YOORROOK Justice Commission

TRANSCRIPT OF DAY 9 – WURREK TYERRANG

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MS SUE-ANNE HUNTER, Commissioner
DISTINGUISHED PROFESSOR MAGGIE WALTER, Commissioner
PROFESSOR THE HON KEVIN BELL AM QC, Commissioner

FRIDAY, 16 DECEMBER 2022 AT 10.07 AM (AEST)

DAY 9

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CHAIR: Welcome all. Today marks the last day of our public hearings on child protection and criminal justice. Before we start, I would like to ask Commissioner Hunter to do the welcome to country.

COMMISSIONER HUNTER: Thank you. I'd like to acknowledge we are on the ancestral lands of the Wurundjeri, I pay my respects to Elders, past and present, acknowledge all those that have come before us so we are able to give voice here today. May Bunjil watch over us as we conduct Aboriginal business. Thank you.

CHAIR: Thank you, Commissioner Hunter. Counsel?

MR McAVOY: Thank you, chair, my name is McAvoy and I appear with my learned junior, Ms Fitzgerald, for the purposes of taking the next witnesses through their evidence. This morning we have Professor Stuart Kinner and Dr Mick Creati. They are in the witness box. I also note Ms Cafarella is appearing for the State. We only have these two witnesses today, Chair. It is intended - it was originally intended that we conclude these witnesses in an hour. My observation of their evidence is that they have a wealth of knowledge and we might go past that to make sure we cover the issues that they are able to speak to and extract as many of their insights if we can, if that's okay with the Commission.

CHAIR: Thank you. Yes.

MR McAVOY: I call Professor Stuart Kinner and Dr Mick Creati. I might first start with you, Professor Kinner. If you could just state your full name for the purpose of the record?

PROF STUART KINNER: Stuart Alistair Kinner

MR McAVOY: And you have provided an outline of evidence to the Commission and the contents of that outline are true and correct to the best of your knowledge?

PROF STUART KINNER: Yes, they are.

MR McAVOY: Do you undertake to tell the truth to this Commission in the evidence you are about to give?

PROF STUART KINNER: Yes, I do.

<STUART ALISTAIR KINNER, AFFIRMED

MR McAVOY: Dr Creati, could you tell the Commissioners your full name please?

DR MICK CREATI: Michael Brian Creati

MR McAVOY: You have also prepared an outline of evidence for this inquiry?

DR MICK CREATI: Correct.

MR McAVOY: And the contents of that outline of evidence are true and correct to the best of your knowledge?

DR MICK CREATI: Correct.

MR McAVOY: Do you undertake to tell the truth in the evidence you are about to give to this Commission?

DR MICK CREATI: I do.

<MICK CREATI, AFFIRMED

MR McAVOY: Thank you, starting first with Professor Kinner, could you just give the Commission a brief explanation of the roles that you currently hold and the basis on which you are appearing today?

PROF STUART KINNER: Sure. My qualifications: I have a PhD in forensic psychology from the University of Queensland in 2004, but for a little over 20 years now I have led a program of research on the health of people who have contact with the criminal justice system, initially in Queensland, but more broadly now around Australia as well as internationally. I'm Professor of Health Equity at Curtin University but I also head the Justice Health Unit at the University of Melbourne and at the Murdoch Children's Research Institute and I'm an adjunct professor at the Griffith Criminology Institute at Griffith University.

I also serve on the WHO's health and prison program steering group and the Worldwide Prison Health Research and Engagement Network Steering Committee, so I have those global connections, and I'm inaugural chair of Australia's National Youth Justice Health Advisory Group.

MR McAVOY: Thank you. Dr Creati, could you likewise assist the Commission by setting out your background and qualifications?

DR MICK CREATI: Thank you. I'm a medical doctor, I'm a paediatrician and adolescent physician. I have worked at the Royal Children's Hospital in Melbourne since 2000 in the Department of Adolescent Medicine. I have worked for almost the last nine years as a general paediatrician at the Victorian Aboriginal Health Service, two days a week, where about 60 per cent of the children I see have had contact or involvement with child protection, and about 50 per cent of those children have been removed from their families at some stage of their life.

Between 2012 and 2014, I was head of the Medical Services five days a week at Parkville Youth Justice precinct where I was responsible for the health care of - not the mental health, but the physical health care of the children in custody there. In 2016 I gave evidence at the Royal Commission - the Commission into the Protection and Detention of Children in the Northern Territory really to give evidence about the medical standards - the standards of medical care of children in detention.

MR McAVOY: Thank you. I just wanted to give you the opportunity to speak to some of the understandings you have, Professor Kinner, in relation to the characteristics of First Nations people in the criminal justice system.

PROF STUART KINNER: A broad overview would be to say that First Nations people in the criminal justice system are that subset of First Nations people in the Australian community who are distinguished by particularly significant health and social needs. So I don't want to get into the weeds of percentages and numbers but we know that the prevalence of mental illness is extraordinarily high, the prevalence of cognitive disability, substance use difficulties, particularly in relation to alcohol, cannabis and, very importantly, also tobacco, and the prevalence of chronic communicable and non-communicable diseases are increased. So, for example, hepatitis C, sexually transmitted infection is less of an issue, but still an issue, and probably getting the least attention but also very important, a markedly increased risk of chronic non-communicable diseases, things like cancer, diabetes, asthma, which are associated with very poor long-term outcomes.

Critically, we know that these health and health-related conditions typically co-occur among both First Nations and non-Indigenous people in custody. In other words, people typically have multiple health problems at the same time, what you can call multi-morbidity. That's really important because we know that to effectively treat people with co-occurring conditions, you need a multidisciplinary coordinated team.

MR McAVOY: Thank you. In particular, a focus of some of your work has been the relationship between incarceration and post-release mortality.

PROF STUART KINNER: We have led a number of studies in Australia which, unfortunately, align very well with international evidence showing that people released from custody are at dramatically increased risk of death from preventable causes. Just to put this in context, since the Royal Commission in 1991 we have had monitoring of deaths in custody and, of course, the number of deaths in custody should be zero.

Just for context, we have done some work recently showing that the number of deaths within a year of release from prison in Australia is about 10 times the number of deaths in custody each year and whereas most of the deaths in custody now are due to natural causes and, of course, we can talk about medical negligence, the vast majority of deaths in people released from prison, particularly in the weeks and months immediately following release, are from preventable causes, so suicide, drug overdose, violence and injury. So there's an enormous under-recognised burden of ill health and mortality and death is very much the tip of the iceberg in those poor outcomes that we see.

COMMISSIONER BELL: I will just ask straightway: what is the proportion between Aboriginal and non-Aboriginal with respect to post-release deaths?

PROF STUART KINNER: So the work that we've done, we developed a system that the Australian Institute of Health and Welfare now uses to routinely monitor deaths after release from prison. What that has shown is that the rates of death for Indigenous and non-Indigenous people after release from prison are about the same, and this, of course, reminds us of one of the findings of the Royal Commission in 1991 which is that the rates of death in prison are similar but, given the extraordinary overrepresentation of Indigenous people in prison, and the very extraordinary representation of - overrepresentation of Indigenous people released from prison, there's a concentration of increased risk in Indigenous people in that period after release from prison.

