can conduct Neuro Assessments are a pivotal component/criteria in staffing.
c) Juvenile services provide planning for sound, measurable and inclusive behavioural management plans as part of the admission process, management, review process.

d) Ensure staff recruitment includes intensive FORMAL training and competency in child development and behaviour management principles and practice.
e) Review and change legislation to ensure juvenile /adult crime reflects community and victims' protection.
f) Decrease 'short cuts' for the offender to avoid outcomes. Far too many 'outcomes' (legislative/systemic outcomes) are toothless tigers and viewed as a joke by offenders.
g) Make breaches of bail a criminal offence with significant meaningful deterring outcomes for the perpetrator.
h) Mandatory training for first responders in cognitive and mental health crisis care and brain/development and behaviour management.
i) Mandatory reporting is NOT being practiced by majority of health/first responders. Implement a system whereby mandatory reporting is recorded in basic documentation reporting.
j) 'Boot Camp' type facility where the perpetrators/offenders are under intense observation and idiosyncratic interventions for at least 12 months before they can be considered for discharge/return to the community. I have regularly offered my assistance to develop a trial/programme to meet anti-social behaviours in this group however no governmental organization has taken up my offer.

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2. <u>Basic Education: -</u>

Students appear to be 'running' the class/education standards and teachers are now victims of the student's antisocial behaviour. Teachers have all responsibility and accountability yet are not allowed to implement control or direction. It's become a very dangerous profession run by the increasing number of uncontrollable children who ultimately will eventually find themselves living the consequences by being unemployable in their future.

My Direct observations/involvement -

a) Australian education standards are now subpar and not preparing students for future employment needs. Graduates (primary, high, TAFE, university) enter the employment realm with poor literacy and numeracy skills because of, what appears to be, the educations system/ focus on funding and the universities reputation, based on number of graduates, rather than graduate's competency. *Student failure does not attract revenue/funding*, consequently students are 'passing' without the necessary basic skills for future needs.

My Direct observations/involvement -

v) Whilst undertaking my Education degree I needed to seek advice from a Senior high school teacher - regarding an issue which I knew I had learnt in Grade 4 (Primary school). Unfortunately, I could no longer recall the required explanation and fully believed a teacher of his status would be well versed in this matter. This senior High School English teacher advised me he couldn't help me as he hadn't learnt about that at school/university and further advised, that none of the other English teachers would be able to assist me either. How could a Senior High School teacher not know, what was basic English being taught in Grade 4 primary school (in my time)?
vi) I had three international exchange students advise me they had thought they would be receiving a high standard of nursing health care education in Australia and were sorely disappointed with the Australian education standards compared to that of their own country. All three believed their parents had wasted their money; the

students were wasting their time and effort with the Australian education standards and firmly believed they would have received a higher standard of education in their own countries. Having compared the relevant countries' education standards, I had to agree with the 3 students.

3. <u>Higher Education:</u> -
   Is not preparing graduates for contemporary workforce needs.

   My Direct observations/involvement -

   a) TAFE educator
      – students in Enrolled Nursing graduate with substandard knowledge and skills. This grave situation now offers far too many graduates who will be dangerous practitioners. I have personally been involved with several students, one of whom I identified to have had learning / intellectual disabilities, yet TAFE allowed them to progress through the course and graduate. Too many students lacked basic numeracy skills yet would be working with patients who will be at high risk of harm by the poorly educated graduates. Once employed, graduates are required to write reports/notes on patients. Far too many of these 'notes' contain multiple spelling errors, poor grammar/syntax or poorly reported activities/actions/planning and whilst they are accepted by management these notes will not withstand the rigors of judicial investigation.

      vii) Students have submitted assignments which did not meet the criteria of the module. One students' assignment had been scribbled over, on every page yet the student submitted it and I was assigned to mark it. I later returned this assignment to the author and asked her to return it in a more professional manner. She returned the original 'damaged and substandard' assignment and expected I mark the very same assignment again. TAFE management accepted the original assignment therefore sending out message that professionalism was not a requirement.

   b) Having worked extensively with people with intellectual disabilities, I readily identified one student in my class to clearly have an intellectual disability yet was conducting her last module before graduation. I raised this with the manager who subsequently liaised with the other TAFE teachers who had been 'passing' her over the course. The feedback exposed the other 'TAFE teachers' had been passing her because "We didn't' have the heart to fail her, because she's nice". I was appalled that these 'professional' TAFE educators were passing this student. Too many ill-equipped students in Enrolled Nursing are graduating and too many will be dangerous practitioners. I have personally been involved with several students whom I identified to have had learning / intellectual disabilities, yet TAFE allowed them to progress through the course and graduate. Too many students lacked basic numeracy skills yet would be working with patients who will be at high risk of harm by the poorly educated graduates. Graduates are required to write reports/notes on patients. Far too many of these 'notes' contain multiple spelling errors, poor grammar/syntax or poorly reported activities/actions and whilst they are accepted by management these notes will not withstand the rigors of judicial investigation.

