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Submission to the Council of Attorneys-General review of age of criminal responsibility

February 2020

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health 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 welcomes the opportunity to provide a submission to the Council of Attorneys-General review of the age of criminal responsibility.

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Responses to review questions

1. Currently across Australia, the age of criminal responsibility is 10 years of age. Should the age of criminal responsibility be maintained, increased, or increased in certain circumstances only? Please explain the reasons for your view and, if available, provide any supporting evidence.

The Royal Australasian College of Physicians (RACP), along with 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. It is inappropriate for 10 to 13 year olds to be in the youth justice system.

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.

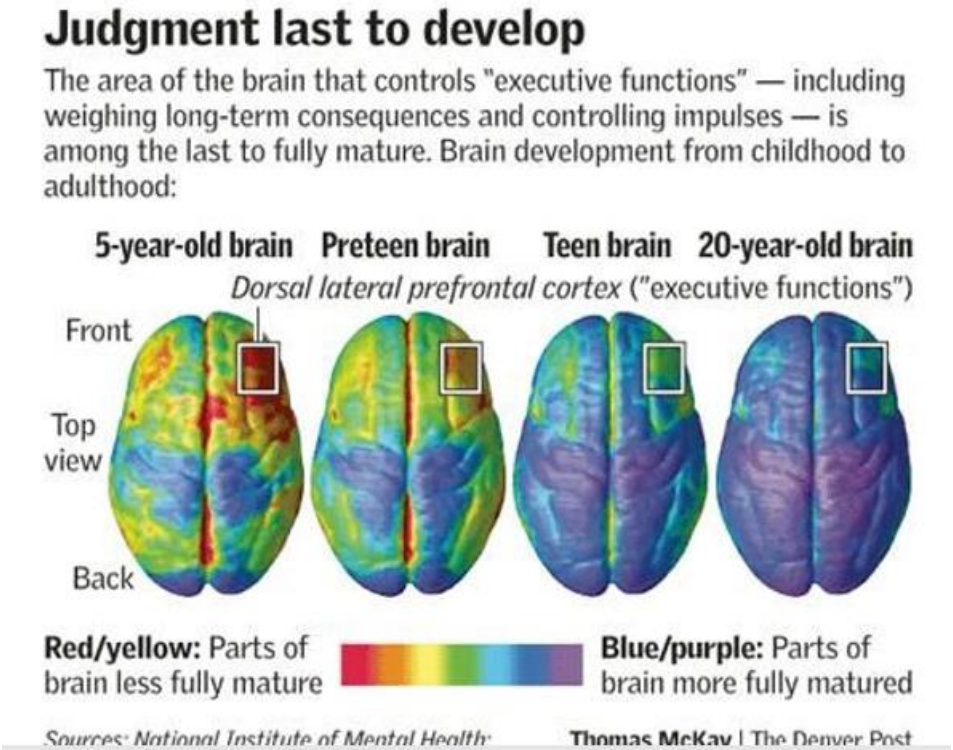
Evidence:

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.

