YOORROOK Justice Commission

OUTLINE OF EVIDENCE OF DR MICK CREATI

DECEMBER HEARINGS 2022
(CHILD PROTECTION & CRIMINAL JUSTICE)

16 DECEMBER 2022

I BACKGROUND

1. Dr Creati currently works as a Consultant Paediatrician and Adolescent Physician in the Department of Adolescent Medicine at the Royal Children's Hospital.
2. He has also worked as a General Paediatrician at the Victorian Aboriginal Health Service (**VAHS**) in Fitzroy since 2014. Approximately 60% of children seen by VAHS have, or have had, child protection involvement. Further, approximately 50% of children seen by VAHS are in, or have been in, out-of-home care at some stage of their life.
3. Between 2012 and 2014, Dr Creati was the Head of Medical Services at the Parkville Youth Justice Precinct. Responsibilities in this role include providing direct clinical care to young people in custody in remand and sentenced.
4. In 2016, he gave evidence in the Royal Commission into the Protection and Detention of Children in the Northern Territory concerning standards of healthcare for children in detention.

II PROFESSIONAL QUALIFICATIONS AND EXPERIENCE

5. Dr Creati graduated from the University of Melbourne with a Bachelor of Medicine, Bachelor of Surgery degree in 1987 and a Masters degree in Public Health (Biostatistics and Epidemiology) in 1999.
6. In 1996, Dr Creati became a Fellow of the Royal Australian College of Physicians (Paediatrics) as a General Paediatrician in 1996.
7. Dr Creati was on a sabbatical placement as a technical advisor to the Department of Child and Adolescent Health at the World Health Organisation (**WHO**)'s headquarters in Switzerland from June 2008 to January 2009.
8. From 2000 to 2011, Dr Creati worked as an international child and adolescent health specialist / senior fellow at The Burnet Institute at the Centre of International Health in Melbourne.
9. Dr Creati has also held various other roles including as a paediatrician, epidemiologist, short term professional, deputy team leader, and lecturer and clinical instructor since 1996.

III THE CRIMINALISATION OF CHILDREN'S EXPLAINABLE BEHAVIOURS

Neurodevelopmental Immaturity

10. Most children incarcerated are never found guilty of a crime.
11. Especially with younger children under the age of 14, most of the actions that bring these children into contact with the justice system are impulsive, and the consequences of such actions are not thought through or properly understood. This is supported by functional MRI neuroimaging of the brain, which shows that the prefrontal cortex – which controls impulse and comprehends long-term consequences of actions – is one of the last areas to fully mature. S**ee Annexure 1, Slide 1.**

Disability and Mental Illness

12. In addition to the relative immaturity of the brains of children, we now have better data about the neurodevelopmental profile of children in custody. Data from Western Australian shows high rates of mental illness and disability amongst children who have been incarcerated. Of 99 children in detention in Western Australian, 89% had at least one severe neurodevelopmental impairment. Most of this disability and mental illness had never been diagnosed before the children were incarcerated and the study was conducted. **See Annexure 1, Slide 2.**

13. This study highlights that opportunities to put in place health and mental health care support and treatment that may have prevented these children from coming into contact with the justice system have been missed.

14. By way of comparison to the general population, in 2015, 7.4% of children aged 0-14 had some level of disability and 4% had a severe or profound level of disability. Disability was more common among boys (9.4%) than girls (5.4%). The most common disability types were intellectual and sensory/speech.

15. My observation from my work in Parkville was consistent with these observations of a high rate of disability and mental illness, as well as behavioural issues. I also observed a lack of coordinated support for these children outside of the justice system, and no therapeutic assessment and work possible for the children going through the remand system.

Trauma from involvement in the Child Protection system

16. Child protection is a driver of being involved in the justice system. Children do not go into the child protection system with a criminal record, but involvement in the child protection system makes involvement with the justice system many times more likely. It is not reducing the risk of entering the justice system.

17. The youngest children in the justice system are the most traumatised. It is not until age 14 that we see a drop in involvement in the child protection system drop to 50%. **See Annexure 1, Slide 3.**

18. I see children exhibiting behaviours that bring them into contact with the police and justice systems. We're criminalising children for behaviours that are age appropriate and explainable by their age and immature neurodevelopment as well as their experiences of trauma.

