

The same four walls

Inquiry into the use of
isolation, separation and
lockdowns in the Victorian
youth justice system



COMMISSION FOR CHILDREN
AND YOUNG PEOPLE



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This report contains material that may cause distress. The illustrations contained in this report are an artist's impressions based on CCTV footage obtained by the Commission.

Letter to the Legislative Council and the Legislative Assembly



COMMISSION FOR CHILDREN
AND YOUNG PEOPLE

22 March 2017

Mr Andrew Young
Clerk of the Legislative Council
Parliament House
Spring Street
EAST MELBOURNE 3002

Mr Ray Purdey
Clerk of the Legislative Assembly
Parliament House
Spring Street
EAST MELBOURNE 3002

Dear Sirs,

The same four walls: inquiry into the use of isolation, separation and lockdowns in the Victorian youth justice system

I hereby request that the inquiry report produced by the Commission for Children and Young People be tabled in accordance with section 50 of the *Commission for Children and Young People Act 2012* (the Act).

I would be grateful if you could arrange for the report to be tabled in both the Legislative Council and Legislative Assembly on 23 March 2017.

I confirm that the Minister for Families and Children and the Secretary to the Department of Health and Human Services have each been provided with a copy of the inquiry report in accordance with section 49 of the Act.

The illustrations contained in this report are an artist's impressions based on CCTV footage obtained by the Commission.

Yours sincerely,

Liana Buchanan
Principal Commissioner



Acknowledgements

This inquiry has benefited from the input and experience of many different people.

Department of Health and Human Services staff helped us understand youth justice legislation and policies, and the rewards and challenges they face every day working in youth justice centres. We are grateful to every staff member who shared their experience and perspective with us. We also appreciate the contribution of Parkville College and health service provider YHaRS. Our findings are richer as a result of the views they shared with us.

The submissions we received from peak bodies and service providers added great value to our understanding of the issues explored in this inquiry.

The observations of our independent visitors were vital to this inquiry and we extend our sincere

appreciation for their efforts. Their reflections are only an example of the amazing work they do each month to make sure the voices of children and young people in Victorian youth justice centres are heard.

We would like to acknowledge the contribution of Dr Jenny Dwyer who provided valuable advice for the section covering the impact of trauma on children and young people.

Most importantly, we wish to sincerely thank the children and young people who told us what it feels like to spend minutes, hours and days in isolation, under separation plans or in lockdowns. They told us what made them angry, what hurt them, what helped them, and how they think it could be done better. We hope to have reflected their stories truthfully and with respect.

Commissioners' foreword

**Liana Buchanan**

Principal Commissioner for
Children and Young People

Andrew Jackomos

Commissioner for Aboriginal
Children and Young People

We initiated this report in the hope it would bring about better compliance with laws and policies that regulate the practice of isolation. We hoped it would prompt action to address long-term staff shortages that see children and young people locked in their rooms arbitrarily.

We still hope to see such action, but our findings have taken on extra significance given the current public attention to youth justice in Victoria. We hope that they will also give some new context to the current instability in the system, highlighting factors that have not featured in the community conversation and media narrative.

This inquiry began amid concerns that children and young people in detention were being isolated and locked down for extended periods without regard to the relevant legislative or procedural rules. Sometimes isolation was imposed to prevent the child or young person harming themselves, others or property. Sometimes it was imposed as part of a 'separation plan' to address a child or young person's behaviour or vulnerability.

At other times, children and young people were confined for extended periods in their rooms because of staff shortages.

No matter what the situation, our review revealed that the result was usually the same: children and young people enclosed alone between four walls with limited access to fresh air, human interaction, stimulation, psychological support and, in some circumstances, basic sanitation.

Youth justice practice must recognise the significant neurological and emotional harms that flow from isolation. Isolation has been found to be ineffective to manage difficult behaviour, and can instead exacerbate it. The problematic nature of excessive isolation has been widely acknowledged. The United Nations Special Rapporteur of the Human Rights Council has stated that the solitary confinement of juveniles – defined as the physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day – constitutes cruel, inhumane and degrading treatment. Victoria's *Children, Youth and Families Act 2005* only permits the use of isolation in limited circumstances and never as a form of punishment.

However, this was not the experience for many of the children and young people we spoke to as part of this review. They reported rolling lockdowns and extended confinement, and believed that isolation is used as a punishment. While some reported that ‘timeouts’ for short periods could help defuse their behaviour and emotions, they also said prolonged confinement made them angry, anxious and despondent. We heard stories of children and young people relieving themselves in isolation rooms due to lack of toilet facilities, and being deprived of toilet paper and personal photos when on separation plans. We also heard of children and young people in isolation rooms who were not given assistance when they requested it, and saw evidence of children being ignored during periods of self-harm. We found evidence of children and young people held in isolation for excessive periods of time, even weeks. These findings show that Victoria’s youth justice system has anything but a therapeutic or ‘soft’ approach to young offenders.

It is worth remembering who we are inflicting these measures upon. Two-thirds of children and young people in detention are victims of violence, abuse or neglect. A similar proportion are now, or have been, subject to a child protection order. Almost a third have mental health concerns. One in five have a history of self-harm and suicidal ideation. Almost a quarter of youth detainees have below-average intellectual functioning. The chronic overrepresentation of Aboriginal children in our youth justice system means that one in six detainees is Aboriginal – with their isolation carrying particularly acute risks of harm.

We understand that, in some circumstances, isolation may be needed for a short time and as a last resort to prevent immediate risk while a more suitable plan is developed and put in place. Instead, we found a compelling picture of systemic over-reliance on isolation. We found a cavalier approach to decision-making, without adequate consideration of the gravity or impact of the consequences – not only on the children and young people but also on the staff and the broader safety of the centres. This culture was reflected in poor or absent record keeping, which posed a significant challenge for us to determine the extent to which these practices were used. Importantly, we found that, in many instances, isolation practices

could have been avoided by rostering enough staff and ensuring staff have the appropriate tools, support and training to respond to problematic behaviours and vulnerabilities of the children and young people.

In this report, we make a range of recommendations to ensure that decisions that lead to the isolation of children are made thoughtfully and lawfully, and are properly recorded. We also recommend infrastructure upgrades to allow access to sanitation facilities in isolation rooms and dedicated areas for the appropriate protection of particularly vulnerable children and young people in detention. Finally, our recommendations reflect the need for appropriate workforce management.

In making these recommendations, we are conscious of parallel work, commissioned by the Victorian Government and led by independent experts Penny Armytage and Professor James Ogloff, that is likely to address the need for improvement across these and other aspects of youth justice. We look forward to the outcome of that important work.

We also note the Australian Government’s recent announcement of plans to ratify the Optional Protocol to the Convention Against Torture. This will bring into force a requirement for independent monitoring in all places of detention, including youth justice centres, and sends a positive message about the importance of monitoring conditions in youth justice.

In the current context of heightened fear about youth crime, many will view extensive isolation and other restrictive practices in youth justice as justified or even deserved. At times like these it is important not to abandon our commitment to a humane, age-appropriate youth justice system. If we want to stop these children and young people from following a pathway to adult offending, we have to focus on working effectively to give them an opportunity to change. By accepting an approach that holds vulnerable children and young people alone, within the same four walls, we are failing them and our community.

Contents

Letter to the Legislative Council and the Legislative Assembly	3
Acknowledgements	4
Commissioners' foreword	5
Contents	7
List of tables	9
List of figures	9
Abbreviations and acronyms	10
Definitions	10
The role of the Commission for Children and Young People	11
Executive summary	12
Recommendations	18
Isolation	18
Separation	19
Lockdowns	19
Minimising harm to children and young people	19
1. Introduction	20
Background	20
Terms of reference	20
Scope	20
Definition of key terms	21
Methodology	22
Context	23
2. Victorian youth justice system	26
Sentencing and custodial orders	27
Youth justice custodial services	27
Changing demand for youth justice services	29
Health and education services	31
Infrastructure	32
Profile of children and young people in custody	35
Impact of trauma on adolescent development	37
At a glance	41
3. Legislation and policy	42
Children, Youth and Families Act 2005	42
DHHS policies and practice guidelines	42
International human rights obligations	43

Contents (cont.)

4. Isolation	45
Use of isolation	46
Reasons for isolation	49
Compliance with legislation and policy	50
Authorisation of isolation	52
Release from isolation	52
Isolation as behaviour management	53
Isolation of Koori children and young people	56
New directions	57
At a glance	64
5. Separation	66
Use of separation	68
Compliance with policy	68
Isolation during separation	71
New directions	72
At a glance	76
6. Lockdowns	77
Use of lockdowns	77
Authorisation of lockdowns	79
Causes of lockdowns	79
Impact of lockdowns	82
New directions	84
At a glance	85
7. The views of children and young people	86
8. Opportunities for improvement	96
Improve information available to staff about children and young people in their care	96
Publish youth justice policies	97
Report the use of isolation, separation and lockdowns	97
Report to the Commission	98
Conclusion	98
9. Opportunity to respond	99
10. Submissions provided	102
11. Bibliography	103

List of tables

Table 1:	Current, or recently completed, Australian reviews of youth justice	24
Table 2:	Number and rate of isolations, February 2015 – July 2016 and 1–14 December 2016, all locations	47
Table 3:	Five most common reasons for isolation, Malmsbury Youth Justice Precinct	49
Table 4:	Five most common reasons for isolation, Parkville Youth Justice Precinct	49
Table 5:	Number and rate of separation plans, February 2015 – July 2016 and 1–14 December 2016, all locations	68
Table 6:	Number and rate of lockdowns, February 2015 – July 2016 and 1–14 December 2016, all locations	78

List of figures

Figure 1:	Proportion of children in Victorian youth justice custody who are on remand, all locations, 2005–16	30
Figure 2:	Isolation room at Parkville Youth Justice Precinct	34
Figure 3:	Isolation room at Malmsbury Youth Justice Precinct (secure site)	34
Figure 4:	Isolation room at Malmsbury Youth Justice Precinct (senior site)	34
Figure 5:	Proportion of Koori children and young people in Victorian Youth Justice system, 2005–16	36
Figure 6:	Isolations in Victorian youth justice facilities, February 2015 – July 2016, by month	46

Abbreviations and acronyms

ABC	Australian Broadcasting Corporation
CCTV	closed-circuit television (video surveillance)
CRIS	Client Relationship Information System
DHHS	Victorian Department of Health and Human Services
DJR	Victorian Department of Justice and Regulation
SSMP	Separation Safety Management Plan
UNHRC	United Nations Human Rights Commission
VALS	Victorian Aboriginal Legal Service
YHaRS	Youth Health and Rehabilitation Service

Definitions

Aboriginal:	the term Aboriginal in this report refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a program, report or quotation.	Parkville:	refers to the Parkville Youth Justice Precinct.
Commission:	Commission for Children and Young People.	Policy:	includes practice instructions issued by the Department of Health and Human Services.
Grevillea:	refers to the Grevillea Youth Justice Centre.	Restrictive practice:	in the context of youth justice, refers to intervening on a child or young person's freedom to decrease a behaviour.
Inquiry period:	The initial inquiry period was 1 February 2015 to 31 July 2016. This was later extended to include 1–14 December.	Separation plan(s):	refers to Separation Safety Management Plans (SSMPs).
Koori:	The term Koori refers to Aboriginal people from south-east Australia.	Youth Justice:	refers to the Youth Justice service of the Victorian Government.
Malmsbury:	refers to the Malmsbury Youth Justice Precinct.	Youth justice system:	refers to the broad system of juvenile justice services in Australia.

The role of the Commission for Children and Young People

The Victorian Commission for Children and Young People is an independent statutory body established to promote improvement and innovation in policies and practices affecting the safety and wellbeing of Victorian children and young people. We have a particular focus on vulnerable children and young people as defined in the *Commission for Children and Young People Act 2012*.

Our vision

That the rights of all children and young people in Victoria are recognised, respected and defended.

What we do

The Commission for Children and Young People:

- provides independent scrutiny and oversight of services for children and young people, particularly those in out-of-home care, child protection and youth justice
- advocates for best-practice policy, program and service responses to meet the needs of children and young people
- supports and regulates organisations that work with children and young people to prevent abuse and makes sure these organisations have child-safe practices
- brings the views and experiences of children and young people to the attention of government and the community
- promotes the rights, safety and wellbeing of children and young people.

Executive summary

This inquiry examines the use of isolation, separation and lockdown practices in Victorian youth justice facilities, primarily between February 2015 and July 2016. The review focused on whether the Department of Health and Human Services (DHHS) complied with legislation and policies that regulate use of these practices, noting the significant impact they have on the rights and wellbeing of children and young people. We also reviewed data about isolation, separation and lockdown practices between 1 and 14 December 2016, following the riot at Parkville in mid-November 2016, to assess the use of these practices during times of particular pressure.

Terms of reference

The inquiry focused on three key areas:

- to determine whether the management of isolation and Separation Safety Management Plans is in accordance with section 488 of the *Children, Youth and Families Act 2005* and relevant operational policy
- to examine the extent and causes of, and risks associated with, lockdowns in Victoria's youth justice centres
- to recommend any changes to policy or practice to maximise compliance with relevant legislation, and to ensure harm to children and young people is minimised and the rights of children and young people are protected.

In conducting the review, we analysed data provided by DHHS, reviewed CCTV footage, examined literature on isolation practices and impacts, made several site visits and inspections, and reviewed reports from our Independent Visitor Program. We also conducted wide-ranging consultation with youth justice staff, union delegates, support workers, DHHS management and children and young people.

Our inquiry was significantly hampered by deficiencies in record keeping, some of which have been acknowledged by DHHS. Data we requested was often incomplete or internally inconsistent. All analyses and conclusions are based on our best assessment of what we have been provided, corroborated against other sources wherever possible.

Poor record keeping suggests that the practice of imposing isolation or seclusion is not taken as seriously as it should be. It also means that these practices are likely to have been imposed on children and young people more than our findings suggest.

Overview

We acknowledge that youth justice settings are complex environments that present a range of management challenges, including difficult and sometimes violent behaviour by children and young people. Safety and wellbeing of detainees and staff are vital. We acknowledge that separating children and young people from peers and staff, for a short time and as an emergency safety measure, is a legitimate tool.

However, our review found widespread use of restrictive practices that led to the confinement and isolation of young people, despite evidence suggesting that such practices can exacerbate harm and hinder rehabilitation, particularly for children and young people who have suffered trauma.

In many instances, we found that decisions to isolate, separate or initiate a lockdown were not made or

recorded in accordance with relevant legislative and policy requirements. Young people were denied access to fresh air, exercise, meaningful activities, education, support programs and visits, sometimes for extended periods. In the case of operational lockdowns, where whole units were locked in their rooms for operational reasons, children and young people were isolated for reasons that had nothing to do with their behaviour. This was often distressing and frustrating for young people, creating additional tensions and management pressures for staff.

We make a range of recommendations to ensure that these restrictive practices are appropriately targeted and confined, to protect the safety and wellbeing of children and young people, and to promote their rehabilitation in accordance with the stated objectives of the Children, Youth and Families Act.

The impact of isolation and seclusion on children

Most children and young people in youth justice centres have a history of trauma or disadvantage. Approximately two-thirds are victims of childhood abuse, trauma or neglect, and the same proportion are, or have been, the subject of a child protection order. Often these children are affected by overlapping issues, for example, around one-third have mental health issues and one-quarter present with cognitive impairment or other issues concerned with their intellectual functioning.

Trauma and abuse affect children's physiological, emotional and cognitive development in many ways, making them more vulnerable to involvement with the criminal justice system. The negative effects of trauma on a child's brain and behaviour also influence that child's response to being detained. Loss of liberty, being isolated, unclothed searches, threats from others and conflict from peers can act as further triggers, activating a 'fight or flight' response that frequently takes the form of aggressive or self-harming behaviour.

International research has demonstrated that isolation is often ineffective in managing behaviour, that it may be counterproductive, and that its misuse can cause significant distress and may lead to psychological damage.

Management of isolation and Separation Safety Management Plans

Isolation

The use of isolation is regulated by the Children, Youth and Families Act. It involves placing a child or a young person in a locked room, separate from others and from the normal routine of the centre. The Act is clear that isolation can only be used to prevent immediate threat of a young person harming themselves or others, or damaging property or if the officer in charge considers it to be in the interests of the security of the centre. Isolating a young person as a form of punishment is expressly prohibited.

Isolation data provided by DHHS showed there was an average of 8.8 isolations in place per day during the primary review period. However, during December 2016, the average dramatically increased to 42.4 isolations per day; a fivefold increase.

DHHS data indicated many recorded isolations were for short periods of one hour (23 per cent), but also that some children and young people were isolated for weeks at a time. As we were finalising the inquiry, DHHS contested this on the basis that their data was subject to 'recording errors'. However, other information reviewed by the Commission found children and young people on separation plans, completely isolated from their peers and the routine of the centre for up to 45 days.¹

In many instances, isolation (particularly isolation for longer than 24 hours) was imposed without appropriate authorisation. Koori children and young people were overrepresented among those placed in isolation, particularly at Malmsbury Youth Justice Centre.

In the 18-month review period, a small but significant cohort of young people was subject to an extremely high number of isolations, with 10 children accounting for 20 per cent of all isolations and four young people being isolated more than 100 times. A broader response to the behaviour of these children and young people was required.

Children and young people reported negative experiences in isolation. While many acknowledged that a short period of isolation could help them calm down, they reported that extended or arbitrary isolation had the counterproductive effect of making them even more angry and frustrated. Our review of footage confirmed this.

Although 64 per cent of isolations occurred in bedrooms, a significant proportion (over 1,700 during the period) involved placing children and young people in isolation spaces. The lack of sanitation in some isolation rooms led to young people urinating, and at times defecating, in isolation rooms. Children and young people also often had limited access to materials or possessions that could assist in de-escalating or occupying them. Clinical or cultural support staff were often not called upon.

In many instances, we found that decisions to isolate, separate or initiate a lockdown were not made or recorded in accordance with relevant legislative and policy requirements. Young people were denied access to fresh air, exercise, meaningful activities, education, support programs and visits, sometimes for extended periods.

¹ Source: SSMPs provided to the Commission by DHHS, p. 512 onwards.

Separation Safety Management Plans

Separation Safety Management Plans are not referenced in the Children, Youth and Families Act, but are regulated by DHHS policy. They provide for a young person to be separated from their peers for up to 72 hours without review, to manage their behaviour and ensure others' safety. Separation plans may also be put in place due to a young person's vulnerability. Separation plans differ from isolation because they should, according to DHHS policy, allow for continued access to education, programs and visits and should not involve confinement in a locked room.

DHHS records showed 138 separation plans were imposed during the 18-month review period. Ten per cent of separation plans were not reviewed as required after 72 hours. The use of separation plans had increased ninefold by the December 2016 review period.

Separation plans routinely involved extended periods of effective isolation with children and young people locked in their rooms. More than half of the separation plans reviewed during the initial 18-month review period required the child or young person to be locked in their room for 20 hours or more each day, often without access to personal items such as books, photos or music players. At least 30 per cent explicitly prohibited the child or young person from receiving visits from family, and access to education, recreation and cultural support was extremely limited. In December 2016, most separation plans confined the children and young people to their rooms or cells for 22 or 23 hours per day.

Issues identified

While isolation and separation are distinct practices, they are closely related. We found that, in many instances, young people on separation plans were effectively held in isolation, confined in a locked room for extended periods without access to peers or the broader routines of the youth justice centre. Despite this, we found these conditions were recorded as isolation only 40 per cent of the plans.

We identified a lack of clarity about the circumstances in which isolation, including isolation in the context of separation plans, should be utilised. For example, we found that staff were often unclear on the purpose of isolation, whether it should occur in bedrooms or designated isolation rooms and the circumstances in which the isolation should end. Separation plans were usually generic and failed to articulate any specific actions or interventions necessary to address a young person's problematic behaviour. We found isolation is used as a core element of managing behaviour in Victoria's youth justice centres, and that a more consistent and sophisticated approach is needed. This will benefit children and young people as well as staff.

We also identified a concerning reliance on these restrictive practices to manage vulnerable young people. We saw examples of children being isolated on separation plans because they had been the victim of an assault or had health concerns.

Separation plans routinely involved extended periods of effective isolation. In more than half of the separation plans we reviewed, a child or young person was locked in their room for 20 hours or more each day.

Extent and causes of lockdowns in Victoria's youth justice centres

Lockdowns refer to when children and young people are secured in their bedrooms during times when they would otherwise be out of their rooms, engaged in activities, education and the routines of the centre. Lockdowns usually apply to a whole unit or several units. They can also be imposed across a whole facility.

The Children, Youth and Families Act provides broad legislative power to order lockdowns in the interests of the security of the centre, and DHHS policy classifies lockdowns as a form of isolation under that Act.

DHHS data revealed a total of 520 lockdowns, each affecting at least one unit (up to 15 individuals), over the initial 18-month review period. Parkville was most affected by lockdowns, with 488 recorded at that location compared to 32 at Malmsbury. The majority (72 per cent) of lockdowns were for an hour, sometimes involving the cycled release of children and young people an hour at a time throughout the day.

However, the data revealed more than 50 occasions when at least one unit of children and young people were held in continuous lockdown for over 36 hours and 88 occasions where detainees were locked in their rooms for 13 to 20 hours. The majority of lockdowns were not appropriately authorised.

DHHS records show most lockdowns (83 per cent at Parkville and 78 per cent at Malmsbury) were attributed to staff shortages, reflecting long-term problems with absenteeism and difficulties recruiting suitable employees. Some staff attributed these shortages to a lack of safety at work, inadequate remuneration, inexperience and the challenging nature of the job. These shortages, along with exceptionally high numbers of children and young people on remand, placed significant pressure on staff and affected staff members' ability to work effectively with children and young people.

The average daily number of lockdowns across all youth justice centres doubled in December 2016.

Issues identified

Overall, our review found that the unacceptably high number of lockdowns had a detrimental impact, not only on young people but also on staff and the long-term stability of youth justice centres.

Young people we spoke to struggled with the frequency and unpredictable nature of lockdowns. Many reported frustration at not being able to participate in meaningful activity during these times, resulting in boredom, anxiety and despondency.

Lockdowns disrupted positive routines and structure within the centres. They restricted access to education, programs and therapeutic support.

Staff reported a range of difficulties arising from the frequent use of lockdowns. Staff said lockdowns restricted opportunities for staff to develop positive relationships with young people, contributed to a tense atmosphere and placed significant demands on staff.

Recommended changes to policy or practice

Our recommendations are directed at clarifying legislative and policy guidance around the use of separation and isolation to avoid excessive use of these interventions. We seek changes to reinforce that these practices should be used for the shortest possible time and not as the primary behaviour management tool. We also recommend that children and young people have a legislatively prescribed hour of access to fresh air, in line with similar requirements for adults in custody.

Where separation plans involve periods of isolation, this should be justified, accurately reflected in relevant records and accompanied by a broader range of individualised interventions to address behavioural issues. Young people should be given a copy of their separation plan and continue to have access to personal visits.

Efforts must be made to mitigate the harmful effects of isolation, particularly for highly vulnerable young people. As a matter of priority, this includes ensuring compliance with policies directed at minimising the acute risks associated with isolation of Koori children and young people, a review into processes and responsibilities for young people who are at risk of self-harm, and expressly prohibiting the use of isolation within separation plans for young people who are at risk of being, or have been, attacked in custody. Specialised needs and vulnerabilities should be addressed through clinical support and appropriate accommodation arrangements, rather than by segregation and confinement.

Immediate improvements to record keeping are necessary to ensure appropriate transparency and accountability for decisions to isolate or separate young people from their peers. We also recommend immediate upgrades to isolation rooms being used at Parkville.

We consider the extensive use of lockdowns due to staff shortages to be entirely unacceptable. We recommend that workforce planning and development be addressed as a matter of priority. This will ensure that children and young people's rehabilitation prospects are maximised through access to education, programs, personal visits, exercise and activities.

Implementation of these recommendations will need to be supported by appropriate training and support for staff.

Additional opportunities for improvement

We consider that staff who have accessible and accurate information about a young person's history are in a much better position to respond effectively to concerns about their behaviour, without recourse to restrictive practices. On this basis, we recommend the development of a new mechanism to more effectively flag key risks and information about young people, to enable staff to deploy appropriate and targeted de-escalation strategies and interventions.

We also consider that the youth justice system would benefit from greater transparency about its policies and operations. This includes:

- making the Youth Justice Custodial Practice Manual publicly available
- disclosing isolation, separation and lockdowns data in an annual report
- reporting regularly on isolation, separation and lockdowns to the Commission for ongoing monitoring of these practices.

Our full recommendations are detailed in the next section.

Recommendations

The Victorian Government will transfer responsibility for youth justice from the Department of Health and Human Services (DHHS) to the Department of Justice and Regulation (DJR) from April 2017. In light of this change, we are directing these recommendations to DJR.

Isolation

1. That the Victorian Government amends the *Children, Youth and Families Act 2005* to clarify the purpose of isolation and the circumstances under which a young person can be isolated. Key principles should ensure that isolation is used for the shortest possible time and that detailed and accurate records are kept of all decisions about isolation.
2. That DJR reviews guidance and training for youth justice staff to ensure isolation is only used when necessary, is not used as punishment, and is always accompanied by other measures to address a child or young person's behaviour or risk.
3. That DJR implements urgent measures to improve Youth Justice compliance procedures for recording periods of isolation.
4. That DJR establishes immediate measures to ensure that Youth Justice complies with all elements of the current Isolation policy relating to Koori children and young people, and reviews Malmesbury's isolation practices to examine the disproportionate application of isolation on Koori children and young people.
5. That DJR immediately upgrades all youth justice isolation spaces to include sanitation and ensures sanitation is included in the design of the new facility.
6. That DJR amends youth justice policy and practice to clarify when isolation should occur in bedrooms and when it should occur in isolation rooms.
7. That DJR reviews the allocation of responsibilities and processes for observing children and young people in youth justice who are at risk of self-harm.

