Royal Commission
into Violence, Abuse, Neglect and Exploitation
of People with Disability

Research **Report**

Care criminalisation of children with disability in child protection systems

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List of Acronyms

Acronym	Meaning
ACCO	Aboriginal Community Controlled Organisation
ACT	Australian Capital Territory
ADD	Attention Deficit Disorder[1]
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
ATSI	Aboriginal and/or Torres Strait Islander
BSP	Behaviour Support Plan
CALD	Culturally and linguistically diverse
CD	Conduct Disorder
CP	Child Protection (statutory service)
CSO	Child Safety Officer
CYPS	Child and youth Protective Services
DJS	Disability Justice Service
FASD	Foetal Alcohol Spectrum Disorder
FIFO	Fly-in-fly-out
ID	Intellectual Disability
IQ	Intelligence Quotient
JJ	Juvenile Justice
MACCSF	Multi-Agency Community and Child Safety Framework
MACNI	Multiple and Complex Needs Initiative
MOU	Memorandum of Understanding
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation

1 We acknowledge that ADD is no longer considered a unique medical diagnosis (e.g., within the DSM-V), however this terminology is included where raised by research participants.

Acronym	Meaning
NSW	New South Wales
NT	Northern Territory
ODD	Oppositional Defiant Disorder
OOHC	Out-of-Home Care, comprising kinship, foster and residential care settings
PBSP	Positive Behaviour Support Plan
PSG	Program Support Group
PTSD	Post Traumatic Stress Disorder
SA	South Australia
SSG	Student Support Group
TAS	Tasmania
TRC	Therapeutic Residential Care
QLD	Queensland
VIC	Victoria
WA	Western Australia
YJ	Youth Justice (statutory service)
YPECN	Young People with Complex Care Needs

Executive Summary

Though it has been long known that children in child protection systems face a higher risk of becoming criminalised,[1] few studies, particularly in Australia, have focused on children with disability at the intersection of the child protection and youth justice systems. These are important relationships to examine, particularly as we know people who have contact with child protection systems often experience worse outcomes in youth and adult justice systems. We also know that there are many children with disability across child protection,[2] youth,[3] and adult[4] criminal justice systems. 'Crossover' or 'dual system' children who experience contact with child protection and youth justice systems tend to experience contact with youth justice systems at younger ages, are more likely to return to the justice system, and are also more likely to enter the adult criminal justice system.[5] We also know that the criminalisation of children in child protection systems is a key pathway leading people of Aboriginal and/or Torres Strait Islander background,[6] females,[7] and people with disability[8] to enter criminal justice systems in Australia. Improving our understanding, and ability to prevent and respond to these pathways is important for improving the life outcomes of children in child protection systems. Additionally, addressing disadvantage for children with multiple overlapping needs in these systems is important for dealing with ongoing inequalities, neglect, and abuse experienced by people with disability in Australia.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (The Disability Royal Commission) commissioned this research to improve understanding of the pathways that lead children with disability from their contact with child protection system to entering the criminal justice system. The research also looked at how effective interventions were that tried to prevent these pathways to the justice system for children with disability in child protection systems. This is the largest Australian study so far to focus attention on children with overlapping experiences of child protection involvement, disability, and criminalisation. It also focused on the experiences of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children who have these overlapping experiences.

Research aims. This study aimed to:

1. Identify risk and protective factors for justice-system entry among children with disability who have child protection system contact;
2. Examine the effectiveness of current policy and practice in child protection systems for preventing and reducing justice system contact by children with disability; and,
3. Identify any interventions, programs or models that can prevent justice-system involvement of children with disability in child protection systems, and any barriers to these being implemented;
4. Focus on the experiences and needs of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children with disability in addressing 1-3.

Approach. The overall study included four research elements:

- **Scoping Review:** a scoping review of the available research was undertaken to find out what was already known in this area across Australia and internationally;
- **Policy Review:** a review of policies across Australian states and territories was conducted, to look at current approaches to preventing and addressing justice system involvement for children with child protection system contact;
- **Survey of Professionals:** an online survey of 73 professionals who work with children with disability in child protection systems was completed to gather their observations of current policies and practices related to preventing the justice system involvement of children with disability in child protection systems;
- **Consultations with Professionals:** individual and group interviews with 19 professionals who worked in Aboriginal Community Controlled Organisations and organisations supporting culturally and linguistically diverse children across three Australian states and territories were completed, to better understand the unique needs and experiences of this group of children.

Key Findings

Research Question 1: Risk and protective factors for criminal justice involvement of children with disability in child protection systems

The research available, particularly in Australia, was insufficient to allow us to identify formal risk and protective factors. Instead, we looked at factors understood to be associated with increased and decreased chances of children with disability in child protection systems being arrested or entering the justice system, which are outlined in the table below.[9] These factors should be viewed with interest, but carefully, because the approach used to identify these factors included anecdotal observation by research participants, as well as those proven by more scientific studies.

Factors **followed by an asterisk** were identified in both the scoping review and by the professionals who were involved in the current study, which shows they are also seen to be important in the Australian context. Factors **highlighted in bold text** were raised by professionals in the current study, but had not been raised in the research included in the scoping review.

Factors associated with increased and decreased chance of criminalisation of children with disability in child protection systems

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Individual	• Male gender • Aboriginal and/or Torres Strait Islander children* • Maltreatment factors: exposure to family violence, neglect, physical abuse, other/mixed abuse, maltreatment that continues • Intersectional/compounding factors: e.g., exposure to family violence at certain ages + presence of conduct disorder • Specific disability diagnoses* and more complex/ multiple disability diagnoses • Lack of diagnosis, underdiagnosis, and delayed diagnosis of disability* • Substance use* • **Lack of connection to culture**	• Type of disability, e.g., children with a physical disability less likely to be criminalised* • Female gender • **Connection to culture** • **Being located in a metropolitan area**
Familial	• Familial criminal justice involvement* • Lower family resources/socioeconomic status* • Lower familial support to children* • **Parental disability and/or complex needs**	• Higher parental level of education

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Environmental	• Residing in lower socioeconomic status neighbourhoods* • Having justice-involved peers*	• Residing in higher socioeconomic status neighbourhoods* • **Prosocial peers** • **Prosocial mentors** • **Prosocial activities**
Systemic: Child protection system	Entry of children with disability to out-of-home care: • Entry to out-of-home care* • Entry to residential care* • Placement in care for behavioural reasons* Systemic neglect of children in out-of-home care: • Vulnerability to criminal exploitation • Vulnerability to peer pressure in OOHC/poor placement matching* • Lack of support on transition from out-of-home care* **Systemic issues in leading to service disruption:** • **Staff turnover** • **Poor engagement with culturally and racially-diverse children and families** • Lack of support on transition from out-of-home care*	• Provision of intensive family support services* • **Children remaining with family** • Placement in care for reasons of abuse/neglect (as opposed to child behavioural reasons), • Placement stability in out-of-home care* • Residential care: detailed assessment, effective care teams*, specialist therapeutic placement*, placement routine & stability*, reduced client numbers, enhanced matching of co-residents, increased staffing, reduced staff rotation, and disability expertise*. • **Placement with siblings or kin** • **Supporting connection to culture and community**

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Systemic: Disability, mental & behavioural health systems & services	Insufficient appropriate therapeutic and support services (disability, behavioural and mental health)*, including: • Lack of preventative* or early intervention services * • Geographic disparities in service availability * • Lack of culturally appropriate care and therapeutic services for Aboriginal and/or Torres Strait Islander peoples and some ethnic and cultural groups* • Lack of disability-informed care and therapeutic approaches* • **Lack of integration between youth and adult service systems for youth transitioning from out-of-home care**	• Mental health service provision* • Alcohol and other drug service provision; • Earlier disability assessment*
Systemic: Education system	• School exclusion* • **Punitive approaches to behavioural manifestations of disability** • **Lack of disability and language support**	• Earlier disability assessment (e.g., targeting educational needs)* • **Providing educational supports** • **Maintaining educational engagement**

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Systemic: Justice system (including police)	• **Poor police and justice system understanding of impact of disability including complex trauma on behaviour** • **Racial profiling**	• **Police education and training on disability including trauma & impacts on children's behaviour**
Systemic: Cross-systems/ other systems	• Supports during the transition from care for children with disability +/- justice system involvement* • Poor service integration across sectors (including collaboration and capacity to move between services as required)* • **Lack of culturally appropriate services and approaches (institutional neglect)** • **Lack of disability-and trauma informed services and approaches (institutional neglect)** • **Institutional racism (institutional violence)**	• Long-term mentoring* • Service/systems collaboration and integration* • **Provision of culturally-appropriate services** • **Provision of disability and trauma-informed services**
Structural	• **Cultural conceptions of disability** • **Stigma and discrimination related to disability (structural violence)** • **Racial discrimination (structural violence)**	

The professionals in this study agreed with the research presented in the scoping review,[10] including finding that neurodisability and complex trauma were the most common disabilities seen among children in child protection systems who experience criminalisation. The research question also asked which risk and protective factors particularly impact Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse (CALD) children, a key research gap identified in the scoping review. We began to address this gap using the survey and consultations with professionals, a critical contribution of this study. The findings suggest that it is important to look at multiple factors at the same time (to use an "intersectional lens") to understand why culturally and racially diverse children with disability in child protection systems are more likely to be criminalised. An intersectional lens best helps us to understand the impact of compounding factors on the likelihood of criminalisation of culturally and racially diverse children with disability in child protection systems, including:

- The cultural views and beliefs around disability held across Aboriginal and Torres Strait Islander and other racially and culturally diverse communities, which might be different to those of disability and mental health services, child protection services, and other service providers;
- The unique barriers to accessing service, and the different service system experiences, of people from different cultural and racial backgrounds. This includes different experiences of having contact with child protection, justice and education systems, or trying to access disability, mental and behavioural health services;
- The impact of broader factors such as past and ongoing experiences of colonisation, trauma, racism, and discrimination - on the experiences of culturally and racially diverse children with disability and their families involved in child protection systems; and
- The value of culturally-led and culturally-appropriate programs to provide culturally safe and accessible services for Aboriginal and/or Torres Strait Islander and CALD children with disability and their families in child protection systems.

The research findings suggest that culturally and racially diverse children and families are more safely able to work with Aboriginal and/or Torres Strait Islander and CALD-led services and programs. In addition, it seems important for mainstream services such child protection and education systems to appreciate that children and families often have multiple overlapping needs related to disability, child protection involvement, and culture.

While the findings of the professional consultations demonstrated a rightful acknowledgement and critical commentary on the impact of structural racism on children's outcomes, particularly in reference to culturally and racially diverse children, there was little to no acknowledgement of the impact of structural ableism. Similarly, within various Commonwealth and state policy frameworks, there is an increasing appreciation the importance of cultural competence in attaining just outcomes for children, even if the evidence indicates little progress in implementing cultural responsiveness into practice. Contrastingly, the disability experience remains elusive to the various policy frameworks, which do not reflect a nuanced understanding of the structural factors contributing to disability exclusions, even in the rare instance when disability and structural ableism is referenced.

The invisibility of the disability experience within the system is reflective of the broader attitudes towards disability within the Australian community, in which disability is viewed at best patronisingly, but more likely and awkward topic of discussion. This social positioning of disability emerged in this study through the testimonies of the participants from the community sector who spoke of a narrative of shame and avoidance when it comes to children with disability. Paradoxically, this is a narrative that is formed by the system and its actors, rather than people with disability themselves. The default in being spoken of, rather than spoken by, paradoxically sustains the trajectory of progressive marginalisation on which children with disability find themselves.

Previous research focusing on children at the nexus of child protection and youth justice systems shows that almost all of these children have contact with the child protection system before they have contact with the youth justice system.[11] This means that supporting children and families early, through early intervention, assessment, and support, is an essential task for child protection, child and family services, and other universal services like education and health.

Research Question 2: Evidence base for interventions, programs and models for preventing children's criminalisation

No interventions, programs or models that target children with disability in child protection systems and try to prevent their criminalisation were identified by the study. Study findings suggested that some interventions and programs could be helpful for reducing the criminalisation of children with disability in child protection systems, but that these would need to be further evaluated by future research:

- **Intensive family-centred support approaches:** including culturally appropriate models, which seek to keep children with family and prevent entry to out-of-home care. For Aboriginal and Torres Strait Islander and CALD children, these approaches may be better delivered through ACCOs or CALD-specific services, given the identified barriers to safe and effective relationships between these communities and child protection services;
- **Early disability assessment and intervention:** for Aboriginal and Torres Strait Islander and CALD children, this may be better delivered through ACCOs, CALD-specific services or school settings; and
- **Culturally, disability and trauma-sensitive and informed responses across all sectors.**

Research Question 3: Effectiveness of current child protection policies and practices for preventing criminalisation of children with disability

The policy review found six policy and practice approaches across Australia which aim to lessen the criminalisation of child protection-involved children with disability,[12] including:

- Joint protocols and practice guidelines between child protection, youth justice and disability services

- Child protection policy aimed at supporting children with harmful or problematic sexualised behaviours
- Joint residential care policies aimed at preventing the criminalisation of children at risk of justice system involvement
- Policy and practice guidance for responding to children in out-of-home care with behavioural difficulties and complex needs
- Child protection and Department of Education policy focused on school exclusion, suspension, and expulsion
- Multi-disciplinary practice policies and panels that include child protection and youth justice and/or disability

The policy review identified many inconsistencies across states and territories in policies and practices, and also found that most policies (except for joint protocols) only apply to children in out-of-home or residential care, rather than all child protection-involved children. While research shows many criminalised children in child protection systems have a neurodisability, the policies tend to focus on the impact of trauma on children's behaviour, with less attention to how other disabilities might influence children's needs and behaviours. More policy and practice guidance about how child protection, out-of-home care, and other staff can support children with disability or suspected disability would be helpful.

The policy review also found many of the policies and practices have not been evaluated. Other research has suggested that Australian policies, including joint practice protocols[13] and policies aiming to reduce criminalisation of children in residential care,[14] are often not properly understood, supported, or implemented. While research from England demonstrates the effectiveness of protocols aimed at reducing the criminalisation of children in out-of-home care,[15] this research does not pay attention to children with disability, and no similar Australian evaluations could be found. Other Australian and UK research presents a more critical view of these policies, showing how inconsistently they are implemented and followed. This research also found that these policies need to be accompanied by training and support for residential care staff, and strategies to shift attitudes (e.g., of police, residential care staff and the broader public) towards children in residential care, and to encourage collaboration between agencies supporting children with disability in child protection systems who are at risk of, or who experience, criminalisation.[16]

Finally, the policy review also identified a lack of attention to CALD children, and a lack of detail regarding supporting Aboriginal and Torres Strait Islander children. Findings of the survey and consultations with professionals suggested that barriers to working effectively with Aboriginal and/or Torres Strait Islander and CALD families in child protection systems often meant that children with disability from these backgrounds entered out-of-home care. A clear policy and practice gap is understanding what evidence-based early interventions can minimise the pathway to criminalisation for children with disability involved with child protection, but who are still in parental care. Finally, findings from professionals suggest that current policies and

practices, not just in child protection but across multiple systems including education and justice services, seem to enhance, rather than decrease the risk of criminalisation of children with disability in child protection systems. Consideration of the findings of the scoping and policy reviews, together with the findings of the survey and consultations with professionals, gave rise to the following evidence-informed policy and practice recommendations in the Australian context for preventing and reducing the criminalisation of children with disability in child protection systems:

1. **That the Commonwealth Department of Social Services in partnership with the Secretariat of National Aboriginal and Islander Child Care (SNAICC), the First Peoples Disability Network and other relevant stakeholders develop national policy guidance to reduce the criminalisation of children with disability in child protection systems.**
2. **That states and territories ensure the availability of intensive family support services for families of children with disability to optimise their capacity to remain safely at home.**
3. **That states and territories should each develop and implement policy between child protection and education departments that seeks to maximise school engagement of children with disability in child protection systems.**
4. **That states and territories should ensure the availability of intensive kinship and foster care support options for children with disability.**
5. **That states and territories should ensure that all residential out-of-home care funded by child protection departments is therapeutic, and able to meet the needs of children with complex disability-related needs.**
6. **That states and territories each develop and implement protocols between residential out-of-home care providers and police which seek to minimise the criminalisation of children in residential care.**
7. **That states and territories ensure the availability of multidisciplinary therapeutic or healing services to children with disability in child protection systems.**

This study recommends that the Commonwealth, States and Territories commit to a National Inclusion framework to provide policy cohesion in this area, embodying principles that:

- centre the voice of children with disability;
- are conversant the disability experience and the impact of ableism; and
- reflect awareness of the intersectional and compounding marginalisation experienced by Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse peoples.

Research Question 4: Barriers to implementation of evidence-based practice within the child protection system

What evidence-based practice in preventing the criminalisation of children with disability in child protection systems should look like has not been properly identified. At the same time, evidence-informed practice can be thought of as approaches which address the factors understood to promote criminalisation, and support the factors understood to prevent criminalisation of this group of children. Based on the study findings, key areas where evidence-informed practice appears inconsistent relate to:

- Lack of early diagnosis of disability;
- Lack of effective/appropriate therapeutic supports to children and families;
- Inadequate engagement with and support for families engaged with child protection to enable them to safely care for children with disability and prevent entry to out-of-home care;
- Provision of safe, appropriate, and non-criminalising out-of-home care placements for children with disability.

The study findings suggested that barriers to implementing evidence-informed practice in these areas include:

- **Child protection and other systems' incapacity to engage effectively with children and families:** particularly parents with complex support needs, Aboriginal and Torres Strait Islander and CALD parents and families. Future research should look at whether failure to support families of children with disability might be contributing to intergenerational child protection involvement, including due to parents needing to relinquish children with complex disability-related support needs that they are unable to meet.
- **Lack of appropriate out-of-home care placements:** particularly those which are disability and trauma informed (including the possibility of disability-specific residential care), and culturally appropriate.
- **Lack of accessible and appropriate disability assessments:** The high prevalence of suspected and undiagnosed disability among criminalised children in the child protection system suggests that there is a lack of accessible disability assessments for this group. Many barriers to disability assessment were identified in the current study, including waiting times, a lack of culturally appropriate assessment practices, unclear referral pathways, assessment pathways reliant on child protection services, financial barriers, and geographic inaccessibility.
- **Lack of accessible and appropriate therapeutic services:** this is particularly the case for children living with complex/developmental trauma and/or neurodisability, highlighted in this study as the most common disabilities observed among criminalised children in child protection systems. There is still a lack of consistent understanding, response, and support across multiple systems for children with these disabilities in child protection systems.

> Children may not meet the threshold for therapeutic services, can be refused psychosocial support from the NDIS, can be labelled as having 'behavioural issues' and refused services from mental health systems, and can experience punishing responses in school, family, and out-of-home care settings. This sets up the justice system as the only system responding to children with these needs. Preventing the criminalisation of children with disability in child protection systems requires access to therapeutic supports that are not too costly or too far away, and that are culturally appropriate, and funded at sufficient duration and intensity to meet children's therapeutic needs.

The above shortcomings point to systemic neglect of children with disability in child protection systems that too often results in devastating outcomes, including criminalisation of this group of children. While the research question asked for a focus on barriers to effective *child protection* policy and practice, the findings indicate that many external factors contribute to the criminalisation of children with disability in child protection systems. An important factor is the generally punitive responses to disability, particularly where disability causes children difficulties with emotional and behavioural regulation. Reliance on punitive responses to these impacts of disability is seen in educational contexts, to behaviours seen as adolescent family violence, and in out-of-home care settings. Punitive responses are exacerbated by a lack of understanding and responsiveness by police and justice systems to children with disability in child protection, as well as the low age of criminal responsibility across much of Australia (10 years), which results in children with disability in child protection systems being criminalised at ages far younger than recommended by international standards.[17] Research consistently demonstrates that the youngest children in the justice system are most often Aboriginal and/or Torres Strait Islander children, those with disability, and those who are involved in child protection systems.[18]

Future Research

Suggestions for much-needed future research in this field are highlighted, including:

- Evaluation of proposed risk and protective factors for criminalisation of children with disability in child protection systems;
- Ascertaining prevalence of diverse disabilities among criminalised children in child protection systems, including complex/developmental trauma, neurodisability, sensory and physical disability;
- Examining additive or interactional effects of disability, race/ethnicity, and gender on the risk of criminalisation of children with disability in child protection systems; and
- Identifying and evaluating effective models, interventions, policies and practices for preventing the criminalisation of children with disability in child protection systems.

Finally, future research could also address the following questions:

- Which disability-related assessments are provided to which child protection-involved children, and when?
- What therapeutic support is provided to which children with disability in child protection systems? How does access to therapeutic support vary by other characteristics of this group (e.g., age, race/ethnicity, gender, geographic location, nature of child protection involvement, nature of disability, and complexity of need)?
- What is the impact of provision of therapeutic supports on the likelihood of criminalisation of children with disability in child protection systems?
- What is the impact of stigmatisation of disability on the access to disability services and other interventions to decrease the likelihood of criminalisation, with an emphasis on Aboriginal and/or Torres Strait Islander children and other cultural groups?

One response to the structural ableism and marginalisation to which children with disability in child protection systems are subjected is enable them to declare their voice in their own right. Advancing the voices for children with disability in child protection systems involves a long-term process to respectful attend to complex array of ethical considerations that was beyond the scope of this particular study. The Disability Royal Commission, along with studies such as these, should be a platform to give impetus to more expansive, intergenerational work on addressing the structural barriers to the exclusion and criminalisation of disability among children in child protection systems.

1. Study Introduction and Overview

Even though it has been long known that children in child protection systems face a higher risk of being criminalised,[19] few studies, particularly in Australia, have focused on children with disability at the intersection of the child protection and youth justice systems. These are important relationships to examine, especially because we know people who have contact with child protection systems often experience worse outcomes in youth and adult justice systems. We also know that there are many children with disability across child protection,[20] youth,[21] and adult[22] criminal justice systems. 'Crossover' or 'dual system' children who have contact with child protection and youth justice systems tend to experience contact with youth justice systems at younger ages, are more likely to return to the justice system, and are also more likely to enter the adult criminal justice system compared with other justice-involved children.[23] We also know that the criminalisation of children in child protection systems is a key pathway leading people of Aboriginal and/or Torres Strait Islander background,[24] females,[25] and people with disability[26] to enter the criminal justice system in Australia. Improving our understanding, and ability to prevent and respond to these pathways is important for improving the life outcomes of children in child protection systems. Additionally, addressing disadvantage for children with multiple overlapping needs in these systems is important for dealing with ongoing inequalities, neglect, and abuse experienced by people with disability across Australia.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (The Royal Commission) commissioned this research to improve understanding of the pathways that lead children with disability from their contact with the child protection system to entering the criminal justice system, and the effectiveness of interventions to prevent the criminalisation of this group. The criminalisation of child protection-involved youth with disability constitutes a critical pathway by which Aboriginal and/or Torres Strait Islander children and children with disability come to be involved in Australian youth and adult criminal justice systems. Better understanding, preventing, and disrupting these pathways is key to addressing the violence towards, and abuse, neglect, and exploitation of, criminalised people with disability in the community.

This project expands on the Royal Commission's work in Public Hearings 8, which explored the experiences of Aboriginal and/or Torres Strait Islander people with disability and their families in contact with child protection systems, and Public Hearing 11, which examined the experiences of people with cognitive disability in the criminal justice system. It also complements Public Hearing 16 on Aboriginal and/or Torres Strait Islander children with disability in out-of-home care (OOHC).

1.1 Study Research Objectives and Research Questions

The researchers were asked by the Disability Royal Commission to develop a study that addressed the following overall **objectives:**

1. Identify risk and protective factors for justice-system entry among children with disability who have child protection system contact;

2. Examine the effectiveness of current policy and practice in child protection systems for preventing and reducing justice system contact by children with disability; and,
3. Identify any interventions, programs or models that can prevent justice-system involvement of children with disability in child protection systems, and any barriers to these being implemented;
4. Focus on the experiences and needs of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children with disability in addressing 1-3.

The specific **research questions** proposed by the Disability Royal Commission to respond to the above objectives were as follows:

1. What are the risk and protective factors of criminal justice involvement among children with disability in child protection systems, particularly Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children? Where along the pathway do these risk and protective factors occur?
2. What is the evidence base for interventions, programs and models that prevent children with disability in child protection systems from becoming involved in the criminal justice system, particularly those targeting Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children?
3. To what extent are the current policies and practices of child protection systems effective in decriminalising and reducing criminal justice contact for children with disability, particularly Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children?
4. What are the barriers to implementation of evidence-based practice within the child protection system?

1.2 Definitions and Terminology

The definition of **disability** utilised for the purpose of this research was based on Commission's Terms of Reference, as outlined in the Interim Report of the Disability Royal Commission,[27] as follows:

> "…any kind of impairment, whether existing at birth or acquired through illness, accident or the ageing process, including cognitive impairment and physical, sensory, intellectual and psychosocial disability."

For the current study, this includes diagnoses and conditions such as complex/developmental trauma, attachment, mental and behavioural health difficulties, physical and sensory disability, as well as neurodisability including (but not limited to) intellectual disability, foetal alcohol spectrum disorder (FASD), attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD).

The definition of **child protection** utilised for the purpose of this research is inclusive of the entire non-statutory and statutory child protection system in each jurisdiction, including processes of intake, investigation, substantiation, formal court orders, and out-of-home care services.[28] The term **child protection-involved children** refers to children who are the subject of child protection notifications, substantiations, and statutory child protection court orders, including those which result in the child's placement in out-of-home care with kinship, foster or residential caregivers.[29] **Out-of-home care** in this report is defined as *"overnight care for children aged under 18 who are unable to live with their families due to child safety concerns. This includes placements approved by the department responsible for child protection for which there is ongoing case management and financial payment (including where a financial payment has been offered but has been declined by the carer). Out-of-home care includes legal (court-ordered) and voluntary placements, as well as placements made for the purpose of providing respite for parents and/or carers".*[30] It should be noted that out-of-home care excludes placements solely funded by disability, youth justice, psychiatric, or specialist homelessness services, and placements for young people aged over 18 years.[31]

The terms **criminalisation** and **justice system contact** in the report encompass any criminal justice system contact of children, inclusive of police arrest and charging, formal youth criminal court involvement, and statutory youth justice system involvement in community or custodial settings. **Youth justice involvement** refers to children's specific contact with statutory youth justice systems, for example, through bail, remand, and other community or custodial youth justice orders. **Crossover child/ren** in this report refers to any child protection-involved child who also experiences criminalisation, while **dually involved children** are a subgroup if crossover children who experience concurrent or simultaneous involvement with the child protection and youth justice systems.

The term **Aboriginal and/or Torres Strait Islander** children or peoples is used when referring to this population, except for direct quotes where research participants used alternative terminology (e.g., First Nations).

The terms **risk factors** and **protective factors** are used to reference factors that are associated with increased and decreased chances of a particular outcome, in this case the criminalisation of children with disability in child protection systems. We acknowledge that this terminology is contentious. Because risk and protective factors often focus on individual or familial characteristics, they are sometimes presumed to suggest these factors are *causing* the particular outcome of interest, and therefore blame individuals and families for outcomes that may be socially constructed, rather than focusing on systemic contributors. We therefore seek to emphasise from the outset that risk and protective factors identified in the current study are not suggested to be causal; rather they point to factors *linked* or *associated* with increased or decreased risk of criminalisation of children with disability in child protection systems. Identifying or understanding such factors can help us understand which children, families or environments may face a greater or lesser chance of a particular outcome. They do not, however, indicate the causal pathways, reasons, or mechanisms by which certain individuals, groups, or environments are associated with particular outcomes. This is an important distinction, which we look to highlight throughout the report.

Except when directly quoting research or policy literature, the terms **child** or **children** are used throughout this report to refer to children under the age of legal adulthood (18 years), while the term **young person** or **young people** references those aged 18-26 years, or a combination of children and young people aged under and over 18 years of age.

1.3 Study Approach

Given the timeframe of the project (9 months) the research team sought to adopt an approach which balanced methodological rigour and pragmatism. Drawing on their existing expertise, an approach was developed which would scope the available research and policy, and then seek to address any identified research gaps in this area within the available time and resource limitations. The overall study included four research elements:

- **Scoping Review:** a scoping review of the available research was undertaken to find out what was already known regarding the specific intersection of child protection, disability and children's criminalisation across Australia and internationally;
- **Policy Review:** a review of the policies in place across Australian states and territories was completed, to examine current approaches to preventing and addressing justice system involvement for children with child protection system contact;
- **Survey of Professionals:** an online survey of 73 professionals who work with children with disability in child protection systems was completed to gather their observations of current policies and practices related to preventing the justice system involvement of children with disability in child protection systems; and
- **Consultations with Professionals:** individual and group interviews with 19 professionals who worked in Aboriginal Community Controlled Organisations and organisations supporting culturally and linguistically diverse children across three Australian states and Territories were completed, to better understand the unique needs and experiences of this group of children.

A key advantage of the chosen approach was that the initial study elements (scoping and policy reviews) could inform the later study elements (survey and consultations with professionals), to address (where possible) gaps in the Australian knowledge base. A further benefit was that the scoping and policy Reviews could be undertaken while ethics approval for the survey and consultations with professionals was sought.

1.4 A Critical Note on the Study Framing and Limitations

As producers of research, it is incumbent on us to critically reflect on the context and approach within which this research is conducted. In the case of the current scoping and policy reviews, these are limited to identifying what is currently present in academic and policy arenas, fields which are often dominated by specific frameworks (e.g., medical/individualising as opposed to structural or social inclusion models of disability), and methodologies which typically privilege Western over other, e.g., Indigenous, knowledges. These limitations are reflected in much of the findings identified throughout Part 1 of the report.

The commissioned study asked the researchers to identify risk and protective factors for criminalisation of children with disability in child protection systems. Language of 'risk' and 'vulnerability' can often sanitise, medicalise, and disembody the lived experience of disability and systems involvement, and is associated with a tendency to represent deficit within individuals. Such language, models and frameworks may replicate the structural violence[32] and systemic neglect[33] which manoeuvre individuals with disability and child protection involvement into positions of vulnerability, and which increase their likelihood of criminalisation. As such, language of risk and vulnerability has been avoided throughout the report, except where directly describing specific policies or literature. Instead, we have adopted language of 'factors that are associated with increased or decreased likelihood of criminalisation' (or justice system contact) among children with disability in child protection systems. Similarly, there is a need to critically reflect on the terminology of 'crossover children', which can be mistakenly be associated with attribution of blame to individual children, deflecting attention from the historical, systemic and structural causes which contribute to their criminalisation. In the context of this report, this terminology references children who are currently or historically involved with child protection systems, and who become criminalised through arrest, court, or youth justice system involvement.

Another limitation inherent in scoping and policy review methodologies is the need to adopt medical terminology to locate the relevant literature and policies. These definitions and terminology of 'disability' default to a medical approach which is reliant on diagnosis, yet an absence of diagnosis in this cohort is a recurrent theme. While this approach provides a depth of understanding within the diagnostic categories highlighted in the literature and policies, these diagnoses tend to become knowledge silos, while the impact of the all too prevalent co-existing disabilities and social, systemic, and structural factors generating outcomes of criminalisation remain insufficiently delineated.

1.5 Report Structure

Part 1 of the Report presents:

- an executive summary of the scoping and policy reviews;
- approach to, and findings of the scoping review of the Australian and international literature related to the criminalisation of children with disability in child protection systems; and
- the review of publicly available Australian child protection policy and practice guidance that aims to reduce criminal justice contact of children with disability in child protection systems.

Part 2 of the Report presents:

- approach to, and findings of the survey and consultations with professionals; and
- the overall study findings addressing the research aims and questions set out by the Disability Royal Commission.

As outlined previously, the study intentionally triangulates multiple data sources and methodologies with a view to developing a holistic perspective concerning the nexus of child protection, disability and children's criminalisation.

Care criminalisation of children with disability in child protection systems

Part 1: Scoping and Policy Review

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2. Scoping and Policy Review Executive Summary

This section of the report presents summaries of the scoping and policy reviews undertaken within the study.

2.1 Scoping Review Summary

2.1.1 Aims

The scoping review aimed to identify and synthesise evidence from primary research studies published since the year 2000 that report on factors associated with increased or decreased likelihood of criminal justice involvement among children with disability in child protection systems. It also sought to describe the nature of disability, maltreatment and child protection involvement, criminalisation and offending behaviour, and service use among children with disability in child protection systems.

2.1.2 Approach

A search strategy including keywords relating to “youth” (e.g., child, adolescent), “child protection” (e.g. child welfare, foster care), “offending” (e.g. delinquency, crime) and “disability” (e.g. intellectual disability, trauma, behaviour regulation) was used to search three databases from the year 2000 to the search date (13th of November 2021). Title and abstract screening of 3447 publications identified 578 studies that were eligible for full-text screening, 88 of which were included in the review.

2.1.3 Sample characteristics

Most of the 88 included publications were journal articles (81%), and three quarters were published since the year 2010 (74%), suggesting a recent recognition of the importance of the intersection of disability, child protection, and children’s criminalisation. Most publications were from the US (68%), and most examined mental health (48%), neurodisability (10%) or both mental health and neurodisability (42%). The only other disability examined in the publications was hearing impairment, which was mentioned in three studies.

2.1.4 Key findings

Seven key themes were identified across studies: 1) Increased youth justice contact of child protection-involved children with disability; 2) Nature of offending and youth justice contact among child protection-involved children with disability; 3) Types of disability observed among child protection-involved children who become criminalised; 4) Diagnosis of disability among child protection-involved children, including those who become criminalised; 5) Factors which impact the likelihood of criminalisation of child protection-involved children with disability; 6) Pathways to criminalisation of child protection-involved children with disability; and 7) Access to mental and behavioural health services.

Increased Youth Justice contact of Child Protection-involved children with disability

In order to prevent and address the criminalisation of children with disability in child, it is important that the nature of disability among those children whose criminalisation child protection systems are failing to prevent is identified. Nineteen studies[34] (19.3%), including one Australian study,[35] identified a greater chance of youth justice involvement among child protection-involved youth with disability compared with those without disability. The chance of criminalisation was particularly heightened among child protection-involved children diagnosed with neurodisability (e.g. intellectual disability, learning disability, or ADHD)[36] or mental health disorders (e.g. mood disorder, attachment disorder, or conduct disorder).[37] Likewise, there is a greater likelihood of justice-system involvement for children in out-of-home care with disability, compared with children in these settings without disability.[38] There also appears to be a greater likelihood of justice system contact during the transition from out-of-home care for children with disability compared to their peers without disability.[39] Greater prevalence of disability is also seen among child protection-involved children in youth justice, compared with the broader justice-involved population.[40]

It is not only the presence, but the severity of disability and mental health diagnoses and experiences that are associated with justice-system contact for child protection-involved children.[41] Contact with mental health[42] and special education[43] services is also linked with increased chance of justice system contact for this group. Such findings do not imply that the services or disability themselves increased children's risk of justice system involvement, however the service responses applied appear to be ineffective at preventing children's criminalisation, and indeed may potentially serve to enhance criminalisation.

Nature of offending and Youth Justice contact of Child Protection-involved children with disability

Earlier justice system involvement. The likelihood of earlier justice system involvement seen among children with child protection system involvement is heightened for those with disability.[44] Two Australian[45] and three US[46] publications reported that a range of disabilities were found to be related to earlier justice system contact among child protection-involved children, particularly neurodisability (e.g., learning disability) and conditions including signs of impulsivity or aggression.[47]

Offending seriousness. US and Australian research shows mixed results about whether child protection-involved children with disabilities display more serious offending (including more violent or voluminous charges) than other children in the *justice* system.[48] However, US research found that child protection-involved youth with certain disabilities (e.g., ADHD) are more likely to experience arrest for violent offending compared to children in *child protection* without disabilities.[49]

Court outcomes. There is some evidence suggesting that the presence of mental health disorders impacts court outcomes for child protection-involved children, though much of this research is from the US.[50] However, Australian research has also found that children in out-of-home care were more likely to have their criminal matters dismissed under the *Mental Health (Forensic Provisions) Act 1990* (NSW)[2] than other children before the NSW criminal courts.[51]

Justice system reinvolvement. The combination of child protection involvement and disability is generally associated with children's greater likelihood of experiencing justice system reinvolvement, however there is a need to distinguish between different disabilities and/or signs of disability when considering how disability relates to children's re-involvement with the justice system. While one US study showed that having any mental health diagnosis is associated with higher levels of repeated justice system contact among child protection-involved children,[52] there is stronger evidence (albeit from the US) for the impact of behavioural disorders linked to aggression or impulsivity,[53] and learning disorders,[54] on repeated justice system contact in this group of children.

Types of disability observed among criminalised children in Child Protection systems

US-based studies demonstrate a significantly greater prevalence of signs and diagnoses of mental health challenges and neurodisability among criminalised children with child protection system involvement, relative to other justice-involved youth,[55] while two Victorian publications reported gender and regional differences in types and prevalence of disability among criminalised children with child protection system involvement.[56]

Neurodisability diagnoses. Compared with other justice-involved children, those involved with the child protection system experience greater prevalence of neurodisability, including intellectual disability, learning and communication disorders, ADHD and FASD.[57] It is notable that three of the five publications reporting this finding were conducted in Australian jurisdictions, including New South Wales, South Australia, and Victoria[3]. As with the broader population, multiple neurodisability diagnoses are common among criminalised children in the child protection system, as well as having co-occurring neurodisability and mental health diagnoses.[58]

A Victorian study of 300 children charged with offending, and who had child protection system involvement found that (48%) had a diagnosed neurodisability, commonly ADHD (29%), learning/communication disorders (23%), or intellectual disability (17%).[59] Neurodisability was more commonly diagnosed in males in this group, and some neurodisability (e.g., intellectual disability) was more prevalent among criminalised children with child protection involvement in regional areas compared with those in metropolitan areas.[60]

2 Note that this *Act* is now repealed.

3 All but Hodgdon (2009), and Corrado & McCuish (2016) were conducted in Australia.

Mental health diagnoses. Among US research, reported rates of mental health issues among criminalised children in child protection systems vary from 56% to 90%,[61] and having multiple mental health diagnoses is also common in this group. Similarly, a Victorian study of 300 criminalised children with the child protection system involvement found that 61% had been diagnosed with a mental health condition, including mood disorder (28%), behaviour disorder (20%), trauma or attachment-related disorder (19%), and 35% had a history of self-harm or suicidal ideation, which was more common among females.[62]

Compared to other justice-involved children, those with child protection involvement are more likely to experience mental health problems,[63] including signs of depression,[64] suicidal ideation and suicide attempts,[65] and mental health experiences such as internalising/externalising behaviour,[66] impulsivity, psychopathy, aggression, and emotional regulation difficulties.[67]

Diagnosis of disability among Child Protection-involved children

Lack of diagnosis and under diagnosis of disability (particularly mental health and neurodisability) is seen in the available research concerning criminalised children in child protection systems, all of which was conducted in Australia (specifically, New South Wales and Victoria).[68] This lack of diagnosis is attributed to several factors, including child protection difficulties engaging with families, children's transience and placement instability, difficulties accessing appropriate assessments, children's refusal to be assessed, and issues with the statutory definition of disability, which at times is not seen to capture the unique circumstances of criminalised children in child protection systems.[69] A lack of disability diagnosis facilitates the criminalisation of children's behaviours, and generates barriers to disseminating practice knowledge, and facilitating appropriate responses and service access for children with disability.[70]

Delayed assessments appear to increase children's chances of justice system contact, and a Victorian study found that for 30% of crossover children who were diagnosed with intellectual disability, the diagnosis was only made after their justice system involvement.[71] However, there are also concerns about whether diagnosis of criminalised children in child protection systems is made by sufficiently skilled professionals, the impact of diagnostic stigma on children, and concerns about the over-reliance on the medical model of disability and diagnosis, which both Australian and US research has found to result in criminalised children in child protection systems receiving multiple diagnostic revisions over time, depending on the professionals involved.[72]

Factors associated with the likelihood of criminalisation of Child Protection-involved children with disability

Individual factors.

Socio-demographic factors associated with greater likelihood of experiencing criminalisation among child protection-involved children with disability include male gender,[73] coming from a racial or ethnic minority background (specifically Aboriginal and Torres Strait Islander children in Australia,[74] and African American children in the US[75]), greater exposure to maltreatment[76] (including family violence)[77], and substance abuse.[78] It is important to note that these factors are not suggested to be causal, but may be indicators of additional disadvantage, marginalisation, disability, and traumatic experiences among child protection-involved children. For example, racial or ethnic minority background may reflect the intergenerational impact of colonisation, ongoing racial discrimination (of individual or systemic nature), or culturally inappropriate service provision. Likewise, Victorian research found that male gender was linked with nearly double the prevalence of neurodisability among criminalised children in child protection systems,[79] and substance abuse is understood to reflect self-medication of the psycho-emotional impact of traumatic experiences among child protection-involved children in both Victorian and US research.[80]

Family and peer factors

US research has found that family and peer factors associated with greater likelihood of criminalisation in this cohort included having a parent, sibling, or peers with justice system involvement,[81] coming from a family with lower socioeconomic resources,[82] and having lower levels of support from parents or caregivers.[83] Conversely, US research has found that higher levels of parental education appear protective against criminalisation of child protection-involved children with disability.[84] It may be the case that that higher education and socioeconomic levels of parents are associated with greater access to resources required to support children with disability.

Child Protection factors

Child protection factors related to a greater likelihood of criminalisation of children with disability include placement in out-of-home care (as opposed to intensive family support with the child remaining in the family home)[85], placement in care for non-maltreatment (e.g., behavioural) reasons,[86] placement instability,[87] and placement in residential care.[88] At the same time, child protection-involved children with disability appear more likely to be placed in out-of-home care[89] (particularly residential care)[90] than similar children without disability. Victorian research found that placement in out-of-home care may be due to relinquishment by parents, often with their own unmet support needs, and who are unsupported to manage children's disability needs.[91] This same Victorian research also found that children with disability also enter out-of-home care due to legalistic responses to adolescent family violence (e.g. intervention orders) resulting in exclusion from the home.[92] Conversely, child protection factors that appear protective against criminalisation of children with disability include intensive family support services,[93] placement in care for reasons of abuse/neglect (as opposed to behavioural reasons),[94] and placement stability.[95]

School and other support factors

US research has found that school exclusion increases the likelihood of criminalisation of child protection-involved children with disability.[96] While this same research suggests that children holding beliefs of the importance of education appear more protected against criminalisation,[97] this should be viewed with caution as it fails to consider the historical, systemic, and structural factors (e.g. racism, discrimination), that may contribute to children's views and experiences of educational systems. Service provision that appears protective against criminalisation of this cohort in US research includes long-term mentoring,[98] some mental health and substance abuse services,[99] and having an earlier age of first assessment for special education.[100]

Neighbourhood factors

Child protection-involved youth with disability who reside in neighbourhoods with greater structural degradation (e.g., abandoned homes) and higher levels of crime[101] appear more likely to be criminalised than child protection-involved youth with disability who reside in higher socioeconomic status neighbourhoods,[102] even when considered at high likelihood of experiencing justice system contact. Contributing factors to these outcomes may be the accessibility of disability services,[103] and the level of policing in different neighbourhoods.

Pathways to criminalisation of Child Protection-involved children with disability

Criminalisation of disability-related behaviour

- A common pathway to justice system-involvement of child protection-involved children strongly emphasised in, UK[104], Australian[105] and US[106] research is punitive and criminalising responses to disability-related behaviours, which may occur in the family home,[107] school,[108] and most commonly in out-of-home care (particularly residential care)[109] settings.
- Compared with other child protection-involved children who experience criminalisation, Victorian research found that children with behaviours responded to as adolescent family violence incidents (either in the family home or in out-of-home care settings) are more likely to have diagnoses of neurodevelopmental, mental and behavioural health disorders (e.g. ADHD, trauma/attachment-related disorders, conduct disorder), coupled with exposure to family violence and other forms of maltreatment;[110] service providers query whether criminalising responses to these behaviours are appropriate, noting these often lead to children being placed in residential care.[111]
- Australian and UK research emphasises that behaviours for which children can become criminalised in residential care, such as property damage, are often managed less punitively in other environments,[112] and children with disability (including neurodisability, mental health or behavioural disorders), are more likely to acquire such charges in residential care, compared with other children placed in residential care.[113]

- Victorian research found that children in child protection systems who have certain kinds of disability are more likely to be criminalised in residential care due to their greater likelihood of being placed in these environments compared with other children in out-of-home care (e.g., children with intellectual disability).[114] Other children with specific neurodisability are more likely to be criminalised than other children in residential care settings without neurodisability (e.g., children with ADHD).[115]
- According to Australian[116] and UK[117] research, drivers of criminalisation of children with disability in residential care include the use of police as a behaviour management tool in these settings,[118] coupled with a failure to recognise disability, or to factor in the impact of disability (e.g. neurodisability, trauma) on children's behaviour, or on decisions to involve police.[119] Policy frameworks, as well as staff experience, skill, training, and support each impact the criminalisation process.[120]
- Professionals in Australia[121] and the UK[122] (including police, magistrates, out-of-home care providers and youth justice professionals) hold a range of perspectives as to whether police responses to behavioural incidents in residential care are warranted or unwarranted.[123] At the same time, it seems children can be supported to regulate behaviour in residential care in non-criminalising ways, for example via detailed assessment, effective care teams, specialist therapeutic placements, culturally appropriate supports and environments, placement stability, reduced client numbers in placements, enhanced matching of co-residents, increased staffing, reduced staff rotation, and staff disability expertise.[124]

Vulnerability to peer pressure and criminal exploitation

UK research has suggested that the social environment of residential care may contribute to children with disability offending with residential care-placed peers inside and outside of these settings; specifically, this research suggests that children may feel pressured to engage in offending with their peers in residential care environments, and that refusal to do so could result in the danger of a child being lower on the "pecking order" in such environments, with consequent risk of social exclusion, bullying, or other victimisation.[125]. New South Wales[126] and Victorian[127] research also emphasised how the systemic neglect of child protection-involved children with disability (particularly children with cognitive impairments) renders them vulnerable to criminal exploitation by peers, older youth, and adults. Such systemic neglect may stem from failure to adequately supervise, provide stability and boundaries, and therapeutic services and settings for children in out-of-home care (particularly residential care) settings.[128]

The role of substance abuse in children's criminalisation

South Australian[129] and US[130] research has found substance abuse is associated with increased likelihood of criminalisation among child protection-involved children with disability.[131] Victorian[132] and US[133] research suggests that substance use in this cohort may be driven by self-medication as a response to trauma, which can escalate to addiction. Victorian research found that supply of illicit substances to child protection-involved children by adults in the general community appears to be a key component of criminal exploitation of this group (particularly children with a history of trauma and other disability), leading to the child's later offending to repay drug-related debts.[134]

Educational marginalisation and school exclusion

- As often critical precursors to children's criminalisation, educational marginalisation and school exclusion are examined in relation to criminalised children with disability in child protection systems. Attendance problems, academic challenges, school transience and grade retention of criminalised children with disabilities in child protection systems have been described in the US literature.[135] One US study found that 39% of criminalised children in child protection systems with emotional and behavioural disorders attended more than one school in an academic year, 59% were grade retained by grade 3, and 49% experienced multiple difficulties in areas such as reading, math and language.[136]
- Victorian and US research has found that many criminalised children with disability in child protection systems experience conduct problems at school, and those with trauma backgrounds and other disability are easily excluded from schools with zero-tolerance behaviour policies.[137] Victorian research also reported that escalation in children's school conduct problems often coincides with difficult life circumstances, including escalating family violence at home, child-parent relationship difficulties, entry or exit from out-of-home care, current abuse, and recent parental death.[138]
- Victorian[139] and US[140] research found that at least 28-36% of criminalised children in child protection systems experience school exclusion (suspension or expulsion). While more often first occurring in secondary school, the Victorian study found that at least 8% of this group of children had experienced school exclusion in their primary years.[141] Additional findings of this study were that school exclusion often occurs in the context of child protection-involved children's emotional and behavioural regulation challenges, and appears more common among males compared to females, and for child protection-involved children with disability, including those with learning and communication disorder, ADHD, trauma and attachment-related disorders, behavioural disorders, and children with any mental health diagnosis.[142]
- This Victorian study also reported that criminalised children in child protection systems can experience a secondary structural form of school exclusion - difficulties re-enrolling in school after being excluded or spending time in youth justice custody.[143] Some of the study's identified barriers to school re-enrolment relate to a systems-level neglect of children with disabilities, for instance, schools lacking appropriate programs to meet the child's disability-related needs, being unable to adhere to safety requirements for the child, being unable to subsidise the level of support required for the child, or the child being too young for the available alternative education options.[144]
- Finally, this Victorian study reported that more than one half of criminalised children in child protection systems engage in alternative education arrangements, including special education, one-to-one tutoring arrangements, and specialist education programs for children in out-of-home care, demonstrating a lack of suitability or capacity in mainstream schooling environments to meet the needs of this group of children.[145]

Other systemic challenges and barriers

Irish[146] and Victorian[147] research has identified barriers to service and systems collaboration for children with disability in child protection systems, including professionals' different conceptualisations of the behaviour and needs of children with disability, their differing frameworks for interventions, barriers to information sharing between services, and unrealistic expectations of other services. Broad systemic challenges identified by these studies also include a lack of appropriate resources to respond to children's support needs (e.g., suitable services or placements), service gatekeeping due to lack of resources, and geographic disparities in service availability.[148]

Access to mental and behavioural health services

Victorian research found at least 49% of criminalised children in child protection systems access mental or behavioural health services,[149] while US research found that 65-78% of criminalised children in child protection systems access mental or behavioural health services.[150] Lower service access was seen among crossover children who had been arrested or sampled from court environments (44-49%)[151] and higher levels were seen among crossover children who had been convicted of offending (67-78%).[152] Additionally, several US studies reported that the level of mental and behavioural service need among this group of children is often greater than the level of services received.[153] Additionally, US research concluded that the mental health treatment provided to child protection-involved and crossover youth appears ineffective for preventing youth justice system contact or reducing justice system reinvolvement.[154] A key service gap seems to exist during the mid-to late teenage years,[155] and causal links have been made between inadequate mental health service provision and children's trajectories, with justice responses being applied to fill gaps in mental health and disability service provision.[156] Additionally, the review found there were negligible studies of disability service access among crossover children aside from those examining mental health service access.

Factors affecting access to disability, mental and behavioural health services

Primarily US research has identified individual level factors that influence disability, mental and behavioural health service access including:

- children's sociodemographic characteristics such as gender, race/ethnicity, and younger age;[157]
- service system involvement, with criminalised children in institutional[158] and out-of-home care settings,[159] and those with longer child protection involvement experiencing more service access;[160] and
- disability-related factors, including New South Wales[161] and US[162] research which identifies children with a lack of diagnosis, children who do not identify as having a disability, and children with greater disability (including mental health) need and complexity being less likely to receive mental health services than other children in child protection systems with disability.

Service system factors

US research suggests that designation of single agency accountability for crossover children[163] and greater administrative data sharing[164] may increase children's likelihood of accessing appropriate mental health and disability services and reduce the unnecessary repetition of children's stories. More integrated systems support referrals to and between systems, provide opportunities for collaborative planning, and encourage the sharing and integration of expertise when working with child protection-involved children with disability.

Australian research suggests that professionals working with criminalised children with disability in child protection systems sometimes face difficulties reconciling ideas of justice system involvement and disability,[165] tending to view children as either having a disability (including mental health or trauma-related disability), or as being justice involved. Compartmentalisation is reinforced by administrative and funding systems in Australian jurisdictions which view these separately, ignoring the complexity of the relationship between justice involvement and disability, and leading to systems neglect of criminalised children with disability in child protection systems.[166] Australian research outlines how systems neglect can manifest as: a lack of care and protection afforded to child protection-involved children who become justice involved; a lack of appropriate disability and trauma-informed support to navigate the justice system (further propelling children's criminalisation); and, a lack of trauma and disability informed services, frameworks and professionals, leading criminalised children with disability in child protection systems to face barriers accessing appropriate services, and to lack safe spaces and relationships.[167]

Finally, gaps in available services are identified in US[168] and Australian[169] research, including a shortage of relevant services and assessments, often further compounded for children with placement instability[170]. US research also stresses the overuse of "crisis" service provision with this group of children,[171] while Australian research emphasises the lack of developmentally appropriate prevention, and disability-informed care and therapeutic approaches.[172] Gaps also arise through service disruption,[173] due to lack of continuity for children traversing multiple systems, those experiencing placement disruptions,[174] or those transitioning from out-of-home care in the Australian context.[175] Conversely, Australian research found that suitable services are seen to be flexible, to have capacity for outreach, to engage in ongoing assessment and treatment with children (rather than solely providing secondary consultation), and to work with children across multiple services systems, catchment areas, or age-groups.[176]

2.1.5 Research gaps

There are clear gaps in the existing research concerning the criminalisation of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children with disability in child protection systems, including those in out-of-home care (including residential care) settings. There are also minimal data related to gender differences in this area, and that includes the voices of children or families. Further, much of the available research at the specific nexus of child protection, disability and children's criminalisation focuses on risk, with limited attention

to protective factors that are associated with reduced criminalisation of this group. Additionally, there is insufficient research that can shed light on what other approaches, particularly non-service responses (e.g., informal support, cultural and community connectedness), child protection-involved families and children with disability find helpful for avoiding or reducing the likelihood of children's criminalisation.