19. The trauma of children in the child protection system is often three-fold. Firstly, there is trauma related to the reasons for removal by child protection. According to Taskforce 1000, such risk factors include family violence, parental alcohol or substance abuse, and parental mental illness. Once removed, there is then trauma related to being removed from parental care. Finally, if the child is put in long-term placements, there is trauma related to frequent and numerous changes in placements which lead to further attachment issues.

20. Most children become involved with child protection in the first year of life. This is often where the trajectory towards the justice system starts.

21. Our removal rates in the first year of a child's life are four times higher than in Scandinavia. Our system is risk-averse, and often defaults to protecting children from their parents rather than putting in place supports for parents to care for and protect their children.

22. Indigenous-led organisations have a broader understanding of family as it pertains to the children. We should be providing families with a link to Aboriginal Community Controlled Health Organisations (**ACCHOs / VACCA**) to provide support for families so as to make it less likely that their children are removed.

23. There is high turnover in child protection and agency staff. Children often have multiple placements and have to tell their stories multiple times. This further traumatises children.

Profile of Children in the Justice System

24. We now have a better understanding of the profile of children in the justice system. Typically we see: -

    a. Aboriginal and Torres Strait Islander children are overrepresented;

    b. Children come from socio-economically disadvantaged families;

c. Children are neurodevelopmentally immature with poor impulse control or capacity to anticipate consequences;

d. High rates of disability, trauma, mental health and child protection involvement;

e. Low rates of mental health diagnoses; and

f. Children are largely disengaged from school.

25. Now that we have a better understanding of the profile of children in the justice system, effective solutions can be better tailored to meet their needs. Criminalisation does not address their needs, and only serves to further traumatise and disadvantage them.

Solutions and reform

26. The appropriate response is not to punish these children, but to care, support and treat these children by putting in place appropriate assessment and linking them with supports.

27. Engagement and mental health services will help to address behaviour and mental health issues. The younger the children receive appropriate mental health care, the better and more effective it will be. I have had enormous trouble getting children access to mental health support.

IV FAILINGS TO ADEQUATELY RESPOND TO CHILDREN WITH SPECIFIC HEALTH AND DISABILITY NEEDS

28. Involvement in the Justice System (even before incarceration) should be a flag, and indeed should be an opportunity, to assess a child's health and development needs.

29. If entering custody, a child should have an initial assessment within 12 to 24 hours performed by trained nursing staff focusing on immediate risk and conditions needing immediate management.

30. This initial risk assessment should ideally be followed by a second more comprehensive health check within 3 days, conducted by a medical professional focusing on general primary health issues, as well as drug and alcohol, sexual reproductive health, and mental health.

31. On leaving custody, children need to be linked to appropriate culturally appropriate community-based care including local Aboriginal Health services.

32. My experience of the Youth Justice system in Victoria is that there were a number of contractors delivering services (including health), but they operate almost independently of each other with no formal forum to coordinate. This leads to a fragmentation of information sharing, poor coordination of service delivery and missed opportunities.

33. Similarly, entry into the out-of-home care system (**OOHC**) is a flag and should be an opportunity to undertake a comprehensive health assessment of a child.

34. In 2019, we published the results of an audit that we did of 103 Aboriginal children in OOHC seen in the Paediatric Service at VAHS over a 24 month period. The audit showed high rates of mental health and behavioural issues amongst children in OOHC as well as high rates of primary healthcare needs. **See Annexure 1, Slide 4.**

35. It is important to note that while health and development issues need to be addressed in their own right, many of these health and development issues are the potential drivers of behaviours that bring children into contact with police, leading to crossover from child protection to the youth justice system.[1]

36. In Victoria, the Pathway to Good Health Program aims to support children going into OOHC to have a GP check-up within 3 weeks. There is then a planned Comprehensive Check by a Paediatrician/Mental Health specialist/Speech Pathologist (as needed) as soon as possible after this, which generates a "Complete Health Care Management Plan".

[1] See *The health needs of Aboriginal and Torres Strait Islander children in out-of-home care*.

