T R A N S C R I P T

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into youth justice centres in Victoria

Melbourne — 14 June 2017

Members

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Ms Nina Springle — Deputy Chair
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Witness

Ms Jennifer Bowles, 2014 Churchill Fellow.

The CHAIR — Ms Bowles, thank you very much for joining us today. Welcome to this hearing of the inquiry into youth justice centres in Victoria. The evidence that is being taken today is recorded. I need to tell you that all evidence is protected by parliamentary privilege; therefore you are protected against any action for what you say here today, but if you go outside and repeat the same things, those comments may not be protected by this privilege. Thank you for distributing a copy of this material. What we have asked people to do is give a very brief — hopefully no more than 5 minutes — —

Ms PATTEN — We have got an hour.

The CHAIR — No, not an hour for introductory comments! We have ideally just a few minutes for the key points that you would like to make today, and then we might open it up to questions.

Ms BOWLES — Has the panel had an opportunity to read my report, or I will not assume that they have?

The CHAIR — Yes.

Ms BOWLES — All right. Thank you very much for the opportunity to present, and I would like to commence by acknowledging the traditional owners of the land on which we are fortunate enough to meet today, the people of the Kulin nations. I am speaking in my capacity as a 2014 Churchill Fellow, not as a magistrate, so I am not speaking on behalf of the Children's Court.

In the packs you will see that I have included a copy of my report; a summary of the report; the submission that was made to this inquiry on behalf of our steering committee; an extract from the annual reports of the Youth Parole Board regarding the characteristics of children in custody; and an extract from the Children's Court annual report, and that is in respect of search warrants — they are emergency care warrants that are issued for children, primarily those missing from care — and you will notice that there has been quite a dramatic increase in relation to that, so that covers those children in the child protection side of our court. I have also included a PowerPoint presentation and a diagram which demonstrates when the proposed orders that I am recommending could be put in place by the court.

I am sure you have all heard evidence about the characteristics of the young people who are in detention, so perhaps I will not say too much about that, except that clearly the chart I have included indicates the link between a history of alcohol and drug abuse and also how relevant that is to offending, and the number of children who are massively over-represented by being in the child protection system. I have not included it, but there is also a number of children who have been expelled or suspended from school, so that is another protective factor that many of these children in detention do not have; and 12 per cent are already parents, so the cycle is starting again.

In relation to the search warrant information, approximately 80 per cent are what are known as section 598 Children, Youth and Families Act emergency care warrants, and they are children who are in care who are not residing where they are meant to be. You will see that in 2014–15 on average each week 95 of those warrants were issued by the court.

The reason I applied for a Churchill Fellowship was that sitting in the criminal division and also in the child protection family division of our court I continued to see this link between children who had left school early, had major drug and alcohol issues and often had emerging mental health issues, and I did not see that they were accessing the treatment. The court has the power to require young people as a condition of an order to access treatment, but when many of the children are the most vulnerable in our community, to expect them to get on a tram or a train and go and access treatment for an hour a week, which is generally what the treatment is, it is not surprising that most of them do not. They spend their lives, having left school early with low literacy levels, with their friends. A lot of these kids are really decent kids, but they have had a very difficult start in life. Our treatment is a voluntary treatment regime, so the court asks them to go, but I would say to you, 'What do you think could be achieved in an hour a week when their chaotic lives are much more about scoring and being with their mates?'. It would take a lot of courage to get on a tram and say, 'Sorry, guys. I'm off to see my drug and alcohol counsellor'.

It really hit home with a young boy who had been stealing vanilla essence. The high alcohol content meant that he was going in and stealing these bottles and he ended up spending time in hospital with alcohol toxicity. He was not in the care system; his mother came to court each hearing. At one stage, when his life was spiralling out

of control, she said, 'What can you do? I'm watching my son die before my eyes'. In the end that was the impetus for me to do something, because I was sick of seeing the lack of hope in these kids' eyes. We need to distinguish in terms of the nuances of criminal offending. A lot of these kids were not doing really serious offending, but they were escalating in their offending because of their need to steal, or whatever it might be, to use substances.