2.2 Policy Review Summary

2.2.1 Aims

The policy review canvassed publicly available child protection policy and practice guidance from Australian jurisdictions that aim to reduce criminal justice contact of children with disability in child protection systems. The policy aim of reducing criminal justice system contact of children with disability in child protection systems was interpreted broadly as policies that addressed behaviour that could potentially be criminalised, and where the policy mentioned disability as defined in the current study. Policies addressing school exclusion among children in child protection systems were included at the request of the Disability Royal Commission, following the emergence of school exclusion as a key factor contributing to the criminalisation of child protection-involved children with a disability in the scoping review.

2.2.2 Approach

In Australia, individual states and territories are responsible for the administration and operation of child protection services. This review used Google searches to locate relevant Australian child protection policy and practice guidance using key terms including: "child protection manual", "child protection guide" and "child protection practice framework". Further Google searches were conducted to locate relevant joint child protection policies such as memoranda of understanding (MOU) in each jurisdiction employing key search terms such as: "MOU, "joint protocol", "youth justice", "residential care", "out of home care", "reduce criminalisation" and "Department of Education". Once relevant and publicly available policies were identified, further Google and Google Scholar searches were conducted including the name of the policy and key words ("Review"/ "Evaluation") to locate formal or informal evidence of policy effectiveness.

2.2.3 Key findings

The policy review presents six key areas of child protection policy in Australian contexts that aim to reduce the criminal justice system contact of children with disability (Table 1).

Table 1. Publicly available policy and practice frameworks by Australian states and territories, March 2022

State/territory	Joint protocols and practice guidelines between child protection, youth justice and disability services	Child protection policy aimed at supporting children with harmful or problematic sexualised behaviours	Joint residential care policies aimed at preventing the criminalisation of children at risk of justice system involvement	Policy and practice guidance for responding to children in out-of-home care with behavioural difficulties and complex needs	Child protection and Department of Education policy focussed on school exclusion, suspension, and expulsion	Multi-disciplinary practice policies and panels that include child protection and youth justice and/or disability[1]
VIC	✓ D	✓ TD	✓ T D A	✓ T D A	✓ D A	✓ T D A
NSW	✓ D	✓ T D	✓ T D A	✓ T D A	✓ D	
QLD	✓ D		✓ T D A	✓ T D A		✓ T D A
WA	✓ D			✓ T A	✓ D	✓ T D
SA				✓ T D A		
NT			✓ T A			✓ T D A
TAS						
ACT	✓ D			✓ T D A		

Note. ✓ **-** Policy available in jurisdiction as at March 2022. **T** – Policy has specifically considered trauma and/or its impact on children's behaviour. **D** – Policy has specifically considered disability other than trauma and/or its impact on children's behaviour. **A** – Policy has specifically highlighted needs of Aboriginal and Torres Strait Islander children with disability. [1] T, D, and A are noted where multidisciplinary panels contain services aimed at specifically addressing trauma, disability and/or Aboriginal and Torres Strait Islander cultural needs.

Joint protocols and practice between Child Protection, Youth Justice, and Disability Services

There is little consistency between Australian joint practice guidelines which include child protection, youth justice and disability services. While VIC[177] and NSW[178] both have joint protocols between child protection and youth justice, the Victorian protocol provides significantly more detail than the NSW protocol for practice with children with disability and even then, the only reviews of the implementation of the VIC protocol are negative.[179] NSW[180] and QLD[181] provide similar information on how practitioners should work with dually involved children who have a disability and focus primarily on the role of the NDIS. This is important information for practitioners; however, it does not provide guidance regarding children who do not yet have a diagnosed disability and an NDIS plan. WA's protocol[182] mentions the Disability Justice Services within their child protection manual, but it does not appear that the DJS provides any specialised care for dually involved children who have a disability, as opposed to children with disability who are solely involved in the justice system. Lastly, the ACT Child Protection Practice Framework[183] mentions children with disability only once. No information on joint protocols could be located from SA, NT and TAS.

Child Protection policy aimed at supporting children with harmful or problematic sexualised behaviours

Only VIC[184] and NSW[185] have publicly available child protection practice guidelines which aim to prevent the criminalisation of children who exhibit harmful or problematic sexual behaviours. Both policies aim to reduce the criminalisation of children by providing a therapeutic response, which in each instance is delivered by child protection and other therapeutic agencies. Child protection practitioners in both states are encouraged to obtain adequate information regarding whether a child has a disability, mental illness, experiences of trauma, neglect or abuse and substance use, and to consider these in planning appropriate interventions for the child.[186] However, beyond considering a child's disability when planning interventions, neither document explores in detail how child protection may directly work with a child in need of support for harmful sexual behaviours who also has possible comorbidities, such as an intellectual disability.

Joint residential care policies aimed at preventing the criminalisation of children at risk of justice system involvement

VIC,[187] NSW,[188] QLD,[189] and NT[190] have recently developed similar joint residential care policies between residential care providers, child protection, police and youth justice, which aim to prevent and reduce the criminalisation of children in residential care settings. All documents acknowledge the role of trauma in causing some children to display challenging or offending behaviours, the importance of trauma informed care, culturally sensitive interventions, considering a child's disability when responding to incidents in residential care, and the development of pre-existing behaviour support plans. In terms of cultural responsivity, all the protocols acknowledge that Aboriginal and Torres Strait Islander have unique experiences of trauma. VIC,[191] QLD,[192] and NT[193] policies state that Aboriginal and Torres Strait Islander children in residential care should have cultural support plans.

Both VIC[194] and QLD[195] state that every child must have an individual behaviour support plan, NT states that all children in therapeutic residential care who demonstrate challenging behaviours must have a behaviour support plan,[196] and NSW encourages the use of behaviour support plans rather than mandating this approach.[197] The NSW policy asserts that behaviour support plans must be completed by a psychologist or skilled professional in behaviour management,[198] and the NT policy advises that behaviour support plans must be prepared by a trained behaviour management professional.[199] Only the QLD practice guidelines[200] which accompany their protocol explore in detail how specific disabilities might lead to behavioural difficulties and provide information for residential care staff on how to prevent unnecessary triggers for neurodivergent children. There is scope for all such protocols to provide further guidance on how different disabilities (other than trauma-related disability) may affect a child and their behaviour, and to provide more detail on how to best support children to prevent and respond to emotional and behavioural escalation.

Policy and practice guidance for responding to children in out-of-home care with behavioural difficulties and complex needs

All Australian jurisdictions except for NT and TAS have out-of-home care, therapeutic residential care, and/or behavioural support policies or practice frameworks aimed at preventing the criminalisation of children who have behavioural difficulties. Each policy clearly outlines the connection between trauma and behavioural difficulties yet not as many of the policies explore the impact of other disabilities on children's behaviour. NSW's therapeutic residential care policy,[201] QLD's Evolve policy[202] and WA's residential care policy[203] all do not mention the term 'disability' other than discussing the impact of trauma. SA is unique in that the state has developed Disability Residential Care and the policy,[204] which explicitly discusses many disabilities including various types of neurodisability. Most of the jurisdictions mentioned the importance of culturally responsive practice when working with Aboriginal and Torres Strait Islander children and consulting with Aboriginal and Torres Strait Islander staff or community members when writing behaviour support plans, however only NSW[205] and SA[206] mentioned the cultural needs of culturally and linguistically diverse (CALD) children. The standard of care for children with disability in general or therapeutic residential care appears to vary across Australian states and territories. In contrast, jurisdictions had mostly consistent behavioural support polices recommending that all children with behavioural issues have a behaviour support plan. Some, but not all, jurisdictions stated that these plans must be created by behavioural experts.

Child Protection and Department of Education joint policies focused on school exclusion, suspension, and expulsion

VIC,[207] NSW,[208] and WA[209] are the only Australian jurisdictions to include joint child protection and department of education policies focused the suspension, exclusion or expulsion of children from school. All three policies also only apply to children who are in out-of-home care (rather than those involved with child protection more broadly), and in WA's policy is only relevant to

children who are in the CEO's care.[210] There are similarities across the joint children protection and education policies including the additional learning and educational supports available to children with disabilities, behavioural or learning difficulties. Regarding school suspensions and expulsions, VIC policy[211] has the most detailed protocol in place to prevent children from being excluded from school. WA[212] addresses school exclusion to some degree although not in as much detail as VIC,[213] and NSW's policy[214] does not address this issue at all.

Multi-disciplinary practice policies and panels that include child protection and youth justice and/or disability

VIC,[215] QLD,[216] WA,[217] and NT[218] all have multidisciplinary practice policies which often include child protection and sometimes youth justice and disability services. All the practice initiatives involve a panel or gathering of services, where staff, family and other supports can review and revise the child or child's needs, case plan and proposed interventions. Each state or territory has a different eligibility criteria required to review a child's case by a multidisciplinary team, with VIC's Multiple and Complex Needs Initiative (MACNI)[219] and High Risk Youth Panels,[220] and WA's Young People with Complex Care Needs (YPECN)[221] only providing services to very complex, 'high needs' and 'high risk children', and in contrast QLD's child protection practice panel,[222] which reviews a child's case any time there are changes in a child protection order, and in NT any person who is worried about the safety of a child or family can make a referral to a MACCS team.[223]

2.2.4 Policy gaps

- Most of the policies (except for the joint protocols) solely target children in out-of-home or residential care, rather than all child protection-involved children.
- Policies tend to focus on the relationship between trauma and children's behaviour, with less attention to other disabilities. Ideally trauma and other disability should be given equal consideration.
- Policies advise staff to consider if a child has a disability, however there is little guidance on how to support and deliver interventions to child protection-involved children with disability or suspected disability.
- Literature concerning the implementation of these policies, where available, generally points to a lack of on the ground adherence, often seen to be driven by deficiencies in training, and lack of support or resources.
- There is lack of attention to culturally and linguistically diverse cohorts, and lack of detail regarding supporting Aboriginal and Torres Strait Islander children beyond ensuring those in residential care have cultural support plans, and culturally-responsive behaviour support plans.

- While an increasing appreciation of the importance of cultural competence in attaining just outcomes for children is evident in many of the reviewed policy, the disability experience remains elusive to the various policy frameworks, which do not reflect a nuanced understanding of the structural factors contributing to disability exclusions, even in the rare instance when disability and structural ableism is referenced.
- Overall, there are inconsistencies across jurisdictions in terms of the responses to child protection-involved children with disability who are at risk of being criminalised.

2.2.5 Policy recommendations

Consideration of the findings of the scoping and policy review gives rise to evidence-informed policy and practice recommendations in the Australian context for preventing and reducing the criminalisation of children with disability in child protection systems (Table 2):

Table 2. Evidence-informed policy recommendations

Recommendation	Details
1. **That the Commonwealth Department of Social Services in partnership with the Secretariat of National Aboriginal and Islander Child Care (SNAICC), the First People's Disability Network and other relevant stakeholders develop national policy guidance to reduce the criminalisation of children with disability in child protection systems.**	The policy review suggests national guidance is required in this area to ensure greater consistency across jurisdictions in the policies and practices implemented to reduce the criminalisation of children with disability in child protection systems. We suggest this national policy guidance or framework address the policy and practice issues outlined in the recommendations below, and: • focus on children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability; • attend to diversity, including in relation to Aboriginal and/or Torres Strait Islander children and families, culturally and linguistically diverse children and families, and gender and sexually diverse children.
2. **That states and territories ensure the availability of intensive family support services for families of children with disability to optimise their capacity to remain safely at home.**	Jurisdictions should invest in research and evaluation to determine the most appropriate, evidence-informed intensive family support services and programs to meet service user needs. Intensive family support services should be culturally appropriate, evidence-informed, and able to meet the needs of children with multiple support needs related to complex trauma, other mental health needs, and/or neurodisability. Such programs may be best delivered by non-government agencies, including Aboriginal Community Controlled Organisations for Aboriginal and/or Torres Strait Islander children and families.

Recommendation	Details
3. **That states and territories should each develop and implement policy between child protection and education departments that seeks to maximise school engagement of children with disability in child protection systems.**	Policies between child protection and education departments in each state and territory should explicitly outline strategies to minimise educational exclusion (suspension and expulsion) and maximise educational engagement for children with disability in child protection systems. Strategies should attend to cultural and racial diversity, as well as the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability.
4. **That states and territories should ensure the availability of intensive kinship and foster care support options for children with disability.**	Jurisdictions should invest in research and evaluation to determine the most appropriate, evidence-informed intensive kinship and foster care options to meet service user needs. Intensive kinship and foster care options should attend to cultural and racial diversity, as well as the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability.
5. **That states and territories should ensure that all residential out-of-home care funded by child protection departments is therapeutic, and able to meet the needs of children with complex disability-related needs.**	Jurisdictions should invest in research and evaluation to determine the most appropriate, evidence-informed therapeutic residential care model/s to meet service user needs. Therapeutic residential care options should attend to cultural and racial diversity, as well as the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability.

Recommendation	Details
6. **That states and territories each develop and implement protocols between residential out-of-home care providers and police which seek to minimise the criminalisation of children in residential care.**	Protocols between residential out-of-home care providers and police should attend to the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability, and to cultural and racial diversity. We recommend that protocols should also be accompanied by resources to support training and implementation, as well as independent oversight and reporting on outcomes related to police attendance and charging of children in residential out-of-home care.
7. **That states and territories ensure the availability of multidisciplinary therapeutic or healing services to children with disability in child protection systems.**	Services should be responsive to the needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability, and to cultural and racial diversity. The roles of the National Disability Insurance Scheme, statewide child and adolescent mental health services, and other specialist providers (e.g. Aboriginal Community Controlled Health or Healing Services, specialist child trauma services) in developing or delivering these services for children with disability in child protection systems should be outlined.

This study recommends that the Commonwealth, States and Territories commit to a National Inclusion framework to provide policy cohesion in this area, embodying principles that:

- centre the voice of young people with disability;
- are conversant the disability experience and the impact of ableism; and
- reflect awareness of the intersectional and compounding marginalisation experienced by Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse peoples.

3. Criminal Justice Involvement of Children with Disability in Child Protection Systems: A scoping review

3.1 Introduction – Scoping review

3.1.1 Rationale

A growing number of studies are looking at the relationship between child protection involvement and youth offending.[224] Research has begun to draw attention to children with disability, who are over-represented at the nexus of child protection and youth justice systems.[225] Child protection-involved youth with some types of disability also experience disproportionately greater levels of certain systemic influences which increase their likelihood of criminalisation, including experiences of school exclusion,[226] and placement in out-of-home care.[227]

The current scoping review aims to consolidate the fragmented body of findings relating to criminalised children within child protection systems disability to provide policy makers, researchers, and practitioners with up-to-date evidence. This knowledge will support the development of preventative and responsive measures, as well as future research that can address the over-representation of child protection-involved children with disability in youth justice systems.

3.1.2 Objectives

- To identify and synthesise evidence from studies that report on factors associated with increased or decreased likelihood of criminal justice involvement among children with disability in child protection systems.
- To describe the nature of disability, maltreatment and child protection involvement, criminalisation and offending behaviour, and service use among children with disability in child protection systems.

3.2 Methods

3.2.1 Scoping reviews

As opposed to systematic reviews, scoping reviews are broader in scope and aim to map the extent and nature of research activity in a field, to enable the identification of research gaps, and areas where more narrowly focused systematic reviews may be helpful.[228] Scoping reviews can summarise and distribute key research findings, but they do not generally include an evaluation of the quality of the evidence reported.

3.2.2 Protocol and registration

All review methods were determined beforehand and written into a protocol, before commencing literature searches and screening. The review followed the reporting guidelines outlined in the PRISMA Extension for Scoping Reviews Checklist.

3.2.3 Eligibility criteria

The following selection criteria were used to determine whether to include or exclude studies identified by the search strategy.

Participants

Participants included children/youth with a history of child protection involvement, disability, and youth offending. Studies were also included that drew on samples of professionals to investigate issues at the nexus of disability, child protection, and youth justice system involvement. Studies describing offending between the ages of 8 to 21 years of age were included with a view to capturing research that examines youth justice involvement across diverse countries (with different minimum ages of criminal responsibility), and justice system involvement of young people transitioning from out-of-home care. As the review is interested in the intersection of child protection and youth justice systems, studies that only report on maltreatment experiences among children with disability involved with youth justice systems, with no reference to any child protection involvement, are excluded.

Because this review focuses on children, studies that included only data from participants' adulthood are also excluded. For example, studies are excluded if they only report on the relationship between child protection involvement and adult crime/criminal justice involvement. Where studies include both child and adult participants, they were only included when most of the participants and data being analysed relate to children under the age of 18, or where sub-analyses separating age groups were included.

Settings

Eligible settings included, but were not limited to, juvenile justice, child welfare, education, disability, homelessness, and health settings. Studies that used surveys or questionnaires, and relevant studies that analysed administrative or other data relating to the target participants are also included.

Study Designs

Studies must have reported on an empirical primary research study relating to the intersection between child protection involvement (either self-reported or indicated by administrative records), and youth offending (crime and/or youth justice system involvement) and must have included some reference to children with disability. Studies that used either quantitative or qualitative methods were eligible for inclusion. Definitions of child protection

involvement included self-reported contact as well as administrative data (e.g. child protection substantiations, court records). Similarly, definitions of youth offending were inclusive of self-report (e.g. self-reported arrest) as well as official records (e.g. youth convictions or sentences). Studies reporting measures relating to aggression, antisocial or externalising behaviour were included with a view to identifying programs and approaches that may prevent or reduce criminalisation. However, studies focusing on substance misuse as a criminal behaviour, rather than any other offending among children of the age of criminal responsibility, were not included. Definitions of disability were intentionally broad with a view to capturing studies that reported on: neurodisability (that is, intellectual disability, attention deficit hyperactivity disorder, foetal alcohol spectrum disorder, learning and communication disorders), epilepsy, hearing impairment/loss, brain injury, mental health conditions (official diagnoses, as well as broader experience of trauma, suicidality, self-harm and other psychological or emotional distress), and psychosocial impairment (including emotional and behavioural regulation challenges).

Measures of Interest

This review provides an overview of studies that describe the nature of disability among criminalised children in child protection systems, the adversity, maltreatment and child protection system involvement of this group, as well as identifying factors that are associated with greater or lesser likelihood of criminal justice contact among child protection-involved children with disability. This review includes studies that report on a range of measures among crossover children with disability, which include, but are not restricted to, the following:

- Child characteristics: *e.g. age, gender, culture*
- Child maltreatment experiences: *e.g. types of maltreatment, experiences of multi-type maltreatment, maltreatment recurrence/persistence, including sexual exploitation*
- Child child protection pathways: *e.g. age at first child protection notification/substantiation, age at first out-of-home care placement, placement stability, placement types*
- Child justice system contact: *any offending/convictions, offence types, violent offending, justice system reinvolvement, contexts of offending (e.g. criminal exploitation, residential care-based charges)*
- Disability characteristics and trajectories: *data concerning assessment, service provision, and nature of disability (including co-occurrence) noted in among crossover children*
- Drivers of criminalisation and protective factors: *any reported qualitative or quantitative risk and protective factors for criminal justice involvement among child protection-involved children with disability*

Sources of Evidence

No limits were placed on the language of sources, while the years of publication were restricted to 2000-2021.

3.2.4 Literature search strategy

An electronic search strategy including keywords relating to "child" (e.g. youth, minor, adolescent), "child protection" (e.g. child welfare, looked after, foster care), "offending" (e.g. delinquency, crime, recidivism) and "disability" (e.g. intellectual disability, trauma, behavioural regulation challenges) was used to search the following electronic databases [See Appendix A]): (1) *Criminal Justice Abstracts via Ebsco (1980 to present);* (2) *ProQuest: Social Services Abstracts Premium Collection (1914 to present);* (3) *APA PsychInfo.*[4] Text word searches were mapped verbatim into each database, excepting adjustments made for database specific syntax.

3.2.5 Data management and software

Reference management software *EndNote X9* was used to compile all titles and abstracts from the search strategy, and duplicates were removed. All citations were then transferred to systematic review software *Covidence* to undertake title/abstract and full text screening of studies, and to identify, track and resolve discrepancies across reviewers.

3.2.6 Study selection

Prior to study selection, all review authors underwent training to ensure a comparable understanding of the purpose of the review and the selection criteria. Titles and abstracts retrieved from the electronic searches were screened to exclude publications that did not meet the selection criteria. This stage of the screening process was highly inclusive, and a full text review was undertaken when the information provided in the titles and abstracts was unclear or insufficient. All 3447 titles and abstracts were screened by one author (SB) and duplicate screening of 10% was undertaken by another author (GKT). There was a 76% agreement rate, and consensus was reached by a discussion between authors, with amendments made to the screening criteria. For example, juvenile justice involvement was clarified to exclude offending behaviour that did not result in criminal justice system involvement in the form of arrest, court-involvement or supervisory sanctions, and disability was to include trauma-related presentations or externalising behaviour, and child protection involvement was to encompass all contact with child protection services rather than solely out-of-home care. For the full text review, each study was assessed by one review author (SB).

3.2.7 Data charting process and items

A data extraction form was developed beforehand, and one reviewer extracted the data (SB). The following data items were extracted: study characteristics (e.g., authors, year published, country, and publication type); study purpose/aims; methods; study design; participant

4 The selection of the databases resulted from the research team's experience via a previous scoping review focusing on criminalised children in child protection systems, during which the lead author worked with a specialist research librarian to identify databases contained relevant empirical research studies in this area.

information (including population, sample size); maltreatment measures, disability measures, and offending measures; relevant findings related to a) disability b) maltreatment and child protection involvement c) offending and criminal justice system involvement d) service use and e) any identified factors associated with increased or decreased likelihood of justice system involvement among children with disability in child protection systems.

3.2.8 Synthesis of results

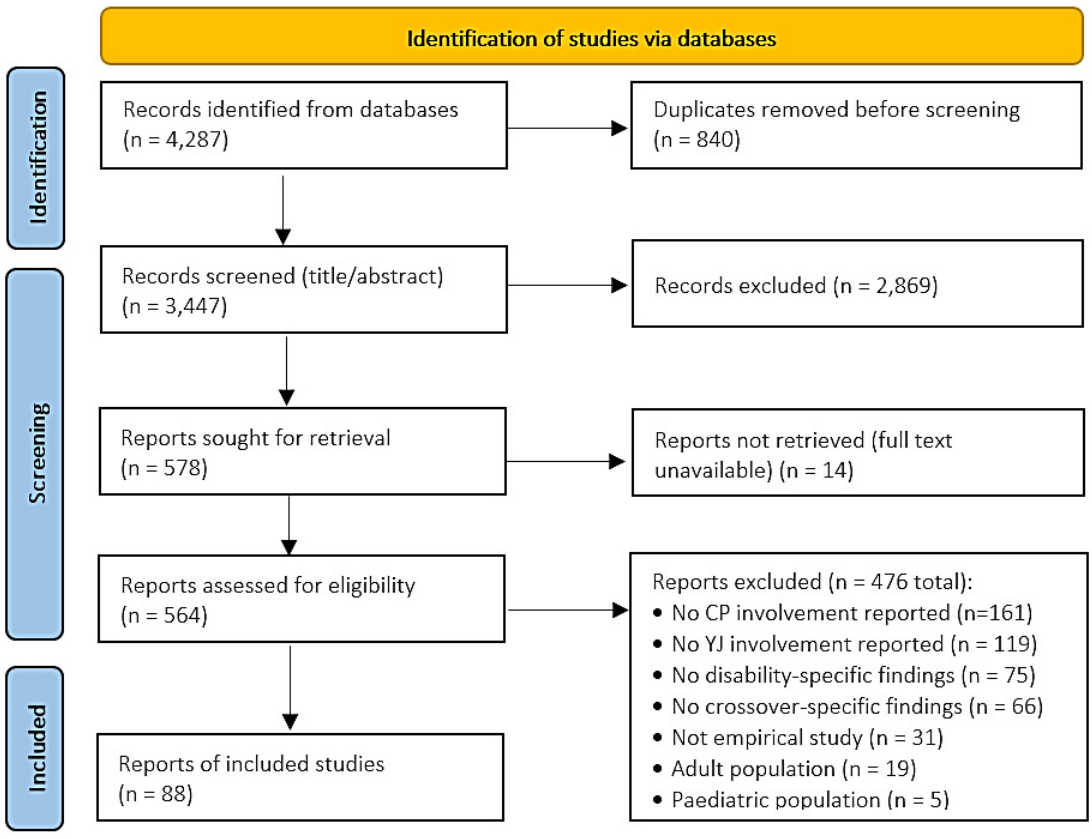
The key results of the scoping review were narratively synthesised.

3.3 Results

3.3.1 Selection of evidence sources

A flow diagram outlining the study selection process is presented in Figure 1. Initial title and abstract screening of the 3447 publications identified 2869 irrelevant studies, with 578 studies deemed eligible for full-text screening. Of these, 88 met the inclusion criteria.

Figure 1. PRISMA Flow Diagram



3.3.2 Sample characteristics

Table 3 provides an overview of the 88 included publications. Most of these were journal articles (80.7%), and three quarters were published since the year 2010 (73.9%), suggesting a recent growing recognition of the importance of the convergence of disability, child protection and youth justice involvement. Most of the publications drew on samples from the US (68.2%), and three quarters (73.9%) related to either child protection samples (e.g. children who were referred, investigated or substantiated in relation to maltreatment, or who were placed in out-of-home care settings), or youth justice samples (including samples of arrested, court-attending, convicted, sentenced, and incarcerated youth). In relation to the types of disability examined, most studies examined mental health (47.7%), neurodisability (10.2%) or both mental health and neurodisability (42.0%). The only other disability examined in the publications was hearing impairment, which was mentioned in three studies. It should be noted that publications which drew from similar data sources have been reported as separate studies throughout, because these investigated slightly different research questions, and/or utilized adapted forms of the data source (e.g. additional longitudinal data, or a data subset).

Table 3. Sample characteristics (n=88)

Variable	n (%)
Year of publication	
2000-09	23 (26.1)
2010-19	52(59.1)
2020-	13 (14.8)
Publication type	
Journal article	71 (80.7)
Thesis	15 (17.0)
Book chapter	1 (1.1)
Report	1 (1.1)
Country of sample	
US	60 (68.2)
Australia	13 (14.8)
Canada	5 (5.7)
UK	4 (4.5)
Sweden	2 (2.3)
Other[a]	4 (4.5)

Variable	n (%)
Sample type	33 (37.5)
Youth justice	32 (36.4)
Child protection	12 (13.6)
Crossover	8 (9.1)
Professionals	2 (2.3)
Other child/adolescent[b]	1 (1.1)
Crossover + professionals	
Design	
Longitudinal	39 (44.3)
Cross-sectional	36 (40.9)
Exploratory	11 (12.5)
Multiple case study	1(1.1)
Mixed methods	1 (1.1)
Disability considered	
Mental health (MH)	42 (47.7)
Neurodisability (ND)[c]	9 (10.2)
Both MH & ND	37 (42.0)

Note. [a]'Other' includes Spain, Denmark, Germany & Ireland (each n=1). [b]'Other child/adolescent' samples include samples of homeless youth and economically disadvantaged school children. [c]Three of these studies also considered hearing impairment.

Relevant information from each of the 88 studies are presented in the supplementary table (Appendix B). Study characteristics and key findings), which is organised by the type of sample the study looked at (child welfare, youth justice, crossover, professional, and other child/adolescent samples)[5]. The findings below summarise the key themes and findings of the included studies.

3.3.3 Increased Youth Justice contact of Child Protection-involved children with disability

A total of 17 publications (19.3%), including one South Australian study,[229] described the greater likelihood of youth justice involvement among child protection-involved youth with disability, compared with those without disability. One set of studies looked at children with signs or diagnoses of disability/mental health problems who were involved in child protection systems (either at risk of/reported/ substantiated for maltreatment, in out-of-home care, or transitioning from out-of-home care). For example, four North American studies examined the likelihood of justice system contact among children who were reported for, or at risk of maltreatment.[230]

5 The Baidawi and Sheehan (2019) report while including both crossover children and professional samples is found in the crossover sample section.

All these studies found that children with disability had more contact with the justice system, though each study looked at slightly different disabilities. For instance, Barton[231] found that the likelihood of offending was higher for maltreated children who experienced any mental health issues (including diagnoses of bipolar disorder, depression, post-traumatic stress, or conduct disorder), as well as a combination of these disorders, or children who were dependent on drugs or alcohol. Two other studies found variable likelihood of justice system-involvement depending on children's type of disability. Van Wert[232] found that compared with maltreated 12-15 year olds who were not involved with the justice system, those who were justice involved experienced much higher rates of depression/anxiety/withdrawal (72% vs 35%), intellectual/developmental disability (39% vs 14%), attachment issues (41% vs 19%), ADHD (60% vs 16%), and aggression (81% vs 17%). Similarly, Morrow and colleagues[233] found that the strongest predictor of arrest among children at risk of or reported for maltreatment was having three or more symptoms of conduct disorder. This study also found gender differences in other mental health diagnoses that were associated with arrest in child protection-involved youth - for boys (but not for girls), post-traumatic stress disorder symptoms were correlated with arrest at age 16, while for girls (but not for boys), oppositional defiant disorder symptoms were correlated with arrest at age 16.[234] A similar study focusing solely on girls with child protection-involvement also found that the strongest predictor of justice system contact was a mental health diagnosis related to aggression; females who were identified as being aggressive had 11 times the likelihood of justice-system involvement as other child protection-involved females.[235] Research suggests that it is not only the presence, but the severity of disability and mental health experiences that are associated with justice-system involvement for child protection-involved children. For example, US research examining child protection cases, found that the odds of having moderate-severe mental health problems was higher for those with justice system involvement compared with those not involved in the justice system.[236]

While the studies described so far have focused on samples of child protection-involved youth, other research specifically focused on children placed in out-of-home care, including foster, kinship or residential care. These studies also found a greater likelihood of justice-system involvement for children in out-of-home care with disability, compared with children in these settings without disability. For example, one US study of a group of children in out-of-home care found that those with depression had 72% greater odds of becoming involved with the justice system, those with bipolar disorder had 85% greater odds, those diagnosed with ADHD were nearly twice as likely, and those with conduct disorder were five times more likely to become involved in the juvenile justice system compared with children in out-of-home care without disability.[237] Another US study identified that children placed in out-of-home care for behavioural reasons were more likely to experience later arrest than those placed for reasons of abuse and neglect.[238]

Other research has focused on children in out-of-home care who have complex or multiple needs related to experiences of trauma or other disability. For example, among Australian children in out-of-home care who had repeated experiences of placement breakdowns, having conduct problems predicted children's justice system contact;[239] in a UK group of children in out-of-home care who had a diagnosis of conduct disorder, those who had co-occurring emotional disorders were more likely to have had contact with the justice system in the past

year (37.2%), compared with those solely diagnosed with conduct disorder (30.7%), or those diagnosed with conduct disorder and comorbid hyperkinetic disorder (17.6%).[240] The authors of this study also outlined that those children diagnosed with co-occurring conduct disorder and emotional disorder were over-represented within the residential care group, were older, and tended to have entered out-of-home care later than the other groups of children.[241] Another US study looked at child protection-involved youth who were in special education and found that those with emotional disturbance (ED) (compared with those with other special education diagnoses), were more likely to have justice system involvement (41% (ED) vs 26% (other diagnoses[6])). Similar patterns were observed among those in foster care placements, of whom 56% with ED had justice system contact, compared with 37% with other special education diagnoses.[242]

Research from the US shows that the likelihood of justice system contact is also higher during the transition from out-of-home care for children with disability. This trend has been identified among children with any mental health disorder,[243] as well as children with specific diagnoses of conduct disorder, antisocial personality disorder, and signs of impulsivity and narcissism.[244]

While the above studies have focused on child protection samples, other studies have looked at general samples of children in the community, or compared justice involved children with non-justice involved children to look at the impact of disability on these pathways. Chen [245] examined the impact of disability (including 'learning disability' and/or 'emotional disturbance'[7]) on justice involvement of students and found that after considering the impact of child welfare involvement, 25% of students with disabilities identified in Grades 1-12 had justice system involvement compared to 15% for students without disabilities. A similar difference was seen for children with disabilities in Grades 1-6 (23% of students with disabilities were involved in justice system vs. 16% without disabilities). This study found an interesting effect depending on the timing of disability diagnosis; for later-identified disabilities, a one-unit improvement in reading comprehension was associated with about a 3% decrease in justice system involvement, but similar effects were not seen for 'high incidence' disabilities diagnosed before Grade 6. Finally, one study also compared justice and non-justice involved children

6 Emotional disturbance in this study was defined as (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors; (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (C) Inappropriate types of behavior or feelings under normal circumstances;(D) A general pervasive mood of unhappiness or depression; (E) A tendency to develop physical symptoms or associated with personal or school problems. Other special educational diagnoses included Early Childhood Special Education, Learning Disability, Mental Retardation, Other Health Impaired, and Speech and Language.

7 Disability status: Learning Disability (LD) - significant difficulties in listening, thinking, speaking, reading, writing, spelling, or mathematical abilities due to the deficits in one or more of the basic psychological processes involved in understanding or using language. Emotional Disturbance (ED) - inability to learn, relationship problems, inappropriate behavior, unhappiness or depression, and physical symptoms or fears over a long period of time.

in the US, finding that after accounting for effects of child welfare involvement, mental health diagnoses related to aggression or impulse control were most strongly associated with justice system involvement (increasing the chance of this outcome by 9.4 times), as did any other mental health diagnosis (3.2 times), emotional and behavioural disturbances (1.8 times), and learning disabilities (1.3 times).[246] While most studies did show that mental, emotional, behavioural health and other disabilities were associated with increased likelihood of justice system involvement for children in child protection systems, there were some exceptions. For example, two studies found that intellectual disability did not necessarily predict justice system involvement among child protection samples in special education and out-of-home care.[247] This may suggest differences in responses or understanding of certain disabilities, or by staff in certain contexts, may be helpful for preventing children's criminalisation.

Each of the above studies considered the impact of *signs or diagnoses* of mental health or other disability on the likelihood of justice system involvement. Five other pieces of research looked at contact with mental health and special education *services* among child protection-involved youth and examined their likelihood of later justice system contact. All these studies (which were based in the US (4 studies) and Sweden (1 study)) found that contact with mental health and special education services was linked with an increased chance of child protection-involved children having justice system contact.[248] For example, one US study found that among all child protection involved children, those who received mental health services had 3.5 times the odds of juvenile justice contact, and those in out-of-home care who received mental health services had 1.5 times the odds of juvenile justice contact.[249] While these kinds of findings do not suggest that the services themselves increased children's likelihood of experiencing justice system involvement, some authors have suggested the services provided do appear to be ineffective at addressing children's needs to prevent this trajectory.[250] A later section of this review looks at mental and behavioural health services access among crossover children with disability.

3.3.4 Nature of offending and Youth Justice contact among Child Protection-involved children with disability

Earlier Youth Justice contact

A total of eleven studies (12.5%), including two Victorian studies,[251] looked at whether child protection-involved children with disabilities had earlier youth justice system contact than child protection-involved children without disabilities. It has been established by previous research that children with child protection involvement who experience justice system involvement tend to do so at an earlier age than other children who make contact with the justice system.[252] Several studies that looked at child protection samples also found that this likelihood of earlier justice system involvement is further heightened for those with disability, including children diagnosed with emotional/behavioural disorders[253] and mental health disorders.[254] Other research with youth justice or crossover samples also found that some mental health and disability diagnoses predicted earlier justice system involvement of crossover children with disability. For example, one US study comparing justice involved children with non-justice

involved children found that, after considering foster care involvement or maltreatment, disorders of aggression or impulse control, any other mental health diagnosis, and special education diagnoses (including emotional/behavioural disorders and learning disabilities) all predicted an earlier age of justice system involvement.[255] The authors highlighted learning disabilities as the most significant predictor of earlier justice system involvement, and reported that children with learning disabilities were almost twice as likely to be first convicted before the age of 14 years compared with other children, even after taking accounting for child protection involvement.[256] In that study, learning disabilities were defined as significant difficulties in listening, thinking, speaking, reading, writing, spelling, or mathematical abilities due to the deficits in one or more of the basic psychological processes involved in understanding or using language. Other studies have also found that special education disability,[257] intellectual disability, any mental health diagnosis (particularly trauma/attachment-related disorders), behavioural disorder and neurodisability[258] were associated with earlier justice system contact in youth justice samples, after considering the impact of child protection system involvement. It should be noted that these studies defined 'special education disability'[259] as inclusive of emotional disability, mental retardation, learning disability, speech/language impairment, hearing impaired, attention deficit, and neurodisability[260] as inclusive of diagnoses of intellectual disability, borderline intellectual functioning, learning or communication disorder, attention deficit/hyperactivity disorder, autism spectrum disorder, Tourette syndrome, foetal alcohol spectrum disorder, organic acquired memory disorder, acquired brain injury, or epilepsy. These are critical findings since earlier contact with the justice system tends to be associated with worse outcomes, including a greater likelihood of progression to the adult criminal justice system.[261]

However, three other studies had opposing findings. For instance, one study showed that eligibility for special education was not associated with earlier justice system contact among a child protection sample[262], another indicated that a diagnosis of FASD did not predict earlier justice system involvement after considering other factors (foster care placement, the child's experiences of maltreatment, and their level of self-control)[263], and a final study found that having a mental health diagnosis did not predict earlier justice system involvement[264] after considering child protection involvement and family poverty. Despite some variations, overall the research does seem to suggest that child protection-involved youth with disability (particularly neurodisability and evidence of impulsivity or aggression) face greater chances of entering the justice system at an earlier age. However, it is important that this finding is not generalised to all child protection-involved children with disability, given the variations across the findings.

Volume and seriousness of offending

There were mixed findings from studies that looked at the volume of offending among child protection-involved children with disability. Across two studies that followed groups of child protection-involved youth, one US study found that having mental health issues did not predict a greater number of property, sex or drug offences[265], while the other (also a US study) found that a diagnosis of ADHD did not predict a greater number of arrests of youth ageing out of foster care, but measures of psychopathy did.[266] On the other hand, two US studies[267] and

one Victorian study[268] that looked at samples of crossover or justice-involved children found that after considering child protection involvement, the presence of mental health disorders, behavioural challenges, or neurodisability were associated with a greater volume of charges or more chronic offending among these children.

Among child protection-involved and crossover children, some evidence suggests that children with certain disabilities are more likely to be charged with violent offences. For instance, one US study found that child protection-involved youth who experienced mental health issues were more likely to be charged with violent offending,[269] while an Australian study of crossover children found that those diagnosed with mental health diagnoses, with a history of challenging behaviour, or diagnoses of ADHD were more likely to be charged with violent offences.[270] However, when compared with other children in the juvenile justice system, the results were more mixed. Two US studies found that justice-involved children who had child protection contact tended to be charged with *less* serious offences, while those with mental health problems[271] and certain other disabilities (diagnoses related to aggressive behaviour, learning disabilities, or emotional/behavioural disabilities)[272] were more likely to be charged with serious or violent offending. Overall, the research shows mixed results about whether child protection-involved youth with disabilities have more violent or serious offending than other children in the justice system; but it appears that child protection-involved youth with certain disabilities are more likely to experience arrest for violent offending compared to other children in child protection without disabilities.

Court outcomes

Four studies in the review, including one NSW study,[273] looked at court outcomes of child protection-involved youth with disability. The first found that after considering the number of maltreatment types, a diagnosis of depression, but not ADHD, was associated with greater likelihood of children being found delinquent (as opposed to remaining under the lower sanction of probation supervision).[274] A second study however, found that suicidal ideation or depression were not associated with an increased likelihood of incarceration after controlling for child protection involvement.[275] A third study examining detention length found a diagnosis of mental health disorder to be associated with a longer period of detention, even after considering child protection involvement.[276] Finally, one New South Wales study found that children with out-of-home care histories were significantly more likely to have their cases dismissed under the Mental Health (Forensic Provisions) Act 1990 (NSW), compared with children before the court without out-of-home care histories. At the time of that study, application of this Act which can apply to defendants who are cognitively impaired, or experiencing a mental illness.[277] Such a finding suggests that there may be scope for improving the policing and prosecutorial processes experienced by child protection-involved children with disabilities.

Justice system reinvolvement

Overall, 13 studies (14.8%, all US-based) reported on justice system re-involvement (i.e., recidivism) of child protection-involved youth with disability. Only one study (based in the US) examined justice system reinvolvement among a child protection sample, and found that children diagnosed with mental health disorder were 81% more likely to experience justice

system reinvolvement compared with child protection-involved children without a diagnosed mental health disorder (this was the only significant predictor of justice system reinvolvement in the sample).[278] Several other studies examined justice system reinvolvement in youth justice and crossover samples. Three studies found that while child protection involvement itself did not significantly predict justice system reinvolvement, disability did, in particular diagnoses relating to aggressive behaviour, any mental health diagnosis, and special education experience/diagnoses (including emotional and behavioural disorders, learning disorders).[279] The combination of child protection involvement and disability in these studies was generally found to be associated with a slightly greater likelihood of justice system reinvolvement. At the same time, in two other studies of youth justice samples, one reported that while mental health problems did not predict justice system reinvolvement, impulsivity did,[280] and one reported that mental health problems did not predict a shorter time to justice system reinvolvement among children under diversion, after controlling for experiences of maltreatment.[281]

Similarly mixed findings were reported in studies of criminalised children in child protection systems. Four studies found that certain disability signs or diagnoses were associated with increased likelihood of justice system reinvolvement among this group, including involvement with multiple services such as mental health, drug and alcohol and special education services,[282] the presence of any mental health problem,[283] diagnoses of disruptive behaviour or anxiety disorders,[284] and signs of post-traumatic risk seeking.[285] On the other hand, two other studies of crossover children found that mental health problems[286] were not associated with greater justice system involvement, while mixed findings were reported regarding the association between mental health service use and justice system reinvolvement among crossover children (one study reported an association with greater justice system reinvolvement,[287] while a second study reported no difference in justice system reinvolvement for crossover children accessing mental health services).[288] Again, the takeaway message from this range of studies is perhaps that there is a need to distinguish between particular mental health or disability-related diagnoses and/or signs when considering their influence on child protection-involved children's likelihood of justice system reinvolvement.

3.3.5 Types of disability observed among crossover children

A total of 24 studies (27.3%), including seven Australian studies,[289] reported on the signs and diagnoses of disability observed among samples of crossover children, often in comparison to a broader population of justice-involved children. These studies overall demonstrate a significantly greater level of neurodisability, mental health diagnoses and signs among crossover children relative to other justice-involved youth, as well as highlighting certain gender differences in the nature of disability seen among crossover children.

Neurodisability diagnoses

Eight studies (9.1%), six of which were conducted in Australia[290], described the nature of neurodisability seen in crossover populations. For example, three studies found a greater prevalence of reading difficulties, intellectual disability and FASD among children in custody

who had a history of out-of-home care placement.[291] Two other studies also documented a greater level of cognitive impairment among children coming before children's courts who had experienced child protection involvement, including maltreatment reports[292] and out-of-home care placement.[293] Another Australian study which examined the types of neurodisability seen among crossover children who were adjudicated in the Victorian Children's Court found that nearly one half of crossover children (48%) had a diagnosed neurodisability, most commonly ADHD (29.0%), learning and communication disorders (22.6%) and intellectual disability (17.2%);[294] the study also found that:

- where data on severity of intellectual disability were available in 81% of cases (38/47 children); for 89%, ID was classified as mild, while 11% were classified as moderate;
- compared to crossover children in metropolitan Courts, those before the regional Court were significantly more likely to have a diagnosed intellectual disability (25.7% vs 14.1%), and to have contact with Disability Client Services (19.2% vs 10.2%);
- neurodisability diagnoses were more common among male crossover children (59%) relative to female crossover children (25%); gender differences were significant for all conditions, with the exception of intellectual disability and 'other' disorders;
- 55% of children with neurodisability had more than one neurodisability diagnosis (known as comorbidity);
- crossover children with neurodisability were also more likely to have a mental health diagnosis compared with crossover children without a neurodisability (72% vs 50%), commonly diagnoses of conduct disorder (34% vs 8%) and trauma and attachment-related disorders (posttraumatic stress disorder and reactive attachment disorder) (30% vs. 11%); and
- crossover children with neurodisability (particularly intellectual disability and learning/ communication disorders) tended to have experienced a greater range of adverse childhood experiences, particularly exposure to family violence, and caregivers who faced their own challenges with mental health and substance abuse.[295]

Mental health diagnoses

A total of 22 studies (25%), including four Australian studies,[296] had findings related to the nature of mental health diagnoses or experiences among crossover children, again with many comparisons to children solely involved with the justice system.

Prevalence of mental health diagnoses. Studies have reported quite varied prevalence rates of mental health issues among crossover children, from 56% to 90%.[297] One Australian study reported that among a cross-sectional court sample of crossover children, 61% had been diagnosed with a mental health disorder, including at least 28% who had been diagnosed with a mood disorder, 20% with behaviour disorder, and 19% with trauma or attachment-related disorder.[298] As with neurodisability, a key feature also seems to be a high level of co-morbidity, or multiple co-occurring mental health challenges among this population, with one study reporting

that over 80% of crossover children in their sample had multiple mental health diagnoses.[299] Research with professionals has also supported this view, with the vast majority of focus groups held with child welfare and juvenile justice stakeholders in an Australian state describing trauma-related mental health issues as prevalent within crossover children population, including forms of depression and anxiety, and in some cases, instances of self-harm and attempted suicide.[300] It was suggested by research participants that residential care settings may worsen existing problems by failing to provide an appropriate therapeutic environment and response to these mental health needs.[301]

Studies have consistently identified a greater level of mental health needs among crossover children relative to other justice-involved children, including those that examined any mental health needs or conditions,[302] and others which looked at specific diagnoses of conduct disorder[303] and attachment-related trauma.[304]

Depression and suicidality. One Australian study of crossover children in a youth court found that 35% had a history of self-harm, suicidal ideation/attempts; self-harming behaviours sometimes commenced from very young ages, and encompassed a range of behaviour from threatening or attempting suicide, to children's scratching, biting, cutting, gouging, punching, strangling and cutting themselves, or overdosing on medications.[305] Depending on the professionals consulted, crossover children's self-harming behaviours were at times characterised as indicators of emotional and psychological distress, while at other times were depicted as behavioural issues, or attempts at manipulation.

Research has also consistently found that crossover children are more likely to experience depression, suicidal ideation and to have prior or current suicide attempts relative to other justice-involved children. These findings have been seen among crossover youth in custodial,[306] and court environments,[307] again illustrating the far greater complexity of mental health and other disability-related need among justice-involved children with child protection involvement.

Other mental health experiences. Finally, five studies that all drew on youth justice samples reported on other experiences related to crossover children's mental health, including internalising/externalising behaviour, impulsivity, psychopathy, aggression, and emotional regulation difficulties. In each case, greater child protection involvement (including maltreatment, out-of-home care involvement, and greater intensity of either) was associated with more of the above mental health experiences. For example, in a group of children in custodial youth justice, experiences of emotional abuse were found to be related to signs of internalising (such as being depressed or withdrawn), while experiences of physical and sexual abuse were associated with signs of externalising (such as aggressive behaviour).[308] Another US study in a youth criminal court sample similarly found higher levels of aggression among children who had experienced physical and emotional abuse (and particularly the combination of both), as well as those who had experienced more severe levels of maltreatment.[309] The study also found links between experiences of sexual abuse and lower levels of emotional regulation in the sample of children.[310] While this study found no differences in impulsivity between maltreated and non-maltreated children, a different study that looked at moderate to high risk

justice-involved youth found that those who were simultaneously involved in the child protection system had higher levels of impulsivity than those who had only previous child protection involvement, or who had no child protection involvement at all.[311] One Australian study of court-involved crossover children reported that 72% were noted to have 'challenging behaviour', which was significantly more likely among those crossover children who were male, as well as those with diagnosed neurodisability (e.g. intellectual disability, ADHD, learning, and communication disorders), as well as mental health disorders (e.g. behavioural disorders, trauma or attachment-related disorders).[312] Other research has also emphasised that mental health challenges tended to be more pronounced among crossover children with current child protection involvement, compared with those who had child protection involvement in the past.[313]

While most research found higher levels of mental health challenges among crossover children relative to other justice involved children, one study found no significant differences in the level of psychological distress experienced by young people aged 18-26 years experiencing homelessness based on whether they had been involved with child protection, youth justice, both, or neither system. It may be the case that the current experience of homelessness was more impactful on these young peoples' current distress than their historical involvement in various systems.[314]

3.3.6 Diagnosis of disability among Child Protection-involved and crossover children

Seven studies (8.0%) explored the complexities of diagnosis of disability among child protection-involved and crossover children, many of which highlighted the under diagnosis or delayed diagnosis of mental health and other disability (particularly neurodisability) among this group.[315] A lack of diagnosis was attributed to several factors, including child protection difficulties engaging with parents and families, difficulties accessing appropriate assessments, children's refusal to be assessed, and issues with the statutory definition of disability, which at times is not seen to capture crossover children's unique circumstances.[316] The impact of lack of diagnosis or delayed diagnosis is evident from US research showing that later assessments (e.g. for special education) are associated with increased likelihood of justice system involvement,[317] and Australian research which found that for 29% of crossover children with intellectual disability, this disability was only diagnosed after their involvement with the criminal justice system.[318]

At the same time, diagnosis of disability is not regarded simplistically in the literature, but seen to have both positive and negative aspects. Practitioners in particular regard a lack of disability diagnosis as facilitating the criminalisation of children's behavioural challenges, by perpetuating the hidden nature of the disabilities underpinning these challenges.[319] Further, a lack of diagnosis also generates barriers to disseminating practice knowledge about disability and appropriate responses to it, for the range of professionals who come into contact with child protection-involved children with disability (e.g. OOHC and youth justice providers, police).[320] Finally, a lack of diagnosis prohibits access to programs and services that could improve support to, and reduce the criminalisation of child protection-involved children with disability, including those transitioning from out-of-home care.[321]

Research has outlined concerns as to whether assessments for crossover children are undertaken by sufficiently skilled professionals (e.g. mental health screening in the youth justice systems).[322] Additionally, professionals are at times critical of the over-reliance on medical models of diagnosis, which they believe may at times delay intervention, enhance stigma, and interfere in the capacity to engage in therapeutic work; however professionals experience pressure from wider systems to classify children in this manner in order to facilitate service access.[323] The usefulness of medical models of diagnoses was also questioned in studies where crossover children were often noted to experience multiple diagnostic revisions and clinical disagreements over time, sometimes depending on the service system/s in which they were currently involved.[324] For example, one Australian study found that ADHD diagnoses among crossover children were often later revised by other clinicians to other diagnoses such as complex post-traumatic stress disorder, or learning disorder,[325] while a US study[326] described one crossover child who was given five different diagnoses in each of child welfare (PTSD), mental health (bipolar disorder and ADHD), juvenile justice (oppositional defiant disorder) and disability (pervasive developmental disorder) systems.

3.3.7 Factors associated with the likelihood of criminalisation of Child Protection-involved children with disability

A total of 24 studies (27.3%), including three Australian studies,[327] described factors associated with greater and lesser likelihood of criminalisation among children with disability in child protection systems. These factors are reported in this section according to the domain to which they relate, starting with those relating to an individual child, then expanding to factors related to the child's family, child protection involvement, peers, school, other support service involvement, and the neighbourhood in which they reside.