Separation

8. That DJR ensures the development of a process that requires senior Youth Justice staff to maintain records of all reviews and renewals of Separation Safety Management Plans.
9. That DJR ensures that all time that a child or young person spends on a Separation Safety Management Plan 'in a locked room, away from others and away from the normal routine of a centre' is recorded, managed and regulated as a period of isolation.
10. That the Victorian Government amends the Children, Youth and Families Act to ensure that all young people in youth justice centres have at least one hour of fresh air each day.
11. That DJR ensures that designated accommodation options for vulnerable children and young people are established in youth justice custodial settings, both in the proposed new facility and in existing centres.
12. That DJR amends youth justice policy to specifically articulate that all young people on Separation Safety Management Plans are entitled to personal visits.
13. That DJR collects additional data about the characteristics of all children and young people on Separation Safety Management Plans to allow oversight, review and continuous improvement of this restrictive practice.
14. That DJR amends youth justice policy to require that all children and young people are given copies of their Separation Safety Management Plans, or their equivalent.
15. That DJR reviews youth justice practice to ensure that children and young people are not subjected to isolation as part of a Separation Safety Management Plan because they have been the victim of an assault, or are otherwise vulnerable.
16. That DJR reviews youth justice policy, practice and training to ensure:
 - i. isolation is not used as the primary behaviour management tool in the youth justice system

- ii. all Separation Safety Management Plans include an individually tailored plan, developed with input from health or therapeutic staff, to address the child or young person's behaviour, the causes of that behaviour and provide a clearly articulated plan identifying when, and how, a child or young person will be able to return to the broader population of the centre.

Lockdowns

17. That DJR immediately reviews the youth justice staffing and recruitment model to ensure that sufficient, suitably trained staff are available to supervise children and young people to prevent frequent and extensive lockdowns.

Minimising harm to children and young people

18. That DJR establishes a mechanism to flag key risks and other relevant information about children and young people for youth justice staff, to enable informed and effective management of children and young people.
19. That DJR publishes the Youth Justice Custodial Practice Manual to make its operations and policies (excluding security-related matters) visible to the community.
20. That DJR publishes annual data about the use of isolation, separation and lockdowns, to acknowledge the importance of these issues and allow interested stakeholders to monitor the use of these restrictive interventions.
21. That DJR provides the Commission for Children and Young People with data on an ongoing, quarterly basis on the use of isolation, separation and lockdowns, including the use of these restrictive practices on Koori children and young people.

1. Introduction

Background

The purpose of this inquiry was to examine the use of isolation, separation and lockdown in youth justice facilities in Victoria. The inquiry included an examination of the incidence of these practices, how well the DHHS complied with legal and other obligations when imposing these restrictions and the impact on children and young people.

This inquiry was initiated by the Commission because of escalating concerns about the use of isolation and lockdowns by DHHS in youth justice facilities. These concerns were based on:

- complaints to the Commissioner for Aboriginal Children and Young People, Andrew Jackomos, PSM, from members of the community who were worried about the excessive use of isolation for Koori children and young people
- the Commission's review of isolation records for Koori children that indicated poor compliance with policies and the Children, Youth and Families Act 2005
- concerns repeatedly raised by the Commission's independent visitors to Victoria's youth justice centres
- the incoming Principal Commissioner's observations about the extent of lockdowns and the frequent use of isolation.

The Commission formally established this inquiry on 31 May 2016.

Terms of reference

The inquiry had three terms of reference:

- to determine whether the management of isolation and Separation Safety Management Plans is in accordance with section 488 of the *Children, Youth and Families Act 2005* and relevant operational policy
- to examine the extent and causes of, and risks associated with, lockdowns in Victoria's youth justice centres
- to recommend any changes to policy or practice to maximise compliance with relevant legislation, and to ensure harm to children and young people is minimised and the rights of children and young people are protected.

Scope

The inquiry originally sought to consider DHHS practice and policy for the 18-month period from 1 February 2015 to 31 July 2016. As the Commission was finalising the inquiry, and following significant events in the youth justice system in November 2016, the Commissioners became concerned that isolation, separations and lockdowns continued to be excessively used. The scope of the inquiry was extended to include an assessment of these practices over the first two weeks of December 2016 (1–14 December).

Definition of key terms

The youth justice system considers isolation, separation and lockdowns to be discrete practices and there are separate policies governing their use, and different recording and reporting requirements.

We consider them to be related practices that warrant investigation together. All three involve 'the involuntary

placement of a young detainee in a room from which they are not able to leave for some or all of the time'.²

The three practices can have the same or similar impact on children and young people, and each represents a significant imposition on their rights.

Definition of terms	
Isolation	Isolation is defined in the Children, Youth and Families Act (section 488) as 'the placing of the person in a locked room separate from others and from the normal routine of the centre'. The use of isolation is governed by the Children, Youth and Families Act (specifically sections 487 and 488).
Separation	Separation is an operational practice where children and young people are separated from their peers for up to 72 hours at a time. Separation is managed using Separation Safety Management Plans. Neither the Children, Youth and Families Act, nor the Children, Youth and Families Regulations 2007, provide a statutory basis for separation plans. The decision to put a young person on a Separation Safety Management Plan is governed by the DHHS 'Separation of Young People' practice instruction. The practice instruction distinguishes separation plans from isolation in that, during a plan, 'the young person continues to have access to education, programs and other aspects of the broader precinct and may not be confined to a locked room'. ³
Lockdowns	Lockdowns refer to instances where children and young people are confined to their rooms in circumstances where they would otherwise be free to move around the facility and engage in daily activities. The use of the term 'lockdown' in this context is distinct from the regular routine of securing children and young people in their rooms at night or during daily staff meetings. Since most of Victoria's youth justice custody bedrooms accommodate only one person, lockdown has the practical effect of confining children and young people alone in their room. The decision to lock down a youth justice unit or facility is governed by the DHHS 'Unit Lockdowns' practice instruction.

For most of the inquiry's initial 18-month period, DHHS operated on the basis that separation plans were different to isolation because they did not meet the three elements of isolation ('in a locked room, separate from others and from the normal routine of the centre') as defined in the Children, Youth and Families Act.

In February 2016, DHHS instructed staff to record the periods within separation plans where the young person was locked in their rooms as isolation. In September 2016, DHHS advised us that this position was being reconsidered. At the time of this report (March 2017), DHHS policy about separation plans remains unchanged.

² Australian Children's Commissioners and Guardians, *Human rights standards in youth detention facilities in Australia: the use of restraint, disciplinary regimes and other specified practices* (Australian Children's Commissioners and Guardians, 2016), p. 60.

³ The extent to which this is the case is examined in Chapter 5 of this report.

Methodology

We used multiple data sources to examine the issues under investigation. For example, the practice of isolation was examined through records provided by DHHS, CCTV footage, and direct interviews with children, young people and staff.

The methodology involved:

- analysis of relevant legislation, policy and practice manuals, previous reviews relating to youth justice, and human rights requirements
- literature review of isolation, seclusion and solitary confinement practices in youth justice and related settings, including mental health and related impacts, and the role of the physical environment
- site visits to the Parkville and Malmsbury Youth Justice Precincts and the Thomas Embling Hospital
- analysis of specific DHHS data and records relating to isolation, separation and lockdowns at youth justice centres
- review of DHHS client exit interview data
- review of a 60-day sample of CCTV footage and audio recordings of children and young people in isolation spaces
- examination of Independent Visitors Program reports
- 35 semi-structured interviews with senior staff, cultural support workers, contractors, children and young people
- four focus groups involving 28 children and young people
- two focus groups involving nine staff members (unit coordinators)
- a consultation meeting with senior representatives and local members of the Community and Public Sector Union (CPSU)
- a staff survey distributed to Youth Justice Workers Level 1 and 2 at Parkville and Malmsbury Youth Justice Precincts
- a brief, public consultation process.

Limitations

We collected a large set of data from DHHS. In August 2016 and February 2017, DHHS acknowledged that records were inadequate, erroneous or unclear in some circumstances. This meant we were unable to confidently draw conclusions related to compliance with legislation and policy, or the extent to which isolation, separation and lockdowns are being used on children and young people. The inadequacy of the records clearly demonstrates the need for improved compliance and recording systems.

When provided with an opportunity to comment on the draft report of this inquiry, DHHS advised that:

Significant improvements have been made to recording practices for more confidence in the data available, however, there are further opportunities for improvement.

The staff survey had a very low response rate (1.8 per cent). This may have been due to the significant incident at Parkville Youth Justice Precinct on 13–14 November 2016, which occurred soon after the survey was distributed. As a result, the survey data was only used to support evidence gathered from other sources.

Context

Debates about government responses to youth crime are not new, and there has been close scrutiny of the Victorian youth justice system in recent years.⁴ However, this inquiry was completed in the context of an unprecedented focus on youth justice across Australia and in Victoria.

In July 2016, shortly after our inquiry was announced, the treatment of children and young people in custody was brought to national attention by the ABC's current affairs program, *Four Corners*. The report included CCTV footage showing the use of tear gas, mechanical restraints and spit hoods on children and young people in custody in the Northern Territory. It was reported that a number of children and young people were held in isolation for 22 to 24 hours a day for periods of six to 17 days.

Since early 2016, there has been growing community concern in Victoria relating to youth crime and public safety. These concerns increased after media reports of alleged criminal behaviour by some children and young people, and a growing number of significant incidents at custodial facilities.

Community fear about safety, concerns for the rights and welfare of children and young people in custody, and the significant problems in Victorian youth justice facilities have contributed to a polarised debate about youth crime and appropriate strategies for managing children and young people in custody.

There has been a high level of fear expressed by victims of crime and the broader community, particularly following the escapes, and subsequent alleged offending, of several children and young people from Malmsbury Youth Justice Precinct on 25 January 2017.

In contrast, it has also been argued that the Victorian media's focus has been narrow and included little coverage of the life circumstances of children and young people involved with Youth Justice, or the causes of their offending.⁵

⁴ Drugs and Crime Prevention Committee, *Inquiry into strategies to prevent high volume offending and recidivism by young people* (Victorian Parliament, 2009); G Brouwer, Whistleblowers Protection Act 2001: *Investigation into conditions at the Melbourne youth justice precinct* (Victorian Ombudsman, 2010); G Brouwer, *Investigation into children transferred from the youth justice system to the adult prison system* (Victorian Ombudsman, 2013).

⁵ Examples include: N Bucci, 'Media coverage of youth crime "corrosive": Legal Aid executive,' *The Age*, 21 July 2016, <<http://www.theage.com.au/victoria/media-coverage-of-youth-crimecorrosive-legal-aid-executive-20160720-gqa43t.html>>, accessed 11 February 2017; J Edwards, 'Youth justice system needs balance', *Probono Australia*, 4 October 2016, <<https://probonoaustralia.com.au/news/2016/10/youth-justice-system-needs-balance/>>, accessed 9 February 2017; Youthlaw, 'Our views on emergency issues: youth crime', <<http://youthlaw.asn.au/campaigns-advocacy/emerging-issues/#section-1>>, accessed 11 February 2017.

Recent reviews of youth justice

There are a number of relevant inquiries, reviews and responses to specific incidents recently completed, or currently underway, in Victoria and nationally (see Table 1).

In 2016, the Australian Children's Commissioners and Guardians published a paper⁶ that looked at jurisdictional differences in youth detention practices, including transparency, accountability and external monitoring. This report's findings, including those relating to isolation, were referenced in this inquiry.

Table 1: Current, or recently completed, Australian reviews of youth justice

Victoria	
DHHS review of youth support, youth diversion and youth justice services	Commissioned in October 2016 and led by Penny Armytage, Partner KPMG, and Professor James Ogloff AM, Director, Centre for Forensic Behavioural Science and Foundation Professor of Clinical Forensic Psychology, Swinburne University. The primary objective of the review is to create an overarching policy framework for the development of a contemporary youth justice program and accompanying service delivery model. ⁷
Review of Parkville Youth Justice Precinct	Conducted by Neil Comrie AO, APM. The review will consider safety and security issues arising from the construction and design of the Malmsbury Youth Justice Precinct that impede the proper supervision of young people and/or provide a risk to staff and young people, and the circumstances leading up to the incidents, and the extent of compliance with operating procedures and guidelines leading up to, during and after the incidents. ⁸
Parliamentary inquiry into youth justice centres in Victoria	In November 2016, the Victorian Parliament announced a wide-ranging inquiry into the youth justice system in Victoria, due to be tabled in August 2017. The terms of reference direct examination of incidents in security and safety of detainees and staff, remand numbers, the implications of incarcerating young people with specific vulnerabilities and the culture of Youth Justice and operational matters (including policies, practices and reporting). It will also examine the role of DHHS in overseeing practices at youth justice centres. ⁹
Queensland	
Independent review of youth detention	In August 2016, Queensland's Attorney-General and Minister for Justice announced an independent review into Queensland's youth detention centres. The review will examine the practices, operation and supervision of the state's two youth detention centres and evaluate current programs and services. The review will also consider allegations of mistreatment of young people made by former staff members and former detainees. ¹⁰

⁶ Australian Children's Commissioners and Guardians, *Human rights standards in youth detention facilities in Australia*.

⁷ Department of Health and Human Services, 'Review of youth support, youth diversion and youth justice services: Terms of reference', *Department of Health and Human Services* [website], <<http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/children,-youth-and-family-services/youth-justice-review>>, accessed 11 February 2017.

⁸ DHHS advised that Mr Comrie is also reviewing the abscond incident from the Malmsbury Youth Justice Precinct in November 2016, which has been extended to include the incidents at the Malmsbury precinct on 25 January 2017.

⁹ Parliament of Victoria, 'Inquiry into Youth Justice centres in Victoria', *Parliament of Victoria* [website], (Parliament of Victoria, 2016) <<http://www.parliament.vic.gov.au/lsc/inquiries/inquiry/447>>, accessed 11 February 2017.

¹⁰ Queensland Government, 'Terms of reference', *Independent Review of Youth Detention* [website], (Queensland Government 2016) <<https://www.youthdetentionreview.qld.gov.au/terms-of-reference>>, accessed 28 December 2016.

Northern Territory	
Own initiative investigation Report: services provided by the Department of Correctional Services at the Don Dale Youth Detention Centre	In August 2015, the Office of the Children's Commissioner published the <i>Own initiative investigation Report: services provided by the Department of Correctional Services at the Don Dale Youth Detention Centre</i> . ¹¹
Royal Commission into the protection and detention of children in the Northern Territory	In July 2016, the ABC's current affairs program, <i>Four Corners</i> , broadcast a report alleging the mistreatment of a number of young people detained in youth justice detention centres in the Northern Territory. ¹² In response, the Australian Government established a Royal Commission into the protection and detention of children in the Northern Territory. ¹³ Hearings began in October 2016 and the Royal Commission is due to report in March 2017.
New South Wales	
Inquiry into behaviour management in youth detention centres	In late October 2016, the New South Wales Government announced a review into behaviour management in the state's youth justice detention centres.
How use of force against detainees in juvenile justice centres in NSW is managed	The New South Wales Inspector of Custodial Services is undertaking a review of how use of force against detainees in juvenile justice centres is managed. In November 2016, the review's terms of reference were amended to include issues relating to separation, segregation and confinement.
South Australia	
Go to your room! The use of seclusion in youth detention	In April 2016, South Australia's Guardian for Children and Young People produced a brief report on the use of seclusion in youth detention. ¹⁴ The paper explored the potential impacts of seclusion on a child's rehabilitation and called for strict protocols, diligent monitoring and careful recording.
Western Australia	
Young people in the justice system: A review of the Young Offenders Act 1994	In December 2016, the Western Australian Government announced a review of the state's Young Offenders Act 1994 to ensure the legislation is achieving its objectives in the context of contemporary research and evidence about what works in youth justice. ¹⁵

¹¹ Northern Territory Office of the Children's Commissioner, *Own initiative investigation report: Services provided by the Department of Correctional Services at the Don Dale Youth Detention Centre* <http://www.childrenscommissioner.nt.gov.au/pdfs/other_reports/PDF%20Final%20Investigation%20Report.pdf>, August 2016.

¹² 'Australia's Shame', *Four Corners*, ABC1, 25 July 2016 [television program].

¹³ Commonwealth of Australia, *Royal Commission into the Protection and Detention of Children in the Northern Territory* [website] (2017) <<https://childdetentionnt.royalcommission.gov.au/Pages/default.aspx>>, accessed 11 February 2017.

¹⁴ Guardians for Children and Young People, *Go to your room! The use of seclusion in youth detention* (2016) <<http://www.gcyp.sa.gov.au/2016/04/go-to-your-room-the-use-of-seclusion-in-youth-detention/>>, accessed 11 February 2017.

¹⁵ Department of Corrective Services, Government of Western Australia, *Young people in the justice system: A review of the Young Offenders Act 1994* (2016), <<https://www.correctiveservices.wa.gov.au/youth-justice/young-offenders-act.aspx>>, accessed 28 January 2017.

2. Victorian youth justice system

Section 482(1)(a) of the Children, Youth and Families Act states that the Secretary of the DHHS, must (among other requirements) 'determine the form of care, custody or treatment which he or she considers to be in the best interests of each person detained in a remand centre, youth residential centre or youth justice centre'.

Section 481 identifies that the Minister may 'issue directions relating to the standards of services' in remand centres, youth residential centres, youth justice centres and youth justice units and 'may establish procedures that are appropriate to ensure that those directions are given effect'.

On 6 February 2017, the Victorian Government announced that responsibility for youth justice will be transferred to the Department of Justice and Regulation (DJR) from 3 April 2017.

The Children, Youth and Families Act defines a child as a person under 18 years (but does not include persons above 19 years when coming before the Court).¹⁶

In Victoria, children and young people in the youth justice system are between 10 and 23 years old. Children under 10 years old are considered legally incapable of committing a criminal offence.¹⁷ A child over 10 and less than 14 years is presumed incapable of committing an offence unless the prosecution can prove that the child is capable of forming a criminal intention.

The Children's Court hears most matters relating to children who are alleged to have committed a criminal offence. If the young person has turned 19 by the time the matter comes to court, the hearing takes place in the Magistrates' Court.¹⁸ Regardless of the age of the accused, certain serious offences involving fatalities, such as murder, manslaughter, arson causing death, or culpable driving causing death, must be heard in the County or Supreme Courts.¹⁹

¹⁶ Children, Youth and Families Act, s 3(1).

¹⁷ Children, Youth and Families Act, s. 344.

¹⁸ Children, Youth and Families Act, s. 3.

¹⁹ Children Youth and Families Act, s. 516(1); and *County Court Act 1958*, s. 36A.

Sentencing and custodial orders

Victoria has a dual track approach to sentencing young offenders. The *Sentencing Act 1991* allows adult courts to order young offenders, less than 21 years of age, who satisfy certain criteria, to serve custodial sentences in youth detention instead of adult prison.²⁰

Children and young people may be held in custody either by way of a remand or detention orders issued by courts.

Remand

- Section 482(1)(c) of the Children, Youth and Families Act requires that, wherever possible, children and young people on remand are accommodated separately from those who are serving a period of detention.
- Section 12 (1AA) of the Bail Act 1977 limits the remand period to a maximum of 21 days. Where this expires, the child must be brought before the Court, with section 12 (1AB) providing for an extension of the remand period for no longer than 21 days.

Detention orders

- The Children Youth and Families Act, and the Sentencing act permit youth residential orders for children 10-14 years at the time of sentencing.
- In the Children's Court, a youth justice centre order can be made for an offender over 15 but under 21 years of age at the time of sentencing.²¹ In an adult court, a youth justice centre order can be imposed on a young offender under 21 years old at the time of sentencing.²²

The Youth Parole Board exercises jurisdiction over all children and young people sentenced to a period of detention in a youth justice centre and those children and young people transferred by the Adult Parole Board from imprisonment in an adult facility to a youth justice centre order and vice versa.

Youth justice custodial services

DHHS describes the role of custodial services as to ensure that:

- youth justice custodial facilities are safe and secure for clients and staff
- young people are rehabilitated with reduced likelihood of further offending
- factors associated with offending are addressed through evidence-based programs
- complex clients are provided with integrated and well-coordinated services that meet their individual needs.²³

Throughout this inquiry, the DHHS Secure Services branch, in North Division, was responsible for the management of youth justice custodial services.²⁴ The Secure Services branch was responsible for youth justice centres, two Secure Welfare Services sites and Disability Forensic Assessment and Treatment Services (DFATS). In November 2016, responsibility for youth justice was transferred to the DHHS Deputy Secretary, Operations.

There are two youth justice custodial precincts: Parkville Youth Justice Precinct and Malmsbury Youth Justice Precinct. A third, temporary, youth justice centre began operation in Greenvale Unit of Barwon Prison in November 2016, because Parkville is being repaired after damage caused by children and young people in November 2016.

²⁰ Sentencing Act, s. 32(1).

²¹ Children, Youth and Families Act, s. 412.

²² Sentencing Act, s. 32(1).

²³ Department of Health and Human Services, 'Custody', *Department of Health and Human Services* [website], <<http://www.dhs.vic.gov.au/for-individuals/children-families-and-young-people/youth-justice/custody>>, accessed 29 December 2016.

²⁴ This reflects the location of the Malmsbury and Parkville Youth Justice Precincts.

Parkville Youth Justice Precinct

Parkville Youth Justice Precinct has two centres: the Parkville Youth Residential Centre and the Melbourne Youth Justice Centre.

Parkville Youth Residential Centre

During the inquiry period, Parkville Youth Residential Centre had three units housing up to 37 children and young people:

- One unit with 15 beds houses girls and young women between 10 and 21 years old.
- One unit with 15 beds houses boys between 10 and 14 years old.
- One unit with seven beds was often used as a transition unit for children and young people preparing to leave custody. Since November 2016, in response to capacity pressures, it has housed a more general group of boys 15 years and older.

Melbourne Youth Justice Centre

During the same period, Melbourne Youth Justice Centre had six units, each holding boys and young men between 15 and 18 years old.

After 14 November 2016, most of Melbourne Youth Justice Centre was closed because of significant damage to five accommodation units and a programs unit.

Malmsbury Youth Justice Precinct

Malmsbury Youth Justice Precinct also has two facilities on one site. The senior site is largely a low-security site that can house up to about 89 young people. There is an admissions unit, three low-security residential units and a secure unit.

Malmsbury's secure site opened in July 2015 and is made up of three secure units, each housing about 15 children and young people, and the Intensive Supervision Annexe (ISA). The ISA is a purpose-built, four-bed secure wing used to manage children and young people being isolated or on separation plans.

Originally, Malmsbury only held sentenced young men 18 years of age and older. In January 2016, it began housing remandees in the secure site. In May 2016, due to capacity pressures at Parkville, Malmsbury's population changed to include sentenced children between 15 and 18 years old. Since late 2016, children on remand have also been placed there.

Grevillea Youth Justice Precinct

As a temporary measure while works are undertaken at Parkville, the Victorian Government has gazetted the Grevillea Unit of Barwon Prison as a youth remand and youth justice centre so children and young people could be accommodated there.

Changing demand for Youth Justice services

Number of children and young people in custody

In 2014–2015, the rate of 10–17 year old children and young people in detention per 100,000 people increased 35 per cent compared to 2013–14.²⁵ Between July 2015 and June 2016, the average number of children and young people in youth justice facilities in Victoria increased from 141 to 177 – an increase of more than 25 per cent in just 12 months.²⁶

- a presumption in favour of proceeding by summons in relation to a child
- children and young people not being remanded for a period longer than 21 days without being released or brought before the Court
- changes to prevent children and young people being charged with a criminal offence just for failing to comply with a bail condition.²⁹

Despite these amendments, the number of children on remand has not reduced since May 2016.

Number of children and young people on remand

In 2013, the Victorian Government made significant amendments to the *Bail Act 1977*. These included the introduction of new criminal offences for contravening bail conditions, and for committing an indictable offence while on bail.²⁷ These new offences applied to adults as well as children and young people. The former Commissioner for Children and Young People and many youth justice advocates blamed these amendments for the surge in the number of young people under 18 years of age who were on remand.²⁸

In May 2016, further amendments to the *Bail Act* came into effect. These were introduced to address the impact the 2013 reforms were having on children and young people. These amendments introduced:

- relevant considerations to be taken into account when making decisions about the bail or remand of a child

²⁵ Productivity Commission, *Report on Government Services* (2017), 'Youth Justice Services' Table 17A.5. It is important to note that the Productivity Commission's *Report on Government Services* only counts children and young people up to 17 years of age. It does not include young people between 18 and 22 years old, who form a large part of Victoria's youth justice population.

²⁶ Australian Institute of Health and Welfare, 'Youth detention population in Australia 2016', *Bulletin 138* (Australian Institute of Health and Welfare, 2016), <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557685>>, accessed 5 January 2017.

²⁷ *Bail Amendment Act 2013*, s. 8

²⁸ 'The Age, "Children languishing on remand "scandalous": child commissioner', 24 August 2015, <<http://www.theage.com.au/victoria/children-languishing-on-remand-scandalous-child-commissioner-20150818-gi1hek.html>>

²⁹ *Bail Amendment Act 2016*

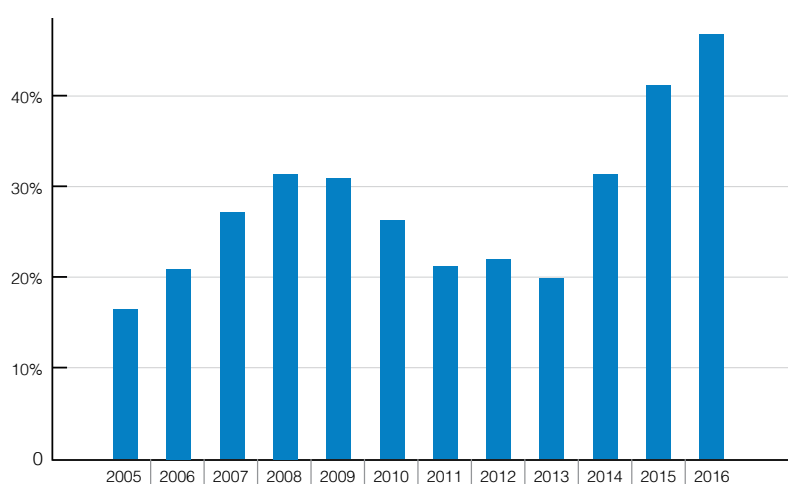
In July 2016, more than 80 per cent of the children and young people at Parkville were on remand.