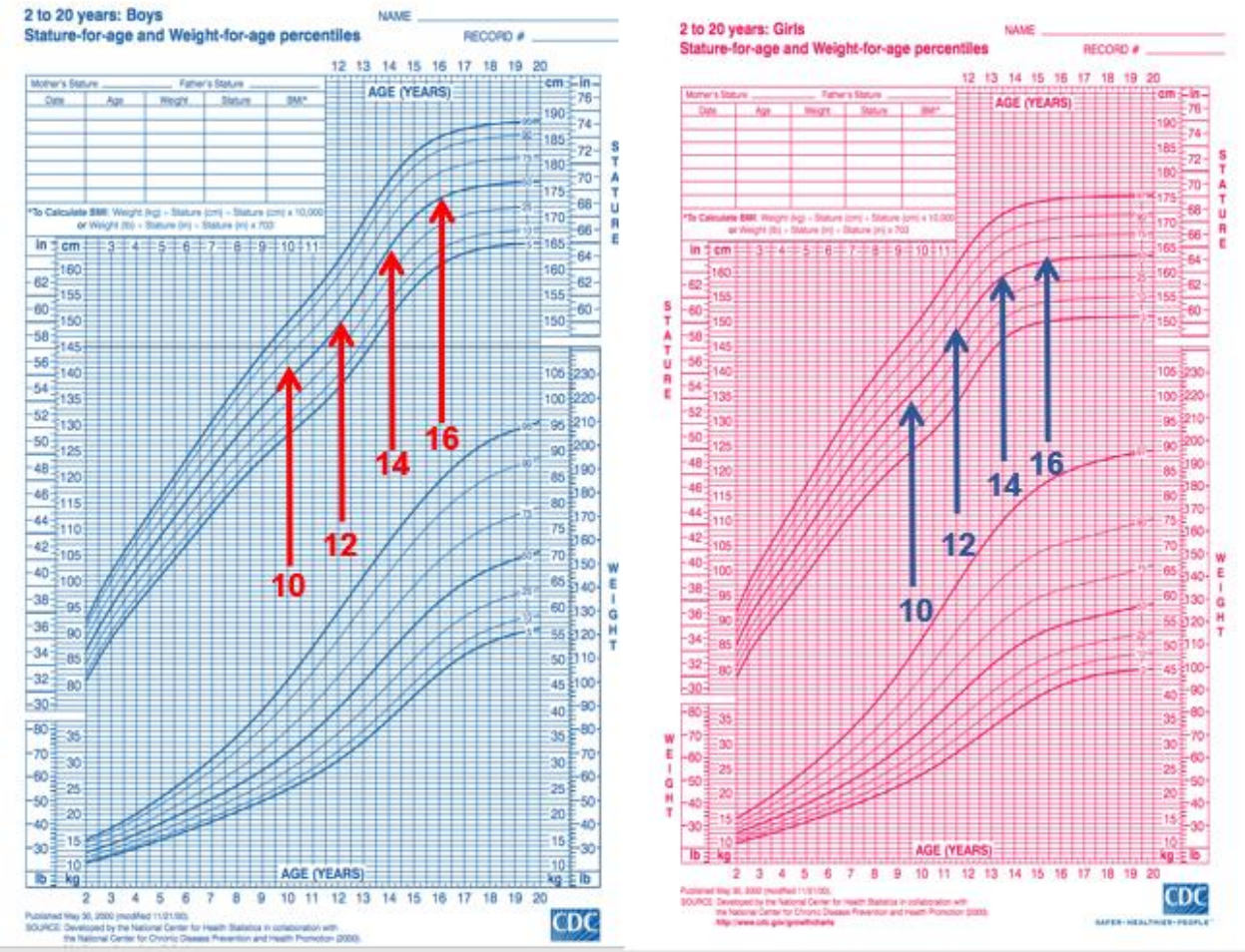
An average 10-year-old boy is 138 cm tall, with some boys still being as short as 125 cm at the age of 10 years. 10-year-old boys weigh on average 31 kg with some still weighing as little as 23 kg.

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.

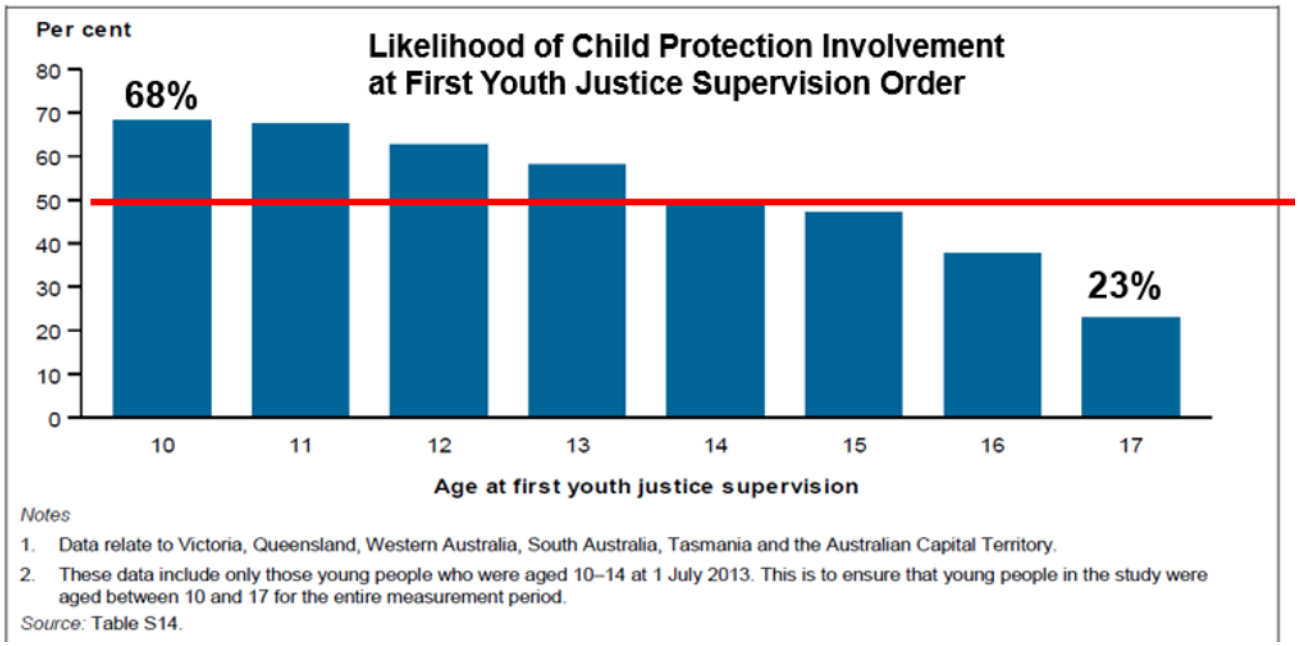
Children who are placed in out-of-home care (OOHC) experience higher levels of behavioural and mental health issues than children from similar backgrounds who are not in placed in care.[17] Green et al identified that children who were placed in out of home care during early childhood were 5 times as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