I applied for a Churchill Fellowship and I went to Sweden, England, Scotland and New Zealand because I wanted to see what they did there. Perhaps they had better ideas than what we had. Really the critical question I wanted to answer was: it is often said that unless the kid wants to change or a person wants to change, you will not effect change. I wanted to know if the court had the power to make an order to mandate treatment so that a young person would be required to go into a treatment facility, which initially they could not leave, so it would be secure, whether or not that can in any way assist them in their drug rehabilitation. The overwhelming evidence I received from very experienced clinicians in those four countries, together with the children interestingly that I had the opportunity to speak to, was yes, provided — and in my report I go through the key criteria that have to be satisfied and I emphasise it has to be in a homely environment. It is not a punitive environment. I am not talking about treatment in a prison. I am talking about treatment in a residential home. I have explained the model in my report, where I set down how it would work. The eight steps are on page 40 of my report.

The proposal is that young people will have had an opportunity to access the voluntary treatment services in the community, so I want to emphasise that for those young people who do access the voluntary treatment services I am not critical of the current services. I am just saying there are not enough and there is a gaping hole. In support of what I have said, not only was there the material I gathered from overseas but on returning I established a steering committee. We have the CEOs of YSAS — you may be familiar with YSAS — of Odyssey House, of Windana, psychiatrists from St Vincent's Hospital who deal with the Severe Substance Dependence Treatment Act for adults, and a number of other professionals with a huge amount of experience in this field. They have agreed with me there is this gap.

I am not sure whether or not you want me to go through the actual model; that sets out the overview. I guess in brief, so that you understand what I am saying, it would be that the court would be satisfied that the young person had a major substance abuse issue. An assessment would be conducted at court. The young person would have had an opportunity to engage in the voluntary treatment regime, and for whatever reason that has not happened or it is not working. The court would not sentence the young person, so I think that is really important. I cherrypicked the best features of the models I saw overseas.

I do not want it to be a punitive penalty. Once you sentence a kid, they are just counting the days until they get out. I want it to be like a carrot so that it is a rehabilitative option; it is not finalising the matter. They would be placed in the facility. We would have regular updates from the people treating them. They would have their own individual treatment plan. They would spend three to four weeks in the secure unit, if necessary, detoxing, and then the therapeutic relationship they establish with the expert clinicians — so these are not babysitters; these are people who are really experts in their field as we saw overseas — would continue where the young person would transition to units on site and the program would continue.

As we saw overseas in all of the facilities I went to except for one, they all had schools on site as well. So this is a chance to be a circuit-breaker for these kids who are leading incredibly chaotic and incredibly sad lives. When I saw these people overseas, these young kids, they were really healthy, they were enthusiastic. A few of them were workshopping saying, 'How are you going to get the kids in Melbourne doing this?'. It was unbelievable. They are normally so narcissistic and worried about themselves. But our kids are really missing out and I think we can do a lot better. The statistics show that link between their substance abuse and their vulnerability, and we are missing an opportunity to intervene at an early stage.

That is a bit of an overview. I hope that makes sense as to what my proposal is. Ultimately, depending upon how well the young person does in the facility, that would be reflected in any sentence. So they would not be penalised if they left early, but if they did well the court could place greater weight on rehabilitation. If they are a child in the child protection system, it might mean that they can return home if their substance abuse issues have been dealt with, because it is very complex as to why they are using and masking the pain that most of them have had to suffer. This is not a quick fix. This will involve, we were told, four to six months at least of intensive therapeutic work. The other thing that is critical is that they cannot just go from that therapeutic

community back into our society. They need support when they leave, so one of the psychiatrists at Cambridge said unless you put that money into supporting them when they leave, they will almost invariably go back to that lifestyle. I think they are really the key features if you wanted an overview.

The CHAIR — Thank you; that is a great overview. I might hand over to Ms Symes, who needs to leave early today.

Ms SYMES — It is more of a conversation than a question probably. In terms of eligibility for your model, are you talking about remand or would you have to plead guilty?