      viii) Sadly, these Educators were prepared to expose the vulnerable public to the care of graduates who clearly demonstrated that they would be unable to undertake the skills required to meet the needs of vulnerable patients and unable to meet National Health Standards.

c) One student asked me to approve his assignment. When I questioned some of his answers it was blatantly clear he had not done the assignment and had not even basic understanding of what 'he' had allegedly written. When I advised him, it was clear to me that he hadn't done the assignment himself and that his knowledge base on the subject was grossly inadequate he just advised me to the effect, 'it didn't matter if I didn't mark it for him, he'd just get someone else to pass him' and he did. A few months later I saw him working on my unit as an Enrolled Nurse.

3) University Education

Students are graduating with poor literacy skills. Too often I observe graduates with master degrees (often multiple Masters) whose literacy skills are very poor. At one time, I raised these concerns to the then PM when he conducted a community forum in our city. The University staff were nodding their heads in agreeance and later came to me to express their frustration and concerns too. They advised me the undergrads enroll into their course and because there is no time in the curriculum to include literacy education skills the students are left to their own devices to improve their literacy skills.

My Direct observations/involvement -

i) I have taught nursing undergraduates at university and was surprised, appalled, embarrassed, and disgusted by the standards of education at that level. Although it did explain why there are so many new nursing graduates entering the health system with poor/incompetent skills levels.

ii) Some international students had very poor English comprehension skills yet had been passing their assignments. When I discussed the assignment content with them, it was clear they lacked the knowledge required for the completion of the assignment.

iii) One student graduated after 6 years of intensive support to conduct a 3-year nursing degree. Whilst she was 'buddied up' with me, it was clear she lacked the required concentration, knowledge and retention skills for her role and was clearly a danger to the public. As a Registered Nurse, she couldn't even perform basic mathematics for her drug calculations nor had the judgement or insight to enter a nursing role. It was later identified she had a brain injury which should have precluded her from entering nursing. She was allowed to resign and then

iv) obtained employment as a Registered Nurse in a specialized health service.

It appears to me that students are only required to prove their computer skills in assignments etc rather than actual knowledge. The number of graduate nurses who do not understand basic infection control and practices is possibly responsible for the increased infection rates in our health service.

v) One student whom I was providing intensive tutoring (her entry education standards were 2nd year high school level and she was semi-literate) , quite openly disclosed how she provided marijuana to her educator and that they shared in smoking it together. She was a regular substance abuser (including Schedule 8 drugs) and frequently under the influence of substances in class, yet she has been allowed to continue with her nursing studies.

vi) Another time, a poor performing student presented his assignment and, as his educator I readily identified he had NOT developed nor written the assignment he presented for marking. I immediately advised management of this however nothing was done, and I observed him working in Emergency Department as a First Year of Practice RN 3 months later.

Shamedly so, University is funded on Graduate numbers and not skilled, safe, and professional Registered Nurses. IT is however producing ineffective academics in the science of nursing but not the practicality/functional role of nursing. Nursing is no longer a patient-based care profession but an academic pursuit.
Australia claims to have a severe shortage of nurses, unfortunately too many of us senior nurses are leaving because of bullying and being victims of disrespect and undervalued (irrespective of the rhetoric of policy)

4. <u>Health Care:</u> -

In my 50 years of nursing, it has been my sad experience to observe the erosion and very dangerous decline in Australian education/health care standards. My primary focus of nursing care has been in mental health and disabilities, and I am appalled at how the standards of mental heath care is now functioning according to the lowest common denominator rather than appropriate WHO or National Standards. Funding is being misappropriated and wasted on programmes doomed to fail because agents involved are not skilled for the role. One significant example is NDIS and NGOs.

a) Mental Health -Contemporary practice is NOT meeting Mental Health National Standards (a significant number of clinicians don't even know of its existence) ; recruitment is not based on competency nor skills set; bullying is rampant and maintained by incompetent management; promotion is not based on competency or performance; cronyism prevails
b) Health management no longer appears to possess the knowledge, skills or high standards of supervision and mentorship and repeatedly allow these poor standards to be become the accepted standards of the organization.
c) International recruitment provides nurses who have a poor command of English (verbal, literacy); cannot provide factual clinical notes; unaware of Australian standards and policy and possess minimal to sub minimal standards in nursing care.