V THE IMPORTANCE OF EMBEDDING MENTAL HEALTH EXPERTISE AND SUPPORT FOR ABORIGINAL CHILDREN WITHIN THE CHILD PROTECTION SYSTEM

37. Both involvement with child protection and having mental health issues are intimately related to involvement in the justice system. I personally experience enormous difficulty in linking children I see who are in the OOHC system and who have behavioural or mental issues with the appropriate long-term trauma-informed mental health care that they need.

38. I have patients with horrible trauma histories, exhibiting very disturbed behaviour (for example self-harming by drinking hand sanitiser with alcohol in it) who I have referred for mental health support 6 months ago who are yet to be seen by a psychologist.

39. In my opinion there is an urgent need to embed quality mental health practitioners within Child Protection, VACCA and the contracted Community Support Agencies responsible for managing children in the child protection system. These practitioners should provide direct care to children in the Child Protection system without having to refer them to external agencies.

40. Many children and adolescents fall into the "missing middle" in relation to their current mental health needs. This term refers to the substantial number of young people with sustained and complex issues too complex for agencies such as headspace, but not critical enough for the CAMHS system. For these children, there are currently very limited options for quality, trauma informed, long term mental health care and support.

41. Currently, any engagement of children in OOHC have mental health services is often short term and often with multiple providers. Services are appointment-based and young people often struggle to attend unless the service provides outreach appointments.

42. The formal Child and Adolescent mental health services (**CAMHS**) system is overwhelmed and struggling to cope with the high-risk clients. While they are at times available for secondary consultation, it is rare and exceptional that they accept a referral for long-term therapeutic support for a child or adolescent.

43. Children in OOHC often change address. CAMHS are quite strict in relation to their geographic boundaries. If a child moves to another CAMHS region, care often ceases in the CAMHS service from the region they have left and the child's case may then have to go through the whole referral process again before they can be seen in a new CAMHS service.

44. Headspace provides mental health support services to young people aged 12 to 25 years experiencing, or at risk of, mental ill-health. However, their funding model usually precludes patients from receiving long-term support. In my 9 years at VAHS, I have only ever referred one patient to Headspace as they are not set up to provide the long-term trauma-informed mental health care and support children in OOHC's needs.

45. Berry Street's Take Two program is a Victoria-wide therapeutic service helping to address the mental health impacts on children of the trauma they have experienced from abuse, neglect or adverse experiences. This is an excellent service, but access to this service is limited and often only occurs late in the course of a child's struggles and only after they exhibit significant behavioural issues or at risk of placement breakdown.

46. The availability for mental health support in rural settings, where many Aboriginal children live, is even more limited. There are very few child psychiatrists in Victoria outside metropolitan Melbourne.

47. I want to see investment in having mental health practitioners embedded in Child Protection and Community Service Agencies (as opposed to a referral out model). There are many advantages of embedding and integrating mental health services within a service which provides other care for children:

    a. mental health providers will be employed by the service for specific expertise in the field (in this case, trauma-informed mental health assessments and care);

    b. mental health providers will know the context for each child and can be more easily involved in case discussions;

    c. there is more likely to be a working relationship between case managers and mental health providers;

d. children are less likely to have to repeat their stories/relive their trauma as information can be shared more easily through case discussions;

e. referrals to external agencies can be avoided.

VI UNDER-UTILISATION OF SERVICES AND HEALTH CHECKS

48. Every Aboriginal and Torres Strait Islander person, regardless of age, is able to access an annual Aboriginal and Torres Strait Islander Peoples Health Assessment through the Medicare Benefits Scheme (MBS item 715). This item is billable by a General practitioner, and there should ideally be an Aboriginal Health Worker involved in the consultation.

49. This MBS funded Health Check is a health assessment that helps to ensure that Aboriginal and Torres Strait Islander people receive primary care matched to their needs by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality.

50. As referred to above, children in OOHC and the justice system have high rates of primary, developmental and mental health needs. Thus, the 715 Health Check provides an important opportunity to detect, at the earliest possible stage, the primary health, developmental and mental health conditions prevalent in Aboriginal and Torres Strait Islander children in the OOHC and justice systems with hope that early intervention can be put in place to ensure better outcomes.

51. Awareness of the availability of this Medicare funded Health Check amongst worked in the child protection and criminal justice systems is far from universal, and many children are referred to us at VAHS without a 715 Health Check ever having been done despite many years in the system.

52. At VAHS, all children have a 715 before being seen by the Paediatrician so as to identify primary health and development needs as soon as possible.