The dramatic increase in the number of children and young people on remand has had a number of consequences:

- Children and young people on remand tend to be more unsettled than those who are sentenced, as they often do not know how long they will be in custody.
- When they first arrive in custody, some children and young people are still under the influence of drugs or alcohol, or withdrawing from substances.
- The constant change in the remand population contributes to a continuously changing dynamic between groups of children and young people, within and across units, which often creates tension and conflict. This makes it harder for staff to establish relationships with them or learn how best to respond to their individual needs.

Parkville has had the most significant increase in remandees.³⁰ Before 2013, Parkville housed only a small proportion of remandees but the number increased during 2016. In July 2016, more than 80 per cent of the children and young people were on remand.³¹

Figure 1: Proportion of children in Victorian youth justice custody who are on remand, all locations, 2005–16³²



³⁰ From January 2016, Malmesbury also held remandees, and the number increased throughout the year.

³¹ Department of Health and Human Services data provided to Commission: Average daily client numbers, February 2015 – July 2016, supplied 17 August 2016. When provided an opportunity to comment on the draft inquiry report, DHHS identified a caveat of incompatibility between states and territories due to variations in definitions.

³² Source: DHHS data, provided 27 February 2017.

Number of incidents in youth justice detention

The 2017 Report on Government Services showed that, in 2015–16, Victoria had the highest number and rate of young people in detention who were injured following a serious assault, across Australia. The report also identified that Victoria had the highest number and rate of young people and staff injured as a result of a serious assault per 10,000 custody-nights for the same period, compared to other states and territories. These patterns have been rising for several years.³³

DHHS uses a two-tiered system to report critical incidents. Category One incidents relate to those that result in serious outcomes or trauma. Category Two incidents relate to events that threaten the health, safety and/or wellbeing of children, young people and others.³⁴

In 2014–15, Youth Justice recorded 34 Category One incidents. In 2015–16, 100 Category One incidents

were recorded, representing a 194 per cent increase. DHHS advised that the increase was largely due to a change to practice in August 2015 whereby young people are now asked upon admission if they wish to report any incidents related to their arrest and treatment prior to arriving at youth justice custodial services.

When these incidents are excluded, the number of Category One incidents increased between 2014–2015 and 2015–2016 by 59 per cent.

Unfortunately, since the end of the 2015–16 financial year, the number of incidents has remained high. The period between November 2016 and January 2017 has been particularly volatile. On 13 and 14 November 2016, a group of children and young people in Parkville engaged in riotous behaviour resulting in significant damage to the centre. On 25 January 2017, a number of children and young people escaped from Malmsbury, allegedly stealing cars and assaulting members of the public. All were returned to custody by the following day.

Health and education services

Parkville College commenced operation as a Victorian government school in January 2013, delivering the Victorian Certificate of Applied Learning (VCAL) and the Victorian Certificate of Education (VCE). The college delivers education services across all youth justice centres, with approximately 200 teachers.³⁵ Classes operate six days a week and youth justice workers provide supervision. At Malmsbury, Parkville College also delivers Vocational Education and Training (VET) subjects.

Health services in youth justice facilities are provided by Youth Health and Rehabilitation Service (YHaRS). YHaRS is operated by a consortium made up of Youth Support and Advocacy Service, St Vincent's Hospital Melbourne and Caraniche.

³³ Productivity Commission, *Report on Government Services*, (2017), 'Youth Justice Services' Table 17A.18.

³⁴ DHHS intranet, 'Module 2 – Incident types and categories' [training material], accessed 1 January 2017.

³⁵ Education services are provided at Grevillea Youth Justice Centre but it is not a registered school.

Infrastructure

The deficiencies of the physical infrastructure of youth justice facilities in Victoria are well documented. In 2010, the Victorian Ombudsman found that ‘the design and location of the Precinct is inappropriate for a custodial facility which houses vulnerable children.’³⁶ Relevant excerpts of the report include:

The dirty, unhygienic and ill-maintained conditions reflect poorly on the management and staff at the Precinct. These conditions are clearly in breach of:

- *the United Nations Rules for the Protection of Juveniles Deprived of their Liberty*
- *the Australasian Juvenile Justice Administration Standards for Juvenile Custodial Facilities*
- *recommendations arising from the Royal Commission into Aboriginal Deaths in Custody*
- *government health regulations, in particular the Food Act 1984.*

While the cleanliness, graffiti and security issues discussed in this report should be addressed promptly, I consider that the structural problems I have identified are beyond simply maintenance and repair. As such, the only practical way to address the conditions at the Precinct in the long term is to develop a new facility at another site.

In November 2015, an internal review commissioned by DHHS identified that Parkville’s infrastructure had significant limitations and contained design features and limitations that were not in line with contemporary standards and practice.³⁷

Another internal review in May 2016 identified that ‘a substantial amount of money could be spent on this Precinct and it would still present significant risks and vulnerabilities’.³⁸

In February 2017, DHHS provided us with a summary of findings of the first stage of the review by Neil Comrie AO, APM, of the incidents at Parkville in November 2016. The review concluded that the precinct is not adequate for its intended purpose and will remain unfit for purpose due to the fundamental structural problems associated with the buildings’ design and structure.

³⁶ Victorian Ombudsman, Whistleblowers Protection Act 2001: *Investigation into conditions at the Melbourne youth justice precinct*, p. 8.

³⁷ P Muir, Review of Parkville Youth Justice Precinct Incident on 31 October 2015 (Internal DHHS document, November 2015), p. 8.

³⁸ P Muir, *Security Review of critical incidents at Parkville Youth Justice Precinct on 6 & 7 March 2016* (Internal DHHS document, May 2016) p. 16.

We have many concerns about the current infrastructure in youth justice facilities:

- The size of the current accommodation units is too large. Housing 15 young people in a small, shared space results in a crowded, complex, high-risk environment that significantly inhibits the development of positive relationships with staff.
- Children and young people in secure units do not have enough access to fresh air and exercise.
- It is difficult to separate vulnerable children and young people, resulting in standovers, assaults, or children and young people remaining in their rooms for days because they are afraid for their safety.³⁹
- There is no specialist facility to support and manage children and young people with acute mental health issues.⁴⁰
- The materials in the units are of poor quality and are easily damaged, as has been shown in recent incidents.

- The lack of insulation means that many units cannot maintain an even temperature. In one unit, Commission staff observed that young people had placed garbage bags against their windows in an attempt to block out glare and heat.
- The units do not have enough office and consulting spaces for health practitioners to engage constructively and safely with children and young people. YHaRS staff told us that, when staff were called to provide urgent debriefing for a distressed young person, they had to meet in the unit's noisy, public kitchen. They resorted to speaking to the children and young people in the laundry, which was the only space where they could have a private conversation.

We support the government's recent announcement of the establishment of a new, purpose-built youth justice facility, including dedicated mental health beds, and look forward to being consulted on the design of the new facility.

³⁹ As cited in Independent Visitor Program report extracts: April 2015, February 2016, May 2016, July 2016.

⁴⁰ This issue is discussed further in Chapter 4 of this report.

Isolation infrastructure

Most of Parkville's isolation spaces, and some of Malmsbury's, lack toilets, hand basins, benches or beds. The rooms that do have toilets or benches are stark and often cold (see figures 2—4).



Figure 2: Isolation room at Parkville Youth Justice Precinct



Figure 3: Isolation room at Malmsbury Youth Justice Precinct (secure site)



Figure 4: Isolation room at Malmsbury Youth Justice Precinct (senior site)

Profile of children and young people in custody

Effective youth justice responses reflect the understanding that children and young people involved in criminal behaviour are not fully developed physiologically, emotionally or psychologically. This provides a good opportunity for rehabilitation. In particular, there is substantial evidence that significant areas of brain development in young people continues into their early twenties.

There is also evidence that children and young people in youth detention have complex needs and are likely to have suffered multiple traumas, such as childhood abuse and neglect, socioeconomic disadvantage, family violence, and poor educational opportunities.⁴¹

A recent Australian Institute of Health and Welfare report identified that in 2014–15, across Australia, 40.8 per cent of people in youth justice detention were involved with the child protection system.⁴² Approximately half of the Aboriginal girls and young women and just over one-third of Aboriginal boys and young men were likely to be involved with child protection.

The most recent snapshot survey, taken on 7 October 2015 in Victorian youth justice facilities, illustrates the significant and overlapping disadvantage, trauma, health and mental health issues of children and young people in the system.

Of the 167 males and nine females surveyed:

- 63%** were identified as victims of abuse, trauma or neglect
- 45%** had been subject to a previous child protection order
- 19%** were subject to a current child protection order
- 30%** presented with mental health issues
- 18%** had a history of self-harm or suicidal ideation
- 24%** presented with issues concerning their intellectual functioning
- 11%** were registered with Disability Services
- 12%** spoke English as a second language
- 66%** had a history of both alcohol and drug misuse
- 62%** had previously been suspended or expelled from school
- 10%** were homeless with no fixed address or living in insecure housing prior to custody.⁴³

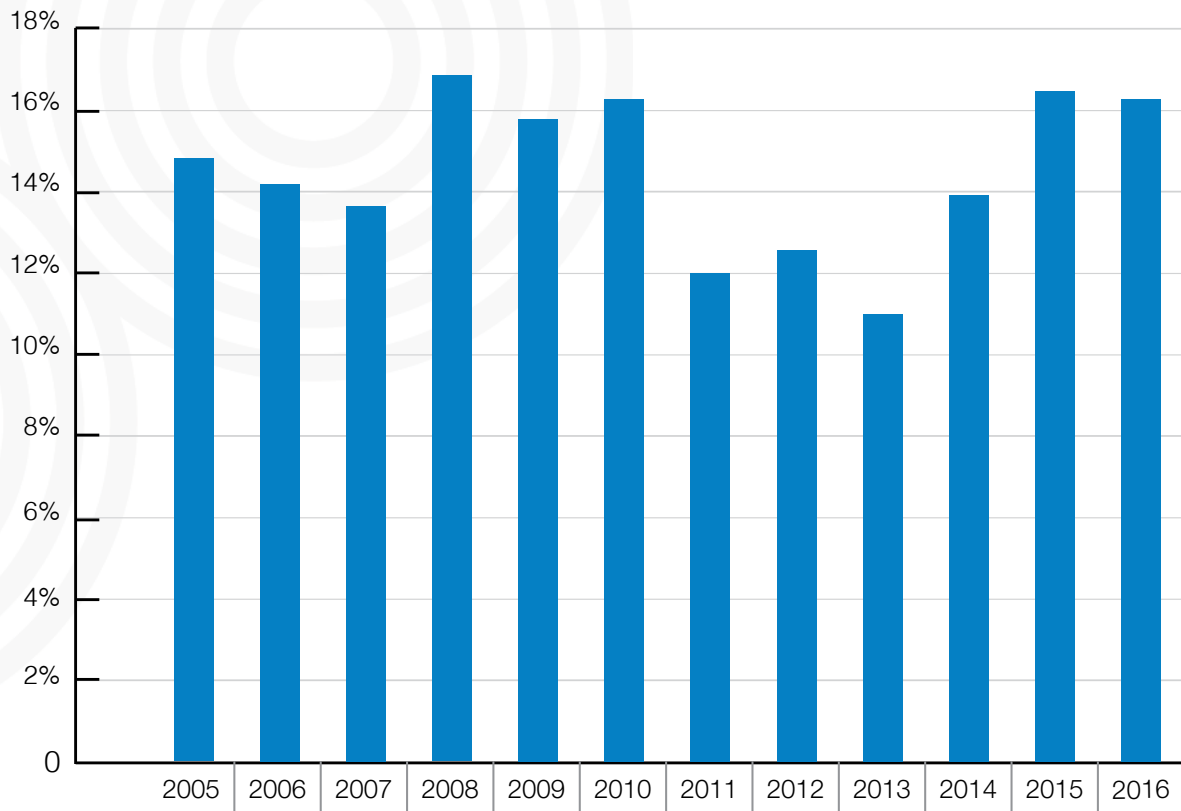
⁴¹ Department of Health and Human Services, *Youth Justice in Victoria Fact Sheet* (2016), <<http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/youth-justice-in-victoria-fact-sheet>>, accessed 11 January 2017.

⁴² Australian Institute of Health and Welfare, *Young people in child protection and under Youth Justice supervision*, Data linkage series no. 22 (Canberra: Australian Institute of Health and Welfare, 2016).

⁴³ Department of Health and Human Services, *Youth Parole Board Annual Report 2015–16* (Melbourne: Victorian Government, 2016).

On 30 June 2016, there were 173 children and young people in custody in Victoria, of which five per cent were female. Fifteen per cent of children and young people in custody on 30 June 2016 identified as Aboriginal or Torres Strait Islander.⁴⁴

Figure 5: Proportion of Koori children and young people in Victorian youth justice system, 2005–2016⁴⁵



This is significantly higher than the percentage of Koori people in Victoria (0.9 per cent)⁴⁶ and means that Koori children and young people in Victoria are 15 times more likely to be in youth custody than are non-Koori children and young people.

⁴⁴ Source: Department of Health and Human Services data provided to Commission.

⁴⁵ Source: Department of Health and Human Services data provided to Commission.

⁴⁶ Department of the Prime Minister and Cabinet, *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report* (2014), <<https://www.dpmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014>>, accessed 13 February 2017.

Impact of trauma on adolescent development

We must bear in mind that children's cognitive capacity develops gradually from the age of around 10 right through young adulthood, which is usually regarded as concluding at around 24 years of age.⁴⁷

Normal adolescent development provides challenges to any institution working with children and young people. Adolescents do not weigh the relative risks and consequences of their behaviour rationally⁴⁸, and often make choices by gut feeling.⁴⁹ For children and young people who have suffered trauma, abuse or neglect, this impulsive behaviour is even more apparent. Trauma, abuse and neglect influence children's physiological, emotional, cognitive and social development in many ways.⁵⁰ This makes them vulnerable to involvement with the criminal justice system.⁵¹

Early and persistent trauma affects the structure and functioning of the brain. When a child's brain is focused on survival, this comes at a cost for the developing cortex.⁵² An underdeveloped cortex is associated with poor impulse control and difficulties with higher level thinking and feeling tasks.⁵³

Children who have experienced trauma often remain in a state of vigilance after the traumatic events have passed.⁵⁴ Their neural pathways have become sensitised to threat, so they may perceive everyday situations as threats – triggering feelings such as anger, powerlessness, shame or fear⁵⁵ – and they have limited capacity to calm themselves or regulate their emotions.

These children may also have difficulty sleeping or understanding interpersonal boundaries. They may have sexual behaviour problems, struggle to navigate peer relationships and they may be socially or emotionally inappropriate for their age.⁵⁶ Many use illicit substances or alcohol to self-manage the symptoms of trauma.

Children's experience of violence can affect how they respond to perceived threats in custody. Many learn to use and rely on physical force to meet their needs.

Children and young people from countries affected by war and conflict can have similar trauma effects, made worse by experiences of racism, displacement, loss of family networks and cultural disruption.⁵⁷ These children are likely to perceive certain situations and people as threats and have limited capacity to calm themselves. Everyday situations may trigger feelings such as anger, powerlessness, shame or fear.⁵⁸

These factors can result in behaviours such as poor impulse control or substance abuse and can lead to children and young people being involved in criminal behaviour.⁵⁹ In custody, experiences such as being isolated, body searches, threats from others and conflict with peers may trigger memories of abuse, neglect, abandonment or conflict. These are then likely to activate an aggressive or self-harming response.

The behaviour of children and young people in custody needs to be understood in the context of past trauma and its effect on their cognitive development. They will need help to develop appropriate skills and strategies to manage emotion, stress and distress.

⁴⁷ M Warren, 'Responding to young people offending': Remarks of the Hon. Marilyn Warren AC, Chief Justice of Victoria, The Hon. Austin Asche AC, QC Oration in Law and Governance, Charles Darwin University, 11 October 2016.

⁴⁸ L Steinberg, Risk-taking in adolescence: What changes, and why? *Annals of the New York Academy of Sciences*, vol. 1021, pp. 51–58 (2004) cited in L Steinberg, 'Cognitive and affective development in adolescence', *Trends in Cognitive Sciences*, vol. 9, no. 2 (2005).

⁴⁹ C Martin et al., Sensation seeking, puberty and nicotine, alcohol and marijuana use in adolescence, *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 41, pp. 1495–1502 (2002), cited in L Steinberg, 'Cognitive and affective development in adolescence', *Trends in Cognitive Sciences*.

⁵⁰ Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents* [resource sheet], (Child Family Community Australia, 2014).

⁵¹ P Mendes, S Baidawi and P Snow, *Good Practice in Reducing the Over-Representation of Care Leavers in the Youth Justice System (Leaving Care and Youth Justice – Phase Three Report)* (Melbourne: Monash University, 2014).

⁵² Child Welfare Information Gateway, *Understanding the effects of maltreatment on brain development*.

⁵³ *ibid.*

⁵⁴ B Perry, 'The neurosequential model of therapeutics: Applying principles of neurodevelopment', in N Webb (ed.), *Working with Traumatized Youth in Child Welfare* (New York: Guilford Press, 2007) pp. 27–52; Australian Institute of Family Studies, *Effects of child abuse and neglect for children and adolescents*.

⁵⁵ F Shapiro, *Eye Movement Desensitisation and Reprocessing: Basic principles, protocols and procedure* (2nd edn, New York: Guilford Press, 2001).

⁵⁶ *ibid.*

⁵⁷ Australian Childhood Foundation, *Discussion Paper 14: Trauma in the contexts of war and relocation – addressing the needs of refugee students* (Australian Childhood Foundation, 2011).

⁵⁸ F Shapiro, *Eye Movement Desensitisation and Reprocessing: Basic principles, protocols and procedure* (2nd edn, New York: Guilford Press, 2001).

⁵⁹ P Mendes et al., *Good Practice in Reducing the Over-Representation of Care Leavers in the Youth Justice System*.

Current best practice – a trauma-informed approach

An effective trauma-informed approach to youth justice is now internationally recommended.⁶⁰ This does not mean being 'soft on crime' or letting children and young people get away with bad behaviour. It is based on the understanding that children and young people '...can be both a victim and a threat to the community'.⁶¹ A trauma-informed model is based on evidence about promoting rehabilitation and developing essential self-regulation skills. The benefits include significant implications for the safe day-to-day operations of youth justice facilities.

DHHS indicated to us that a trauma-informed model was being developed in 2016, with plans to implement it across youth justice custodial centres in March 2017. After the events at Parkville in November 2016, this work was put on hold.

Trauma-informed models for youth justice

An effective trauma-informed model for youth justice includes:

- a commitment to the safety of staff, children and young people and the community
- the development of an individualised assessment and treatment plan for children and young people
- an understanding of the behaviour of the young person in the context of their history of trauma
- an appreciation that a punitive approach heightens the perception of threat and can lead to more problem behaviours

- an essential role for frontline staff in developing respectful relationships and creating an environment that assists children and young people to feel safe and learn self-regulation skills
- the provision of specialist therapeutic support to staff, children and young people on the unit
- a commitment to the concepts and characteristics of the model at all levels of the organisation
- family involvement.⁶²

A trauma-informed approach may include the use of medications or counselling, but has a greater emphasis on accurately assessing the role of past trauma in current behaviour and engaging the young person in developing self-regulation skills. Unit staff play a central role in building relationships that help children and young people to establish and maintain their safety.

Well-developed and supported trauma-informed models allow units to be more open and less restrictive. This can substantially reduce the use of isolation and restraint, and can improve behaviour and safety.⁶³

⁶⁰ G Griffin, E Germain and R Wilkerson, 'Using a Trauma-Informed Approach in Juvenile Justice Institutions', *Journal of Child & Adolescent Trauma*, vol. 5, no. 3 (2012), pp. 271–283; National Child Traumatic Stress Network, *Essential elements of a trauma-informed juvenile justice system*, <<http://www.nctsn.org/products/essential-elements-trauma-informed-juvenile-justicesystem>>, accessed 13 February 2017.

⁶¹ G Griffin et al., 'Using a Trauma-Informed Approach in Juvenile Justice Institutions', p. 272.

⁶² National Child Traumatic Stress Network, *Essential elements of a trauma-informed juvenile justice system*; G Griffin et al., 'Using a Trauma-Informed Approach in Juvenile Justice Institutions'; M Robinson, *A report to the Winston Memorial Trust*; S Bloom, 'The Sanctuary Model of Organizational Change for Children's Residential Treatment', *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, vol. 26, no. 1 (2005), pp. 61–78.

⁶³ Jones R.J. & Timbers G.D (2003) 'Minimising the need for physical restraint and seclusion in residential youth care through skill-based treatment programming,' *Families in Society*, Vol 84, no. 3, pp. 21-29

The impact of isolation

There is a growing recognition that inappropriate isolation can harm children and young people and undermine efforts to create a safe environment for staff and detainees.

International research has demonstrated that isolation is often ineffective in managing behaviour,⁶⁴ may be counterproductive,⁶⁵ and has little, if any, recognised therapeutic value.⁶⁶

There is evidence that the misuse of isolation can cause significant distress and may lead to psychological damage.⁶⁷ Research indicates that isolation should play a limited role in managing the behaviour of children and young people in custodial settings.

In 2016, the Australian Children's Commissioners and Guardians produced a paper on human rights standards in youth detention facilities, and identified the following concerns about isolation and segregation practices:

- Children in detention are particularly susceptible to medical, social and psychological problems, and these may be made worse by extended periods in isolation.
- Segregation can be used as a legitimate behaviour management tool, or an emergency safety measure, provided it does not restrict a child's access to education, physical activity or family contact.
- Solitary confinement constitutes cruel, inhuman or degrading treatment and is a violation of international human rights norms and standards. Children should never be subjected to solitary confinement.
- The use of seclusion and segregation must consider the individual circumstances of the affected child and should not be used in any form on children with known psychosocial issues, indicators of self-harm, mental illness or other related vulnerabilities.⁶⁸
- External monitoring is important, and therefore detention centres should be required to record and report their use of seclusion and segregation to an independent oversight agency.⁶⁹

⁶⁴ B Arrigo and J Bullock, 'The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change', *International Journal of Offender Therapy and Comparative Criminology*, vol. 52, no. 6 (2007), pp. 622–640; HM Inspectorate of Prisons, *Behaviour management and restraint of children in custody: A review of the early implementation of MMPR* (London: HM Inspectorate of Prisons, 2015).

⁶⁵ American Civil Liberties Union, *Alone and Afraid: Children Held in Solitary Confinement and Isolation in Juvenile Detention and Correctional Facilities* (New York: American Civil Liberties Union, 2014); Council of Juvenile Correctional Administrators, *Administrators Toolkit: Reducing the Use of Isolation* (Massachusetts: Center for Coordinated Assistance to States, 2015).

⁶⁶ J Howell, M Lipsey and J Wilson, *A handbook for evidence-based juvenile justice systems* (London: Lexington Books, 2014), pp. 95–99; Council of Juvenile Correctional Administrators, *Administrators Toolkit*; American Civil Liberties Union, *Alone and Afraid*.

⁶⁷ R Mendel, *No Place for Kids: The Case for Reducing Juvenile Incarceration* (Baltimore: The Annie E. Casey Foundation, 2011); American Civil Liberties Union, *Alone and Afraid*; J Ogloff, *Review of Mental Health and Psychosocial Needs of Prisoners Detained in Restrictive Environments* (Melbourne: Department of Justice Health and Corrections, 2008); HM Inspectorate of Prisons, *Behaviour management and restraint of children in custody: A review of the early implementation of MMPR* (London: HM Inspectorate of Prisons, 2015).

⁶⁸ Australian Children's Commissioners and Guardians, *Human rights standards in youth detention facilities in Australia*.

⁶⁹ This finding is discussed further in Chapter 8 of this report.

Solitary confinement

The terms ‘isolation’ and ‘solitary confinement’ are sometimes used interchangeably in the literature.

In 2011, the United Nations’ *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment* identified that ‘there is no universally agreed upon definition of solitary confinement’.⁷⁰ For the purposes of that report, the Special Rapporteur defined solitary confinement as ‘the physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day’.⁷¹

In the same report, the Special Rapporteur warned that even a few days of solitary confinement can induce harmful and abnormal neurological and emotional symptoms, and noted that the health risks rise each day.

In 2015, the United Nations’ Special Rapporteur called upon State Parties to ‘prohibit solitary confinement of any duration and for any purpose’ of children deprived of their liberty.⁷²

The same year, the United States Attorney General conducted a review of ‘the overuse of solitary confinement across American prisons’ that recommended the practice should be ‘used

rarely, applied fairly and subjected to reasonable constraints’.⁷³ The report noted that ‘it is the responsibility of all governments to ensure that this practice is used only as necessary – and never used as a default solution’.⁷⁴ In January 2016, the then President of the United States, Barack Obama, announced a ban on solitary confinement for juvenile offenders in the federal justice system.⁷⁵

When provided an opportunity to comment on the draft report, DHHS told the Commission that it ‘refutes that the practices of “solitary confinement” used in the United States context have relevance in Victoria.’

We acknowledge that the majority of periods of isolation examined in this inquiry do not meet the United Nations’ definition of solitary confinement, however, based on the data provided by DHHS and our own observations, the Commission found a number of occasions where children and young people were kept in conditions that met the United Nations’ endorsed definition of solitary confinement.

⁷⁰ J.E Méndez, United Nations General Assembly, *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment*, (A/66/268, 5 August 2011)

⁷¹ J.E Méndez, United Nations General Assembly, *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment*, (A/66/268, 5 August 2011)

⁷² J.E Méndez, United Nations General Assembly, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, (A/HRC/28/68, 5 March 2015)

⁷³ United States Department of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing*, <<https://www.justice.gov/restrictivehousing>>, accessed 13 February 2017.