My Direct observations/involvement -

i) Remote Clinical Nurse earning over $100,00 p/a lacked the knowledge/capacity to conduct a basic mental health assessment or risk assessment yet had been in the role for over 3 years. Her literacy levels were primary school standard, and she would often save blank pages as clinical notes. She was a known marijuana user and would frequently present to work under the influence of the same. I was later nominated to teach her these basic tools of trade whilst she remained in her CN position and pay rate. Her incompetency and substance use (known by many) were never addressed, and the clients remained under her 'care'.
ii) Remote Clinical Nurse exhibiting an Acquired Brain Injury from alcohol was recruited and retained in an acute role.
iii) International Clinical Nurse, with long term employment at the facility, who didn't possess the basic skills for a RN, was unable to write basic clinical notes or

identify basic chart items and didn't even have the skills to open his emails. I expressed my concerns to management on 3 separate occasions and included my suspicions that it was highly likely that he'd been employed under a 'false identity'; that he was a dangerous practitioner and a high risk to the patients - I was directed to "Shut up" and not raise the issue anymore.

iv) One international RN was administering a Scheduled drug as per written prescription. When I had raised my concerns with her that the prescription was in error, she repeatedly informed me it was "Doctors orders" and had been administering it even though she knew it contained an error. She further advised, in her country, the nurses follow the doctors' orders regardless. When I raised the issue of Australian Drugs and Poisons Act she wasn't aware of its existence and wasn't aware she was breaching it, as were the other RNs from her country in that establishment.

v) I had police assistance to transport a self-harming client with serious risk to her person. The admission CN in charge on the acute units shift and the second nurse, had no idea how to manage the clients risk and I had to explain the required nursing risk management plan required for such high risk. Their incompetency was alarming and very concerning.

vi) Bullying is rampant and it appears management promote the perpetrators. I have personally witnessed a number of formal complaints and a team's formal complaint about the serial bully in the establishment. I found one highly experienced RN in the foetal position in dark broom cupboard as a direct consequence of that same bully. That RN had to resign and has never worked a day since because she was so brutalized and traumatized by the serial bully. I know of 20 nurses resignations, directly related to that same bully and yet that same bully was later promoted to a more senior position.

vii) In the clinical notes of one client (Rehabilitation unit) I observed a clinical intervention that was grossly illegal, unethical, immoral and unprofessional and had placed the client at a very high risk of renal damage or cardiac failure or death. From the notes, this programme had been ongoing for a number of weeks and implemented by all the staff. I raised this programme with the non-nursing Team Leader who was unaware of the gravity of the interventions consequences. . When I advised her that even under the Geneva Convention, this particular practice was illegal. She didn't know what the Geneva convention was and I had to explain it to her. When I asked when the client had had a medical assessment to justify this intervention, she advised none had been undertaken and she didn't know that such an assessment was required. When I asked which doctor formally approved it, she advised she wasn't aware it was required. As it turned out, the programme had been developed by a First Year of practice RN who had absolutely NO experience in behaviour management development nor the medical, health legal requirements nor the scientific based practice needs, reliability nor validity. I was sick with concern for this client as she was under Qld Health care and yet her health and life had been put at risk by so called professionals. I did report same however management seemed to be uninterested, and I was no longer privy to the clients files.

viii) I have witnessed falsified clinical notes over multiple shifts in several organizations. Not only is this illegal, it's also unprofessional and unethical.

ix) One international RN advised me, in her country, the family care for their elderly and if the families of the elderly in Australia, didn't care enough to home their elderly, then why should she. Her behaviour with the residents reflected her attitude yet NOTHING was addressed by management.

x) When reporting a patient are concern, a highly experienced RN was advised by her young (newly graduated) RN manager that patient care was no longer the focus of nurses now, as patent care was about funding. That RN immediately retired from the profession because she felt her(obviously antiquated) patient foci care no longer had any value in contemporary nursing practice and she was not prepared to prostitute her values, dignity, ethical and moral values for the sake of the almighty dollar.

xi) A personal friend of mine was depressed with suicidal ideation. The young and inexperienced Psychologist 'treating' this person, advised my friend of a mode of operandi which would maximize his chances of completing suicide. The Psychologist even suggested a long quiet road (location)

xii) I personally retired earlier than I planned because of my own similar experiences as in (x). I too refused to prostitute my professional, ethical and moral values for the sake of Australia's new health care model and (Preventable) and predictable dilemma.

5. <u>Child Safety:-</u>
   It became my overall observation that Mandatory Reporters are NOT making Child Safety reports because each service assumes "the other" service providers will have or will do it. The child is therefore further compromised by the critical risks and future negative impacts because Mandatory reporting has NOT been implemented for 'years'.