Individual factors

Individual socio-demographic factors associated with increased likelihood of criminalisation of child protection-involved youth with disability include male gender and having a racial or ethnic minority background (specifically Aboriginal and Torres Strait Islander children in Australia,[328] and African American children in the US).[329] It is important to note that these factors are not suggested to be causal, but may be indicators of additional disadvantage, marginalisation, disability, and traumatic experiences among child protection-involved children. For example, racial or ethnic minority background may reflect the intergenerational impact of colonisation, ongoing racial discrimination (of individual or systemic nature), or culturally inappropriate service provision. Likewise, Victorian research found that male gender was linked with nearly double the prevalence of neurodisability among criminalised children in child protection systems,[330] and substance abuse is understood to reflect self-medication of the psycho-emotional impact of traumatic experiences among child protection-involved children in both Victorian and US research.[331] Conversely, female gender appeared to be associated with a lower likelihood of criminalisation in several studies after accounting for child protection involvement and disability,[332] including among higher risk populations such as children with high rates of physical and sexual abuse, and mental health service utilisation,[333] and children diagnosed with

conduct disorder[334]. There were conflicting findings as to the impact of children's age on their likelihood of criminalisation, but this may reflect differences in the groups of children examined in each study. One US study found that compared with child protection-involved youth who solely received mental health services, those who also had contact with the justice system were significantly younger.[335] A second Australian study[336] found that among an out-of-home care sample who had experienced multiple placement breakdowns, after controlling for disability, older age was associated with increased likelihood of justice system contact.

Other individual factors that were associated with increased likelihood of criminalisation related to children's maltreatment experiences. For example, one study found that among children with three or more symptoms of conduct disorder, those who had witnessed family violence before 14 years of age were twice as likely to be arrested as those who had not (38% vs 19%).[337] Other studies found that experiences of neglect, physical abuse, other/mixed abuse, and maltreatment recurrence increased children's chances of being criminalised, even after accounting for disability.[338] The high level of maltreatment recurrence often seen among criminalised children with disability in child protection system is supported by other Australian research which found a significantly higher number of protective notifications, and earlier child protection involvement, among crossover children with a neurodisability, compared to those without a neurodisability.[339] Several studies have also investigated the impact of medication and substance use on the chances of justice system contact across this cohort. One study found that child protection-involved youth who were never given psychotropic medication had a lower likelihood of justice system involvement compared with inconsistently medicated youth, and consistently medicated youth; the author concluded that psychotropic medication treatment of at-risk youth does not appear to have a protective effect on their entry into the justice system when examined long-term.[340] Finally, studies have found that greater substance abuse is associated with increased chances of criminalisation of this cohort,[341] and this was supported by research that captured narratives of females in youth justice who described self-medication of childhood trauma, including experiences of abandonment and instability in foster care, and the use of substances for self-medication escalating to addiction and resulting in justice system involvement.[342]

Family and peer factors

Family factors associated with greater likelihood of criminalisation in this cohort included having a parent or sibling with justice system involvement,[343] and the family having lower socioeconomic status or resources,[344] and lower levels of family support[345] to children. Indeed these kinds of factors appear to be linked, with some research showing that child protection-involved parents facing their own hardships (for example related to homelessness, mental health and substance abuse challenges), and with limited social and economic resources sometimes relinquished children with disabilities to child protection due to their need for greater support.[346] Among crossover children with neurodisability, this pathway was particularly apparent for older children and adolescents with diagnoses of ADHD and speech and communication disorders, with such children very likely to enter residential care settings.[347] Conversely, several studies have found that parental education could be protective, with child protection-involved children with disability whose parents had higher levels of education being

less likely to be criminalised than those with parents who had lower levels of education.[348] It may be that parent's higher education levels are associated with higher socioeconomic status of the family, with resultant greater access to resources required to support children with disability. Finally, in relation to peer factors, two studies reported that after considering child protection involvement and disability, children with 'deviant' peers were more likely to experience justice-system involvement.[349]

Child Protection factors

Child protection factors related to a greater likelihood of criminalisation of children with disability include placement in out-of-home care (as opposed to solely receiving intensive family supports), placement in care for non-maltreatment (e.g. behavioural) reasons; placement instability; and placement in residential care settings (including when compared to foster or kinship care).[350] The impact of out-of-home care (particularly residential care) for the criminalisation of this cohort is particularly concerning given evidence suggesting that crossover and child protection-involved children with disability appear to be more likely to be placed in these settings than similar cohorts of children without disability.[351]. For example, Vostanis and colleagues' UK study[352] found that children with conduct disorder and comorbid emotional disorders were over-represented within the residential care (comprising 44% of children in residential care), compared with other children in out-of-home care. Australian research has found that placement in out-of-home care for adolescents with behavioural challenges may be due to relinquishment by parents (often sole mothers) unsupported to manage children's disability-related needs, or due to legalistic responses to adolescent family violence (e.g. intervention orders) resulting in the child's removal from the home.[353]

Finally, there were conflicting findings as to whether children's running away from out-of-home care resulted in increased[354] or decreased[355] chances of justice system involvement. Conversely, child protection factors that have been identified in the literature as protective against criminalisation of children with disability include provision of intensive family support services, placement for reasons of abuse/neglect (as opposed to child behavioural reasons), and longer length of time in a placement (i.e., when the number of placements is held constant).[356]

School and other support factors

One study found that among child protection-involved youth with two or fewer symptoms of conduct disorder, school suspensions resulted in a significantly greater likelihood of arrest (13% vs 4% for those not suspended); however this same study found that even among child protection-involved children who had more symptoms of conduct disorder and who had witnessed family violence, a belief that it was extremely important to do well at school was associated with significantly lower likelihood of arrest (13% vs 33%).[357] A qualitative study of justice-involved people with ADHD, many of whom had been in foster care, shed light on these findings; children described how their difficulties sitting still, concentrating, restless and impulsiveness (all traits of ADHD and for many also a consequence of being reared in chaotic environments with maltreatment and abuse), resulted in difficulties at school,

including fights with peers and negative relationships with teachers, leading to their own negative associations with school.[358] In relation to other support services, several studies have found that receiving mental health or special education services is associated with a greater likelihood of criminalisation among child protection-involved youth;[359] such findings may simply reflect children's diagnoses, and/or a lack of efficacy of the services to which they were referred in terms of preventing criminalisation.[360] At the same time, there is some evidence of service provision that is protective against criminalisation of this cohort, including long-term mentoring,[361] some mental health and substance abuse services,[362] and having an earlier age of first assessment for special education.[363] In relation to this last finding, the results of a US study[364] indicated that each year of earlier assessment for special education was associated with around a 40% decrease in the chance of justice system involvement.

Neighbourhood factors

Four studies pointed to the importance of neighbourhood factors in influencing the criminalisation of child protection-involved children with disability. First, after considering the impact of disability, child protection-involved youth who reside in more 'disordered' neighbourhoods appear more likely to be criminalised compared to those residing in higher socioeconomic status neighbourhoods.[365] It should be noted that 'disordered neighbourhoods' in this study were defined as those characterised by a greater level of 'structural degradation' (e.g. abandoned homes), and higher levels of crime; such neighbourhoods may also be subject to greater policing, which may explain such findings. Other evidence found that residing in higher socioeconomic status neighbourhoods was protective against justice involvement.[366] Another contributing factor to these outcomes may be the accessibility of disability services in different neighbourhoods, with one qualitative study reporting that participants believed the development of mental health problems in this cohort is also influenced by the shortage of mental health services in particular communities.[367]

3.3.8 Pathways to criminalisation of Child Protection-involved children with disability

Pathways by which child protection-involved youth are observed to be criminalised were described in 14 publications (15.9%), eight of which were conducted in Australia.[368] Such pathways included the criminalisation of disability-related behaviour, peer pressure, and criminal exploitation, as well as the highlighting of specific facilitators such as substance abuse.

Criminalisation of disability-related behaviour

A common pathway to justice system-involvement of child protection-involved children strongly emphasised in, UK[369], Australian[370] and US[371] research is punitive and criminalising responses to disability-related behaviours, which may occur in the family home,[372] school,[373] and most commonly in out-of-home care (particularly residential care)[374] settings. For example, one US study that captured the voices of crossover youth found that behaviours that might be conceptualised as being provoked by stress or anxiety for youth not involved with child

protection, were treated as offences in their own situations; they observed that they had been punished rather than being provided with counselling or other support in both school and care settings.[375] Another Australian study found crossover children with behaviours responded to as adolescent family violence incidents (either in the family home or in out-of-home care settings) were significantly more likely than other crossover children to have diagnoses of neurodevelopmental, mental and behavioural health disorders (e.g. ADHD, trauma/attachment-related disorders, conduct disorder); service providers in this study queried whether criminalising responses are the best response for this cohort, noting these often lead this group of children to be placed in residential care environments.[376]

In other Australian research, crossover children's initial police charges were often observed to be first acquired around the time of entry to residential care, and professionals often comment that behaviours for which children can become criminalised in residential care, such as property damage, are often managed less punitively in other environments.[377] The link between disability and criminalisation of behaviour occurring in the direct residential care placement context (e.g. property damage, threats, assaultive behaviour), has become more evident through recent Australian research which has revealed that, compared with other crossover children, the odds of acquiring such charges are elevated in children with neurodisability diagnoses (e.g. ADHD, intellectual disability, learning/communication disorders), as well as those with mental health or behavioural disorders (e.g. emerging personality disorders, trauma/attachment-related disorders, or behavioural disorders).[378] Since children with disability are more inclined to be placed in residential care settings compared with other crossover children, Australian research attempted to disentangle these factors. When examining neurodisability specifically, it was found that compared with other children placed in residential care, children diagnosed with intellectual disability or learning/communication disorders were no more likely to receive residential care-based charges, however those diagnosed with ADHD were more than twice as likely to receive these charges.[379] Overall, the research suggests that crossover children with some kinds of disability are more likely to be criminalised in residential care simply because of their propensity to be placed in these environments, such as crossover children with intellectual disability, who were twice as likely to have residential care-based charges compared with other crossover children (31% versus 16%).[380] At the same time, other crossover children with specific neurodisability are more likely to be criminalised compared with other children in residential care without the same specific neurodisability (e.g. children with ADHD).[381]

Other UK and Australian research has explored the drivers of criminalisation of children with disability in residential care, which professionals generally note to result from the use of police as a behaviour management tool in these settings, coupled with a failure to recognise disability, or to account for the impact of disability (including neurodisability, trauma, and other mental health conditions), on children's behaviour, or professionals' decisions to involve police.[382] Thus policy frameworks, as well as staff skill, training and support are all seen as factors contributing to the criminalisation process.[383] Consultations with a range of professionals who come into contact with criminalised children in residential care reveal a range of perspectives as to how warranted, or unwarranted such responses are. Generally, where criminalising responses are viewed as warranted by residential care staff, these behaviours

are conceptualised as a continuation of behaviour which children had, or to which they were exposed, in the family home; such behaviour was attributed to individual backgrounds and psychosocial 'deficits'.[384] Residential care staff themselves often report the use of carefully planned processes of intervention, in which police responses are used only as a last resort to deal with genuine danger and violence to staff or other children.[385] In UK research, police responses were also described as being utilised with children who are unresponsive to other staff 'sanctions', with criminalisation seen as a method of providing 'consequences' to children, preserving the 'authority' of the residential care unit's staff, providing a 'calming' presence, and sending a 'message' to other children about what behaviour would not be tolerated.[386] Staff in these studies reported a limited capacity to impose boundaries and consequences, with their lack of relationship limiting their influence with children's behaviour; however it was also noted that some staff are more skilled, indicating that staff training and experience may have a part to play in these outcomes.[387] Conversely, in both UK[388] and Australian[389] research it is usually police, magistrates, youth justice and leaving care workers who express views that the police intervention with children in residential care is unnecessarily frequent, harsh, lacking in consistency, and leading to further placement instability. One UK study noted that criminalisation often occurs in response to the frequency, rather than the seriousness of children's behaviour in residential care,[390] a finding supported by other research that found that the proportion of children with residential care-based charges increased with the cumulative time a child had spent in residential care.[391]

Despite the above, examples were provided by practitioners in one Australian study where children were better-supported to regulate behaviour in residential care via detailed assessment, effective care teams, specialist therapeutic placements, placement routine and stability, reduced client numbers, enhanced matching of co-residents, increased staffing, reduced staff rotation, and disability expertise.[392]

Peer pressure and criminal exploitation

UK research has identified the social environment of residential care as contributing to children's offending with their residential care-placed peers outside of these settings; specifically, this research suggests that children may feel pressured to engage in offending with their peers in residential care environments, and that refusal to do so could result in the danger of a child being lower on the "pecking order" in such environments, with consequent risk of social exclusion, bullying, or other victimisation.[393] While these UK findings are not specific to children with disability, more recent Australian research found that crossover children with neurodisability (including those in residential care, and those involved with child protection more broadly), were significantly more likely to be involved in group-based offending with peers, and to have specific charges related to motor vehicle thefts, than crossover children without neurodisability in these contexts.[394] Relatedly, other Australian research drawing on interviews with professionals as well as case file examples, has emphasised the systemic neglect of child protection-involved children with neurodisability (particularly children with cognitive impairments), renders them vulnerable to criminal exploitation by older youth and adults.[395] Such systemic neglect may

stem from failure to adequately supervise, provide stability and boundaries, and therapeutic services and settings for children in out-of-home care (particularly residential care) settings.[396]

The role of substance abuse in children's criminalisation

As indicated previously, several studies have identified that substance abuse is associated with increased likelihood of criminalisation among child protection-involved youth who live with disability.[397] Some research has described substance use in this cohort as driven by self-medication of childhood trauma, escalating to addiction.[398] Other studies have noted that the supply of illicit substances to children by adults in the general community, including strangers, loose acquaintances, and much older 'romantic partners', is often a key component of criminal exploitation of this group, leading to the child's later offending to repay drug-related debts, or to otherwise appease exploiters.[399] Again, children with disability in child protection systems are identified in the examined research as particularly vulnerable to such criminal exploitation.[400]

Educational marginalisation and school exclusion

As often critical precursors to children's criminalisation, educational marginalisation and school exclusion are examined in relation to criminalised children with disability in child protection systems. Four of the studies (4.5%), including one Victorian study,[401] described the educational marginalisation and exclusion of crossover children with disability.

Educational challenges. Attendance problems, academic challenges, school transience and grade retention of crossover children with disabilities are described in the available studies.[402] For example, Malmgren and Meisel[403] found that 39% of crossover children with emotional and behavioural disorders attended more than one school in an academic year, 59% were retained in the primary grades (kindergarten to grade 3), and 49% experienced multiple difficulties in areas such as reading, math and language prior to their disability diagnosis. Similarly, Baidawi and Sheehan[404] described the high degree of primary and secondary school transience among crossover children more broadly, though this was ascribed to both family and child protection system factors (e.g., family transience, placement changes), as well as at times being related to disability (e.g., emotion and behaviour regulation challenges). In this study, at least 12% of crossover children had a classroom aide or funding for education-related behaviour supports.

School conduct problems. Conduct problems at school were described both in research with professionals and noted in primary studies of crossover children with disability. For example, Malmgren and Meisel[405] reported that 92% of crossover children with disability experienced conduct problems at school prior to receiving special education referrals, while Marshall[406] noted that children with trauma backgrounds are easily excluded from schools with "zero-tolerance" behaviour policies. Baidawi and Sheehan[407] noted that escalation in conduct problems at school often coincided with life difficult circumstances among crossover children with disability, including escalating family violence at home, child-parent relationship difficulties, entry or exit from out-of-home care, current physical or sexual abuse, and recent parental death.

School exclusion. Studies have identified that at least 28-36% of crossover children had experienced school exclusion (suspension or expulsion), and while commonly emerging in secondary school, one Australian study found that for 8% of crossover children school exclusion commenced from primary school, though it was unclear what proportion of these children experienced disability.[408] School exclusion often occurs in the context of crossover children's emotional and behavioural regulation challenges, and appears more common among males relative to females (45% vs 17%), and for crossover children with disability.[409] For example, an Australian study of 300 crossover children found that school exclusion was more likely among those with diagnosed learning and communication disorder (54%), ADHD (56%), trauma and attachment-related disorders (51%), behavioural disorders (62%), and children with any mental health diagnosis (46%), than crossover children without these diagnoses. Case file data noted that the reasons for school exclusion varied from poor attendance, to not completing school work, 'oppositional', 'disruptive', 'sexually inappropriate' or aggressive behaviours, as well as other dangerous, destructive or illegal behaviour at school (e.g. destroying property, bringing weapons to school);[410] again these reasons for school exclusion were not specific to crossover children with disability. A secondary structural form of school exclusion for crossover children was also described in this study, which found that some crossover children experienced difficulties re-enrolling in school after being excluded or spending time in youth justice custody.[411] While some barriers to re-enrolment concerned child protection or educational systems issues (e.g. classes being full, the child lacking a birth certificate or current address), other barriers related to systemic neglect of crossover children with disability, for instance:

- Schools lacking an appropriate program to meet the child's disability-related needs;
- Schools unable to adhere to the safety requirements for the child;
- Schools unable to subsidise the level of support required for the child (e.g. classroom aides);
- The child being too young for the available alternative education options; and
- Schools refusing to enrol the child due to their educational history or criminal charges.[412]

Special and alternative education engagement. US studies have found that special education is often the initial service system encountered by crossover children with disability, and while eligibility for special education was on average identified at 10.2 years in this study, there were gender and ethnic differences apparent (with females and Hispanic youth being identified as eligible at older rages).[413] This same US research found that special education referral was most commonly made for behaviour problems among crossover children (55%), followed by both behavioural and academic difficulties (23%), speech and language difficulties (10%), and academic problems only (6%).[414] The initial category of disability identified for the crossover children in this US study was serious emotional disturbance (56%), learning disability (17%), and speech or language impairment (10%), while 13% of children were still in need of assessments. In an Australian study of crossover children, 56% had engaged in alternative education (including special disability schools, home schooling, one-to-one tutoring and education in youth justice custody), demonstrating a lack of suitability or capacity for mainstream schooling environments to meeting the needs of many crossover children.[415]

Other systemic challenges and barriers

The research base often describes service system challenges to meeting the needs of crossover children. Professionals are often challenged by crossover children with disability across all service systems with which they are involved, describing themselves as feeling 'bewildered', 'frustrated', 'embarrassed' and lacking confidence and their ability to respond to children's multiple needs.[416] Barriers to service and systems collaboration are also regularly identified, including professionals' different conceptualisations of children's needs and behaviour, their differing frameworks for conceiving of necessary interventions or supports, barriers to information sharing, and unrealistic expectations of other services.[417] Broad systemic challenges also include a lack of appropriate resources to respond to children's support needs (e.g. services, suitable placements), service gatekeeping due to lack of resources, and geographic disparities in service availability.[418] The following section specifically outlines findings regarding access to mental and behavioural health services and supports for crossover children with disability.

3.3.9 Access to mental and behavioural health services

A total of 12 studies (13.6%), including one Victorian study,[419] reported findings related to crossover children's level of access to mental and behavioural health services and supports, and/or the factors associated with higher or lower levels of service access. These studies reported that 44-78% of crossover children access mental or behavioural health services, with lower levels seen among crossover children who had been arrested or sampled from court environments (44-49%)[420] and higher levels seen among crossover children who had been convicted of offending (67-78%).[421] For example, Chuang and Wells[422] found that while approximately 20% of crossover youth did not receive any behavioural health services, 78% received outpatient mental health services and 33% received inpatient mental health services within three years of entering the child protection system. In Victoria, Baidawi and Sheehan found that 13% of a court-involved sample of crossover children had engaged with a disability service, 49% had engaged with clinical mental health services, 45% had engaged with generalist counselling or psychology services, 31% had engaged with trauma-specific services and 6% had engage with speech or occupational therapy.[423]

At the same time, several studies emphasised that the level of mental and behavioural service need among crossover children is often greater than the level of services received.[424] For instance, among crossover youth Hirsch and colleagues[425] reported that an average of 2.56 mental health referrals were received, while only an average of 1.76 mental health services were accessed. Similarly, Herz and colleagues[426] found that around 20% of crossover youth with mental health needs in the US did not receive treatment. Finally, multiple studies have concluded that the mental health treatment provided to child protection-involved and crossover youth appeared ineffective for preventing youth justice system contact or reducing justice system reinvolvement.[427] A key service gap appears to exist for those in their mid-to late teenage years, and research suggests a causal link between inadequate mental health service provision and children's negative trajectories, with the justice system being ultimately utilised to fill gaps in mental health and disability service provision to this group of children.[428]

Factors affecting access to disability, mental and behavioural health services

Factors identified in the literature as affecting access to disability, mental and behavioural health services among crossover children include individual level factors as well as service system factors. It should be highlighted that most publications discussed in this section (6/10) only looked access to mental health services, while one looked at access to behavioural health services,[429] one examined disability-specific service provision in out-of-home care[430], and two discussed both metal health and disability service access among crossover children transitioning from out-of-home care.[431] The key message is that there were negligible studies of disability service access among crossover children aside from those examining mental health service access.

Individual factors. Individual factors that influence disability, mental and behavioural health service access include those relating to children's sociodemographic characteristics, service system involvement, and disability-related factors. In relation to sociodemographic characteristics, Kim and colleagues[432] found that while female crossover youth had significantly greater mental health service receipt, their service dosage was in fact lower than that of male crossover youth. This study also found that African American crossover youth and older youth each had lower dosage of mental health services, while younger crossover youth experienced greater mental health service access.[433] In relation to systems involvement, the research suggests that crossover children in institutional settings, and out-of-home care experience greater service access than children remaining in the family home; further, a longer duration of involvement with child protection appears to be associated with greater support service access.[434] There were mixed findings about the relationship between placement instability and support service access among crossover children; one study found that crossover children who experienced a placement change during their probation period were less likely to access mental health services,[435] while two other studies found that placement changes among crossover youth were associated with increased mental health service access.[436] However once Kim and colleagues[437] accounted for co-occurrence of mental health disorders, placement instability no longer predicted mental health service access among crossover children, suggesting that these factors are linked. Finally, disability-related factors identified as impacting support service access for criminalised children in child protection systems include a lack of diagnosis and/or children not identifying as having a disability.[438] Disturbingly, two studies have found that crossover children with greater levels of disability (including mental health)-related need and complexity were less likely to receive mental health services than crossover children with lower levels of disability-related needs.[439]

Service system factors. Service system factors related to disability, mental and behavioural health service access include those relating to service system integration (e.g., between child protection, youth justice and other support services), and those specifically relating to disability, mental and behavioural health service provision. In relation to service system integration, one US study found that designation of single agency accountability (specifically to child protection) for crossover youth was associated with children's greater likelihood of receiving outpatient

mental health services, and that greater administrative data sharing between child protection and youth justice was associated with greater odds of children receiving inpatient mental health services, but not outpatient behavioural health services.[440] Other research highlighted the importance of data sharing across service systems, outlining that the lack of background information prohibits more targeted and appropriate service provision for crossover youth, and results in children having to repeat their stories unnecessarily.[441] Having integrated systems also includes the ease of referrals to and between systems, opportunities for collaborative planning, and professionals' expertise around, and attitudes towards child protection-involved and crossover children with disability. For example, one study found that greater education system referrals were associated with greater referrals to mental health services among crossover youth.[442] At the same time, research has identified that professionals working with crossover children with disability face difficulties reconciling the ideas of criminal justice system involvement and disability, tending to view child protection-involved children as either having a disability (including mental health or trauma) or as being justice involved.[443] Such compartmentalisation is reinforced by administrative and funding systems which regard these as separate needs, ignoring the complexity of the relationship between justice involvement and disability, and leading to systems neglect of crossover children with disability.[444] Systems neglect was seen to manifest in many ways, including (but not limited to): a lack of attention to protective issues being afforded to child protection-involved children who become justice involved; a lack of appropriate disability and trauma-informed support to assist this group to navigate the justice system (further propelling their criminalisation); and, a lack of trauma and disability informed services, frameworks and professionals, leading crossover children with disability to face barriers accessing appropriate services, and to feel misunderstood, dismissed, and lacking in safe spaces and relationships.[445] This last point was outlined by crossover children with disability, but also by youth justice professionals in the US, who acknowledged they lack the frameworks to understand crossover children in the context of disability, including the impact of their often traumatic histories.[446] Similarly, a lack of staff disability training in the out-of-home sector in Australia was seen to contribute to children's lack of diagnosis, and to facilitate the criminalisation of their behaviour, for instance in residential care settings.[447]

The final service system factor identified as impacting crossover children's access to disability, mental and behavioural health services were gaps in the available services. This included a shortage of or delays accessing relevant services (e.g., mental health providers),[448] and was supported by findings indicating that child protection-involved youth who were residing in areas with greater mental health treatment availability were less likely to exit care into youth detention, compared with those residing in areas with lower mental health treatment availability.[449] The research has emphasised crossover children's difficulties accessing disability and mental health-related assessments and specialist supports, which is further compounded for children with placement instability and those in regional and rural areas; suitable services were seen to be flexible, to have the capacity to operate on an outreach basis, and to engage in ongoing assessment and treatment with children, rather than simply providing secondary consultation.[450] The need for appropriate services was emphasised further in research which stressed the overuse of "crisis" service provision with this group of children, and conversely a lack of developmentally appropriate prevention services,[451] and disability-informed care and

therapeutic services.[452] Finally, gaps in the available services were also seen to arise through service disruption, either due to unstandardised services that were unable to provide continuity of child protection-involved youth with disabilities as they traversed multiple systems, or when they experienced placement disruptions, or were transitioning from out-of-home care.[453] Conversely, services and programs capable of working with children and young people across multiple services systems, catchment areas, or age-groups were highlighted as valuable.[454] For example, a Victorian study noted that while a number of support services terminated when young people turned 18 years of age (generally also the time of their transition from out-of-home care), some regions had established child and youth mental health and substance abuse services that were able to provide services until 21 or 25 years of age, enhancing the possibility of young people experiencing continuity of these supports as they exited the child protection and/or youth justice systems.[455]

3.4 Research Gaps

There are clear gaps in the existing research concerning the criminalisation of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children with disability in child protection systems, including those in out-of-home care (including residential care) settings. There are also minimal data related to gender differences in this area, and that includes the voices of children or families. Further, much of the available research at the specific nexus of child protection, disability, and children's criminalisation focuses on risk, with limited attention to protective factors that are associated with reduced criminalisation of this group. Additionally, there is insufficient research that can shed light on what other approaches, particularly non-service responses (e.g., informal support, cultural and community connectedness), child protection-involved families and children with disability find helpful for avoiding or reducing the likelihood of children's criminalisation. These identified research gaps have informed later study elements (survey and consultations with professionals), the findings of which are presented in the study's second report.[456]

One response to the structural ableism and marginalisation to which children with disability in child protection systems are subjected is enable them to declare their voice in their own right. Advancing the voices for young people with disability involves a long term process to respectful attend to complex array of ethical considerations that was beyond the scope of this particular study. The Disability Royal Commission, along with studies such as these, should be a platform to give impetus to more expansive, intergenerational work on addressing the structural barriers to the exclusion and criminalisation of disability.

The next section presents the review of publicly available child protection policy and practice guidance that aims to reduce the criminal justice system contact of children with disability in child protection systems.

4. Child Protection Care Criminalisation Policy and Practice Review

4.1 Aim

This report reviews publicly available child protection policy and practice guidance from each Australian jurisdiction that aims to reduce criminal justice system contact of children with disability in child protection systems. The policy aim of reducing criminal justice system contact of children with disability in child protection systems was interpreted broadly as policies that addressed behaviour that could potentially be criminalised, and where the policy mentioned disability as defined in the current study. Policies addressing school exclusion among children in child protection systems were included at the request of the Disability Royal Commission, following the emergence of school exclusion as a key factor contributing to the criminalisation of child protection-involved children with a disability in the scoping review.

4.2 Method

In Australia, individual states and territories are responsible for the administration and operation of child protection services. This review employed a Google search to locate relevant Australian child protection policy and practice information in each jurisdiction coupled with key terms including: “child protection manual”, “child protection guide”, “Child Protection practice framework”. Further Google searches were conducted to locate relevant joint Child Protection policies such as memoranda of understanding (MOU) in each jurisdiction employing key search terms such as: “MOU”, “joint protocol”, “youth justice”, “residential care”, “out of home care”, “reduce criminalisation” and “Department of Education”. Once relevant and publicly available policies had been identified, further Google and Google Scholar searches were conducted including the name of the policy and key words (“Review”/“Evaluation”) to locate formal or informal evidence of policy effectiveness. These searches were supplemented by a review of Australian reports and peer-reviewed literature known to the authors which references these policies.

4.3 Results

The policy review is presented in six sections, each outlining a key area of child protection policy aimed at reducing criminal justice system contact of children with disability as follows:

1. Joint protocols and practice between child protection, youth justice and disability services;
2. Child protection policy aimed at supporting children with harmful or problematic sexualised behaviours;
3. Residential care policy aimed at preventing the criminalisation of children at risk of justice system involvement;
4. Out-of-home care policy and practice aimed at preventing the criminalisation of children with behavioural difficulties and complex needs;

5. Child protection and Department of Education joint policies focused on school exclusion, suspension, and expulsion of child protection-involved children; and
6. Multi-disciplinary practice policies and panels that include child protection and youth justice and/or disability.

Publicly available policies are presented from each Australian state and territory (See Table 4 for summary). Where information is available, policies are explored individually, including policy description, identification of service sectors impacted by the policy, and any formal or informal evaluations or evidence as to the policy's effectiveness. Where no relevant publicly available policy from an Australian jurisdiction was identified, this is noted.

4.3.1 Joint protocols and practice guidelines between Child Protection, Youth Justice, and Disability Services

Some jurisdictions have publicly available policies directing collaborative practice between child protection and youth justice when working with children with disabilities. For instance, VIC has a protocol between child protection and youth justice, while NSW has a Memoranda of Understanding and Joint Operational Practice Guidelines between Youth Justice and Child Protection.

Table 4. Publicly available policy and practice frameworks by Australian states and territories, March 2022

State/ territory	3.3.1 Joint protocols and practice guidelines between child protection, youth justice and disability services	3.3.2 Child protection policy aimed at supporting children with harmful or problematic sexualised behaviours	3.3.3 Joint residential care policies aimed at preventing the criminalisation of children at risk of justice system involvement	3.3.4 Policy and practice guidance for responding to children in out-of-home care with behavioural difficulties and complex needs	3.3.5 Child protection and Department of Education policy focused on school exclusion, suspension, and expulsion	3.3.6 Multi-disciplinary practice policies and panels that include child protection and youth justice and/or disability[1]
VIC	✓ D	✓ TD	✓ T D A	✓ T D A	✓ D A	✓ T D A
NSW	✓ D	✓ T D	✓ T D A	✓ T D A	✓ D	
QLD	✓ D		✓ T D A	✓ T D A		✓ T D A
WA	✓ D			✓ T A	✓ D	✓ T D
SA				✓ T D A		
NT			✓ T A			✓ T D A
TAS						
ACT	✓ D			✓ T D A		

Note. ✓ **-** Policy available in jurisdiction as at March 2022. **T** – Policy has specifically considered trauma and/or its impact on children's behaviour. **D** – Policy has specifically considered disability other than trauma and/or its impact on children's behaviour. **A** – Policy has specifically highlighted needs of Aboriginal and Torres Strait Islander children with disability. [1] T, D, and A are noted where multidisciplinary panels contain services aimed at specifically addressing trauma, disability and/or Aboriginal and Torres Strait Islander cultural needs.

NSW, QLD, and WA have sections within their child protection manual/guidelines which mention working with children with disability who are involved in the justice system, particularly regarding the NDIS and disability services. ACT uses a single practice model for both child protection and youth justice services within which children with disability are mentioned once.

VIC

The Victorian *Protocol between Child Protection and Youth Justice* was implemented in 2016. It provides direction on how child protection and youth justice practitioners should collaborate, share information, and share and responsibility for 'dual order' clients who are co-supervised under both statutory systems.[457] Within the protocol, a section on 'Disability services and young people involved with child protection and youth justice' outlines the role and aim of disability services with such children, and specifies which children qualify for disability services. The protocol notes the greater likelihood of children with disability experiencing involvement in both the child protection and the criminal justice systems, and further emphasises:[458]

- the importance of role clarification between youth justice, child protection and disability services for such children;
- the need to promptly identify a primary case manager for children at the intersection of these three systems; and
- the need to ensure an assessment is conducted for children suspected of having a disability.

The protocol advises that readers should refer to the *Protocol between Youth Justice and Disability Services* and guidelines for workers, Department of Human Services (2009) or the *Children, Youth and Families and Disability Services Operating Framework*, Department of Human Services (2012) for further information.

The 2017 Ogloff and Armytage *Youth Justice Review and Strategy (Meeting Needs and Reducing Reoffending)* report critiqued the current Victorian protocol, noting that despite the many children dually involved with child protection and youth justice, 'the current approaches to information sharing and service integration for these young people are ad hoc at best and non-existent at worst, despite the existence of a protocol'.[459] Further, qualitative research with professionals in this jurisdiction similarly suggests a lack of on the ground adherence to the policy.[460] Although aspects of the protocol aimed at young people with disability are not explicitly mentioned, these critiques nonetheless bear relevance to the provision of services to children with disabilities at this interface.

NSW

*__NOTE__: On 1 July 2019, Juvenile Justice became Youth Justice NSW. In addition to this, youth justice and child protection amalgamated and became one government department now known as the Department of Communities and Justice. The departmental restructuring process was still underway at the time of writing, and as such, the policies discussed below may not currently be in use.

The *2014 NSW Joint Operational Practice Guidelines to Accompany the Memorandum of Understanding Between Department of Family and Community Services And Department of Justice, Juvenile Justice About Children or young people who are shared clients of Family and Community Services and Juvenile Justice* briefly mentions collaborative work between youth justice, child protection and disability services.[461] Sections 3.6 and 6.11 of the policy outline the importance of juvenile justice and child protection collaborating with other relevant agencies to 'facilitate access to government and non-government programs and services' based on the needs of the young person'. The policy further states that all agencies involved with the child should be part of case planning and case implementation processes, including disability and the National Disability Insurance Agency (mentioned in both sections 3.1 and 6.1).

The 2019 NSW *Caseworker guidelines for Early Intervention, Child Protection and Out of Home Care (OOHC) Staff* outlines:[462]

- **The roles and responsibilities** of Department of Communities and Justice (DCJ), DCJ funded non-government organisations (NGOs) and the Department of Justice, Juvenile Justice NSW (JJ NSW) in supporting shared clients with disability to access the National Disability Insurance Scheme (NDIS);
- **Identifying who has Parental Authority for a child** under Parental Responsibility of the Minister for Family and Community Services, and NDIS, and involved in the Department of Justice - it is outlined that 'the person with out-of-home care (OOHC) case management responsibility (DCJ or NGO) will be the child's representative. The Parental Responsibility of a shared client and their representative for NDIS purposes remains unchanged when entering custody.'
- **The responsibility of NDIS planning when a dually involved child with disability *who does not have an NDIS Plan* enters custody** - 'it is the responsibility of DCJ (or NGO) staff with OOHC case management responsibility to undertake activities related to the NDIS access, planning, monitoring and review process.'

Responsibilities when a dually involved child with an existing NDIS plan enters custody - [463] 'JJ NSW will confirm there is an NDIS plan in place by contacting the DCJ or NGO with OOHC case management responsibility. Where the person has funded support coordination, JJ NSW staff will also contact the Support Coordinator responsible for coordinating their NDIS Plan. Additionally, 'the OOHC caseworker, in collaboration with JJ NSW, will need to determine if an urgent NDIS plan review request is required. If one is required, the OOHC caseworker must submit this request to the National Disability Insurance Agency (NDIA) as soon as possible.' JJ NSW staff are required to support this review process by 'providing copies of relevant assessments and other information on the person's functional needs that may assist the Support Coordinator or the NDIA to determine whether a plan review is required or to inform a plan review. JJ NSW centre staff may also need to meet with the Support Coordinator and/or NDIS representative, subject to the OOHC caseworker's consent. Should a review be approved by the NDIA, JJ NSW will need to have input regarding the young person's revised needs and reasonable adjustments whilst in the detention centre and post release.'

When preparing for a dual order client with disability to leave custody the OOHC caseworker and JJ NSW staff must undertake joint case planning and/or facilitate multi-agency transition planning, particularly with Housing NSW and other relevant agencies and support services, to ensure that no child or young person exits care or custody into homelessness.

Overall, the guidelines emphasise that throughout all processes it is essential for 'JJ NSW and DCJ/NGO caseworkers collaborate to inform a shared client's NDIS plan and related supports.'

QLD

The current QLD Child Safety Practice Manual guides the delivery of child protection services. Within the manual the section titled '*NDIS support for a young person in contact with the youth justice system'* provides direction for child protection, youth justice and NDIS practitioners working with dual order young people with disability.[464] The manual advises that children subject to a child protection order and in contact with youth justice should continue to have access to disability supports from the NDIS if they continue to be eligible. For a child in the community under all three systems, the NDIS is responsible for providing:[465]

- 'coordination of NDIS supports in collaboration with the supports offered by the youth justice system, including for victims, witnesses and alleged offenders with disability;
- supports to address behaviours of concern (offence-related causes) and reduce the likelihood of offending and reoffending. This includes social, communication and self-regulation skills, where these are:
    - additional to the needs of the general population;
    - required due to the impact of the person's impairments on their functional capacity; and
    - additional to reasonable adjustment;
- reasonable and necessary supports in line with the usual NDIS planning process, which may include assistance with planning, decision making, scheduling, communication, self-regulation and community living. Refer to Reasonable and necessary supports on the NDIS website.'

The manual also outlines that for children who are NDIS participants and in youth detention (including on remand or as a result of a sentence or other court order), the NDIS is responsible for providing the following supports, when the supports required are due to the impact of the child's impairments on their functional capacity and additional to reasonable adjustment:[466]

- 'coordination of NDIS supports with the supports offered by the justice, disability, education, health, community services and other systems (including Child Safety);
- aids and equipment (excluding fixed aids such as hoists or specialised beds);
- allied health and other therapy directly related to a young person's disability, including for young people with disability who have complex, challenging behaviours';

- disability-specific capacity and skills-building supports that relate to a young person's ability to live in the community after release;
- supports to enable young people to successfully re-enter the community; and
- staff training in custodial settings where this relates to an individual child's disability needs.'

Regarding information sharing, the manual outlines that NDIS information is shared between Child Safety and Youth Justice. For children also subject to youth justice orders, the child safety officer is responsible for recording the child's NDIS information, although youth justice staff may help to maintain it.

WA

Within the WA *Child Protection Casework Practice Manual* there is a section which speaks to the Disability Justice Service (DJS). While the manual does not address the unique needs of children with disability involved with both child protection and youth justice, it does present information in the Casework Practice Manual about the DJS.

The manual states that young people with disability face higher likelihood of justice system involvement, particularly those who experience of disability impacts their impulsivity levels, consequential thinking skills, emotional regulation skills, and ability to understand body language. The manual also states that the DJS is available to all people with disability who are engaged with the justice system and can provide:[467]

- In-reach services to Banksia Hill Detention Centre and adult prisons;
- Multi-disciplinary offender diversion services with a multi-disciplinary team;
- Information and referral provision to relevant legal services when a person with disability has contact with the Western Australia Police;
- Fast-track diagnostic assessment pathways and assessment reports for people with disability who are facing Court; and
- A Disability Justice Centre (residential facility) for people with disability who are deemed Mentally Impaired Accused, i.e. are unfit to stand trial.

ACT

In the ACT, the 2019 CYPS (Child and Youth Protective Services) Case Management Framework is used for across child protection and youth justice systems. Within this framework, children with disability who have child protection and/or justice system involvement are only mentioned once. The framework states:

'In cases of children with complex needs, the transition of case management from CYPS to ACT Together will commence with a period of co-working. Complex needs encompass children:[468]

- with complex disability or medical issues;
- who have experienced multiple changes in placement and may present greater challenges for carers;
- with behavioural, psychological or emotional issues that require specialist support; and/or
- in residential care.'

ACT Together, a government funded initiative, is a consortium of agencies who together provide predominantly out-of-home care services for children in the ACT. ACT Together case management is generally used for children on longer term orders.

SA No information available.

NT No information available.

TAS No information available.

Summary

There appears to be very little consistency between Australian joint practice guidelines which include child protection, youth justice and disability services. While VIC and NSW both have a joint child protection and youth justice protocol, the Victorian protocol provides significantly more detail than the NSW protocol for practice with children with disability and even then, the only review of the implementation of the VIC protocol is negative. Additionally, findings within the Victorian literature suggest a lack of on the ground adherence to these policies. NSW and QLD appear to provide similar information on how practitioners should work with dually involved children who have a disability, and focus primarily on the role of the NDIS. This is important information for practitioners; however, it does not provide information regarding young people who may not yet have a diagnosed disability and an NDIS plan. WA mentions the DJS within their child protection manual, but it does not appear that the DJS provides any specialised care for dually involved children who have a disability, as opposed to children with disability who are only involved in the justice system. Lastly, the ACT CYPS Practice Framework mentions children with disability only once. SA, NT and TAS did not provide any information.

4.3.2 Child protection policy aimed at supporting children with harmful or problematic sexualised behaviours

VIC and NSW are the only two Australian jurisdictions with specific child protection policies that guide responses to young people who have exhibited harmful or problematic sexual behaviours. Both pieces of policy acknowledge that some children with disability are at higher likelihood of demonstrating harmful sexual behaviours. In VIC and NSW child protection practitioners work with the young person and their family to address the sexually harmful behaviours, however child protection can also simultaneously be involved with the same child and their family to address protective concerns. Both policies emphasise the importance of providing a therapeutic, rather than criminalising, responses to this cohort.

VIC

The Adolescents with sexually abusive behaviours and their families, Best interests case practice model Specialist practice resource 2012 is currently utilised by Victorian child protection services. In Victoria, children who exhibit sexually abusive behaviours can be placed by the Children's Court on a statutory Therapeutic Treatment Order if the young person and their parents/carers have not already voluntarily engaged in therapeutic treatment. Victoria is the first and only state presently to have a legislated and completely funded therapeutic response to children exhibiting sexually abusive behaviours.[469]

The 2012 practice model encourages child practitioners who are working with children exhibiting sexually abusive behaviours to consider if the young person has a mental illness and/or intellectual disability.[470] In terms of mental health, the practice model outlines how conduct disorder (CD), attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), oppositional defiance disorder (ODD), depression, anxiety disorders, bipolar disorder and substance abuse can commonly occur in children exhibiting sexually abusive behaviours and also states that complex post-traumatic stress disorder (PTSD) being present should not be overlooked.[471] The model stresses the importance of considering whether the mental illness or sexually abusive behaviour is the most significant issue, or if both require equal treatment. Furthermore, child protection practitioners are encouraged to gather any information as to whether the child demonstrating sexually abusive behaviours may have a disability to assist in case formulation and treatment planning. Child protection is advised to explore the child's: 'family-of-origin factors, personal health history, developmental history, care history, educational history, assessment of general cognitive functioning, social functioning, psycho-sexual history, history and meaning of sexually abusive behaviours'.[472] The practice resource guide generally encourages thorough investigations to be carried out, and for child protection practitioners to always speak with other professionals involved with the child especially when relevant, including youth justice, child protection, housing and/or disability services.

NSW

In 2016 the NSW Department of Family and Community Services issued the practice guide: Working with children who display sexually harmful behaviour - See, understand and respond to child sexual abuse. This document was issued for use by Child Practitioners when working with children who exhibit sexually harmful behaviours, and their family. The practice guide offers questions for practitioners when they are assessing the level of risk and vulnerability of a child, in addition to the types of interventions the child exhibiting sexually harmful behaviours may need. There are questions exploring intellectual disability, mental health, behavioural difficulties, emotional dysregulation, experience of abuse, neglect and/or trauma and substance use, all of which should inform practitioners' assessment and planning of appropriate interventions.[473]

QLD No information available.

WA No information available.

ACT No information available.

SA No information available.

NT No information available.

TAS No information available.

Summary

In Australia, only VIC and NSW have child protection practice guidelines which aim to prevent the criminalisation of children who have exhibited harmful or problematic sexual behaviours. Both policies aim to reduce the criminalisation of children by providing a therapeutic response to this cohort, which in each instance is delivered by child protection and other therapeutic agencies. Child practitioners in both states are encouraged to obtain adequate information regarding whether a young person has a disability, mental illness, experiences of trauma, neglect or abuse and substance use, and to consider these in designing appropriate interventions for the child. However, beyond considering a child's disability when planning interventions, neither document explores in detail how child protection may directly work with a child needing support for harmful sexual behaviours who also has possible comorbidities, such as an intellectual disability.

4.3.3 Joint residential care policies aimed at preventing the criminalisation of children at risk of justice system involvement

NSW first released their *Joint protocol to reduce the contact of young people in residential out of home care with the criminal justice system* in 2016. QLD produced a similar protocol and practice guidelines in 2018 titled: *Joint protocol to reduce the contact of young people in residential out of home care with the criminal justice system* and the associated *Practice Guidelines Reducing Preventable Police Call-outs to Residential Care Services Guide 1*. In 2019 NT produced the *Protocol for Police Contact with Children Living in Therapeutic Residential Care* and then VIC in 2020 released the: *Framework to reduce criminalisation of young people in residential care*. All four documents mention children with disability and provide child protection, youth justice, police and residential care staff with directions on how to respond to children who may exhibit difficult, complex, or offending behaviours and prevent their unnecessary criminalisation. No other Australian states or territories have produced similar protocols to date.

VIC

The Victorian *Framework to reduce criminalisation of young people in residential care* mentions children with disability, with a particular focus on children who have experienced significant trauma who may demonstrate behaviours of concern as result of these traumatic experiences.[474] The document clearly outlines how trauma can result in challenging behaviours, and stresses that all staff must provide and be trained in trauma informed care when working with children in residential care settings. The framework states that children in residential care 'experience a higher incidence of mental health, disability, emotional and behavioural difficulties than other children and are at greater risk of contact with services such as police and the youth justice system'.[475] The policy also highlights Aboriginal and Torres Strait Islander children's unique experiences of trauma, which should be considered and responded to in a culturally safe manner.

To address these needs, the policy states that all children in residential care must have a behaviour support plan which considers the child's unique set of needs, to prevent incidents from occurring. The policy advises that for Aboriginal and Torres Strait Islander children their behaviour support plan should:[476]

- 'align with the young person's cultural plan and must consider Aboriginal decision making principles;
- Aboriginal people should be involved in developing their behaviour support plan; and
- consideration should be given to consulting with an Aboriginal community controlled organisation as part of developing the behaviour support plan'.

Should the police be involved when a child exhibits behaviours of concern, the framework instructs residential staff to provide the attending police officer with information regarding the: the nature and context of the incident (for example, severity, injury/damage caused, triggers, timeline), the individual (for example, history of behaviour, mental health including trauma, physical health, disability), the victim(s) (for example, their relationship to the individual, harm caused, their wishes), their approaches to deescalate or respond to the behaviour, strategies for engagement or addressing behaviours of concern that have proved effective in the past, the nature of police assistance sought. The framework outlines that Victoria police must consider all of these factors and when appropriate use discretionary powers as an alternative to criminal charges.

NSW

The NSW 2019 *Joint protocol to reduce the contact of young people in residential out of home care with the criminal justice system* acknowledges that there are many children residing in residential care who have experienced 'complex trauma'.[477] The protocol emphasises that past experiences of trauma can result in children demonstrating challenging behaviours which can involve: 'risk taking, poor impulse control, resistance to boundaries (for example being absent from care without permission) and in some situations, can escalate into violent and/or criminal behaviour'.[478] The policy states that Aboriginal and Torres Strait Islander children also have

unique experiences of trauma which need to be considered and responded to in a culturally safe manner and that children from culturally and linguistically diverse (CALD) backgrounds have the right to feel connected to their culture and community. The protocol states that residential care staff must respond in a trauma informed manner which involves providing children with planned, positive and supportive strategies to assist them in working towards more positive patterns of behaviour. The use of Individual Behaviour Support Plans (BSPs) are also encouraged when a child consistently exhibits challenging behaviours and existing de-escalation strategies are ineffective. BSP's are usually prepared by a psychologist or another skilled professional in behaviour management.

When directly responding to a young person demonstrating challenging behaviours, the protocol states that residential care staff should also consider the mental health of a child, or if they have an intellectual disability. Furthermore, should residential staff be given authorisation to call police, they must provide relevant information about the children involved including 'any mental or physical health issues or if the young person has an intellectual disability'.[479] Police are also then required to consider the 'Information provided by the service about the young person's situation (including disorders/ illnesses/medication issues) or other factors impacting on the young person's behaviour and the young person's behaviour support plan (BSP)' when determining the least punitive response necessary. The protocol is signed by NSW Police Force, Child and Family, Communities and Justice Association of Children's Welfare Agencies, and AbSec.

Qualitative research from NSW has presented a critical view of these policies, highlighting the inconsistency with which they are implemented and adhered to, the need for such policies to be accompanied by measures to better train and support residential care staff, to shift attitudes (e.g. of police, residential care staff and the broader public) towards children in residential care, and to encourage interagency collaboration which can easily remain unaddressed by 'just another policy document'.[480] Research suggests that such attitudinal shifts may be brought about through hearing the voices of children and young people with lived experience of out-of-home care, including at conferences, seminars and other training opportunities.[481]

QLD

QLD Queensland Family and Child Commission released a *Joint protocol to reduce the contact of young people in residential out of home care with the criminal justice system* in 2018. The protocol provides guidance for staff working in residential care, Child Safety Services and police. The protocol stated that all children in residential care have a right to be 'cared for within a trauma-responsive system that does not criminalise behaviours resulting from previous experiences of neglect or abuse'.[482] The protocol also states that residential care workers to be culturally proficient and consider the impacts of intergenerational trauma relating to Aboriginal and Torres Strait Islander children. Furthermore, all Aboriginal and Torres Strait Islander children in residential care should have cultural support plans in place, and Aboriginal and Torres Strait Islander elders, communities or agencies should be involved in ensuring plans are culturally responsive. The protocol states that should the police be involved with a child in residential care for demonstrating possible offending behaviours, police must consider 'information provided by the residential care service about the child's personal circumstances, situation or other factors impacting on the child's behaviour (e.g. mental health, trauma, illnesses)'.[483]

To accompany the joint protocol, Queensland also published the document Practice Guidelines Reducing Preventable Police Call-outs to Residential Care Services Guide 1. The guidelines state that all children must be included in the development of 'case plans, care plans, safety plans, individual crisis management plans, positive behaviour support plans and cultural plans, all of which must be living documents that residential care workers refer to, to guide their daily work'.[484] All of these plans should aim to address each child's individual needs and should contain responses that may prevent children from engaging in offending behaviours. Should an incident occur in residential care, the guidelines state that staff should review all case plans and to consider how a child's medical conditions or disabilities could lead to difficulties in their behaviour. For example, the guidelines state that:[485]

- 'young people with attention deficit hyperactivity disorder (ADHD) may find it very hard to stay still or concentrate for long periods of time;
- young people with an autism spectrum disorder (ASD) diagnosis may become unsettled by changes in routine, causing them to become upset or anxious. They can also react strongly to their environment, for example when other young people escalate, they may also escalate;
- young people who have sensory impairments may be over or under stimulated by sounds, sights, smells and noise. This can significantly affect the way they respond to their environment;
- young people with specific learning difficulties (e.g. reading or writing) or speech and language difficulties may find learning at school difficult and stressful without good support If appropriate support is lacking, a young person's behaviour may change or become challenging; and
- some young people have a disability that impacts on their ability to speak and may need alternative ways to communicate their needs.'

The practice guidelines require staff to consider a child's disability in reviewing and revaluating case plans after an incident so that staff can respond in a more supportive way to the child should they be in a heightened state.

NT

The 2019 *Protocol for Police Contact with Children Living in Therapeutic Residential Care* developed by Territory Families and Northern Territory police, outlines both the purpose of Therapeutic Residential Care and the protocols in place to reduce the unnecessary criminalisation of children in care. In the NT, children who have specific, high or complex needs can be placed in therapeutic residential care, where they are able to receive trauma informed care, a safe nurturing environment, a place to recover from abuse and trauma, and support 'to avoid becoming unnecessarily involved with Police and the youth justice system.[486] The policy also advises that all parties to the protocol should be culturally responsive to Aboriginal and Torres Strait Islander children by ensuring all children have cultural support plans in place, and by residential care staff completing mandatory cross-cultural training.

To support the unnecessary criminalisation of children and young people in Therapeutic Residential Care, the Protocol outlines where a child demonstrates challenging behaviours a Behaviour Support Plan (BSP) must be prepared by a trained behaviour management professional with TRC staff and a Case Manager from Territory families. The BSP must include 'contextual information, expected behaviours, known triggers and de-escalation strategies'.[487] BSP's may also be shared with NT Police when appropriate to support their responses to children. Staff working at Therapeutic Residential Care are also provided with after hour support including de-escalation and behavioural management support (phone or in person support).