⁷⁴ *ibid.*

⁷⁵ E Pilkington, ‘Obama administration urges states to curb use of solitary confinement’, *The Guardian*, 28 April 2016, <<https://www.theguardian.com/world/2016/apr/28/obama-administration-urges-states-to-curb-use-of-solitary-confinement>>, accessed 13 February 2017.

At a glance

The system

Victoria's youth justice system can accommodate children between 10 and 17 years, and young people up to 23 years of age. In the past two years, both Parkville and Malmsbury Youth Justice Precincts have experienced many changes, including the establishment of a new secure site at Malmsbury and a marked increase in the number of remandees.

The deficiencies of the physical infrastructure of youth justice facilities in Victoria are well documented. The Victorian Government recently announced the establishment of a new youth justice site. This is welcome, but the government must work to minimise the impact of existing shortfalls until the facility is commissioned in 2020.

History of trauma

Children and young people in the Victorian youth justice system have typically experienced significant trauma and disadvantage. As outlined in this chapter, the most recent report by the Victorian Youth Parole Board identified that the majority of these children and young people (63 per cent) have been subject to previous, or

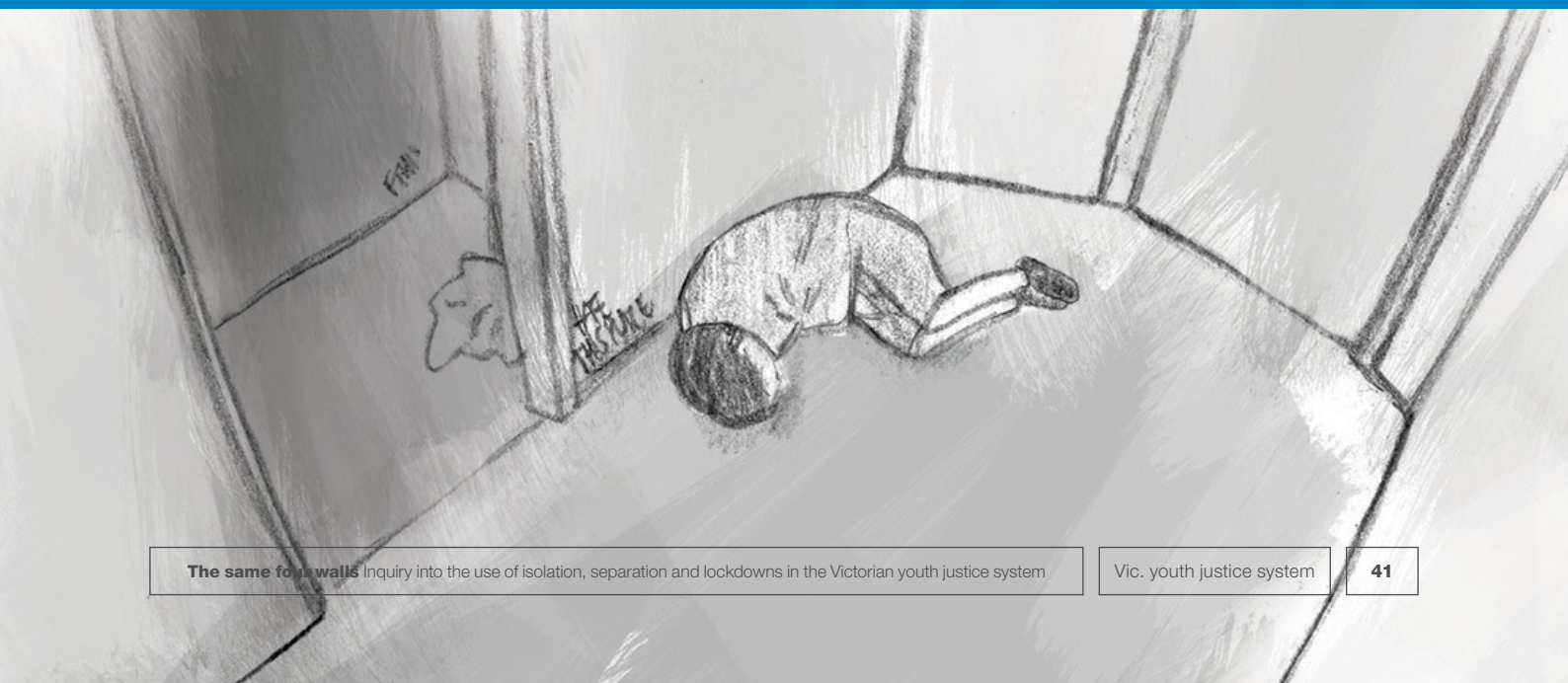
current, orders and are victims of abuse and neglect. Significant proportions have mental health issues, a history of self-harm or impaired intellectual functioning.

Early and persistent trauma affects the structure and functioning of a child's developing brain, making that child more prone to aggressive or self-harming behaviour when they feel threatened.

There is a disproportionate number of Koori children and young people in Victorian youth justice custody.

Impact of isolation

The use of isolation in detention can significantly harm children and young people and undermine efforts to create a safe environment for staff and those in custody. The misuse of isolation can cause significant distress and may cause significant psychological damage for children.



3. Legislation and policy

In considering the practices of isolation, separation and lockdowns, a range of instruments regulate the treatment of, and articulate the rights of, children in custody. These are summarised below.

Children, Youth and Families Act 2005

The Children, Youth and Families Act is the principal legislation governing the management of children and young people in detention in Victoria. The obligations regarding children and young people in custody can be found in part 5.6 and part 5.8.

Victoria's legislation requires that the management of children and young people in detention is conducted with due consideration of the young person's best interests. Section 482(1)(a) requires the Secretary to:

determine the form of care, custody or treatment which he or she considers to be in the best interests of each person detained in a remand centre, youth residential centre or youth justice centre.

Section 482(2)(a) states that children and young people are entitled to 'have their developmental needs catered for'. The Act defines 'development' as physical, social, emotional, intellectual, cultural and spiritual development.⁷⁶

The legislation relating to the isolation of children and young people is outlined in sections 487 and 488. The specific details of the obligations under this Act are discussed in chapters 4, 5 and 6.

DHHS policies and practice guidelines

There are a number of policies within the Youth Justice Custodial Practice Manual that relate to the use of isolation, separation and lockdowns. The following policies will be referred to in this report:

- Isolation
- Separation of young people
- Unit lockdown
- Deliberate self-harm and suicide prevention
- Observation of young people in custody
- How we work with young people in custody
- Managing difficult behaviour.

Charter of Human Rights and Responsibilities

The Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) sets out the basic rights, freedoms and responsibilities of all people in Victoria and how government should interact with people.

The Charter creates an obligation on all public authorities to act consistently with human rights and to take all human rights into consideration when making decisions.⁷⁷

⁷⁶ Children, Youth and Families Act, s. 3.

⁷⁷ Charter of Human Rights and Responsibilities Act, s. 38.

Of relevance to the use of isolation, separation and lockdowns in the youth justice system in Victoria are the following human rights obligations:

- A person must not be treated or punished in a cruel, inhuman or degrading way.⁷⁸
- Every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child.⁷⁹
- All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.⁸⁰
- An accused person who is detained or a person detained without charge must be treated in a way that is appropriate for a person who has not been convicted.⁸¹
- A child who has been convicted of an offence must be treated in a way that is appropriate for his or her age.⁸²

The Youth Justice Custodial Practice Manual identifies that the Unit Manager should 'ensure through staff supervision and training that the Charter is fulfilled in the precincts'.⁸³

International human rights obligations

There are a number of specific international instruments that provide for the rights of children and young people, including those who are held in custody.

Convention on the Rights of the Child

Australia ratified the United Nations Convention on the Rights of the Child in December 1990.⁸⁴ The convention establishes the rights of children and young people.⁸⁵ The following articles are relevant to this inquiry:

- In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.⁸⁶
- State Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has care of the child.⁸⁷
- State Parties shall ensure that no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.⁸⁸
- State Parties shall ensure that every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.⁸⁹
- State Parties recognise the right of every child alleged as, accused of, or recognised as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others and which takes into account the child's age and the desirability of promoting the child's reintegration and the child's assuming a constructive role in society.⁹⁰

⁷⁸ Charter of Human Rights and Responsibilities Act, s. 10(b).

⁷⁹ Charter of Human Rights and Responsibilities Act, s. 17(2).

⁸⁰ Charter of Human Rights and Responsibilities Act, s. 22(1).

⁸¹ Charter of Human Rights and Responsibilities Act, s. 22(3).

⁸² Charter of Human Rights and Responsibilities Act, s. 23(3).

⁸³ Department of Health and Human Services, 'Young People's Legal Entitlements', *Youth Justice Custodial Practice Manual* [internal document], (2016).

⁸⁴ United Nations, *Convention on the Rights of the Child*, Treaty Series, vol. 1577 (UN General Assembly, 1989).

⁸⁵ Philip Alston and Glen Brennan, *The UN children's convention and Australia* (Canberra: Human Rights and Equal Opportunity Commission, 1991).

⁸⁶ United Nations, *Convention on the Rights of the Child*, Treaty Series, vol. 1577 (UN General Assembly, 1989), Article 3(1).

⁸⁷ United Nations, *Convention on the Rights of the Child*, Treaty Series, vol. 1577 (UN General Assembly, 1989), Article 19(1).

⁸⁸ United Nations, *Convention on the Rights of the Child*, Treaty Series, vol. 1577 (UN General Assembly, 1989), Article 37(a).

⁸⁹ United Nations, *Convention on the Rights of the Child*, Treaty Series, vol. 1577 (UN General Assembly, 1989), Article 37(c).

⁹⁰ United Nations, *Convention on the Rights of the Child*, Treaty Series, vol. 1577 (UN General Assembly, 1989), Article 40(1).

Beijing Rules and Havana Rules

We examined the use of isolation, separation and lockdowns against the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules)⁹¹ and the Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules).⁹²

Some of the Beijing Rules relevant to this inquiry include:

- The juvenile system shall emphasise the wellbeing of the juvenile.⁹³
- The juvenile system shall ensure that any reaction to juvenile offenders shall always be in proportion to the circumstances of both the offenders and the offence.⁹⁴
- Contacts between the law enforcement agencies and a juvenile offender shall be managed in such a way as to respect the legal status of the juvenile, promote the wellbeing of the juvenile, and avoid harm to her or him, with due regard to the circumstances of the case.⁹⁵
- While in custody, juveniles shall receive care, protection and all necessary individual assistance – social, educational, vocational, psychological, medical and physical – that they may require in view of their age, sex and personality.⁹⁶
- The objective of training and treatment of juveniles placed in institutions is to provide care, protection, education and vocational skills, with a view to assisting them to assume socially constructive and productive roles in society.⁹⁷
- Juveniles in institutions shall receive care, protection and all necessary assistance – social, educational, vocational, psychological, medical and physical – that they may require because of their age, sex and personality and in the interest of their wholesome development.⁹⁸

The Havana Rules, established in 1991, are intended to establish minimum standards accepted by the United Nations for the protection of juveniles deprived of their liberty in all forms. Some of the Havana Rules relevant for this inquiry include:

- The juvenile justice system should uphold the rights and safety and promote the physical and mental wellbeing of juveniles.⁹⁹
- Juveniles detained in facilities should be guaranteed the benefit of meaningful activities and programs which would serve to promote and sustain their health and self-respect, to foster their sense of responsibility and encourage those attitudes and skills that will assist them in developing their potential as members of society.¹⁰⁰
- The design in detention facilities for juveniles and the physical environment should be in keeping with the rehabilitative aim of residential treatment, with due regard to the need of the juvenile for privacy, sensory stimuli, opportunities for association with peers and participation in sports, physical exercise and leisure time activities.¹⁰¹
- Every juvenile should have the right to a suitable amount of time for daily free exercise in the open air whenever weather permits, during which time appropriate recreational and physical training should normally be provided. Adequate space, installation and equipment should be provided for these activities.¹⁰²
- All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.¹⁰³

⁹¹ United Nations General Assembly, United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 29 November 1985 (96th plenary meeting), <<http://www.un.org/documents/press/45/450133.htm>>, accessed 13 February 2017.

⁹² United Nations General Assembly, Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), adopted by General Assembly resolution 45/113, 14 December 1990, <<http://www.un.org/documents/press/45/450113.htm>>, accessed 13 February 2017.

⁹³ United Nations General Assembly, Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 29 November 1985, Rule 5.

⁹⁴ United Nations General Assembly, Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 29 November 1985, Rule 5.

⁹⁵ United Nations General Assembly, Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 29 November 1985, Rule 10.3.

⁹⁶ United Nations General Assembly, Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 29 November 1985, Rule 13.5.

⁹⁷ United Nations General Assembly, Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 29 November 1985, Rule 26.1.

⁹⁸ United Nations General Assembly, Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 29 November 1985, Rule 26.2.

⁹⁹ United Nations General Assembly, Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), 14 December 1990, Clause 1.

¹⁰⁰ United Nations General Assembly, Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), 14 December 1990, Clause 12.

¹⁰¹ United Nations General Assembly, Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), 14 December 1990, Clause 32.

¹⁰² United Nations General Assembly, Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), 14 December 1990, Clause 47.

¹⁰³ United Nations General Assembly, Rules for the Protection of Juveniles Deprived of their Liberty (the Havana Rules), 14 December 1990, Clause 67.

4. Isolation

Legislation, regulations and practice instruction

Legislation

The legislation relating to the isolation of children and young people is articulated in sections 487 and 488 of the Children, Youth and Families Act.

Section 487(a) prohibits 'the use of isolation (within the meaning of section 488) as a punishment' upon 'a person detained in a remand centre, youth residential centre or youth justice centre or a child detained in a police gaol.'

Section 488(1) identifies that 'the officer in charge of a remand centre, youth residential centre or youth justice centre may authorise the isolation of a person detained in the centre, that is, the placing of the person in a locked room separate from others and from the normal routine of the centre.'

Section 488(2) authorises isolation only if:

- (a) all other reasonable steps have been taken to prevent the person from harming himself or herself or any other person or from damaging property; and
- (b) the person's behaviour presents an immediate threat to his or her safety or the safety of any other person or to property.

Section 488(3) requires that 'the period of isolation must be approved by the Secretary.'

Section 488(4) permits that 'if necessary, reasonable force may be used to place a person in isolation under this section.'

Section 488(5) states that 'a person placed in isolation must be closely supervised and observed at intervals of not longer than 15 minutes.'

Section 488(6) identifies that 'the officer in charge of a remand centre, youth residential centre or youth justice centre must make sure that the prescribed particulars of every use of isolation under subsection (1) are recorded in a register established for the purpose.'

Section 488(7) states that 'in addition to his or her powers under this section, the officer in charge of a remand centre, youth residential centre or youth justice centre may cause a person detained in the centre to be isolated in the interests of the security of the centre.'

Section 488(8) states that 'this section (except subsection (4)) does not apply to the use of isolation under subsection (7).'

Regulations

Regulation 31 of the Children, Youth and Families Regulations 2007 prescribes that the following information must be recorded in the register of isolations:

- name of the person isolated
- the time and date isolation commenced
- the reason why the person was isolated
- the authorising officer's name and position
- the frequency and nature of staff supervision and observation
- the time and date of release from isolation.

Practice instruction

The DHHS 'Isolation' practice instruction describes isolation as 'an intervention of last resort, used only when all other less restrictive practices have been tried and have not been successful, and where there is an immediate threat to the safety of the young person or others'.

The practice instruction requires that all children and young people placed in isolation must be observed constantly for the first five minutes, then at a minimum of every five minutes (close observations) thereafter. In July 2016, DHHS amended the practice instruction to require all Koori children and young people in isolation to be observed constantly.

Observations registers must be completed.

This chapter examines the use of isolation during the initial 18-month inquiry period and a period of two weeks in December 2016, and assesses compliance against the relevant legislation, regulations and policy. We identified significant areas of improvement that require the immediate attention of the Victorian Government to ensure the use of isolation is humane, appropriately recorded, consistently applied and well-informed.

In August 2016, DHHS commissioned Merlo Consulting to undertake an independent review of isolation practices in Youth Justice, covering a 60-day period to August 2016 ('the Merlo review').¹⁰⁴ The Merlo review overlapped our inquiry period, and its findings are discussed in this chapter.

Use of isolation

The inquiry examined DHHS data to determine whether isolation was managed in accordance with the Children, Youth and Families Act and relevant policies. However, the quality of records was poor, records were often inaccurate or inadequate and current templates do not capture all of the information required under Regulation 31 of the Children, Youth and Families Regulations.

According to DHHS data, 4,829 separate episodes of isolation were recorded during the inquiry's initial 18-month (547-day) period:

- 25 per cent of the children and young people isolated recorded only one isolation
- 47 per cent experienced 2–9 episodes of isolation
- 28 per cent experienced 25 or more episodes.

Despite the lack of clarity in the data, the records showed extremely high levels of isolation in the period from March to May 2016 (see Figure 6).

There are a number of possible reasons for this increase, but the data did not allow us to draw definitive conclusions. From the available information, the increase may relate to:

- a temporary response to advice received by DHHS in February 2016 to record periods of isolation within separation plans¹⁰⁵
- a significant incident at Parkville on 6–7 March 2016.

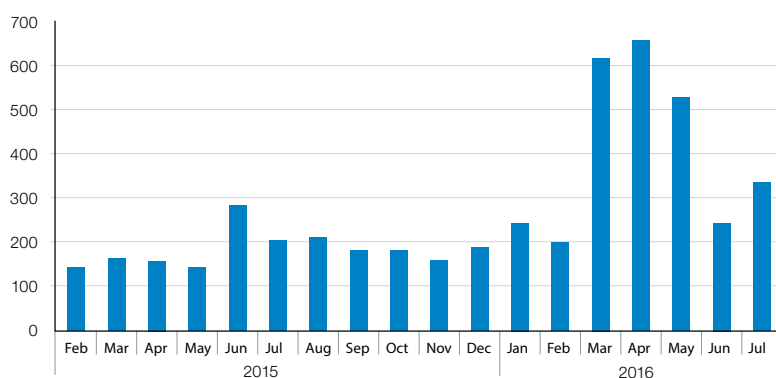
As explored in Chapter 5, we are of the view that these figures are likely to significantly underrepresent the total use of isolation because:

- For much of the period, the policy did not require time spent by children and young people 'in a locked room, away from others and separate from the routine of the centre' within separation plans to be recorded as isolations.
- DHHS have acknowledged 'compliance issues regarding the accurate recording of isolations on CRIS (Client Relationship Information System)'.¹⁰⁶

During the course of providing comment on the draft report, DHHS stated that:

while the department acknowledges issues related to isolation records, the extent to which this may have impacted on the accuracy of isolations figures is unknown.

Figure 6: Isolations in Victorian youth justice facilities, February 2015 – July 2016, by month



¹⁰⁴ Merlo Consulting, 'Isolations review, Secure Services – DHHS', November 2016.

¹⁰⁵ This issue is discussed further in Chapter 5 of this report.

¹⁰⁶ Correspondence: 26 August 2016, Dorothy Wee, Acting Deputy Secretary, North Division to Brenda Boland, Chief Executive Officer, Commission for Children and Young People

Use of isolation in December 2016

During our onsite monitoring of Parkville, Malmsbury and Grevillea in November and December 2016, we became concerned about the extent of isolation, separation and lockdowns observed. We expanded the scope of the inquiry and requested records about the use of these three restrictive practices for the two-week period from 1 to 14 December 2016.

The figures outlined in Table 2 demonstrate that the average number of isolations per day (42.4) during the first two weeks of December was more than five times greater than that of the initial 18-month inquiry period (8.8 per day). If isolations continue to be used at a similar rate for the rest of 2017, the average number of isolations per year would grow to 15,460.

Table 2: Number and rate of isolations, February 2015 – July 2016 and 1–14 December 2016, all locations¹⁰⁷

	Feb 2015 – Jul 2016	1–14 Dec 2016
Number of isolations	4,829	593
Number of days within the period	547	14
Average number of isolations per day	8.8	42.4

The data provided in Table 2 is extremely concerning. It was of further concern that, when providing this material on 20 January 2017, DHHS advised that, of the 593 periods of isolation recorded in the first two weeks

of December 2016, 14 took place in Grevillea. This figure contradicted isolation data provided separately by DHHS on 29 December 2016 about Grevillea, which identified at least 32 incidents of isolation during the same two-week period.

Length of time spent in isolation

The overall length of time spent in isolation was also difficult to calculate with certainty due to inconsistent DHHS compliance with recording requirements. For example, in the data provided to us, one isolation was recorded to be negative 1,070 minutes in duration and 46 instances were recorded to have been for ‘zero’ minutes.

Based on the information provided to us during the course of the inquiry, the most common length of time spent in isolation was one hour (23 per cent across both locations), followed by two hours (eight per cent).

The DHHS data provided in August 2016 showed several instances of extended periods of isolation:

- One young person at Malmsbury was recorded to have been in isolation for 745 hours (31 days) between March and April 2016. The reason for the isolation was recorded as ‘threatened assault to staff’.
- The second longest period in isolation, also at Malmsbury, was 280 hours (more than 11 days) in February 2015 for ‘aggressive behaviour altercation’.
- There were 20 other instances of isolations lasting 24 hours or longer: two at Parkville and 18 at Malmsbury.

¹⁰⁷ On 27 February 2017, DHHS provided updated isolation figures showing a total of 4817 periods of isolation for the 18-month period (12 fewer than previously provided) and 595 periods of isolation for the fortnight of 1–14 December 2016, two more than previously provided.

When provided an opportunity to comment on the inquiry's draft report,¹⁰⁸ DHHS advised that the records provided to us in August 2016 were incorrect 'mostly to data error and system error'. On 27 February 2017, DHHS advised that:

There are acknowledged issues with recording data related to isolations. However, the length of most periods of isolation does appear to be recorded correctly and are less than three hours in duration.

Most isolations do not last for periods exceeding three hours. Very long periods of isolation appear to be exceptional. The department has identified that the duration of these instances were due mostly to data entry and system error. The department refutes the implication made that the Act has been breached as it is evident that any suggested instance of isolation for 31 days is a data error.

Following a recommendation made in the Merlo review of isolations (November 2016), the department is developing a periodic audit process which will seek to identify and address these errors.

We were unable to verify the alternative information provided by DHHS within the timeframe available. However, other records provided to the Commission during the course of the inquiry confirmed that young people were subject to continuous separation plans totalling up to 45 days and featuring days without access to any other children or young people.¹⁰⁹

The introduction of periodic audits to identify errors in the management of data relating to isolation of children and young people is appropriate.

Frequent use of isolation for particular children and young people

DHHS data showed that 16 children and young people were isolated between 50 and 100 times in the initial 18-month inquiry period. Of even greater concern, four children and young people were isolated more than 100 times in the initial 18-month inquiry period.

The Children, Youth and Families Act clearly intends that isolation should only be used as an emergency response, not as an ongoing behaviour management strategy. This use of extended and repeated periods of isolation for individual children and young people also raises questions about how effective the practice is. At a minimum, it suggests that isolation does not effectively deal with the behaviour it seeks to address.

We examined the 10 children and young people most frequently isolated. As a group, these children and young people were subject to 934 episodes of isolation, accounting for 20 per cent of all periods of isolation examined during the inquiry.¹¹⁰

The average age of the 10 children and young people most frequently isolated was 16.75 years. All 10 were male and three were Koori.

¹⁰⁸ Section 48 of the *Commission for Children and Young People Act 2012* requires that if the inquiry report includes material that is adverse to a person or service, the Commission must give that person or service an opportunity to comment on the adverse material about them that is contained in the inquiry report.

¹⁰⁹ Source: page 662 of SSMPs provided to the Commission, August 2016.

¹¹⁰ On 27 February 2017, DHHS advised that they identified that the 10 children and young people most frequently isolated were subject to 895 episodes of isolation. The 934 episodes were as recorded in the data originally provided by DHHS.

Reasons for isolation

As outlined in tables 3 and 4 (below), most children and young people were isolated for aggressive behaviour or altercations (45 per cent at Malmesbury and 31 per cent at Parkville). At Malmesbury, the second most common reason for isolating a child or young person was 'escape – attempted escape'. At Parkville, the second most common reason was 'physical assault – client to client – no medical attention required'.

Table 3: Five most common reasons for isolation, Malmesbury Youth Justice Precinct

Recorded reason for isolation	
Aggressive behaviour altercation	44.66%
Escape – attempted escape	11.74%
Physical assault – client to client – no medical attention required	9.38%
Verbal abuse	6.98%
Physical assault – client to staff – no medical attention required	5.96%
Threatened assault – to staff	5.47%

Table 4: Five most common reasons for isolation, Parkville Youth Justice Precinct

Recorded reason for isolation	
Aggressive behaviour altercation	30.57%
Physical assault – client to client – no medical attention required	20.16%
Verbal abuse	8.79%
Threatened assault – to staff	8.57%
Physical assault – client to client – medical attention required	7.92%

The average time spent in isolation varied greatly, depending on the reason. In analysing the data provided, we excluded 10 per cent of the records (47) because either a negative time period or 'zero' minutes was recorded.