COMMISSIONER BELL: Thank you.

MR McAVOY: Professor Kinner, I just want to take you to paragraph 6 of your outline. In that paragraph, you identify that Indigenous women released from prison are at approximately 13 times higher risk of death post-release compared to their counterparts from the general population. That's a quite extraordinary figure; would you agree?

PROF STUART KINNER: It's an appalling figure. It's an absolute tragedy. These are clearly highly marginalised women. Again, there are two parts to this. Clearly, there is a desperate need for greater support but, secondly, what we now know increasingly is that a lot of the women that we see at risk after release from prison were at risk before they went to prison in the first place. So it begs the question: what do we need to do about that? Sending people to prison is not a solution to any of those risks but not sending them to prison in and of itself is not sufficient to mitigate those risks.

COMMISSIONER WALTER: Can I just ask, this is aggregate Australian data, do you have any data - I note the numbers might be too small, just aggregated to Victoria or is the pattern similar in Victoria as it is to other states?

PROF STUART KINNER: I have led research on this issue in Queensland. There have been studies in New South Wales and in Western Australian. The first study on this issue in Australia, actually, was in Victoria led by Graham 2003 but only using coronial records. And there hasn't been, to my knowledge, any research on this specific to Victoria since that time.

The AIHW data that I mentioned do cover all Australian states and territories and could be disaggregated. Without going into the weeds of this, that's not a gold standard way of looking at mortality. It's actually exclusively using Centrelink data, which is only possible because nearly everyone released from prison gets a crisis payment. Rates of employment are so low, you can follow people through those crisis payments and Centrelink is very diligent in terminating benefits when people pass away.

MR McAVOY: Thank you. Dr Creati, you've also done some work in helping to build some picture around the incarcerated population, and, in particular, with respect to children, you've put together in your statement, at least, a profile of children in the justice system. Can you just speak to the Commissioners about that?

DR MICK CREATI: Yes. If we go to paragraph 24 of my statement, I think that's probably - from my work in this area, really since Don Dale, I think there's a lot better understanding of the profile of children in the custody system, and that's important, because that should be driving the interventions, or supporting the children.

We know that Aboriginal and Torres Strait Islander children are overrepresented in the justice system. If we look at Australian population data, maybe three to four per cent of Australia's population may identify as First Nations people. We know in the adult prison system, it's about 30 per cent of the prison population is First Nations people.

If we look at the prison population, I will call it youth justice in prison interchangeably - if we look at the population incarcerated under the age of 14 years of age, about 60 to 70 per cent of children incarcerated under that age are Indigenous. The younger the cohort, the higher the percentage of Indigenous people incarcerated. We know that Aboriginal and Torres Strait Islander people are overrepresented.

Children in custody come - involved in the justice system come from lower socioeconomic groups. If you break socioeconomic profile down by quintile, the bottom 20 per cent of children - children from the bottom 20 per cent socioeconomically are eight to 10 times more likely to be involved in the justice system. So it's not just an issue of Aboriginality, they go hand in hand, Aboriginality and disadvantage at times. So we know that the children who are incarcerated are young and, you know, developmentally immature. There is a slide I've got about neurodevelopment of the brain.

We now know through functional MRI that the part of the brain that's responsible for impulse control and seeing the consequences of your actions is not fully developed until you are about a 25-year-old. So if any of you have got older adolescent teenagers, you probably realise this.

MR McAVOY: Dr Creati, we might have slide 1 shown on the screen and I would ask you just to speak to that slide.

DR MICK CREATI: Yes. These are functional MRI pictures and it shows that the part of the brain which is responsible for what we call executive functioning, including impulse control and weighing up long-term consequences of your actions, is not fully developed in your 20s. So even us as adults are not fully in charge of our impulses. You might go to the supermarket and there might be chocolates in the trolley, and you don't want to buy them, but we all do things impulsively. But a 10 to 12-year-old will be much more impulsive and not think through the consequences of his or her actions.

I have seen a lot of kids being incarcerated on remand for getting in a stolen car, for example. 12-year-olds on the side of the road, they get pressured to jump in the car or get left on the side of the road. They jump in the car, not thinking through the consequences of the action. Because the car is stolen they are an accessory to a crime and that's sufficient to incarcerate someone for behaviour which is completely understandable on the basis of their neurocognitive development at that age.

MR McAVOY: In terms of the slide, Dr Creati, there is a small box on the top right-hand corner of those images. That's the --

DR MICK CREATI: Represents the prefrontal cortex.

MR McAVOY: We can see its colour starts out largely red and moves to a less red colour at the --

DR MICK CREATI: The age, yeah. If you see the spectrum along the bottom, red, yellow parts of the brain, less fully mature; blue is fully mature. So it is the part of the brain which is still to develop, and we know that part of the brain is responsible for giving you control over your impulses and thinking through actions.

MR McAVOY: So even at the age of 20, there is still - it is still --

DR MICK CREATI: It's not fully developed.

MR McAVOY: Not fully developed. The development of the brain, particularly in respect of those functions, is affected by trauma?

DR MICK CREATI: Other parts of the brain are affected by trauma, yes. It is interesting that children that are traumatised from a very young age, even in utero, exposure to trauma before you are born, the synapsis which the brain linkages which develop are affected by trauma, high cortisol levels in utero, which might be maternal trauma, and it effects that part of the brain which lets you calm down. You are more likely to have a fight and flight response if you have had early childhood trauma.

So, as an example, as an adult, if I have a police car come behind me and the lights flash, I get scared, and I - but I have got enough impulse control to calm down. A young person who has had trauma won't have those developmental - those neuro connections as formed and they may hit the accelerator and go off and then they'll be charged with evading police. So there is a lot of evidence. Any conflict or pressure, they may react in a way which brings them in contact with the police and be able to be charged.

We know that early childhood trauma affects those neuronal networks which allow you to just slow down, take your time, and not do something which may get you in trouble with the police. That's particularly important in this case because if you go to - there's another slide about the involvement - if we accept involvement with child protection as a proxy for trauma, we know that the children in the justice system are very traumatised. So there is another slide --

MR McAVOY: Slide 3.

DR MICK CREATI: Slide 3 which shows the rate from Victoria of - the rates of your likelihood of being child protection involved at your first involvement at youth justice and it's not until 14 years of age that it's a less than 50 per cent chance that you've been involved with child protection if you are involved with youth justice. We know even one in four children under the age of 14 involved in child protection have even been in residential care which is the extreme end of the child protection placement system.

The trauma is three-fold. It's the trauma for which they are removed. If you look at the evidence from Taskforce 1000, high rates of violence in the home, high rates of mental health and high rates of parental drug and alcohol use. So they have been removed because of trauma. They have had the trauma of being removed. Second trauma of being removed from your parents is always traumatic. Then they have the trauma often of being in the child protection system and having multiple placements. I have had an 11-year-old with 30 placements over her time and she's involved in the justice system.