WA No information available.

ACT No information available.

SA No information available.

TAS No information available.

Summary

In summary, VIC, NSW, QLD and NT have each recently developed similar residential care policies aimed at preventing and reducing the criminalisation of children at risk of justice system involvement. All documents acknowledge the role of trauma in causing some young people to display challenging or offending behaviours, the importance of trauma informed care, culturally sensitive interventions, considering a young person's disability when responding to an incident, and the development of pre-existing behaviour support plans. Both VIC and QLD state that every child must have an individual behaviour support plans, NT states that all children in therapeutic residential care who demonstrate challenging behaviours must have a behaviour support plan and NSW encourages the use of behaviour support plans rather than mandating this approach. The NSW policy asserts that behaviour support plans must be completed by a psychologist or skilled professional in behaviour management and the NT policy advises that behaviour support plans must be prepared by a trained behaviour management professional. Only the QLD practice guidelines which accompany their protocol explore in detail how specific disabilities might lead to behavioural difficulties and provide information for residential care staff on how to prevent unnecessary incidents from occurring by triggering a neurodivergent child. Qualitative research from NSW has presented a critical view of these policies, highlighting the inconsistency with which they are implemented and adhered to, the need for such policies to be accompanied by measures to better train and support residential care staff, to shift attitudes (e.g. of police, residential care staff and the broader public) towards children in residential care, and to encourage interagency collaboration which can easily remain unaddressed by 'just another policy document'.[488] At the same time, recent research from South Australia, which has yet to implement such policies, recommends an urgent review of current practice and implementation of a system to monitor critical incidents in residential care that result in a police response.[489] There appears to be room for all such protocols to provide more detail on how different disabilities (other than trauma related disabilities) may affect a child and their behaviour, and to provide more detail on how to best support children to prevent and respond to emotional and behavioural escalation.

4.3.4 Policy and practice guidance for responding to children in out-of-home care with behavioural difficulties and complex needs

To categories of polices throughout Australian states and territories aim to prevent the criminalisation of children with disability or behavioural difficulties in out-of-home care. The first category are policies describing therapeutic residential care and how children with high or complex needs are supported through intensive and therapeutic interventions in such placements; VIC, NSW, QLD, WA, and SA all have policies in this area. Secondly, there are behaviour support policies aimed at supporting children in residential care who have a disability, complex or challenging behaviours that require additional management and support for the child; VIC, NSW, QLD and ACT have policies in this area. Both types of policies appear to provide added supports to children with challenging behaviours, with a view to reducing their criminalisation.

VIC

The Victorian policy *Program requirements for the delivery of therapeutic residential care in Victoria, 2016* provides information on how residential care staff can support complex and high needs children in out-of-home care. Therapeutic residential care (TRC) is a contemporary model of care that aims to improve life outcomes for children with complex needs and who have experienced trauma from abuse or neglect. The Program requirements state that in TRC 'every interaction between children and residential care staff is recognised and valued as an opportunity to counter and heal the effects of past trauma and disrupted attachment'. In Victoria, TRC must:[490]

- 'be based on a guiding framework that incorporates theories of attachment, trauma and the neurobiological development of children and young people that can lead to complex, challenging and trauma-related presentations
- address the therapeutic needs of each child or young person based on specialised, comprehensive and ongoing assessment and the development of an individualised therapeutic treatment plan which responds to their particular characteristics and needs so they can heal, develop and grow'.

Within the policy, residential care staff are encouraged to work collaboratively with other organisations who are working with the children to provide a holistic and effective therapeutic response. The policy outlines minimum TRC program documentation for each child that requires staff to state partnership arrangements for organisations including child protection, youth service and youth justice, disability services and mental health. The program documentation requires that children are effectively linked with needed service supports, and there are plans in place for case planning, collaboration and access to consultation when needed.

The 2018 policy document *Practice Guide: Behaviour planning to best support children and young people in out-of-home care* aims to provide information to residential care staff on how to best support children in out-of-home care who may have behavioural difficulties due to their experiences of trauma and neglect. The policy states the residential care and child protection staff have a responsibility to:[491]

- have current and comprehensive assessment of the child or young person including disability, mental health, strengths and abilities and other aspects of a child's development, as well as the impact of trauma and neglect, for the individual child or young person.'
- A positive and proactive approach to behaviour support.
- Including children and young people in the development of a plan and appropriate responses; and
- Minimising responses that might re-traumatise a child or young person through the use of punitive or restrictive responses'.

The policy also advises that Aboriginal people should be involved in the development of behavioural support plans for Aboriginal and Torres Strait Islander children, and consideration should be given to consulting with an Aboriginal Community Controlled Organisation when developing the plan.[492] The Practice guide indicates that individualised behaviour support plans should be created for each child.

NSW

In NSW, a Therapeutic Care framework is used throughout residential care is described in the *NSW Therapeutic Care Framework 2017* document. The practice framework states that Therapeutic care is a 'holistic, individualised, team-based approach to the complex impacts of trauma, abuse, neglect, separation from families and significant others and/or other forms of severe adversity'.[493] The framework states that children who have children who have experienced high levels of trauma and who are placed in residential care need an intensive approach including the guidance of therapeutic specialists. The framework requires that the 'individual programming for each child or young person is developed with clinical input and is evidence-informed, culturally respectful and responsive; and provides positive, safe, reparative and healing relationships and experiences to address the complexities of trauma, attachment and developmental needs'.[494]

The 2021 *NSW Government Communities and Justice, Behaviour support in out-of-home care* policy document also outlines added supports available for children in out-of-home care with complex or concerning behaviours.[495] One of the criteria for added support is if a child demonstrates dangerous behaviours to themselves or others and/or is impacting seriously on their daily functioning. A behaviour support plan (BSP) must be prepared by a behavioural expert for these children. The policy advises that all BSP's must be culturally appropriate for both Aboriginal and Torres Strait Islander children, and children from culturally and linguistically diverse (CALD) backgrounds. The policy states that 'behaviour support provided for Aboriginal children is to be culturally appropriate, consistent with the child's cultural care plan, actively involve the kin and family that care for the child, as well as the child's biological family whenever possible and facilitated by Aboriginal staff and carers whenever possible, or when not possible, by culturally competent non-Aboriginal staff and carers'.[496] Staff are also advised to provide culturally respectful behaviour support for children from CALD backgrounds that is sensitive to their experiences, particularly if they are from refugee or migrant backgrounds. Children with disability are mentioned in the document, and the NSW Government defines disability in this

instance as ‘any condition that affects a person’s ability to perform daily tasks and participate in the community’.[497] The policy states that some children from refugee backgrounds may also have ‘complex psychological needs, such as post-traumatic stress, depression, anxiety and developmental delays’. When caseworkers are preparing and implementing a BSP for a child with disability, they are directed to ‘have a clear understanding of the child’s disability itself and the behaviours and triggers’.[498] Caseworkers are advised ‘not to make plans to eliminate a child’s concerning behaviour without having a clear understanding about what purpose that behaviour may serve’.[499]

QLD

QLD’s *Child Safety Residential care policy no 606-4* outlines that children and young people with complex and extreme support needs are eligible for Therapeutic Residential Care, where they are provided with intensive therapeutic care, in a therapeutic living environment.[500] Children are provided with a space to recover from impact of their trauma whilst receiving behavioural support tailored to their individual needs. The policy states that children in therapeutic residential care will receive evidence-based services informed by theories of child development, attachment, trauma and grief and loss and that Aboriginal and Torres Strait Islander children will receive care that considers their cultural and spiritual wellbeing.

Within the 2021 QLD *Child Safety Practice Guidelines Procedures Support a child in care* Evolve Therapeutic Services (Evolve) is outlined. Evolve is a partnership between Child Safety and Queensland health and provides ‘specialist intensive therapeutic interventions for children in care with severe and complex mental health support needs’. Some of the criteria for a child to receive Evolve services include:[501]

- residing in out-of-home care
- presenting with severe and complex psychological or behavioural problems
- experiencing:
    - multiple, intense and persistent emotional or behavioural problems
    - a high level of risk
    - a severe functional impairment across a variety of domains

Evolve can provide comprehensive assessment and treatment plans, a crisis response to stabilise behaviours, therapy and secondary consultation to other agencies on the effects of trauma and abuse. Also, within the 2021 QLD *Child Safety Practice Guidelines Procedures, Support a child in care, Respond to a Child’s Challenging or High Risk Behaviour* are instructions for Child Safety practitioners for when a child in out-of-home care is demonstrating challenging or high-risk behaviours. The policy provides a range of intervention suggestions for Child Safety officers once it has been assessed that a child has significant behavioural or emotional stability needs including completing a referral to: Evolve, a psychologist specialising in high-risk behaviour or engaging an NDIS registered behaviour support practitioner for children already engaged with the NDIS.[502]

There are also additional practice guidelines in *QLD's Child Safety Policy Positive Behaviour Support Policy No: 604-5 for* children engaging challenging or high-risk behaviour because of their disability, trauma or mental health challenges. For these children and young people, the policy advises Child Safety practitioners to: ensure that all children have a positive behaviour support plan, to consider if disability specific training funded by NDIS could be arranged for careers and to use a child's support network in assessing, managing, and reviewing behavioural risk. The policy advises all staff to utilise a positive behaviour support approach throughout all stages of working with children who have behavioural difficulties.[503] The policy states that when undertaking positive behaviour support with Aboriginal or Torres Strait Islander children, connection with family, community, culture and country is an important consideration.

SA

SA's child protection website (last updated in 2020) outlines their *Service Specifications* and includes a section exploring *Residential Care: Disability* policy and practice guidelines. The SA government website states that for children and young people in care who have a disability who need a residential care place will receive an 'individualised and flexible disability, developmental and trauma informed response' in a disability placement. Children with a range of diagnoses are eligible for support however the most frequent diagnoses include: 'autism spectrum disorder, intellectual disability, developmental delay, physical disability, hearing loss, or a combination of these'.[504] The guidelines state that Aboriginal and Torres Strait Islander children in disability residential care must receive culturally safe and responsive support, and that all disability residential care service providers must:[505]

- operate in accordance to the five key elements of the Aboriginal and Torres Strait Islander Child Placement Principle[506] – Prevention, Partnership, Placement, Participation and Connection, and Identification (as the precursor);[8]
- build a culturally competent workforce by ensuring all staff successfully complete Aboriginal cultural competence training;
- provide culturally safe and responsive placements;
- collaborate with Aboriginal Community Controlled Organisations (ACCOs) and Principal Aboriginal Consultants to support connection to family and culture; and

8 As outlined by SNAICC, The Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) recognises the importance of connections to family, community, culture and country in child and family welfare legislation, policy and practice, and asserts that self-determining communities are central to supporting and maintaining those connections. The ATSICPP aims to: 1.ensure an understanding that culture underpins and is integral to safety and wellbeing for Aboriginal and Torres Strait Islander children is embedded in policy and practice; 2.recognise and protect the rights of Aboriginal and Torres Strait Islander children, family members and communities in child welfare matters; 3.increase the level of self-determination of Aboriginal and Torres Strait Islander people in child welfare matters; and 4.reduce the over-representation of Aboriginal and Torres Strait Islander children in child protection and out-of-home care systems.

- provide flexible and tailored support and skills development opportunities to Aboriginal children in their communities, including the use of appropriate Aboriginal interpreters.

The policy also states that disability residential care service providers must provide culturally and linguistically diverse children with: 'culturally suitable placements that support connection with culture and a strong sense of cultural identity utilising a hierarchy of placement principles including cultural, ethnic, language and religious matching'.[507]

The practice guidelines advise that all children in disability residential care should receive 'quality placements that support their safeguarding in alignment with the NDIS Practice Standards', 'Where eligible, access to NDIS specialist disability supports', therapeutic support to facilitate recovery from the impacts of trauma and individualised interventions which addresses each child's disability, behavioural and environmental support needs[508].

WA

The Residential Care and Secure Care Services Sanctuary Framework 2020 policy document outlines the model the WA Department of Communities utilises operating therapeutic residential care services. The framework is based upon the Sanctuary Model principles. The document advises that all children in therapeutic residential care must have their trauma history, including triggers and coping strategies explored and documented, and for this information to be accessible to all placement staff. All plans are to be regularly updated. Staff are encouraged to always work therapeutically to support each individual's 'sense of safety, healing and day to day behaviour'.[509] The Aboriginal Practice Leader is available to provide consultation support during therapeutic care planning and 'assistance to staff in developing culturally safe practice.' The framework aims for:[510]

- a reduction in violence (physical, verbal, emotional);
- a system understanding of the impact of trauma;
- a reduction in victim blaming: reduced punitive and judgemental responses
- clearer, more consistent boundaries and higher expectations (linked to rights and responsibilities); and
- earlier identification of, and strategies to deal with, perpetrator behaviour.

ACT

The 2020 *ACT Child and Youth Protection Services Behaviour support response Policy* and 2020 ACT *Child and Youth Protection Services Behaviour support response Procedure* documents both outline the supports children in out-of-home care who are demonstrating 'behaviours of concern' are eligible to receive. The documents state that children in out-of-home care often require behaviour support due to their experiences of trauma and for some children, their disability. The ACT Child and Youth Protective Services behaviour support response consists of:[511]

- a planned process of identifying behaviours of concern
- endeavouring to understand the behaviours and their triggers through a behaviour of concern consultation process; and, where required
- developing and implementing positive behaviour strategies to help reduce the behaviour and support the individual needs and circumstances of the child or young person.'

These responses can include referrals to the Therapeutic and Assessment and Planning Team (TAPT) and developing a Positive Behaviour Support Plan (PSBP). Staff are advised to 'seek the advice of the Aboriginal and Torres Strait Islander Cultural Services Team where the child is Aboriginal and/or Torres Strait Islander to ensure proposed responses demonstrate cultural sensitivity'.[512] For children with disability who are engaged with NDIS, staff are encouraged to work collaboratively with the child's NDIS plan coordinator, and for children with disability who are displaying behaviours of concern but without an NDIS plan, staff are advised to seek an NDIS plan as soon as possible.

NT No information available.

TAS No information available.

Summary

All Australian jurisdictions except for TAS and the NT have publicly available out-of-home therapeutic residential care and/or behavioural support policies or practice frameworks. All polices clearly outline the connection between trauma and behavioural difficulties, yet few explore the impact of other disability on children's behaviour. NSW's therapeutic residential care policy, QLD's Evolve policy, and WA's residential care policy all neglect to mention the term 'disability' other than discussing the impact of trauma. SA is unique in that the state has developed Disability Residential Care and the policy, explicitly discusses many disabilities including various types of neurodisability. The standard of care for children with disability in general or therapeutic residential care appears to vary across Australian states and territories. In contrast, most states and territories had mostly consistent behavioural support polices recommending that all children with behavioural issues have a behaviour support plan. Some jurisdictions stated that these plans must be created by behavioural experts, but not all.

4.3.5 Child protection and Department of Education policy focused on school exclusion, suspension, and expulsion

VIC, NSW and WA are the only three Australian states and territories to have publicly available joint Child Protection and Department of Education policy focused on school exclusion, suspension, and expulsion. These policies focus on children in out-of-home care who are in school, and explore how key needs such as: disability, behavioural difficulties, school engagement and school retention may be addressed collaboratively by child protection and

education systems. It is known that children in out-of-home care are more likely to have poor education outcomes relative to their peers not in out-of-home care, and that school exclusion can form a key component of children's pathways to the criminal justice system. These policies all appear to aim to reduce the criminalisation of children with disability in out-of-home care by providing additional educational supports to this cohort.

VIC

In 2018 the Victorian Government produced the *Out of Home Care Education Agreement a Partnering Agreement between: Department of Health and Human Services, Department of Education and Training, Catholic Education Commission of Victoria, Independent Schools Victoria, Victorian Aboriginal Child Care Agency, Centre for Excellence in Child and Family Welfare*. This policy document outlines some of the support available to children in out-of-home care to address their educational and social/emotional needs while they attend school. Some of the interventions include:[513]

- Student Support Group or Program Support Group (SSG/PSG):
- SSG/PSG is the primary mechanism for supporting children in out-of-home care who are attending school. The SSG/PSG involves the child, school staff, all services involved with the individual, carers, and family meeting to collaboratively support the child through school. The SSG/PSG meets at least once per term and more frequently to address when a student's engagement, wellbeing, attendance, or behaviour is of concern. The policy also indicates that for Aboriginal students, the Koori Engagement Support Officer will attend the first SSG meeting and should continue to attend in complex matters such as a student with a disability/PSD, multiple accommodation and/or school placements, significant attendance issues and multiple behavioural challenges' (p.20). The SSG/PSG is also responsible for developing an Individual Learning Plan which can focus on 'academic, physical, social and emotional or behavioural skills to achieve quality learning outcomes for the student' (p.20).
- Students with disabilities and additional needs should receive additional supports including individualised learning programs and access to support staff. Students with disabilities are also able to apply to receive support from the Program for Students with Disabilities (PSD). Children in OOHC are prioritised for entry into this program.

If a student begins to disengage from school, the SSG/PSG must address these concerns as soon as possible. Suspensions and expulsions should only be used by the principal as a last resort. The policy outlines that Secretary approval is required to expel a child aged eight or less, and the Regional Director must be informed when expulsion is being considered for students who belong to one or more of the following cohorts:[514]

- a student in OOHC
- a student with a disability who is eligible for PSD provided by the Department for Education and Training

- an Aboriginal or Torres Strait Islander student.' (p.24)

Additionally, schools must also complete multiple tasks before suspending or expelling a student including[515]:

- Ensuring that all available interventions to address the behaviour of concern have been provided
- Convene a Behaviour Support and Intervention meeting (or PSG for Catholic schools)
- Advise the student and their carers of their risk of expulsion and arrange for an independent person of their choice to be involved in meetings

NSW

In 2013 NSW government produced the policy: *Memorandum of Understanding between NSW Department of Education and Training (Schools) and Department of Human Services NSW, Community Services in relation to educational services for children and young people in Statutory Out of Home Care.* The Memorandum of Understanding (MOU) states that children in out-of-home care (OOHC) are entitled to receive learning and educational support whilst attending school. The MOU outlines that both Community Services and Education have a responsibility to coordinate their approaches to 'educational planning, information sharing, enrolment, engagement or attendance issues and suspension, expulsion, placement, and transition procedures'.[516]

The NSW Government Education Department has also released an *Out of Home Care in Government Schools Personalised learning and support planning procedures* policy to accompany the 2013 MOU described above. This personalised learning policy states the principal of the school must ensure that all students from OOHC enrolled in the school have a personalised learning and support plan. The plan 'may include disability, transition, behaviour or health care planning', 'the academic, social, behavioural, emotional and wellbeing needs of the child or young person' and strategies to address these needs. All key people involved in the student's life including family members, staff from the school, and support services should be involved in implementing and reviewing the learning plan.[517]

WA

The Government of WA released a Memorandum of Understanding (MOU) between the Department of Communities and Department of Education in 2021. The MOU specifically addresses children with high needs, which includes individuals with disability. The MOU states that when a student in the CEO'S care enrols in a school, their child protection worker must advise the school of any 'behaviour, disability or other condition that may impact the child's participation in education'.[518] Both the school and child protection must also communicate openly and work collaboratively to implement the Documented Plan which identifies the supports necessary for a child to engage in education.

Section 9.4 of the MOU addresses managing child behaviour and attendance. When the principal of a school proposes suspending a child in the CEO'S care, the student's child protection worker must be notified and there should be an opportunity for both parties to discuss options in relation to the suspension. If a child is suspended, the school and child protection must develop or review the existing behaviour management plan.[519]

To support a child's continued participation in education child protection should access specialist resources including speech therapy, occupational therapy, psychological assessment and treatment, behaviour therapy or an alternative education program. In exceptional cases for children demonstrating complex and challenging behaviours, the school principal, child protection and the school's Lead Psychologist may assist the child to access education programs (including the Department of Education's School of Special Educational Needs: Behaviour and Engagement) and support services.

When a child has been excluded from school, both the school and child protection and the relevant Department of Education Regional Office must work together collaboratively to develop and action a transition plan for the child to relocate to a new school or education arrangement.

QLD No information available.

ACT No information available.

SA No information available.

NT No information available.

TAS No information available.

Summary

VIC, NSW, and WA are the only three Australian states or territories to include joint child protection and department of education policies focused on the suspension, exclusion or expulsion of children from school. All three policies also only apply to children who are in out-of-home care (rather than those involved with child protection more broadly), and in WA's policy only relevant to children who are in the CEO's care. There are similarities across the joint children protection and education policies including the additional learning and educational supports available to children with disabilities, behavioural or learning difficulties. Regarding school suspensions and expulsions, VIC policy has the most detailed protocol in place to prevent children from being excluded from school. WA addresses school exclusion to some degree although not in as much detail as VIC, and NSW's policy does not address this issue at all.

4.3.6 Multi-disciplinary practice policies and panels that include child protection and youth justice and/or disability

VIC, QLD, WA, and NT all contain multi-disciplinary practice initiatives, mostly in the form of practice panels. All the panels or programs listed below can include children who are involved in child protection, disability services and youth justice, however they are also open to children involved in different services. Most of these initiatives are aimed at high-risk children who are considered to have complex needs and to require a multidisciplinary practice approach.

VIC

VIC's 2021 *Service Provision Framework: Getting it Together - A guide for individuals, carers and services on accessing the Multiple and Complex Needs Initiative* advises that 'MACNI provides targeted, time-limited and flexible interventions to a small number of people aged 16-years and over with combinations of mental illness, substance dependency, intellectual impairment, acquired brain injury, and who pose a risk to themselves and/or others'.[520] MACNI is funded by the Department of Health and Human Services, the Department of Justice and Community Safety, and the Director of Housing. There is some evidence supporting MACNI from a youth justice perspective in the Victorian Ogloff and Armytage *Youth Justice Review* (2017), which noted that while MACNI is 'highly effective intervention for complex clients', very few youth justice clients are accepted into MACNI.[521] Given this policy review is focussed on reducing the criminalisation of child protection involved children who have a disability, it is concerning that very few youth justice clients are accepted into MACNI.

Additionally, within VIC'S 2020 *Child Protection Manual* there is a section titled 'High risk youth panels and schedules' which describes additional supports available to child protection involved children aged 10-17 years who are considered high risk, extremely vulnerable, and who have multiple, complex difficulties.[522] The high-risk youth schedule and panel aims to assist with identification of vulnerable clients, decision-making, service integration and case planning. The panels meet monthly and generally include: child protection practitioner and team manager responsible for the registered client, youth justice, disability services, out-of-home care and case management services, mental health services, drug and alcohol and other drugs treatment services, therapeutic treatment services, ACSASS, Department of Education and Training and other programs or professionals as appropriate.[523]

QLD

QLD'S *Department of Child Safety, Youth and Women, Practice Guide, Practice Panels* policy was produced in 2019. The policy states that the practice panel is a facilitated process of engaging Child Safety staff along with representatives from other services or departments, family and friends to gather important information and make critical decisions or recommendations about the case plan direction for the child.[524] Referrals to the Practice Panels are made by the Child Safety Officer (CSO) responsible for the case, and are made prior to any child protection order expiring, cases where reunification is being considered or planned, when considering the most appropriate type of ongoing intervention, or when making a decision to

close an Intervention with Parental Agreement case. Practice Panel members typically consist of the CSO, Senior Team Leader, Senior Practitioner and Manger (for any complex cases), Cultural Practice Advisor (for all Aboriginal and Torres Strait Islander children), workers from other government services or community agencies who are working with the child, family and where appropriate, a professional with specialist knowledge or expertise, for example, disability, domestic and family violence, drug and alcohol, mental health.[525]

WA

WA's child protection practice manual (last updated in 2022), *section 3.4.26 Supporting children with disability*, outlines the inter-agency state government initiative*: Young people with complex care needs (YPECN).* YPECN provides 'young people with the highest level of care needs with a comprehensive and co-ordinated response from services through interagency coordination, information sharing. This service is for young people who have experienced gaps in regular service provision'.[526] Many of the children engaged in YPECN are in the care of the state care, however it is not considered a pre-requisite for the service.

'Partner agencies in the program are:[527]

- Department for Child Protection.
- Disability Services Commission.
- Mental Health Commission.
- Department of Housing.
- Department of Health, Child and Adolescent Mental Health.
- Department of Education.
- Department of Corrective Services, Youth Justice.
- Drug and Alcohol Office.
- Office of the Public Advocate'

NT

In 2020 the Northern Territory Government released *the Multi-Agency Community and Child Safety Framework (MACCSF).* MACCSF is a relevant collaboration between 'community members with cultural authority, locally based heads of government agencies, and non-government organisations' who all meet fortnightly across 27 remote territories and some major centres in the Northern Territory.[528] MACCS Teams (MACCSTs) come together to identify concerns, create action plans for child, family and community safety, and address issues such as youth crime, education, health, or child safety. The group discusses 'emerging or thematic community needs' as well as specific children and families. Any person in the who is worried about the safety of a child, family, group of children or the broader community can make a referral to the MACCST. 'MACCST membership must include:[529]

- At least two Aboriginal members of Aboriginal Community Controlled Organisations, local staff of the relevant government agencies and /or members with cultural authority.
- Locally based non-government service providers that provide services for families, children, and communities.
- The most senior delegate based in the community from each of the following agencies:
    - Territory Families, Housing and Communities
    - Northern Territory Police
    - Department of Health and/or Aboriginal Medical Service
    - Department of Education and/or Independent School
    - Department of the Chief Minister and Cabinet
    - Department of Attorney-General and Justice (Correctional Services)
    - Manager, Children and Families Centre
    - Government Engagement Coordinator (Commonwealth)'.

Although MACCSF is not a child protection policy, in the context of this review, it is a relevant collaborative framework that brings together both government and community to support the protection and welfare of children and families in the Northern Territory.

NSW No information available.

ACT No information available.

SA No information available.

TAS No information available.

Summary

Although the policies discussed above are not solely for children with child protection involvement, VIC, QLD, WA and NT all have multidisciplinary practice policies which often include child protection and sometimes youth justice and disability services. All the practice initiatives involve a panel or gathering of services, where staff, family and other supports can review and revise the child needs, case plan and proposed interventions. Each state or territory has a different eligibility criteria required to review a child's case by a multidisciplinary team, with VIC's MACNI and High risk youth panels, and WA's YPECN only providing services to very 'complex', 'high needs' and 'high risk' children, and in contrast QLD's child protection practice panel reviewing a case any time there are changes in a child protection order, and in NT any person who is worried about the safety of a child or family can make a referral to a MACCS team.

4.4 Policy Gaps

- Most of the policies (except for the joint protocols) solely target children in out-of-home or residential care, rather than all child protection-involved children.
- Policies tend to focus on the relationship between trauma and children's behaviour, with less attention given to other disabilities. Ideally trauma and other disability should be given equal consideration.
- Policies advise staff to consider if a child has a disability, however there is little guidance on how to support and deliver interventions to child protection-involved children with disability or suspected disability.
- There is lack of attention to culturally and linguistically diverse cohorts, and lack of detail regarding supporting Aboriginal and Torres Strait Islander children beyond ensuring those in residential care have cultural support plans, and culturally-responsive behaviour support plans.
- While an increasing appreciation of the importance of cultural competence in attaining just outcomes for children is evident in many of the reviewed policy, the disability experience remains elusive to the various policy frameworks, which do not reflect a nuanced understanding of the structural factors contributing to disability exclusions, even in the rare instance when disability and structural ableism is referenced.
- Overall, there are inconsistencies across jurisdictions in terms of the responses to child protection-involved children with disability who are at risk of being criminalised.

5. Summary and Recommendations

Part 1 of this report brought together a review of recent primary empirical research on factors understood to increase and decrease the likelihood of criminalisation among children with disability in child protection systems. It also described what the included research outlined as the nature of disability, maltreatment and child protection involvement, criminalisation processes, offending behaviour, and service use among children with disability in child protection systems. Finally, it presented a review of publicly available Australian child protection policy and practice guidance that aims to reduce criminal justice contact of children with disability in child protection systems.

Scoping review summary. The scoping review findings made clear that child protection-involved children with disability face a disproportionately greater likelihood of experiencing criminalisation compared with child protection-involved children without disability. This is particularly for children with neurodisability and mental health diagnoses, including those related to trauma, and children with disability in out-of-home care settings. The criminalisation of children within child protection systems is a key pathway by which children with disability come to enter the youth justice system in Australia, and the evidence shows that this group criminalised at younger ages and tend to return to the justice system more frequently. Lack of diagnosis, underdiagnosis, and delayed diagnosis contribute to these outcomes, and certain groups of children with disability face heightened chances of criminalisation, including Aboriginal and/or Torres Strait Islander children, children with family criminal justice involvement, children who are excluded from school, those who enter out-of-home care, and those who reside in lower socioeconomic status neighbourhoods.

A common pathway to justice system-involvement of child protection-involved children is punitive and criminalising responses to behaviours related to neurodisability, mental health challenges, complex trauma, or a combination of these. Such punitive and criminalising responses to disability-related behaviour and needs tend occur in the family home, school, and most commonly in out-of-home care settings. Systemic neglect in child protection systems can place children with cognitive impairments in positions of vulnerability, resulting in their increased likelihood of being caught up in group offending, including via criminal exploitation by older youth and adults.

The level of mental and behavioural service needs of crossover children are often greater than the level of services received, and mental health treatment provided to child protection-involved and crossover youth appears ineffective for preventing youth justice system contact or reducing their justice system reinvolvement. Inadequate service provision appears to underpin some crossover children's trajectories, with justice responses applied to address systemic neglect in the provision of mental health and disability supports for families and children. Gaps in available services include a shortage of relevant services and assessments, overuse of "crisis" service provision, a lack of developmentally appropriate prevention, culturally appropriate and disability-informed care, and therapeutic approaches. A lack of service integration enables crossover children with disability to continue to experience systems neglect, and this compartmentalisation is reinforced by administrative and funding systems that view these separately, ignoring the complexity of the relationship between justice involvement and disability.

Scoping review research gaps and limitations. There are clear gaps in the identified research concerning the criminalisation of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children with disability in child protection systems, and minimal research related to gender differences in this area, or which includes the voices of children and their families. Further, much of the available research at the specific nexus of child protection, disability, and children's criminalisation focuses on risk, with limited attention to protective factors that are associated with reduced criminalisation of this group. Additionally, there is insufficient research that can shed light on what other approaches, particularly non-service responses (e.g., informal support, cultural and community connectedness), child protection-involved families and children with disability find helpful for avoiding or reducing the likelihood of children's criminalisation. These identified research gaps have informed later study elements (survey and consultations with professionals), the findings of which are presented in Part 2 of this report.[530]

The research specifically pertaining to disability among criminalised children in child protection systems also does not account for broader systemic and practice issues which have been identified contributors to the criminalisation of child protection-involved children, including but not limited to:

- A lack of support for child protection-involved children in the criminal justice system (e.g., at the time of arrest, interview, or hearing);[531]
- The failure of child protection workers to provide criminal courts with information about the complex needs of child protection-involved children;[532]
- Lobbying by child protection workers for children to enter or remain on custodial remand;[533]
- The use of police to locate children who have breached the conditions of their bail by going missing from placements;[534]
- The higher rate of remand experienced by children in child protection systems, relative to other justice-involved children;[535]
- A lack of safe accommodation leading some children to prefer youth detention over out-of-home care placements;[536] and
- A lack of judicial understanding of care criminalisation.[537]

While the above issues are not specific to criminalised children with disability in child protection systems, they will disproportionately impact children with disability given their identified over-representation among criminalised children in child protection systems. They should therefore be noted as providing a wider context of systemic and institutional neglect within which the issues specifically pertaining to criminalised children with disability in child protection systems should be understood.

Finally, it should be noted that the identified research was limited by the inclusion of primary empirical studies, as well as the definition of disability, which was based on Commission's Terms of Reference, as outlined in the Interim Report of the Disability Royal Commission.[538]

The impact of this is that the scoping review findings do not canvass other non-research literature (e.g. inquiries, commissions), and other frameworks by which the behaviour or experiences of children in child protection systems may be characterised, including in relation to their experiences of trauma, grief, and loss. This includes non-Western frameworks. The primary research literature summarised in the scoping review does not, for example, align with Indigenous models of social and emotional wellbeing, which are more holistic in nature, and which emphasise social, political, and historical determinants of health and wellbeing, including the interconnected and interdependent importance of connection to family and kin, to community, culture and Country, as well as mind, body and spirituality.[539] The identified literature at the nexus of child protection, disability, and children's criminalisation also does not emphasise links between institutionally driven harm (e.g. stemming from child protection, police, disability, mental health and/or youth justice system interventions), and the impact of enhanced traumatic and neurological stress among children within these systems, particularly among children of Aboriginal and/or Torres Strait Islander backgrounds.[540] Finally, references to therapeutic support in the identified literature are centred in Western models, and do not align with concepts of 'healing' in Aboriginal and/or Torres Strait Islander and broader Indigenous social and emotional wellbeing frameworks, which "recognise the context of historical and ongoing trauma and violence inflicted by colonisation, racism and oppression, how they are experienced individually and collectively, and the importance of actively addressing these issues".[541]

Policy review summary. The policy review identified six types of policy and practice approaches across Australian jurisdictions that aim to reduce the criminalisation of child protection-involved children with disability. Some of these concern practice guidance for working with children with complex needs, behavioural difficulties or problematic sexualised behaviours, while others are joint protocols which provide practice guidance for working with other agencies and departments (e.g. education, residential care providers, police, youth justice, and disability services) in relation to child protection-involved children with disability.

The policy review also identified wide inconsistencies across jurisdictions in terms of the responses to child protection-involved children with disability who are at risk of experiencing criminalisation. It also found that most policies (except for the joint protocols) solely target children in out-of-home or residential care, rather than all child protection-involved children. In contrast to the research which shows a high prevalence of neurodisability in this cohort, policies tend to focus on the relationship between trauma and children's behaviour, with less attention to other disabilities. While policies often advise staff to consider if a child has a disability, more guidance on how to support and deliver interventions to child protection-involved children with disability or suspected disability is needed. Literature concerning the implementation of policies generally demonstrate a lack of on the ground adherence, often seen to be driven by deficiencies in training, and lack of support or resources. A lack of attention to culturally and linguistically diverse cohorts, and a lack of detail regarding supporting Aboriginal and Torres Strait Islander children beyond ensuring support plans for those in residential care was also identified.

Implications and recommendations for policy and practice. The findings suggest that policy and practice aiming to reduce the criminalisation of children with disability in child protection systems likely requires:

- Greater consistency across jurisdictions;
- To attend equally to mental health/trauma-related presentations and those related to other disability (e.g. neurodisability);
- To consistently attend to the culturally-diverse needs of children with disability in child protection systems; and
- To ensure the priority availability, continuity and coordination of disability, mental health and trauma support services, including those supporting families (e.g. respite services) for this group of children.

Consideration of the findings of the scoping and policy review gives rise to the following evidence-informed policy and practice recommendations in the Australian context for preventing and reducing the criminalisation of children with disability in child protection systems:

Recommendation	Details
1. **That the Commonwealth Department of Social Services in partnership with the Secretariat of National Aboriginal and Islander Child Care (SNAICC), the First People's Disability Network and other relevant stakeholders develop national policy guidance to reduce the criminalisation of children with disability in child protection systems.**	The policy review suggests national guidance is required in this area to ensure greater consistency across jurisdictions in the policies and practices implemented to reduce the criminalisation of children with disability in child protection systems. We suggest this national policy guidance or framework address the policy and practice issues outlined in the recommendations below, and: • focus on children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability; • attend to diversity, including in relation to Aboriginal and/or Torres Strait Islander children and families, culturally and linguistically diverse children and families, and gender and sexually diverse children.
2. **That states and territories ensure the availability of intensive family support services for families of children with disability to optimise their capacity to remain safely at home.**	Jurisdictions should invest in research and evaluation to determine the most appropriate, evidence-informed intensive family support services and programs to meet service user needs. Intensive family support services should be culturally appropriate, evidence-informed, and able to meet the needs of children with multiple support needs related to complex trauma, other mental health needs, and/or neurodisability. Such programs may be best delivered by non-government agencies, including Aboriginal Community Controlled Organisations for Aboriginal and/or Torres Strait Islander children and families.

Recommendation	Details
3. **That states and territories should each develop and implement policy between child protection and education departments that seeks to maximise school engagement of children with disability in child protection systems.**	Policies between child protection and education departments in each state and territory should explicitly outline strategies to minimise educational exclusion (suspension and expulsion) and maximise educational engagement for children with disability in child protection systems. Strategies should attend to cultural and racial diversity, as well as the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability.
4. **That states and territories should ensure the availability of intensive kinship and foster care support options for children with disability.**	Jurisdictions should invest in research and evaluation to determine the most appropriate, evidence-informed intensive kinship and foster care options to meet service user needs. Intensive kinship and foster care options should attend to cultural and racial diversity, as well as the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability.
5. **That states and territories should ensure that all residential out-of-home care funded by child protection departments is therapeutic, and able to meet the needs of children with complex disability-related needs.**	Jurisdictions should invest in research and evaluation to determine the most appropriate, evidence-informed therapeutic residential care model/s to meet service user needs. Therapeutic residential care options should attend to cultural and racial diversity, as well as the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability.

Recommendation	Details
6. **That states and territories each develop and implement protocols between residential out-of-home care providers and police which seek to minimise the criminalisation of children in residential care.**	Protocols between residential out-of-home care providers and police should attend to the specific needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability, and to cultural and racial diversity. We recommend that protocols should also be accompanied by resources to support training and implementation, as well as independent oversight and reporting on outcomes related to police attendance and charging of children in residential out-of-home care.
7. **That states and territories ensure the availability of multidisciplinary therapeutic or healing services to children with disability in child protection systems.**	Services should be responsive to the needs of children with psychosocial disability related to complex trauma and other mental health needs, and/or neurodisability, and to cultural and racial diversity. The roles of the National Disability Insurance Scheme, statewide child and adolescent mental health services, and other specialist providers (e.g. Aboriginal Community Controlled Health or Healing Services, specialist child trauma services) in developing or delivering these services for children with disability in child protection systems should be outlined.

This study recommends that the Commonwealth, States and Territories commit to a National Inclusion framework to provide policy cohesion in this area, embodying principles that:

- centre the voice of children with disability;
- are conversant the disability experience and the impact of ableism; and
- reflect awareness of the intersectional and compounding marginalisation experienced by Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse peoples.

Implications for future research. The findings of the scoping and policy reviews suggest that further research is needed concerning:

- The unique pathways to criminalisation of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children with disability involved with child protection systems (Part 2 of this report begins to address this research gap);
- Gender differences in the criminalisation of child protection-involved youth with disability;
- The lived experience of criminalised children with disability in child protection systems;

- The efficacy of the identified policy and practice approaches aiming to prevent the criminalisation of child protection-involved children with disability; and
- Approaches or non-service responses child protection-involved families and children with disability find helpful for avoiding or reducing the likelihood of children's criminalisation.

One response to the structural ableism and marginalisation to which children with disability in child protection systems are subjected is enable them to declare their voice in their own right. Advancing the voices for young people with disability involves a long term process to respectful attend to complex array of ethical considerations that was beyond the scope of this particular study. The Disability Royal Commission, along with studies such as these, should be a platform to give impetus to more expansive, intergenerational work on addressing the structural barriers to the exclusion and criminalisation of disability among children in child protection systems.

Part 2 of this report[542] presents findings of the survey and consultations with professionals, which aimed to address some of these research gaps, alongside the consolidated findings responding to the key research questions.

Care criminalisation of children with disability in child protection systems

Part 2: Survey and Consultations with Professionals

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Centre for Evidence and Implementation

6. Survey and Consultations with Professionals

Part 2 of this report presents findings of an online survey and consultations with professionals who work with children with disability in child protection systems who are at risk of criminalisation. Given the minimal research evidence at the nexus of child protection, youth justice and disability, the second phase of primary research was intentionally set at an exploratory level of research design. Exploratory research aims to uncover initial insights or knowledge available, to test whether any ideas about a particular topic may have merit, and to clarify the direction needed for future research.[543]

6.1 Survey of Professionals

The survey of professionals aimed to examine in an Australian context:

- if findings of the scoping review resonated with practitioners' observations and experiences;
- if additional insights could be gained that might point to directions for future research;
- any promising models and interventions that could be identified; and
- any observations about the effectiveness of current policy and practice for preventing and reducing the criminalisation of children with disability in child protection systems.

The survey of professionals specifically sought to gather information about:

i. the nature of disability observed in this cohort, and any challenges to its identification;

ii. the observed risk and protective factors for criminalisation of children with disability in child protection systems; (informing Research Question 1)

iii. any promising interventions, programs, and models for reducing or preventing the criminalisation of children with disability in child protection systems that could be identified evaluated by future research (informing Research Question 2)

iv. professionals' experiences and observations of the extent to which current policies and practices of child protection systems are effective in decriminalising and reducing criminal justice contact for children with disability in child protection systems (informing Research Question 3)

v. understanding how any of the above might vary for Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children at these systemic intersections (informing Research Questions 1-3).

6.2 Consultations with Professionals

Given the mandate and request of the Disability Royal Commission to specifically focus on the experiences and needs of Aboriginal and/or Torres Strait Islander and other culturally diverse peoples, a series of consultations (individual and group interviews) were conducted with Aboriginal Community Controlled Organisations and organisations working with CALD children and youth in child protection systems at risk of, or experiencing, criminalisation. These consultations adopted a more culturally appropriate methodology for gathering data with these key populations, with a view to supplementing the survey findings with richer data about the unique experiences and needs of Aboriginal and/or Torres Strait Islander and CALD children with disability in child protection systems who face criminalisation, and the experiences of professionals of policy and practice in this space. This research component directly informed Research Questions 1-3.

6.3 Ethics

Critical to conducting this research was ensuring an ethical approach. Particular attention was paid to including where possible the perspectives of lived experience, and to strengthening external feedback to the project from relevant communities. Key approaches incorporated in the project to achieve these ethical competencies included those listed below.

- **Research Team Composition:** The research team is comprised of individuals with lived experience of child protection system involvement, disability, and criminalisation. We include two proud Aboriginal academics, one of whom is also profoundly deaf (Robyn Newitt and Dr Scott Avery respectively), and three team members who identify as being from culturally and linguistically diverse backgrounds (Dr Susan Baidawi, Dr Gayatri Kembhavi-Tam and Rubini Ball). Further, the team also includes three members with direct experience working in professional roles with children with disability in child protection systems who have been criminalised (Dr Susan Baidawi, Rubini Ball, and Lena Turnbull).
- **Human Research Ethics Review and Approval:** While a lengthy process (3 months and 20 days from initial submission until final approval), formal ethical review to conduct the Survey and Consultations components of the study was sought from the NSW Aboriginal Health and Medical Research Council (Project 1896/21).
- **Partnership with Aboriginal Community Controlled Organisations:** Paid partnerships with two Aboriginal Community Controlled Organisations (the Victorian Aboriginal Child Care Agency and the First People's Disability Network) strengthened external Aboriginal and/or Torres Strait Islander Community oversight of the study. Feedback was gathered from these organisations at two points, namely in developing data collection instruments, and when reviewing the findings from the Survey and Consultations with professionals.
- **External CALD Community Oversight:** Findings emanating from the CALD organisation consultations were also reviewed externally by an individual with expertise in youth justice who identifies as being from a CALD background.

- **Lived Experience Consultations:** Paid consultations with individuals with lived experience of child protection (including out-of-home care), and disability. Specifically, three consultations (one via email and two via zoom) were undertaken with three lived experience young consultants (aged under 25 years), two of whom identified as being from Aboriginal and culturally and linguistically diverse backgrounds respectively, and all of whom had left out-of-home care in Australia. All of the Lived Experience Consultants also identified as having a disability, and one identified as having experienced criminalisation. Lived Experience Consultants provided feedback concerning the design of the survey and consultation data collection instruments, as well as the key findings. Substantial revisions were made to data collection instruments following consultations, for example defining disability as broadly as possible, rearranging the order of questions, splitting broad questions into more specific ones, and asking respondents if anything had been missed. In relation to the review of key findings, feedback from the Lived Experience Consultants was that these concurred with their experience and observations. Feedback was given as to points to further emphasise, which was incorporated into the drafting of findings.

6.4 Limitations

The limitations to the project elements presented in Part 2 were driven by restrictions in access to data and the timeframe available for the study. For example:

- It was not possible within the project timeframe for the researchers to acquire ethics approvals and to include as participants children with lived experience of disability, child protection systems and who are at risk of criminalisation, as well as their families (including extended families). The lack of voices of children and families in this Report is therefore a limitation. However, the project included paid consultation with young people who had lived experience of child protection (including out-of-home care), and disability, including consultants from Aboriginal and/or Torres Strait Islander and CALD backgrounds.
- It was not possible within the project timeframe for the researchers to acquire ethics approvals in each state and territory and from each relevant statutory department (e.g., child protection, youth justice and disability services) necessary for recruitment of professionals currently working in these statutory settings to the study. The findings from the Survey and Consultations with professionals are therefore primarily limited to professionals not currently working in these statutory roles. At the same time, all professionals consulted in the study have experienced working either in or alongside these statutory professionals, for instance as lawyers or in non-government organisations, and with children with disability in child protection systems who are at risk of criminalisation. Additionally, many of the research participants did in fact have experience working in these statutory systems.
- The time between ethics approval and the due date of the Final Report (4 months) limited the capacity to gather and analyse data from a larger and more diverse sample of professionals for the current report (Survey and Consultations with Professionals). The final sample of 92 professionals contributing to the survey and consultations is

more than sufficient for the purposes of exploratory research. However, as with all exploratory research, readers should not generalise findings of Part 2 to all Australian jurisdictions, populations, and contexts.[544]

- The consultations with organisations serving CALD youth at the nexus of child protection, disability, and justice systems were all conducted in a single jurisdiction and primarily with organisations working with South Sudanese children. This limitation is further emphasised in the methodology section of this study component; however, it should be re-emphasised that caution should be exercised by readers in generalising these findings to other CALD subgroups and across jurisdictions.
- Finally, for the purposes of this study, a diagnostic approach to defining disability was applied. This is consistent with the dominant understanding of how disability is defined within care and justice systems. However, it is acknowledged that a diagnostic definition of disability is not neatly compatible culturally with Aboriginal and/or Torres Strait Islander peoples[545] and other ethnic groups, which when applied to a research methodology, can limit a more comprehensive appreciation of the social and cultural contributors to the care outcomes of children.

Data from the survey and consultations with professionals undertaken for Part 2 of the report are presented in Sections 7 and 8, followed by a discussion (Section 9) which draws together findings from both Parts of the report, summarises responses to each Research Question, and notes remaining gaps to be addressed by future research.

7. Survey of Professionals

7.1 Survey Method

This section details the survey aims, design, as well as the processes of recruitment, data collection, and data analysis.

7.1.1 Survey aims

The aim of the survey of professionals in Australia was to understand their experiences working with children with disability in child protection systems who are at risk of becoming or who have become criminalised. As front-line staff, their insights and experiences working within one or more systems (youth justice, disability, child protection) are valuable in understanding the systemic and programmatic barriers and facilitators faced by those who work with vulnerable children. Specifically, the survey of professionals specifically to gather information about:

i. the nature of disability observed in this cohort, and any challenges to its identification;

ii. the observed risk and protective factors for criminalisation of children with disability in child protection systems (informing Research Question 1);

iii. any promising interventions, programs, and models for reducing or preventing the criminalisation of children with disability in child protection systems that could be identified evaluated by future research (informing Research Question 2);

iv. professionals' experiences and observations of the extent to which current policies and practices of child protection systems are effective in decriminalising and reducing criminal justice contact for children with disability in child protection systems (informing Research Question 3); and

v. how any of the above might vary for Aboriginal and/or Torres Strait Islander and CALD children at these systemic intersections (informing Research Questions 1-3).

7.1.2 Survey design

Informed by the scoping and policy Review findings, alongside their practice experience, the research team developed a mixed methods survey consisting of both closed- and open-ended questions. Both the Victorian Aboriginal Child Care Agency (VACCA) and Lived Experience Consultants provided valuable feedback to the survey design, which was also tested with two members of the research team who had practice experience at the nexus of disability, child protection and youth justice, to ensure clarity of questions and approximate time required to complete the survey. The survey instrument was hosted via Qualtrics software online and distributed via an email link. A copy of the survey instrument is included in Appendix C.

7.1.3 Survey recruitment, consent, and anonymity

The survey link was distributed via email to individuals and organisations known to the research team as the first point of contact. Recruitment targeted a range of non-statutory organisations across the child and family welfare, out-of-home care, youth disability, and legal aid sectors,

including a specific focus on Aboriginal specific and Aboriginal Community Controlled Organisations (ACCOs). A snowball technique was used to further distribute the survey link via email, including names and organisations provided to the team during consultations with ACCOs and organisations working with CALD children. The survey link was also distributed online in several places, including via social media (LinkedIn, Twitter, and Facebook) and other online forums (e.g., Australian Association of Social Work website for research projects). Respondents were asked to provide consent (via clicking a button) upon entering the survey. No identifiable information was collected from participants other than place of work and years of experience.

7.1.4 Data collection and analysis

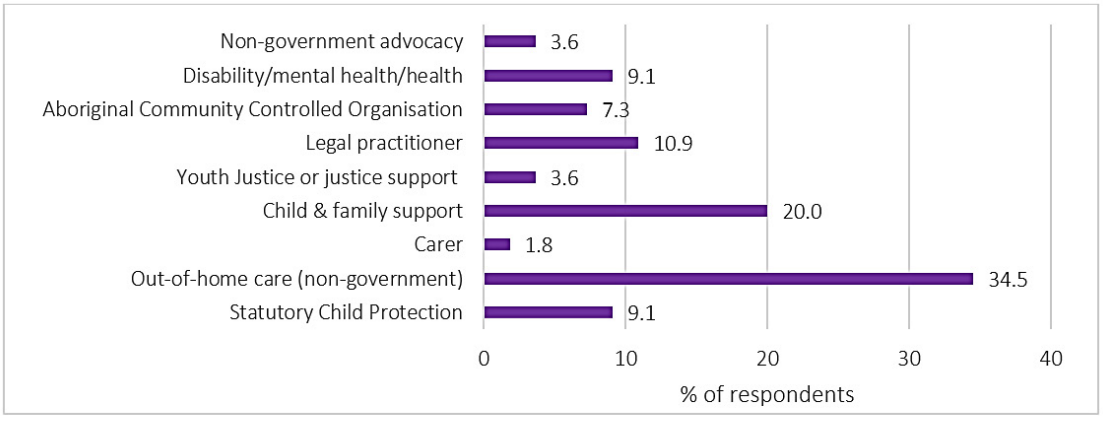
Survey data were collected and stored online via Qualtrics. Upon closing the survey, quantitative data were then extracted and entered in Microsoft Excel for basic descriptive analysis while qualitative (short answer response) data were thematically analysed. In the presentation of survey findings, the number of respondents answering each question is also shown to provide context to the data.

7.2 Survey Findings

7.2.1 Participant characteristics

A total of 73 responses were submitted to the online survey between 21st April and 14th July 2022, however not all respondents submitted answers to all questions. Survey respondents represented a variety of sectors as shown in Figure 2. Fifty-five of the respondents identified their current area of work, with eight (14.6%) working in a program that delivers services exclusively to Aboriginal or Torres Strait Islander children. In terms of experience, respondents had worked in the nominated sector from less than one year (n=3, 5.45%), between 1-5 years (n=18, 32.73%) and more than 5 years (n=34, 61.82%). Overall, the respondents could be classified as moderate to highly experienced in their fields of practice.