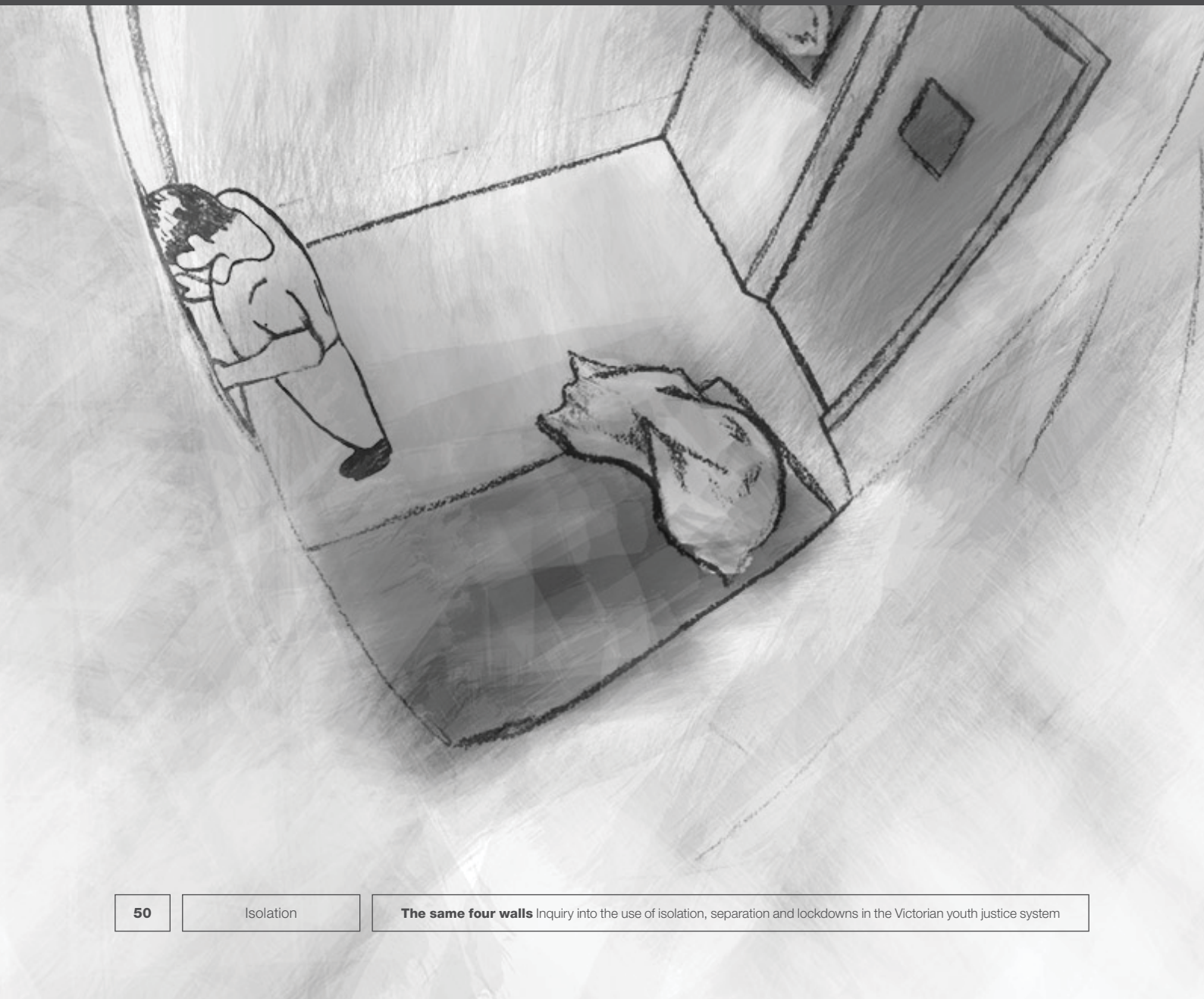
Isolations as a result of 'physical incident involving staff to client, where medical attention is required' recorded the longest durations, with an average of 10 hours (three periods). This is concerning, as the child or young person was the victim of the assault.

Children and young people placed in isolation for property matters, sexual assault against another client, verbal abuse or substance abuse/possession spent the least amount of time in isolation (one to two hours).

Compliance with legislation and policy

We identified several areas where DHHS collected insufficient detail to satisfy legislative requirements for recording isolation. However, the information supplied was sufficient to demonstrate significant cause for concern. These included:

- inadequate record keeping
- lack of clarity about the reasons that children and young people were placed in isolation
- failure to follow authorisation processes
- lack of consistent process in determining when children and young people would be released from isolation
- absence of adequate strategies to prevent and intervene in situations of escalating risk
- inadequacies in the facilities used for isolation, including the absence of resources to assist a young person to self-regulate
- lack of clarity about responsibilities to intervene in situations of self-harm
- inadequate involvement and supervision by health services.



Legislative basis for isolation

As noted earlier, the Children, Youth and Families Act describes two different circumstances under which a young person may be isolated.

If a young person is placed in isolation under section 488(2) of the Children Youth and Families Act, it may only be if all other reasonable steps have been taken and the young person's behaviour presents an immediate threat to his or her safety, or the safety of any other person or to property. In these circumstances, the Act prescribes that several conditions apply.

If the young person is being isolated under section 488(7) of the Children Youth and Families Act, 'in the interests of the security of the centre', no additional conditions apply (with the exception that reasonable force can be used).

The shortcomings of the reporting template meant that we were unable to assess DHHS's compliance with the Act's legislative requirements, including identifying if children and young people were isolated:

- when their behaviour presented an immediate threat to his or her safety, or the safety of any other person or to property

or

- in the interests of the security of the centre.

The Merlo review identified that periods of isolation were used for a range of reasons, 'not limited to' those defined in the Act. Additional reasons cited included being 'part of a safety separation management plan', 'as part of an individual behaviour management plan' and 'client rotations due to staff shortages'.¹¹¹

Thirty-one incidents examined by the Merlo review found no evidence that reasonable steps were taken prior to isolation.¹¹² In each of these 31 incidents, the child or young person was not deemed to be an immediate threat. In eight of these 31 incidents, the review found that the decision to isolate appeared to be made well after the incident. Two occurred only after the location's Safety and Emergency Response Team (SERT)¹¹³ reviewed the relevant CCTV footage.¹¹⁴

¹¹¹ Merlo Consulting, *Isolations review*, p. 20.

¹¹² Merlo Consulting, *Isolations review*, p. 15.

¹¹³ The Safety and Emergency Response Team (SERT) is a specialist team of youth justice workers that lead the management of, and response to, incidents and emergencies.

¹¹⁴ Merlo Consulting, *Isolations review*, p. 15.

¹¹⁵ Merlo Consulting, *Isolations review*, p. 20.

We appreciate that youth justice centres are complex environments that can only be effectively managed when the safety and wellbeing of children, young people and staff are equally attended to. The wellbeing of children and young people in youth justice custody is interdependent with staff safety and wellbeing.

There will be, at times, circumstances in which children and young people presenting with violent behaviour will need to be isolated in order to maintain safety. It is vital that isolation is only used when absolutely necessary, and for the shortest time possible.

Recommendation 1

That the Victorian Government amends the *Children, Youth and Families Act 2005* to clarify the purpose of isolation and the circumstances under which a young person can be isolated. Key principles should ensure that isolation is used for the shortest possible time and that detailed and accurate records are kept of all decisions about isolation.

Recommendation 2

That DJR reviews guidance and training for youth justice staff to ensure isolation is only used when necessary, is not used as punishment, and is always accompanied by other measures to address a child or young person's behaviour or risk.

The current recording requirements make it difficult to monitor the use of isolation or compliance with legislation. This leaves staff, children and young people unclear about their rights and obligations. The Merlo review also found that the lack of accountability for inadequate or incorrect recording created risks meaning that the system could be misused.¹¹⁵

Recommendation 3

That DJR implements urgent measures to improve Youth Justice compliance procedures for recording periods of isolation.

Authorisation of isolation

DHHS policy identifies a hierarchy of positions that can authorise periods of isolation:

- unit managers or duty managers can authorise for up to two hours
- general managers, operations managers or senior managers on call can authorise for between two and 12 hours
- the Director of Secure Services can authorise for between 13 and 24 hours
- the Executive Director, North Division, can authorise for 25 hours or more.¹¹⁶

The inquiry examined all periods of isolation of 13–24 hours duration and found that 73 per cent were not authorised correctly. Of 14 isolations longer than 24 hours, none were authorised by the Executive Director, North Division, as required by the DHHS policy.

The Merlo review of 166 isolations also found a number of discrepancies in authorisations. Half did not have appropriate authorisations recorded. For Koori children and young people, more than 91 per cent were not correctly authorised. The same review found that appropriate authorisations were not recorded in two very lengthy isolations of more than 47 and 38 hours.¹¹⁷

Release from isolation

In analysing how and when children and young people are released from isolation, we tried to understand the purpose of isolation, and the criteria staff use to decide when to release a young person from isolation.

Most of the staff members we interviewed described isolation as ‘reset’ for the young person; a time for them to calm down and regain control of their emotions before they return to their unit.

The DHHS ‘Isolation’ policy requires that when a young person is placed in isolation, staff must:

*Tell the young person they will be released from isolation when they have settled and are no longer presenting an immediate threat to themselves, others, property or the security of the precinct.*¹¹⁸

The policy states that:

A young person must be released from isolation as soon as they have settled, are calm and are no longer an immediate threat to themselves or others.

Despite the policy, there was a lack of clarity among those who spoke to us about when and under what circumstances children and young people were permitted to leave isolation. As an example, a senior staff member told us that they expect staff to tell children and young people that they will be released from isolation rooms ‘as soon as you’re settled’ or ‘as soon as [the] unit is safe’.

We learned that these two criteria can be mutually exclusive: the young person can be settled, but it may still not be safe for them to return to mix with other children and young people, or for the staff in the unit. A senior staff member told us that staff often need to work through a range of steps to ensure it is appropriate to release the young person from isolation.

¹¹⁶ In January 2017, DHHS advised us that, in response to the Merlo review’s findings, the hierarchy of authorisations was being amended to lower the level of authorisation required. In February 2017, the policy instruction remained unchanged.

¹¹⁷ Merlo Consulting, *Isolations review*, pp. 12–13.

¹¹⁸ Department of Health and Human Services, ‘Isolation’, *Youth Justice Custodial Practice Manual* [internal document], (2016).

These steps may include speaking to managers, affected staff, other children and young people involved, to be clear on the relevant risks. While we recognise that these processes are important, it is also important to ensure children and young people remain in isolation for the shortest period possible and have a clear understanding of the circumstances under which they will be removed from isolation.

Children and young people told us they did not consistently receive advice when they entered isolation:

No, never – not once – they never tell you.

Just tell us what is happening. A lot of boys if you put them in the slot, they are not going to calm down if they don't know how long they are going to be in there. The reason they are angry is because they want to get out. Put us in our rooms as soon as possible.

Kids are kept in long after they are calm. For example, yesterday, [young person] was isolated for three hours over a minor incident. He was completely calm immediately he was put in, but still left there for at least three hours.

Our review of a random selection of CCTV footage illustrated the cycle described by these children and young people. They often became calm soon after being isolated but, as time passed, they became angry again and were seen shadow boxing or hitting and kicking walls.

DHHS is not consistently complying with the requirement to provide children and young people with advice about how long, and in what circumstances, they will remain in isolation.

Isolation as behaviour management

DHHS's 'Managing difficult behaviour' policy identifies isolation as one of a number of consequences that staff can impose on a child or young person in response to managing difficult behaviour. Other consequences identified in the policy include timeout,¹¹⁹ a thinking report, warnings and fines. In August 2016, DHHS advised us that these policies were being reviewed as part of the introduction of a trauma-informed model. This work was placed on hold in November 2016.

In February 2017, DHHS advised the Commission that 'steps have been taken to require the consultation of Practice Leaders in decisions regarding the use of isolation and separation is an important initiative to ensure appropriate consideration of the individual needs of the young person.'¹²⁰

The current policy acknowledges the limitations of imposing consequences on children and young people as a means of changing their behaviour:

Consequences will not produce long-term behavioural change and may have unintended consequences, such as escalating an incident, increasing unwanted behaviours due to resentment by the young person, or damaging a positive working relationship that staff may have with a young person.

Using sanctions or consequences frequently can lead to behaviours just being controlled as opposed to modifying the behaviour.

The DHHS 'How we work with young people in custody' policy identifies the importance of staff building trusting relationships with children and young people.¹²¹ Several interviews with experienced staff highlighted the significant protective influence that positive relationships between staff and children and young people can have on defusing incidents and minimising the need to use isolation.

¹¹⁹ DHHS policy states that a 'timeout' can occur in the young person's bedroom, a separate section of the unit, a 'timeout' room or outdoor area. It identifies that under no circumstances is the young person to be locked in an area or led to believe they cannot exit the area of their own volition.

¹²⁰ DHHS adverse comment, 27 February 2017

¹²¹ Department of Health and Human Services, 'How we work with young people in custody', *Youth Justice Custodial Practice Manual* [internal document], (2016).

Children and young people suggested that, when they were distressed, they appreciated talking to a staff member they knew or being taken outside for a walk or given the opportunity to exercise.

During the course of the inquiry's interviews, staff and management acknowledged a disparity between the ideal model of working with children and young people in a custodial setting and the current reality. They referred to pressures on the system and the transient nature of the population (exacerbated by the increase in remandees) limiting their development of positive and trusting relationships.

We observed CCTV recordings that showed a number of staff effectively supporting children and young people who were having trouble dealing with isolation. These interventions worked to subdue the behaviour. However, few children and young people were able to identify a time when other strategies were deployed before they were placed in isolation.

Other times they've tried to just have a SERT member take me off and talk to me – that's worked. But other times they just put you in the slot.

Some workers that you may have a good rapport with, they can tell when you're getting angry and stuff, they can tell. But others, they don't know what's happening to you. They just know when you start throwing stuff around and they won't step in because they don't feel safe.

The majority of staff we met showed a genuine commitment to helping children and young people and cared greatly for their welfare. Staff agreed that isolation is an effective method for immediate containment, but consistently told us that the effectiveness of isolation varied greatly, depending on the young person and the circumstances preceding their isolation. One group of staff told us that isolation 'takes the young person off the [unit] floor', but fails to address the young person's behaviour.

Staff told us that children and young people with histories of significant trauma and those experiencing mental health problems often find isolation extremely difficult. International literature confirms that those most likely to be placed in isolation are those with the most significant trauma histories.¹²² A high proportion of children and young people in Victorian youth justice facilities identify as victims of abuse, trauma or neglect. For many, isolation can 'vividly reawaken painful feelings of being powerless, worthless, fearful, and alone'.¹²³

Some children and young people acknowledged that a short period of isolation was helpful, but that it did not stop them behaving badly in the future.

To get you away – reset – it works while you're in there but when you're out [again], you forget.

We did not review all the incidents leading to isolation and therefore could not establish if the use of isolation by DHHS was punitive. It is, however, noteworthy that a recent DHHS internal review found that isolations were used for reasons other than immediate threat. This adds to our concern.

It is essential that Victorian Government employees adhere to the Children, Youth and Families Act and ensure that isolation is not used as a punishment.

Staff training

Staff raised concerns that some periods of isolation may occur because of inadequate staff training. In particular, they were concerned that the induction training course had been reduced from five to three weeks in 2016. We acknowledge that the induction training included lessons on trauma-informed practice and de-escalation; however, there were a number of areas staff felt were not explored enough.

Staff wanted more time allocated to scenario-based training to allow new staff to develop skills in de-escalating children and young people and managing

¹²² Provincial Mental Health and Substance Use Planning Council, *Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review* (British Columbia: Ministry of Health, 2012); Australian Children's Commissioners and Guardians, *Human rights standards in youth detention facilities in Australia*.

¹²³ S Burrell, *Trauma and the Environment of Care in Juvenile Institutions* (The National Child Traumatic Stress Network, 2013).

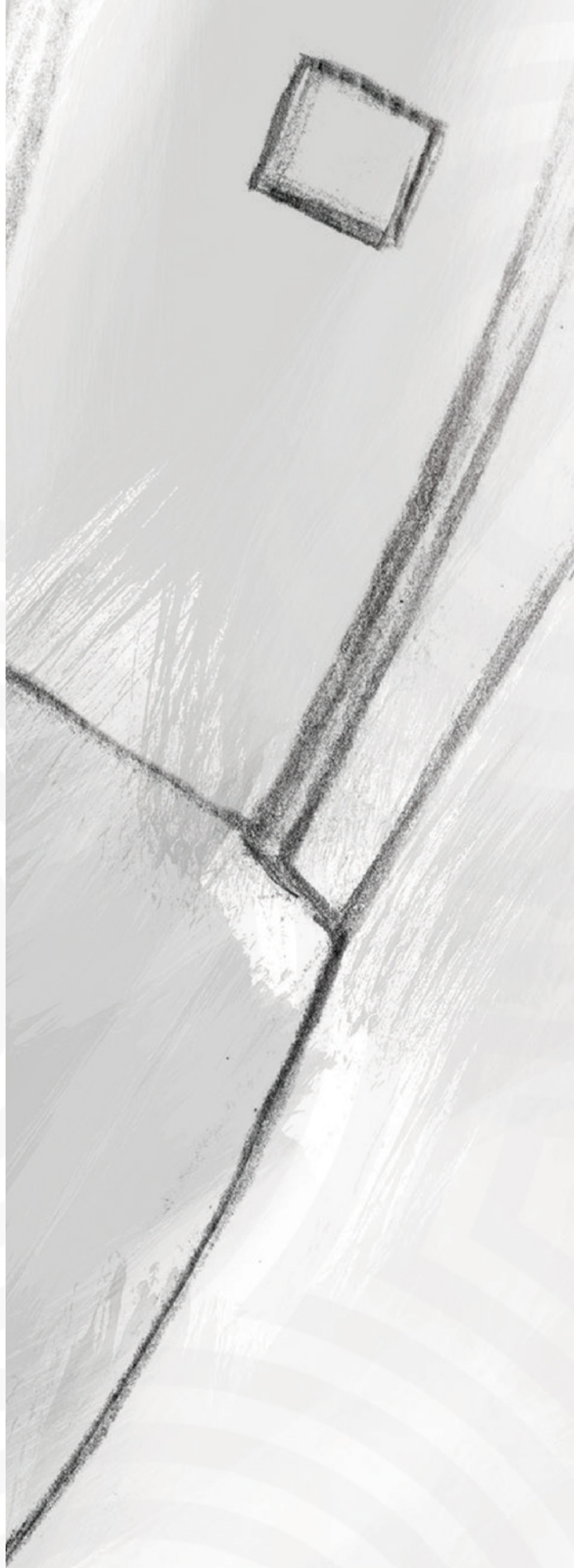
difficult conversations. Female staff wanted new staff to have more training in how to respond to sexualised behaviour exhibited by children and young people.

Training material about working with Koori children and young people, Maori and Pacific Islanders and other cultural and linguistically diverse backgrounds is covered in just one hour, and information about Parkville College is discussed for only 15 minutes, despite it being a key feature of both locations' daily operations.

When provided an opportunity to provide comment on the draft inquiry report, DHHS advised that:

Youth justice staff receive comprehensive induction training and mandatory ongoing training to ensure their skills are up to date. The induction training course has been revised to ensure that staff were 'on the floor' earlier after receiving initial training and that this is complemented by on-the-job training to embed capability.

We encourage DJR to review opportunities to improve the current content and breadth of the recruit training materials where needed.



Isolation of Koori children and young people

The DHHS 'Isolation' policy requires a range of specific practices when isolating a Koori young person:

- All periods of isolation of a Koori child or young person, regardless of duration, must be authorised by the General Manager, Operations Manager or a senior manager on call.
- When considering placing a young Koori person in isolation, staff must contact the cultural support worker¹²⁴ as soon as logistically possible.

In July 2016, DHHS amended observation practices to require 'constant' observations of all Koori children and young people in isolation.

Advice to us was that some Koori children and young people feel uncomfortable with the uninterrupted scrutiny by staff, which may escalate their behaviour. One Koori young person told us that being constantly observed made him 'paranoid'. A senior staff member also indicated that some children and young people struggle with the constant supervision. While some benefit from observation, it can make others' behaviour worse.

A number of staff told us that, if there were concerns about the impact of the observations, they could seek exemptions from senior managers to reduce the level of observations for Koori children and young people from 'constant' to 'close' (every five minutes). DHHS policies do not reflect this capacity.

Frequency of periods of isolation of Koori children and young people

The isolation data provided by DHHS indicated that Koori children and young people were placed in isolation more often than non-Koori children and young people.

In 2015 and 2016, 16 per cent of all children and young people in youth justice custody identified as Koori.¹²⁵

Both Parkville and Malmesbury had a similar proportion of Koori children and young people.

During the inquiry period, across the two locations, there was a different proportion of Koori children and young people isolated, compared to non-Koori children and young people.¹²⁶ At Parkville, 17 per cent of children and young people isolated were Koori, reflecting a similar proportion to the population. At Malmesbury, 30 per cent of children and young people isolated were Koori.

Across both locations, Koori and non-Koori children and young people appear to have been isolated for similar reasons, with the exception of one category. The data showed that across both locations, 12 per cent of isolations of Koori children and young people were initiated because they were deemed to be at risk of escape or attempted escape, compared to five per cent of non-Koori children and young people.

Compliance with policy

We identified that DHHS's practices were not compliant with its own 'Isolation' policy in a number of areas relevant to the management of Koori children and young people.

Our interviews with cultural support workers revealed an ad hoc approach to being informed when Koori children and young people were subjected to isolation. One staff member estimated they are called '50 per cent of the time'. Koori cultural support staff told us that they are also rarely called on to assist when children and young people first become distressed, leaving a missed opportunity for these trained specialists to help to de-escalate situations and, possibly, reduce the need for isolation.

We reviewed a sample of isolations of Koori children and young people that took place across the inquiry period and found that 73 per cent of isolations involving Koori children and young people did not record the required authorisations. The Merlo review of isolations found over 91 per cent of isolations of Koori children and young people in July and August 2016 did not record the appropriate authorisation.

Improving management of isolations of Koori children and young people

In its written submission to the inquiry, the Victorian Aboriginal Legal Service (VALS) told the inquiry that isolation, separation and lockdowns re-traumatise Koori children and young people. VALS described the incarceration of children and young people as ‘completely adverse to the nature of Aboriginal and Torres Strait Islander cultural practices, and only serves to further contribute to the breakdown and decimation of cultural practices that began with the onset of colonisation’.

Cultural support workers told us that the Koori children and young people find isolation particularly hard.

They are removed from country, removed from family – their families struggle to get enough money to come to visit. Community is everything for them...family – it’s everything.

These observations reflect the findings of the 1991 Royal Commission into Aboriginal Deaths in Custody:

The effects of institutionalisation on Aboriginal children is particularly destructive because Aboriginal culture and ‘institutional’ culture are virtually direct opposites, the former being permissive, egalitarian, strongly interactive, and kin based while the latter is authoritarian, punitive, hierarchical, individualistic and impersonal.¹²⁷

The failure to adhere to the requirements of the policy for Koori children and young people is unacceptable. It is essential that DHHS ensure that periods of isolation of Koori children and young people are managed sensitively and with due recognition of the accrued harms they, and their families, have suffered.

Further discussion about our ongoing oversight of this important area of practice can be found in Chapter 8 of this report.

Recommendation 4

That DJR establishes immediate measures to ensure that Youth Justice complies with all elements of the current Isolation policy relating to Koori children and young people, and reviews Malmsbury’s isolation practices to examine the disproportionate application of isolation on Koori children and young people.

New directions

Improve isolation infrastructure

Access to toilets

Most periods of isolation took place in the young person’s bedroom (54 per cent at Malmsbury and 69 per cent at Parkville), however, a significant number involve isolation spaces.

Most of Parkville’s isolation rooms and a small number of Malmsbury’s isolation spaces do not have toilets. Children and young people may ask staff to escort them to a toilet, but CCTV footage and interviews with children and young people confirmed that these requests are not always effectively responded to. We learnt that children and young people urinate, and at times defecate, in the isolation rooms:.

[T]hey don’t let you go, I just hold on. About a year ago I just went on the ground.

No sink, no toilet, no tap. Just a window and the door that’s it.

In Oakview if you need to go to toilet you buzz up, sometimes they come down sometimes they don’t.

I’ve had a piss in there before. It was all day and if there’s not enough staff to take you to the toilet... holding on for three to four hours, that’s hard.

¹²⁴ Secure Services has four Koori cultural support positions to support children and young people. These positions attend to Koori children and young people across Parkville and Malmsbury, both Secure Welfare Units and DFATS.

¹²⁵ Source: DHHS data provided to the Commission 27 February 2017.

¹²⁶ The inquiry’s 18-month timeframe sat within those two years (1 February 2015 – 31 July 2016).

¹²⁷ J Wooten, *Royal Commission into Aboriginal Deaths in Custody*, ‘Regional Report of Inquiry In New South Wales, Victoria and Tasmania’ (Canberra: Australian Government Publishing Service, 1991).

At Parkville? I ask them, buzz up. They say they have to wait until you're settled. I had to wait until they think I'm settled. I'll be settled but they don't think I'm settled. One time I just pissed on the ground. Then I had to stay there for a couple more hours.

Cultural support workers advised that some Muslim boys and young men will not ask a female staff member about the need to use toilet facilities. Extracts from the Commission's Independent Visitor Program reflected the feedback collected during the inquiry:

...[young person] claims that when she was in isolation on Monday evening (7/3) at about 5pm, no-one spoke to her and no-one communicated with her. She claims that she was not given any water and was not allowed to go to the toilet. She claims to have been there for approximately six hours (March 2016).

These practices are inconsistent with DHHS's obligations under the Charter of Human Rights, which requires that all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.¹²⁸

Managers and staff we interviewed held differing views about whether toilets should be included in isolation rooms. Many referred to the risks associated with staff safety during escorts to the toilets, and that the toilets for children and young people in the unit have closed doors and potential hanging points that staff cannot supervise. Other staff suggested that children and young people could damage the toilets or use the toilets to flood the isolation room. Of serious concern was the dismissive approach shown by a senior staff member to the situation faced by children and young people in isolation:

I really don't care if they piss or bronze up. We deal with it. Sometimes they just want to piss you off.

When provided with an opportunity to comment on the draft report of this inquiry, DHHS advised that:

The design of isolation rooms, including removal of wet areas, is intentional and allows mitigation against the risk of self-harm for some young people and provides a low-stimulus environment to assist in de-escalating heightened behaviour.

DHHS also referred us to the Australasian Juvenile Justice Administrators (AJJA) 'Design Guidelines for Juvenile Justice Facilities for Australia and New Zealand', published in 1996.¹²⁹ DHHS considers 'these standards recognise the opportunities for self-harm to be caused through the presence of toilet facilities in rooms that are used to house high-risk clients...'.¹³⁰

We note that the design guidelines identify that additional considerations need to be given when toilet facilities are included:

Special consideration is needed in relation to the provision of toilet facilities. If such facilities are to be included in the room, careful detailing is required to avoid self-harm risks.¹³¹

The inclusion of toilets and handbasins is standard in all cells within adult corrections, including those designed to manage those at the highest risk of self-harm, agitation or psychiatric illness. The toilets and handbasins are specifically designed to eliminate 'hanging points' to reduce the likelihood of suicide.