Ms BOWLES — I am talking about anyone who is before the criminal division and also child protection. I did not think it was appropriate for the child protection young people not to have access to the facility. But effectively a lot of the kids are in both divisions. I hate using the word 'crossover', but they are in both so they would be eligible. They would not have to be on remand, but remand would be an area where instead of remaining in custody they could be bailed to this address, or alternatively we have got young people who are not at the threshold of being remanded but whose lives are really chaotic so it could be a bail condition, so either.

Ms SYMES — Yes. I am just getting my head around it. So it is kind of a cross between the Drug Court and a remand centre?

Ms BOWLES — Except that I do not like linking it to a remand centre, because if you look in my report you will see the photographs — —

Ms SYMES — Or a remand house — the non-remand centre. Obviously it could benefit a range of offenders?

Ms BOWLES — There has to be some nuancing, you are right. In terms of the assessment, it was explained to us that for each home — so there might be eight beds in the initial detox area, six and two for emergencies — there has to be some nuancing to make sure that you are not going to have people that are not going to be able to work in that environment. I cannot emphasise enough that the initial assessment is really critical. Then it is a case of working out do you have certain ages, do you have certain genders, do you have certain types of offending? Again, that is a matter for ultimately the clinicians to advise the court as to what is going to work in that therapeutic environment.

Ms SYMES — Would it be correct to say that very serious, high-level offending would make you ineligible if you are looking more at the next cohort down?

Ms BOWLES — Look, we cannot have people going in there that are going to smash the place up, so part of that assessment would involve either those offenders getting to the point in custody where they do not present that kind of risk, or alternatively, you are right, it is that other tier of offending.

Ms SYMES — Okay. So you could almost go out on parole to a place like this as well?

Ms BOWLES — I had not thought of parole, because, like I said, I think it has to be presentence. It is really looking at a health and welfare approach for these young people who have got those very serious issues and who are not accessing treatment. They would then come back to court to be sentenced. So not parole because that is at the end.

Mr MULINO — You have looked at a lot of schemes overseas. Evaluation of these kinds of schemes can be quite difficult.

Ms BOWLES — That is true.

Mr MULINO — I am just wondering if any of the schemes you have looked at had evaluations that struck you as particularly robust and interesting for us to look at?

Ms BOWLES — If you have a look, there is an evaluation of Glebe House on page 66 of the report. That is in Cambridgeshire in England and it is different to the model in the sense that it is a two-year program and is for sex-offender young people, many of whose sentences are much more severe than ours. Some of them have

started their sentence and then they are placed in this facility. It is in a very isolated location, so whilst they can actually leave, it is not secure in that sense, except that at night all of their bedrooms are locked, but otherwise it is not. They have only ever had one young person try and leave, and they went to the end of driveway and came back. That is an incredibly strong model, and it has been robustly evaluated. It is a 12-year longitudinal study, and you will see in the report the findings, which I think are incredibly impressive.

Apart from that, you are right, it is very difficult in terms of evaluation. In Sweden they have had secure homes since the 1830s. The person in charge in Stockholm explained to me that their statistics indicate that one-third of the young people who are placed in their secure homes go on to live productive lives, and these are kids at the extreme end, because Sweden works very hard on a family-based model of working with kids in the community wherever possible. One-third kind of get their lives on track but still have a few issues; and then one-third are in custody and it basically probably has not made a great deal of difference in terms of their downward trajectory.

Mrs PEULICH — So it is a one-third success rate?

Ms BOWLES — One-third, and then one-third that you would say are obviously more successful than if they had not been in the facility because their lives are pretty much on track. But as he said, it is not quite the Volvo and the two kids and whatever, which is the typical Swedish home model. But for two-thirds it has made a positive impact; for one-third they said no.

Mr MULINO — Varying degrees, yes.

Ms BOWLES — But is very broad, and I agree that it is very difficult. The steering committee at the moment is working on a literature review to confirm what anecdotally we saw and heard overseas.

Mr MULINO — Apologies if I missed this in my initial look, but I am just wondering what is your understanding of the overall diversion rates in the countries that you looked at or in other countries. Does it vary a lot?

Ms BOWLES — It does because the age of criminal responsibility is very different in a number of those countries, so effectively they would say that they have diverted their young people from the criminal justice system earlier than we would with our age of criminal responsibility being 10. It is 16 in Sweden, for example, so it is very difficult to talk about diversion when you see that it is such a different model.