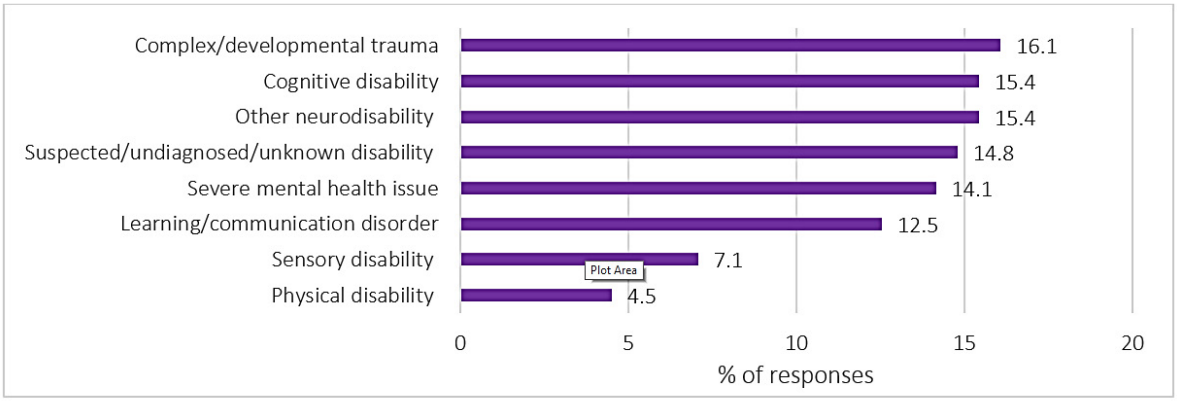
Figure 2. Respondent's current or most recent field of practice



7.2.2 Types and prevalence of disability

Respondents were asked a series of questions about the nature of disability among children with whom they had worked. In their work with children, the range of disability that respondents encountered are summarised in Figure 3, which demonstrates that complex trauma, cognitive, neurological, and severe mental health disorders/issues are the most common disabilities encountered.[9] Additionally, the issue of suspected and undiagnosed disability was highlighted by respondents.

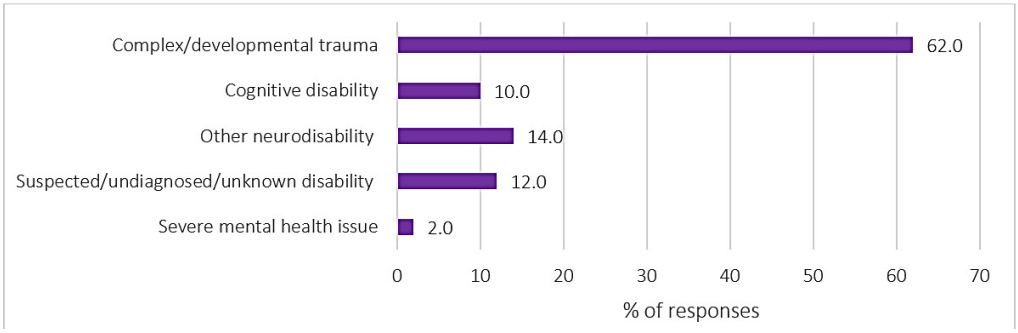
Figure 3. Types of disability among children with whom respondents worked



9 The following inclusions apply to the categories of disability shown in Figures 3 and 4: Complex/ developmental trauma: psychological and behavioural impacts of multiple, chronic and prolonged developmentally adverse traumatic events, most often of an interpersonal nature, and atypically occurring within a child or young person's caregiving system. Domains of impact commonly include: (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatization, and (f) systems of meaning. Cognitive disability: e.g., intellectual disability, borderline intellectual functioning, difficulties with memory or planning. Other neurodisability: e.g., ADHD, autism spectrum disorder, foetal alcohol spectrum disorder, acquired brain injury, or epilepsy. Suspected/undiagnosed/unknown disability: including challenges regulating emotion and behaviour of unknown origin, or in relation to which clinicians revise diagnoses. Severe mental health issue: e.g., that requiring medication and/or intensive treatment, including severe self-harm, often described as "behavioural" by mental health services. Learning/communication disorder: e.g., dyslexia, language or speech disorder. Sensory disability: e.g., visual or hearing impairment. Physical disability: e.g., cerebral palsy, spina bifida, other spinal impairments, limb deficiency and physical disability arising from abuse.

Types of disability encountered *most often* by respondents among criminalised children in child protection systems are shown in Figure 4, below. This highlights complex/developmental trauma as the most frequently encountered disability by respondents, perhaps reflective of the respondent group who were often working in out-of-home care, child protection, and child and family welfare contexts.

Figure 4. Types of disability most frequently encountered by respondents



When asked how many criminalised children in child protection systems had a formal disability diagnosis, around one quarter of respondents indicated that very few (10%) or few (16%) had formal diagnoses; 38% indicated that many had formal diagnoses; and one fifth indicated that most (18%) or all (1%) children had formal disability diagnoses. These variations may reflect the settings in which respondents worked. For instance, those working in disability or mental health services would predominantly work with children with formal diagnoses. At the same time, 69% of respondents (34/49) indicated that certain disabilities were commonly overlooked or not formally diagnosed among children involved with child protection who are criminalised, or at risk of criminalisation in child protection systems. Examples provided by respondents included[10]:

- Impacts of trauma (i.e., complex or developmental trauma) not understood or considered;
- Foetal alcohol syndrome disorder (FASD);

10 Verbatim responses included: Various/complexity in conditions: “Often kids are presenting with disturbed and/or out of control behaviors (sic) noted as mental health issues with nothing diagnosed”, “Most of the disabilities noted above are either missed or not formally diagnosed”, “The focus is often on the intellectual disability or autism and the trauma aspect disregarded”. Neurodisability: “Intellectual disabilities are often undiagnosed. Primary schools often overlook “problem children” and wait for them to reach secondary schools rather than deliver them services and assessments that are funded through the department of education”, “autism ADHD”, “FASD, ID”, “ASD is often missed”, “Disabilities as a result of substance use”. Impacts of traumatic exposure: “Undiagnosed trauma that is misrepresented as behaviour”, “Trauma is often overlooked or minimised”, “Impacts of trauma are not properly understood and considered”, “Trauma goes unrecognised as a disability in the justice system”, “Trauma is almost never diagnosed.”

- Cognitive disability such as intellectual disability, acquired brain injury (ABI), learning and communication difficulties;
- Sensory disability;
- Autism spectrum disorder (ASD);
- Attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD); and
- Mental health issues, including post-traumatic stress disorder (PTSD).

7.2.3 Risk and protective factors for criminalisation of children with disability in child protection systems

Factors listed in Table 5 were seen by professionals as being particularly relevant to the criminalisation of children with disability, most prominently placement in out-of-home care (particularly residential care), substance use, lack of family involvement, and school exclusion.

Table 5. Factors viewed as associated with increased chance of criminalisation among children with disability in child protection systems (multiple responses possible)

Response	Count (% of responses)
Placement in residential care	37 (14.0)
Substance use	36 (13.6)
Education exclusion	35 (13.3)
Placement in out of home care	34 (12.9)
Lack of family involvement	34 (12.9)
Placement instability	33 (12.5)
Cultural or ethnic background	17 (6.4)
Location	11 (4.2)
Individual characteristics or support needs of the child	11 (4.2)
Age	9 (3.4)
Other (no additional detail provided)	7 (2.7)

Additional information about the factors respondents identified as being associated with increased chance of children with disability becoming criminalised was provided as follows:

Cultural or ethnic background

Respondents suggested that Aboriginal and/or Torres Strait Islander status was a relevant factor in children's criminalisation, for example due to cultural bias, disadvantage, lack of culturally appropriate services, systemic racism, and over-policing. Comments were also provided about the historical and ongoing impact of colonisation, resulting in fractured connection to country and community, and the impacts of intergenerational trauma which together were seen by respondents to contribute to the criminalisation of Aboriginal and Torres Strait Islander children with disability in child protection systems:

> Aboriginal children in [Western Australia] are grossly overpoliced and this is a catalyst for their overrepresentation in the justice and detention systems.

Location

Where location was seen as relevant to the criminalisation of children with disability in child protection systems, comments indicated that regional and remote locations lacked adequate services to support these children. Respondents highlighted service gaps in some rural areas, particularly those known to experience socioeconomic disadvantage, resulting in children not accessing the supports required to prevent criminalisation. The criminal justice system was seen to become the default service response to children whose disability-related needs were not met by appropriate services and supports. Additionally, it was noted that children in rural and remote areas often had to move away from their home and country which resulted in disadvantage, thereby contributing to criminalisation:

> Children in rural and remote areas are more disadvantaged and often have to move away from home and country.

For children with disability in metropolitan areas, the key factor in criminalisation was seen to be living in suburbs that experienced high crime and socioeconomic disadvantage.

Individual characteristics of children with disability

When asked about individual characteristics of children with disability in child protection systems at risk of criminalisation, respondents indicated that drug and alcohol use, familial pro-criminal attitudes, loss of connection to birth family, attachment issues, severe mental health issues, and trauma related behaviours were all factors impacting criminalisation, for example:

> A very large majority of young people I have supported in the justice system have severe mental health conditions and or substance use disorders, when these conditions lead to behaviours that are not socially acceptable, I have noticed children and young people be afforded much less empathy.

Some respondents outlined factors that reflect more of a systemic issue, such as lack of access to prosocial recreational activities, professional services struggling to engage a child or services lacking the resources to effectively respond to their needs.

> Child protection caseloads appear to be much too high for them to provide the relational dynamic young people need, therefore often missing their specific needs.

Age

When asked to elaborate on how age was associated with the criminalisation of children with disability, late adolescence (17-18) was seen as a pivotal time for criminalisation of children and young people due to the withdrawal of child protection services, and less lenient responses from law enforcement and justice systems. There was also a suggestion that children aged 12-14 years with disability were particularly susceptible to criminalisation due to peer pressure, and that some teens exhibiting developmentally normative behaviours (such as pushing boundaries with carers) in residential care settings were responded to with police intervention, ultimately increasing their likelihood of criminalisation:

> Older teens and young people not receiving support from CP once they turn 17yrs [child protection] withdrawing/disinterested.

Possible protective factors identified by respondents that may prevent the criminalisation of children with disability in child protection are listed in Table 6 below.

Table 6. Factors viewed as associated with reduced chance of criminalisation of children with disability in child protection systems (multiple responses possible)

Response	Count (% of responses)
Therapeutic supports	36 (18.7)
Children remaining with family	29 (15.0)
Children in kinship placement	26 (13.5)
Therapeutic placement	25 (13.0)
Children placed with siblings	19 (9.8)
Younger children	14 (7.3)
Individual characteristics of the family	12 (6.2)
Individual characteristics of the child	10 (5.2)

Response	Count (% of responses)
Other	8 (4.1)
Children with certain types of disability	8 (4.1)
Children in metropolitan areas	6 (4.1)

Some respondents provided additional information about the observed protective factors outlined in Table 6 above. For example:

Individual characteristics of the family

Respondents commented that children who came from *"White, middle class"* families who were well supported, were not involved in the criminal justice system themselves, and who were *"willing to do whatever it takes"* to meet the child's development needs were less likely to become criminalised. Regular and ongoing connection to biological family members, and a safe and secure home environment were also seen as protective factors for those children who are placed in out-of-home care.

Individual characteristics of the child

Respondents indicated that individual characteristics that acted as protective factors were absence of behaviours of concern, natural insight and awareness of behaviour, having size and strength and avoiding antisocial peers. Other responses provided in this section highlighted the importance of environmental supports and system responses; protective factors included maintaining connection to family, culture and community and having needs met prosocially (for example via school).

Type of disability

Where the type of disability was seen as a protective factor, respondents indicated that severe disability, such as physical disability, autism and intellectual disability, and formal diagnoses which led to comprehensive support were a factor in reducing the risk of criminalisation. This suggests that disability that brings about increased environmental support and positive system responses are somewhat protective against children's criminalisation. One respondent indicated that among children with a history of trauma, how the child responds to trauma is a key factor in their criminalisation, consistent with understanding of psychosocial disability. For example, if traumatic experiences are internalised rather than externalised through behaviours of concern, whilst still harmful to the child, the child is less likely to be criminalised.

Other

Respondents who indicated that there were other protective factors for the criminalisation of children with disability highlighted the important role of system responses and informal supports:

> Higher socio-economic status, having family members that have not been or are not currently incarcerated, school engagement, social network, sense of belonging and sense of worth, hobbies/interests, passion being supported via an apprenticeship or work outside school.

Other protective factors that were mentioned include proactive case management, positive role models, early intervention, culturally sensitive supports and placements, family involvement, and therapeutic supports.

7.2.4 Aboriginal and/or Torres Strait Islander children: challenges and recommended approaches

The next set of questions asked respondents about their experiences working with Aboriginal and/or Torres Strait Islander children. Of the 47 respondents who responded to this question, almost all (93.6%) had worked with or interacted with Aboriginal and/or Torres Strait Islander children in child protection systems. Similarly, most of these respondents (76.7%) were unaware of any programs specifically targeting the reduction or prevention of criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems.

Approaches seen to be working well

Of those who were aware of such programs, the factors that were seen to be working well were programs that utilised identified Aboriginal and/or Torres Strait Islander roles to support program participants' connection to country and culture. An additional factor seen as beneficial were programs that were highly tailored and comprehensively responding to the needs of participants:

> I have seen these programs work very successfully when workers have built respectful and close relationships with young people and have been able to identify personal goals for them, such as being able to get a job that they are interested in. These close relationships have been what has kept young people coming back to engage with the program and the supports in place to get jobs etc., has allowed them to develop skills, keep busy and gives an intrinsically motivating reason to do things such as attend school more often or not stay out late at night for example.

One respondent identified therapeutic parenting programs as beneficial, and another felt that 'not much' was working well in these programs.

Challenges preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems

Respondents were asked to share challenges they faced in preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in the child protection system. Key themes centred on challenges related to inadequate service provision.

Limited service provision. Limited service provision was seen as a key challenge in preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems. Respondents overwhelmingly indicated that lack of appropriate support services, long wait times, lack of resourcing and funding, lack of access to appropriate diagnosis and insufficient quality of services were the key challenges in appropriately supporting Aboriginal and/or Torres Strait Islander children with disability in child protection systems:

> I have seen children and young people face long wait times for clinical assessment services, specialists and treatment to assist with symptoms of their disabilities. Criminalisation prevention programs are in high demand and I have seen young people easily lose placements with these services due to non-attendance because of the high demand.

Lack of culturally safe service provision. Where there were available services, respondents indicated that many of them were culturally insensitive. This was seen as another key challenge in preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability:

> Lack of understanding of trauma through a cultural lens, lack of understanding on the intergenerational trauma experienced by First Nations children and families, lack of culturally appropriate services, lack of culturally appropriate staff to support these young people.

Lack of trauma informed service provision. Highlighting the relationship between trauma and criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems, several respondents highlighted the lack of trauma informed service provision as a key factor in their criminalisation. This ranged from lack of trauma informed care within government, police, child protection services, courts and within the education system:

> Teachers in the education system treating trauma as behaviour and excluding children from school, which seems to happen more to First Nations children than other groups.

Services unable to engage Aboriginal and/or Torres Strait Islander children and families. A lack of engagement between service providers and children or families was also seen as a challenge in preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems. Respondents identified that culturally unsafe service provision contributed greatly to this lack of engagement. Additionally,

stigma related to working with government services was a barrier, as was children's fears of being further targeted by police. Trust and engagement between Aboriginal and/or Torres Strait Islander families and child protection systems was highlighted as particularly challenged in the context of ongoing impacts of colonisation and the Stolen Generations, and intergenerational trauma due to generational involvement in child protection systems:

> I have noticed a lot of mistrust of the child protection system and services available on the part of families and children and young people in the system which leads to attitudes where children end up absconding from placements and in situations where they are more likely to engage in criminal activity. Often this mistrust has come from traumatic experiences with the child protection system or out of home care such as abuse, whether this is a young person themselves or someone they know.

Issues around diagnosis of disability. Another challenge identified in preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems was related to disability diagnosis. Respondents indicated that in some cases Aboriginal and/or Torres Strait Islander children move through the justice system without their disability being accurately assessed and identified, which results in lack of appropriate support. In cases where the child does have a formal diagnosis, at times they were reluctant to identify as disabled or engage in disability-specific programs, due to perceived stigma.

Solutions to challenges in preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems

Respondents were asked to share potential solutions to the challenges they faced in preventing and responding to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems. Key solutions identified by respondents included:

Maintaining connection to culture, family, and community. Respondents overwhelmingly indicated that supporting connection to culture, family and community was a key solution to the challenges faced in working with Aboriginal and/or Torres Strait Islander children with disability at risk of criminalisation in child protection systems. Respondents felt that connection to culture, family and community helped children to develop a sense of pride and connection which would act as a protective factor against criminalisation:

> Being connected to culture and feeling like they belong. Culturally sensitive and aware support services.

Increased Aboriginal and/or Torres Strait Islander workforce and ACCO self-determination. The importance of maintaining cultural connection extended to service provision; Aboriginal and/or Torres Strait Islander workers and organisations were seen as pivotal in providing good quality culturally safe services to Aboriginal and/or Torres Strait Islander children at risk of criminalisation. Respondents identified increasing the Aboriginal and/or Torres Strait Islander

workforce, expanding Aboriginal Community Controlled Organisations (ACCO) and full self-determination of ACCOs as key solutions to respond to the challenges faced in working with Aboriginal and/or Torres Strait Islander children with disability at risk of criminalisation in child protection systems:

> There needs to be more ACCO's with ATSI employees working with ATSI children and young people.

> Listening to Aboriginal voices and empowering and capacity building Aboriginal communities, families and ACCOs to design and deliver responses and programs.

This extended to improving the collaboration between mainstream services and ACCOs:

> Better collaboration with First Nation Co-op centres. Better and culturally sensitive information sharing.

Overall system reform. Systemic reform was seen as a key solution to some of the challenges faced in working with Aboriginal and/or Torres Strait Islander children with disability at risk of criminalisation in child protection systems. This was specified particularly in relation to the justice system (police and courts), child protection systems, and the education system:

> A focus on training teachers in therapeutic teaching methods, which will also have a huge benefit on all children. Secondly, training all teachers in Kinship, how to support it for First Nations children, and how to involve the kinship model in educating the child.

> Justice system for children needs reform. Youth law is a great start but there needs to be a focus around educating police bodies regarding children's disabilities.

Respondents were of the view that police, teachers, child protection staff and support services staff needed more education and training to work effectively with Aboriginal and/or Torres Strait Islander children, including those with disability and trauma. This indicates that respondents believed inadequate system responses to be a key factor in the criminalisation of Aboriginal and/or Torres Strait Islander children with disability in child protection systems:

> Further training of support workers in all areas of the system of trauma informed practice.

> Better trained education staff who understand the intersectionality between trauma, culture, religion and systemic abuse.

Increased funding and services, particularly in early intervention. In addition to system reform, respondents identified the need for increased funding and services available to Aboriginal and/or Torres Strait Islander families with a child with disability within child protection systems. Respondents suggested that increased services and funding could improve service system responses, which would act as a key solution to the challenges faced in responding to Aboriginal and/or Torres Strait Islander children with disability at risk of criminalisation in child protection systems. In particular, respondents highlighted the need for increased early intervention responses:

> More funding to be put into early intervention and tertiary family support to help keep families together.
>
> Early intervention led by ACCOs and communities for the children; funding families at the rate that 'high needs placements' are funded.

Two specific programs highlighted as deserving of increased funding by respondents were Family Group Conferencing and Circle of Security.

7.2.5 Culturally and Linguistically Diverse (CALD) children

The next set of questions related to CALD children with disability in child protection systems. Of the 46 respondents who answered, 63% had experience interacting with CALD children in the child protection system. Most of these respondents (85.7%) indicated that they were unaware of programs that specifically seek to prevent or reduce the criminalisation of this group of children in child protection systems.

Of those who were aware of programs, the two approaches identified to be working well were:

- Having workers or mentors from the same cultural background as the child; and
- Having workers with the language skills to be able to communicate effectively with children.

> Mentors from the same cultural background as the young person.
>
> Bilingual workers, which allow better and clearer communication for participants.

Challenges encountered when trying to prevent or respond to the criminalisation of CALD children with disability in child protection systems

Respondents identified the following challenges preventing or responding to the criminalisation of CALD children with disability in child protection systems:

Lack of service provision and culturally appropriate services. Like Aboriginal and/or Torres Strait Islander children, respondents felt there was a lack of services generally to support CALD children, and where services were available, they were seen to be culturally insensitive. Respondents identified that it was important for these children and families to receive culturally informed responses but observed this to be rarely the case. The lack of culturally responsive support was seen as a key challenge in preventing and responding to the criminalisation of CALD children with disability in child protection systems.

Failure to address language barriers. As an extension to the lack of culturally appropriate services, language was also seen as a key challenge in preventing and responding to the criminalisation of CALD children with disability in child protection systems. Services were being delivered without the use of interpreters or appropriate language support.

> Language is a significant barrier. Universal services often fail to use interpreters for significant interactions with families, fail to translate documents like assessments so families can understand their children's needs and respond to them.

Difficulties in engaging CALD families. Respondents indicated another key challenge in preventing and responding to the criminalisation of CALD children with disability in child protection systems was that services had trouble engaging CALD families:

> Working with families in a culturally informed way, gaining the trust and support of the family to work with the young person.

This extended to an identification that some CALD families did not view their child as 'disabled' which was impacting disability identification and service provision.

> Families don't recognise disability and refuse assessments.

Solutions to the challenges in responding or preventing the criminalisation of CALD children with disability in child protection systems

When asked to identify solutions to the challenges in preventing and responding to the criminalisation of CALD children with disability in child protection systems, responses mainly related to increasing support for families and children. For example:

Increase CALD specific and culturally sensitive supports. Respondents felt that there was a need for CALD specific workers and services in all aspects of the service system.

> Culturally appropriate supports. Culturally relevant workers working in the child protection and police agencies.

Another solution to culturally unsafe services was more education and cultural training in existing services. The need for culturally sensitive support was again extended to the need for language-specific workers.

> Engage bilingual workers with background in child development/education/social work who will understand the information they are interpreting and also potentially become part of a child's support team.

Increase funding and services. Increasing funding for services and programs was seen as a key solution to address some of the challenges in preventing and responding to the criminalisation of CALD children with disability in child protection systems.

> Additional funding in early and tertiary intervention services, more access for AOD, DFV, mental health services.

There was an additional specified need for an increase in services for children who are not Australian citizens:

> We need so much more focus on community engagement, service delivery for children who are not citizens to access disability supports.

Support families to understand systems and processes. Another key solution to the challenges responding and preventing criminalisation of CALD children with disability in child protection systems was the need to support the families more, so they can understand the systems they are dealing with and make appropriate choices.

> Support families in conceptualising the criminogenic needs of their young person holistically.
>
> Support families to understand the disability and justice systems more to help empower them to deal head on with the situation.
>
> Explaining criminal justice decisions to families and the implications of these. E.g., where a 16 year-old young person is placed on a community-based order, examples of where e.g., a mother is unable to enforce or encourage boundaries of the order; the young person is the 'man of the house'.

Reduce discrimination. Reducing discrimination within the wider community was also seen as pivotal to preventing the criminalisation of CALD children with disability in child protection systems:

> Reduction in discrimination and bullying in schools and workplaces.
>
> Wider community education to reduce stigma and support inclusion.

7.2.6 Sector collaboration

Respondents were then asked about experiences of collaboration between the youth justice, disability, and child protection sectors. Of the 44 respondents:

- 72.7% had observed or experienced collaboration between youth justice and disability, mental health, or trauma services;
- 74.4% had observed or experienced collaboration between youth justice and child protection systems; and
- 64.3% had observed or experienced collaboration between disability services and the child protection system, indicating that collaboration between disability and child protection services were seen to be less developed than other service sector connections.

The nature of these collaborations observed or experienced by respondents are listed in Table 7 below.

Table 7. Collaborations between child protection, disability/mental health, and youth justice services observed or experienced by respondents

Response	Count (% of responses)
Participation in team meetings	34 (23.8)
Information sharing	31 (21.7)
NDIS or other disability/mental health providers	28 (19.6)
Joint case planning	21 (14.7)
Shared decision making	17 (11.9)
Disability justice plans	6 (4.2)
Disability justice services	4 (2.8)
Other*	2 (1.4)

Most respondents (76.3%) indicated that these collaborations were either somewhat or largely effective at preventing or reducing the criminalisation of children with disability in the child protection system. The remaining 23.7% of respondents felt that the collaborations were either largely ineffective, or neither effective nor ineffective. No respondents indicated 'very' effective or ineffective.

Collaborative sector approaches seen to work well

Respondents outlined the following collaborative approaches between sectors supporting this group of children that were seen to work well:

- **Information-sharing:** where this occurs, it supports all care team members to be on the same page, to find a balance between over servicing and under servicing children and/or families, and ensures provision of useful supports (e.g., support letters for court hearings);
- **Focusing on the child:** Child focused supports included connecting to the child to build trust and rapport; and advocating for the child. The major obstacles are described as being the education system (focused on schooling rather than the child), inefficient child protection departments and services (e.g., high staff turnover, children in out-of-home care not able to form good relationships with staff, high mistrust of adults in those agencies);
- **Child protection and youth justice systems understanding of disability:** including trauma, mental illness, other disability. In the absence of this understanding, these services do not follow behaviour support plans or understand the importance of consistency for supporting children with disability;

- **Interagency communication and collaboration:** Particularly in cases where children experience dual systems involvement, this allows for greater consistency in communication, decision-making and goals to support children. It also allows for a streamlining of access to services by pooling resources and knowledge. This works well when supported by good communication, delineation of roles, clear responsibilities, but is largely reliant on individual workers and teams to effect, and requires services working meaningfully together; and
- **Supported referrals:** Using established and trusting relationships as a means for children to engage with new services.

According to respondents, the reasons underpinning ineffective sector collaboration included those listed in Table 8, most commonly difficulties with communication, different priorities or agendas across services, and the child not wanting to engage with certain services.

Table 8. Perceived reasons for ineffective sector collaboration

Response	Count (% of responses)
Difficulties with communication	7 (9.7)
Different priorities or agendas	7 (9.7)
Child not wanting/refusing services	7 (9.7)
Poor service collaboration	6 (8.3)
Services not successfully engaging children/families	6 (8.3)
Ineffective service models (insufficient intensity, not culturally responsive, etc.)	6 (8.3)
Child not wanting/refusing assessment	6 (8.3)
Lack of disability/mental health/trauma expertise	5 (6.9)
Time constraints	5 (6.9)
Workload constraints	5 (6.9)
Difficulties with information sharing	3 (4.2)
Lack of role clarification	3 (4.2)
Child did not identify as having a disability	3 (4.2)
Child was ineligible for services	2 (2.8)
Other	1 (1.4)

Additional information was provided for some of the above responses, as follows:

Poor service collaboration was described as a lack of responsibility by the care team for the child, no agency wanting to 'take the lead' in supporting the child, a lack of awareness of roles and responsibilities of the involved services and one service perceived as knowing the child/ family better than others.

Ineffective service models included a lack of cultural understanding from services or individual care team members, particularly child protection and youth justice, and insufficient support from NDIS. Lack of disability or mental health and trauma expertise was observed by one respondent to be particularly prevalent in the youth justice systems compared to other services, while another respondent shared:

> When disability services moved from the state to NDIS there were huge losses to collaboration, expertise and shared problem solving. The NDIS is not fit for purpose.

Approaches for improving sector collaboration

When asked how collaboration between youth justice, child protection, and disability mental health services could be improved, respondents referred to the need for systems reform. This included an identified need for clear protocols between agencies determining roles and responsibilities, which would allow for stronger partnerships and relationships between agencies. Better understanding of trauma, disability and intergenerational trauma was also seen as key to improving collaboration. There was also a stated need to put children at the centre of family, with more input from families. One respondent suggested an increase of experts with lived experience within the system, and a need for systems to be less racist.

7.2.7 Residential care and policing joint protocols

The next set of questions were asked of those participants who worked in Queensland, New South Wales or Victoria, where protocols between police and residential care providers have been implemented with a view to reducing the criminalisation of children in residential care settings.[546] Forty-four of the 73 respondents answered this question, of whom 81.8% collectively worked in these three jurisdictions. Of these respondents, 55.6% had encountered protocols between residential care providers and police. When asked about the perceived efficacy of these protocols in reducing the criminalisation of children with disability in residential care:

- 45% of respondents believed they were somewhat or largely effective;
- 20% of respondents believed they were neither effective nor ineffective; and
- 35% of respondents believed they were either largely or very ineffective.

As identifying data were not collected concerning respondents' jurisdictions, it was not possible to examine whether these differences were due to variations in protocols/implementation across different states. For respondents who believed the protocols were effective to some degree, the reasoning is outlined in Table 9 below.

Table 9. Perceived reasons for efficacy of residential care-police protocols for reducing criminalisation of children

Response	Count
Residential care providers implementing more therapeutic/non criminalising responses to children with disability	4
Residential care providers utilising behavioural management plans outlining a child's disability/mental health needs to consider non-criminal justice responses	3
Less criminalising responses to children with disability in residential care	1
Greater communication between residential care and police regarding the needs and appropriate responses to children with disability	1

Respondents who indicated that the protocol was somewhat or largely ineffective were asked to indicate reasons from a drop-down list. Responses are shown in Table 10 below, and most prominently concerned the lack of preventative supports for children with disability in these settings, police lack of knowledge and training concerning the relationship between disability (including the impacts of trauma) and children's behaviour, and the protocols lacking sufficient guidance.

Table 10. Perceived reasons for lack of efficacy of residential care-police protocols for reducing criminalisation of children

Response	Count
Lack of policy implementation or application by residential care providers	3
Residential care provider lack of knowledge about how disability relates to children's behaviour of concern	5
Lack of supervision for policy implementation within police	5
Lack of supervision for policy implementation in residential care	5
Policy is insufficient to prevent criminalisation of children in care	8
Insufficient guidance in the protocol (e.g., minor behaviours still attracting police consequences)	8
Police lack of knowledge about how disability relates to children's behaviours of concern in residential care	9
Police lack disability/mental health knowledge and training	9
Lack of preventative supports	10

When asked what policy or practice changes could reduce the criminalisation of children with disability in residential care, respondents indicated training to be a key factor. This included training police and residential care staff. Additional changes suggested to reduce criminalisation of these children related to receiving early diagnosis of disability, and provision of culturally relevant services.

7.2.8 Child protection systems

The next series of questions focused on child protection systems, including observed pathways to criminalisation of children with disability, barriers, and facilitators of disability assessments for children in these systems, approaches which work well, and challenges and potential solutions for preventing and reducing the criminalisation of children with disability in child protection systems.

Pathways to criminalisation

Respondents were asked about pathways to criminalisation for children with disability in child protection systems, with responses provided in Table 11 below.

Table 11. Perceived common pathways to criminalisation of children with disability in child protection systems

Response	Count (% of responses)
Vulnerability to influence of offending peers	38 (28.8)
Vulnerability to criminal exploitation by older youth or adults	33 (25.0)
Adoption of criminal justice response to disability/mental health related behaviours in residential care (e.g., by child protection, out-of-home care providers, police and/or youth justice workers).	31 (23.5)
Adoption of criminal justice response to disability/mental health related behaviours in other contexts (e.g., by child protection, out-of-home care providers, police and/or youth justice workers).	25 (18.9)
Other	5 (3.8)

Vulnerability of children with disability in child protection systems to offending peers was most identified by respondents (28.8%). Exposure of children to offending peers often comes about through systems intervention, such as placement of children with disability in residential care settings with other young people who are already involved in the justice system, and placement in remand settings which introduces children to a wider network of other justice-involved children.[547] Similarly, vulnerability to criminal exploitation is also identified in the existing literature as particularly prominent among children with disability placed in residential care settings.[548]

As shown above, 19% of respondents also indicated that the adoption of criminal justice response to disability/mental health-related behaviours in *other contexts* was a pathway to criminalisation of children in child protection systems with disability. When asked to provide more detail, respondents indicated that family violence was a key factor, including adolescent family violence where the child is listed as an alleged offender on a family violence order with limited capacity to understand the consequences of breaching conditions of the order. Respondents also indicated that in situations of alleged adolescent family violence, police lack of understanding of trauma, including how this might shape the behaviour of a child, results in criminal charges and full exclusion family violence orders which prohibit the child from residing in the home or sometimes from having contact with family. Once subject to such orders, children with disability often enter out-of-home care, particularly residential care.[549] Further criminalisation of children with disability is seen to emanate from breaches of these orders, which are often complex in nature and confusing for children.

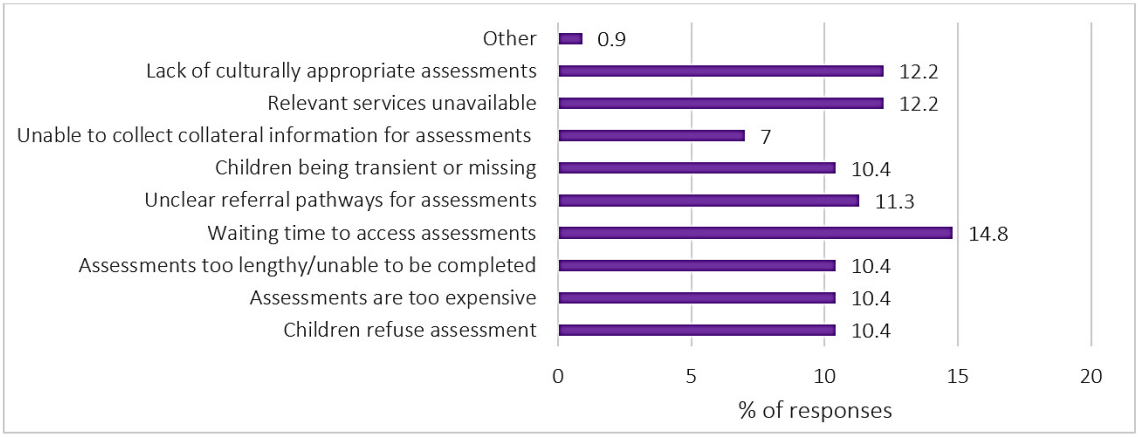
Other respondents who indicated that there were 'other' pathways to criminalisation indicated that inappropriate police responses were a factor, including lack of understanding of mental health challenges and other disability:

> One example would be a young woman, 15, with a low IQ and significant trauma, was engaged in sexual exploitation by a male in his 50s (sex for exchange in cash and drugs). He drove her to a petrol station to withdraw cash, she took his car and fled. She was charged, remanded, and faced charges for theft of a motor vehicle while this perpetrator was identified as the victim and no consequence for him in the justice system.

Barriers to disability assessments for children in child protection systems

When attempting to access assessments for children in child protection systems who may have a disability, respondents outlined common barriers shown in Figure 5 below, most prominently waiting times, a lack of culturally appropriate or relevant services, and unclear referral pathways. When asked to elaborate on 'other' barriers, respondents indicated that assessment processes can be traumatic for families due to their overly clinical and deficit-based approach. Additionally, children and families may not understand the importance of assessment in terms of its ability to lead to funding and support.

Figure 5. Barriers faced in accessing assessments (multiple responses possible)



Facilitators of disability assessments for children in child rotection systems

Respondents were asked to identify factors that were helpful in supporting the process of disability and/or mental health assessment of child protection involved youth at risk of criminalisation. Thematic analysis of their qualitative responses led to the identification of the themes below.

Service system responsiveness and flexibility. Robust, responsive, and engaging service systems were seen as key to supporting the process of disability and mental health assessment of child protection involved youth at risk of criminalisation. This included services able to provide collaborative and timely responses to assessment need, and which were delivered in a therapeutic way, with the support of trusted people, and related funding:

> Collaboration between service providers, case workers, justice centres if relevant. encouragement about getting assessed from workers and family/friends. Assessments being age, disability and culturally appropriate and accessible (in terms of length, language used, practitioner rapport with patient).

> Understanding that these assessments need to occur in a therapeutic environment and with the right supports including the right funding and in a timely manner.

Respondents felt that service flexibility was key to ensuring appropriate disability and mental health assessment to child protection involved youth at risk of criminalisation. This included approaches which would shorten waiting times, services providing outreach, or delivering assessment in areas familiar to the child and having the capacity to act quickly when a family is ready to engage, and having the ability to reschedule missed appointments.

> Being able to act when the young person or family are showing signs of readiness to engage (i.e.: being able to book in an assessment, therapeutic session etc in the near

> future while they are still willing to participate.) The long, long waitlists are a huge barrier to progression and access to support, as when they feel ready for the support they are often unable to access it leaving them to feel further unsupported and hopeless.

Advocacy and support. Advocacy was seen as a key factor that assisted child protection involved children at risk of criminalisation to access mental health and disability assessment.

> Relationship based practice, family involvement and advocacy to help mitigate against power imbalances.

Respondents also indicated that existing workers who have a good relationship with the child were pivotal in facilitating access to mental health and disability assessment.

> Funding services that young people are more likely to trust to organise the assessments and be present at them (in waiting room etc.). This would be their support worker or a trusted therapist - this is hardly ever (in my experience) a child protection or youth justice worker.

Two Western Australian programs were mentioned by name as helpful in this aspect: Nyoongar Patrol Outreach Services and Aboriginal Legal Service of Western Australia's (ALSWA) Youth Engagement Program.

Approaches working well to prevent or reduce criminalisation of children with disability in child protection

Respondents were asked what approaches were working well to reduce or prevent the criminalisation of children with disability in child protection, with responses analysed and grouped into the following themes:

Justice system processes. Respondents indicated that some justice system processes were working well to reduce the criminalisation of children with disability in child protection systems. This included restorative justice practices, diversion, group conferencing, and changes to police manuals regarding children in contact with police.

Trauma and disability-informed and culturally aware service delivery. Respondents felt that where services were provided in a trauma informed, disability informed, and culturally sensitive way, this helped to reduce the criminalisation of children with disability in child protection systems:

> If the client has a well-trained and compassionate worker they have a better outcome. If they have a well-trained carer or kinship family it works well.

Service collaboration. Respondents indicated that in instances where services collaborated to provide more holistic and comprehensive care for a child, that this helped to prevent and reduce the criminalisation of children with disability in child protection systems.

> The more supports available and the more they collaborate and show understanding and patience to the young person to build trust, the better.
>
> Accurate and relevant information sharing with all services. Care team meetings. Flex[ible] funding and brokerage to shorten the gap between these young people and access to supports.

Relationship-based approaches. Respondents observed that relationships with key workers were important for preventing and reducing the criminalisation of children with disability in child protection systems:

> Support workers in the community and in diversion programs are working hard to build lasting relationships with young people and children and to encourage them to engage with programs and develop goals for the future to reduce likelihood of criminalisation.

Challenges to preventing and reducing criminalisation of children with disability in child protection systems

In this section, respondents identified the key challenges they faced in reducing or preventing the criminalisation of children with disability in child protection systems.

Systemic issues. Respondents identified a range of systemic issues which were key challenges in reducing or preventing the criminalisation of children with disability in child protection systems. Specifically, the following issues were identified:

- Police systems have a poor understanding of disability and responding in heavy handed ways;
- The education system is not trauma-informed and punishes behaviour related to trauma;
- Funding structures within support services focused primarily on output rather than relationship; and
- Discriminatory and outdated views of disability within support services:

> Teachers with fixed ideas regarding behaviour/trauma which are not therapeutically and/or culturally appropriate and who are out of date with children's rights.

Child protection systemic challenges. Respondents identified systemic issues within child protection which created challenges in responding to and preventing criminalisation of children with disability, including:

- Workforce issues that result in high turnover of workers, disrupting provision of services, and contributing to child and family disengagement;
- Child protection services not utilising 'whole of family' approaches to support children with disability;

- Negative attitude of some child protection and youth justice workers; and
- Child protection workers not able to effectively engage the child:

> Inability to effectively engage with child protection. Child protection not responding to calls or requests and acting generally oppositional to the child's best interest.

Ageing out of child and youth systems. Consistent with previous research,[550] another key challenge in responding or preventing the criminalisation of children with disability in child protection systems was related to a lack of access to services when the young person reaches 18 years, and child protection services and other services are commonly reduced or withdrawn:[11]

> As children hit late teens mental health services start to distance themselves as do child protection, and adult services (such as mental health services) are not equipped to manage adolescents, nor are they open to.

Lack of funding and support. Limited funding which led to insufficient support was noted by respondents as a major challenge in preventing and responding to the criminalisation of young people with disability in child protection systems. The key themes were lack of services in regional communities, long or restrictive waitlists to access assessment and treatment programs, lack of specialised support for children with disability, frontline workers not being provided best practice knowledge and training with regard to disability, limited funding for therapeutic support (which was seen as best practice), and demand for services outweighing availability:

> Lack of funding in services, long waitlists for support services, high demand but lack of resources.

Residential care placements unable to provide tailored disability support. In line with previous findings that residential care was a risk factor for the criminalisation of children with disability in child protection systems, respondents felt that residential care was a problematic place for this group of children, due to the perceived risk associated with exposure to antisocial peers. Residential care settings were also seen as ill-equipped to provide disability-appropriate and trauma-informed care, and were observed to be staffed by practitioners who were often not trained to provide the specialist care required to reduce criminalisation of these vulnerable children:

> Resi homes aren't equipped, and staff aren't trained in disability, they easily pick up antisocial behaviours from 'resi kids'.

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11 It is acknowledged here that at the time of writing, multiple Australian jurisdictions have now enacted legislation and/or implemented policy extending the provision of out-of-home care to some young people beyond the age of 18 years. However, these provisions are not consistently available to all care leavers in all jurisdictions.

At the same time, as can be seen in the above quote, stigmatisation of children in residential care, is also an ongoing problem that sees them labelled as children behaving badly, rather than in need of support.

Unrecognised and undiagnosed disability. Respondents identified the challenge of working with children in child protection systems who had unrecognised or undiagnosed disability, which in turn negatively impacted their access to services and supports that could prevent criminalisation. This was partly seen to result from a lack of access to timely assessment and treatment. When a child is unable to acquire a diagnosis and access appropriate treatment, respondents felt that the behaviours which could later become criminalised became more fixed, and harder to change:

> Lack of diagnosis. Waiting times for professional appointments. Children slipping through the cracks and not having disability recognised.

> Children often go untreated/inadequately supported for many years allowing symptoms and negative views to develop which become very deep rooted and difficult to change as they age.

Children's experiences. Respondents observed children not wanting to engage with formal support services and believed that this was an ongoing challenge in appropriately responding to and preventing the criminalisation of children with disability in child protection systems. This also extended to children having limited understanding of the impact of their behaviours (for example when on bail) with regards to criminalisation. Another factor identified by respondents was related to stigmatisation of children who had been charged with offences, and the subsequent impact on their engagement with services. One respondent identified stigma as particularly relevant to service engagement for children charged with sex offences:

> Children being labelled as offenders at very young ages, particularly around sexual offending, incorrectly, which then makes it difficult for these children to be placed with foster families.

Possible policy and practice approaches for preventing and reducing criminalisation of children with disability in child protection systems

Respondents were asked to share their ideas of potential solutions to the challenges they experienced in preventing and responding to the criminalisation of children with disability in child protection systems. Respondents identified the need for reform at all levels of systems and services that have contact with this cohort of children, for instance:

> In all honesty the system is deeply flawed at every level, and it is difficult to suggest solutions when at every level children and young people are being failed, particularly with broader and more ingrained social attitudes about their culture, disability and behaviours. Radical change is required at every level to combat the issues these young

> people face: trauma informed practice and disability education at every level of the system (including law enforcement and child protection) cultural[ly] safe practice education, access to services and treatment, facilitating and supporting ongoing relationships between the young person and individuals in the system supporting them to provide consistency and support.

Systems reform. Overwhelmingly, the solutions provided by respondents called for systemic reform to better support children with disability at risk of criminalisation in child protection systems. Suggested solutions included:

- Teachers and teaching staff receiving mandatory training in therapeutic support;
- Retaining frontline workers and limit the high turnover of staff supporting these children; and
- Improving the transition from 'children's services' to 'adult services' to ensure continuity of care for children with disability in child protection systems at risk of criminalisation, as this is a key time of transition for young people.

Justice system reform. Respondents also highlighted the need for justice system reform. This included solutions such as:

- Disability training for police so they hold the knowledge and skills to appropriately respond to these children, particularly for cognitive and neurological disability;
- Increasing disability training for child protection workers;
- Establishing a dedicated disability response team within child protection systems; and
- Providing more options within Children's Courts to divert children with disability in child protection systems away from the justice system.

Increase in services and funding. Respondents called for increased funding so that children with disability in child protection systems received the appropriate support required to reduce criminalisation, particularly early intervention programs and family support services. Respondents were of the view that such services were required to keep children with disability at risk of criminalisation within their family environments, and out of residential care:

> Supporting families to reconnect, get therapy, education, real community- from local community. Work with people on a very basic human level- they are not numbers.

Other potential solutions included:

- More mentoring programs;
- Longer rounds of funding to ensure staff and service consistency;
- Disability specific residential care housing;

- Increasing therapeutic support for children with disability in child protection systems; and
- Funding more long-term intensive support programs.

Decrease discrimination and increase safety within services. Respondents highlighted the need to reduce stigma and discrimination experienced by children with disability in child protection systems to reduce their criminalisation. This included the need for Aboriginal and/or Torres Strait Islander-designed and led responses, culturally sensitive services, trauma-informed practice, and disability training for a range of professionals coming into contact with these children:

> Increased understanding of the impact of trauma on children's behaviours and the poor trajectory if we start to criminalise these young people from a very young age, community campaigns that raise awareness rather then vilify young people who are experiencing these issues, better disability support services that incorporate trauma in their approach.

Supporting children with disability in child protection systems prior to youth justice system entry

In this section, respondents shared thoughts about how children with disability in child protection systems can be better supported *before* they enter the youth justice system. The responses echoed themes in the previous section asking for solutions to challenges faced in responding to and preventing the criminalisation of this group of children, including:

Increase formal support before justice system contact. Respondents believed that providing children with disability in child protection systems with increased support could steer them away from criminalisation. This included the following kinds of supports:

- Aboriginal and/or Torres Strait Islander-led support for Aboriginal and/or Torres Strait Islander children;
- Intensive mental health support;
- Increasing early intervention family support;
- Increasing assessment services so that children can receive earlier diagnosis; and
- Decreasing wait times for disability support including NDIS (National Disability Insurance Scheme):

> Fund programs to engage high risk young people in early intervention / prevention programs. Community programs which are consistent and unstructured and allow workers to develop genuine relationships with young people and then pick up on their needs that may have been missed.

Support families to keep children at home. Respondents called for increased support for families before their child with disability has had contact with the justice system. Indicating that prevention of justice system involvement was more effective than intervention after the fact, respondents felt that children would avoid contact with the justice system by staying at home and out of residential care. Respondents indicated that with the right support and early intervention, families could better support their child with disability to avoid justice system involvement.

> More tertiary family support funding to support them to stay at home with family in a trauma informed, relationship focused, therapeutic way to break the cycle.

Improve education systems to better support children with disability. Respondents believed that the exclusion of children with disability from the education system due to challenging behaviours was a significant factor increasing their risk of criminalisation. Keeping children in school and receiving support was seen as a key factor in reducing their criminalisation:

> Getting kids into mainstream schools with appropriate supports.

Supporting children with disability in child protection systems after youth justice system entry

When asked about how to support children with disability in child protection systems who had already experienced contact with youth justice systems, respondents overwhelmingly called for tailored responses. Acknowledging the unique and complex needs of children with disability with involvement in both child protection and justice systems, respondents highlighted the need for comprehensive interventions that addressed the individual needs of each child. This included the need for disability specific therapeutic interventions that addressed their criminogenic factors, for example:

Increased supports. Again, respondents called for increased support for children with disability who have involvement in both the child protection and justice systems. Recognising recidivism as a key challenge for these children, respondents called for an increase in disability-specific and other therapeutic supports, culturally sensitive support across all sectors, and comprehensive mental health and trauma support. This included ensuring the services that support these children have a comprehensive understanding of disability and trauma-informed practice:

> Systems that understand their disability and disability behaviour and the nature of the trauma they have experienced before and during [out-of-home care].

Improved transition between dual systems. Respondents recognised the need to better support children with disability moving between youth justice and child protection systems. This included the need to continue providing support once children were exited from juvenile detention and returned to the child protection system:

> Many clients I have worked with have received access to necessary assessment and support services while in detention or under the supervision of youth justice. However, this level of care has not been offered or maintained by the child protection system once the child is no longer under the supervision of youth justice.

Increased collaboration between services. Recognising that children with disability who are dually involved in justice and child protection services often have several services supporting them, respondents highlighted the importance of collaborative approaches for working with this cohort.

7.3 Summary of Survey Findings

The 73 survey respondents represented a variety of sectors that have contact with children with disability in child protection systems at risk of criminalisation, with almost half of participants working in either OOHC, child protection services, or child and family services. Over 60% of respondents had over five years' experience working with children with disability in child protection systems at risk of criminalisation.

Factors increasing and reducing the likelihood of children's criminalisation. Key factors associated with increased chance of criminalisation of children with disability in child protection systems were identified as: placement in residential care; substance use; education exclusion; placement in OOHC; lack of family involvement, and placement instability. Key protective factors were identified as: access to therapeutic support, children remaining with family, and placement in kinship or therapeutic care settings.

Aboriginal and/or Torres Strait Islander children and young people. Respondents identified several challenges in preventing or responding to the criminalisation of Aboriginal and/or Torres Strait Islander children and young people children with disability in child protection systems, including: limited service provision; lack of culturally safe service provision; lack of trauma informed service provision; services unable to engage Aboriginal and/or Torres Strait Islander children and families and issues around disability diagnosis. Respondents then outlined the following suggested solutions to these challenges: maintain connection to culture, family and community; increase Aboriginal and/or Torres Strait Islander workforce and ACCO self-determination; overall system reform; increased funding and services, particularly in early intervention, and improving collaboration between mainstream services and ACCOs.

CALD children and young people. Respondents identified the following key challenges in preventing or responding to the criminalisation of CALD children with disability in child protection systems: lack of service provision and culturally appropriate services; language as a barrier; and services experiencing difficulty engaging families. The following potential solutions to these challenges were then identified by respondents: increase CALD specific and culturally sensitive supports; increased funding and services, particularly those which support families, and provide mentors or workers from the same cultural background as the child; support families to understand systems and processes; and reduce racial discrimination in the broader community.

Sector collaboration. Three quarters of respondents had observed or experienced collaboration between youth justice and disability, mental health or trauma services; 74% had observed collaboration between youth justice and child protection systems and only 64% had observed or experienced collaborations between disability services and child protection systems. The most common forms of collaboration observed were participation in team meetings and information sharing, and most respondents (76%) believed these collaborations were effective to some degree. Approaches seen to work well were: information sharing; focusing on the child; statutory services having good understanding of disability; interagency communication and collaboration; and supported referrals. Key contributors to ineffective collaboration were identified as: difficulties with communication; different priorities or agendas; and child not wanting or refusing services.

Residential care and policing joint protocols. Of respondents those who had encountered protocols between police and residential care services, 45% felt they were to some degree effective in preventing or reducing the criminalisation of children with disability in child protection services; 20% felt they were neither effective nor ineffective, and 35% felt they were ineffective. Protocol effectiveness was seen to rely on residential care providers implementing more therapeutic and non-criminalising responses to children with disability. Protocol ineffectiveness was seen to stem from police lacking disability and mental health knowledge and training, including how disability relates to children's behaviours of concern in residential care.

Child protection system. The most common pathways to criminalisation of children with disability in child protection systems identified by respondents were vulnerability to influence of offending peers (29%); vulnerability to criminal exploitation by older youth or adults (25%); adoption of criminal justice response to disability related behaviours in residential care (23%) and adoption of criminal justice response to disability/mental health related behaviours in other contexts (19%). Family violence order involvement was also seen as a key pathway to criminalisation.

Disability assessments. Common barriers to accessing disability assessments included waiting times, lack of relevant services available and lack of culturally appropriate assessments. Conversely, service system responsiveness and flexibility; and advocacy and support were seen to be helpful to support children in accessing disability assessments in child protection systems.

Approaches generally seen to be working well to reduce children's criminalisation. Approaches seen as working well to prevent and reduce the criminalisation of children with disability in child protection systems included: justice system processes (particularly diversion, restorative justice practices, group conferencing and changes to police manuals regarding children's contact with police); trauma informed and culturally aware service delivery; service collaboration that resulted in more holistic support to children and families; and relationship-based approaches. The overall challenges in preventing and responding to the criminalisation of children with disability in child protection systems included: systemic issues particularly within child protection; children with disability ageing out of youth services; lack of funding and support; residential care placements being unable to provide tailored disability support; children having unrecognised and undiagnosed disability; and children's experiences of stigma. Suggested solutions to these challenges included: systems reform particularly within the justice system; increase to services and funding; decreasing discrimination and increasing safety within services.

With regard to supporting children with disability in child protection systems **before** they enter the youth justice system, respondents identified the following: increase formal support before justice system contact; support families to keep children at home; and improve the education system to better support children with disability. With regard to supporting children with disability in child protection systems **after** they enter the youth justice system, respondents identified the following: increase supports; improve transition between dual systems; and increase collaboration between services.