Our team also attended Thomas Embling Hospital as part of our inquiry and learned that their isolation spaces also all included toilets and handbasins. In some rooms, a sliding door can be remotely activated to prevent the patient from entering the bathroom in the event that access could present unreasonable risks. There is also capacity for staff to shut the water off to any of the rooms if patients are trying to flood the rooms.

¹²⁸ Charter of Human Rights and Responsibilities, s. 22(1).

¹²⁹ During the course of providing feedback on the draft inquiry report, DHHS advised that, in October 2016, the AJJA meeting agreed on a number of key priority projects including the review of the AJJA design standards. Work is likely to commence to review the current design guidelines during 2017.

¹³⁰ DHHS, response to draft inquiry report, 27 February 2017

¹³¹ Australasian Juvenile Justice Administrators, *Design guidelines for Juvenile Justice Facilities in Australia and New Zealand*, Department of Human Services and Australasian Juvenile Justice Administrators' Forum (1996), p. 72.

Beyond the infrastructure of these spaces, the Commission also notes that children and young people identified to be at active risk of self-harm or suicide are typically under constant observation by DHHS staff. This level of supervision, coupled with infrastructure design that mitigates the risks of self-harm, should ensure children and young people remain safe and have direct access to toilets when they require it, in a manner that maintains their dignity.

Recommendation 5

That DJR immediately upgrades all youth justice isolation spaces to include sanitation and ensures sanitation is included in the design of the new youth justice facility.



The use of bedrooms or isolation spaces for isolation

The DHHS 'Isolation' policy states that the 'safest option is to use a designated isolation room as this provides a more controlled environment. If this room is already in use, a young person may be isolated in their bedroom.'¹³² Despite this requirement, managers and staff had different interpretations about whether or not bedrooms or isolation spaces should be the first option for isolation.

The data reflected this varied understanding. As previously noted, most periods of isolation took place in the young person's bedroom (54 per cent at Malmsbury and 69 per cent at Parkville). Youth justice bedrooms are generally fitted with a bed, toilet and shower facilities, a television, a desk and a chair. Reading material and a small number of personal items are typically available.

During the interviews we found that, at times, staff were unsure if securing a young person in their bedroom qualified as isolation. However, the then Director of Secure Services told us that he was clear that it was, on the basis that it met the required criteria of the legislation (in a locked room, separate from others, away from normal routine of the centre).

Our interviews with children and young people identified that the negative effects of isolation can be reduced in their bedrooms.

*It's better [in bedrooms], more comfortable
– when heart rates up – lay down, calm
– then your heart rates goes down.*

*Yes, that's what I prefer. It's just your room.
You can do what you want...[in isolation] there
is just nothing. Here, there's a table, and you
can look through your photos and stuff.*

Staff also acknowledged that isolating a child or young person in a bedroom had advantages:

*Majority of time we try to keep them
in rooms – escalates them in isolation
room because there's no TV.*

The potential benefits need to be measured against the limited capacity for effective observations in bedrooms, which do not have CCTV capacity or large viewing panels. Isolating a child or young person in their room could pose a range of concerns in some situations if there is access to materials that could be used for self-harm or to injure staff. Use of a bedroom for isolation will also be inappropriate if the room is shared with another young person or if children and young people could damage the room, fittings and fixtures and their own property.

Having access to their bedroom and personal belongings may help a calm down a child or young person. Such a decision should be made with appropriate risk assessment and considering the key purpose of isolation is to allow the child or young person to gain control of their behaviour.

There was significant confusion among staff about which spaces were to be used first for isolation. As the use of bedrooms has both risks and benefits, a process for staff to assess options on a case-by-case basis, which guides them to make that assessment, should be implemented.

The youth justice system should ensure there is a consistent understanding of what children and young people can be provided with in isolation spaces. There should be greater emphasis on using spaces to help calm children and young people, and in developing safety plans that include personal items that may safely be taken into isolation and separations.

Recommendation 6

That DJR amends youth justice policy and practice to clarify when isolation should occur in bedrooms and when it should occur in isolation rooms.

¹³² Department of Health and Human Services, 'Isolation', *Youth Justice Custodial Practice Manual* [internal document], (2016).

Supply of materials

Children and young people largely had to rely on their own resources to work out how to regulate their feelings and behaviours.

Two isolation rooms in Parkville have chalkboards, which were well-regarded by the staff, children and young people interviewed. Isolation spaces also have access to radios through the intercom, which provided relief for some children and young people, who are not permitted to bring any items into the isolation rooms. The provision of materials to address boredom, anxiety or distress while in isolation needs further exploration. Providing materials such as stress balls could assist children and young people to calm, and reduce the length of time they spend in isolation.¹³³

In December 2016, DHHS advised that, following the recommendations of a recent internal report, sensory rooms will soon be introduced at Parkville and Malmsbury. The introduction of sensory rooms will provide heightened children and young people with opportunities to de-escalate, relax and reflect.¹³⁴

Increase involvement of clinical services

We found that current policy does not require staff to advise, consult with or engage YHaRS in isolation processes. YHaRS staff told us they often inadvertently learn about isolations when they attend units for other purposes.

We found that YHaRS' involvement in isolation processes should be increased. This should include roles for YHaRS in prevention and management planning to limit circumstances in which isolation is needed, risk assessments and de-escalation efforts, and the management of children and young people placed in isolation.

'At risk' observations

The DHHS 'Isolation' policy identifies that observations help to:

- ensure the safety of a young person who has been assessed as being at risk of harm
- maintain the safety of staff and other children and young people
- support children and young people through appropriate engagement, interaction and attention from staff
- monitor behaviour, mood and general presentation
- develop a plan to provide the required level of support while the young person remains at risk of harm, together with a process for their longer term management.

Observations are operational decisions. Managers are required to consult with the health service when considering reducing or ceasing observation levels.¹³⁵

In the Victorian adult correctional system, observation regimes for 'at risk' prisoners are discussed by a multidisciplinary team; however, the final decision about whether or not observations are required, and how often those observations should be, are made by suitably qualified medical staff.¹³⁶

We found that a clinician in consultation with cultural staff, rather than operational staff, should determine the likelihood of risk of self-harm or suicidal actions, and the corresponding observation regime. Health staff should have a greater role in assessing and managing children and young people subject to isolation.

Recommendation 7

That DJR reviews the allocation of responsibilities and processes for observing children and young people in youth justice who are at risk of self-harm.

¹³³ S Wigglesworth and L Farnworth, 'An Exploration of the Use of a Sensory Room in a Forensic Mental Health Setting: Staff and Patient Perspectives', *Occupational Therapy International*, vol. 23, no. 3 (2016), pp. 255–264.

¹³⁴ A sensory room is a space typically fitted with special lighting, music and objects, to provide therapeutic support.

¹³⁵ Department of Health and Human Services, 'Observation of young people in custody', *Youth Justice Custodial Practice Manual* [internal document], (2016).

¹³⁶ Corrections Victoria, Commissioner's Requirement – E*Justice Risks and Recommended Actions, August 2016 <<http://www.corrections.vic.gov.au/utility/publications+manuals+and+statistics/commissioners+requirements+part+2>>

Monitor and respond to self-harming behaviour

In 2012, the UNHRC identified that ‘children in detention are prone to self-harm as a result of violence, neglect, poor detention conditions, prolonged periods of detention, isolation and mental health conditions that may or may not have existed prior to detention’.¹³⁷

We reviewed a sample of CCTV footage of isolations. Of particular concern were two instances where a young person was seen banging their head against a wall and a window, for approximately six minutes on each occasion. Unit staff did not enter the isolation room to stop the young person from hurting themselves further and there was no evidence that any staff members talked to the young person. One young person told us that he regularly self-harmed when placed in isolation.

The Youth Justice Custodial Practice Manual is clear that if a child or young person is seen to be:

harming themselves, is visibly bleeding or is seriously unwell, you should immediately radio for assistance or call an emergency code over the radio...when support staff arrive, the bedroom door can then be unlocked, but all precautions still need to be maintained before doing so. No door is to be opened without the authorisation of the Night Manager/Supervisor. [...]

*if a suicide attempt or deliberate self-harm incident has already taken place, it must be treated as an emergency...*¹³⁸

A review of the young person’s Client Relationship Information System (CRIS) notes identified that, in one instance of self-harm, the responsibility for

observations had been transferred to Parkville’s control room staff because of a unit staff meeting. It was not feasible for control room staff to effectively monitor the wellbeing of an ‘at risk’ young person in addition to their other duties.

Senior Parkville staff indicated that control room observations could be effective if unit staff attended the central control room and completed the observations from there.

We are concerned about the lack of clarity about processes and responsibilities when CCTV is used for self-harm observations, and the failures to intervene when children and young people were self-harming.

Overall, we found the use of isolation rooms to manage children and young people at risk of self-harm was contrary to therapeutic principles. There was inadequate support and intervention, unreliable observations and the rooms did not help young people to recover.

Meet the need for an adolescent forensic mental health facility

Unlike adult prisoners, children and young people in the youth justice system who are acutely mentally unwell do not have access to designated facilities.¹³⁹ There are five community-based acute inpatient units for children and young people in Victoria – one child unit and four adolescent units. DHHS has no priority access for admissions into these facilities and told us that they need to negotiate with providers to find a bed.¹⁴⁰ As

¹³⁷ UN Human Rights Council: Joint Report of the Office of the High Commissioner for Human Rights, the United Nations Office on Drugs and Crime and the Special Representative of the Secretary-General on Violence against Children prevention of and responses to violence against children within the juvenile justice system. United Nations. A/HRC/21/25., (27 June 2012), p10.

¹³⁸ Department of Health and Human Services, ‘Deliberate self-harm and suicide prevention’, *Youth Justice Custodial Practice Manual* [internal document], (2016).

¹³⁹ At Melbourne Assessment Prison, the Acute Assessment Unit is a special mental health unit that provides assessment and treatment for male prisoners with serious psychiatric conditions. At Dame Phyllis Frost Centre, Marmak Unit provides assessment and treatment for female prisoners with serious psychiatric conditions. Prisoners who require involuntary mental health care are transferred to Thomas Embling Hospital under the *Mental Health Act 1986*. Involuntary treatment is not provided in Victoria’s prisons.

¹⁴⁰ Then Director of Secure Services told us he has always been ultimately successful in obtaining a bed for an acutely mentally unwell young person.

these facilities are not custodial environments, patients coming from youth justice require constant custodial supervision. This can reduce the effects of therapy.

During our inquiry, there were up to four children and young people in custody who were deemed 'unfit to plead' due to mental illness or intellectual disability, under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA). One unit experienced a significant number of serious self-harm and suicide attempts, many of which involved a young person on a CMIA order.

Staff described their significant concerns for these children and young people as well as the extreme pressures on staff working in that unit:

The heightened vigilance required to observe that critical incidents don't happen is exhausting. Even during observations, staff worry about their minds switching off for the shortest time.

The need for a dedicated adolescent forensic mental health unit has been identified in at least two previous reviews. In 2009, an inquiry recommended that:

the Department of Human Services in partnership with relevant service providers develop and implement a new residential forensic mental health treatment centre or contained therapeutic facility for juvenile offenders.¹⁴¹

The following year, the Victorian Ombudsman also recommended that a purpose-built facility, operated by trained professionals, be established to treat young people with mental health needs.¹⁴²

In February 2017, the government announced the establishment of a new youth justice facility, to be

built in Werribee South, including a 12-bed mental health unit.¹⁴³ We strongly support the establishment of a dedicated unit to support children and young people who are experiencing significant psychiatric and psychological issues. We also encourage DJR to find ways to better help this vulnerable group until the new facility is operational.

¹⁴¹ Drugs and Crime Prevention Committee, 'A forensic treatment centre for adolescents', *Inquiry into Strategies to Prevent High Volume Offending by Young People* (Melbourne: Parliament of Victoria, 2009), p. 282.

¹⁴² Victorian Ombudsman, *Whistleblowers Protection Act 2001: Investigation into conditions at the Melbourne youth justice precinct*.

¹⁴³ D Andrews (Premier), *Building A Stronger And More Secure Youth Justice System* [media release], 6 February 2017, Premier of Victoria, <<http://www.premier.vic.gov.au/building-a-stronger-and-more-secure-youth-justice-system/>>, accessed 13 February 2017.

At a glance

Having examined DHHS's use of isolation, and in light of the evidence discussed in Chapter 1 about the serious negative impact isolation has on the mental health and wellbeing of children and young people, our findings are as follows.

Legislative criteria for use of isolation

The Children, Youth and Families Act allows isolation on two different grounds. One establishes clear and well-defined criteria and requires that a set of safeguards accompany the use of isolation, but the other is too broad and requires no safeguards.

Inadequate recording and authorisation

The data indicated there was confusion about when, where and for how long isolation should be imposed.

Poor compliance with recording requirements indicates that DHHS has not treated isolation as seriously as is warranted given the serious impact the practice can have.

Over-reliance on isolation

Across 547 days, DHHS recorded 4,829 periods of isolation – an average of 8.8 per day. In the first two weeks of December 2016, this rate increased fivefold. Because of under-reporting, the actual incidence of isolation was likely to be much higher.

We cannot definitively conclude that DHHS is using isolation as a form of punishment, contrary to the Children, Youth and Families Act. However, it is concerning that DHHS policies contemplate the use

of isolation as a 'consequence' for poor behaviour, and children and young people were clear isolation is imposed as punishment.

Repeated and extended periods of isolation for some children and young people

A number of children and young people were subject to repeated instances of isolation. During the initial 18-month inquiry period, there were 10 children and young people as a group who were subject to more than 900 periods of isolation, and four were each subjected to more than 100 periods of isolation. Extended and repeated use of isolation reflects a failure of the youth justice system's capacity to effectively understand and address children's behaviours.

The data included examples of children and young people who were subjected to extended periods of isolation, including one instance where a young person was recorded to have been isolated for 31 days and another for more than 11 days. DHHS has since advised that they believe this data to be inaccurate, but other information reviewed by the Commission showed young people on separation plans for up to 45 days without contact with peers and away from the routine of the centre.

Koori children and young people

We were deeply concerned to find that Koori children and young people were overrepresented in the use of isolation. Policies and practices set up to protect the interests of Koori children are not routinely followed and must be attended to immediately.

Infrastructure of isolation spaces

The designated isolation spaces are bare and do not help children and young people to settle. They may even make their behavioural and mental health problems worse. Most of Parkville's isolation spaces do not have a bed, toilet or handwashing facilities. Taking children and young people out of isolation to go to the bathroom creates additional risks to children, young people and staff.

Mental health issues

Decisions about 'at risk' observations in youth justice are primarily determined by operational, not clinical, staff. We believe this is inappropriate. A random review of CCTV footage identified instances in which children and young people who were harming themselves in isolation spaces were not attended to by youth justice staff.



5. Separation

Practice instruction	
Practice instruction	<p>The DHHS ‘Separation of Young People’ practice instruction states that:</p> <ul style="list-style-type: none"> Occasionally, young people present with behaviours that are so extreme and difficult to manage that we need to use all mechanisms at our disposal to keep them, and everyone else, safe. In general, consequences for negative, violent or otherwise disruptive behaviours are provided within an overall approach which is trauma-informed, proactive and promotes positive behaviour. Separation complements and supports behavioural strategies already in place, with the aim of preventing violence among this client group. Separating a young person under the directions contained in this procedure should only occur after other less intrusive options have been tried without success. <p>The same practice instruction identifies that separation is used to provide a time-limited response to incidents of extreme acts of aggression or other unsafe behaviour to:</p> <ul style="list-style-type: none"> ensure the safety of the young person, staff and others on the precinct by temporarily restricting the young person’s movements and contact with peers demonstrate that violence against other people is entirely unacceptable and will not be tolerated allow time and space for a plan to be developed to assist the young person to change violent and maladaptive behaviours, with a focus on both the custodial period and the return to the community beyond this gradually reintegrate the young person into the broader precinct – both physically by returning them to a unit, and in an interpersonal sense by encouraging them to make restoration to others who have been harmed through their actions <p>Temporary separation of a young person also provides an alternative to transfer to prison where this may have been considered as a final resort, and allows us to meet our mandate of managing young offenders in an age and developmentally appropriate setting</p>
	<p>The key reason for initiating separation is ‘consistent or extreme violence or destructive behaviour that has continued despite all attempts to prevent it’.</p> <p>This includes:</p> <ul style="list-style-type: none"> physical assault of staff or another client or significant self-harm multiple or significant verbal threats (where there appears to be an intention to follow through with the threat) – such as telling a staff member or another client that they will kill them, or that they will harm the staff member’s family escape attempt or actual escape extreme vandalism such as the destruction of a bedroom or other space. <p>The practice instruction states that:</p> <p>[S]ome young people may fit the criteria not because of violent behaviours but because of their vulnerability. They may be identified by precinct management as requiring intensive interventions, for example because of their vulnerability due to mental health or developmental disorders (such as Asperger’s Syndrome).</p> <p>...</p> <p>Young people in this category may be targeted by their peers due to noticeable or disruptive behaviours that may be out of their control. In these situations, the purpose of separation is to create a time-limited safe place in which to support the young person to develop more adaptive behaviours that will allow for their long-term safety.</p>
Criteria	

Practice instruction

Establishing a Separation Safety Management Plan	<p>The Unit Manager is responsible for ensuring all other less restrictive options have been attempted before considering a Separation Safety Management Plan (SSMP). The Unit Manager is responsible for developing a separation plan, in collaboration with the care team.</p> <p>The General Manager is responsible for ensuring the criteria for separation are met and that the separation is not used for punishment, or as a substitute for isolation.</p> <p>Every 72 hours, the General Manager is responsible for reviewing the plan and ensuring the interventions are being provided. The Director of Secure Services authorises the initial plan and each update of the plans.</p>
Starting a separation plan	<p>At the time a young person commences a separation plan, the General Manager must:</p> <ul style="list-style-type: none"> • identify the location for accommodating the young person • determine the level of observation needed to keep the young person safe • ensure that a referral is made to the health service for immediate assessment • ensure that arrangements are made to identify the care team who will be responsible for the young person on separation • ensure arrangements are in place for the young person's continued access to education, recreation and cultural services and supports • ensure the separation is recorded in the Separation Register maintained at each precinct.
Composition, and role of, a young person's care team	<p>Separation plans should be informed by a comprehensive assessment of the young person's behaviour, supported and overseen by their care team.</p> <p>The membership of the young person's care team is dependent on the young people's needs. At a minimum, a care team must include:</p> <ul style="list-style-type: none"> • Unit Manager (who leads the team and coordinates the separation plan) • regional youth justice worker • member of the youth justice health team • Parkville College teacher.
Reviewing a separation plan	<p>As noted above, every 72 hours after the commencement of separation, the separation plan must be reviewed to ensure that interventions are being provided as stipulated and that the plan includes a process for re-introducing the young person to the unit.</p> <p>If required, staff can create a new plan, following expiry of the original plan.</p> <p>There is no limit to how many consecutive plans a young person can be placed upon, as long as each plan is no longer than 72 hours.</p>

What is separation?

Separation is an operational practice where children and young people are separated from their peers for up to 72 hours without review. Separation is managed by Separation Safety Management Plans (known as SSMPs or separation plans), which often feature significant periods of time in which the child or young person is locked up in his or her room. This chapter examines the use of separation and considers whether the management of separation plans complies with DHHS policy.

Use of separation

DHHS provided us with 138 separation plans for 80 children and young people for the initial 18-month inquiry period. We analysed a random sample of 57 separation plans in detail.¹⁴⁴ Of those, 24 (42 per cent) were from Parkville and 33 (58 per cent) were from Malmsbury.

Use of separation in December 2016

DHHS was also asked to provide records relating to the use of isolation, separation and lockdowns for the two-week period of 1–14 December 2016. The figures outlined in Table 5 demonstrate that the average number of separation plans per day in the first two weeks of December was almost nine times greater than during the initial 18-month inquiry period.

Table 5: Number and rate of separation plans, February 2015 – July 2016 and 1–14 December 2016, all locations

	Feb 2015 – Jul 2016	1–14 Dec 2016
Number of separation plans	138	38
Number of days within the period	547	14
Average number of separation plans per day	0.3	2.7

Compliance with policy

The separation plans included examples of the extreme vulnerability of some children and young people in detention. Examples included children and young people suffering from foetal alcohol syndrome, intellectual disability, psychosis, encopresis and drug withdrawal. There were also examples of extreme violence and risk to staff and other children and young people. Incidents included children and young people causing damage to facilities; physically assaulting staff and detainees, including kicking, punching, or using improvised weapons; and threatening to injure or sexually assault staff or other children and young people. In such a volatile and highly charged context, ensuring the safety and human rights of everyone concerned is a priority.

Monitoring how separation plans are used and administered is one way to assess compliance with the policy requirements. We noted significant variation in the plans, which made such examinations and comparisons difficult. The templates, level of detail and evidence of rehabilitative intent all varied between facilities, units and the staff members completing them.

¹⁴⁴ This is the number required to achieve a 95 per cent confidence level for 137 plans.

Lack of individualised responses

The quality of the separation plans varied considerably. Most were basic and contained minimal information. Others were more comprehensive and explored the young person's triggers and possible health-related issues. One included a detailed social history of the young person. Some included more context, describing initial attempts to address the conduct through warnings or Individual Behaviour Management Plans.

There was little evidence of individualised approaches that considered the child or young person's circumstances, the incidents that led him or her to be placed on a plan, or any exploration of strategies to support the child or young person to successfully transition back to their unit and remain there safely.

In January 2017, DHHS advised that 'practice leaders are now involved in the development of any SSMPs to ensure they are appropriately tailored to individual needs of the young person'.¹⁴⁵ This is an encouraging development and one the Commission hopes will soon provide better outcomes for children and young people in custody, and the staff that work with them.

Criteria

The DHHS 'Separation of Young People' policy identifies that separation is for consistent or extreme violence or destructive behaviour that has continued despite all attempts to prevent it; or due to a young person's vulnerability.

We found several common themes in the criteria recorded in the separation plans.

Of Malmesbury's separation plans, the majority (64 per cent) were due to 'physical assault of a staff member'.

Parkville's separation plans were more evenly spread, with 'multiple incidents' and 'assault another client' being the most common reasons (21 per cent each).

Two children and young people were placed on separation plans because they were perceived to be vulnerable. One was placed on a plan to recuperate following an assault that required hospitalisation and was on a plan for 38 consecutive days. The second one involved a young person who was described as agitating other children and young people and was on a plan for 14 consecutive days. The plan indicated:

*Authorisation of a Separation/ Safety Plan is being sort [sic] for *** as a means of maintaining his safety. *** is at great risk of being assaulted due to antagonizing [sic] other clients and his inability to regulate behaviours. *** has a significant history of trauma and self-harm, which makes him quite vulnerable amongst our client group. *** has previously displayed poor hygiene and often soils himself when distressed. Clients are aware of this and have bullied *** in the past leading to several incidents. *** will be placed in a low stimulus environment with minimal contact with peers until it is deemed safe for him to interact with others.*

Two children and young people were placed on separation plans for 'other' reasons. One young person had returned from hospital following a suicide attempt (three days on a plan) and the other was experiencing significant drug withdrawal (one day).

Many children and young people, independent visitors and staff expressed concerns about the management of vulnerable children and young people in youth justice. There were frequent references to vulnerable children and young people 'self-isolating' (staying in their rooms for extended periods of their own accord) due to safety concerns. One separation plan noted a young person had claimed to have caused incidents so that he could be separated 'without looking afraid'.

¹⁴⁵ Correspondence 20 January 2017, Christina Asquini, Deputy Secretary, Operations, DHHS, to Liana Buchanan, Principal Commissioner, Commission for Children and Young People.

Starting a separation plan

We assessed the randomly sampled plans against the policy requirements about starting an SSMP. The following requirements were consistently met:

- identifying the location for accommodating the young person (100 per cent)
- identifying that a care team was in place (96 per cent, but few plans had active arrangements for the care team to meet).

The following requirements were not consistently met:

- Parkville recorded planned observation regimes 38 per cent of the time. Malmsbury identified an observation regime in only three per cent of the separation plans.
- Only 52 per cent of the separation plans identified that a new referral, or re-referral, had been made to YHaRS or another health service. The remaining plans included general references to children and young people being able to access health services.
- The requirement to ensure the child or young person's continued access to education, recreation and cultural services and supports varied greatly. Some were tailored specifically for the individual, but the majority referred more generally to services available at the centre.

Reviews and renewals

DHHS policy requires that each separation plan is reviewed no later than 72 hours after it is established. We examined each of the 138 plans and identified 376 reviews within those plans. Forty were completed outside the required 72-hour period, representing a 10 per cent non-compliance rate.

The format of the separation plans contained no information about factors considered during the review processes or approvals for renewal, although copies of brief approval emails were seen on CRIS. It is important that reviews are rigorous, defensible and consistent. Separation plans should also contain all details and dates of approvals.

Recommendation 8

That DJR ensures the development of a process that requires senior youth justice staff to maintain records of all reviews and renewals of Separation Safety Management Plans.

Time spent outside bedrooms

The DHHS 'Separation of Young People' policy requires that children and young people on a separation plan must be kept busy each day with meaningful and targeted interventions that will make a positive contribution to addressing concerning behaviour.

Using the daily schedules attached to the separation plans, where available, we assessed the amount of time scheduled for children and young people to be out of their rooms. We were not able to establish with confidence how long the children or young people were permitted out of their rooms, because the plans frequently added broad caveats such as, 'if staff are available', 'if the young person is calm' or 'if there are no other children and young people on the unit'.

Of the plans reviewed:

- The amount of time scheduled for children and young people to be out of their rooms ranged from 1.5 to 12 hours per day. The most common period of time out of rooms was 3.5 hours (23 per cent).
- More than half of the separation plans scheduled each young person to be out of their rooms for four hours or less.
- Four of the separation plans permitted two hours or less out of their room each day. All of these were at Malmsbury.
- Four separation plans did not include a daily schedule.