Mr MULINO — Right. But it can be quite a high rate of intervention in some jurisdictions?

Ms BOWLES — Absolutely, yes.

Ms SPRINGLE — Thank you so much for your presentation. I do have a couple of questions. My first one is around whether there is provision in your vision for this for kids that have not yet offended who are in that acute period but have not necessarily gone before a court?

Ms BOWLES — I think that is why I have included the child protection side of the court. They do not have to have offended; they are before the court because of issues to do with their families not being safe.

Ms SPRINGLE — Sure. But outside of that paradigm, I guess?

Ms BOWLES — I know it is very difficult, because there are families who have approached me who do not have their kids in the system yet and are saying, 'What about me? I don't know what to do. What am I going to do with my child?'. I guess the model that I have looked at has been through the eyes of being in court and the court making orders, and I think there has to be external rigour and there has to be judicial oversight. So the difficulty is I am not sure how that would work if it was someone not before the court.

Ms SPRINGLE — So that is a key element of this. The judicial oversight is the key element of what you have got here.

Ms BOWLES — Absolutely. Because we do not want to reinstitutionalise kids again, there has to be either the children's commissioner or independent bodies that are rigorously making sure that these kids are being cared for appropriately and also that regular assessments are being provided to the court.

Ms SPRINGLE — So I suppose there is nothing precluding something like this being accessible hypothetically to kids that have not ended up in the court yet but are in that —

Ms BOWLES — That is a really difficult area.

Ms SPRINGLE — high-risk area before and time frame phase before they have offended.

Ms BOWLES — I have had parents say to me, 'I don't want to ring the police, it is my child', but they will not go to treatment, and they are destroying themselves and their family.

Ms SPRINGLE — Yes, that is right.

Ms BOWLES — I am not sure how you would be able to. There would have to be some authority directing those kids to go.

Ms SPRINGLE — As you just suggested, it could be the child commissioner or some other body that could be responsible for that.

Ms BOWLES — In terms of the effectiveness of treatment, I do not think there would be any difference.

Ms SPRINGLE — Right, okay. My second question is around modelling of how much this would cost; has that been done?

Ms BOWLES — We have got two of the big accounting firms that are vying to do that work for us at the moment, so the steering committee has spoken to them.

Ms SPRINGLE — And is there a time line on that?

Ms BOWLES — We have been told that we really need to have all our ducks lined up in the next three to four months, and so we are working to that deadline.

Ms SPRINGLE — Great.

Ms PATTEN — Did I not see a number like $1470 a day from KPMG?

Ms BOWLES — There is a KPMG report that has done that, and they have done some modelling.

Ms PATTEN — They have done modelling on a therapeutic treatment and care service?

Ms BOWLES — That is right. But their model is not the same as the one I am recommending —

Ms SPRINGLE — Not the same.

Ms BOWLES — so I have kind of steered a bit clear of that. I do not shy away from the fact that this will be expensive. We are talking about clinicians. We are talking about relatively small numbers, but when you look at the number of offences a lot of these kids are committing and you look at safety in our community, when you are looking at the fact that most of these kids will have non-productive lives like the boy who wrote the poem — he has just spent 12 months in a psychiatric ward — their trajectory to custody is very high.

You have got to look at all of those opportunity costs as well. These children are incredibly vulnerable, and we have got an opportunity to do something. You all know about crystal methamphetamine. We have got kids as young as 10 using ice I saw in the *Herald Sun* today or yesterday. That depletes the dopamine in the brain, and anyone who has known anyone with Parkinson's disease — and I have — knows that this is what is going to happen to these kids, because it does not regenerate. They are 11 times more likely to have psychosis. That cost to the community is absolutely massive, and so that has to be factored in, not just the up-front cost of how much it will be to set something like this up.

Ms SPRINGLE — One last question around the compulsory nature of this, and how that fits in with the restrictions around human rights and the charter. Can you just unpack that a little bit for us?