VII UNDER RECOGNITION OF DISABILITY OF CHILDREN WITHIN CRIMINAL JUSTICE SYSTEM

53. The NDIS offers new opportunities for support for children and young people with disability. The NDIS is the insurance scheme and while it does not provide direct medical care, it can support the provision of early intervention services for children with physical and intellectual disability as well as speech and language delay.

54. To access NDIS for early intervention and disability support, the child must be assessed by a health professional.

55. As stated above, entry into the Justice System should be a flag for a health assessment for a young person due to the high rates of disability and mental illness in this cohort.

56. Young people in the Justice System are not being referred or linked to health professionals who can properly diagnose their disability. Consequent to this they are not then referred to the NDIS for the support they need.

57. Providing intervention as early as possible is key in altering the trajectory of young people through the Child Protection onto the Youth Justice and potentially the adult Criminal Justice System. It is inexcusable that children who have been through the Child Protection system can get to the Justice System without having their developmental needs assessed and support put in place through NDIS as needed.

58. My experience is that over the last 2 to 3 years, Child Protection and Community Service Agencies are becoming more aware of the supports available through NDIS, and more children in the OOHC system are being brought for assessment and supported through NDIS as needed.

59. Unfortunately, there are still many children in the OOHC system who are not referred for assessments until they start attending primary school and the schools raise the issue because of learning or behavioural issues, and early intervention is less effective at this age.

60. Additionally, NDIS is structured so that early intervention is funded only for children 0-6 years of age. Once the child reaches the age of 7 years, NDIS will only fund services for children with a permanent disability. So, for example, it will not fund speech pathology for a child who is struggling

with Speech and Language Disorder if the child does not reach the threshold of a permanent disability. Therefore it is important that children in the OOHC system are referred to a Child Health Specialist / Paediatrician as early as possible so that their developmental needs can be assessed and met.

VIII PARALLELS WITH A WESTERN AUSTRALIAN STUDY INTO THE HIGH NUMBERS OF ABORIGINAL CHILDREN IN CUSTODY WITH FASD AND/OR OTHER SEVERE NEURODEVELOPMENTAL DISABILITIES AND THEIR PROGRESSION AND ESCALATION INTO YOUTH CUSTODY

61. We now have a much better understanding of the neurodevelopmental profile of children in custody based in a survey completed in Western Australia.
62. This study found that 90% of incarcerated children have as least one severe neurodevelopmental impairment. These conditions were largely undiagnosed before the children went into custody are they were not getting access to services.
63. From my time in Parkville, it was evidence that there were high rates of disability and mental health disorder amongst the children we were treating.
64. There is only one service in Victoria which offers a diagnostic assessment for Foetal Alcohol Spectrum Disorders (**FASD**). I do see a number of children who have a history of high maternal alcohol and other substance abuse during pregnancy, which has potential to cause brain damage *in utero*.

IX IMPORTANCE OF EARLY IDENTIFICATION OF ABORIGINAL STATUS IN CHILDREN

65. Identifying children as Aboriginal at an early stage after they have been referred to us is important. The hope is that through early identification we can reduce the removal of Aboriginal children from their families.
66. The most proactive thing we can do to help children is to support their parents.
67. In my experience, this assessment is improved if key family members are considered within the appropriate cultural framework.
68. I have also found that Aboriginal health workers usually get a very different history from a young person compared to what I obtain.
69. We need to consider how to work in partnership with Aboriginal Health Practitioners.
70. Early identification of Aboriginal status allows the child to be case managed by and Aboriginal Organisation (i.e.VACCA) and to have access to culturally appropriate health services at an ACCHO.
71. Aboriginal children are eligible for subsidised / free health services including dental, optometry, PBS, as well as easier access to allied health services either through an ACCHO or through the 715 (Aboriginal and Torres Strait Islander Health Check) system.
72. Aboriginal children are eligible for Early Start Kindergarten and other supports at school not available to non-Aboriginal Children

X URGENT NEED FOR AN EFFICIENT, UNIFIED, READILY ACCESSIBLE HEALTH RECORD FOR CHILDREN IN THE CHILD PROTECTION SYSTEM

73. The current system for information-sharing is ad hoc, inadequate, relies on managers from DFFH, VACCA, CSOs and even carers to email assessments to me or other workers. The system is clunky and relies on people with good intentions updating the system. I have been on hold for hours trying to get information about one child. These children have assessments and recommendations that get stuck in the system
74. I often have young people referred to me with a combination of behavioural, mental health and learning issues. In the course of my assessment, it often becomes evident that the child has had multiple previous assessments, all of which I have no direct access to.