So there's that triple - what I call the triple trauma of being involved in the child protection system, the trauma - reason behind your removal - trauma of being removed and then trauma of multiple placements and attachment issues which come inherent in most - in a lot of placements in the child protection system.

MR McAVOY: Thank you, Dr Creati. Returning back to paragraph 24 --

DR MICK CREATI: 24, yes I've gone off-piste a bit there. Neurodevelopmentally immature. High rates of trauma, which we have discussed. High rates of mental health issues,

and although - I don't know specific data from Victoria, there was research undertaken in Western Australia - and if we could refer to slide 2 - done by the Telethon Kids Institute, 99 children in detention in Western Australia. Some researches went in and found that 89 per cent of the children in detention, so children under the age of 18, had at least one severe neurodevelopmental impairment and that's the list of impairments or issues, foetal alcohol spectrum disorder, ADHD, depression, learning difficulties, intellectual disability, trauma, attachment, anxiety, speech and language disorder.

Those figures are shocking in themselves. We are locking up children for behaviours which are largely explained by disability. So rather than supporting their disability, we are locking them up.

MR McAVOY: Returning back to 24, the other item that you've identified as part of the profile of children in the criminal justice system are the low rates of mental health diagnoses.

DR MICK CREATI: Yes.

MR McAVOY: So not only are they suffering from mental health conditions, but they are not being treated as people with those conditions?

DR MICK CREATI: They have never been assessed. That's really appalling because many of these have been through the child protection system and there's been ample opportunities - and we'll get to that later - about using involvement as a child protection - involvement in child protection as an opportunity or a flag to assess - appropriately assess these children or their disability behaviour, mental health, and put in supports earlier before that trajectory into the justice system. So it's a really missed opportunity that they have got into the system, the justice system, without - rather than being through the child protection system, as we have seen, but never been assessed.

MR McAVOY: We are going to have a bit of a closer look at the way in which there might be a health response to this behaviour. Professor Kinner, is there something that you would add to the observations from Dr Creati?

PROF STUART KINNER: Yes. And just what may be a useful way of thinking about this, I think Mick and I have both been talking about what's being described as the sedimentation of disease. It's not a term I love but basically making the point that the criminal justice system, for a variety of reasons, effectively filters and selects from our society the most marginalised, disadvantaged, unwell members of our community, and puts them in a place where we then arguably compound that marginalisation, trauma, disadvantage, and ill-health.

Now, why do we do that? Just to give context, again, when you look at the drivers of contact with the criminal justice system in our communities, disadvantage, Mick has spoken to, rurality, like, being in a rural and remote location, structural racism, disability, mental illness, homelessness. We know these are important drivers for contact with the criminal justice system and then remarkably not only do we often fail to identify the underlying health and social needs that led to the person being there in the first place, we adopt an entirely myopic, hyper-individualistic narrative suggesting that the person just needs to change their criminogenic thinking, and it is so strikingly at odds with the evidence and with commonsense.

I think Mick and I have been speaking about this enormous burden of need and it's really strikingly inconsistent with our response.

MR McAVOY: Thank you. I might just explore that issue for a moment before returning back to Dr Creati. In your work, have you had cause to consider why it is, at a population level, why it is we are moving to much larger imprisoned population and why we are pursuing this path, it seems, where we are locking up more and more people at almost an exponential rate?

PROF STUART KINNER: Sure. I mean, I'm not a criminologist, but I think a couple of key drivers. One is a cultural shift to a more punitive conceptualisation of behaviours that lead people to the criminal justice system. I think nobody's willing to take ownership of driving that. The media will say that they are communicating the views of people they speak with, politicians will say that they are listening to experts, but trying to reflect community sentiment and community listens to the media and politicians and forms an increasingly punitive view.

That coupled with increasing underinvestment in our basic social safety net and supports and we know that the more we disinvest in those supports and the more inequality we see in our society, the more incarceration we are going to see because this is a symptom of the failures of those upstream systems.

MR McAVOY: Thank you. Dr Creati, returning back to paragraph 24, the last item you have identified is that, as part of that profile of children involved in the criminal justice system, is that they're largely disengaged from school.

DR MICK CREATI: Yes. There's no doubt about that. The high rates of disengagement from school in all the children I saw in Parkville, and in data from every state I have looked at, again, we can get to that, there is another reason and very intertwined with the child protection system, I mean, I see children in my practice at the Aboriginal Health Service as young as grade prep who are sent home from 10 o'clock in the morning because of - kids in out-of-home care - because of behavioural issues, they've had multiple placements, they don't settle in a crowded classroom. So carers are rung to take their child home, so the child is excluded from school from a young age and has a terrible school journey feeling unwelcome at school and excluded from school.

The other issue from that is from the carer's perspective. We have a child protection system, I think probably based on a 1950s model, where there's an expectation where there is a parent at home to pick the kid up from school at short notice. If any of you got kids, we've relied on before school care, after school care, and the stability of school hours to be able to work ourselves. A lot of the carers of these children in out-of-home care don't have such stability, they can't work, so the replacement is relinquished and that's the language child protection use.

Child goes off to another family. Additional trauma - we talked about before, multiple placements, more issues settling into school. If that's repeated three or four times, children often end up - I have seen children as young as eight-years-of-age not being able to be placed in family-based care, in residential care from the age of eight, because they have had multiple family break downs and their behaviour and attachment issues are so significant they can't

safely be placed in families or the agencies don't have families who can deal with that type of attachment-driven behaviour. So the carers need support and the schools really need support.

Schools are restrained by their resources and liability issues. I would recommend that the schools are resourced to keep children in out-of-home care at school, even if it's outside the classroom, so they have a better school experience. Schools do have some funding under the program of students for disability, DSP, to be able to support that, but universally - it's not universal, it's applied for, and I still see kids with restricted hours going into high school. It's just more traumatising.

COMMISSIONER HUNTER: Dr Creati, can I just ask, from your experience, when the child moves placement, they move schools again?

DR MICK CREATI: Often do, yes. Often do. Not always, but often do. Yes. Exactly. It's another issue of resettlement and attachment.

COMMISSIONER HUNTER: The disability - so a child has to be - and correct me if I am wrong - a child has to be diagnosed with a disability to get that funding?

DR MICK CREATI: Under the Department of Education, I think it is, there are different streams for DSP - there is a program for students with disability, there's intellectual disability autism but there's also a funding stream for severe behavioural disorder and they can apply for that and I often fill in applications for that. So they don't have to have a diagnosed intellectual autism disability but the specific funding under - can be of a significant behaviour disorder category.

MR McAVOY: Professor Kinner, you've done some work in terms of trying to map the trajectory of First Nations children and young people following release from the criminal justice system. Are you able to speak to the Commissioners about that trajectory?