Ms BOWLES — Sure. I have discussed that in my report, where I speak about the UN Convention on the Rights of the Child at pages 71 and 72 and the Charter of Human Rights and Responsibilities Act. I have spoken to the Attorney-General who introduced the charter to see whether or not he felt that it infringed the charter. He said no, he did not think it did. I think it is important to note that the UN Convention on the Rights of the Child, article 33 states:

> Governments should provide ways of protecting children from dangerous drugs.

Article 36 states:

> Children should be protected from any activities that could harm their development.

And article 6 states:

> Children have the right to live a full life. Governments should ensure that children survive and develop healthily.

In the charter, section 25 states:

> (3) A child charged with a criminal offence has the right to a procedure that takes account of his or her age and the desirability of promoting the child's rehabilitation.

So I accept that whenever you talk about anything to do with compulsory or mandated, clearly we have to look at human rights, and these are children, but in my view the balance can be struck by the therapeutic facility. As one of the judges of the Youth Drug Court in New Zealand told me, 'I can send a kid to prison, but I can't order them to have rehabilitation'. So that is the thing we have to think about if we are prepared to place them in custody. Custody is not meant to be a facility to rehabilitate. I mean, it rehabilitates with education but primarily we have detention facilities to punish kids. They have got to the end of the line and the community needs to be protected or whatever it might be. This is different to what I am talking about, so as a lawyer I am of course concerned about human rights, but I am also concerned about the health implications for these children.

Ms SPRINGLE — Just as a follow-up to that, did you see any evidence overseas of the model not being effective, because it is not necessarily the person voluntarily opting in; they are effectively being forced to rehab? I think there is a good body of evidence to say that opting in is a vital part of the success of rehabilitation.

Ms BOWLES — That is true, but what we heard overseas was that provided you have got the essential features that I am speaking about, the kids will buy in, because their lives at the moment are not happy.

Ms SPRINGLE — Of course they are not.

Ms BOWLES — These kids out there, I have spoken to them, and when they are really frank, they will say things. You see this big, burly person on the train with his baseball cap on and you would be thinking twice, but he has to sleep with the light on at night because he is so anxious. Their lives are chaotic, and at the moment to expect them to make an informed choice when their health is so deleterious is I think putting too much on them.

What we saw overseas was that with the right quality staff and right physical environment in terms of being a homely environment, the children will buy in. They just need that opportunity. One boy in Sweden said to us, 'Look, I think I would have been dead if I did not come here, but I did not want to come here'. So it is providing the environment where they feel that someone actually cares. It seems pretty basic, but we have lost a lot of community spirit and we have lost a lot of mentoring. A lot of these kids have not had good male role models, and often even their female role models are not good. When they actually think that someone genuinely cares and wants to help them, it takes a while because of the trust issues, but they will respond, and I see that in court every day. But they need to have a clear head to respond.

The CHAIR — I have a couple of questions about the current functioning of the Children's Court. One is to do with evidence we have had from people who have told us about situations where children or young people are charged with offences over a period of time. Eventually these are dealt with by the courts, but it was put to us that, and it has been put to me outside of the hearing, that there is a lack of a sense of immediate consequences because of this delay — that someone can go out and do something quite violent and unacceptable but their life does not really change in any way. Is there some better way that the Children's Court can deal with this undoubtedly very difficult problem?

Ms BOWLES — Given I am not speaking on behalf of the court and the President of the court is giving evidence, I really think I cannot go outside of the Churchill realm because I am not speaking as a magistrate of the Children's Court. Suffice to say that if a young person was in custody, this would be an option that would have an immediate consequence.

The CHAIR — I guess my other question, which is about what has been put forward through your study, is: what is the threshold to qualify? You have made the point — —

Ms BOWLES — Sorry, the threshold to?

The CHAIR — To qualify for this form of outcome.

Ms BOWLES — It would be that they had a severe substance dependence issue. So it is not a young person who might have dabbled a couple of times. These are kids for whom every day this is their life. They will have had the opportunity to access the voluntary treatment service and, as I said, for whatever reason they have not or could not or would not engage; and the court, once it has been provided with the assessment — and as I mentioned earlier the need for there to be suitability and working out young people for whom it is going to work in the one therapeutic home — then considers that the order should be made.