75. Multiple assessments have the real potential to re-traumatise the child. Stories have to be repeated again. I had one grandmother tell me her 11 year old grandson had had 30 previous assessments, none of which I had access to on the day I was seeing the child.

76. If the child has never been seen at the VAHS I need to email the DFFH/VACCA worker, the CSO case manager, the school, etc. for previous assessments. I do not have access to the reports on the day, so I don't know if I should request them again.

77. The health literacy of child protection workers is often low and it should not be expected that these workers have specific knowledge about all aspects of a child's health. Often case managers are new and not all over health issues. Again, a centralised and accessible portal for health information sharing would significantly address this problem.

78. Often the person who accompanies a young person to a paediatric appointment does not have sufficient background information regarding a child's health information and may not even be in a position to inform me about the child's mental health or behavioural status in a way that makes it possible for me to make completely informed decisions about a child's management, need for referral or medications.

79. If I need to refer a child to a mental health practitioner, it is not possible for me to collate all previous assessments in my referral letter. Children often need to repeat their entire history again with the new mental health provider which, as above, has real potential to re-traumatise a child.

80. I have no way of sharing my assessments, Health Management Plans and outcomes of any subsequent paediatric appointments with those involved in a child's care other than to email them to the DFFH / VACCA case manager and hope that they are distributed to all those involved in a child's care.

81. It is difficult for me to know if my Health Management Plans generated by my assessments are acted on.

82. There is an urgent need to invest in a system where these stories are collated and can be shared. Early adverse events in childhood may not be remembered by a child at the stage of assessment, and vital pieces of history will be lost. A child is also not likely to provide information until they trust a practitioner, which may never happen.

83. It is desperately important to have a unified record of children in child protection, where DFFH can control accredited providers uploading the reports and recommendations. A portal with this information should be accessible to accredited practitioners so they can read previous reports.

84. The same situation applies to children in the Youth Justice system. It is difficult to obtain an accurate and complete past medical and mental health history. I have assessed children in the Youth Justice System who have had an intellectual disability, known to case managers in the community, but not known to the health team in the Justice Precinct.

XI CAPACITY BUILDING IN THE EDUCATION SYSTEM TO SUPPORT THE GREATER RETENTION OF ABORIGINAL CHILDREN IN SCHOOL

85. Schools generally lack sufficient resources to manage children who have behavioural difficulties due to attachment issues and past trauma.

86. Schools are constrained by resources and often cannot cater for a child who is distressed and acting out in the classroom. Unless the child has an aide, schools may not have the resources to take the child out of class for a period of time to allow them to settle and then re-integrate them back in the class. Schools have access to funding through the Program for Students with Disability: Severe Behavioural Category, but workers are not always available and funding is not always utilised.

87. I continue to see children in the OOHC system with reduced hours at school due to behavioural concerns. I have seen children in Prep have their hours reduced to go home at morning recess. I continue to see carers who tell me that the school frequently calls them to pick their child up before the end of the day because they are "having a bad day".

88. Most families rely on the predictability of school hours, and many times the availability of out-of-hours school care in order for the parents to work. Sustaining stable OOHC placements often

depend on a carer being available to pick up a child from school at short notice. Carers having to leave work to pick up children early from school is a great stress and is a common reason for carers 'relinquishing' placements.

89. If carers do relinquish a child's placement, the child then has to be re-integrated into a new family. The child can often feel rejection and develop a sense of insecure attachment. Behaviour at school can continue to escalate with increasing attachment issues to the extent that school attendance is greatly diminished and the child falls behind in educational milestones.

90. It is critical that children, especially those in the children protection system, are not excluded from school. Children who are in child protection tend to be more disengaged. Disengagement from school and involvement in residential care are very strong predictors of a child transitioning to interactions with the youth justice system.

91. Schools should be provided with extra support for children in the OOHC system so as to maintain their engagement at school even if they have behavioural difficulties.