Under resourced and inappropriate recruitment of inexperienced or immature young practitioners results in high turnover, inadequate stable care management and serious risks to the public/clients. Inexperienced staff (Life skills) are ill prepared for the atrocities involved with child safety issues resulting in inconsistent care and service. Far too many times, I've observed a new clinicians exhibit confidence far superior to their competence.

a) Poorly skilled (compromised competence) staff, Inadequate assessment, and lack of timely responses lead to further damage to the victims and future risk of biopsychosocial trauma. Neural pathways are set very early in a child's development; however, these are being destabilized/damaged through ongoing trauma and further disadvantages their development, learning, maturing and adult life.
b) Reactive management fails the child and significant others in that circle.
c) Prevention measures are failing due to lack of adequate effective/efficient management and resources.
d) **Health professionals not reporting child safety issues, irrespective of their mandatory training regarding mandatory reporting responsibilities.**

   It is my observations and opinion, "Mandatory Reporting" is <u>**NOT**</u> clearly understood by the employees who are mandated to conduct 'Mandatory Reporting'. As such far too many children are 'slipping through the cracks', which is

a sad indictment on our society and a derelict of our duty as professionals.

e) Substance using parents/mother need to have more supervision with parenting & skills development.

My Direct observations/involvement -

i) I worked at a specialist health services where management directed me not to conduct child safety reporting till, I had received approval from management. I advised them that as an RN I was required under APHRA and mandatory reporting policy to report. I later worked with their long-term medical officer and when I advised him, he was mandated to report a specific child safety issue, he advised me he had NEVER made a child safety report, EVER, even though that service had extremely high risk children in their care.

ii) Multiple child safety reports were made on an at-risk female child. That child remained in her mother's care, even though the mother was bringing men into the home, [redacted]. That young child grew up into a promiscuous, drug-abusing teenager with antisocial behaviour and frequently in contact with the police. That young girl grew up believing her only purpose was to sexually please and be available to men.

iii) A mother would harm herself in front of her very young daughter. This young child would be the one who would have to ring the ambulance and care for her mother, clean up the blood and provide post hospitalization care. Child safety left that child in her unstable mothers' care on every occasion.

iv) On regular and frequent occasions, it surprised me, the number of mandatory reporting agents who did not report because each service left it to the other services to report. Subsequently too many mandatory reports were not made through lack of responsibility by each agent.

***Child safety mandatory reporting is failing and too many children are left at high risk by professionals mandated to protect them*.**

v) Accountability for poor management and poor adherence to professional activities / guidelines/ legislation is at a substandard level

COMPREHENSIVE RECOMMENDATIONS

i) Water tight assurances that National Standards are met and proven to be met (no more box ticking actions). On line training is no reflection of skills development.

ii) Royal commissions need to conclude with directions not recommendations.

iii) Return nursing to patient/humanity foci and hospital training. This would improve nursing knowledge and comprehension and alleviate the national nursing shortages .

iv) Neuropsych assessments on all clients who come into juvenile and adult correctional services

(i) Insure recruitment of competent and highly skilled staff with a proven/qualified record with effective behaviour management programming skills

(2) Focus on the clients need rather than the budgets need. Employing inadequately skilled staff is ineffective and inefficient and highly dangerous

v) Proactive management rather than Reactive management

vi) Provide adequate ongoing funding for juvenile 'boot camp' type programmes and programmes which demonstrate significant positive outcomes through professional and ethical processes, and which decrease recidivism, antisocial behaviours etc Animal care/therapy has proven to be positively effective.

vii) Politicians to cease responding (to contact from concerned constituents), with the now expected rhetorical, templated, generic type emails etc. Politicians need to exhibit genuine interest in the community's concerns and keep us updated with their responses to the concerns of the individuals. Take us seriously! *In ALL my endeavors to approach parliamentarians, Bob Katter and Phillip Thompson are the only ones who demonstrated an assertive interest by responding personally to the individual issues I had raised and followed up with what I had discussed with them*.

viii) Committee members need to include personnel who have first hand experience with the foci issues and not just other governmental bodies.

The verbosity of my document, I feel, is required to reflect the enormity of the issues in the new Australian accepted standards (or lack thereof 'standards') and contemporary social issues and responses/ practices across services and disciplines.

The above issues are by no mean definitive and I have many more to discuss if called upon to do so.

As a qualified Programme Officer (Behaviour and Skills Building) I have experienced significant success in my field am I am able to avail myself for consultancy work with developing assessments (& tools) and relevant programming activities.

Thank you for taking the time, from your busy schedule, to read my submission and I would like to hope I will hear from a member who genuinely wants to improve our service/care delivery in Australia and who values the rights of each citizen to be heard and valued for their input.

Regards

Desley Bettens.