We noted with concern that some of the separation plans scheduled a child or young person's first time out of their room as late in the day as 1:45pm, meaning they spent more than 17 hours confined in their room. A number of the separation plans also required children and young people to eat all their meals in their rooms, within several metres of their toilets.

A preliminary analysis of the additional information we requested for isolation, separation and lockdowns during the first two weeks of December 2016 found:

- Separation plans in Grevillea involved 23 hours in a cell every day for every child and young person.
- Separation plans in Parkville and Malmsbury varied, but most involved 22 or 23 hours of effective isolation.

The daily schedules attached to the separation plans regularly lacked specific information about how much time a young person would have access to fresh air, as opposed to time in the unit's common area or corridors. We were therefore only able to identify the amount of time identified for each person to be out of their room.

The templates should require more specific detail about how long, and where, children and young people will be spending their time while on separation plans. This will improve transparency for children and young people, and enable genuine scrutiny.

Isolation during separation

DHHS advised us that in the past it has taken different views on the definition of isolation in the context of separation.

Until February 2016, isolation imposed during separation was not recorded as such. This is despite the parallels between the legislated definition of isolation (in a locked room, separated from others and the normal routine of the centre) and the fact many children and young people on separation plans spend, on average, 20 hours of their day in identical conditions.

All the separation plans we reviewed included periods of time in a room or cell that we consider to be isolation. Despite this, only 23 (40 per cent) of the separation plans recorded corresponding periods of isolation. Our analysis showed that the approach to isolation was inconsistent, with 45 per cent of the separation plans at Malmsbury having periods of isolations recorded, compared to only 33 per cent at Parkville.¹⁴⁶

Recommendation 9

That DJR ensures that all time that a child or young person spends on a Separation Safety Management Plan 'in a locked room, away from others and away from the normal routine of a centre' is recorded, managed and regulated as a period of isolation.

¹⁴⁶ Eight separation plans recorded isolations occurred prior to February 2016. This suggests the approach to recording isolations within separation plans has been ad-hoc for a number of years.

New directions

Provide a legislated minimum period of fresh air

Neither legislation nor policy stipulate a requirement for children and young people in Victorian youth justice centres to have a set number of hours of access to fresh air. This is in contrast to section 47(1) of the *Corrections Act 1986*, which states that all adult prisoners are entitled to one hour of fresh air each day, if weather permits.

The failure to establish, and maintain, a minimum amount of time each day that a child or young person is entitled to fresh air is contrary to the United Nations' Havana Rule 47, which requires that:

Every juvenile should have the right to a suitable amount of time for daily free exercise, in the open air whenever weather permits, during which time appropriate recreational and physical training should normally be provided.

Recommendation 10

That the Victorian Government amends the Children, Youth and Families Act to ensure that all children and young people in youth justice centres have at least one hour of fresh air each day.

Improve the protection of vulnerable children and young people

Placing children and young people on separation plans for their own protection is unreasonable and unfair. In future, DJR should create designated accommodation spaces to provide vulnerable children and young people (such as those with an intellectual disability)

with a safe environment. It may also be necessary to create designated areas for children and young people who may pose ongoing risks to others (for example, those with problematic sexual behaviours). Staff generally agreed there is a need to improve existing protections for vulnerable children and young people.

The Beijing Rules appreciate that some children and young people need to be separated, in some circumstances, for their own welfare:

Varying physical and psychological characteristics of young detainees may warrant classification measures by which some are kept separate while in detention pending trial, thus contributing to the avoidance of victimization and rendering more appropriate assistance.

Recommendation 11

That DJR ensures that designated accommodation options for vulnerable children and young people are established in youth justice custodial settings, both in the proposed new facility and in existing centres.

Ensure access to visits

We found that almost 30 per cent of separation plans prohibited personal visits. Approximately 45 per cent referred to children and young people being permitted visits and the remaining 25 per cent did not contain any reference to visits.

The policy identifies that 'best interests principles' mean that children and young people are entitled to receive visits from parents, relatives, legal practitioners, persons acting on behalf of legal practitioners and others. This is consistent with section 482(2)(b) of the Children,

Youth and Families Act and the following sections of the Charter of Human Rights and Responsibilities Act:

- Families are the fundamental unit of society and are entitled to be protected by society and the state (s17[1]).
- All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person (s22[1]).

Prohibiting visits for children and young people on separation plans is contrary to the Children Youth and Families Act, the young person's best interests and the Charter of Human Rights.

Recommendation 12

That DJR amends youth justice policy to specifically articulate that all children and young people on Separation Safety Management Plans are entitled to personal visits.

Improve record keeping

The documentation associated with the management of separation plans was poorly administered. Poor record keeping and inconsistent documentation limits the capacity for review and supervision of these important decisions.

We also identified differing approaches within DHHS in relation to managing reviews within a separation plan. Some staff created a single document and recorded multiple reviews within it. Others created one document for the initial separation plan and then additional documents for subsequent revisions. There were examples where some children and young people had a number of separation plans in place for the same dates, or where one day was unaccounted for between two successive separation plans.

The separation plan templates do not require staff to specify particular characteristics of a young person. The absence of this information limits the understanding

of the young person's circumstances, both by staff in the units and the Director authorising the separation plans. At a minimum, the following information about the young person should be captured on all plans:

- Aboriginality
- cultural background
- age
- gender
- any known disability, mental health or special needs.

Of the 57 plans we selected randomly, 19 per cent related to Koori children and young people. This is greater than the average proportion of Koori children and young people in Victorian youth justice in the same period (15 per cent).

Recommendation 13

That DJR collects additional data about the characteristics of all children and young people on Separation Safety Management Plans to allow oversight, review and continuous improvement of this restrictive practice.

Provide copies of separation plans

The separation plan template requires staff to acknowledge (by signature) that children and young people on separation plans have had their plans explained to them.

Staff are not currently required to provide children and young people with a copy of their separation plan. We believe it would be beneficial to provide them with a copy of their plans to provide a degree of structure and predictability to their days and enable them to have access to information that directly affects them.

When given an opportunity to comment on the draft inquiry report, DHHS responded:

SSMPs contain information beyond outlining the structure of a young person's day. They can include the opinions of health professionals and others relevant to ascertaining the needs of the young person. As such, it would be inappropriate to provide young people with a full copy of their SSMP.

...the department is replacing SSMPs with secure care plans. The department will consider including within the new plan template a section which can be provided to young people that appropriately communicates the structure of their day whilst subject to the plan.

We consider that children and young people should be provided a copy of the document that outlines why they have been placed on a plan, the objective of the plan and the structure of the day.

Recommendation 14

That DJR amends youth justice policy to require that all children and young people are given copies of their Separation Safety Management Plans, or their equivalent.

Provide personal items

The separation plan template requires staff to list personal items that children and young people are permitted to access during their separation plans. However, we found that the items listed were standard items issued by the facility, such as towels, bedding and toiletries. Other separation plans simply referred to personal issues issued 'as per unit procedure.' A small number of plans referred to the provision of portable compact disc players to help children and young people occupy themselves.

Rather than 'personal items', we consider bedding and basic toiletries to be basic essentials these children and young person are entitled to. Over the past 12 months, we have been extremely concerned to learn of a number of instances where children and young people have been denied access to toilet paper, sheets, pillows and basic toiletries.

A quarter of a century ago, the Royal Commission into Aboriginal Deaths in Custody identified the impact of child removal and disconnection from family and community.¹⁴⁷ Through our oversight activities, we have heard many stories of children and young people being denied access to photos of loved ones. While 'personal items' are not defined in the policy, our firm view is that children and young people should be entitled to their own photos, books or other items that, where appropriate, could assist them to regulate their behaviour.

When provided an opportunity to comment on the draft inquiry report, DHHS responded:

the availability of specific items are operational decisions made by unit staff based on an assessment of the circumstances and needs of the young person. Only items that are safe and appropriate should be provided.

We encourage DJR to explore options to proactively require staff working with those on separation plans to consider the provision of personal items.

¹⁴⁷ Royal Commission into Aboriginal Deaths in Custody, (Canberra: Australian Government Publishing Service, 1991).

Inadequate protection of vulnerable children and young people

There was evidence that separation plans featuring isolation are used as a strategy to protect the most vulnerable children and young people, including those who have mental health or other disabilities. Among the separation plans provided by DHHS for the inquiry period, the Commission identified examples such as:

- [...young person] is currently experiencing a period of mental health instability for which he has just commenced a regime of medication.
- authorisation of a Separation/ Safety Plan is being sort [sic] for [...] as a means of maintaining his safety. [...] is at great risk of being assaulted due to antagonizing other clients and his inability to regulate behaviours.
- this [plan] is an intervention for the safety and well being of the client who was involved in an apparent suicide attempt on [date].
- authorisation of this Safety Plan is being sort [sic] for [...] as a means of maintaining the safety of [...] and those around him. [...] has placed himself at significant risk of being seriously assaulted due to his low functioning and inability to self regulate.

The lack of safe accommodation for vulnerable children and young people in custody exposes a weakness within the system. We found that in some cases the use of separation plans was inappropriate.

Recommendation 15

That DJR reviews youth justice practice to ensure that children and young people are not subjected to isolation as part of a Separation Safety Management Plan because they have been the victim of an assault, or are otherwise vulnerable.

Lack of individualised responses to children and young people

The separation plans contained little evidence of a tailored approach to managing individuals' behavioural, therapeutic or health needs. The use of separation plans did not generally demonstrate an adequate attempt to understand, address and change individual children's behaviour. Rather, the plans reviewed suggested a need to develop a substantially more sophisticated approach to manage behaviour and supporting children and young people's rehabilitation.

The Commission was very pleased to note that, in January 2017, DHHS has introduced changes to involve Practice Leaders in the development of separation plans. We hope this amendment improves the quality of the individual support provided to each child and young person on a plan.

Recommendation 16

That DJR reviews youth justice policy, practice and training to ensure:

- i. isolation is not used as the primary behaviour management tool in the youth justice system
- ii. all Separation Safety Management Plans include an individually tailored plan, developed with input from health or therapeutic staff, to address the child or young person's behaviour, and the causes of that behaviour, and provide a clearly articulated plan identifying when, and how, a child or young person will be able to return to the broader population of the centre.

At a glance

In assessing the current separation practices, we identified a range of concerns:

- Separation plans generally impose substantial periods of isolation.
- Recording systems are poor.
- Separation plans suggest a generic, unsophisticated and largely punitive response to challenging behaviour by children and young people.

Legislative and policy basis for isolations and separation plans

Most separation plans reviewed included extended periods of isolation. Those periods should have been recorded as isolation and treated accordingly under the Children, Youth and Families Act.

One young person had 15 successive separation plans totalling 45 days; another had successive separation plans totalling 38 consecutive days. Isolation was a significant feature in these plans.

Children and young people on separation plans were confined in their rooms and subjected to effective isolation. The consistent use of isolation as a standard element of separation plans suggests isolation was used as a core behaviour management tool in Victoria's youth justice centres. Children on plans were regularly locked in their rooms for 20 or more hours per day and many ate all their meals in their room. This does not provide the young person with guaranteed access to fresh air, education or recreation.

We are concerned that many separation plans specifically prohibited visits. Those periods should have been recorded as isolations and treated accordingly under the Children, Youth and Families Act and the Charter of Human Rights.

Record keeping and compliance

Poor record keeping was a significant barrier to monitoring the use of separation plans. The separation plan templates were inadequate and did not ensure sufficient information was recorded to ensure compliance.

Compliance failures included:

- Ten per cent of plans were not reviewed within the time required.
- Insufficient detail was included to demonstrate the factors considered in reviews and the basis for approvals.
- There was great variation in children and young people's access to education, recreation and cultural support.

Inadequate protection of vulnerable children and young people

There was evidence that separation plans are used as a strategy to protect the most vulnerable children and young people, including those who have mental health or other disabilities.

Lack of individualised responses to children and young people

The separation plans contained little evidence of a tailored approach to managing individuals' behavioural, therapeutic or health needs. A substantially more sophisticated approach is required to managing behaviour and supporting children and young people's rehabilitation.

What are lockdowns?

Lockdowns refer to times where children and young people are secured in their rooms during times of the day when they would otherwise be out of their rooms, engaged in daily activities and routines. Lockdowns can be across a whole location or only specific units or parts of a unit at a time. This chapter investigates lockdown practices to examine the extent and causes of, and risks associated with, lockdowns in Victoria's youth justice centres.

6. Lockdowns

Legislation and practice instruction	
Legislation	Section 488(7) of the Children, Youth and Families Act states that: 'In addition to his or her powers under this section, the officer in charge of a remand centre, youth residential centre or youth justice centre may cause a person detained in the centre to be isolated in the interests of the security of the centre.'
Practice instruction	The DHHS 'Unit Lockdown' practice instruction identifies lockdowns as a period of isolation, as described in section 488(7) of the Children, Youth and Families Act. ¹⁴⁸

Use of lockdowns

DHHS provided us with records of 488 lockdowns at Parkville and 32 lockdowns at Malmsbury within the inquiry period. The most likely reasons for the less frequent use of lockdowns at Malmsbury is the inability to lock down units on Malmsbury's open site and the fact that Malmsbury's secure site (three units) did not become operational until August 2015, halfway through the inquiry period. A review of our Independent Visitor Program reports at Malmsbury for the 18-month period showed few references to lockdowns, which reassured us that the data was accurate.

The data in Parkville's lockdown registers was inconsistently collected. There was no template for youth justice staff to use when completing the register and the register does not currently allow easy data capture to reflect two or three units being locked down at once.

¹⁴⁸ Department of Health and Human Services, 'Unit Lockdown', *Youth Justice Custodial Practice Manual* [internal document], (2016).

Lockdowns at Parkville

According to the records provided, 358 of Parkville's 488 lockdowns affected only one unit at a time (usually 15 individuals). There were 34 'whole of location' lockdowns and 93 lockdowns involving two or more units.

We have concerns about the accuracy of the data, noting that there were no lockdowns recorded at Parkville in June 2015, but in November and December 2015 there were lockdowns recorded every day.

Most of the lockdowns took place in the afternoon, with 258 (53 per cent) happening between 2.00 pm and 4.00 pm. They were evenly spread across the week.

Most (350 instances or 72 per cent) of Parkville's lockdowns lasted for one hour. Some of these occurred 'on rotation', meaning children and young people were confined in their rooms for one hour, then out for one hour, and so on. The next most common duration was 11 hours (48 instances). We tried to establish the number of consecutive hours of lockdown of instances that ran continuously from evening, through the day and into the next evening. The data identified 50 instances of more than 36 hours of continuous lockdown. A further 88 instances (18 per cent) began at the morning unlock or ended with the evening lockdown, resulting in continuous lockdowns for 13 to 20 hours.

Lockdowns at Malmsbury

At Malmsbury, the lockdowns only involved the three units on the secure site and the admissions unit. Most of the lockdowns were in Deakin Unit.

There were no 'total' lockdowns recorded across the secure units. Most of the lockdowns were via rotations, and almost half of those rotations took place over an entire day.

Use of lockdowns in December 2016

DHHS was also asked to provide records relating lockdowns for the two-week period of 1–14 December 2016. The data showed an increase in the use of lockdowns (see Table 6) compared to the initial 18-month inquiry period:

- three at Parkville Youth Justice Precinct
- 14 at Malmsbury Youth Justice Precinct
- 10 at Grevillea Youth Justice Precinct.¹⁴⁹

Table 6: Number and rate of lockdowns, February 2015 – July 2016 and 1–14 December 2016, all locations

	Feb 2015 – Jul 2016	1–14 Dec 2016
Number of lockdowns	520	26
Number of days within the period	547	14
Average number of lockdowns per day	0.95	1.8

¹⁴⁹ It was concerning that DHHS was only able to provide lockdown data for 10 of the 14 days for Grevillea Youth Justice Precinct.

Authorisation of lockdowns

The DHHS 'Unit Lockdown' policy identifies that general managers may authorise lockdowns of up to six hours. Lockdowns longer than six hours must be authorised by the Director of Secure Services. The data provided by DHHS showed:

- most lockdowns at Parkville were authorised by an operations manager, rather than a general manager
- at Parkville, 68 of the 488 lockdowns (14 per cent) were recorded to be longer than six hours, but were not recorded as authorised by the Director of Secure Services
- 15 of the lockdowns at Malmesbury exceeded six hours, but only two were authorised by the Director of Secure Services.

In future, DJR should improve youth justice practices and ensure all locations comply with the required protocols for lockdowns.

Causes of lockdowns

The DHHS 'Unit Lockdowns' policy states that lockdowns may occur due to staff shortages or because of safety concerns associated with the behaviour of children or young people.

We found it difficult to determine the reasons for the lockdowns with any certainty. The documentation required staff to enter 'reason for lockdown', in a 'free text' field. The data provided to us drew out many different explanations for the lockdowns. Examples included:

Three separate sections of the Unit in operation with minimal staff coverage; one staff member off site attending a medical appointment leaving unit unable to exit staff on lunch breaks.

To facilitate entire staffing group lunch break at once due to low staff numbers

Staff shortages

DHHS records showed that 405 (83 per cent) of the lockdowns at Parkville were attributed to staff shortages. At Malmesbury, 25 of the 32 lockdowns (78 per cent) were attributed to staff shortages.

Examples of staff notes explaining the lockdowns included:

Half of the client group will remain in lockdown while the other half will access the unit proper and vice versa as a result of reduced and unsafe staff numbers through excessive sick leave.

Excessive staff sick leave across the Precinct and all Welfare Personnel resources have been exhausted; forcing Remand South and Oakview into a lockdown for staff lunch and Remand South into a client group rotation in and out of bedrooms for the day.

Staffing shortages have been an issue for some time, as demonstrated by the following extracts from Independent Visitor Program reports:

[de-identified young person] mentioned that sometimes he doesn't get his medication on time prior to school. He mentioned that this occurs when there are staff shortages (September 2013)

The school program was unable to be conducted due to staff shortage (March 2014)

[de-identified young person] complained that the unit had been locked down yesterday because of staff shortages (September 2014)

Lockdown occurred in Southbank from 2–3pm due apparently to insufficient staff. I understand that new staff are being trained so hopefully this can be avoided in the near future (February 2015)

In November 2015, an internal review of an incident at Parkville recommended that DHHS ‘conduct an immediate recruitment campaign and ensure sufficient casual, temporary and agency staff to ensure that all lines are filled’.

In June 2016, DHHS implemented a ‘pipeline model’ of recruitment in an attempt to maintain a steady flow of new staff. At the end of November 2016, vacancies remained high at both sites and most were in positions that require skilled and experienced personnel.

We appreciate that the full benefits of the pipeline model will not be appreciated for a number of months. It is, however, a concern that DHHS has been aware of staffing issues over a number of years and have indicated on numerous occasions that the issue is being resolved.

Staff absenteeism

DHHS provided us with data on absenteeism during the inquiry period. For comparative purposes, we also requested sick leave data for the three-month period of August to October 2016. The data shows that annual rates of sick leave increased across the locations, most notably at Malmsbury’s secure site.

Staff focus groups revealed a range of suggestions about the cause of staff absences. When asked what they thought the causes of the lockdowns were, staff offered the following views, which we have not tested further:

- The lack of ‘team environment’ in units creates challenges for new staff, who meet stressed, busy colleagues rather than welcoming staff who have the time and energy to provide on-the-job training and show new staff how to work effectively with children and young people.
- The roles are poorly paid, particularly compared to other DHHS roles and considering the risks associated with a custodial environment. One staff member told us that youth justice staff are ‘the lowest levels of public servants in one of the hardest jobs’.

- Several staff felt unappreciated by managers. One interviewee felt that managers consistently identify faults, but do not acknowledge positive outcomes.
- Staff felt there was insufficient experience among their colleagues, and that created risk. One staff member said they were ‘sad we don’t have the depth in the workforce we used to have – the knowledge and understanding isn’t there anymore’.

Other comments included:

[staff] don’t feel safe, not enough of us to feel safe.

...[de-identified] Unit has male, experienced, stable staff and the last six months it has still been dangerous/disruptive, [with staff] feeling unsafe and jumping at noises.

Staff are getting tired/burnt out and not showing up to work.

Staff said that the significant incidents at Parkville and Malmsbury in late 2016, and the associated media coverage, had been very difficult for them and their families.

Our interviews suggested that absenteeism is a reflection of broader staffing and organisational issues. These factors create difficult working environments for staff, which have ‘flow-on’ effects on the staff’s capacity to manage challenging children and young people. It is possible that a combination of these and other factors impacted on staff attendance.

Recruitment concerns

Staff told us that incoming staff often found there was a mismatch between the job they applied for (working with and helping children and young people) and the reality (management of children and young people in a custodial context).

DHHS advised that there has been a recent change in the psychometric model used for recruitment purposes. The new tool will assess a candidate's organisational fit, emotional intelligence and engagement levels, and aim to predict the likelihood of success or failure at work, or that someone may be involved in:

- counterproductive work behaviours (such as misconduct, bullying, theft)
- occupational health and safety issues (such as behaving unsafely at work)
- attitudes towards diversity (such as behaving disrespectfully to different ethnic groups).

We encourage DJR to engage with the broader staffing group to explore opportunities to better reflect the role of a youth justice worker in recruitment materials.

Unit staff meetings

Children and young people were placed in lockdown at 4.00pm every weekday so all staff can attend a team meeting. These meetings were an opportunity for staff to discuss daily issues in the unit, including safety and matters involving children and young people.

During our inquiry and previous engagements with the Independent Visitor Program, many children and young people raised concerns about being locked down for daily staff meetings.

The youth justice manual does not stipulate the length of the meeting lockdowns and there were varied views about how long these meetings take. Staff, children and young people confirmed to us that the meetings often extend beyond half an hour.

DHHS does not currently record daily staff meeting lockdowns in the Lockdown Register, as management consider them to be 'daily routines'. We believe that these lockdowns should be recorded, and encourage DJR to explore options that do not require children and young people to be locked in their rooms.

Lunch lockdowns

Another common reason for children and young people to be locked in their rooms was for a staff lunch break. Most staff worked a 12-hour day shift, which included a one-hour lunch break. When there were insufficient staff to manage the units during staff lunch breaks, children and young people were locked down. DHHS advised that when this occurred the daily 4.00pm staff meeting lockdowns did not take place.

In November 2015, an internal DHHS review of a series of incidents at Parkville found that a unit lockdown to allow staff to have lunch breaks was a key factor in the children and young people's unrest.

The Duty Manager had made an assessment of the risks that the staffing shortages had posed. She believed that when staff took their lunch breaks that they did not have the capacity to respond to potential incidents. For this reason she made the decision to lock the precinct down for one hour from 3.00 to 4.00pm. I cannot criticise this decision.

However, some staff report that this had the effect of unsettling the centre. Young people generally resent lockdowns in my experience, especially when it is time that they believe they should be out of their rooms.

I cannot establish a cause-effect between the client behaviour and the lockdown. Neither can it be eliminated as a contributing factor.¹⁵⁰

Lockdowns due to staff absences, insufficient staff, daily meetings and lunch lockdowns represent poor workforce management, create significant risks and impact negatively on the operations and culture of the centres.

¹⁵⁰ Peter Muir, *Review of Parkville Youth Justice Precinct incident on 31 October 2015*, pp. 8–11.

Impact of lockdowns

Our interviews with children, young people, staff and stakeholders identified a wide range of flow-on effects from Parkville's extensive lockdowns. Children and young people experienced lockdowns as another form of isolation. Some told us that they considered lockdowns to be a form of punishment.

Despite the policy requirement that 'educational and recreational materials should be made available to children and young people during the lockdown period to prevent boredom', children and young people told us that during lockdowns they did sit-ups and push-ups, and watched television, but had little access to any other meaningful activities.

I don't have my music....I need my music.

There's only a certain number of games you can play.

Lockdowns are the bigger problem because people are being punished for no reason.

One of the most consistent observations from children and young people was how hard they found the unpredictability of lockdowns. Predictability and routine is a fundamental aspect of trauma-informed models of care. Unpredictability contributes to emotional instability in children and young people who have a history of complex trauma. Some Independent Visitor Program reports indicated that:

**** wants lockdown to be predictable and times maintained.*

**** would like more structure on the unit, as he was often woken up very late. He claimed he was woken up at 10am and said this was hard to stay in his room for this lengthy period.*

**** said that there needs to be more communication with clients when there are major incidents and they have to go into lockdown for long periods of time. She thinks this would help to settle young people as the uncertainty of not knowing is hard.*

These observations are similar to the reflections of children and young people:

Very depressing – you're just stuck with your thoughts.

[you] feel walls closing in on you.

The hard thing is not knowing how long you've gone in for, may be told we'll get up in an hour but then won't be released for three hours. That's hard.

It's really hard being locked in room at 4pm, not knowing if you'll get out before morning.

Everyone hates lockdown, it gets everyone down.

People get angry, pull out sprinklers, take out anger on staff etc...

Lockdowns by way of rotations refers to the splitting of units to allow half of the children and young people in a unit to be out of their rooms at a time, then swapping with the other half of the unit. Children and young people told us that, although they appreciate the attempt to give them time out of their rooms, they still struggled with lockdowns being managed by rotations.

Access to education

One of the most serious impacts of locking children and young people in their room for extended periods is their inability to participate in education. Young people in custody often have poor experiences of education. Many of them fall within the age of compulsory education (up to 17 years) but, even for those who are older, engaging in education is an important aspect of rehabilitation and promoting skills for the future.

Parkville College advised us that its daily schedules were developed around the daily 4.00pm staff meeting, but unexpected lockdowns for lunchbreaks or due to staff shortages significantly affected its capacity to run classes and deliver programs effectively.

Children and young people said that, during lockdowns, teachers sometimes came and gave them work through

the doors of their rooms. However, they struggled to do the work alone and lacked motivation to complete the set tasks, which is unsurprising given the cohort.