Notes

1. Data relate to Victoria, Queensland, Western Australia, South Australia, Tasmania and the Australian Capital Territory.
2. These data include only those young people who were aged 10–14 at 1 July 2013. This is to ensure that young people in the study were aged between 10 and 17 for the entire measurement period.

Source: Table S14.

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.[22] In Victoria, of 181 children in a Custodial Setting, 145 incidents of school expulsion were noted in one year.[23]

2. If you consider that the age of criminal responsibility should be increased from 10 years of age, what age do you consider it should be raised to (for example to 12 or higher)? Should the age be raised for all types of offences? Please explain the reasons for your view and, if available, provide any supporting evidence.

Given the physical and neurodevelopmental vulnerabilities outlined above, the RACP recommends that the minimum age of criminal responsibility be raised to at least 14 years of age.

The evidence presented in response to question 1, relating to the physical and neurodevelopmental vulnerabilities of children, and the effect of exposure to childhood trauma, applies to all children regardless of offence.

The RACP is a medical organisation and is not able to comment on specific types of offences.

3. If the age of criminal responsibility is increased (or increased in certain circumstances) should the presumption of doli incapax (that children aged under 14 years are criminally incapable unless the prosecution proves otherwise) be retained? Does the operation of doli incapax differ across jurisdictions and, if so, how might this affect prosecutions? Could the principle of doli incapax be applied more effectively in practice? Please explain the reasons for your view and, if available, provide any supporting evidence.

The RACP is a medical organisation and is not able to comment specifically on doli incapax or jurisdictional matters.

To reiterate the response to question one, given the high rates of undiagnosed neurodevelopmental impairment and mental health issues concerns, it is likely that children in contact with the youth justice system have diminished capability. Consequently, we recommend a thorough trauma informed psycho-social, developmental and educational assessment of all children coming in contact with the youth justice system is conducted by paediatricians and relevant medical professionals.

4. Should there be a separate minimum age of detention? If the minimum age of criminal responsibility is raised (eg to 12) should a higher minimum age of detention be introduced (eg to 14)? Please explain the reasons for your views and, if available, provide any supporting evidence.

The RACP recommends government investment in strategies that reduce of the number of children in detention.

The most important determinants of a positive adolescence, (e.g. the transition from childhood to adulthood), are connection to family, connection to community, engagement with the education system and positive peer experiences. Incarceration effectively removes a child from all of these potentially positive influences and may increase the risk of a child experiencing a negative trajectory towards adulthood.

Incarceration is also likely to exacerbate existing mental health issues in children with existing trauma issues. Practices such as, “isolation” and experiences such as “boredom, bullying, and victimization” are significant stressors experienced by young people during incarceration.[24]

The RACP would like to stress that children should only be held in remand and detention when absolutely necessary. Children’s hearings should be fast tracked to avoid long periods in detention. There are cases of children spending unnecessary time in remand awaiting a charge, only to not receive a charge.[25]

5. What programs and frameworks (eg social diversion and preventative strategies) may be required if the age of criminal responsibility is raised? What agencies or organisations should be involved in their delivery? Please explain the reasons for your views and, if available, provide any supporting evidence.

Framework: A different paradigm is needed to respond to problematic behaviour

The RACP suggests a framework that would allow provision of assessment, appropriate care, treatment and support for children exhibiting problematic behaviour. Children who have immature neurocognitive development, experienced trauma and neurocognitive impairment behaviour (poor impulse control, inability to fully understand the consequences of one’s actions) have complex health needs.