Ms PATTEN — Thank you very much. It is a very interesting model. Obviously looking at the numbers, the significant majority of kids who come before your court actually do have significant drug and alcohol issues —

Ms BOWLES — That is right.

Ms PATTEN — so a large number of them would qualify for this. I am just trying to get my head around a kid who comes before the court with a significant drug problem, who commits a significant crime, possibly under the influence but separating that, and they are given a treatment order per se to go through this program. They come through this program very well. It is a four-month program. This really gives them something. Are they still having a guilty plea at the beginning?

Ms BOWLES — They could have pleaded or they could have been on bail or remanded in custody, so it is a rehabilitative order. That is the focus I want to emphasise and that then, if they have done well in a program, that can be recognised in terms of the ultimate sentence. Whether they still go to custody or are placed in detention because the offending is so serious, it might be that it is a shorter period of time in detention because of the fact that I can tick off the rehabilitative prospects as much greater than had they not attended the facility.

Ms PATTEN — So this process happens and then they still would be coming before the courts after that.

Ms BOWLES — They have to come back, so there has got to be a consequence at the end.

Ms PATTEN — Got it. Thank you; that has made it very clear.

Mrs PEULICH — All I want to say is I am impressed. My only concern is, as I think was indicated by Ms Symes, that people have to have severe substance abuse or severe issues before they can access it and already be within the justice system in a sense. I can just imagine the public saying precisely, 'How about my kid? I don't want him to end up there'. So I think that is the public policy dilemma.

Ms BOWLES — I am happy to give that some more thought, because I know there is a huge need out there.

Mrs PEULICH — The other thing is what I am hearing more and more about — and this obviously goes contrary to the parameters of your research and proposal and the human rights charter, but what parents are saying to me when their kids are addicted to ice, the most addictive drug in the history of humanity — is how about involuntary treatment orders? I know they are less successful, but, as you said, unless they have got a clear mind they cannot make a decision.

Ms BOWLES — The fact that this is mandated could also be said to be involuntary in the sense that the court would be saying, 'Enough; this is what needs to happen', and at the moment that is not what is happening. We do not say to children, 'Do you want to go to school or not?', but I tell the young person to go to treatment and if they do not, effectively we are giving them that right to say no. One of the girls in New Zealand said to

me, 'Aren't you the adults? Aren't you meant to know what is good for us?'. That sounds pretty basic, but I think we are meant to know what is best for them. They are still children.

Mrs PEULICH — Whether they are children — in particular obviously the case is strong here, but they are people. The question of cost was alluded to beforehand, so are you able to flesh out what the cost would be, given the numbers that are before us at the moment?

Ms BOWLES — It is incredibly difficult because it would depend on whether we have got an existing facility — in England they have lovely manor houses that they were able to utilise — or whether we have to build a facility. It depends whether there is one already that we can add on to, say, Birribi or one of the other current units. It is very difficult. I do not want to scare people off and I do not know that it is very informed when I have got accounting firms hopefully doing the work properly for me, but I will not shy away from the fact it will be many millions of dollars.

Mrs PEULICH — In terms of proximity to other services and public transport and all of that, does it need to be — —

Ms BOWLES — That is really interesting, because in my report I talk about the benefits of an urban location and a rural location.

Mrs PEULICH — Having it remote.

Ms BOWLES — There are actually pros and cons with both.

Mrs PEULICH — I think there are lots of remote possibilities. There are a few vacant ones that we can think of.

Ms BOWLES — Probably that is right. If there was to be one established as a pilot-type program — and I know pilot is an unusual thing to say when we are talking about legislative change, which would be required — on balance I think it would be best if it was somewhere in Melbourne because of the availability of the expert clinicians that we need, the location in terms of transport for families, because families who are still involved with these children is one of the important things. You want to see them create and remould that relationship, which is often very fractured. So on balance I think probably in Melbourne, but I know it is going to be very difficult for that to take place. I know that a lot of the regional communities are really hurting, and I can imagine that in terms of getting support there would be huge levels of support in Mildura, Shepparton and some of these regional areas where there are a lot of Aboriginal children who are really in a perilous state. So I do not close off any options. I am just really keen to try to see if we can do it, and I am very confident it would do well and that it could be expanded.