PROF STUART KINNER: Yes. There's a lot we still don't know and a lot more work we need to do but our group has probably been a leader in following people after release from custody to understand their health trajectories a whole lot better. More of our work is focused on adults. The work that we have done so far that's published with respect to children released from youth detention has been focusing on mortality, death. That particular study was a study based in Queensland where we looked at every young person who had contact with the criminal justice system over a 14-year period and we looked at their contact with the adult criminal justice system and their risk of death.

A couple of the key findings from that whole group of young people, almost 50,000 young people, there were more than 1,400 deaths, and, you know, I sometimes stop and remind myself, try counting from one to 1,400 and remind myself that each one of those is a young person with a family.

The rate of death in these young people is more than four times what you would expect of children of that age and distribution in the community. The rates of death are consistent with what we see in adults, higher among Indigenous than non-Indigenous kids in contact with that system. One third of those deaths is due to suicide. Other important causes of death include violence, overdose, injuries, notably including road traffic injuries in these young

people, but even the rates of death due to non-communicable diseases in young people, who have been through the system, are around twice what you would expect.

So, again, the sedimentation of disease, it's the most unwell at-risk young people in our communities who are put in this system and what we see after their very brief contact with that system is often really bad news. We found that subsequent contact with the adult criminal justice system increases the risk of death. We found that the more times they have contact with the system, the more at risk they are of death. We found that the deeper they penetrate into that system, the more they are at risk of death.

So children who had been in detention are more than six times as likely to die during the follow-up in this study. Children who are only ever charged with a crime, never convicted of anything, never served an order, still at more than three times higher risk of death. So the point here is that these are children who weren't really exposed to the system other than being charged with a crime and they are still at extraordinarily increased risk of death. That's more than 300 per cent increase in risk of death.

MR McAVOY: Stark figures. Can I try and summarise both of your outlines of evidence in this way: the system that is needed is one in which there's a health-based response to antisocial behaviour?

DR MICK CREATI: Yes.

MR McAVOY: You agree with that?

DR MICK CREATI: Yes.

MR McAVOY: We don't have that at the moment in Victoria?

DR MICK CREATI: Not adequately. We don't have access to the resources needed to support these children both from a young age and while they are in the system. I would say, as an observation, children do not go into the child protection system as criminals. Often it drives them into a criminal pathway. It's clear. We don't have - you know, if we look at that profile of children, health-wise, it's - neurodevelopmentally they should not be locked up, or charged, even charged is - should not be locked up or charged before the age of 14. We have got laws in this country, in this state, where children can wake up as young as 10 on Christmas day in a prison cell. We have --

MR McAVOY: Just to be clear, given what you know about the development, the brain development of children at that age, you are opposed to that way of dealing with young people?

DR MICK CREATI: Absolutely. I mean, I see children every week who have got behaviours that could bring them in touch with the police or have brought them in touch with the police. I don't think oh we are going to lock them up, I think let's get them the family social supports, let's have an assessment of where that child is at neurodevelopmentally, how's their learning, how's their engagement with school, have they got a disability, and really get a better understanding of mental health. I think that, to me, is the biggest lack of support, if you want to call it, in the health sector for these children.

MR McAVOY: My understanding of both of your approaches to children being involved in the criminal justice system, but also in relation to the way in which they are dealt with in the child protection system, is that their involvement in that system ought to be a flag from which then the health resources are brought to bear and to assist that child and the family?

DR MICK CREATI: Absolutely. I think there are two flags. I think we don't want to wait until they are involved, but you want to wait until they are at risk of getting into the system and that opportunity is missed.

PROF STUART KINNER: Yes. I mean, to draw an analogy again with hospitals, just imagine if we had a system where we failed to maintain good health in the population and people who started to get sick didn't get identified, or flagged, and just got sicker, and ended up in hospitals, and we had good evidence that sending people to hospitals made them sicker and more likely to come back to hospital. I think as a society we would be quite concerned about that. If you replace the word "hospital" with "incarceration", that's precisely what we have.

MR McAVOY: Some of the things, drawing from both of your outlines, that might be involved in a properly resourced health-based response to behavioural issues is - one of them is an embedded set of mental health services. I think you speak to that, Dr Creati.

DR MICK CREATI: I will go back a step. I mean, I think there are examples of programs that try to do health assessments for children, going into the out-of-home care system, and Pathways to Good Health is an example of that, where there would be an assessment by a speech pathologist, psychologist and paediatrician to look at health and mental health issues. That is completely under-resourced and not really taken - hasn't really reached the Aboriginal children I see. So there is a model which is not being funded and utilised.

I think Pathways to Good Health, at best, was a welcome mat where they get assessed but then they weren't linked - it wasn't possible to link these children to any ongoing services after the assessment. Assessments are often there but then referral on to other systems. We need to assess children going into services. The mental health - I mean I have a patient at the moment, she's early teenager, she has been traumatised in care, abused in care in another State., significant mental health issues, drinking hand sanitiser with alcohol, forms of self-harm. I referred her to a mental health service six months ago, I haven't been able to engage her with a psychologist over six months. Too late. I would say this should have all happened much earlier and, you know, I can talk specifically about the mental health service, CAMHS service in this state, which is a high risk - which caters for high-risk children of serious self-harm.

There is a federally funded service or network called Headspace, which, because of its funding model, can see children for a limited time period, maybe 10 sessions because the practitioners will Medicare. Pat McGorry himself talks about this missing middle of - I have referred one person to Headspace in my nine years because they cannot provide the long-term trauma informed care.

Take 2 is a good model, but you have to be really at that high end extreme self-harming risk before you can even get in there. The capacity for this state to provide funded, free, whatever you want to call it, mental health support for children who have been through trauma, you know, we talked about trauma - even being removed is trauma, there is no easily accessible

mental health service for children in out-of-home care who have been traumatised by being in the system.

It's not until they are acting out and too late and then at risk because of the behaviours, they are acting out, getting into the justice system, that we have some traction in getting support for these children. So, yes, we need a health response. We need a health response earlier before they are in the justice system.

MR McAVOY: Do you have anything to add on that point of early coordinated mental health services, Professor Kinner?

PROF STUART KINNER: Other than I agree with Dr Creati. I think this is entirely consistent with the conclusions of our group recently led, the health part of - a thing called the UN Global Study on Children Deprived of Liberty that looked at the evidence globally on what we should do with regard to these matters. I think, broadly speaking, it's applicable here. It basically says, number one, prevention, investing meaningfully in community supports that are appropriate and trauma-informed so that children stay well and don't end up going down the road that Mick has been characterising.

Then at the point of being at risk and contacting the system, investing more in diversion, so that children don't start to penetrate into this criminogenic system, but also not to the exclusion of also investing in quality care for children who do end up in that system, including in detention, and investing in quality support for their ongoing wellbeing because eight days on remand in youth detention is not going to fix a lifetime of trauma and ill-health.

COMMISSIONER BELL: I was not aware about the limitation on Headspace services. I understand you to be saying that the services are capped at 10?

DR MICK CREATI: Most cases because the funding model of the Headspace is that the psychologist will Medicare the client and I need to --

COMMISSIONER BELL: So it's part of a mental health plan, is it?