8. Consultations with Aboriginal Community Controlled and Culturally and Linguistically Diverse Organisations

> "There is no thing as a single-issue struggle because we do not live single-issue lives" – Audre Lorde[551]

The above quote, by Audre Lorde, is a reflection from the authors relating to the findings from consultations with Aboriginal Community Controlled and culturally and linguistically diverse organisations. Like the quote, findings of these consultations emphasise the requirement for an intersectional approach to prevent and address the criminalisation of children with disability in child protection systems.

8.1 Consultation Method

This section details the consultation aims and approach, as well as processes for recruitment, data collection, and data analysis for this study component.

8.1.1 Consultation aims

A series of consultations were conducted with Aboriginal Community Controlled Organisations (ACCOs) and organisations working with CALD children and youth in child protection systems at risk of, or experiencing, criminalisation. These consultations adopted more culturally appropriate methods for gathering data with these key stakeholders, with a view to supplementing the survey findings with richer data about the intersectional experiences and needs of Aboriginal and/or Torres Strait Islander and CALD children with disability in child protection systems who face criminalisation. It sought to gather the views and experiences of professionals of policy and practice in this space, to directly inform Research Questions 1-3.

It should be noted that due to timeline and ethics approval constraints, we were unable to directly contact statutory services or programs for the purposes of this study, so we were limited to undertaking consultations with non-statutory organisations working in this space.

8.1.2 Consultation approach and research method

The design of consultations was intentionally exploratory in nature, attempting to generate some initial insights to support the findings and recommendations of the Disability Royal Commission, within the available timeframe and resources. At the same time, it should be recognised that additional research is required to fully canvass the diverse topics and potential solutions at these intersections. Data were collected via semi-structured interviews which focused on what professionals identified as helpful strategies for preventing and reducing the criminalisation of children with disability in child protection systems (addressing Research Question 2), barriers to accessing supports, and suggestions for systems improvement. A copy of the semi-structured interview data collection instrument is provided in Appendix D.

8.1.3 Consultation recruitment and data collection

Relevant organisations in each state and territory were contacted via email and provided with a copy of the study information sheet (as shown in Appendix C). Individuals interested in participating in the research then opted-in by contacting the researchers to arrange interview times. Individual and group consultations (interviews) were then conducted via Zoom by two of the researchers (RB and RN), who identify as being of Aboriginal and CALD backgrounds respectively, with organisational staff who expressed interest in opting-in to the study.

Prior to commencing the interview recordings, the researchers reminded participants of the purpose of the study aims, as well as the definition of disability being adopted by the Disability Royal Commission. Participants were provided the opportunity to ask any questions prior to commencement of the recording. Informed consent was affirmed by participant's agreeing (via clicking a button) to the recording of the interview.

8.1.4 Consultation data analysis

Consultations with ACCOs and organisations working with CALD children were transcribed verbatim, then thematically analysed as separate datasets by the researchers who conducted the consultations. A deductive thematic analysis approach was utilised, by coding responses to individual questions and identifying recurring themes in responses.[552] Additionally, consistent with the exploratory approach adopted, diverging themes were also identified, particularly those relating to participants' unique contexts, roles, and settings.

8.2 Participants: Consultations with ACCOs and CALD Organisations

As outlined in Table 12 below, nine consultations were undertaken with 19 participants across ACCOs and CALD organisations. These consultations were undertaken with organisations in Victoria, Northern Territory, and Western Australia, and ranged from 40-62 minutes in duration.

The study aimed to include a range of organisations who support Aboriginal and/or Torres Strait Islander and CALD children at the nexus of child protection, youth justice and disability services. Ultimately, CALD consultations were held with seven participants from five different community, cultural or health focused organisations and programs in one jurisdiction, with six participants who identified as South Sudanese and one identified as Māori. It is important to note that this sample does not represent the breadth of the CALD population at the cross-section of child protection, youth justice and disability, a limitation previously highlighted in the report. While the findings cannot be generalised to the broader population of CALD children with such systems involvement and experiences, the study is intentionally exploratory in nature, aiming instead to capture key insights which can be further developed via future research and consultations.

Table 12. Consultations with ACCOs and CALD organisations

Consultation	Organisation Type	Participants
1	ACCO	3
2	ACCO	2
3	ACCO	1
4	ACCO	2
5	ACCO	5
6	CALD	2
7	CALD	2
8	CALD	1
9	CALD	1
Total		19

8.3 Findings: Consultations with ACCOs

Findings from the consultations with ACCOs are outlined across three sections, namely:

- Areas of need/barriers faced by Aboriginal and/or Torres Strait Islander children;
- Current practices seen to work well with Aboriginal and/or Torres Strait Islander children; and
- Suggestions for future practice with Aboriginal and/or Torres Strait Islander children.

8.3.1 Areas of need / barriers faced by Aboriginal and/or Torres Strait Islander children with disability

Participants in the consultations with ACCOs highlighted four broad areas of need and barriers faced by Aboriginal and/or Torres Strait Islander children with disability in child protection systems who were at risk of criminalisation, specifically:

- Understanding, assessing, recognising and responding to disability;
- The need for culturally safe and appropriate services and systems;
- Disrupting specific pipelines to criminalisation – educational exclusion and entry into residential care; and
- Broader systemic barriers and needs of children and families in child protection systems.

Each of these areas of need is further described below.

Understanding, assessing, recognising, and responding to disability

Several key themes concerning understanding, assessing, recognising and responding to disability were identified across consultations with ACCOS.

Understanding and defining disability. Identifying what disability is, and how it impacts on individual children, their families and wider community was identified as a barrier to accessing disability and other services for Aboriginal and/or Torres Strait Islander children in child protection systems. Challenges identifying and defining disability were identified by participants as originating both within community and from service systems. In relation to the community response, one participant noted that the wider *"community doesn't understand their disability, and so, they're treating them as criminals from the get go".* One participant spoke about services not providing a holistic approach in relation to disability:

> Anyone within the care team meeting that works with kids with disabilities and families with disabilities, they sometimes don't have this 360 lens of the way in which you should deal with a family that's experiencing disability.

Similarly, in relation to NDIS, one participant stated that *"we've got [disability case management plans] that don't even understand profound disability"* and push through on assessing families where the parent and children all have a disability that impacts on their ability to complete assessments. Aboriginal and/or Torres Strait Islander families also often experience considerable shame, blame and guilt in relation to disability being identified within their family, with one participant stating that many families do not *"like the word disability"*:

> …because then they think it's their fault because of their – during their pregnancy or whatever. There's a lot of – still, within the community, lack of understanding that you could be anyone and you can have a child with a disability.

Participants also spoke about accessing services through NDIS as a barrier, specifically the understanding or meaning of disability used by NDIS, which in practice was often seen to exclude support around psychosocial disability. Both participants agreed that:

> …some of our families actually fall under the psychosocial as well as disability and we're being told by the NDIS people, 'Don't even try putting in a psychosocial. You'll never get it'.

One participant from a different jurisdiction concurred that different understandings of disability could be a *"massive barrier"*:

> …what we've noticed is particularly for children and young people who might, for example, have a diagnosis of foetal alcohol spectrum disorder, there's kind of almost a sense of that's all it is. So, we don't actually acknowledge that is creating a range of challenges for the young person, but it all gets put into the behavioural bucket rather than looking at what the real difficulties are for that child or young person and how that might lead to behaviour that eventually could be construed as criminalised behaviour. So, the understanding disability is important.

Stigma of disability. The stigma, shame, blame and expectations that families and community experience in relation to a child having a disability was also a common theme amongst participants. The criminalisation of children with disability was described by one participant as:

> …when there is someone with a disability and they're in the system of child protection or there's criminalisation of some sort, I feel as though they're not given a fair go to – no one's checking to see if they understand what they're doing. No one's checking to see whether or not they're making these mistakes, because they can't read and write. They're getting themselves into really difficult situations […] I've got an example where they're not apparent of what's happening; therefore, they're sort of in this situation, but it's not their fault and no one's helping them get out of it. I think it's very easy to put someone with a disability into a category and there's stigma around that.

Another participant from a different jurisdiction stated that "the system fails Aboriginal people experiencing disability or medical conditions, because they have this stigma of what else might it be" and that "…there's all of these stigmas around what people think our families are doing and what's actually happening and it's really hard to break that stigma".

Furthermore, participants outlined that services do not adequately respond to the family's needs, particularly when the parents have a disability, either undiagnosed or diagnosed. It was seen by participants that *"the NDIS expect that a lot of things are deemed as parental responsibility and when we've got parents with disabilities, trying to support kids with disabilities and child protection's involved. NDIS still don't see that the parental responsibility needs to be shifted".*

Need for earlier and more appropriate disability assessment and interventions. A lack of early intervention and early assessments were identified as a barrier for Aboriginal and/or Torres Strait Islander children with disability, as one participant described that:

> …we just catch them too late because by the time they get to [youth criminal] court – and often you'll get doli kids and then they transition to 14 and really the interventions haven't been intense enough.

The participant above is referencing the legal principle of *doli incapax,* which requires that before a child under 14 years can be convicted of offending behaviour, the prosecution (police) must prove that the child understood what they did was seriously wrong, rather than only naughty or mischievous.[553] Where this is unable to be proven, a child may be found *doli incapax*, meaning 'incapable of crime'. While younger children found *doli incapax* are rightfully diverted from the justice system, they are often not provided with the necessary services to address their support needs, for example those related to disability and mental health. This can result in the child's entry to the justice system simply being delayed a few years, rather than prevented all together, as their needs persistently remain unaddressed within a societal setting that ultimately views related behaviours through a lens of criminality rather than disability. As outlined by one participant:

> …once they're in [youth justice] territory it's pretty difficult to get them out again because we sort of use youth justice as a last measure because we like to keep – I think we can all agree we like to keep them away from youth justice if we can, because often that can serve as a more like criminalising them even more because they're on [youth justice] orders.

On the other hand, it was repeatedly pointed out that disability assessments are often only conducted once children enter the justice system. For example, one participant stated that:

> …kids refuse to engage in assessments, their behaviours are too problematic, and then they're absconding. And so I think they – often a lot of the time it's only when they've got [youth justice involvement] or they're really properly in the criminal justice system that those reports are ordered and that you get a comprehensive [neuropsychological] report that identify – kids get diagnosed with Autism and a whole range of different things that very clearly are connected to the offending behaviour but it hasn't been picked up earlier – quick enough or early enough to really put in any preventative measures.

This view was echoed by a participant from a different jurisdiction, who emphasised that:

> … these kids don't stand a chance from the get-go. So sadly, often born into highly-dysfunctional families and there's no interventions at that stage. And they cycle along until they're old enough to offend, and then they get prosecuted. By the time there's an assessment done, it's too late invariably, because a lot of the time they've committed serious offences and they land either on remand or via sentence.

Participants also identified that there was often a rush to complete referrals when a child or young person was exiting the child protection system. One participant stated that it was important *"not finally deciding that their disability should be prioritised at 17 and 17.5 when they're about to exit the [child protection] program"* and *"obviously disabilities are quite complex but when you go through the file it looks like there's very little that's been done between when they first got involved with the young person and 17.5. And so, they're rushing to make referrals to get them on … referrals to NDIS."*

Another participant from a different jurisdiction explained that:

> … everyone bangs on about early intervention and we know that that is what works but the early interveners that are funded by the Territory are this child protection team who are supposed to – called the Intensive Family Support Service - but what actually happens is it's just so rare that someone is not touched by the child protection system and that doesn't lead to a child being removed. That might not be the first time but it's the second time there's a notification and there's all this history of like, 'Oh well, we tried to engage with the mother, and she didn't respond'. There's no unpacking of why that might be. It's also that the early intervention supports that are established don't work and don't do the early intervention work of [diverting] children and families away from this system. Instead, they are touched by it, and they never ever escape it.

Trust was also identified as a risk factor in assessments, with one participant stating that children's engagement in assessments *"depends on them trusting whoever's arranged the assessment"* and *"a lot of kids don't think they've got a disability and they're just being ordered around to go and do these things. They don't have any real understanding of why".*

Need for culturally-appropriate disability assessment. Several aspects of disability assessments were identified as culturally inappropriate. First, it was seen as important to have services explain to the child why the assessment was needed, and what support would be in place for the child. One participant explained that word of mouth, in relation to assessments, was a factor in whether a child would undertake an assessment. If Aboriginal Community Controlled Organisations do the assessment *"they'll do it, but then as soon as it's [child protection]-related – I've got one kid who's like no fucking chance*".

Another participant explained the issues with assessments in relation to Foetal Alcohol Spectrum Disorder (FASD), specifically *"to develop a FASD diagnosis you have to have confirmation of prenatal drinking from the mother. That's extremely – who's going to admit to drinking while pregnant with your baby to a white clinician. It's extremely – there's a lot of shame and trauma attached to that. And also sometimes the young person's mother is deceased and that means there's never a determined diagnosis. What happens a lot is that young people are kind of diagnosed with generalised adjustment disorders or some kind of catchall term and – but the psychologist or whoever is developing the diagnosis will note, "I think there's domains of impairment of FASD here".* This participant went on to stress the culturally inappropriate nature of these assessments:

> …it uses this weird eugenicist measurement of an Aboriginal person's skull that is actually based on African American measurements of how wide someone's – the diameter of someone's skull … for a FASD assessment a paediatrician will take a kid through a series of puzzles that are designed to assess their decision-making ability and assess their motor skills and, I mean, for a kid living in an urban setting probably they're relatively easy but kids coming from communities, "What the hell is this?", so they might perform more poorly than if they had another assessment tool but there is no other assessment tool and there is no culturally appropriate assessment tool. So those – I mean, again, that's an issue, the cultural appropriateness of the tools.

Several participants mentioned the lack of validated assessments for this group of children, as outlined in the following quotes:

> … [There is no] validated cognitive assessment tool at the moment that can assess [Aboriginal and/or Torres Strait Islander children].

> ….There is a Western bias in all of those assessments, and we're using the best assessments we have on hand, but they're not normed on people having English as an additional language. They're not culturally informed.

> …there's not an Australian adaptive functioning assessment – there's not an adaptive functioning assessment or functional assessment with standardised Australian norms. So, forget culturally appropriate norms. We don't even have one with Australian norms. And then if we think about culture, and then applying that – there's just so many intricacies around culture that is unique.

Finding the right medication. Ensuring Aboriginal and/or Torres Strait Islander children with disability are on the right medication, after the assessment process for their disability was identified a protective factor for reducing criminalisation. It was pointed out that:

> …a lot of kids who are not on the right medications and that's where their emotions are fluctuated, their capacity to get up in a day changes and then medications, any supports just goes out the door. So I think at that initial stage is the – they find the right medication, they have the right support as well.

Diagnosed or undiagnosed disability among parents of child protection-involved Aboriginal and/or Torres Strait Islander children. Given that Aboriginal and/or Torres Strait Islander children with disability are more likely to be criminalised in out-of-home care, the pathways of these children into care are important to understanding these outcomes. The ongoing over-representation of Aboriginal and/or Torres Strait Islander children in out-of-home care, and the inefficiency of the system in keeping Aboriginal and/or Torres Strait Islander children together with family was highlighted by participants, for instance:

> …nearly 100% Aboriginal kids are being removed from their families. And across the state the numbers are massive right now, and so many families are being broken by the system rather than them actually having some supports and having some help.

Participants raised the issue of disability among parents (diagnosed or undiagnosed) being unacknowledged or unsupported by child protection and broader systemic responses to Aboriginal and/or Torres Strait Islander families. This was seen as a key contributor to Aboriginal and/or Torres Strait Islander children with disability being removed from parents and entering out-of-home care. Participants outlined how services might claim the parents are not accommodating or non-compliant, rather than recognising when undiagnosed disability results in them not understanding the process, goals, and assessments in relation to their child/ren. This was best described by one participant as the parent being blamed by child protection as being non-compliant, when smaller goals needed to be made in order to achieve the overall goal:

> There's mum who's a little bit non-compliant, because mentally, she's not able to understand, and I was the one who picked up on that. No one else. They just thought she was non-compliant. It's not just that she's non-compliant. She physically doesn't understand what's going on and needs things to be broken down and needs smaller steps in order to achieve goals. They're giving her these massive steps and these massive goals to achieve and then she's not achieving them.

One participant mentioned how difficult providing appropriate services is for parents with an undiagnosed disability, which can result in delayed diagnosis for their own children:

> …a lot of my families that I work with have parents with an undiagnosed disability or mental health, or the children have only just got diagnosed".

In relation to children who are already engaged with child protection systems without having a diagnosed disability or disabilities, one participant stated that:

> …70% of our people who are in prison fit one of those categories, and then in the Indigenous community, there is so much more disability and cognitive impairment, or even just trauma that's not diagnosed, not identified […] therefore there's a very small number – I don't know the stats – that don't have a disability that are children in our system.

Need for culturally appropriate and culturally safe services and systems

Extending from the theme of culturally appropriate assessment practices, this section outlines broader themes raised by participants in relation to the need for culturally appropriate and safe services and systems.

Culturally inappropriate services and approaches. A lack of connection for Aboriginal and/or Torres Strait Islander children in child protection systems to culturally appropriate supports was another theme identified by participants. One participant gave an example of:

> …a client that has been saying to me for a number of years that he wants – he's not very connected to his community and he's really interested in that. And nothing's happened. I've repeatedly told [youth justice] and [child protection] "What are we doing in this space?" because that could really serve as a protective factor for him. But nothing ever – "He's on the wait list", yeah, yeah, yeah. So that's my view. And certainly, I don't think the services – unless they're already linked in with, and have strong connections to community, and often that support and those protective factors come from their family and not from the actual support services that they've been referred to.

As outlined in the previous section concerning disability, assessments were also often identified as being culturally inappropriate as they are based on Western frameworks and are mainstreamed by services that undertake assessments. This was observed to apply to referrals, according to participants. For instance, one described that:

> …the first direct referrals I see for Aboriginal kids would be straight to the mainstream services. Or if they had tried once with an Aboriginal corporation service because it didn't gel well there's no other options and they go straight back to mainstream. So, I find services here tend to refer to mainstream rather than cultural referral.

Another participant from the same group further explained that:

> …Child protection workers automatically go straight to the mainstream, not applying the Aboriginal Placement Principal, not acting on the having an Aboriginal family-led decision-making meetings.

Similar perspectives were given in relation to culturally-specific teams and positions within mainstream services, For example, one group of participants mentioned a Youth Justice Koori Team and explained:

> …it's just like a title. Do you find any – there's no more understanding of these kids' needs. It's probably worse honestly and it's like they probably are "Look we're championing and really representing these kids and making sure these Aboriginal kids are being looked after" but they – it's the same thing. It's a tick box thing… But there's no Aboriginal workers looking after them, or very little, and then they're just referred to mentoring or whatever it is".

Furthermore, in the same consultation group, another participant extended their experience as *"there's no Aboriginal workers looking after them, or very little, and then they're just referred to mentoring or whatever it is"*. The YJ Koori Team *"arguably they're a lot more harsh and not as understanding".*

In terms of cultural loss and grief, one participant stated that children in detention, far from their country experience loss and grief for their culture, community, language, and family. The participant explained it is a range of factors that relate to:

> …culture bound illnesses and longing for country as one of those illness... I would say that's a huge psychological symptom that a lot of young people in care experience that is then exacerbated by things like Territory Families who are both their carers and their jailers here in that they will have care of a young person under a child protection order but also operate Youth Detention Centre. It's like one arm is supposed to be caring for them, the other is this punitive arm. That's like a criminalisation kind of in and of itself. But that punitive arm will make the decision to move a young person away, thousands of kilometres away from family. They know that their family can't afford to come to visit. The caring arm is kind of like, "Oh, well, what can we do about this?"

A lack of systemic appreciation of cultural loss, grief and trauma was evident to participants in the way disability, mental and physical health challenges are conceptualised in solely Western frameworks. For example, in relation to children experiencing trauma and insomnia in detention settings, one participant explained:

> … young people end – so they feel like quite – they can't sleep in Youth Detention because it's an adult prison for young Aboriginal people. People have died in there, so they say it's like – they feel like there are spirits around, they feel like – they feel culturally unsafe. They're also – there's also this kind of symptom of real longing for country and missing it and being so far away.

Another participant describes that "these young people are being caught between two cultures… the presentation is mourning the loss of Country, and not being able to go back there, or not being able to go there when they feel they need to". The same participant gave an example of a child's experience of how the justice system is culturally inappropriate, which resulted in the child's experience: *"lost my language, I lost my culture, I lost my songs".* The same participant stressed that:

> …access to assessment and appropriate assessment is such a barrier. And then I think following assessment – access to ongoing services that are meaningful and appropriately titrated and shaped and influenced, and respectful of cultural knowledge and expertise and – it's lacking.

Culturally inappropriate and traumatising policing practices. The approach of police in Aboriginal and/or Torres Strait Islander communities was also seen as a risk factor for children with disability entering the criminal justice system Policing practices, which included over policing and/or over-surveillance and the use of police dogs to attack children with little to no knowledge of whether the child(ren) has a diagnosed or undiagnosed disability, were seen as culturally inappropriate, and served to increase collective trauma within Aboriginal and/or Torres Strait Islander communities. One participant described the impact of short-term policing in Aboriginal and/or Torres Strait Islander communities as *"some FIFO police officer or some cop who's been there for three months who doesn't follow protocol and introduce themselves to community and who will be gone in the next three months to their next placement".*

Participants also mentioned that for FIFO police it is *"an incredibly lucrative thing for police to go regional. So, they have a list of people wanting to do it and then the most ill-equipped people doing it".* Furthermore, the police who are FIFO in remote Aboriginal communities *come "into the community and who deal with our children are not culturally appropriate".* In a different jurisdiction, one group of participants stated that in their area Aboriginal children are:

> …the most overpoliced community in the country by a considerable margin - we've got the data to prove it - and I daresay it's the most overpoliced community in the world. There are more Aboriginal people per head – Aboriginal males per head of population in custody tonight than there are in the US [United States].

Participants noted that the government had implemented policing methods that include the use of *"drones in the sky that the young kids can see, the police drones in the sky",* and described traumatising practices such as the use of police dogs:

> …police use dogs to apprehend people in this state. So the recent statistics we got was that 61% of people injured by police dogs were Aboriginal, bearing in mind that they're 3% of the population here. And one-fifth of those were kids, the majority of that one-fifth being Aboriginal kids. Aboriginal kids, including a nine-year-old, who's not even the age of criminal responsibility, being bitten by police dogs in the course of being apprehended.

Systemic and/or institutional racism. The ideologies of systemic and institutional racism are often used interchangeably; however, systemic racism "occurred throughout Australia during much of the twentieth century where Aboriginal people were separated in various social spaces from hospitals to movie theatres, from housing to cemeteries, and where denial of service was commonplace",[554] and continues to occur for Aboriginal and/or Torres Strait Islander peoples. Institutional racism, on the other hand, "draws our attention towards the institutional processes through which racism is enacted".[555] Examples of institutional racism raised in the current

consultations included funding inequality and cultural barriers to accessing services. Overall, systemic and/or institutional racism was one of the most common themes raised by participants. For example, one participant noted that:

> …[institutional racism] is a big factor and the incredibly low expectations all of these institutions and organisations have for young Aboriginal people" […] at every turn for whatever reason because of racism, institutional inefficiencies, things are just missed, there's all these opportunities to intervene that aren't used…racism is a huge factor.

Another participant from the same jurisdiction similarly stated that *"there's a lot of variability in terms of, again, the level of entrenched racism in the system and how that impacts on the end result".* In relation institutional racism by the government, one participant from a different jurisdiction stated:

> none of the government interventions targeted at Aboriginal kids generally, let alone Aboriginal kids with disability, assist them in any meaningful way to be diverted out of the justice system or the care and protection jurisdictions. Government in this state are an abject failure when it comes to Aboriginal people overall, but most specifically for Aboriginal kids and their families with disabilities.

Limited funding for culturally-specific services and programs. The limited funding available for services that support Aboriginal and/or Torres Strait Islander children with disability was identified across all consultations as a risk factor for the criminalisation of these children. One participant stated that *"it's really hard to get them into programmes or services that might help them. It's hard, because they're getting funding for that".*

Participants from the same consultation noted the lack of per capita funding for Aboriginal-specific services, and the precarious and onerous nature of funding that was available, as outlined in the following quotes:

> …money for supporting children and families goes to big, non-Aboriginal not for profits and none of the money goes to Aboriginal community control organisations to assist these kids and their families.

> …the funding for this is really uncertain. The reporting requirements to government are ridiculously onerous, so we sort of stagger from year to year wondering whether or not we'll be able to continue.

This impacts on the capacity of ACCOs' to support families and children with disability in child protection systems, as they *"only have the capacity to work with a small number of children within each region, when [they] know that there's so more – there's so many other children out there that [they] could be helping but [they] don't have the capacity to do so".*

Tokenism. Tokenism was a barrier identified by three participants from three different interviews, which applied to youth justice, child protection and mental health services. Tokenism was also referred to, as a barrier, in relation to cultural appropriation of the needs for children, with one participant stating, *"I just don't understand why [child protection] is so involved, and they just have such a tokenistic way of looking at culture and their cultural plan includes a few little buzz words here and there where they actually don't do anything"*.

Another participant described tokenism within child protection institutions, noting that *"there needs to be a willingness for them to listen. And they need to listen to Aboriginal voices, because too often in my dealings with them, it's their way or the highway. Tokenistic gestures aren't going to cut it …*" and despite having *"regular meetings with the Department of Communities because we've been so critical of them in the past, and it's the most tokenistic exercise imaginable".* Tokenism was also identified as problematic in relation to the way referrals were made. For example, one participant stated that *"often the workers will just put in a referral for mentoring or something like that and then they're put on a – it feels tokenistic. That's my view. It doesn't feel genuine".*

Pipelines to criminalisation – educational exclusion and entry into residential care

A pipeline to contact with the criminal justice system was identified by participants, which *"all falls into a bit of a predictive pattern with kids and offending."* Consistent with the broader literature,[556] participants highlighted educational exclusion and entry into residential care as key turning points in the pipeline for Aboriginal and/or Torres Strait Islander children with disability in child protection systems.

Educational exclusion. In relation to educational exclusion, a participant outlined a typical subsequent pathway for Aboriginal and/or Torres Strait Islander children with disability in child protection systems:

> Often, they'll be kicked out of school and then that'll just spiral and you'll mix with other kids who are also not in school, and then those kids are the same kids that you'll hang out with at night time, then you'll meet other people through them. And if they end up in [youth justice detention] then they meet more people in [youth justice detention]. And that's just how it's – it always starts off, in my opinion, usually it's when school drops off it escalates pretty quickly after that. And that's just because they've got nothing to do during their day.

Educational exclusion was seen as a critical part of the process of criminalising Aboriginal and/or Torres Strait Islander children with disability:

> School education is a huge pipeline … for young people with disabilities… What generally happens is that a young person will kind of be identified as an issue at school. They'll be reduced to go in the school for a few hours a week, then eventually they get transitioned to a re-engagement centre which is like the school for naughty kids. Eventually they go from the re-engagement centre to incarceration.

Another participant from a different jurisdiction mentioned that, despite the fact that there are teachers who are committed to children's education, ongoing punitive responses that are not disability informed are still pervasive across educational systems:

> [Some teachers are] overwhelmed and fairly jaded, and will approach things from a very punitive lens and having a punitive approach automatically, you're going down a pathway of exclusion, and as soon as you're going into exclusion, then you've got a young people just floating around and then they get themselves into even more trouble. So, when I think about all of the teachers that I've met… it probably would weight towards the more punitive style approach. And I think for some of them that is just a lack of, ironically, a lack of education or around how to understand what's happening for a child with a disability and how to put the right supports in place in a classroom setting.

Entry into residential care. Consistent with the broader literature,[557] participants described entry into residential care as another key point on the pipeline to criminalisation for Aboriginal and/or Torres Strait Islander children with disability. For example, one participant stated that they have *"seen a young person who was removed from her family, placed in residential care unit, all the offending happened there within seven months, they just kept escalating."*

The participant observed that the same child was able to be better supported in a culturally-appropriate non-residential care placement:

> …she moved to a stable family, with an Aboriginal family, that has really changed things. She's in a stable placement. She's connecting to the community and culture, she's in the culturally appropriate placement. I think that's really important. I think that's really had a significant impact on her, getting the right support and getting back on track and seeing life in a different way.

According to participants, placement in a culturally appropriate setting reduced children's criminalisation, and supports the surfacing of more positive outcomes for the child. In relation to child protection and the pipeline to criminal justice, one participant stated that *"often kids who are managed by child protection do end up in secure, secure welfare quite often".* One participant related disability to offending in the following manner:

> …a significant proportion of offending by young people is related to their disability, whether that's diagnosed or undiagnosed" … incidence of disability in youth detention centres is shocking. Compared to May last year, by May this year admissions to NT youth detention centres had increased by 220%. It's literally doubled since May last year the number of young people locked up. Almost all of them are disabled but that disability isn't identified until they go to youth detention.

The same participant further explained that:

> … almost all the kids in care I know are crossover kids.[12] They are criminalised through their care experience in that often the first time they get arrested is for something that happens at their resi care house or something that happens at their foster carer or the reason that they've got arrested is because they've absconded from that house because it's unsafe.

Broader systemic barriers and needs of Aboriginal and/or Torres Strait Islander children and families in child protection systems

Key to preventing the criminalisation of Aboriginal and/or Torres Strait Islander children with disability is ensuring timely and appropriate access to services and systems of support. This section outlines the challenges faced by Aboriginal and/or Torres Strait Islander families and children with disability in accessing these timely and appropriate supports, which participants outlined as contributing to the criminalisation of Aboriginal and/or Torres Strait Islander children with disability. Many of these relate to child protection systems, while others relate to service provision more broadly across a range of systems who come into contact with this group, including NDIS, mental health and criminal justice systems.

"Too Hard Basket". Many participants commented on how child protection, NDIS, the criminal justice system and other services placed Aboriginal and/or Torres Strait Islander children with disability in the 'too hard basket'. This was identified in all jurisdictions where the consultations took place, as illustrated in the following quote:

> …you've got a team of people who are supposed to come in for parenting supports to help mum and they've actually just decided, "No, it's just too hard. It's unsafe. We're not sending our staff out to the home, because it's not safe. Mom won't engage. We've tried to engage with her two times, and she won't engage. She's not doing what we asked. This is not what she needs right now. She doesn't want our help," and it's just so easy to label it like that.

Another participant relayed the importance of continual support by youth justice and child protection regarding support as *"young people, when they enter the system, they get that starting position where [youth justice] are supporting and [child protection] are supporting, but the moment they become too problematic and keep offending … I feel like they're just doing what can they do to keep them in [custody] because their lives are easier when they're in custody".* According to participants, while Aboriginal and/or Torres Strait Islander children with disability are viewed as deficits to society, these outcomes are in fact a result of systemic failures and neglect to support this group of children.

12 'Crossover' kids or children is a term sometimes used to reference children who experience dual systems involvement (often concurrently) across child protection and youth justice systems.

Appropriate use of language. Language was identified as a barrier to service access for Aboriginal and/or Torres Strait Islander children with disability across all consultations. This included the terminology used to label various disabilities, whether English is a second or third language for the child and/or family, and language used in education. Some participants stressed *that "a lot of the kids are struggling and language – even though they might speak English at home, genetically and intergenerationally, English is not their first language. They think different. They learn differently".*

Participants emphasised the default use of English as often challenging for children who speak multiple languages:

> …so many of these kids have multiple languages, but then they get into an education system and it's English. Or they're removed from country, to Darwin or Katherine, and they're expected to use English all the time because their carers are English-speaking, or English is the shared language between them. And school – there's a few exceptions, but school is generally English-speaking. And what we know, and what the research actually says, is that where children can use both languages, when they're allowed to be fluent in both, they actually do better academically than when they're asked to only use one language.

Another participant stressed the importance of language and communication, emphasising the multiple languages often spoken by Aboriginal and/or Torres Strait Islander children:

> …if you don't have that right, you're automatically creating a barrier to being able to support that young person. And for a lot of children and young people, particularly Aboriginal and Torres Strait Islander young people, English might be a second or even a third language for some of them. So getting the language pace right and then I think having enough resource to be able to do the work around, supporting them in whatever.

One group of participants outlined the stigmatising and discriminatory use of language by individuals in the criminal justice system:

> …it's the language as well, and the language with kids with disability. I know sitting in court one day one of the magistrates said to one of my young people, 'You're brain damaged.' And then I was like, "Oh my goodness." So, when I went into custody the next time, I had to explain to him – I said, "Don't listen to what was said to you. This is what's going on with you" because he had been diagnosed with FASD. So, the language that's getting spoken to kids with disabilities.

This same participant outlined their approach to requesting appropriate use of language from disability services:

> ….even when we go to NDIS, before we go and have the meeting, we actually state to them, 'Please do not use the word disability. Explain to the young person what's going on with their cognitive thinking and we don't call it a disability'. The language that they're not only getting called criminal, they're getting [told] that they've got brain damage, that they're useless at the end of the day.

As the above quote emphasises, systemic responses to Aboriginal and/or Torres Strait Islander children with disability may easily serve to amplify stigma, applying layers of labelling and exclusion that can compromise children's self-worth, and contribute to their criminalisation.

Stability and consistency of systems and supports. Lack of stability and consistency were issues that participants expressed as barriers. Children with disability did not have a consistent youth justice worker, child protection worker and/or other key stakeholders in the case management team, which impacted on trust, building a positive rapport and relationship with the child/ren. For instance, one participant expressed that the role of *"consistency is really a huge thing. I really – if consistency's not there then everything else kind of falls apart. And that's not just consistency in our space, that's across the board with [child protection], with their carers".*

Taking time to build positive relationships with children, families, and community. Building positive relationships take time. This was a barrier that was identified by all participants. Particularly when trying to build and maintain relationships with children, their families, and the wider community in remote and/or regional areas. One participant stated that:

> …we need to build relationship, but good relationships build over time" and "relationships can be incredibly healing, but you need to have a level of consistency and availability and presence for that healing – for that shift, for that relationship to be found as positive and understanding and empathetic.

Another participant stressed the importance of relationship building with families, noting the time required to develop meaningful relationships:

> …families take a long time to let us in. I've got some families that I've been working with since November and they have been in transition, so they've been – like different schools, different doctors to collate all those reports for NDIS has been a nightmare" as they are "sharing pretty sensitive things and often they're isolated and there's a blame, guilt and shame is because there's disability out.

Trust. A lack of trust was stressed as a barrier that impacts on Aboriginal and/or Torres Strait Islander children and families accessing services, completing assessments, and engaging with services in general. Shame and stigma were related to the distrust of families and services, with one participant relaying that intergenerational trauma was the main driver, with some families concerned their child would be removed from their care and placed into an institution, such as a residential home. One participant spoke about the parents of a child with disability not trusting the services, child protection, or the justice system, as they were removed from their parents at an early age:

> …a lot of our families see disability or NDIS as the department and [child protection], so there's a lot of blurring of, "You're going to take our kids". And that's what's happened to the parents throughout their life.

For families to trust services takes time, however there are many things going on in the family's life that are prioritised over diagnosing a disability, as a participant stressed that:

> …sometimes families want other things addressed first. "Yes, we want you on board to help with my son's disability, but I've got a rat infestation in my house, and my house is not big enough for my four kids where two of them have got intellectual disabilities. I need to actually move house before I can clearly even start working with you to help my kids with disability, because I need to tick one thing off at a time.

Aboriginal and/or Torres Strait Islander families involved with the child protection system were observed to sometimes be blamed when services were ineffective due to culturally inappropriate service approaches. For example, services:

> ….treated [assessments] as though it's a normal family, and then when those strategies don't work, they either say the family's too difficult to work with, family don't want our support, family are non-compliant and that family slips through the cracks and then they don't get the support and the services they need. And they end up having children removed, parents removed, lots of other things ....

Service access in remote and regional communities. Barriers to accessing services and assessments for Aboriginal and/or Torres Strait Islander children in remote or regional areas was observed as a risk factor for their criminalisation. One participant stated that there was *"extremely limited disability support services in remote areas".* While this issue could be perceived as a barrier more broadly, national data demonstrate that the percentage of Aboriginal and/or Torres Strait Islander children in child protection systems residing in inner/outer regional, remote or very remote locations is far higher than that of non-indigenous children.[558]

Services lack the outreach component of support for Aboriginal and/or Torres Strait Islander children with disability, as one participant recognised that:

> …expecting these kids to conform to a system of going to the city or going to this place at a specific time and if they're half an hour late then the psych can't see them. There isn't that like doing outreach, there isn't that sort of flexibility or a kid's absconding a lot.

Services assessing children needed to have flexibility in assessments. One participant, from a different jurisdiction noted that "access to services is a big issue" and people "don't have reliable internet to do video links for therapists or to follow through when – and they move between their different communities that they're connected to, and that mum and dad and the bigger community are impacted by alcohol use, and – and so the consistency and the rhythm that is needed for that kind of protection and change are barriers that you work with".

Specific challenges related to COVID-19. The impact of COVID-19 on this group of children and their families was also raised by participants, with one stating that despite trying to provide as much assistance in access to services, they didn't *"think COVID did anything positive for a lot of my families and for their carers as well who struggle with mental health and disability, and they're quite isolated from any community or family support".*

Implications of resource reductions were emphasised as a barrier to accessing services during COVID-19, with ongoing impacts due to services clearing the backlog of required assessments:

> ...people are starting to provide services now, they're trying to clear the backlog. I had [neuropsychological] assessments booked for January and February [2022], got pushed out April, May and now it's got pushed out July, August, and for Royal Children's Hospital to do an assessment, it's over an 18-month wait.

Relationship building during COVID-19 was difficult for practitioners and was *"really tricky trying to build rapport with the young people but for the young people as well".*

Other barriers. One participant described how government departments are outsourcing care arrangements to services who are not trained with dealing in children with disability. This was seen to result in the *"outsourcing care of young people to these kind of mass [residential] care houses, that's an institution and then Don Dale's an institution so these young people are set up to only thrive in institutions".*

One of the consultation groups identified that certain laws, specifically mandatory sentencing, where Aboriginal and/or Torres Strait Islander children are:

> …subject to mandatory sentencing penalty pretty quickly, so sometimes there's not a lot of time for services to get involved to try and work through some of those underlying issues at home. So we've got 12-year-olds who are - the state arguing that they're subject to repeated offender legislation; they're a third striker.

8.3.2 Current practices seen to work well for supporting Aboriginal and/or Torres Strait Islander children with disability

Consistent with many survey respondents, some participants argued that they *"can't think of any"* practices that are effective at supporting Aboriginal and/or Torres Strait Islander children with disability. However, various practices and approaches were seen to work well by other participants, as outlined below.

Aboriginal Community Controlled Organisations

Several participants stressed the importance of Aboriginal Community Controlled Organisations leading case management, as these organisations understand the needs and wants of Aboriginal and/or Torres Strait Islander children. Programs aimed at connecting Aboriginal and/or Torres Strait Islander peoples to community were viewed as helpful for preventing children from becoming criminalised:

> …what works really well are Aboriginal led organisations, Aboriginal led workers who understands the culture and what it means to heal, what it means to connect to community and family and country.

Furthermore, when ACCOs are leading the case management of children this participant observed, *"it's just like how do we make this young person's life better? How do we support this young person? And that is answering to these calls, getting those appointments, picking them up, finding them when we can't contact them. Those little things really makes the difference".*

Service consistency and flexibility

While inconsistency in services and supports was noted as a barrier, participants highlighted the value of service stability and flexibility:

> …whether it's in their placement, whether it's in their workers, whether it's in the support services that they're getting.

Participants also noted that*, "… we see what works well is when they're being asked "What would you like to do? What would help you do X, Y, Z?". What also worked is when the workers that they're working with are flexible".*

Aboriginal Youth Cautioning Program

Regarding good initiatives, participants mentioned that the Aboriginal Youth Cautioning Program in Victoria *as "a great initiative that has – that is aimed at preventing those kids from being further criminalised and entering the criminal justice system. So, increasing cautions for young Aboriginal and Torres Strait Islander kids whilst offering the therapeutic component and offering different things that the young person needs aimed at reducing further offending".*

Ensuring systems accountability and oversight

Ensuring accountability in relation to services provided to Aboriginal and/or Torres Strait Islander children and families was identified as an important approach for reducing children's criminalisation. Children's Courts were seen as a particularly important avenue for ensuring oversight and accountability at a case level of decision-making and service provision to Aboriginal and/or Torres Strait Islander children and families, for example in relation to accessing assessments, services and adherence with the Aboriginal Child Placement Principle. As outlined by one participant, there is a:

> Magistrate who sits there every fortnight reinforces the Aboriginal Placement Principals. This puts the pressure on child protection workers to really, first of all, do the Aboriginal familyled decision-making meeting… Then the magistrate who sits there – consistent again, magistrate, would be able to reinforce [Aboriginal Placement Principals]… "You need to do that. Come back in a week's time and make sure you have that meeting". So that placement is culturally appropriate.

Community policing

Finally, in relation to policing, one participant expressed the importance of working with police, specifically how in Victoria *"community policing are a great resource, because they can help families help with things, like curfews or things like that or understanding the law".*

8.3.3 Suggestions for future practice with Aboriginal and/or Torres Strait Islander children with disability

Participant's suggestions for future practices that would assist in preventing Aboriginal and/or Torres Strait Islander children with disability involved in child protection systems from entering the criminal justice system are outlined below.

Training and education

Services were identified by all participants as needing further training and/or education in relation to disability. One participant stated that services:

> …should have to undergo some sort of training education course regarding, 'Okay, these are all your fundamentals. This is how you work with a family, now let's talk about how you would work with a family with disability'. This is where the gap is. There is no education for these other professionals to come in and know how to work with a family with disability.

Another participant expressed the need for services to understand the unique intersectional needs of Aboriginal and Torres Islander children with disability:

> These workers aren't trained in how to communicate and different methods of communication with a lot of these kids with disabilities. And so you have just this – 'they're refusing to engage, blah, blah, blah' when I think […] they don't have the adequate training to be able to support those kids that are more complex with those needs. So if you're not going to have an Aboriginal Controlled Organisation looking after these kids, then [the services available] need to be more properly supported and trained, and committed.

Similarly, in relation to child protection, one participant suggested that "*if they get cultural awareness training, perhaps a bit more specific rather than what's appropriate to say and what's not appropriate to say, but for them to understand the community a little bit better".*

Aboriginal identified positions

Having Aboriginal identified positions within the services that support Aboriginal and/or Torres Strait Islander peoples with disability was highlighted as necessary for future practice. One participant highlighted the importance of:

> Aboriginal liaisons within every area, like east, west, south and north, so that we can actually talk to them about that, because our plans are getting knocked back, because they're not recognising the cultural impact, the trauma and the chaos.

Another participant from a different jurisdiction similarly mentioned that:

> …it would be a good improvement if there was more identified positions, more Aboriginal and Torres Strait Islander people in these positions. I think that makes a big difference.

Another participant emphasised the need for community outreach, to assist in employing Aboriginal people in services to provide culturally appropriate support. For example:

> … the need to invest in education platforms where they go and reach out to communities and explain what options are out there, what courses, what programs community members can engage with. Because one of the things is while we want identified roles in these positions and organisations there is a lot of work to do beforehand.

Funding for ACCOs and services in regional and remote areas

According to participants, increased funding for ACCOs would enable the cultural support of Aboriginal and/or Torres Strait Islander children with disability. One participant said that they would *"just like to see them expand. I think we can't really see their full potential without giving them that funding and that room to be able to have a bigger impact and a say".* Similarly, another participant stressed that *"more funding for young people living in regional and remote areas is really important"* was needed to reduce offending behaviour and the involvement of children with disability with the criminal justice system.

Diverse and culturally appropriate therapeutic options

Finally, the need for diverse options in terms of therapeutic or healing supports that were more culturally appropriate was raised:

> Counselling sitting one-on-one does not always work. We need to look into music, art. I've seen camping works well, especially going out bush. First Nation's kids have grown and may have heard from their families, brothers, cousins about going fishing, going camping, sitting by a campfire. It's healing in itself being on country having – sharing dreamtime stories and so forth. So we need to look at other options, not just like you must engage with mental health counsellor. There are other ways to heal.

8.4 Findings: Consultations with Organisations working with Culturally and Linguistically Diverse Children and Youth

Findings from the consultations with organisations working with CALD youth are outlined across three sections, namely:

- Areas of need/barriers faced by CALD children;
- Current practices seen to work well with CALD children; and
- Suggestions for future practice with CALD children.

8.4.1 Areas of need / barriers faced by CALD children with disability

The needs and barriers relevant to the experiences of CALD children with disability in child protection systems which were raised by participants are presented by key themes relevant to various sectors as follows:

- **Disability services:** limiting beliefs around disability, families struggling to access NDIS;
- **Child protection system:** disempowerment and discrimination;
- **Youth justice / criminal justice system:** disrespect of family systems and cultural knowledge, imposing a criminal identity on CALD children, poor quality of health care, and failing to meet basic needs within justice systems;
- **Education:** Impacts of undiagnosed disability, lack of language support, racism and bullying
- **Service provision more broadly:** lack of understanding and compassion for the unique struggles of CALD families; and
- **Wider Australian Community:** Racism and racial profiling.

Findings related to each of the above themes are described below.

Disability services

Limiting beliefs around disability. One of the barriers identified are the negative views associated with having a disability in some African communities. All participants who identified as South Sudanese conveyed that in some African communities having a disability can mean that a person is *"crazy"* or be "*attributed to an angry experience or a curse from dead ancestors, or from an magician, or from a devil spirit".* It was described by some participants that these views can result in families hiding that their child may have a disability out of shame and fear of receiving judgement from their community. Participants acknowledged that in their community disability was not viewed as a medical condition and therefore families were often not aware of support services available in Australia due to there not being any in their home country. It was emphasised by participants that perceptions regarding disability were slowly changing within CALD families due to the work being done by community leaders and cultural organisations to shift the narrative around what having a disability can mean by emphasising the supports available to support the child and their family.

Barriers for CALD families to access the NDIS. Participants outlined various difficulties encountered by CALD children and their families in accessing the NDIS including a lack of formal disability diagnosis for many children, which can result in them being ineligible for the NDIS; and some CALD families not being aware of the services available through the NDIS even though their children may be eligible:

> … there are big numbers of these people who are – who can be eligible for NDIS for instance, who are not accessing NDIS. They can be eligible for other support services which they are not aware of.

Additional difficulties were outlined around obtaining interpreters for health and disability appointments:

> …the challenge is around interpreter use more than anything else, that we can't gauge responsiveness. Because getting an appointment doesn't mean you're getting a medical consult, if there's no interpreter used.

Other barriers included some CALD families not being Australian citizens and being on Special Subclass 444 visas (for example children and families from New Zealand) rendering this cohort ineligible for NDIS services. Participants also discussed the issue of some families, including those from Māori Indigenous backgrounds, not trusting the NDIS or mainstream government services due to negative past experiences, and NDIS services not being experienced as culturally inclusive and responsive:

> … we're going through problems with disability getting NDIS for a family because the family won't sign the forms. Why is that? Because they don't have any trust in the system, because it's failed so many times for this particular family and they're kind of over it. And the thing is that – and the problem with the NDIS is that it's not targeted to bringing the actual Indigenous people forward to be able to heal their communities.

Finally, it was explained that the NDIS often did not respond adequately to more CALD children with more complex needs, for example those who also have child protection or justice system involvement. Examples of poor responsivity included medical appointments being too short, and children needing more experienced NDIS 'complex planners' to meet their needs:

> …15 minutes is not a long time for a chaotic young person. So I think there's something that needs to be done around appointments for young people, especially that are complex and that are in touch with the justice system.

Child protection systems

Participants outlined how child protection services are often unable to work collaboratively with CALD children and their families, generating significant barriers for supporting children with disability involved these systems:

> … rather than removing kids from a loving home, how about we work with the family if we think…'parents are doing something wrong. They don't understand', Rather than take [children] from home to resi once you go to resi there's no care…Family, usually, they don't get involved until it was too late. I have some cases with parents would be like, 'already – you guys have already done one, two, three'. It's like… step ten. What do you need some input?

Participants conveyed that CALD families often feel excluded from key decision-making processes regarding their children and generally feel misunderstood and unsupported in child protection systems. Participants were of the view that child protection services did often not understand the unique struggles some CALD families who had migrated to Australia faced, including the impacts of intense traumatic experiences, financial struggles, and challenges adjusting to a different language and cultural context. Participants described that child protection did not always appear aware of how CALD families' protective concerns could be attributed to difficulties associated with the migrant experience such as physical punishment being acceptable in their home country but not in Australia, or undiagnosed parental mental illness resulting in aggressive behaviours from parents due to a lack of mental health care in their home country. Participants stated that in many instances child protection needed to conduct more thorough 'investigations' by working closely with the family to discover the root of the problem instead of 'reaching conclusions' prematurely:

> …most CALD people, especially Sudanese, back home, they'll use physical punishment to discipline kids…But here it's totally different. Rather than, as I said, trying to remove kids from home, how about we seek other extended family...mental health not something that is well diagnosed in many CALD communities. So, parent may be going through work stress and stress of trying to run the household, and to run the house and things. And when a child do something, they over-react…They maybe throw something out of anger, but didn't mean to harm the child. The police get involved, then that child is taken away.

Participants advised that child protection services would often focus exclusively on the child instead of empowering the family as a whole and working with the parents to improve parenting. Participants also expressed the view that child protection services placed high importance on meeting physical and material needs of a child and did not understand the role of culture, family, and community connection in supporting positive outcomes for CALD children. Child protection services were also seen to make decisions that did not support CALD children maintaining ties to their family and cultural identity, which are key protective factors against justice system involvement:

> …we remove the children from the parents, but there's nothing in the system that actually supports the parent…So, what is our system doing about getting support and some sort of counselling as a couple, rather than you do this and you do that? We're missing something here…we've had to, in community, bring the parent alongside and give them, from a cultural lens, how important that parent is in the decision-making for this child, rather than empowering the child to make decisions for themselves.

Finally, some participants also perceived that some child protection workers did not treat CALD families with the same level of commitment or deliver the same quality of support as they would to other young 'White' people, and attributed this observation to racism:

> …three years it took the system to finally do something. Just because he's African background. Even the magistrate said like, "I don't want to sound racist." But…"if that kid was White, child protection would have done something long, long time ago".

Participants conveyed that this lesser quality of care negatively impacts future outcomes for CALD children.

Youth Justice / criminal justice system

Participants communicated similar areas of need within justice systems to those described above in child protection systems reiterating views that youth justice services often failed to work collaboratively with, and to empower CALD families to support their child, focused too heavily on providing material and financial supports to children, and were more punitive toward CALD young people due to racial bias.

Disrespect of family systems and cultural knowledge. In some cultures, knowledge held by older generations within the family system is seen as valuable and needs to be passed down to younger generations within the family unit. One participant advised that when service workers exclude older family members from their work with the child, they disrespect these knowledge systems and structures within certain cultural family systems. The participant explained that by working exclusively with the child, staff not only disempowered parents but also failed to support the passing on of cultural knowledge:

> A lot of them don't have children, but they're telling us what to do with our kids… From cultural perspective, that's actually quite disrespectful, because you're taking their learnings from her parent, from her grandparent, up the stream of her ancestors, those have all been traditionally passed down, and then you've got this young woman who should be brought up in those cultural values, creating their own pathways…We've created trauma for the child. We've created trauma for the parent. We're creating trauma within the family structure.

Labelling theory: the impact of imposing a criminal identity on CALD children. A key barrier to reducing CALD children's chances of entering the justice system that participants identified is that many children carry a sense of isolation due to feeling excluded and rejected, including by their family and/or the wider Australian community. Participants expressed that CALD children whose families migrated to Australia often struggled to find a sense of belonging due to varying cultural identities within their family and often felt judged and criticised by the wider community. This struggle for belonging could be amplified for CALD children with disability. Participants expressed that these same children developed feelings of anger and frustration due to these experiences, which sometimes translated into antisocial behaviour:

> Even though they look like their parents, no one understand them. So therefore, they can't communicate. The wider society, they can't fit in. So that's why they kind of create their own group. They can't fit in at home…part of our role is trying to – that role model, positive behaviour. Like, "okay, you could be different, but you don't have to behave that way… Even though some of them come with disability or challenging behaviour, they're great kids. They just feel like they're misunderstood…the media hasn't been great… People do forget they're kids. And if you prop up a kid in a negative way, he's going to behave that way.