Mrs PEULICH — We have got to try something, but the question in terms of dealing with public policy imperatives of having kids who are not in the justice system being able to access these things is something we have got to think about.

Ms BOWLES — Sure. I agree with that.

Ms CROZIER — I again echo the words of Mrs Peulich. It is a comprehensive and excellent report that you have provided on this and it puts some very viable options on the table, or some necessary options — I do not know if they are viable — in terms of consideration by this committee, the government et cetera.

I want to go to the point about some numbers, and this might go towards your role as a magistrate, which you possibly will not be able to answer. I refer to the wait times for counselling — and you said partly why you conducted this report is due to those wait times. You also said there is the frustration about children making the decisions whereas we as adults should be caring for them and taking that responsibility. So what are the wait times for counselling at the moment for some of these children who are drug and alcohol affected?

Ms BOWLES — It is difficult for me to say, because in my role I make the order or I defer sentence and I ask the young people to engage and then youth justice is responsible for then organising the drug and alcohol counselling. What I can say is that we have relatively few residential beds for detox for young people. When I wrote my report there were only 32 or 34 for the whole of Victoria, and I have had young people in custody who at that time, when they are desperate, basically will say, 'Can I go to detox?'. Then I have had young

people have to wait in custody until a detox bed has been available, so I am probably not the best one to be answering anything further about delays. I think a number of the drug treatment providers provide a really good service, but it relies on the young person engaging.

Often I get reports from youth justice that 'Yes, Johnny went to the first assessment, but he has not been back'. And when I say to the young person, 'Well, you need to go to these counselling appointments', they will not say that it is because there is a delay; what they will say is, 'Oh yeah, I know'. I have got kids every day who have seen their parents commit suicide. They have seen horrible family violence matters. If you are self-medicating, it is very hard for me to say, 'Go and confront all of that. You have to do it'. Effectively you might say that that is what you are asking them to do in this model, but I am asking them to do it in a therapeutic, safe environment, not in an environment where they go for 1 hour a week and then go back to their normal chaotic lifestyles.

That does not really answer your question. I am not aware of what the delays are. I just know there are limited facilities, and I know that all of the drug treatment providers want more. I do know in relation to Orygen and in relation to mental health issues that there are delays. I have heard Professor McGorry speak about the number of young people he has to turn away, which is just unbelievable. I have visited a number of his facilities, and again it is a voluntary model. For some young people it works, but there are a whole lot who are not accessing any treatment at all.

Ms CROZIER — Can I just follow on from that. So in terms of the people that come before you, the percentage that are drug and alcohol affected, have you got a rough idea of the percentage so the committee can have an understanding of the magnitude of this issue?

Ms BOWLES — The statistics that I have included that relate to the snapshot of young people in custody, you will have seen them. With a history of alcohol or drug misuse it is 92 per cent of those in custody, and their drug or alcohol use relating to their offending is 90 per cent. Obviously there are a whole lot of young people we see who do not get to detention. I think one of you said, 'Look, the majority of the kids you are seeing have got these issues'. It is incredibly high. Whether it is to the level that their lives are pretty much chaotic and out of control, not necessarily, but it is not uncommon; it is frequent. That is what we are seeing.

Ms CROZIER — One question in relation to the transition that you mentioned from the experience of those that you visited and how important that it is.

Ms BOWLES — It is so vital, and it is hard.

Ms CROZIER — Can you just give us a little bit more detail about the transition and what that included in terms of contact? Was it case managed? Did it vary across the different areas?

Ms BOWLES — It did vary. I have included in my report examples that were provided at the different facilities. For example, in Sweden there was one transition where they had an open house on the site, so the kids transitioned to that. A number of them went to school each day, and a number went to jobs, and then came back. So they had that way of having security but just slowly transitioning. They went from that to a unit where they were next to a fire brigade, and a number of them did work with the firemen. They would not attend fatalities, but firemen were regarded as good role models — fitness and keeping them out of trouble — but touching base, again, with the staff.