Some principles to keep in mind for supporting children who have been traumatised include:

- Trauma informed models of care
- Provide safe environments;
- Support children and caregivers to understand links between traumatic experiences and cognitive difficulties;
- Develop and support positive relationships in children's lives;

- Offer all children in care targeted trauma-specific interventions;
- Maintain these interventions throughout childhood and adolescence; and
- Ensure separate cognitive difficulties are addressed directly.[26]

The current approach of criminalisation of problematic childhood behaviour does not align with the above recommendations. The current approach may further traumatise children who have already experienced trauma. Trauma informed and developmentally appropriate approaches to managing problematic behaviour are likely to be less damaging to young children, and evidence shows incarceration in this age group does not deter future offending.[27]

Prevention
The trajectory towards involvement with the youth justice system may start even before birth for some children, as can be demonstrated through the established links between: alcohol consumption during pregnancy, FASD/neurocognitive impairment, OOHC, OOHC placement breakdown, drug and alcohol misuse, and juvenile justice.[28]

To prevent this trajectory investment is required in upstream programs that:

- Reduce alcohol consumption during pregnancy
- Support the needs of parents and families so that children can remain within families
- Support stable family based placements for those in Child Protection Out of Home Care
- Support children with neurocognitive, learning and behavioural issues to receive appropriate health care and remain engaged with education
- Provide trauma based mental health services for children with trauma histories

See also response to question 6.

Assessment of needs and addressing needs

Children will only receive the support that they require if their needs are assessed. To this extent there are several sentinel points where this may/should occur including: schools, child protection and health care.

While there are number of national standards and recommendations from peak bodies relating to the care of children at risk of entering the justice system, paediatricians anecdotally report that these systems are currently struggling to meet the needs of these children.

Schools
Schools are ideally well place to detect children who are struggling behaviourally and/or academically, arrange for assessment of learning, behavioural and mental health needs. Schools also need support to retain children with problematic behaviour in the school environment.

However, rates of school suspensions, even in primary school are high. There were 9000 primary school students in NSW who received a suspension in 2018.[29]

Child protection: National Standards for Children in Out of Home Care
There is currently a missed opportunity to assess children's needs and arranging supports while in the Child Protection System.

The National Standards for Out of Home Care outline at least three relevant standards to providing children in OOHC with the assessments, care and support which they need:

- **Standard 4 -** Each child and young person has an individualised plan that details their health, education and other needs.

- **Standard 5 -** Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way (ideally within months of

entering OOHC with a multidisciplinary assessment by paediatrician, psychologist and Speech Pathologist).

- **Standard 6 -** Children and young people in care access and participate in education and early childhood services to maximise their educational outcomes.[30]

The common experience of RACP paediatricians who see children in the OOHC system is that relevant assessments have not been done, and children are not having their developmental, mental health and emotional needs met.

Child mental health services
The Victorian Chief Psychiatrist in 2011 recommended that Child and Adolescent Mental Health prioritise Children in OOHC.[31] However, the Victorian Auditor General's Report: Child and Youth Mental Health Services, tabled in parliament in June 2019, noted: only one of the five audited child mental health services has implemented the Chief Psychiatrist's 2011 guideline to prioritise children in OOHC.[32]

The National Disability Insurance Scheme (NDIS)
The NDIS deserves specific mention as it is new, largely untapped and has the potential to provide support for children with neuro-cognitive and other developmental disabilities, based around their needs.

The role of the paediatrician: a behavioural approach based on a developmentally appropriate assessment

Behavioural paediatricians are skilled at working with children and their families to help them develop appropriate strategies and consequences to manage problematic childhood behaviour. Paediatricians often see children with behaviours (e.g. climbing onto a school roof) which under some circumstances might result in a child being charged for a criminal offence. However, our approach is to assess the child and try to better understand the cause of the behaviour, and based on this assessment work with the child and family to address the problematic behaviour

RACP members including adolescent physicians and paediatricians (specifically developmental and behavioural paediatricians) are available to:

- Diagnose and manage behavioural issues such as attention deficit hyperactivity disorder, oppositional defiance disorder.
- Conduct developmental assessments and mental health reviews.
- Provide referrals to educational assessments to enable appropriate school support.
- Support and treat children with behavioural and developmental issues.
- Arrange appropriate links to National Disability Insurance Scheme services.