92. Carers should be offered more support if their employment is impacted by their child having reduced school hours.

XII THE NEED FOR AN ADEQUATE EDUCATIONAL ASSESSMENT OF CHILDREN IN THE OUT-OF-HOME CARE SYSTEM AS THEY GO TO SCHOOL

93. In addition to the comprehensive check, every child in the OOHC system must have an educational needs analysis (**ENA**) as they go to school. This is stated by Education Victoria also.

94. The ENA process is a collaborative process where distinct roles are prescribed for the school, DHHS Child Protection, contracted Community Service Organisations and Student Support Services or equivalent.

95. To be effective, it is essential that the ENA is completed before the child goes home. My experience is that an ENA is far from universally done on school entry,

96. Additionally, transition from primary to secondary school is a critical educational junction with high potential for exacerbation of behavioural difficulties. My experience is that ENA's are rarely repeated at this transition point, and if they were then children could be better supported to remain in the school system, reducing their risk of becoming involved in the justice system.

XIII MORE SUPPORT FOR THE CARERS OF CHILDREN IN CHILD PROTECTION SYSTEM (INCLUDING ABORIGINAL CHILDREN)

97. There needs to be better supports in place for carers of children in the child protection system. These could be in the form of income support to ensure that the children, particularly those who have issues attending school, do not have their care relinquished.

98. This greater level of support for carers should include an improved understanding of the services that may be available to these children.

99. The need to support carers is often left out of any discussion of children in OOHC. From a health perspective, my observation in general is that if the carers are not family they have very limited information about the child's health and developmental history when the child comes into a new placement. This lack of knowledge can be about basic, but potentially critical, things like asthma. Medications and scripts frequently do not get transferred to new carers.

100. New carers often have no knowledge of the services available to Aboriginal Children like PBS co-payments for medications, the fact that VAHS can provide free dental and glasses for $10 for Aboriginal children. These carers often end up incurring unnecessary out-of-pocket expenses paying for these things.

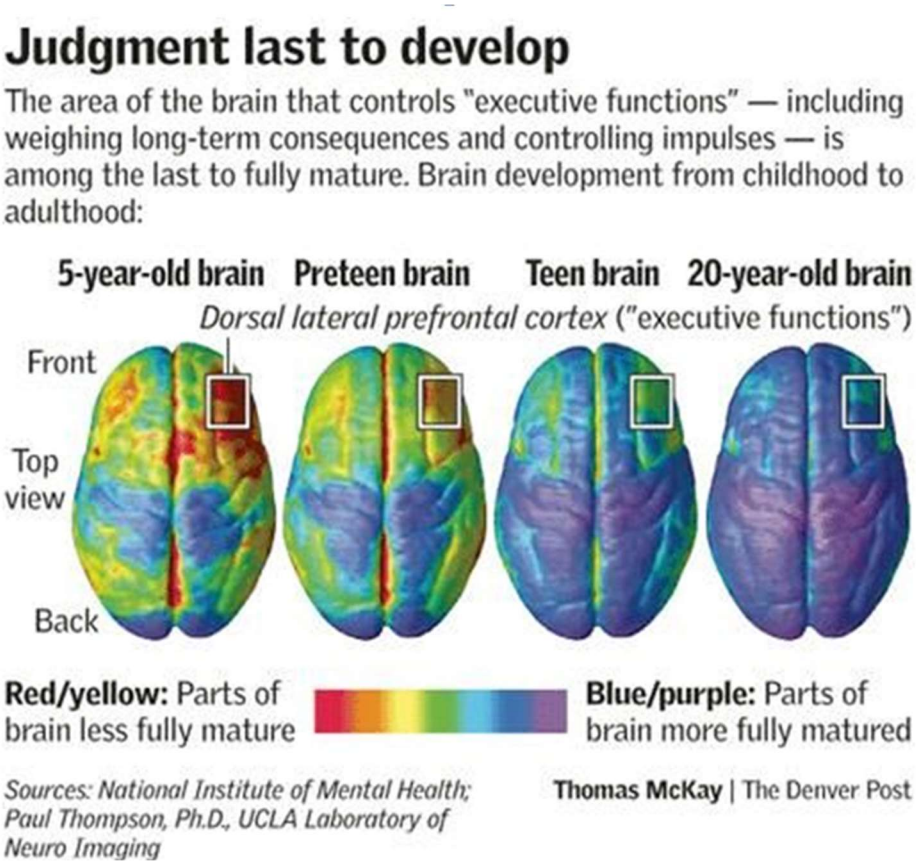
101. For non-Aboriginal carers, there is often also a lack of knowledge of the impacts of early childhood trauma, and how these traumas may impact on a child settling into a family, or how it may affect their behaviour. This can lead to inappropriate responses by carers to a child's trauma driven behaviour.