Participants expressed the experience that in many ways the wider community and services impose the belief that children from CALD backgrounds are inherently criminal, believed to sometimes result in disproportionately punitive actions from the justice system:

> I see it in the justice system. When that present, we tend to go a lot to punitive with that. And then you hear – it feels like CALD communities, you're like, "oh, that's their way." When with Caucasian kids it's like, "oh, that's unlike Johnny behaviour. Johnny had a bad day".

Poor quality of healthcare within justice systems. Participant described CALD children with disability as being inadequately supported by health services within custody and broader justice systems. The participant highlighted areas of need in these services including:

- Healthcare is observed to be poor within youth detention centres, and there is a lack of follow through concerning the supports and services needed for children released back to the community;
- There is a lack of allied health support for children with disability in custodial and community justice settings, particularly speech pathology which is often needed to address difficulties with communication;
- There is a lack of culturally responsive health services for CALD communities with disability *'that allow for that cultural healing'*; and
- For CALD children with disability who have engaged in offending there is a tendency for health services solely arrive at a forensic diagnosis and exclude other diagnoses such as mental health or disability diagnoses.

> …If you look at the way we treat a forensic assessment for anyone else is we exclude a disability, we exclude a mental health condition, and then arrive to a forensic diagnosis. For a lot of the young people with disability, we are just arriving at the forensic diagnosis. And the media inflames it, right? So the media pushing all of that means the system in itself perpetuates that. So there's no assessments at all. We're just getting a forensic diagnosis, and a term, and that is it.

"We are setting children up to fail" basic needs are not being met for those involved in the justice system. Participants identified a broad range of needs currently remain unmet for young CALD people in the justice system who have a disability, particularly those exiting custody. CALD children were often seen to struggle to access housing, or lacked basic materials such as a phone, all of which disadvantages their capacity to comply with conditions attached to their parole order such as obtaining work and attending appointments.

Participants expressed that even obtaining car insurance was almost impossible for children with a criminal record. There were concerns raised by participants about the high expectations placed on children by the justice system often with very little support, when in every other aspect of the law they are still considered children. One participant expressed that government systems should reconsider when we should be holding children criminally responsible:

> I think our policy and the system seem to be recognising that a young person is a child until they become 18 years old. That's when they can be held accountable…I think there is inconsistency in relation to the provision that seem to be not mandating a young person to vote until they turn 18 years old. Can't purchase any alcohol, because they not adult. Cannot sign a medical examination form because they are children.

Education systems

Undiagnosed disability. There were concerns raised by participants relating to the difficulties some CALD children with disabilities face engaging with education, particularly those who do not have a formal diagnosis. Education and employment are considered protective factors in preventing criminalisation and so participants advised that CALD children with disabilities were facing multiple barriers to remaining engaged in schooling which then effects their ability to obtain employment. One participant raised that there are many children who are not diagnosed with disabilities and involved with the justice system, who are struggling to meaningfully engage with education. The participant advised that there was a lack of awareness of this cohort and therefore a lack of support available to this cohort to seek a possible diagnosis and educational support.

Another concern from participants was that teachers in education settings were often punitive towards children who may have behavioural and classroom engagement difficulties, rather than considering the possibility of undiagnosed disability:

> …the teachers really had a lot of bad grade for them, because they're saying, 'well, they don't pay attention. They don't listen'. But they didn't see there was a challenge behind paying attention, and for doing multiple thing at the same time.

Participants stressed that CALD young people were often blamed for difficult behaviours yet required additional time and attention from teachers to support their learning.

Lack of language support. The lack of language support in schools for children from CALD backgrounds who often do not speak English at home was also highlighted in consultations. One participant outlined that this *"sets that child back a few years in school",* which can result in educational disengagement due to children avoiding *"sitting in a class that he's two years old[er] than the next [student], because it's an embarrassment for him".*

Racism and bullying. Multiple participants outlined how CALD children experience racism, bullying and exclusion from other young people at school which adds to the stigma against children who also live with disability. Participants provided examples of parents instilling negative beliefs about children from other cultures, and even removing children from school out of fear that they were associating with children from CALD (e.g., African) backgrounds, who the parents assumed to be gang-affiliated. Some of these fears were attributed by participants to negative media representation of African children.

Service provision more broadly

Lack of understanding and compassion for the unique struggles of CALD families. When discussing areas of need for services generally, participants focused on the importance of services understanding the unique experiences of CALD families and the need for services to be culturally responsive and inclusive of families in their work. Participants stated that it is important for services to know that in some families, multiple languages can be spoken within

the home across generations which can result in multiple language barriers between the child and their parents, and then again between services and the family. Additionally, participants advised that many children come from families in which there is a *"likelihood that the parents could be living with mental illness; either due to their trauma, or even just having a diagnosis of a mental illness".* Participants stressed that many families came from countries wherein a 'village' would raise a child, which is very different to Australian communities resulting in CALD families often feeling overly stretched and as though 'they're always chasing their tail'. Participants emphasised the need for workers to be understanding of these additional barriers instead of blaming or making assumptions about the family. Participants stated that some workers would start "…acting on behalf of the family, because, *'oh, they don't speak English,'* or 'they don't understand'" which completely disempowered families.

Another participant described many government services as coming "from a biased space, rather than from culture, or from heart" which inevitably disadvantages CALD children, particularly those experiencing cross-involvement in child protection, disability and justice systems.

Wider Australian community

Racism and racial profiling. Many participants stated that racism against CALD children from the wider Australian community was a concern, and directly increased CALD children's risk of becoming criminalised. Consistent with existing research,[559] participants advised that some CALD young people feel rejected and unsupported by the wider community, fuelled by negative media portrayals, particularly of CALD children of African backgrounds. Participants explained that children do not feel accepted as Australian because of their ethnic heritage, which directly impacts their motivation to contribute positively to the Australian community. Participants advised that some children question why they should abide by Australian laws, when they experience the Australian community as excluding, discriminating against, and viewing them as criminal:

> …when those needs are not being met, then they will go to the extent to really force the system or the community to recognise them… there has been this racial issues again, in this African community, with what is called 'African gang'. Australian heard – happen to be calling this kid 'African gang' when they are – even their certificate at birth are all Australian here. These are all Australian kid…A child being born in Dandenong, in Casey, in Pakenham. He's a child of Pakenham. Why, when their needs are not being met, why labelling them that they are African, when they are all Australian? All the identity card, everything else, is Australian. This is where we get it wrong. And it come from professional, like media. Media will go to lengths and report things like that.

Another participant described that experiencing racial slurs and police racial profiling was a common experience for almost everyone in the African Australian community. The participant described that children were even more vulnerable to racism and police racial profiling as they may not have the emotional and communication skills due to their developmental stage, to protect themselves and not inflame situations by responding with frustration and anger.

> …racism that is quite prevalent around. You walk around, there's so many racial slurs and things like that. It happen almost to everyone... I've been a community leader for more than four years here in Victoria, for the South Sudanese community…But yet again I faced racism and I faced profiling...So just imagine, if it could happen to me, what about these young people?...young people when they happen to be in such situation, they overreact, and then immediately they get arrested. Like me, if I overreacted, they – I would have been arrested of course, obviously. You see? So, these are the thing that normally we deal with, almost on a daily basis.

8.4.2 Current practices seen to work well for supporting CALD children with disability

Practices seen to work well for supporting CALD children with disability included those specifically focused on disability services, and those relating to service provision more broadly.

Disability services

Early intervention and whole of family support. Participants stated that the earlier children with disabilities were assessed and supported, the better. One participant advised that as soon as a child begins to demonstrate difficult behaviours in school, or disengage from education, best outcomes occur when the school involves the parents as early as possible to work together to support the child.

Assessments conducted early, with the child and their whole family were viewed as optimal and most effective practice, allowing for children to be linked in with paediatricians and future planning around education and NDIS involvement to occur, all of which can prevent future difficulties for the CALD child and their family:

> If an assessment was done that encompassed the entire family, it means...you're able to link them in with a paediatrician sooner rather than later, for either a diagnosis of their disability, or supports. Whether those supports are going to be psychosocial, whether they're going to be medical – intervention with medication, depending upon the diagnosis. You link them into the right schools…They are put into specialist schools with the right supports. Or if the family opts in to go into a regular school, that you've got the supports in place. It also means we can link them into the NDIS sooner rather than later.

The importance of providing meaningful and consistent health care for the entire family was stressed by participants:

> ...making sure that enough supports are in place for the parents…So I think having that whole holistic look at health, and making sure that families have had a thorough health assessment and have got engagement. Because I think in all of the assessments that are existing, families that have a practitioner who checks in on whether they're linked into health in a meaningful way, have better outcomes than families that don't.

Conversely, one participant advised that the NDIS has "*been a blessing*" for children that have been eligible for the service. NDIS was observed to have provided financial support for a child to access supports needed to better engage in education:

> Once they're accepted into the NDIS then now all these assessment, the OT that they need, the NDIS will pay for it. And let's say, for example, a school-aged kid, they'll get a tutor. They'll get someone that will give them extra work. So when they start doing good at school, parents are happy. If they need the speech therapy, and then the NDIS funding paid for it, and then the kids are getting better, the parents are seeing more and more.

Service provision more broadly

Community run and culturally focused organisations. Throughout consultations regarding service systems including disability, child protection and youth justice services, participants identified that the most successful services were often those run by community-controlled organisations, and run by members of the community which the service was seeking to support. Participants observed that CALD children and their families only felt safe, understood, and respected by community organisations where they were able to work with service providers who spoke their language and understood their culture. Participants expressed that often it was less formal, non-government organisations that were most successful at engaging CALD families:

> I find that a lot of families, our children, will go towards where the voice is quiet rather than the voice is loud, and when I say it like that, I'm talking about they would rather go to somewhere where they feel comfortable with, people that talk in their language...

Participants provided several examples of community run initiatives and services which were seen to work well for CALD children and young people with disability in child protection systems, as listed below.

- A not-for-profit organisation aimed at housing Pacifica and Māori children but that has also housed children from all backgrounds. The organisation supports *"children on the streets, or those children that are coming out, say, residential care and that are still connected with child protection, a lot of them don't want to go home"*. The organisation houses the young person until they can try "*get that relationship back with family, and then they go home"*. The organisation is not funded by government.
- An organisation aimed at supporting multicultural children provides culturally specific care for each child and works collaboratively with surrounding culturally specific services to cater for the Victoria's multicultural population.
- A culturally specific mentoring program which provides a safe space for CALD children with disabilities to receive positive role modelling:

> …they need this place where there is a good – where they like, where there is space, where they can have a role model, and also a place where values can be instilled in them. And also they can take ownership of their own story and make it a positive story.

> Not a story of being rejected from society, or being different from the society. That it is just like any learning disability; is common to all children, all race, all culture, regardless of where they are from. And if they know that, they kind of feel they are not alone.

- A CALD community-run trauma informed mental health services aimed at refugee populations that provides interpreters and are not reliant on Medicare funding.

Real relationship building with the child and family. Participants advised that the most effective services and practitioners focused on creating real, consistent, and meaningful relationships with the child and their family. Participants stated that the best service workers were able to work from a client-centred approach which prioritised the voice of the child, and in which service planning was led by the young person. Participants advised that real relationships took time, and that service workers who were able to consistently invest in the child and their family achieved the best outcomes:

> … there are some agents or carers that would be willing enough to work together with the young person, and as a result eventually the young person will see the love and care, and would eventually have the support that is required. So I really witnessed that when I was a youth leader, and as a community leader… I think it take the social work philosophy, which is working alongside someone.

8.4.3 Suggestions for future practice with CALD children with disability

Service provision more broadly

Increase funding and support for new and existing CALD community-controlled services. Participants suggested that more positive outcomes could be achieved for CALD children with disability in child protection systems where there was greater availability of CALD-run and -focused community health centres able to meet the unique health and cultural needs of community. Community driven health centres were viewed as best positioned to provide culturally responsive health care and community engagement:

This included the need for increased funding to existing community-controlled organisations that support CALD communities, who were viewed as being currently underfunded:

> All these services, they are under-resourced, and they are struggling in addressing these issues. Like now, with our limited resources, they send us these South Sudanese kids for us, to cater to their issues or needs, which I think that there's no problem in that. They are our kids, and that's why we are here for, to address them. But of course we should share the resources together. They have more worker than us. They have more access to all these resources. So if you want to refer that young person to us, of course, obviously – yeah, pay us to employ some other people of course who can work with you collaboratively in addressing those issues. But by just referring them to us, you are over-stretching our resources, and you are depleting our energies and resources that we can use to address some other issues.

Family and culture-centred practice. Participants emphasised the need for services need to be sensitive to what disability means in the child's culture and language. This involves services seeking to understand what having a disability may mean for each child and their family and then delivering culturally responsive support. It was also suggested that services need to invest in forming relationships with the child's family even if they are primarily responsible for working with the child. In many CALD communities, family and community are central to the life of every child, and services need to prioritise family centred service delivery:

> For example, in our Sudanese culture, for a lot of workers, part of what we do here for my colleague, if you come from home and they offer you coffee or tea, don't just say, "no." Take it. Because if you say, "no," then they say, "if you can't drink our coffee, how can you help our son?"

Accordingly, it was advised that services should listen to, and be guided by the child and their family instead of assuming what culture may mean to a family:

> …rather than looking at putting Indigenous cultures or culture in general in a box and saying, "This is who they are."…it needs to go back to the ownership, which is amongst the people, where these children come from. I find that there is so much knowledge, healing, so much understanding, so much supports you could actually get in that space...I feel that sometimes when a child is misrepresented or misunderstood and the voice is being shut down and taken away, our children tend to reoffend…

Finally, it was outlined that services could more effectively empower CALD families and parents to improve their parenting capacity instead of focussing exclusively on the child and their circumstances or 'taking over' parenting responsibility:

> Give it back to the family. Empower the family to do something with that… That's a journey he has to take with his family because it's about fixing what has been broken, and this is where the system depowers and demoralises family within family within family systems, because they've gone and taken over. Hand it back to the family, and let them empower themselves. Let them try and fix that…it's not about ticking the boxes at work…

Address racial bias and lack of cultural competence within services. It was suggested that continued efforts were required to address racism within mainstream services, which was seen to currently disadvantage the care CALD youth are receiving. The following quote highlights the issue of institutional racism, during a discussion of African Australian children engaging in offending behaviours:

> I've had workers, colleagues, or whatever, like, 'oh, that's the way they are.' Sometimes discourage the kids to try harder…Sometimes they'll be like, 'maybe that's the way they behave.' And I'm like, 'what do you mean?'... So I guess, as a system, we need to be better, that we're actually mindful of our own bias sometimes.

Service systems and providers should be mindful of the variety of cultures present across the community, including among children with disability, and be willing to understand and learn about the unique cultural needs of each child and their family"

> …it's always awareness, cultural awareness. The trouble is it's very diverse and very multicultural. I don't think everyone will know each individual culture. But being sensitive to one thing in the group you work with, and where you work with. Making an effort to learn as well.

It was emphasised that further cultural training may be required to achieve these outcomes:

> …they need to do also some sort of capacity building around culturally appropriate – working with CALD communities… you need to understand where these people come from. You need to know their history so that you can be able to support them. So without understanding their background, it's going to be difficult for you to provide whatever necessary support….there are more, deeper issues which that person is not seeing, which I think is missing. Unless they have some cultural training around that.

It was further suggested that greater CALD community involvement in policy development and government decision-making processes could strengthen the cultural appropriateness of service delivery approaches:

> What I think we need to be looking at is how do we introduce community into part of these decision-makings. How do we get the real people in there…What has happened over the last five years, and it hasn't been good out there within our multicultural communities. Who are the writers in here? What I would like to see in terms of policy is the writers, a change in the writing system and those who can write.

It was suggested that meaningful engagement with community members and leaders from all cultural groups could improve the cultural responsivity of welfare and justice polices:

> I'm talking about going in and sitting down and being a part of those communities, so that you can then look through the eyes of the elders, the eyes of the people, because the problem that sits in this area is how we communicate. Our communication styles from culture, Indigenous to culture, to mainstream is totally different… we need to get all of those on the one page, so that we can have a proper understanding of what's actually lacking in terms of these policy writings.

Education systems

Increase awareness and supports for CALD children with disability in schools. Key suggestions raised concerning the support for CALD children with disability in schools included:

- The need for schools and teachers to be proactive and work collaboratively with family when noticing symptoms of a disability in a child, including arranging assessments and increasing supports for the child;

- The need to for more one-on-one school support for CALD students with additional needs;
- The need for cultural training in schools on how to work collaboratively with CALD families;

> … I think schools should always have cultural training really on different culture, and have – and try to foster a good relationship with a parent. Especially if they have a disability kid. And especially if the kid have any child abuse.; and

- The need for schools need to address racism within their community.

Wider Australian community

Finally, suggestions for future practice that concerned the wider Australian community included the perceived benefit of improving representation of CALD people in human and health services sectors, accountability and education of the public around representation of CALD communities, and understanding the impact of racism.

Representation. Participants suggested that governments need to support the education of CALD people so that they can increase their representation across various health and social care sectors, to ensure culturally appropriate service provision, for instance disability, health, justice and child protection services:

> …there's really a need to work with institution like education to really invest in people of this background, so that what is really impacting now can better be understood… make sure that members from these communities need to be involved in the system itself… we will get it wrong all the time, if we don't have the members of this targeted group being involved in the system.

Accountability and education of the public. Participants suggested that media needed to be held accountable for the representation of CALD communities:

> ...one of the thing I really think both sides can do better, is really holding the media accountable for the way they share stories. And also, the way that they have to know there are consequences to the way you frame those issues… Because real people are listening, and they're watching. And real people are in fear. And you will be feeding to their fear already.

Additionally, an investment in educating the public around the effects of racism on the lives of CALD people was believed to be of benefit:

> … can tell you a lot of these young people are now not getting employment opportunity as a result of a generalisation promoted by the media, that all these African young people are gang, that they are not productive. It become indoctrinated in the mind of employers and of everyone else… Education matters. Services that deal with these young people need to be educated. Parent and carers that are caring for these young people need to be educated.

8.5 Summary of Findings from Consultations with Aboriginal Community Controlled Organisations and Organisations working with Culturally and Linguistically Diverse Children and Youth

This section presented the approach to, and findings of, consultations with Aboriginal Community Controlled Organisations and CALD organisations working with Aboriginal and/or Torres Strait Islander and CALD children with disability in child protection systems. These exploratory consultations gathered valuable insights, providing a rich intersectional lens through which the previous literature and survey findings can be interpreted. Four key themes were highlighted across these consultations, namely:

- The cultural conceptions of disability held across Aboriginal and/or Torres Strait Islander and culturally diverse communities, which may be at odds with those of disability and other service providers;
- The unique barriers to service access, and service system experiences, of diverse cultures and races, including those related to child protection, disability (including mental and behavioural health services), education and justice systems;
- The impact of broader micro-, meso-, exo-, macro- and chronosystemic factors[13] [560] – including historical and ongoing experiences of colonisation, trauma, individual and systemic racism, and discrimination - on the experiences of culturally-diverse children with disability and their families involved in child protection systems; and
- The value of culturally-led and culturally-appropriate programs in generating culturally safe and accessible services for Aboriginal and/or Torres Strait Islander and CALD children with disability and their families involved in child protection systems.

The consultation findings strongly resonate with existing literature which has long highlighted the necessity of Aboriginal self-determination and sufficiently resourced culturally appropriate services and programs to address wellbeing and healing for Aboriginal and/or Torres Strait Islander peoples, including those with disability, or who are involved in child protection systems.[561]

13 The terms micro-, meso- and macrosystemic factors are derived from Ecological Systems Theory, which highlights the reciprocal influences on an individual child's experience of development of immediate (microsystems) influences (including family, school and other services with which they come into direct contact), mesosystems factors (the interactions between elements of their microsystems such as interactions between parents and child protection systems), exosystems factors (formal and informal systems that impact a child's microsystems, such as parents' economic situation) and macrosystems factors (attitudes and ideologies of the culture in which the child exists).

9. Consolidated Findings and Discussion

While research has long-since noted the over-representation of criminalised children in child protection systems,[562] few studies, particularly in Australia, have focused on disability experienced by children at the nexus of child protection and youth justice systems. These are critical relationships, especially considering the poorer outcomes across youth and adult justice systems experienced by individuals with a history of child protection system involvement, as well as the known over-representation of children with disability across child protection,[563] youth,[564] and adult[565] criminal justice systems. 'Crossover' or 'dual system' youth who have contact with child protection and youth justice systems have been shown to experience earlier youth justice system involvement, greater likelihood of recidivism, and greater risk of entry and entrenchment in the adult criminal justice system.[566] Further, the available research suggests the criminalisation of children with child protection involvement is a critical pathway by which people of Aboriginal and/or Torres Strait Islander background,[567] females,[568] and individuals with disability[569] come to enter and become entrenched in Australian criminal justice systems. Better understanding, preventing, and responding to these pathways is critical for improving outcomes for children in child protection systems, particularly those removed from family, and for whom the State is the legal guardian. Additionally, addressing intersectional disadvantage in these relationships is crucial for tackling the ongoing structural inequalities, systemic neglect and abuse experienced by individuals with disability in contemporary Australian society.

The Disability Royal Commission commissioned this research to improve understanding of the pathways that lead children with disability from their contact with the child protection system to entering the criminal justice system, and the effectiveness of interventions to prevent the criminalisation of this group. It constitutes the largest Australian study to date to focus attention to the group of children with overlapping experiences of child protection system involvement, disability, and criminalisation. Critically, it also sought to ensure a focus on the intersecting experiences of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse children at these junctures.

This final section of the report draws together the project findings across the scoping and policy reviews, as well as the survey and consultations with professionals, to respond to the research questions posed. It also notes research questions that remain unaddressed, and highlights directions for further research, as well as suggestions for policy and practice reform, the evidence-base for which can be explored by future research, evaluation, and policy studies.

9.1 Study Limitations and Gaps

It is important to again outline the limitations of the current study, with a view to contextualising its key findings, which are presented by research question below. First and foremost, the study is exploratory in nature, and attempted only to generate initial insights concerning this under-examined but critically important nexus of child protection, disability, and children's criminalisation. As outlined earlier, the policy review was limited to publicly available policies, so Part 1 (scoping and policy reviews) may have not included relevant policies which were unavailable to the researchers. Other limitations of the scoping and policy reviews are outlined in Part 1, including the reliance on a diagnostic definition of disability.[570]

The survey and consultations only reflected the views of professionals, and did not include the voices and experiences of children with lived experience of disability, child protection systems and who are at risk of criminalisation, as well as their families (including extended families). Findings from the survey and consultations were also primarily limited to professionals not currently working in statutory roles. However, some respondents did have experience working in these statutory systems. Reliance on the perspectives of professionals in the survey and consultations may have resulted in findings being more open to the frameworks and systems within which these professionals worked, including an acceptance of the need for processes of assessment, diagnosis and information sharing between services, concepts of risk, and the legitimacy of statutory systems such as child protection, youth justice, and police.

The final sample of 92 professionals contributing to the survey and consultations is more than sufficient for the purposes of exploratory research. However, consultations with organisations serving culturally and linguistically diverse children at the nexus of child protection, disability, and justice systems were all conducted in a single jurisdiction and primarily with organisations working with South Sudanese children and are not reflective of the breadth of CALD children with disability in child protection systems who experience criminalisation. As with all exploratory research, readers should not generalise findings of Part 2 to all Australian jurisdictions, populations, and contexts.[571] Finally, for the purposes of this study, a diagnostic approach to defining disability was applied. While consistent with dominant definition of disability within care, justice and disability systems, diagnostic definitions of disability are not necessarily culturally compatible with understandings of Aboriginal and/or Torres Strait Islander peoples[572] and those of culturally and linguistically diverse communities.

As a result, it is possible that the findings were perhaps more weighted towards views that reflected an acceptance of the need for various statutory systems, concepts of risk and protective factors, and Western views of diagnosis and intervention. Additionally, the researchers were restricted by the terms of reference to focusing on child protection system policies and processes, and so did not examine factors and policies related to other systems (e.g., youth justice, policing) that may also contribute to these outcomes.

9.2 Key Findings by Research Question

Research Question 1: Risk and protective factors for criminal justice involvement of children with disability in child protection systems

The first research question was:

1. What are the risk and protective factors of criminal justice involvement among children with disability in child protection systems, particularly Aboriginal and/or Torres Strait Islander young people? Where along the pathway do these risk and protective factors occur?

While research question 1 called for the identification of risk and protective factors in this space, the evidence base, particularly in Australia, is insufficiently developed to permit the identification of formal risk and protective factors. Formal risk and protective factors are attributes, characteristics, or exposures that are statistically shown to increase or decrease the likelihood within a particular population, of individuals (e.g., children with disability in child protection systems) experiencing a certain outcome (e.g., criminalisation). Identification of such factors in a strict sense requires study methodologies that have not yet been undertaken. Instead, factors understood to be associated with increased and decreased chances of criminalisation of children with disability in child protection systems, outlined in Table 13, were drawn from the scoping review.[573] These should be viewed with interest, but caution, as the scoping review methodology used to identify these factors did not restrict study inclusion by design type, and in line with internationally-accepted research approaches in this area,[574] did not appraise the quality or presence of bias among the included studies.

Factors **followed by an asterisk** were identified in both the scoping review and by the professionals who were involved in the current study, which shows they are also seen to be important in the Australian context. Factors **highlighted in bold text** were raised by professionals in the current study, but had not been raised in the research included in the scoping review. The evidence for these proposed risk and protective factors should be rigorously assessed in future research.

Table 13. Factors associated with increased and decreased chance of criminalisation of children with disability in child protection systems

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Individual	• Male gender • Aboriginal and/or Torres Strait Islander children* • Maltreatment factors: exposure to family violence, neglect, physical abuse, other/mixed abuse, maltreatment recurrence • Multiple compounding factors: e.g., exposure to family violence at certain ages + presence of conduct disorder • Specific disability diagnoses* and diagnostic complexity • Lack of diagnosis, underdiagnosis, and delayed diagnosis of disability* • Substance use* • **Lack of connection to culture**	• Type of disability, e.g., physical disability less likely to be criminalised* • Female gender • **Connection to culture** • **Being located in a metropolitan area**
Familial	• Familial criminal justice involvement* • Lower familial resources/SES status* • Lower familial support to children* • **Parental disability and/or complex needs**	• Higher parental level of education
Environmental	• Residing in lower socioeconomic status neighbourhoods* • Justice-involved peers*	• Residing in higher socioeconomic status neighbourhoods* • **Prosocial peers** • **Prosocial mentors** • **Prosocial activities**

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Systemic: Child protection system (including OOHC)	Entry of children with disability to OOHC: • Entry to out-of-home care* • Entry to residential care* • Placement in care for behavioural reasons* Systemic neglect of children in OOHC: • Vulnerability to criminal exploitation • Vulnerability to peer pressure in OOHC/poor placement matching* • Lack of support on transition from OOHC* **Systemic issues in leading to service disruption:** • **Staff turnover** • **Poor engagement with culturally and racially-diverse children and families** • Lack of support on transition from OOHC*	• Provision of intensive family support services* • **Children remaining with family** • Placement in care for reasons of abuse/ neglect (as opposed to child behavioural reasons), • Placement stability in OOHC* • Residential care: detailed assessment, effective care teams*, specialist therapeutic placement, placement routine & stability*, reduced client numbers, enhanced matching of co-residents, increased staffing, reduced staff rotation, and disability expertise*. • **Placement with siblings or kin** • **Supporting connection to culture and community**

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Systemic: Disability, mental & behavioural health systems & services	• Insufficient appropriate therapeutic and support services (disability, behavioural and mental health)*, including: • Lack of preventative* or early intervention services* • Geographic disparities in service availability * • Lack of culturally appropriate care and therapeutic services for Aboriginal and/or Torres Strait Islander peoples and some ethnic and cultural groups* • Lack of disability-informed care and therapeutic approaches* • **Lack of integration between youth and adult service systems for youth transitioning from out-of-home care**	• Mental health service provision* • Alcohol and other drug service provision • Earlier disability assessment*
Systemic: Education system	• School exclusion* • **Punitive approaches to behavioural manifestations of disability** • **Lack of disability and language support**	• Earlier disability assessment (e.g., targeting educational needs)* • **Providing educational supports** • **Maintaining educational engagement**
Systemic: Justice system (including police)	• **Poor police and justice system understanding of impact of disability including complex trauma on behaviour** • **Racial profiling**	• **Police education and training on disability including trauma & impacts on children's behaviour**

	Factors associated with increased chance of criminalisation of children with disability in child protection systems	Factors associated with decreased chance of criminalisation of children with disability in child protection systems
Systemic: Cross-systems/ other systems	• Supports during the transition from care for children with disability +/- justice system involvement* • Poor service integration across sectors (including collaboration and capacity to move between services as required)* • **Lack of culturally appropriate services and approaches (institutional neglect)** • **Lack of disability-and trauma informed services and approaches (institutional neglect)** • **Institutional racism (institutional violence)**	• Long-term mentoring* • Service/systems collaboration and integration* • **Provision of culturally-appropriate services** • **Provision of disability and trauma-informed services**
Structural	• **Cultural conceptions of disability** • **Stigma and discrimination related to disability (structural violence)** • **Racial discrimination (structural violence)**	

Research participants and respondents concurred with the literature assessed in the scoping review[575] in suggesting that neurodisability and complex trauma were the most frequently encountered disabilities among children in child protection systems who experience criminalisation. At the same time, survey respondents also identified that sensory and physical disability (including that caused by physical abuse), each not prominently highlighted in the existing literature, were also often seen among this cohort. The prevalence of physical and sensory disability among criminalised children in child protection systems warrants examination in future research. Lived Experience Consultants supported these findings and added that experiences of stigma and discrimination associated with disability compounds the trauma experienced by children who already live with the impact of trauma from childhood maltreatment, adversity and separation from family, community and/or culture.

The research question also asked which risk and protective factors particularly impact Aboriginal and/or Torres Strait Islander children, and culturally and linguistically diverse children. The scoping review found that while culturally and racially diverse children with disability in child protection systems (including Aboriginal and/or Torres Strait Islander children) face increased risk of criminalisation compared with their non-culturally or racially-diverse peers, there has to date been limited research to understand why this is the case. We sought to begin to address this research gap in the survey and consultations with professionals, forming a critical strength and contribution of the current study. It should be noted that 7.3% of survey respondents worked in an ACCO, 14.6% worked in a program that exclusively provided services to Aboriginal and/or Torres Strait Islanders, an additional nine consultations were undertaken with a total of 13 professionals working in ACCOs, and six professionals working in organisations supporting culturally and linguistically diverse children and youth around Australia to contribute to these findings. While the data are exploratory in nature, they constitute the most robust evidence in this space generated by an Australian study to date.

The findings suggest that an intersectional lens is required to understand why culturally and racially diverse children with disability in child protection systems are more likely to be criminalised. An intersectional lens best captures the impact of compounding factors on the likelihood of criminalisation of culturally and racially diverse children with disability in child protection systems, including:

- The cultural conceptions of disability held across Aboriginal and/or Torres Strait Islander and other racially diverse communities, which may be at odds with those of disability and other service providers;
- The unique barriers to service access, and service system experiences, of individuals from diverse cultural and racial backgrounds, including those related to child protection, disability (including mental and behavioural health services), education and justice systems;

- The impact of broader micro-, meso-, exo-, macro- and chronosystemic factors[14] [576] – including historical and ongoing experiences of colonisation, trauma, racism, and discrimination - on the experiences of culturally-diverse children with disability and their families involved in child protection systems; and
- The value of culturally-led and culturally-appropriate programs in generating culturally safe and accessible services for Aboriginal and/or Torres Strait Islander and CALD children with disability and their families involved in child protection systems.

Such findings are consistent with the broader existing literature, which focuses on the experiences of Aboriginal and/or Torres Strait Islander peoples with disability, demonstrating that as a population, this group experience greater odds of interpersonal racism and violence compared with their non-disabled peers.[577] It remains unclear whether such multiple disadvantages (disability x race) are additive or interactional (multiplying) in their impact on children's likelihood of being criminalised in child protection systems. This is a critical area for future research.

Regardless of how these effects are brought about, respondents and participants in the current study were clear that they often observed culturally and racially diverse children and families more safely and easily able to engage with Aboriginal and/or Torres Strait Islander and CALD-led or informed services and programs. Further, they made plain the need for mainstream and generalist services to appreciate the complexity of these intersections, including in relation to child protection practice, disability, mental and behavioural assessments and support services, education, and justice systems.

While the findings of the professional consultations demonstrated a rightful acknowledgement and critical commentary on the impact of structural racism on children's outcomes, particularly in reference to culturally and racially diverse children, there was little to no acknowledgement of the impact of structural ableism. The invisibility of the disability experience within the system is reflective of the broader attitudes within the Australian community, in which disability is viewed at best patronisingly, but more likely and awkward topic of discussion. This social positioning of disability emerged in this study through the testimonies of the participants from the community sector who spoke of a narrative of shame and avoidance when it comes to children with disability. Paradoxically, this is a narrative that is formed by the system and its actors, rather than people with disability themselves. The default in being spoken of, rather than spoken by, paradoxically sustains the trajectory of progressive marginalisation on which children with disability find themselves.

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14 The terms micro-, meso- and macrosystemic factors are derived from Ecological Systems Theory, which highlights the reciprocal influences on an individual child's experience of development of immediate (microsystems) influences (including family, school and other services with which they come into direct contact), mesosystems factors (the interactions between elements of their microsystems such as interactions between parents and child protection systems), exosystems factors (formal and informal systems that impact a child's microsystems, such as parents' economic situation) and macrosystems factors (attitudes and ideologies of the culture in which the child exists).

The last component of research question one inquired about when along the pathway various risk and protective factors for the criminalisation of children with disability in child protection systems operated. This was unable to be answered by the existing literature which was canvassed in the scoping review, however the broader literature concerning children at the nexus of child protection and youth justice systems indicates that the vast majority of such children (upwards of 90%) will encounter the child protection system prior to the youth justice system.[578] Thus the emphasis on early intervention, assessment and support in relation to family wellbeing, maltreatment and disability largely relies in the approach of child protection and other universal services (e.g., education and health) to be effective. Another critical period is the transition from out-of-home care (typically between 17-21 years of age), when young people with disability must navigate a compressed and accelerated transition to early adulthood,[579] compounded for those with disability who must concurrently navigate transitions from youth to adult service systems, too often with minimal support. This period of transitioning from care has been identified as a critical time for criminal justice system contact in this cohort,[580] however understanding how disability factors into care leavers' trajectories and outcomes in relation to criminal justice involvement is an area for future research.

Research Question 2: Evidence base for interventions, programs and models for preventing children's criminalisation

The second research question was:

2. What is the evidence base for interventions, programs and models that prevent children with disability in child protection systems from becoming involved in the criminal justice system, particularly those targeting Aboriginal and/or Torres Strait Islander children?

No interventions, programs or models that specifically target children with disability in child protection systems, aiming to prevent their criminalisation, were identified by the current study. This therefore remains a gap, potentially able to be explored through the development and evaluation of programs informed by the available evidence in this area.

At the same time, evidence across the scoping review, survey and consultations with professionals suggests the following interventions and programs could be helpful for reducing the criminalisation of children with disability in child protection systems, but would need to be further evaluated by future research:

- **Intensive family-centred support approaches:** including culturally appropriate models, which seek to keep children with family and prevent entry to out-of-home care where possible. For Aboriginal and/or Torres Strait Islander and CALD children, these approaches may be better delivered through ACCOs or CALD-specific services, given the identified barriers to safe and effective relationships between these communities and child protection services;
- **Early disability assessment and intervention:** for Aboriginal and/or Torres Strait Islander and CALD children, this may be better delivered through ACCOs or CALD-specific services, or in school settings, given the identified barriers to safe and effective relationships between these communities and child protection services;

- **Culturally, disability and trauma-sensitive and informed responses across all sectors;** in particular, consideration should be given to culturally-appropriate approaches which address social and emotional wellbeing for Aboriginal and/or Torres Strait Islander and CALD children and families, with the understanding that such communities are diverse, and have the right to determine the approaches deemed suitable for the needs of their community, families and children;[581] and
- **Other specific programs mentioned by participants:** Circle of Security, Family Group Conferencing, Aboriginal Youth Cautioning Program, Community Policing.

Future research could usefully design and evaluate, or assess what interventions, programs and models are effective for reducing the criminalisation of children with disability in child protection systems, including when they are effective, and for whom (e.g., age groups, placement types, and attending to diversity, for example across gender, race/ethnicity and types of disability).

Research Question 3: Effectiveness of current child protection policies and practices for preventing criminalisation of children with disability

The third research question was:

3. To what extent are the current policies and practices of child protection systems effective in decriminalising and reducing criminal justice contact for children with disability, particularly Aboriginal and/or Torres Strait Islander children?

The policy review undertaken for this study identified six policy and practice approaches across Australian jurisdictions which aim to reduce the criminalisation of child protection-involved children with disability,[582] including:

- Joint protocols and practice guidelines between child protection, youth justice and disability services;
- Child protection policy aimed at supporting children with harmful or problematic sexualised behaviours;
- Joint residential care policies aimed at preventing the criminalisation of children at risk of justice system involvement;
- Policy and practice guidance for responding to children in out-of-home care with behavioural difficulties and complex needs;
- Child protection and Department of Education policy focused on school exclusion, suspension, and expulsion; and
- Multi-disciplinary practice policies and panels that include child protection and youth justice and/or disability.

The policy review identified wide inconsistencies across jurisdictions in terms of the relevant policies and practices applied with this cohort, and also noted that most policies (except for joint protocols) solely target children in out-of-home or residential care, rather than all child protection-involved children. While the research evidence suggests a high prevalence of neurodisability in this group, policies tend to focus on the relationship between the impact of trauma and children's behaviour, with less attention to how other disability might influence children's needs and behaviour. Though Australian policies in these areas often advise staff to consider if a child has a disability, more guidance on how to support and deliver interventions to child protection-involved children with disability, or suspected disability, would be beneficial.

The policy review also noted a lack of formal evaluation of the implementation and/or effectiveness of current policies aiming to reduce or prevent the criminalisation of children in child protection systems. No evidence is available concerning the impact of these policies on reducing the criminalisation of children with disability in child protection systems, again demonstrating a lack of attention to intersectionality. However, in relation to the broader cohort of child protection-involved children, community and government reports, and qualitative research evidence suggests the available Australian policies, including joint practice protocols and residential care, are insufficiently understood, supported, or implemented. For example, in relation to joint practice protocols between child protection and youth justice, the *Review of the Victorian Youth Justice System* noted that 'current approaches to information sharing and service integration for these children are ad hoc at best and non-existent at worst, despite the existence of a protocol between the two'.[583] Qualitative research with professionals in this jurisdiction similarly suggests a lack of 'on the ground' adherence to the policy.[584]

While there is both formal and informal evidence from England of the effectiveness of protocols aimed at reducing the criminalisation of children in care,[585] this did not pay particular attention to children with disability in these placements, and no such evaluation evidence could be located in an Australian context. Further, research from the UK and Australia has presented a more critical view of these policies, highlighting the inconsistency with which they are implemented and adhered to, the need for such policies to be accompanied by measures to better train and support residential care staff, to shift attitudes (e.g., of police, residential care staff and the broader public) towards children in residential care, and to encourage interagency collaboration which remains unaddressed by solely delivering a policy document.[586]

Finally, the policy review also found a lack of attention to CALD cohorts, and a lack of detail regarding supporting Aboriginal and/or Torres Strait Islander children beyond ensuring cultural support plans for those in residential care was identified. Findings from the survey and consultations with professionals again helped illuminate some of these areas, demonstrating that barriers to working effectively with Aboriginal and/or Torres Strait Islander and CALD families in child protection systems led too often to children with disability from these backgrounds entering out-of-home care. It is noteworthy that all identified child protection policy and practice relates to children with disability in out-of-home care, rather than children with disability whose families voluntarily engage with child protection services or who are on statutory orders that result in them remaining in the care and guardianship of their parents. A clear

policy and practice gap is what evidence-based early intervention can minimise the trajectory to criminalisation for this group of children with disability involved with child protection, but who are still in parental care. Findings from professionals suggest that current policies and practices, not just in child protection, but across multiple systems including education and justice services, often serve to enhance, rather than decrease the risk of criminalisation of children with disability in child protection systems. Consideration of the findings of the scoping and policy reviews, as well as the findings of the survey and consultations with professionals, gave rise to the following evidence-informed policy and practice recommendations in the Australian context for preventing and reducing the criminalisation of children with disability in child protection systems:

1. **That the Commonwealth Department of Social Services in partnership with the Secretariat of National Aboriginal and Islander Child Care (SNAICC), the First Peoples Disability Network and other relevant stakeholders develop national policy guidance to reduce the criminalisation of children with disability in child protection systems.**
2. **That states and territories ensure the availability of intensive family support services for families of children with disability to optimise their capacity to remain safely at home.**
3. **That states and territories should each develop and implement policy between child protection and education departments that seeks to maximise school engagement of children with disability in child protection systems.**
4. **That states and territories should ensure the availability of intensive kinship and foster care support options for children with disability.**
5. **That states and territories should ensure that all residential out-of-home care funded by child protection departments is therapeutic, and able to meet the needs of children with complex disability-related needs.**
6. **That states and territories each develop and implement protocols between residential out-of-home care providers and police which seek to minimise the criminalisation of children in residential care.**
7. **That states and territories ensure the availability of multidisciplinary therapeutic or healing services to children with disability in child protection systems.**

This study recommends that the Commonwealth, States and Territories commit to a National Inclusion framework to provide policy cohesion in this area, embodying principles that:

- centre the voice of children with disability;
- are conversant the disability experience and the impact of ableism; and
- reflect awareness of the intersectional and compounding marginalisation experienced by Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse peoples.

Research Question 4: Barriers to implementation of evidence-based practice within the child protection system

The fourth research question was:

4. What are the barriers to implementation of evidence-based practice within the child protection system?

What constitutes evidence-based practice in preventing the criminalisation of children with disability in child protection systems is yet to be rigorously identified. At the same time, evidence-informed practice can be considered as that which addresses factors understood to increase the chance of criminalisation, and fosters factors understood to prevent criminalisation of this group of children. Based on the study findings, key areas where evidence-informed practice does not appear to be consistently applied include:

- Early diagnosis of disability;
- Provision of effective/appropriate therapeutic supports to children and families;
- Sufficient engagement with and support to families engaged with child protection to support them to safely care for children with disability, and prevent entry to out-of-home care;
- Provision of safe, appropriate, and non-criminalising out-of-home care placements for children with disability.

According to the research findings, key barriers to implementing evidence-informed practice in relation to the above areas appear to include:

- **Child protection and other systems' incapacity to engage effectively with children and families:** particularly parents with complex support needs (including disability), Aboriginal and/or Torres Strait Islander, and culturally and linguistically diverse parents and families. Future research should examine whether failure to adequately support families of children with disability is a contributor to intergenerational child protection involvement, including due to relinquishment of children with complex disability-related support needs.
- **Lack of appropriate out-of-home care placements:** particularly those which are disability and trauma informed (including the possibility of disability-specific residential care), and culturally appropriate.
- **Lack of accessible and appropriate disability assessments:** The high prevalence of suspected and undiagnosed disability in this cohort both reflects and implies a lack of accessible assessments. Numerous barriers to disability assessment were identified in the current study, including waiting times, a lack of culturally appropriate assessment practices, unclear referral pathways, assessment pathways reliant on child protection services, and financial and geographic inaccessibility.
- **Lack of accessible and appropriate therapeutic services:** this is particularly the case for children living with complex/developmental trauma and/or neurodisability, highlighted in this study as the most common disabilities observed among criminalised children in child protection systems. There remains a lack of consistent understanding, response, and

support across multiple systems for children with these disabilities in child protection systems. Children may not meet the threshold for service provision, may be refused psychosocial support from the NDIS, labelled as having 'behavioural issues' and refused services from mental health systems, and be met with punitive responses in school, family, and out-of-home care settings. This effectively sets up, from a systemic perspective, the justice system as the single default system to respond to children with these needs. Prevention of the criminalisation of children with disability in child protection systems requires access to therapeutic supports which are geographically and financially accessible, culturally appropriate, and funded at sufficient duration and intensity to meet a child's therapeutic needs.

The above shortcomings point to systemic neglect of children with disability in child protection systems that too often results in devastating outcomes, including criminalisation of this group of children.

While the research question asked for a focus on barriers to effective child protection policy and practice, the research findings make clear that many external factors influence the criminalisation of children with disability in child protection systems, most prominently, the generally punitive responses to disability that includes challenges to emotional and behavioural regulation. An ongoing reliance on punitive responses to these impacts of disability is observed in educational contexts, to behaviours conceptualised as adolescent family violence, and within out-of-home care settings. Punitive responses are reinforced by a lack of understanding and responsiveness by police and justice systems to children with disability in child protection, as well as the low age of criminal responsibility across much of Australia (10 years), which permits children with disability in child protection systems to be criminalised at ages far younger than recommended by international standards.[587] Indeed, research consistently demonstrates that the youngest children in the justice system are most often Aboriginal and Torres Strait Islander children, those with disability, and those who are involved in child protection systems.[588]

9.3 Future Research

Several suggestions for much needed future research in this field have been identified, including:

- Evaluating the proposed risk and protective factors for criminalisation of children with disability in child protection systems, particularly in Australian contexts
- Ascertaining the prevalence of diverse disabilities among criminalised children in child protection systems, including complex/developmental trauma, sensory and physical disability
- Examining the additive or interactional effects of disability, race/ethnicity, and gender on the risk of criminalisation of children with disability in child protection systems
- Identifying and evaluating effective models, interventions, policies and practices for preventing the criminalisation of children with disability in child protection systems.

Finally, future research could also usefully examine the following questions:

- Which disability-related assessments are provided to which child protection-involved children, and when?
- What therapeutic support is provided to which children with disability in child protection systems? How does access to therapeutic support vary by other characteristics of this group (e.g., age, race/ethnicity, gender, geographic location, nature of child protection involvement, and nature of disability, including complexity of need)?
- What is the impact of the provision of therapeutic supports on the likelihood of criminalisation of children with disability in child protection systems?
- What is the impact of the stigmatisation of disability on the access to disability services and other interventions to decrease the likelihood of criminalisation, with an emphasis on Aboriginal and/or Torres Strait Islander children and other cultural groups?

One response to the structural ableism and marginalisation to which children with disability in child protection systems are subjected is enable them to declare their voice in their own right. Advancing the voices for young people with disability involves a long term process to respectful attend to complex array of ethical considerations that was beyond the scope of this particular study. The Disability Royal Commission, along with studies such as these, should be a platform to give impetus to more expansive, intergenerational work on addressing the structural barriers to the exclusion and criminalisation of disability.

Appendix A. Database Translations

PsycINFO

#	Query
1	Child Welfare/
2	child abuse/
3	child abuse.mp.
4	Protective Services/
5	*Residential Care Institutions/
6	Foster Care/
7	((foster or residential or secure or forensic or out-of-home or group) adj2 care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
8	((group or residential or foster) adj2 home).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
9	looked after.mp.
10	child welfare.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
11	child protecti*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
12	child*.mp.
13	foster children/
14	minor*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
15	adolescen*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
16	teen*.mp.
17	youth.mp.
18	young people.mp.
19	juvenile.mp.