Section 482(1)(a) of the Children, Youth and Families Act states that the Secretary of DHHS, must (among other requirements) determine the form of care, custody or treatment which he or she considers to be in the best interests of each person detained in a remand centre, youth residential centre or youth justice centre.

Section 482(2)(a) also states that children and young people are entitled to 'have their developmental needs catered for'. The Act defines 'development' to be physical, social, emotional, intellectual, cultural and spiritual development.¹⁵¹

We believe that DHHS's failure to ensure that children and young people can regularly attend school may be considered in breach of this legislation. The failure to allow compulsory schooling is unacceptable and sends an unfortunate message to these children about the importance of education.

Access to health services

YHaRS told us that staff shortages can affect the availability of staff to take children and young people to their internal appointments with YHaRS. YHaRS senior staff also told us that the predictability and continuity of therapy is negatively affected by lockdowns and that it would be ideal to be able to successfully deliver therapy programs as per the scheduled days and times.

Children and young people told us that they were comfortable that they could still access health services during lockdowns.

Impact of lockdowns on staff

Staff consistently told us that working during lockdowns was difficult. Lockdowns limited their ability to engage with the children and young people to develop or further cultivate relationships. They

also said that children and young people often directed their frustrations and anger at staff:

Staff member said that the boys are angry about the lockdowns and it makes it harder to work with them because they are not in a positive space (Independent Visitor report, August 2015).

Staff told us that lockdowns represented a busy time for them, because children and young people were very reliant on staff and regularly requested items through the intercoms. This was an additional source of significant tension in the units.

While some children and young people recognised that staff were busy, they said that being on lockdowns was frustrating:

You press the intercom and wait an hour.

They don't respond or listen to you – as soon as the doors are closed they're happy they have the key, they have the power...they love it.

Those with a history of neglect and abuse were more likely to interpret lockdown practices as being ignored, unsupported or punished.

Access to visits during lockdowns

Section 488(2)(b) of the Children, Youth and Families Act states that children and young people are entitled to receive visits from parents, relatives and other persons. Section 488D(1)(a) states that if an officer in charge of a youth justice facility believes on reasonable grounds that the security of the facility is threatened they may prohibit a person from entering the facility as a visitor or request that the visitor leave immediately.

Section 17(1) of the Charter of Human Rights and Responsibilities Act states that families are a fundamental unit of society and are entitled to be protected by the state. Section 19(2) states that Aboriginal persons must not be denied the right to maintain their kinship ties.

¹⁵¹ Children, Youth and Families Act, s.3.

The DHHS ‘Unit Lockdown’ policy is silent on facilitating visits during lockdowns.

While some children and young people told us that their visits went ahead during lockdowns, other children and young people and some staff told us visits were sometimes cancelled:

My visitors come all the way from Ballarat, the first time they came to visit and I couldn’t see them because of lockdown – shattering.

If there’s not enough staff, visits can get cancelled.

Family connections are vital for all children and young people, and partnering with families is fundamental to a trauma-informed approach. For children and young people who have a history of forced separation from their families due to child protection involvement, incarceration or other loss, the unpredictability and tenuous nature of their ability to connect with family and friends can be traumatising. We believe that, when lockdowns occur due to insufficient staff, it is not reasonable to prohibit visits. All visits scheduled to take place during lockdowns should go ahead.

Supports in place to help children and young people cope during and after lockdowns

YHaRS facilitates two ongoing programs for children and young people – ‘Coolheads’ and ‘Do No Harm’ – and provides psychological support to all children and young people upon request. However, DHHS has not made arrangements for universal assistance to children and young people who have been held in their rooms for extended periods, or for short periods over successive days.

The unpredictability and perceived unfairness of lockdowns is difficult for children and young people to understand or accept. Given that so many of them have pre-existing mental health conditions, suicidal and self-harming behaviour, and histories of trauma and violence, their capacity to cope with extensive confinement is likely to be limited.

A thoroughly integrated trauma-informed approach would find other ways to help children and young people to manage such times. The introduction of a program to support children and young people cope with lockdowns would enable them to learn self-care or self-regulation techniques. It could include provision of a range of materials to assist them while they are confined.

New directions

Improve workforce management

A fully staffed, well-trained and supported team is imperative to a well-run youth custodial facility. DHHS should review the recently revised training structure, in conjunction with youth justice staff, to ensure risks and relevant operational issues are appropriately and proportionally addressed.

DHHS should prioritise the recruitment and ongoing retention of staff across both locations to achieve a full staffing complement and eliminate the regular suspension of daily operations at both centres.

Recommendation 17

That DJR immediately reviews the Youth Justice staffing and recruitment model to ensure that sufficient, suitably trained staff are available to supervise children and young people to prevent frequent and extensive lockdowns.

At a glance

This chapter has examined the use, extent, causes and risks associated with lockdowns.

We found that DHHS, responsible for the care and welfare of vulnerable children and young people, has failed to successfully staff its facilities for a number of years. This has caused frustration, anxiety and distress among children and young people and is likely to have exacerbated mental health concerns for some. The extensive lockdowns have reduced the school attendance of children and young people, affected their access to clinical and therapeutic services and possibly interfered with their relationships with family and friends. The lockdowns contributed to heightening tensions between staff and children and young people.

Poor quality data and compliance

The data related to lockdowns was again poor. Lockdowns are frequently used for staff lunch breaks and meetings. While these may be part of the normal routine of the centre, the duration of lockdowns for lunch meetings was often extended, creating much frustration for the children and young people. Routine lockdowns that extend beyond their usual time should be recorded.

The requirement for the Director of Secure Services to authorise lockdowns of greater than six hours was not routinely met.

Staffing issues

The work environment in custodial settings can be extremely challenging, but ensuring and supporting an effective staff group remains fundamental to the provision of youth justice services. Despite this, staff shortages have affected the operation of youth justice centres for many years. Staffing issues included absenteeism, lack of recruitment and vacancies, with 83 per cent of lockdowns at Parkville and 78 per cent at Malmsbury being attributed by DHHS staff to be the result of staff shortages.

The high numbers of children and young people in custody, combined with the increase in remandees, placed additional pressure on staff and affected their ability to form effective relationships with some children and young people. At a time when the system was most under stress, the loss of experienced staff and increased reliance on casual staff led to more unpredictable and inconsistent staffing.

Contribution to unrest

Staff, children and young people identified that lockdowns were a source of increased tension and frustration. Children and young people commonly experienced them as punitive and unfair, just like being isolated for bad behaviour.

Lockdowns interfered with children and young people's access to education, recreation and visits. Many of the children and young people emphasised the boredom of lockdowns and isolations, and the difficulties of being left alone to think. These experiences would have been even greater for the many children and young people with a history of significant trauma.

7. The views of children and young people

The voices of the children and young people have appeared throughout this report. When given the opportunity to be heard they were forthright and reflective. Even the most vulnerable were able to identify the issues that were most important to them, and tell us what they thought would help.

Children and young people's comments demonstrated an understanding that aggression and other negative behaviours could not be tolerated, but they also showed that they needed help and support to learn how to manage their behaviour better. Talking to these children and young people, both individually and in focus groups, highlighted many of the themes that the literature has identified as important to a trauma-informed system of youth justice.

Children and young people identified:

- the need for help to learn strategies to calm themselves and manage their own behaviours
- the importance of predictability, routine and their relationships with staff
- their assessment of their relationships with staff by whether or not they met their most basic needs – comfort, food, warmth, respect
- the risks of restrictive practices becoming part of an escalating pattern of conflict between themselves and staff
- the fine balance between effective timeout and feeling alone and abandoned
- insight into the pressures on staff.

They also gave insight into the harm caused by current practices, even when this is not intended. We have a lot to learn from these children and young people, including those who caused serious damage and harm to themselves and others.

We have to stop the violence in this centre. Then they could come to work. This centre is run by violence. **They use restraint to stop the violence.**

Need to learn skills, become more mature.

It's fed. We're not alright. Some of us are psycho c**ts you know. I'm serious. We all have our bad days – that's every day in here to be honest.**

Everyone's ringing up for stuff and they [staff] **can't respond to everything.**

Impact of their behaviour

Depends on staff – if they don't want to show up because **boys don't show them respect.**

People don't go off for no reason. Sometimes you can't help it – things are just going to set you off.

They're trying to help us not do it again, but it doesn't work.

Every time they lock us down here they give us something – not just pizza, but that doesn't really help it's treating us like kids you know.

Don't know why we're complaining about this stuff – this isn't a hotel – it's a prison – we've got to think about other people – **These people come to get us up, put food on our plates.**

*As a group we have to come together and **teach our unit to not be violent.***

They just say, be calm, and then you are calm **but they leave you there for a few hours and you get angry again.**

They should take you out earlier – when you're calm, they still keep you in.

Isolation is fine but should be one hour max. Long periods are just ridiculous... just a place to calm down then back.

Sometimes they will just leave you there. As I said before, you will calm down and two or three hours later you are still there and you get angry again so they say you're not settled. They don't talk to you that whole time you were calm.

The effects of isolation

*Recently they have just let me go for the day to clear my head. That helped me. **But when they leave you there for a long time, that just messes with your head.***

I don't see how you can rehabilitate them by just throwing them in the slot. I'd give them help. Try to get someone they can talk to, express their feelings. Someone who has a better rapport with you.

You think to yourself I shouldn't have done that.

**Isolation's not
the best plan.**

*Isolation – It makes them
more angry – It makes me
angry – The same doors
are in our room as in the
isolation room. We should
just go to our room instead
where it is more comfortable.*

I wasn't even angry at the time –
they just put me in there – when you
come out makes you more angry
– makes you want to hurt people –
the staff for putting you in there.

**In isolation feel like I should kick
off more/lose it more – can't calm
down. 2x2 space – can't breathe
feel panic then kick doors.**

Restrictive practices

Mentally fks with
my head – same
thing all the time.**

*..when you're trapped in
the room with **your own**
thoughts you get pretty
angry and pissed off.*

**They find reasons to
keep us in there. They
keep us there until we're
calm but leave us there
and we get angry again.**

*Being in a room with a toilet and a
sink only. It just makes you more
angry that you're in there, that
you're going to be in there for a
while. I don't think it works.*

***It makes them
more angry – it
makes me angry.***

They came when I said I was going to kill myself – **to get on constant observations.**

Being listened to

Need to be able to communicate
– no-one to talk to – need person to talk to

Talk over issues that cause behaviour.

Workers – to talk to you through – positive people sometimes with a relationship.

Using peers to talk about these issues etc.

Think I want to talk to someone.

To hear someone say 'it's okay to feel that way', 'when I was a kid... I understand'.

Use support worker and talk down or another client to say 'it's okay', 'we all make mistakes', 'calm down'.

Someone you have a good rapport with, they can tell when you're getting angry and stuff, they can tell. But others, they don't know what's happening to you. They just know when you start throwing stuff around and they won't step in because they don't feel safe.

It was four or five days before I made a phone call to my mum to tell her I was safe. She even rang here to see if I was OK. Usually I speak to my mum 2-3 times per day. So that makes me more depressed, too.

Just talk to me... I don't know how to explain it. When you have a lot of rapport, they know where you're coming from. Workers who are always here, they know how I deal with stuff, they know the triggers. Sometimes they give [me] the chance.

They just walk off. I want them to talk to me – we're not still kids, we're not animals – [I] covered up my windows – tied something around my neck – [They] didn't respond for 10–15 minutes – why didn't you get SERT down? Why didn't you call code blue? – I've seen that heaps of times kids cover up the windows.

[Have staff helped?] Yeah a lot of times. You don't really think of yourself, you think about how it might affect them as well.

Need a support worker to calm people down; need some positive words.

When I was in [one unit] I was smashing the sink, trying to get it off the wall. They [staff] spoke to me and said 'Calm down, I'm trying to get you out of here'.

They [observation staff]
pick up [the stenophone]
and hang up.

Don't care what happens.

One officer pissed me off –
he'd come up to the door and
laugh and then walk away.

If we ask a worker to
do something for you
they say no – that
they're too busy.

**Even if you ask for food,
water they don't give it to
you – you have to fill your
bottle before lockdown.**

Relationships with staff

Staff say to young people
'that's not an excuse' –
no understanding of the
triggers for their behaviour.

Us against staff.

Nothing
positive –
just makes
me angry.

If we ask DHHS workers for stuff
they say no – that gets in our head
and then we ask agency staff
and they do it for us – we ask for
toasties the agency staff make it
for us and then they cop it for us.

Staff say 'that's not an excuse',
for example, dad dying – left
feeling like they don't care.

We should be allowed to eat when
we want, we're growing men.

**Staff throwing their
weight around at our
stage. But doesn't work
cause it makes you
more angry, anxiety.**

Could make it a bit more cosy – like they could let us have a photo or a letter.

I don't have music – they gave me a radio but it makes me more angry.

Reading material, books to read in isolation. They say we're allowed to have books but they never give them to us. They say they don't want us sticking the pages over the camera and that. I think we should be given a chance. If we do that with the pages (stick them over the camera), then take the books off us.

Girls have been given chalk board paint in their rooms. That'd be mad, you could do a picture.

Radios – we have them but they're broken.

Ideas for change

MP3s – it keeps the whole unit calm – that was better when we could have them.

I asked for my guitar in my room because **that's what makes me feel calm,** so I got approved to have it with me.

I'd like access to letters and photos.

No lockdowns from 4-5pm.

Sport equipment in our rooms – medicine ball; yeah so you can work out.

Want 'straight up' – don't lie to us about lockdown.

I prefer [my room]. It's just your room. You can do what you want. There [in ISA] there is just nothing. Here there's a table, look through your photos and stuff.

*I don't feel safe – you
can take a rock and cut
yourself – you could choke
yourself out – you go nuts
– **you try being on your
own** – you don't even have
a family member to talk to.*


*It's a bit f*cked up because
they basically just leave you
there. No-one talks to you.
I've been to ISA. That's shit
....you can't rehabilitate
there. Yeah, like teachers
come and they talk to you
for say three minutes. You
can't get any help there.
They just leave. It's like
you're just forgotten about.*

Injustice, fear or powerlessness

*They say it's not for
punishment. But you
could be in your room.
You can't use shampoo,
body wash. Just no-one
to talk to. I hated it there.*

*I've had so many fights I
don't want to anymore.
I never feel safe here.
They call me a bitch.*


*I know myself when I don't
have radio or TV, I become
suicidal because I think
about things all the time.*




There was a lockdown and they let everyone out except for these two – they left them there, they didn't come out – they said there were no staff but there were heaps of staff.




Lockdown is used as a punishment.



Because I know when I become depressed I know what I'm capable of doing in those rooms, you think about it a lot.



Last time I actually cried when they said I was going there. You are constantly watched. Just a camera there. You don't have any contact with your peers.



I've been locked in an isolation unit for something I didn't even do – I got king hit and had facial injuries – they put me in the slot and just left me for the whole day – I wasn't allowed to go outside they brought me food and stuff but I couldn't leave – they were trying to work out where I could go – I was just sitting there with a swollen face and nothing to do.

8. Opportunities for improvement

This chapter identifies additional changes to policy or practice that would maximise compliance with relevant legislation and minimise harm to children and young people.

Improve information available to staff about children and young people in their care

We found that there were significant limitations to the systems for providing staff with information about a young person's risks – for example, their history of violence in custody, whether they have a mental illness, an intellectual disability or any relevant past trauma or vulnerabilities that may affect their behaviour or risk of harm.

Staff had morning and afternoon briefings and Daily Safety Advice documents. Ongoing staff had access to CRIS.

Staff and senior staff told us that morning meetings did not always occur or were sometimes cut short. One senior staff member said they were not confident that all staff read the unit's Daily Safety Advice.

*[the processes are] not effective...
CRIS is not an intuitive or easy to use system...
Handovers...rely on people sharing the right information in a consistent manner. Staff need quick and easy access to essential information.*

Information about an individual's trauma history and vulnerabilities can inform responses and reduce episodes of isolation. This can help prevent incidents and contribute to the safety of staff, children and young people. It is vital that youth justice staff responding to inappropriate behaviour understand a young person's background.

In 2015, an internal review recommended a review of the system of client alerts to ensure it provided timely and accurate advice to staff. DHHS's most recent advice is that work on this recommendation will be integrated into the classification and risk management framework, reported to be currently underway.

Corrections Victoria and Victoria Police share a system that communicates and flags adult offenders' backgrounds, risks and management strategies. Where applicable, each offender is allocated a level of risk, which allows staff to get a quick, consistent understanding of the offender's circumstances and respond accordingly.

Providing staff with fast, comprehensive information about children and young people in their unit could help them manage challenging behaviour more quickly and effectively and reducing the need for isolation.

Recommendation 18

That DJR establishes a mechanism to flag key risks and other relevant information about children and young people for youth justice staff, to enable informed and effective management of children and young people.

Publish youth justice policies

DHHS currently publishes the Child Protection Manual and the Youth Justice Community Practices Manual on its website. In contrast, the Youth Justice Custodial Practice Manual is not publicly available.

Corrections Victoria includes an extensive range of its policies and manuals on its website including most of its Commissioner's Requirements and the Sentence Management Manual. We also identified that at least two Australian states publish their youth justice policies or extensive materials about their systems' operations.¹⁵²

By not publishing youth justice policies, DHHS prevented community scrutiny of its procedures, including:

- how children and young people's rights are facilitated
- how children and young people's behaviour is managed
- how Koori children and young people are supported
- how restrictive practices are used and monitored.

Publishing the relevant manuals would improve the community's understanding of how these custodial facilities operate.

Recommendation 19

That DJR publishes the Youth Justice Custodial Practice Manual to make its operations and policies (excluding security-related matters) visible to the community.

Report the use of isolation, separation and lockdowns

International evidence shows that facilities that publish their isolation data halved the time that children and young people are isolated.¹⁵³ DHHS already reports the number of 'seclusions per 1,000 occupied bed days' in mental health facilities in its annual report.¹⁵⁴ Reporting the number of isolation, separation and lockdowns would increase public understanding of the operation of Victoria's youth justice facilities.

Recommendation 20

That DJR publishes annual data about the use of isolation, separation and lockdowns, to acknowledge the importance of these issues and allow interested stakeholders to monitor the use of these restrictive interventions.

¹⁵² New South Wales Department of Justice [website], <<http://www.justice.nsw.gov.au/>>, accessed 13 February 2017; the Australian Capital Territory's Community Services Department has detailed information about how the youth justice facility operates, <<http://www.communityservices.act.gov.au/ocys/bimber/>>, accessed 22 February 2017.
¹⁵³ J Howell, M Lipsey and J Wilson, *A handbook for evidence-based juvenile justice systems*, p.146.
¹⁵⁴ Department of Health and Human Services, *Annual Report 2015–16* (Melbourne: Victoria State Government, 2016).

Report to the Commission

In 2016, the Australian Children's Commissioners and Guardians produced a paper on human rights standards in youth detention facilities. Among the report's findings, the report identified the importance of external monitoring and noted that detention centres should be required to record and report the use of seclusion and segregation to an independent oversight agency.

In addition to including data about isolation, separation and lockdowns in future annual reports, we believe that frequent and regular receipt of detailed isolation data to the Commission would enable ongoing monitoring and, if required, lead to further examination and escalation of emerging trends or risks.

Recommendation 21

That DJR provides the Commission for Children and Young People with data on an ongoing, quarterly basis on the use of isolation, separation and lockdowns, including the use of these restrictive practices on Koori children and young people.

Conclusion

We found a number of shortcomings in the administration and use of isolation, separation and lockdowns. The evidence collected through the course of this inquiry confirmed our initial concerns that isolation is frequently used arbitrarily and with inadequate oversight and accountability.

The management of these practices did not take into account the serious impact the plans have on children's wellbeing, behaviour and capacity for rehabilitation. The overrepresentation of Koori children and young people being placed in isolation, and the failure to consistently engage with cultural staff to support them, is unacceptable and does not recognise the acute risk of harm these placements in isolation present.

The issues we raise in this inquiry require the urgent attention of the Victorian Government. A youth justice system that meets the rehabilitative needs of children and young people is good for both the children and the community. These children and young people will return to our community, to which they belong. They will be our neighbours, go to school with our children, travel with us on public transport or work with us. How they are managed in youth justice will determine their futures, and impact on us all.

9. Opportunity to respond

The Commission for Children and Young People Act requires us to give a person or service an opportunity to comment on any material in the inquiry report that may be adverse to them.

We also have a common-law obligation to afford any person or service an opportunity to respond to comments which may negatively affect their interest. We must fulfil these obligations before we provide the report to the Minister for Families and Children, the Secretary of the Department of Health and Human Services, and any other relevant Minister.

We provided DHHS a copy of the draft inquiry report as at 10 February 2017 to afford it an opportunity to respond to any adverse comment or opinion. A copy of the formal response by DHHS is overleaf.

We considered the additional information DHHS provided, and amended the report to correct any inaccuracies and provide further clarity. Differing views between the Commission and the Department on information or comments have been specifically noted in the report.

Two references were removed from the report following consideration of DHHS's response:

- any inference that conclusions as to whether isolation is warranted can be drawn from the observation of young people walking calmly into isolation
- a recommendation that design guidelines for isolation spaces be developed following DHHS's advice that this work falls in scope of work currently being progress by the Australian Juvenile Justice Administrators.

In light of the Victorian Government's announcement that youth justice centres will be managed by DJR from April 2017, we also consulted with DJR on draft recommendations about the administration of youth justice.



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ADD/17/3993

Ms Brenda Boland
Chief Executive Officer
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Dear Ms Boland

The department acknowledges the Commission's role in reviewing and assisting in the improvement of the provision of services to children and young people in youth justice facilities, pursuant to section 39 of the *Commission for Children and Young People Act 2012* and appreciates the opportunity to comment on the draft report relating to the Commission's *Inquiry into the use of isolation, separation and lockdowns in youth justice facilities*.

Youth justice facilities are highly complex environments that accommodate some of the most violent and challenging young people in the State, the majority of whom are detained for crimes against the person, many who have mental health issues, intellectual disability, drug and alcohol dependencies along with an inability to self-regulate or to manage conflict. The department's focus is on ensuring these facilities are safe and secure for young people, staff and the broader Victoria community. It should be recognised that 2015 to 2017 has seen significant pressures on the Victorian youth justice custodial system, particularly through the unprecedented increase in remand numbers. The remand cohort of young people demonstrates even greater unrest than sentenced clients.

As outlined in the draft report, the use of isolation is authorised by the *Children Youth and Families Act 2005*. The foundation of authorisation under the Act is an acceptance that isolation can assist in de-escalating heightened behaviour and contributing to the safety of clients, staff and the security of the centre.

The use of isolation in Victoria is consistent with contemporary practice in other Australian jurisdictions. The comparisons included in the draft report with international jurisdictions, such as the United States, where fundamentally different practices are used, are problematic and imply that similar frameworks apply in Victoria. The department does not accept that this is the case.

It is however accepted that isolation must be used judiciously and with appropriate safeguards in place. As outlined in correspondence from the department to the Commission dated 20 January 2017, steps have been taken to require the consultation of Practice Leaders in decisions regarding the use of isolation and separation is an important initiative to ensure appropriate consideration of the individual needs of the young person. Similarly, all



Safety Separation Management Plans require Practice Leader input and yet the report does not acknowledge the move towards therapeutic plans for young people.

The department concurs with the the draft report's confirmation that isolations predominantly take place in bedrooms. Despite this, the findings and recommendations have focussed disproportionately on the use of isolation rooms. The department also contends that although a young person was recorded as having walked to isolation, it is not sound to draw any conclusion from this that the subsequent isolation was not warranted.

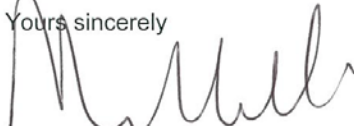
The Commission has made comments based upon both the Return of Government Services (RoGs) data and increases in the number of incident reports. In respect to the RoGs data, the caveat of incompatibility between States and Territories due to variations in definitions has not been sufficiently considered. The increase in Category 1 incident reports has not taken into account the 2015 change in practice to include allegations of assaults prior to admission (particularly assaults by police). Once this is taken into account, there has been only a minor increase in Category 1 incidents.

The department is committed to maximising the time out of locked rooms for young people, however the department is ultimately responsible for maintaining a secure environment for young people and staff and lockdowns can be necessary to achieve this. The department does not agree with the suggestion that the use of lockdowns are directly linked to staff absences, rather that these result from a complex mix of factors including client behaviour, staff experience, mix and capabilities. In recognition that staffing numbers are one of the factors, a comprehensive staff recruitment and retention model has been implemented including a program of rolling recruitment which has resulted in over one hundred new youth justice workers being recruited since late 2016. Needless to say, it is vital that staff are provided opportunity to properly consider the sharing of intelligence and information to enhance the safety of the units. Daily staff meetings are consistent practice across all such custodial environments and 30 minutes is considered to be a reasonable time for these to occur.

The department acknowledges that there continue to be opportunities to improve the recording of data and there have already been significant improvements made in this area. Reliance on data alone is problematic and does not identify recording errors that suggest isolation for extended periods, such as a young person being held in isolation for 31 days.

In 1996, The Australasian Juvenile Justice Administrators (AJJA) published *Design Guidelines for Juvenile Justice Facilities for Australia and New Zealand*. Standards for isolation rooms can be found at *Chapter 6.3 - Specific Accommodation: Time-out and segregation rooms*. These standards recognise the opportunities for self-harm to be caused through the presence of toilet facilities in rooms that are used to house high risk clients and as a member of AJJA, the department contends that given there exist current national standards for facilities, that there is no need to create an additional Victorian specific set of standards.

Yours sincerely



Alan Hall

Acting Deputy Secretary, Operations

27/2/2017

10. Submissions provided

In November 2016, submissions were called for publicly on the Commission's website and via direct invitation to a number of our key stakeholders.

Submissions were received from the following organisations:

- Jesuit Social Services (JSS)
- Victoria Legal Aid (VLA)
- Victorian Aboriginal Legal Service (VALS)
- Victorian Equal Opportunity and Human Rights Commission (VEOHRC)
- Young People's Legal Rights Centre (YPLRC)
- Youth Affairs Council Victoria YACVic.

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