Accompanying documents:

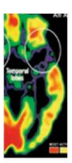
The health needs of Aboriginal and Torres Strait Islander children in out-of-home care

ANNEXURE 1

Slide 1



Slide 2



INCARCERATED CHILDREN

DISABILITY AND MENTAL ILLNESS

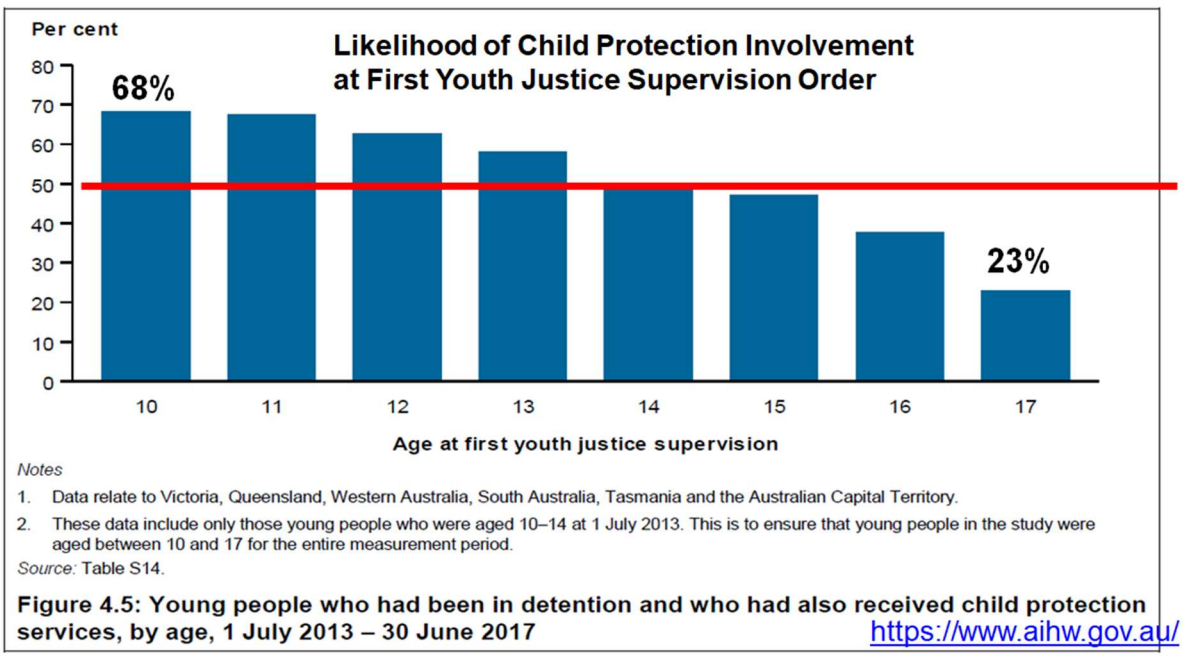
Of 99 children in detention in Western Australia
89% had at least one severe neurodevelopmental impairment
Ref: bmjopen.bmj.com/content/8/2/e019605

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

LARGELY UNDIAGNOSED BEFORE STUDY

Slide 3

THE YOUNGEST CHILDREN IN JUSTICE SYSTEM ARE THE MOST TRAUMATISED



Notes

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

Source: Table S14.

Figure 4.5: Young people who had been in detention and who had also received child protection services, by age, 1 July 2013 – 30 June 2017 https://www.aihw.gov.au/

Slide 4

Mental health diagnosis	66%
School difficulties	63%
Behavioural difficulties	60%
Developmental delay	46%
Intellectual disability	22 %
Hearing Problem	37%
Vision Problem	34%
Dental Problem	40%
Respiratory Problem	49%