DR MICK CREATI: Yes. Absolutely. I need to do a mental health plan to get patients seen by a health - some mental health worker at Headspace, yes, I do. Sorry, Counsel, I diverted from your question, do I want to see them embedded in the system? I didn't get to that. If I can.

MR McAVOY: Yes, please.

DR MICK CREATI: The referral out-process doesn't work. We have effective models even in the hospital where our mental health team for our eating disorder program are part of our - mental health practitioners, sorry, are part of our team. So we don't need to refer out. There is scope for case management. We employ them because they have got skills in that area. If I refer to CAMHS, or wherever, I'm not sure that person even has the skills to inform a report. The child has to tell the stories again. I can't share the documents because they are an external organisation.

So it is very inefficient to - and it's not working, to refer patients out. If we had mental health practitioners with trauma-informed skills embedded in child protection - and when I say child

protection, it's the VACCA and the community service organisations, like Anglicare, who do the day-to-day case management. I think that would be a much more effective model with many advantages.

Like I said, it's really impossible to get children into the care and support they need. It's struggling. I end up being the prescriber and I'm not a psychiatrist. So there's practitioners, a psychiatrist, and in the country, rural regions, the supports are even less. A lot of Aboriginal children in Victoria do live outside of Melbourne.

The other massive limitation with the CAMHS service is - this has come out in the Royal Commission - CAMHS is very strict on their geographic intake locations. Children in the child protection system, out-of-home care system, often get moved around a lot. If they go from this area, and have had CAMHS involvement, CAMHS close the case. I've got to re-refer - not even transfer, re-refer, you know, it goes through intake, tell the story again, it's appalling, and I think the chief psychiatrist a few, about six years ago recommended that, for children in out-of-home care or child protection, there be soft boundaries within the CAMHS system so the children could stay at the service, even if they moved out of region. That's not universally applied into the CAMHS system, in my experience. They changed region, and they may even go from one side of Hoddle Street to the other, so they go from the Royal Children's to the Austin region and, you know, it starts again.

MR McAVOY: It's a very unsatisfactory situation is what I hear you saying.

DR MICK CREATI: Absolutely, yes. Heartbreaking. Actually. I find it stressful.

MR McAVOY: Speaking about the transfer of information and data, Professor Kinner, you've been involved in the research aspect with respect to adult incarceration and you address that in your outline. Can you just speak to the Commissioners about your concerns about the area of research that you're involved in?

PROF STUART KINNER: I want to distinguish between two things: one is research and the other is routine monitoring and reporting. So research is one-off activities that people like me do. The other thing is routine monitoring and reporting, which is things that governments, or other entities might do. Both involve collection of data and making of the summary of that available to people. But they serve non-identical purposes and the challenges are not the same. My experience is, having done work as a researcher in this space for two decades, a lot starting off in Queensland, but nearly around the country now as well as internationally is that I have, with all due respect, found Victoria to be uniquely difficult to undertake this work in for a number of reasons.

I found it particularly difficult to have meetings and engage with people in Justice Health, for example, to even discuss what might be useful. I have repeatedly had experiences where I have proposed research and it's been declined and a key concern that I have articulated in my brief of evidence is that one reason cited for that is that it doesn't align with the Department's current strategic priorities. Now in my view, this is nonsensical, because, let me give you an example, a piece of research I'm involved in in South Australia at the moment is looking at rates of cancer in people who experience incarceration.

Now, those cancers may develop 10, 15, 20 years after incarceration. So clearly that's not going to be a strategic priority for the Department of Corrections but, clearly, it's an

important issue. So for a department of corrections to decline a piece of research on the basis that it doesn't help them with their day-to-day mandate is basically issuing their responsibility to the broader society, in my view, is very disappointing. Also, in my personal experience and view, all correctional departments are very cautious and risk averse, and cautious about engaging with researchers but my career has been built on building relationships of mutual trust and respect.

I have, again, found that particularly difficult in the Victorian context, unfortunately, and that's not to say that that's been no progress but it's been a particularly difficult and challenging experience to do that. It's a particularly, in my view, closed shop. There's a word we have used to describe this, epistemophobia, a pathological fear of knowledge. I think, you know, one speculation I have is that criticism at an opaque system is perhaps better than the criticism that will be levelled if there were a full and unfettered view of that system.

In my view, supporting and facilitating researchers to engage in this space and access data is important. But, in addition, to have mechanisms for routine public reporting on health and health services in all places of detention in Victoria, not a research activity, but a routine reporting activity is really critical to give scrutiny to that system. The seventh Director General of the WHO, Margaret Chan, often said what gets counted gets done and if it's not getting counted, in my view, it's not going to get done.

MR McAVOY: The system for approval of research in Victoria, in the custodial settings, can you just explain that?

PROF STUART KINNER: Sure. It's a two-stage process. First submit an application to CVRC, the Corrections Victoria Research Committee, and that committee is not an ethics committee, but it considers a number of matters. I don't purport to speak for CVRC, but they consider the feasibility, the resource implications on the systems, security implications, and as I mentioned before alignment with the Department's priorities.

Some unknown sub-set of proposals that are considered by CVRC, if they get past that threshold, get passed on to JHREC, which is Department of Justice Human Research Ethics Committee. I'm a member but I'm in no way speaking on behalf of the committee or in that capacity at the moment. I'm on that committee because it's NHMRC registered which means that it's obliged to conduct itself in accordance with the national statement and, in my experience, we do a fantastic job, but obviously we are only able to consider the sub-set of proposals that makes it through the CVRC filter.

I have, on a number of occasions, suggested, requested and implored there be greater transparency whereby, at a minimum, JHREC has access to a list of all proposals considered by CVRC so that we have a sense of what's being knocked back and why. But to date that hasn't occurred.

COMMISSIONER HUNTER: Can I just ask: is it because the health is privatised and sent out to others; could that possibly be part of it?

PROF STUART KINNER: That, in my view, is an issue in Victoria. I can't imagine why that would be a reason for CVRC to knock back a proposal. You know, Victoria is also, in my experience, uniquely messy, complex and disaggregated which, no doubt, produces

enormous inefficiencies and barriers, and unavoidable opacity. But none of that is a necessary impediment to any of what I am suggesting.

MR McAVOY: If the Commission, using some of its powers, were able to obtain the information about the matters that have been before the CVRC and been rejected, is that something that the Commission could call on you to then have a look at and make some comment about at a future time?

PROF STUART KINNER: I'd be happy to. I need to make sure I understand if I have any conflict of interest in my role as a JHREC member but that, notwithstanding, I'd be really happy to. I think, you know, more broadly it would be good for that to occur on an ongoing basis but even if it were to occur once to get a glimpse of what's going on under the hood, as it were, I think would be very helpful.

MR McAVOY: Certainly, what appears to be an absence of transparency is not consistent with a well functioning governance model?