Clinicians work with children and families to help children develop a sense of responsibility for their own actions. In fact we do this from a young age (for example, if a three-year-old throws their Lego across the room, they help clean it up and the Lego goes away for a while).

The RACP argues that access to health care and support services should be available for 10 to 13-year olds with problematic behaviour. A child with problematic behaviour turning 10 years of age should not result in contact with the youth justice system instead of appropriate health assessment and treatment. Government investment is needed to ensure children have access to affordable and necessary services.

The RACP position statement on the Health and Wellbeing of Incarcerated Adolescents provides further detail on the health issues of young people in contact with the criminal justice system.

Please note this submission does not discuss alternate approaches to sentencing within the legal system which may include Diversion Programs, and Restorative Justice approaches such as Group and Family Conferencing as this is outside of the RACP's areas of expertise.

6. Are there current programs or approaches that you consider effective in supporting young people under the age of 10 years, or young people over that age who are not charged by police who may be engaging in anti-

social or potentially criminal behaviour or are at risk of entering the criminal justice system in the future? Do these approaches include mechanisms to ensure that children take responsibility for their actions? Please explain the reasons for your views and, if available, provide any supporting evidence or suggestions in regard to any perceived shortcomings.

Please see response to Question 5.

The approaches, including trauma informed, developmentally and culturally appropriate approaches outlined in response to Question 6 are equally applicable to children under the age of 10 years.

In most jurisdictions, if a 9 year old child was found by police to be in a stolen car, or if they were involved in an assault on another child, these actions would be considered serious child protection issues and attempts would be made to put supports around this child and their family. The child may be referred to a mental health worker/service for assessment and management of behavioural issues. They may be referred to a paediatrician for consideration of medication and attempts would be made to keep this child in the education system.

7. If the age of criminal responsibility is raised, what strategies may be required for children who fall below the higher age threshold and who may then no longer access services through the youth justice system? Please explain the reasons for your views and, if available, provide any supporting evidence.

In reality, the youth justice system currently offers few direct services for children with problematic behaviours or developmental needs. In fact, the responses to Questions 5 and 6 indicate that the responses outside of the youth justice system are needed to address health issues.

Age should not be a discriminator for appropriate service provision. RACP recommends full access to appropriate health services for children of all ages. There is an opportunity to reframe the problematic behaviour as a child protection concern and provide support through the child protection and health systems.

8. If the age of criminal responsibility is raised, what might be the best practice for protecting the community from anti-social or criminal behaviours committed by children who fall under the minimum age threshold?

As per the response to question 5, the RACP recommends trauma informed, bio-psycho-social culturally appropriate approaches for children and their families to support children with behavioural needs.

9.Is there a need for any new criminal offences in Australian jurisdictions for persons who exploit or incite children who fall under the minimum age of criminal responsibility (or may be considered doli incapax) to participate in activities or behaviours which may otherwise attract a criminal offence?

This is outside of the RACP's areas of expertise.

10. Are there issues specific to states or territories (eg operational issues) that are relevant to considerations of raising the age of criminal responsibility? Please explain the reasons for your views and, if available, provide any supporting evidence.

No further comment.

11.Are there any additional matters you wish to raise? Please explain the reasons for your views and, if available, provide any supporting evidence.

Alternatives to incarceration of young children are available, a shift in paradigm is needed to appropriately support vulnerable children with problematic behaviour. While there may be a call for new and alternative approaches, it should not be overlooked that the framework to support children with trauma histories, and those with developmental, learning, behavioural and mental health needs exist. Unfortunately, those with the greatest need for these services, are often the ones most likely not to access these services.[33] The reasons for this are multifactorial and are often related to intergenerational socio-economic disadvantage.

Incarcerating young children increases the likelihood of further intergenerational disadvantage. Chronic underfunding of health, mental health and education services is a contributing factor. The NDIS offers new hope for those with neuro-cognitive disability.

We need a model that better supports families to protect their children, rather than a model where this responsibility is devolved to the state.

The over-representation of Aboriginal and Torres Strait Islander children in the youth justice system is well documented. We need to work with Aboriginal and Torres Strait Islander stakeholders to develop and resource community led solutions.

Raising the minimum age of criminal responsibility to at least 14 years allows extra time to put in place the appropriate supports for children, to address health issues and behaviour that may result in contact with the youth justice system.

RACP resources

The RACP position statement, The role of paediatricians in the provision of mental health services to children and young people, is a useful resource for further addressing children's mental health issues.

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