A number of the facilities overseas said that the transition was the thing they found the hardest, and in the Glebe House evaluation to which I was referring that was picked up — that they needed to do better with that. One of the facilities in New Zealand would look at houses near to the facility so that they would still come for sessions at night.

In my model what I am talking about is that the young person, similar to what I have just described, would be spending time going to school or going to a job and then coming back to the facility, and they would then transition to a house in the community. There would be some staff, but a relatively skeleton staff; it is not meant to be intensive like it is in the therapeutic environment. What is really critical is that the staff with whom they have formed a therapeutic relationship would continue to work with them in that house. So you do not just cut them off and send them out.

I have got a photo of the facility in New Zealand, the house where they start their journey, and then after they are back they go to that same house. So there were various options where the different facilities did everything they could to try to transition the young people back into the community, and a lot of that is preparation. When I described the young person who was so anxious and sleeps with the light on, he was at Birribi, which is a YSAS facility. He had been at Birribi a number of weeks and they said, 'Go up to the local shops' — it is a rural setting — 'and have an afternoon walking around, just being on your own'. He lasted about 15 minutes. So it is then working on what was the anxiety. He said, ' It is so long since I have been at the shops and I have not been substance affected, I thought that everyone was looking at me'. He became quite paranoid.

When you have expert staff they know to expect those reactions and they know how to speak to the young people. That is why the schooling is so important. Unless you can actually set them up, it is going to be very difficult for them. If they go back to emptiness and to not feeling part of the community, that will be very hard.

In Scotland we saw a salon that had been set up within one of the facilities, because a lot of the girls like beautician work and doing their nails. They could actually get a qualification whilst they were in there. So that is an investment, but it is a really practical one.

Ms CROZIER — So very varied in that description that you have just given to us.

Ms BOWLES — It is very varied.

Ms CROZIER — Was there one that you thought would perhaps work best here?

Ms BOWLES — I think the idea of the house or houses being geographically relatively close to the therapeutic facility and that constant re-engagement with the staff, and also being in an area that they have become familiar with would be the best.

Mrs PEULICH — How would you go about implementing it? What would be the stages?

Ms BOWLES — I have tried speaking to politicians, and I have met with some. We have a steering committee, as I said, and it is an incredibly diverse and experienced steering committee. We have got CEOs from the three organisations that I mentioned. We have got — and I think I have already said this — Forensicare psychiatrists and a number of other experts that are on the steering committee. So through each of them we have been able to tap into the people that are involved in this whole part of the world.

I have just been prepared to speak at as many conferences as I have been able to, and I have met with children's commissioners. So everybody who I thought has got a stake in this and who is interested I have explained the project to. I have done interviews on the TV, and an editorial in the *Age* took it up. So I have tried really hard. I do not know what else I can do, except ultimately I need a government on board that is prepared to make the legislative change and provide the funding. I am just heartened that a couple of the big accounting firms are interested enough, because I am more hopeful now they are involved that they have potentially got access to people who might be interested in assisting.

Mrs PEULICH — Just on the multicultural dynamic, that obviously requires a level of specialisation, and because that sort of a facility would probably need to be in an urban or metropolitan base in terms of critical mass, how do you see that sort of client profile being accommodated?

Ms BOWLES — Again a lot of that depends upon having the appropriate staff and the assessment that is done. I refer to culture in my report and observed a Maori treatment centre in New Zealand. I have had meetings with a number of Aboriginal groups, and certainly their view is that it should be culturally specific for Koori kids rather than mixing with non-Koori kids. In terms of other cultural groups, again I think the experience of YSAS has been that if you have kids of the one cultural group, it is probably more effective. So I think on balance I would go that way.

The CHAIR — Ms Bowles, thank you very much for your time today. Can I say I think you have achieved the near impossible: you had Ms Patten and Mrs Peulich both nodding in approval at the same time. That does not happen very often. That is a good sign.

Ms BOWLES — Thank you very much, and I am sorry I could not answer your question, but I feel I cannot go outside this parameter.

The CHAIR — I understand; that is absolutely fine. More seriously I want to say thank you very much for bringing and speaking to your research. It has been enormously useful. You will receive a copy of the transcript within a few weeks in draft form for you to peruse.

Committee adjourned.