PROF STUART KINNER: No. And, as I say, I think it's understandable for the Department to be cautious and to not just allow anybody in. But I think, with appropriate provisions, there should be a default position of supporting rather than blocking research. I think there should be transparent justifiable reasons for not supporting research.

A particular issue is that my group does a lot of data linkage. So combining administrative data rather than doing surveys. In those cases, the administrative burden on the Department is near zero. So I think that administrative impost is really decreasing as an excuse for not supporting research. I have had experiences where research has not been supported or it's been very difficult for research to proceed, even when it's being research of that sort.

COMMISSIONER WALTER: Professor Kinner, are you aware of any Aboriginal framed research projects that have been rejected or have not made it through the first committee?

PROF STUART KINNER: Unfortunately, because I have no knowledge of what's going to that committee, in my role at JHREC, I'm aware of Indigenous-led and Indigenous-focused research that has got to JHREC and has been supported. But I don't want to diverge from what the Counsel is asking me about but the challenges in getting the cultural capability of that JHREC committee where it needs to be is another issue.

MR McAVOY: Another aspect of a properly resourced health-based response, it appears from your outlines of evidence, is access to the full suite of health services. Professor Kinner, in particular, you've made comment about access for inmates to the Medicare Benefits Scheme, PBS and NDIS. Can you just speak about that for the Commissioners? We have heard evidence on that earlier this week, but I would like you to give your view.

PROF STUART KINNER: Sure. This is a long-term issue, and I think there's a whole lot of imperfect overlapping understandings and the lack of clarity and agreement on exactly what the issue is has been a big impediment to reform. So at the core of it is the fact that people in custody in Australia, in prisons and youth detention, are considered to be ineligible for Medicare and PBS subsidies and that's as a consequence of section 19(2) of the *Health Insurance Act* 1973 which basically precludes double-dipping. If somebody else is paying for it, then the Commonwealth funds don't apply.

Implicit then in that is the belief that the states and territories, including Victoria, are paying for that such that there is no need for the Commonwealth to chip in. And so that begs the question: what are they paying for and are they paying enough for it? Which goes to our question of opacity. A couple of years ago I had the opportunity to lead a national prison mental health benchmarking exercise where we, through the chief psychiatrist in every state and territory, collected data on the number of, importantly, therapeutic, not assessing risk of violence, but therapeutic mental health positions funded and filled in each state and territory.

We compared that to the only known international benchmark called the Sainsbury model, and what we found is, with the exception of the ACT, which is very small, every state and territory was funded at a level well below where it ought to be. So we knew this, that there was a woefully inadequate highly biomedically oriented response to mental health in custodial settings. Most states and territories, I think, were very keen to support this project because it was helping them demonstrate to their governments that they needed more funding to do their job well.

Unfortunately, after initially receiving the data from Victoria, via the chief psychiatrist, the Department of Justice and Community Services required that we withdraw those data, which we, of course, respectfully did, so we now have a national, except for Victoria, prison mental health benchmarking exercise.

MR McAVOY: I would ask if we could go to slide 4 of the statement of Dr Creati. Another aspect of a properly resourced health-based response is, of course, the assessment of needs, and this slide speaks very clearly to the need that is understood to be there. Can you just explain for the Commissioners what this slide shows?

DR MICK CREATI: Their data, which we generated from VAHS, we published this data, that data comes from a survey of 103 children seen at the Victorian Aboriginal Health Service over a two year period. 103 children in out-of-home care. And these were the rates of mental health and behavioural difficulties, and primary health care problems in that cohort of children in out-of-home care we saw at VAHS. We published that, I think, in 2019 in a Journal of Paediatrics and Child Health in Australia. So children from the age of one or two right up to the end of secondary school. The data is staggering, but not surprising in my experience. Massive rates of mental health, school difficulties, behavioural difficulties, developmental delays. So we generated that data by doing an audit retrospectively of the electronic files of our patients.

So, again, it shows the high rate of burden of disease. A lot of that's trauma - as a result of their trauma, as we've discussed. The primary health care ones are interesting and this data - so the hearing, vision, dental, out-of-home care. This is consistent with data in New South Wales. As children get moved around a lot, the carers don't have time to get to know them and say, "Oh, they have trouble hearing or they've got trouble with their vision." So these issues are missed and obviously very important because it affects their capacity to get to school and that puts them behind educationally, which we have seen it can be a driver into the justice system. So very high rates of primary health care and those other issues which are up there.

Again, we talked about the issues of getting access to these services. There are two things where we could go from here. One is the very high rates of developmental delay and

disability, which we now have a better system to support children with through the NDIS. I think the community service agencies are actually getting better at recognising the need of disability and supporting children through the NDIS.

I don't know how much you know about the NDIS system but between zero and seven-years-of-age, up to the age of seven you can get NDIS support for developmental delay. It does not have to be a permanent disability. Over the age of seven you have to have a permanent disability. Over the age of seven, if you've got low IQ, but not quite intellectual disability, you are not eligible generally. So it, again, emphasises the importance of that health check early when children get into out-of-home care to identify disability. There's another thing about data sharing and record sharing. I don't know if we are going to get on to that later --

MR McAVOY: Yes, if you'd like to speak to that now.

DR MICK CREATI: Yes. So, two anecdotes: working in youth justice, I saw children who had an intellectual disability but were quite verbal, known to child protection to have an intellectual disability. When you assess children in youth justice you don't have their parents or guardian there. So it wasn't flagged that these children had an intellectual disability coming in because there is no shareable health record.

So we are taking this young person's history on their health needs, not knowing you had an intellectual disability. He wasn't telling us about his trips to hospital or his - you know - and similarly in dealing with children in out-of-home care, I often see children from resi care who have brought in by the worker on the day, who's really like the Uber driver, who might be - and it's like sending your kids to the hospital for a health assessment with the Uber driver who doesn't know that child very well or only knows them two weeks, so making decisions about this child's health needs based on an incomplete history.

Child protection often have multiple reports, educational psychology reports, from previous CAMHS reports, previous psych reports, previous speech pathology reports, which may be in their system, maybe not, but I have no access to them when I'm assessing children at all unless I email and can find the child protection worker responsible, who then has to trudge through CRIS - I think they still use CRIS - to find reports, and then he may email them back to me but he doesn't really know the child.

So I have no access to previous assessments. So I haven't got - don't have an idea of where the kid's function is, what their past health record is, if they have come in from child protection, and I don't know what assessments they have had before. So I may be referring kids off for another mental health assessment where they have already spilled their story before and again that can re-traumatise.

COMMISSIONER WALTER: What's the point of having all these assessments if they are never collated and provided?

DR MICK CREATI: Thank you, Commissioner. Yes. Exactly. It's appalling. If I go and use my credit card in Timor, the bank will ring me up, because I'm a valued customer to the bank. I wonder what investment child protection has in these children. This has been a chronic long-term problem for many, many years. It was one of my recommendations to the Commission in Darwin and they did put some investment in a unit by a health record and a shareable health record. What I would like to see I've outlined - so the problem is clear:

these kids are - don't know the story, further traumatised and I'm making health decisions on inadequate data and possibly not getting --

COMMISSIONER WALTER: And there are reports probably that exist already?

DR MICK CREATI: Yes. Yes. Absolutely. I'm not even confident my assessment - the only way I can share my assessments with the CSOs and the residential team is to email them legally to child protection case manager because, if they are the guardian - legally I can only share information with the guardian but not the person - not the carer, legally. It's a mess.

So I would like to see some sort of system where a portal or something where I would have access to relevant documents, and I could upload my reports. I don't think with IT these days - you could probably get a grad student of the company to do it but it needs investment. It is a severe barrier to integrated services. Not only you don't get the best health service but I think it traumatises the children. I had one mother say - grandmother say her grandson had 30 assessments. I don't know if that's true but she was, "oh, not another assessment."

COMMISSIONER HUNTER: If I come to you as a mother and I'd had previous assessments of my daughter and I didn't give them to you but I sent the Uber driver to bring her down, would you class that as neglect, the guardian of that child?

DR MICK CREATI: Yes. Absolutely. Exactly. So as a parent of my child, I hold that story of my son going to the dentist, physio, has he broken his leg. The parents hold that story. But this system relies on people with very good intentions from VACCA, community service organisations, but they haven't got the - there's turnover, there's stress, there's leave, they are not consistent, the parents of children in residential care are youth workers up to the age of 30 on 12-hour shifts.

COMMISSIONER HUNTER: They would be our most vulnerable in case.

DR MICK CREATI: Yes. Absolutely. The more vulnerable you are, the further down the system you are because your placements have broken down, the less reliable - it's impossible to get to the story. Even - so I have to make another referral. They may have seen a dentist in Doncaster or something two weeks ago. The person that brings them in is the shift worker who doesn't know that, so I'm referring to dental. It is appalling and dangerous and inefficient and I think easily fixed with a portal - electronic solution because someone has to hold these stories.

I have had children in my nine years who have had four people they call mum. Mum may know the story for the last two weeks but she's not been given the story of this kid's asthma coming in. She doesn't know whether the kid's been to the dentist or not. There's massive fragmentation. Again, you can see the - that's why the primary health care issues get missed and that's why the mental health stories don't get shared and retraumatises it. That's why I don't get the school reports. I don't know if an educational needs analysis - every child in out-of-home care has to have an educational needs analysis on entering school, transitioning to secondary school, or changing schools. I don't know if they have been done.

I'm spending time emailing the case manager saying, "Can you check, you know, if an educational needs analysis has been done?" This is the day-to-day work of the health workers on the line, the paediatricians, and it is inefficient, at times dangerous, if you're looking at - I

don't know what the system in justice is now but if you're seeing a kid with an intellectual disability in justice and you don't know that kid has an intellectual disability and you are taking his word that he hasn't got diabetes, it's dangerous. Or asthma. It is dangerous, as well as inefficient, as well as traumatising, as well as stressful.

So if there was one recommendation for investment, I'm not sure I'm allowed to say that, it would be a shareable unified health record, which is accessible to registered people, who, either the manager from the CS - child protection don't case manage. Case management is done by the community service organisation, but shareable with them - maybe even shareable with the residential care workers. I'm making decisions on medication for kids' behaviour, anxiety, depression, with the Uber driver often, or ADHD. It's not best practice. If I can put it that way.

COMMISSIONER BELL: Does this exist with respect to children who are not Aboriginal?

DR MICK CREATI: Yes. Absolutely. It is any child in the child protection system, Aboriginal or not, there is no unified platform, process to share health records, educational records, mental health assessments. No. Aboriginal and non-Aboriginal kids in justice - I only see Aboriginal kids at VAHS, but it's the same for non-Aboriginal. It needs - yes.

MR McAVOY: Dr Creati, at the risk of over-personalising it, your role in this appears to affect you.

DR MICK CREATI: Yes.

MR McAVOY: So you and other paediatricians, people working in this area, have to figure out how to manage this system and that causes - must cause difficulties for the practitioners?

DR MICK CREATI: Yes. Look, to be honest, the most stressful thing for me is placement break down, which can be prevented. I find it enormously stressful and sad when children's placements are broken down for behavioural issues or school issues which could be better managed.

MR McAVOY: Thank you. I just wanted to raise with you both now the issue of intersectionality and the option, or the importance of having an educational lens or educational response to some of the breakdowns that we see for these kids and their families. It's often the case that kids who are caught up in the system then suffer through lack of access to education; that's correct?

PROF STUART KINNER: Yes.

MR McAVOY: And you are aware that there are some programs internationally that focus - have an educational response as opposed to say a health response as being the real focus of assistance for young people who engage in the criminal justice system?

PROF STUART KINNER: I think the "as opposed to" is the difficulty there. There's a common mistake that we make when we think about solutions to these problems, which is a system centric response, should it be a health or a justice system or education system issue. If we are thinking about the wellbeing of young people, who have educational and health needs and disability needs, we need to think about orienting a coordinated system around those

young people. I think it would be a mistake to say education rather than or as opposed to health but rather how can we have a coordinated response to this young person's various needs and achieve a best life out come as we can for them. I wouldn't encourage any kind of either or thinking about it.

DR MICK CREATI: I would agree with that. I don't want - like, there's quite a lot of debate in America about gun control, is it mental health or is it gun control. It is both. If you look at some really successful public health interventions in this country, they are on the back of lots of incremental changes, like smoking or road toll is a good example. You know, smoking, pricing, legislation, access, so on, so it's not one or the other. There is no silver bullet, we need to address - we know the drivers - we need to address each of those in proportion to the impact.

Road toll is the same - safer cars, seatbelts, speed limits, speed cameras, alcohol. There is not one or the other, Counsel, it is, as Professor Kinner was saying, about looking at what are the drivers and we know them. Aboriginal overinvolvement. Get the communities involved in the solution. School, you know, get support for schools. Child protection, why - they don't go in as criminals, they come out. All of those things. We talk about stability of placement and record sharing.

So I think that understanding the profile drives the interventions, and not causing damage by punitive responses by locking up young kids. So support and not further damage. Care, support and treatment, not punishment. This state has a vulnerability framework and we have a criminal framework. We need to design which one of those frameworks we are going to use.

MR McAVOY: Thank you. That concludes the questions I have, but I would like to offer each of you the opportunity to make any further observations, given that we haven't touched on all of the matters in each of your respective outlines. Professor Kinner?

PROF STUART KINNER: Thanks very much for the opportunity. Just building back on what Dr Creati was saying before, we need to recognise that criminal justice settings, prisons, youth detention centres, are a setting through which marginalised young people in our communities pass. It's a blip in their lives and the question is should they be there and, if they are, what do we do about it.

With respect, to take an example, Dr Creati's comments about information sharing and having a shared health record is a sensible solution to a problem that possibly shouldn't exist. The WHO, for more than a decade now, has been encouraging all countries to have health care in detention run by a Department of Health, not by a Department of Justice, for multiple reasons, but including continuity of information sharing.

Now, since the Royal Commission in the NT, responsibility for health care in Don Dale has shifted from the Department of Corrections, most recently to Danila Dilba Health Service, a community controlled health service, which, in my view, is a fantastic reform. That's the same service providing care for those young people in the community. Notably Danila Dilba cannot bulk bill for its healthcare in detention yet. That's a separate matter.

Over the same time period, when that terrific reform has happened in the NT, despite there having been a review of youth justice in Victoria, responsibility for health care in youth

detention here has moved from the Department of Health and Human Services to the Department of Justice and Community Safety and, most recently in, in my view, an appalling precedent in Australia, been out-sourced to a US based for-profit company that's been the subject of litigation for its quality of health care in detention on numerous occasions. So I see that in Victoria as a staggering case of regression, in the context of a parallel example of progress happening in another state, where there was a Royal Commission.

MR McAVOY: So the equivalent response in Victoria would be to enter into some arrangement with VAHS?

PROF STUART KINNER: VAHS and/or multiple community providers. Basically, yes, ACCHOs, the organisations that provide appropriate culturally capable care for these young people in the community are very well placed to provide that care particularly when we're talking about youth detention where the average time for those in remand, the majority, is eight days. Having a separate health service do intakes, do assessments and then discharge them after eight days, building on what Dr Creati has been talking about, just makes no sense.

MR McAVOY: Thank you. Dr Creati, are there any closing remarks you would like to make?

DR MICK CREATI: Children just don't end up in the justice system without a history and I think - or a journey - and I think we have many places to intervene. We have seen the drivers for children going into out-of-home care are parental, mental health, drug and alcohol, violence. So there is an opportunity to intervene there. Most children in this country who get removed get removed in their first year of life. They don't go into that system as criminals in their first year of life.

It's interesting to reflect our removal rates in Australia in the first year of life are four times out of Scandinavia. Why is that? They have got better parental support. So we have a risk averse child protection system, which protects children from their parents, essentially. You need to support parents to protect their children. I think we can put in much more support for parents to keep children within their families so they don't start in this journey.

Once they are on that journey, the child protection system is fragmented, and it further traumatises the children. Multiple placements we haven't really talked about. Often lost in this conversation is the support that carers need and we need to listen to carers, why are these children being relinquished. I hate that word. Similarly, the school system and, similarly, if they have problematic behaviour, how we understand that behaviour in terms of their development at a young age and how we assess and support children so we can put in interventions to support them and address those behavioural issues in a safe and culturally safe way.

Once they are in the justice system, there are health issues, but that should be a flag for further assessment and support, at least further intergenerational disadvantage. They are more likely to go into the adult system. So I would see - I wrote down. Yes. I think the mental health support to me - if we were looking at investment, that's the health record and sharing stories, because they are not shared, and it further traumatises children. And mental health support for the young people, because I cannot get the support these kids need. Thank you.

MR McAVOY: Thank you. Commissioners, are there any questions?

COMMISSIONER HUNTER: I have one for Dr Creati. So the children are being brought into care, children are being removed from their families, do you see the issue for them being removed being resolved whilst the children - or being dealt with - while the children are in care?

DR MICK CREATI: Not really. The parental support, you mean?

COMMISSIONER HUNTER: Yes.

DR MICK CREATI: Sometimes. But not always. I think there are some very good child protection workers who will look at that. Child protection always go in, I hope, with a lens of family reunification, if possible. So a good worker will support - will encourage or support getting support for the family's parents, but not universal. I am not sure that the parents or carers always get culturally appropriate support, because VACCA will do it - once you are 18, you are maybe not eligible for all the programs, but you could be if your child is not with you, I'm not sure --

COMMISSIONER HUNTER: That's a really good point, do you have to be in the system to get these supports?

DR MICK CREATI: I don't know. I can't answer that. I think that really would be appropriate work for the Commission to look at. Most kids don't get - a lot of kids don't ever get back to families. Again, because I don't have access to data, I'm relying on the Uber driver often to tell me what's happening or the - I shouldn't use that word, sorry - I'm relying on the person who brings the child in, who may not know the whole story and I've not got access to the story.

COMMISSIONER HUNTER: I do have one more question I wrote down earlier but I think you have answered it. You spoke about the trauma of removal from home. Is that trauma of removal addressed while the child is in care, I think you spoke to --

DR MICK CREATI: Yes. Not necessarily. I mean, stability does help trauma. I'm not even sure that carers who are non-Aboriginal even understand the impact of intergenerational trauma on children. I have had to talk to carers. This child is acting out because of attachment issues, he's had three placements, just sit with a behaviourist. Don't confront - even at that carer level - we've talked a bit that parents are the most important carers and therapists really for children in their care - I'm not sure all carers, like I said, let's have the understanding of how to manage children who have had a trauma history, and if they could manage the trauma and see it as trauma-informed behaviour rather than relinquish a placement, that child may be more stable, less traumatising. So no, Commissioner, is the answer to your question.

COMMISSIONER HUNTER: Thank you. I just want to thank you for highlighting the issue of when - I don't think we have ever really looked at when people leave custodial settings what that looks like. So that would be really interesting for the Commission to look at. So thank you for that evidence.

COMMISSIONER WALTER: Thank you.

COMMISSIONER BELL: Nothing from me. Thank you.

MR McAVOY: Thank you, Commissioners. I tender the outline of evidence of Professor Stuart Kinner, that's document 9.1, and the outline of evidence of Dr Mick Creati, and that's document 9.2.

CHAIR: Those documents will be allocated the next exhibit numbers.

<EXHIBIT 2.27 PROFESSOR STUART KINNER OUTLINE OF EVIDENCE

<EXHIBIT 2.28 DR MICK CREATI OUTLINE OF EVIDENCE

MR McAVOY: Thank you. That concludes the witnesses for the Commission today and the witnesses, Dr Creati and Professor Kinner, might be released. If there is no other administrative matters, the Commission can adjourn to the next sitting.

<THE WITNESSES WITHDREW

CHAIR: Thank you. I will just make a couple of comments for the closing of this session, if that's okay. This concludes this set of hearings on child protection and criminal justice system, and we have heard from experts, community organisations, service providers, professionals, advocates and allies. These witnesses have provided context on the current situation, shared observations, proposed solutions, many have shared deeply personal stories, and I hear the anguish in the voices of many that have come before us.

This is traumatic, of course, for those who are giving their stories to us but these contributions are foundational to the work of the Yoorrook Justice Commission in order for us to have evidence to enable the kinds of changes that we think should happen in this space. Finally, I would like to thank everybody who has been part of this block of hearings. I thank Counsel, KWM, Yoorrook Justice staff, the witnesses who have come before, all giving us their evidence in such a gracious way.

I would like to thank everybody who has been watching, people who have been on the livestream, and just to say thanks again to staff, Counsel and the Yoorrook Justice Commission team that's supported this, and people who have come and watched with us in the hearings as well. So thank you all. This hearing of the Yoorrook Justice Commission is now closed.

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