#	Query
20	disab*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
21	Physical Disorders/
22	Neurodevelopmental Disorders/
23	Developmental Disabilities/
24	neurodevelopment*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
25	developmental delay.mp.
26	((neurodevelopmental or cognitive or learning or sensory or communication or language or speech) adj2 disab*).mp.
27	((cognitive or intellectual or hearing or visual) adj2 impair*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
28	neurodisab*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
29	learning difficult*.mp.
30	Intellectual Development Disorder/
31	Cognitive Impairment/
32	mental* retard*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
33	((attention or conduct or behavio?r* or autism or pervasive or f?etal or mental or personality or bipolar or attachement or post-traumatic or complex) adj3 disorder).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
34	((acquired or traumatic) adj2 injur*).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
35	neurodivers*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
36	Hearing Disorders/
37	hearing loss.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]

#	Query
38	Deaf/
39	deaf*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
40	Blind/
41	blind.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
42	((emotion* or behavio?r*) adj2 regulation).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
43	Emotional Regulation/
44	Behavior Problems/
45	Behavior Disorders/
46	behavio?r* problem*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
47	externali?ing behavio?r*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
48	Dyslexia/
49	dyslexi*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
50	Tourette Syndrome/
51	tourette syndrome.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
52	(mental adj2 (illness or health)).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
53	Suicidal Ideation/
54	suicidal*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
55	Self-Injurious Behavior/
56	self harm.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]

#	Query
57	psychosis/
58	psychosis.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
59	psychotic episode*.mp.
60	Schizophrenia/
61	schizophrenia.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
62	trauma.mp.
63	Psychological Stress/
64	stress.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
65	(complex adj2 needs).mp.
66	“Onset (Disorders)”/
67	Indigenous.mp.
68	perceptions.mp.
69	cross-over.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
70	Juvenile Delinquency/
71	youth offend*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
72	Criminal Offenders/
73	Crime/
74	criminal*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
75	offend*.mp.
76	offen?e*.mp.
77	delinquen*.mp.
78	Recidivism/

#	Query
79	recidivis*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
80	arrest*.mp.
81	youth justice.mp.
82	juvenile justice.mp.
83	juvenile delinquen*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
84	juvenile offen*.mp.
85	remand*.mp.
86	dual-track.mp.
87	sentenc*.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
88	Psychosocial Rehabilitation/
89	psychosocial intervention.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]
90	rehabilitat*.mp.
91	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11
92	12 or 13 or 14 or 15 or 16 or 17 or 18 or 19
93	20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68
94	69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 or 83 or 84 or 85 or 86 or 87 or 88 or 89 or 90
95	91 and 92 and 93 and 94

EBSCO – Criminal Justice Abstracts

((ZU “child welfare”) OR (ZU “child abuse”) OR (TI “child abuse”) OR (AB “child abuse”) OR (KW “child abuse”) OR (ZU “child protection services”) OR (ZU “residential care”) OR (ZU “foster home care”) OR (TI (foster or residential or secure or forensic or out-of-home or group) N2 care) OR (AB (foster or residential or secure or forensic or out-of-home or group) N2 care) OR (KW (foster or residential or secure or forensic or out-of-home or group) N2 care) OR (TI (group or residential or foster) N2 home) OR (AB (group or residential or foster) N2 home) OR (KW (group or residential or foster) N2 home) OR (TI “looked after”) OR (AB “looked after”) OR (KW “looked after”) OR (TI “child welfare”) OR (AB “child welfare”) OR (KW “child welfare”) OR (TI “child protecti*”) OR (AB “child protceti*”) OR (KW “child proceti*”)) **AND** (TI (child*) OR AB (child*) OR KW (child*) OR (ZU “foster children”) OR TI (minor*) OR AB (minor*) OR KW (minor*) OR TI (adolescen*) OR AB (adoelscen*) OR KW (adolescen*) OR TI (teen*) OR AB (teen*) OR KW (teen*) OR TI (youth) OR AB (youth) OR KW (youth) OR (TI “young people”) OR (AB “young people”) OR (KW “young people”) OR TI (juvenile) OR AB (juvenile) OR KW (juvenile)) **AND** (TI (disab*) OR AB (disab*) OR KW (disab*) OR (ZU “disabilities”) OR (ZU “neurological disorders”) OR (ZU “developmental disabilities”) OR TI (neurodevelopment) OR AB (neurodevelopment) OR KW (neurodevelopment) OR (TI “developmental delay”) OR (AB “developmental delay”) OR (KW “developmental delay”) OR (TI (neurodevelopmental or cognitive or learning or sensory or communication or language or speech) N2 disab*) OR (AB (neurodevelopmental or cognitive or learning or sensory or communication or language or speech) N2 disab*) OR (KW (neurodevelopmental or cognitive or learning or sensory or communication or language or speech) N2 disab*) OR (TI (cognitive or intellectual or hearing or visual) N2 impair*) OR (AB (cognitive or intellectual or hearing or visual) N2 impair*) OR (KW (cognitive or intellectual or hearing or visual) N2 impair*) OR TI (neurodisab*) OR AB (neurodisab*) OR KW (neurodisab*) OR (TI “learning difficult*”) OR (AB “learning difficult*”) OR (KW “learning difficult*”) OR (ZU “intellectual development”) OR (ZU “cognition disorders”) OR (TI “mental* retard*”) OR (AB “mental* retard*”) OR (KW “mental* retard*”) OR (TI (attention or conduct or behavio#r* or autism or pervasive or f#etal or mental or personality or bipolar or attachement or post-traumatic or complex) N3 disorder) OR (AB (attention or conduct or behavio#r* or autism or pervasive or f#etal or mental or personality or bipolar or attachement or post-traumatic or complex) N3 disorder) OR (KW (attention or conduct or behavio#r* or autism or pervasive or f#etal or mental or personality or bipolar or attachement or post-traumatic or complex) N3 disorder) OR (TI (acquired or traumatic) N2 injur*) OR (AB (acquired or traumatic) N2 injur*) OR (KW (acquired or traumatic) N2 injur*) OR TI (neurodivers*) OR AB (neurodivers*) OR KW (neurodivers*) OR (ZU “hearing impaired”) OR OR (TI “hearing loss”) OR (AB “hearing loss”) OR (KW “hearing loss) OR ZU (deaf) OR TI (deaf) OR AB (deaf) OR KW (deaf) OR ZU (blind) OR TI (blind) OR AB (blind) OR KW (blind) OR (TI (emotion* or behavio#r*) N2 regulation) OR (AB (emotion* or behavio#r*) N2 regulation) OR (KW (emotion* or behavio#r*) N2 regulation) OR (ZU “self regulation”) OR (ZU “behavior disorders in children”) OR (ZU “behavior disorders”) OR (TI “behavio#r* problem*”) OR (AB “behavio#r* problem*”) OR (KW “behavio#r* problem*) OR (TI “externali?ing behavio#r*”) OR (AB “externali?ing behavio#r*”) OR (KW “externali?ing behavio#r*”) OR ZU (dyslexia) OR TI (dyslexi*) OR AB (dyslexi*) OR KW

(dyslexi*) OR (ZU “Tourette syndrome”) OR (TI “Tourette syndrome”) OR (AB “Tourette syndrome”) OR (KW “Tourette syndrome”) OR (TI (mental N2 (illness or health)) OR (AB (mental N2 (illness or health)) OR (KW (mental N2 (illness or health)) OR (ZU “suicidal ideation”) OR TI (suicidal*) OR AB (suicidal*) OR KW (suicidal*) OR (ZU “self-injurious behavior”) OR TI (self-harm) OR AB (self-harm) OR KW (self-harm) OR ZU (psychoses) OR TI (psychosis) OR AB (psychosis) OR KW (psychosis) OR (TI “psychotic episode*”) OR (AB “psychotic episode*”) OR (KW “psychotic episode*”) OR ZU (schizophrenia) OR TI (schizophrenia) OR AB (schizophrenia) OR KW (schizophrenia) OR TI (trauma) OR AB (trauma) OR KW (trauma) OR TI (stress) OR AB (stress) OR KW (stress) OR (ZU “psychological stress”) OR (TI (complex N2 needs)) OR (AB (complex N2 needs)) OR (KW (complex N2 needs)) OR (ZU “conduct disorders in children”) OR (ZU “conduct disorders in adolescence”) OR TI (indigenous) OR AB (indigenous) OR KW (indigenous) OR TI (perceptions) OR AB (perceptions) OR KW (perceptions)) **AND** (TI (cross-over) OR AB (cross-over) OR KW (cross-over) OR (ZU “juvenile delinquency”) OR (TI “youth offend*”) OR (AB “youth offend*”) OR (KW “youth offend*”) OR ZU (criminals) OR ZU (crime) OR TI (criminal*) OR AB (criminal*) OR KW (criminal*) OR TI (offend*) OR AB (offend*) OR KW (offend*) OR TI (offen#e*) OR AB (offen#e*) OR KW (offen#er*) OR TI (delinquen*) OR AB (delinquen*) OR KW (delinquen*) OR ZU (recidivism) OR TI (recidivis*) OR AB (recidivis*) OR KW (recidivis*) OR TI (arrest*) OR AB (arrest*) OR KW (arrest*) OR (TI “youth justice”) OR (AB “youth justice”) OR (KW “youth justice”) OR (TI “juvenile justice”) OR (AB “juvenile justice”) OR (KW “juvenile justice”) OR (TI “juvenile delinquen*”) OR (AB “juvenile delinquen*”) OR (KW “juvenile delinquen*”) OR (TI “juvenile offen*”) OR (AB “juvenile offen*”) OR (KW “juvenile offen*”) OR TI (dual-track) OR AB (dual-track) OR KW (dual-track) OR TI (sentenc*) OR AB (sentenc*) OR KW (sentenc*) OR (TI “psychosocial intervention”) OR (AB “psychosocial intervention”) OR (KW “psychosocial intervention”) OR TI (rehabilitat*) OR AB (rehabilitat*) OR KW (rehabilitat*))

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(TI,AB,IF(“child abuse” OR ((foster OR residential OR secure OR forensic OR out-of-home OR group) NEAR/2 care) OR ((group OR residential OR foster) NEAR/2 home) OR “looked after” OR child welfare “ OR child protecti*”) OR mainsubject.Exact(“child welfare” OR “child abuse & neglect” OR “child protection” OR “residential care” OR “foster care”)) **AND** (TI,AB,IF(child* OR minor* OR adolescen* OR teen* OR youth OR “young people” OR juvenile) OR mainsubject.Exact(“foster children”)) **AND** (TI,AB,IF(disab* OR neurodevelopment* OR “developmental delay” OR ((neurodevelopmental OR cognitive OR learning OR sensory OR communication OR language OR speech) NEAR/2 disab*) OR ((cognitive OR intellectual OR hearing OR visual) NEAR/2 impair*)) OR TI,AB,IF(neurodisab* OR “learning difficult*” OR “mental* retard*” OR neurodivers* OR “hearing loss” OR deaf* OR blind OR externali?ing OR dyslexi* OR “tourette syndrome” OR suicidal* OR “self harm” OR psychosis OR “psychotic episode*” OR schizophrenia OR trauma OR stress OR indigenous OR perceptions) OR TI,AB,IF((attention OR conduct OR behavior OR behaviour OR behavioral OR behavioural OR autism OR pervasive OR fetal OR foetal OR mental OR personality OR bipolar OR attachment

OR post-traumatic OR complex) NEAR/3 disorder OR problem) OR TI,AB,IF((acquired or traumatic) N/2 injur*) OR TI,AB,IF((emotion or emotional or behavior or behaviour or behavioral or behavioural) N/2 regulation) OR TI,AB,IF(mental N/2 (illness or health)) OR TI,AB,IF(complex NEAR/2 needs) OR mainsubject.Exact("disability" OR "neurodevelopmental disorders" OR "developmental disabilities" OR "intellectual disabilities" OR "cognitive impairment" OR "hearing loss" OR "deaf" OR "blind" OR "emotional regulation" OR "behavior problems" OR "behavior disorders" OR "dyslexia" OR "tourette syndrome" OR "suicidal ideation" OR "self-injurious behavior" OR "psychosis" OR "schizophrenia" OR "psychological stress" OR "conduct disorders")) **AND** (TI,AB,IF("cross over" OR ("youth offender" OR "youth offenders" OR "youth offending") OR criminal* OR offend* OR offen?e* OR delinquen* OR recidivis* OR arrest* OR "youth justice" OR "juvenile justice" OR ("juvenile delinquency" OR "juvenile delinquent" OR "juvenile delinquents") OR ("juvenile offender" OR "juvenile offenders" OR "juvenile offenses") OR remand* OR "dual track" OR sentenc* OR "psychosocial intervention" OR rehabilitat*) OR mainsubject.Exact("juvenile delinquency" OR "criminals" OR "crime" OR "recidivism" OR "psychosocial rehabilitation"))

Appendix B. Study Characteristics and Key Findings

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Agnich et al. (J) (CP)	2016	US	To examine the impact of open adoption, demographics, and other factors on adopted children's mental health, delinquent behaviour, and family relationships.	Longitudinal.	From nationally representative survey sample; parents (n=1554) of children and youth aged 5 -17 years adopted in non-familial foster care or private adoption.	Non-familial foster care adoption. Adoptive parents report of child's maltreatment history.	Adoptive parents report of police contact for children over 13 years.	Adoptive parents report of PTSD or attachment disorder diagnoses.	For children 13 years and older adopted from foster care, males (OR = 5.08 p < .01), and those placed after 1 year of age (OR 11.31, p < .01) were significantly more likely to have police contact. While children who adoptive parents indicated had any abuse history prior to foster placement were significantly less likely to have police contact (OR = 0.21, p < .05). Diagnoses of PTSD and attachment disorder did not significantly predict police contact among the sample.
Barton (T) (CP)	2001	US	To ascertain what factors increase the likelihood a maltreated youth will participate in later delinquent or criminal activity.	Longitudinal.	Follow-up study maltreated youths aged 6-9 years in 1990-92 in Ohio (n=479).	Child welfare sample. Administrative data: type of maltreatment, OOHC placement,	Administrative data – police and court records: offense type, and date of occurrence.	Administrative data (self report, social services, psychologist reports). 'Mental health issues' - bipolar, depression, post traumatic stress disorder, conduct disorder, multiple diagnosis, chemically dependent, and other.	**Prediction of any offending**. Risk of offending was significantly higher among youth who experienced mental health issues (p < .05). Other significant predictors included male gender, race, older age at first maltreatment report, academic issues, increased OOHC placements, and placement in foster or kinship care. **Prediction of violent offending.** Risk of offending was significantly higher among youth who experienced mental health issues (p < .001). Other significant predictors included male gender, race, older age at first maltreatment report, maternal parenting skills issues, increased OOHC placements, and placement in foster or kinship care. **Prediction of number of other offence types**. Number of property, sex and drug offences were each not predicted by mental health issues in the sample. Additionally, youth with mental health issues were less likely to have been charged with a status offense.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Björkenstam et al. (J) (CP)	2013	Sweden	To examine associations between delinquency and suicidal behaviour in a national child welfare population.	Longitudinal.	All Swedish former child welfare clients born between 1972-1981, who were alive at age 20, and experienced interventions before age 13 (N = 27,228).	Child welfare sample. Individuals who were placed in out-of-home care or received provision of a "contact" family (corresponding to respite care).	Administrative data: Any convictions from age 15-19 years.	Administrative data: Any inpatient psychiatric care from age 13-19 years.	Child welfare involved youth who experienced inpatient psychiatric care from age 13-19 were more likely to have convictions and more justice involvement from age 15-19 years. This was even more pronounced for females, of whom 33% in the highest conviction group had experienced inpatient psychiatric care, compared with 12.4% among males.
Bright & Jonson-Reid (J) (CP)	2015	US	To investigate patterns of childhood and adolescent experiences that correspond to later justice system entry, and explore if timing of supports to the child or onset of family poverty, according to developmental periods and gender, distinguished among latent classes.	Longitudinal.	Children aged 0-11 years when first reported for maltreatment or when living in families receiving income maintenance as of 1993-94 or 1994-2009 (n=8587).	Child welfare sample. First report of maltreatment in 1993-94 and who were 17 years or older mid-year 2009: Maltreatment type, ongoing maltreatment (3+ reports).	Administrative data of offences.	Administrative data. Mental health services provided.	**Latent classes and juvenile delinquency:** Latent classes with low maltreatment and mental health services tended to have low levels of juvenile delinquency. Also associated with lower levels of delinquency were parental education levels (having a diploma). Children in latent classes with higher levels of delinquency tended to have higher levels of maltreatment or other violence exposure (e.g. community violence), and more mental health service usage. Female gender and residing in higher socio-economic status neighbourhoods were also protective against delinquency, even in a class with high rates of sexual and physical abuse and mental health service utilisation during and before elementary school.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Byrne (T) (CP)	2012	US	To examine elopement among young people living in substitute care in Canada and the United States.	Cross-sectional.	Youth aged 13-18 years (n = 2,296, M = 14.9 years) assessed at entry into care between July 2005-May 2010.	Child welfare sample. Maltreatment type.	Youth self-report - Child and Adolescent Needs and Strengths tool.	Youth self-report – Child and Adolescent Needs and Strengths tool. Behavioural/ emotional needs domains – psychosis, attention deficit/ impulse control, depression, anxiety, oppositional behaviour, conduct, substance abuse, attachment difficulties, eating disturbances, affect dysregulation, behavioural regression, somatization, anger control.	**Runaway risk** – Among children aged 10-12 years, both disability-related needs and delinquency predicted running away. Other significant predictors in the model were male gender, school attendance (low school attendance predicted running away), substance abuse, and placement in non-community settings. Among children aged 13-15 years, and those aged 16-18 years, both disability-related needs and delinquency predicted running away. Other significant predictors in the model were school attendance (low school attendance predicted running away), and substance abuse. Greater strengths and female gender were protective against running away. Strengths included family connection, interpersonal strengths (positive relationships and social skills), educational strengths (e.g. in school, has an education plan), vocational skills, wellbeing (coping and savouring skills), optimism, creative/artistic strengths, moral/spiritual strengths, community belonging (e.g. activities, neighbours), and stable relationships.
Cho et al. (J) (CP)	2019	US	To examine risk factors of first time delinquency for maltreated youth between ages 9 and 14.	Longitudinal.	Students with maltreatment histories in 3rd grade in Minnesota followed up over 6 years (n= 5002).	Child welfare sample – both substantiated and unsubstantiated reports. Age at first known episode of maltreatment, Number of maltreatment episodes.	Administrative data. Juvenile justice system involvement over a 6-year period from 2008–09 through 2013–14.	Administrative data. Disability - identified for students who were eligible for an Individualized Education Plan (IEP) for a disability in 2008–09. Emotional and behavioural disorders (EBD) - primary disability for individualised education plan listed as emotional/ behavioural disorder.	Overall, 7% of maltreated youth engaged in delinquency. Youth with emotional/behavioural disorders were 96% more likely to engage in delinquency at younger ages. Other significant predictors of younger onset of delinquency in the sample included: • Male gender • Black, Hispanic, or Native American race • Out-of-school suspension • More than 3 child maltreatment reports Eligibility for IEP, age at first CP involvement, and out-of-home placement did not significantly predict engagement in delinquency at younger ages.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Chuang & Wells (J) (CP)	2010	US	To examine associations for three dimensions of collaboration between local child welfare and juvenile justice agencies –jurisdiction, shared information systems, and overall connectivity – and youths' odds of receiving behavioural health services.	Longitudinal.	Secondary analysis of Child Protective Services cohort of the National Survey of Child and Adolescent Well-Being (NSCAW), national study of children in the U.S. child welfare system. Study sample restricted to children& youth who (1) needed behavioural health services, and (2) were involved with juvenile justice system (n=407).	Child welfare sample. Assessments with child, caregiver & case worker at baseline, 12 & 36 months. Directors of 86/92 child welfare agencies in the NSCAW sample interviewed at baseline (Wave 1) about agency management practices and policy contexts, including existence of formal, collaborative agreements with other agencies such as juvenile justice.	Youth/caregiver self-report. Current caregiver reported that youth had gone to court for misbehaving – including delinquency, running away, truancy, or other offenses or if the youth reported participating in any delinquent or criminal activities.	Youth/caregiver self-report. **Needing behavioural health services** – if meeting any of the following criteria: (1) clinical Child Behaviour Checklist score (>64 on either the internalizing or externalizing behaviour scales); (2) caseworker report that youth had drug/alcohol abuse problem; or (3) youth self-report of drug/alcohol use indicated medium to high risk of substance abuse problem.	Of the children and youth assessed as needing behavioural health services and involved with juvenile justice, approximately 20% of youth did not receive any behavioural health services, 78% received outpatient mental health services, 33% received inpatient mental health services, 14% received outpatient substance abuse treatment, and 13% received inpatient substance abuse treatment within three years of entering the child welfare system (p. 8). **Designation of single agency accountability and sharing of administrative data were significantly associated with youths' odds of receiving necessary behavioural health services** - Compared to youth under concurrent child welfare-juvenile justice jurisdiction, youth whose care was under child welfare control had higher odds of receiving outpatient behavioural health services (OR 3.09, $p<0.05$ for outpatient mental health; OR 6.07, $p<0.05$ for outpatient substance abuse treatment). (p. 9) Greater sharing of administrative data between local child welfare and juvenile justice agencies was not significantly associated with youth odds of receiving outpatient behavioural health services. However, administrative data sharing was positively associated with youths' odds of receiving inpatient mental health services (OR 3.55, $p<0.01$). (p. 9)

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
								Receipt of behavioural health services - (1) outpatient mental health, day treatment program, mental health/ community health centre, receipt of services from private for behavioural health problem; (2) inpatient mental health services (3) outpatient substance abuse treatment; and (4) inpatient substance abuse treatment.	A court order for youth to receive services increased youth's odds of receiving outpatient mental health services (OR 23.17, p<0.001). Co-morbidity for both a mental health and substance abuse treatment problem reduced crossover youth's odds of receiving outpatient mental health treatment (OR 0.14, p<0.05) but significantly increased youth odds of receiving outpatient and inpatient substance abuse treatment (OR 13.93, p<0.05; OR 38.97, p<0.05). Having either private insurance or being self-pay (i.e. no insurance), relative to having Medicaid or other public insurance, was negatively associated with youths' odds of receiving inpatient behavioural health services. (p.9)
Colvin (T) (CP)	2015	US	To analyse data from the six years of services delivered in a program an integrated multi-disciplinary treatment program for youth dually diagnosed with developmental disability and mental or behavioural health disorders.	Multiple case study - mixed methods sequential explanatory design.	Five youth who completed the program in New York (maximum variation sample).	50% of the families in the program had involvement in child welfare out-of-home care system.	Involvement in juvenile justice system.	Sample with developmental disabilities and mental or behavioural disorder.	**Discrepancies in disability diagnosis between systems –** Describes one child given three separate diagnoses in each of child welfare (PTSD), mental health (bipolar disorder and ADHD) juvenile justice (oppositional defiant disorder) and developmental disabilities (Pervasive developmental disorder) systems. **Movement between multiple systems –** Describes one child whose placement history spanned child welfare, mental health, juvenile justice and developmental disability placements.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Cuellar et al. (J) (CP)	2004	US	To examine the effectiveness of mental health and substance abuse treatment in reducing crimes committed by juveniles.	Longitudinal.	Youth aged 13-18 who received services from the Colorado child welfare system from Jul 1994-Jun 1997 (N=82,288).	Child welfare sample.	Administrative data. Arrest and detain in juvenile justice (including remand), offence type.	Administrative data. Provision of mental health and substance abuse treatment – number of treatment months in previous 3 months. Treatment includes outpatient treatment, treatment in a therapeutic residential treatment facility (group home), and inpatient psychiatric hospitalization.	Youth involved in the child welfare system who receive mental health or substance abuse treatment have lower probabilities of being detained for any offence. Youth who live in areas with greater treatment availability also have a lower probability of exiting into detention.
Frederiksen & Lausten (J) (CP)	2018	Denmark	To determine the prevalence of aftercare as well as to analyse the characteristics of its recipients in Denmark.	Longitudinal.	Young people born in 1995 who were in out-of-home care in Denmark before turning 18 years (N=2185).	Child welfare (out-of-home care) sample.	Administrative data – having been convicted of a crime.	Administrative data – having one or more psychiatric diagnoses by age 18.	**Aftercare service access** – **All young people** - Compared to young people leaving care who received aftercare services, those who did not were more likely to have attended special schools, to have a psychiatric diagnosis and to have been convicted of a crime. Among those leaving **foster care** or their **own dwelling,** the likelihood of receiving aftercare services did not differ by crossover or disability status. Among those leaving **residential care,** the likelihood of receiving aftercare services was lower for those who attended special school, but did not differ for those with psychiatric diagnoses nor those who had received a conviction.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Goodkind et al. (J) (CP)	2013	US	To examine relationships between juvenile justice system contact, and child welfare experiences, mental health and substance abuse service receipt, with particular attention to racial and gender differences.	Longitudinal.	White and African American youth born between 1985-94 whose families received in-home services from the child welfare system and/or who were placed in out-of-home care for any length of time in Allegheny County, Pennsylvania (n=17,471)	Child welfare sample.	Administrative data. Juvenile justice involvement - youth has spent time in a juvenile justice detention/ residential facility.	Administrative data - Mental health service involvement (prior to juvenile justice for crossover youth).	**Predictors of juvenile justice involvement (whole sample)–** among the whole sample, mental health service receipt was associated with 3.5 times the odds of JJ involvement. Other significant predictors were African American race (OR = 2.6), male gender (OR= 4.5), children whose child welfare cases were still open at age 13 years (OR = 3.3), and children who experienced out-of-home care placement (36% increased likelihood). **Predictors of juvenile justice involvement (OOHC placement sample) –** among children placed in OOHC, mental health service receipt was associated with 1.5 times the odds of JJ involvement. Other significant predictors were African American race (OR = 1.9), male gender (OR= 3.4), and child welfare cases remaining open at 13 years (OR = 2.7). Substance abuse service receipt was associated with decreased likelihood of juvenile justice involvement. Each additional placement is associated with an 11% increase in likelihood of JJ involvement, while total length of time in placement, when number of placements is held constant, is related to a decreased likelihood of JJ involvement (i.e., the longer a youth spends in placement, the less likely they are to have JJ involvement). Congregate care placement was associated with a 25% increase in likelihood of juvenile justice involvement, while running away is associated with a decreased risk.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Goodkind et al. (J) (CP)	2020	US	To examine the effects of child welfare, mental health, and drug/ alcohol system experiences on jail involvement, as mediated by juvenile justice placement, for Black and White youth/ young adults.	Longitudinal.	Individuals born between 1985 and 1994 with child welfare involvement in an urban Pennsylvania county (N =37,079) and an out-of-home placement (OOHP) subsample (n = 8,317).	Child welfare sample. Age when child welfare case closed, out-of-home care placement, ever placed in congregate care, length of time in OOHC.	Administrative data. Juvenile justice involvement - youth has spent time in a juvenile justice detention/ residential facility. Jail involvement – youth spent time in county jail.	Administrative data - Mental health service involvement (prior to juvenile justice for crossover youth).	**White youth -** The relationship between prior receipt of mental health services and jail involvement was mediated by juvenile justice placement (p< .001). **Black youth -** The relationships of prior receipt of mental health services, having a case open after a youth turned 14 years old, and being in an OOHC with jail involvement were mediated by juvenile justice placement (p<.001). Authors suggested that it is likely that even though youth are receiving mental health services, the services provided are not meeting their needs. **Placement subsamples –** Among young people in OOHC, receipt of mental health services bore no significant relationship to juvenile justice or jail involvement.
Hoskowitz (T) (CP)	2017	US	To examine how psychotropic medication influenced total delinquent behaviours in a given year, as well as entry into juvenile justice, over a seven-year time period with a sample of at-risk youth.	Longitudinal.	Youth and caregivers from National Survey of Child and Adolescent Well-being database – baseline (Oct 1999-Dec 2000) and at 12, 24, 36 and 48 month follow-up data post child welfare involvement.	Child welfare sample.	Administrative data. Juvenile justice system involvement.	Youth and parent self-report. Child Behaviour Checklist – internalizing and externalizing behaviour problems. Psychotropic medication usage.	**Psychotropic medication and entry into JJ -** There were significant differences between the medication groups, with higher survival probability for never-medicated youth, followed by inconsistently-medicated youth. Psychotropic medication treatment of at-risk youth does not appear to exert a protective effect on these youths' entry into the JJS over a seven-year time span. That is, youth who were either consistently- or inconsistently-medicated were at significantly increased risk of entry into the JJS – up to 9.3 times higher risk for consistently medicated youth – particularly within the first 20 months of the study. Further, while such risk stabilized after the two-year mark, youth who received psychotropic medication remained at higher risk than never-medicated youth, particularly if the medication regimen was consistent.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Jaggers et al. (J) (CP)	2018	US	To consider how demographic differences, justice involvement, type of treatment agency involved, and child welfare effectiveness impact mental health.	Cross-sectional.	Random sample of child welfare cases (in a Midwestern state from 2009-15 (n= 2110).	Child welfare sample.	Administrative data. Juvenile justice system involvement.	Administrative data. Mental health system involvement.	**Mental health problems and juvenile justice involvement -** A lack of juvenile justice involvement reduced the odds of minor mental health problems compared with those involved in the juvenile justice system. For those involved with the juvenile justice system, the odds of exhibiting moderate-severe mental health problems was higher compared with those not involved in the juvenile justice system.
Jonson-Reid (J) (CP)	2002	US	To investigate whether child welfare services moderated the risk of later juvenile corrections entry and what factors explained juvenile corrections entry among children who received child welfare services.	Longitudinal.	Children 5+ years old reported for child maltreatment in Missouri in 1993-94 and tracked to 2000 (n=36,653).	Child welfare sample. Maltreatment type, recurrence, & services received.	Administrative data. Commitment to the statewide juvenile corrections system.	Administrative data. Mental health service involvement within 6 months of maltreatment report; type of mental health problem.	**Mental health problems and juvenile justice involvement -** Children who received mental health (including substance abuse) services within 6 months of child welfare report were significantly more likely to have youth justice system contact. Author suggested that "failed" cases among those receiving child welfare intervention may also be those that have comorbid issues such as mental health disorders present at the point at which child welfare authorities become involved; children who were also receiving services for a mental health disorder (including substance abuse) and who entered foster care for reasons beyond a maltreatment report were most at risk of juvenile justice system entry.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Lee & Jonson-Reid (J) (CP)	2009	US	To examine the needs and outcomes of children in special education (comparing those with emotional disturbance (ED) and those without) according to child welfare involvement.	Longitudinal.	Maltreated and low income children (n= 345) compared to low income only children (n=126) born 1982-94. All children in the sample were involved in special education.	Child welfare sample – substantiated/ multiple report cases of maltreatment.	Administrative data. Juvenile delinquency - having a court petition for any delinquent offense (i.e. excluding status offenses).	Administrative data. Emotional disturbance (ED) listed - a condition exhibiting 1+ of the following characteristics over a long period and to a marked degree that adversely affects child's educational performance: (A) Inability to learn that cannot be explained by intellectual, sensory, or health factors; (B) Inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (C) Inappropriate types of behaviour or feelings under normal circumstances; (D) General pervasive mood of unhappiness/ depression; (E) A tendency to develop physical symptoms or associated with personal or school problems.	Among youth in special education and child welfare involvement, those with emotional disturbance were more likely to have juvenile justice involvement compared with those who had other special education diagnoses. E.g. among those with child abuse and neglect (notifications only), delinquency rates were 46.1% among those with emotional disturbance vs 23.4% for those with other diagnoses. Among those with child welfare services involvement, delinquency rates were 41% (ED) vs 26.2% (other diagnoses) Among those with foster care involvement, delinquency rates were 55.9% (ED) vs 36.8% (other diagnoses). **Predictors of delinquency** – Among the overall sample, the strongest predictors of a delinquency petition were having a parent that did not complete high school (HR=2.22), ED diagnosis (HR=2.07), and age at first assessment for special education (about 40% increased risk per year of age up to 17 years). In addition, children with an IQ of less than 70 and females were about half as likely to have this outcome. There was no difference in risk for children with child welfare contact compared to the poverty only group.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Lee (T) (CP)	2009	US	To increase knowledge about the potential role of foster care placement in problem behaviour (juvenile delinquency, runaway, teen pregnancy, and truancy) among foster care youth.	Longitudinal.	Children and their families with child abuse report between 1991-94 in large Midwestern metropolitan area including those receiving financial aid (n=5,019) and second group of children with CAN report but no history of financial aid prior to or at the time of the report (n=2,274). Both followed up to 2006.	Child welfare sample – reported for abuse and neglect. Maltreatment report characteristics (type, number), foster care placement characteristics.	Administrative data - Child had a juvenile court petition after exit from foster care placement.	Administrative data - Child received Medicaid treatment for mental health or special education.	**Impact of foster care -** Compared to youth who received family preservation services only, the foster care only group had a moderate increase in risk of juvenile delinquency (HR=1.38, p=0.02), after controlling for family care service involvement, and the child's mental health service and special education involvement. There was increased risk for children who had a record of MH treatment following first service (HR=1.88, p=0.001). **Impact of family care services** - A single episode of Family Care Service (FCS) during or following placement decreased the risk of delinquency significantly (p= .01) and multiple episodes had further impacts (p = .002). This is a less intensive family support program to promote healthy development, and the services it provides may include counselling, parent education, home visits, or referral to family resource centers. **Factors increasing risk of delinquency among children in foster care -** Both children's mental health service record and special education record were significant risk factors. Children who received mental health services (49% vs. 38%) or special education (53% vs. 34%) had higher risk than children who did not participated in any services.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									In a regression analysis, children's special education was a significant risk factor of juvenile delinquency: participation of special education during/after foster care was associated with higher risk of delinquency behaviour (OS: HR=1.61, p=0.01). A range of other sociodemographic, placement and maltreatment factors also increased this risk (e.g. male gender, African American race, older age at placement (>11 years), parental education level (< high school), placement for < 2 months, placement for non-maltreatment reasons, maltreatment recurrence, longest stay in residential care (vs licenced foster care or kinship care), 4+ placements). Regardless of service initiation time and frequency, receipt of FCS was associated with lower risk of juvenile delinquency compared to children who had no FCS. Caregiver record of mental health or substance abuse treatment prior to foster care placement was associated with higher risk of delinquency (FS: HR=1.51, p=0.009; OS: HR=1.69, p=0.001), but a record during or after foster care was not significant.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Malvaso & Delfabbro (J) (CP)	2015	Australia	To determine which factors differentiate offenders from non-offenders among a sample of high support needs young people in out-of-home care.	Cross-sectional.	Purposive sample of children and young people aged 4+ years who experienced 2+ unplanned placement breakdowns within 2 years of their placement in care (n=364)	Child welfare (OOHC) sample. Administrative data + interviews. Child welfare history – e.g. age of first OOHC entry, primary reasons for OOHC entry, type of order, number of prior foster placements, years in care, number of prior reunifications; type of OOHC; number of unplanned placement terminations in past 2 years; number of placements moves due to behavioural issues, contact with birth families.	Administrative data: documentation of criminal activity, arrests or police caution in case file.	Administrative data & case worker assessment. High support needs - included identification of conduct disorder, hyperactivity, depression or anxiety, attention deficit hyperactivity disorder (ADHD), personality disorder or mental illness, physical disability, and intellectual disability or developmental delay. Emotional or behavioural problems – case workers completed Strengths & Difficulties Questionnaire.	**Predictors of offending –** Included disability and child welfare factors such as conduct problems (on SDQ), placement in residential care (11.79 times greater likelihood of offending) and being placed in care due to physical abuse. Other predictors included older age, male gender, being of Aboriginal and Torres Strait Islander background, substance abuse, and having poor social adjustment. Intellectual disability was not a significant predictor of offending in the model.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Morrow, Villodas & Cunius (J) (CP)	2019	US	To prospectively identify ecological risk factors for juvenile arrest in a sample of youth at risk for maltreatment	Longitudinal.	Children reported for CAN or at risk of maltreatment (recruited aged 4 or 6) and who participated in a multisite consortium of prospective studies, the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) & interviewed when aged 14 or 16 (n=592).	Child welfare sample. Administrative data: CP records reviewed & coded using Modified Maltreatment Classification System for allegations of physical abuse, sexual abuse, neglect, and emotional maltreatment to age 14.	Youth self-report: past year self-reported arrest at age 16.	Youth self-report. Mental health at age 14 - National Institute of Mental Health Diagnostic Interview Schedule for Children.	**Correlates of arrest at age 16 –** For boys (but not for girls), post-traumatic stress disorder symptom count was correlated ($p < .05$). For girls (but not for boys), oppositional defiant disorder symptoms were correlated ($p < .05$). **Conduct disorder and arrest-** The strongest predictor of arrest was conduct disorder symptom count. Youth with 3+ CD symptoms were at significantly greater risk of arrest than those with 2 or fewer symptoms (26% vs 7%, $p < .05$). Among youth with 3+ CD symptoms, those who had witnessed family violence before age 14 years were significantly more likely to be arrested than those who had not (38% vs 19%, $p< .05$). Among this group who had 3+ CD symptoms and who had witnessed family violence before 14 years, males were significantly more likely to be arrested 47% vs 23%, $p < .05$). Among youth with 3+ CD symptoms who had not witnessed family violence, believing it was extremely important to do well at school was protective against arrest (13% vs 33% $p < .05$). Among youth with 2 or fewer symptoms of CD, those who had been suspended from school were at significantly greater risk of arrest (13% vs 3.9%, $p< .05$). Among youth with 2 or fewer symptoms of CD who had not been suspended, those who had a family member in jail before age 14 were at greater risk of arrest (8% vs 1.6%, $p < .05$).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Munson & McMillen (J) (CP)	2009	US	To examine the relative contribution of demographic characteristics, clinical characteristics, custody status, and mentoring on outcomes of foster youth.	Longitudinal.	Older youth transitioning from the foster care system in Missouri, followed up post-care (n=339).	Child welfare (foster care) sample.	Administrative data & Youth self-report. Custody status at age 19 years.	Youth self-report. Lifetime history of mental health diagnoses via Diagnostic Interview Schedule for DSM-IV.	**Mentoring and arrest -** After controlling for mental health history, youth with a long-term mentor were less likely to have been arrested at age 19 years. The only mental health variable that significantly predicted arrest was history of Disruptive Behaviour Disorder.
Ryan (J) (CP)	2012	US	To investigate whether the reason for placement was associated with the subsequent risk of arrest.	Longitudinal.	Stratified sample of youth aged 8-16 years with at least one episode in a substitute care child welfare in Washington between 2000-09 (n = 5,528).	Child welfare (substitute care) sample.	Administrative data. Delinquency records.	Administrative data. Placement in substitute care for child behavioural problems, child abuse and neglect, or a mix of these.	**Rates of arrest after placement by reason for placement –** Child abuse and neglect – 38% Child abuse and neglect with prior arrests – 75% Behavioural problems – 62% Behaviour problems with prior arrest – 85% Both child abuse and neglect and behavioural problems – 65% Both child abuse and neglect and behavioural problems with prior arrest – 88% Youth with child behavioural problems (BEH and BEHP) account for 23%of the sample, yet account for 31% of arrests. Youth referred only for child physical abuse and neglect issues (CAN and CANP) account for 62% of the sample, yet only 50% of arrests. Youth coming to child welfare with a history of delinquency appear to be at the greatest risk of offending. Youth entering placement for behavioural problems appear to be at an increased risk of arrest (44-73%) as compared with youth placed for abuse/neglect (14% at 24 months). Youth placed for a mix of maltreatment and child behavioural problems experienced similar rates of arrest as com-pared with youth placed only for reasons of maltreatment.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Increased risk of arrest was correlated with male gender, placement in congregate care, placement instability and African American race (particularly those children without prior arrest/justice system involvement). **Placement type –** Children placed for BEH or BEH + arrest were more likely to be placed in congregate care settings, and were more likely to have only experienced congregate care placements. **Placement stability** – Youth placed for child maltreatment experienced the greatest stability as compared with youth placed for behavioural problems or youth placed for both maltreatment and behavioural problems. Prior juvenile justice involvement seemed to have no association with placement stability.
Sabaté-Tomas et al. (J) (CP)	2021	Spain	To understand the treatment progress of adolescents with severe behavioural problems who were placed in intensive educational residential centres.	Cross-sectional.	All young people who had left the intensive educational residential centres in the 3 years prior (n=206).	Child welfare (residential treatment care) sample.	Administrative data - criminal offences.	Administrative data – mental health disease.	**Mental health and criminal offences –** youth in the program with mental health conditions were less likely to have criminal offences (52.1% vs 69.2%, $p < .005$).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Shook et al. (J) (CP)	2011	US	To analyse the mental health, substance abuse, juvenile justice, and criminal justice system involvement of youth who have aged out of child welfare.	Longitudinal.	Children born 1985-94 whose families received in-home services from the child welfare system or who were placed in out-of-home care in Allegheny County, PA, and who aged out of care between Jan 2002- March 2008 (n=1,361).	Child welfare (OOHC) sample.	Administrative data. Juvenile justice involvement - time in the county detention facility or a residential juvenile justice facility.	Administrative data. Receipt of mental health services in Allegheny County at any point.	**Compared with youth who received mental health services only,** those also involved with JJ: • Were significantly younger, younger when ageing out of care, younger at first OOHC placement • Had a greater number of placement and spells in OOHC • Spent less time in foster care and more time in congregate care • Were significantly less likely to have only been placed in foster care (11% vs 29%) • Were more likely to have run away from care
Shook et al. (J) (CP)	2009	US	To explore the role that deviant peers play in the lives of young people ageing out of foster care.	Cross-sectional.	Youth turning age 17 in the foster care system in eight Missouri counties in 2001-03 (n=404)	Child welfare (foster care) sample.	Youth self-report. Past 12 month arrest (Y/N).	Youth self-report. Mental health – lifetime conduct disorder/ antisocial personality disorder, psychopathic traits.	**Latent Class Analysis –** Three classes emerged including a high deviant peer class (14% of the sample) with significantly higher rates of past 12 month arrest (19.1% vs 5-6.3%, p = .006). This class had greater lifetime prevalence of conduct disorder (29.1% vs 13.4-24.6%, p =.026) and antisocial personality disorder (41.8% vs 12.5-22.4%, p < .001), as well as higher levels of impulsivity and narcissism. This group also had: • Come from greater neighbourhood disorder • Significantly lower family support • Significantly greater substance use
Southerland et al. (J) (CP)	2009	US	To examine the young adult outcomes of a nationally representative cohort of transition age youth who were involved with the Child Welfare System during adolescence.	Longitudinal.	Transition aged youth (18-21 years) who participated in Wave 5 (2006-07) of the National Survey of Child and Adolescent Well-being. Note: incarcerated youth (n=21) excluded.	Child welfare (investigated maltreatment) sample.	Youth self-report. Past 12 month arrest, incarceration & probation.	Youth self-report. Composite International Diagnostic Interview Short Form & self-reported need for inpatient MH/AOD support.	**Arrest and mental health -** Youth at risk for mental health problems were significantly more likely to have been arrested at least once in the last 12 months (4.4x) compared with youth not at risk for mental health problems (65.9% VS 41.3%). Other factors significantly associated with arrest were male gender.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Taussig & Clyman (J) (CP)	2011	US	To examine the relationship between length of time living with kin and adolescent well-being in a cohort of children in out-of-home care.	Longitudinal.	Youth aged 7–12 who entered out-of-home care between May 1990-Oct 1991 (n=148).	Child welfare (OOHC) sample.	Youth self-report. Lifetime tickets or arrests.	Youth self-report. Youth self-report (YSR) & Child Behavioural Checklist (CBCL).	**Behaviour problems and tickets/ arrests –** In a multivariate analysis, behaviour problems (CBCL) at time 1 (age 7-12) were not associated with lifetime tickets/arrests. Arrests were associated with: increased age, a greater number of placements, and increased time living with kin vs in foster care during their life.
Van Wert (T) (CP)	2015	Canada	To deepen current understanding of the relationship between maltreatment and behaviour problems, and to understand the potential intervening role of child welfare services in influencing this relationship.	Longitudinal.	Children investigated for maltreatment during a three month period in 2013 as part of Ontario Incidence Study of Reported Child Abuse and Neglect (n=5265).	Child welfare (investigation) sample.	Administrative data. Child charged, incarcerated, or dealt alternative measures under the federal Youth Criminal Justice Act.	Administrative data. Noted depression/ anxiety/ withdrawal, intellectual/ developmental disability, attachment issues, ADHD.	**Comparative analysis by justice system involvement (12-15 year old)** – Youth involved in the justice system had greater levels of all maltreatment and child risks. In relation to disability, significantly greater levels of depression/anxiety/ withdrawal (72% vs 35%), intellectual/ developmental disability (39% vs 14%), attachment issues (41% vs 19%), ADHD (60% vs 16%), and aggression (81% vs 17%).
Vaughn et al. (J) (CP)	2008	US	To examine the construct of psychopathy in a community sample of foster care youths transitioning out of care (N=404).	Longitudinal.	Youth turning age 17 in the foster care system in eight Missouri counties from Dec 2001-May 2003 (n=404).	Child welfare (foster care) sample.	Youth self-report. Self-reported arrests from 17-19 years).	Youth self-report. Psychopathic Personality Inventory-Short Form; lifetime & current mental health diagnoses.	**NB:** Children with IQ scores below 70 excluded **Predictors of number of arrests** – In a multivariate model, ADHD did not predict number of arrests, however measures of psychopathy did, as well as male gender, deviant peers, and neighbourhood disorder.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Vostanis et al. (J) (CP)	2008	UK	To examine data from the England survey on the use of services by looked after children with behavioural problems.	Cross-sectional.	Children looked after by 142 local authorities in England aged between 5-17 years (n=1039).	Child welfare (OOHC) sample.	Youth and carer self report – seen by YJ/probation worker in past year, been in trouble with police.	Caregiver and youth self-report. Development and Well-being Assessment.	**Conduct disorder and youth justice involvement** – Overall 16.8% of looked after children with CD were seen by a YJ/probation worker in the last year, however this was higher among children with CD and comorbid emotional disorder (26.7%) and those with CD only (17.7%), and lower among those with CD/comorbid hyperkinetic disorder (5.4%). Similarly, while overall 29.3% of looked after children with CD had been in trouble with police, this was highest among those with CD/ comorbid emotional disorder (37.2%), and those with CD only (30.7%), and lower among those with CD/comorbid hyperkinetic disorder (17.6%). Children with CD and comorbid emotional disorders were over-represented within the residential care group (43.5%), and had the highest mean age, and had entered care later than the other groups.
Weeks (T)	2015	US	To examine the life and offending of transient adult males.	Longitudinal.	Non-probabilistic national sample of male youth in foster care who participated in baseline survey at age 17 years, 3 waves of follow-up to 21 years (n=3085).	Child welfare (foster care) sample.	Administrative data. Incarceration - confined in a jail, prison, correctional facility, or juvenile or community detention facility due to allegedly committing a crime.	Administrative data. Special education.	**Incarceration by age 21** – In a multivariate model, special education receipt was not significantly predictive of incarceration in the sample of males transitioning from foster care.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Williams et al. (J) (CP)	2010	US	To examine the relationship between maltreatment and the likelihood of a delinquency petition among a sample of African American males.	Longitudinal.	African American males whose families had a child abuse report between 1991-94 in large Midwestern metropolitan area and who were receiving financial aid (n=2332).	Child welfare (maltreatment report) sample.	Administrative data. Juvenile justice petition.	Administrative data. Special education, prior mental health treatment.	**Mental health and delinquency** – Youth who received mental health treatment were 1.99 times more likely to have a delinquency petition ($p < .001$). Other significant predictors were experiences of neglect, physical abuse, other/mixed abuse, multiple maltreatment reports, and a lower rate of delinquency was seen for children with a parent with a high school education.
Yampolskaya & Chuang (J) (CP)	2012	US	To examine the effect of specific mental health disorders on risk of juvenile justice involvement and recidivism among maltreated children in out-of-home care.	Longitudinal.	All children in Florida aged 7–17 years investigated for maltreatment and subsequently placed in out-of-home care between July 2004 –June 2005 (n=5720).	Child welfare (OOHC) sample. Administrative data: type of maltreatment, number of OOHC placements.	Administrative data. Juvenile justice involvement: placement in detention centre/juvenile justice facility <18 years,	Administrative data. Diagnosed mental health disorders.	**Mental health disorders and time to JJ involvement -** positive significant associations were found between all examined mental health disorders and the time to involvement with the juvenile justice system except for posttraumatic stress disorder (PTSD) where the association was inverse. Compared to children with no identified mental health disorder, children diagnosed with bipolar disorder had 85% greater odds of being placed with a juvenile justice facility; children diagnosed with depression had 72% greater odds of becoming involved with the juvenile justice system; children diagnosed with attention-deficit disorder were almost twice more likely to be placed in a JJ facility; Children diagnosed with conduct disorder were 5 times more likely to become involved with the juvenile justice system. At 10 months post-OOHC, 28% of children with CD had JJ involvement, vs 1% of children without CD. **Predictors of recidivism -** Results of multivariate logistic regression indicated that the presence of a mental health disorder was the only factor significantly associated with delinquency recidivism. Children who were diagnosed with any mental health disorder were 81% more likely to experience recidivism (odds ratio = 1.81, $p < .05$) as compared to children who did not have identified mental health problems.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Alltucker (T) Alltucker et al. (J) (YJ)	2004, 2006	US	To examine contextual factors representing family disruption and coercive family processes that influence the age-related development of juvenile delinquency, and community reintegration outcomes for previously adjudicated youth.	Longitudinal.	Youth transitioning out of Oregon correctional facilities from 1994-98 (n=531).	Youth and family self-report. Any foster care experience (62.6% of the sample)	Custodial youth justice sample Administrative data - 'Early start juvenile delinquency' – adjudicated prior to 14 years (Y/N)	Administrative data (institutional & educational records). 'Special education disability' (57.7% of the sample) – includes emotional disability, mental retardation, learning disability, speech/ language impairment, hearing impaired, attention deficit, and 'other'. ADHD	**Early start delinquency -** For youth with foster care experience, the cumulative probability of early start juvenile delinquency was 41.1% (p. 108); this group were four times more likely to experience early start juvenile delinquency. A history of parental/ sibling criminal justice involvement significantly added to the probability of early start delinquency. Foster youth with special education disability did not significantly predict early start delinquency in this mode but were slightly more likely to have early start juvenile delinquency (increased cumulative probability by around 3% in the model, see p. 108). **Recidivism** - Youth with special education experience were more than twice as likely to return to a correctional facility in the 12 months following release (OR = 2.1, p < .01); this group returned within 12 months 43.5% of the time. Foster care experience did not significantly predict this outcome, but author reported that youth with special education and foster care experience were a further 5% more likely to return within 12 months (45.8% returned within 12 months of release) (p.114).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Barrett et al. (J) (YJ)	2014	US	To examine the role of early adverse experiences, mental health problems, and disabilities in the prediction of juvenile delinquency and recidivism.	Longitudinal.	Delinquent group - youth, born 1981-88, whose cases were processed by the South Carolina Department of Juvenile Justice (n=99,602). Control group - youth, matched by age, race, and gender were drawn from the records of the South Carolina Department of Education (n=99,602)	Administrative data. Foster placement (Y/N, age, duration of placement, and number of placements, CPS custody/ guardianship (Y/N, reason for and timing of CPS).	Juvenile justice sample.	Administrative data. School-based diagnoses for learning disabilities (LD) and emotional and behavioural disorders (EBD); Age at first, second, and most recent referrals to mental health services and primary diagnosis at each referral.	**Prediction of juvenile justice involvement –** In a model incorporating several variables, significant effects were observed for foster care and maltreatment were observed (1.35 and 2.54 times more likely to experience juvenile justice involvement); a DSM-IV diagnosis involving aggression or impulse control made the strongest independent contribution (children were 9.36 times more likely to be involved in JJ). Presence of any other DSM-IV diagnosis increased the odds of JJ involvement by 3.24 times. Finally, with all other variables in the equation, special education diagnoses significantly contributed to prediction. Odds ratios were 1.78 for EBD and 1.27 for LD. **Age at first offence -** Presence of either foster care or maltreatment increased the odds of early offending; $\chi^2 = 20.13$, $p < .001$ and $\chi^2 = 373.14$, $p < .001$, respectively. In addition, both presence of a DSM-IV diagnosis involving aggression or impulse control ($\chi^2 = 600.48$, $p < .001$) and presence of any other DSM-IV diagnosis ($\chi^2 = 89.41$, $p < .001$) increased the odds of early offending. Finally, with all other variables in the equation (e.g. gender), special education diagnoses contributed significantly to prediction; $\chi^2 = 337.19$, $p < .001$ and $\chi^2 = 20.07$, $p < .001$ for EBD and LD, respectively. The magnitude of the AOR for LD (.58 for predicting older age of first referral) was the highest of any in the equation; youth with a diagnosis of a LD were almost twice as likely to commit their first offense before age 14 than youth without this diagnosis (pp 8-9).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Felony vs misdemeanour - Mental health diagnoses were significantly related to the severity of the offense, with youth with either a diagnosis relating to aggressive behaviour or any other diagnosis more likely to be referred for serious crimes. Youth with a classification of an EBD were more likely to commit felony-level crimes; $\chi 2 = 16.59$, $p < .001$. There was a tendency for youth who had been maltreated to commit less serious crimes and for youth with LD to commit more serious crimes however, adjusted odds ratios were of low magnitude. Foster care did not make a significant contribution to the model (p. 9). **Recidivism** - While the effect for foster care was not significant, there was a significant effect for maltreatment; $\chi 2 = 335.01$, $p < .001$. Youth who had been in CPS were approximately 50% more likely than those who had not been in CPS to commit a second crime. Mental health diagnosis was significantly related to the likelihood of a second offense, with youth with either a diagnosis relating to aggressive behaviour or any other diagnosis more likely to be referred for a second offense; $\chi 2 = 3119.36$, $p < .001$ and $\chi 2 = 1545.63$, $p < .001$, respectively. The values for AOR show that youth with mental health diagnoses relating to aggressive behaviour were more than three times more likely to commit a second offense than other first offenders and that youth with another mental health diagnosis were almost twice as likely as nondiagnosed youth to commit a second offense. Youth with a classification of an EBD or a LD were more likely to commit a second offense than youth without these special education classifications; $\chi 2 = 99.43$, $p < .001$ and $\chi 2 = 24.68$, $p < .001$, respectively (p. 9).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Authors suggested most compelling finding in the present study is the disproportionate role of pre-existing mental health problems and, in particular, conduct-related disorders, in delinquency and recidivism. Suggested that these may be related to environmental factors that were amenable to intervention (e.g. safety, relationships, connection to school etc.). Suggest that there is a role for special education to help with socialisation and decision making "There is evidence that many students with disabilities, in addition to having difficulties with academic performance, may experience difficulties in social information processing and decision making (Katsiyannis et al., 2012), problems that can also contribute to the youth's involvement in delinquent behaviours."
Barrett, Ju et al. (J) (YJ)	2015	US	To examine the role of mental health history and family dysfunction or disruption on female juvenile delinquency.	Longitudinal.	Delinquent group - female juvenile offenders born 1981-88, who had a juvenile justice referral in South Carolina (n=34,414). Control group - randomly selected from previously created control sample of youth matched on age, gender and ethnicity (n=99,602).	Administrative data: Foster care placement (Y/N), placement in child protection custody (Y/N).	Juvenile justice sample.	Administrative data: Aggressive behaviours (i.e., whether a child had been diagnosed as having disorder of aggression and/or impulse control based on DSM-IV classification)	**Predictors of delinquency among females**: In a logistic regression, female juveniles who had received child protection services were 3.2 times more likely to be delinquent than those who had not been placed in CPS (b=1.171,p < .001). Female juveniles who were placed in foster care were two times more likely to be involved in delinquency(b=.814,p<.001). The strongest predictor of delinquency was a mental health diagnosis related to a disorder of aggression (female youth identified as aggressive were 11 times more likely to be delinquent, b = 2.415, p < .001). Eligibility for free lunch (partially indicated the family's socioeconomic status) also had a significant predictor effect (1.4 times more likely to become delinquent).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Barrett, Katsiyannis et al. (J) (YJ)	2015	US	To examine the role of childhood behavioural and mental health problems in the prediction of adolescent childbearing.	Longitudinal.	Delinquent group - 35,100 females born 1981-88 who had a juvenile justice referral in South Carolina. Control group - 35,100 females matched by age, who did not have records of referrals to the DJJ.	Administrative data: Foster placement (Y/N, age, duration of placement, and number of placements, CPS custody/ guardianship (Y/N, reason for and timing of CPS)	Juvenile justice sample. Information about first, second, and third referrals including age of referral and severity of offense.	Administrative data. Age at first, second, and most recent referrals to mental health services and primary diagnosis at each referral. Classification of child by school system as having a learning disability, emotional/ behavioural disorder or intellectual disability (Y/N)	**Predictors of childbearing:** In a multivariate logistic regression, several factors significantly increased the odds of childbearing, including delinquency (2.8 times increased odds), child protective services involvement (1.61 times increased odds), learning disability (1.18 times increased odds), and DSM diagnoses related to aggression, mood or anxiety disorder, or other (1.56-1.74 times increased odds). Foster care and intellectual disability each significantly reduced the risk of childbearing in the sample.
Bath et al. (J) (YJ)	2020	US	To describe the substance use profiles of youth impacted by commercial sexual exploitation (CSE) and explore associations between substance use, mental health diagnoses and child welfare involvement.	Cross-sectional.	All youth who were served by the STAR Court program for youth experiencing child sexual exploitation (CSE) between Jan 2012- Dec 2016 (n=364) in LA County.	Administrative data: child welfare service history and out-of-home placement profiles.	Juvenile justice sample.	Administrative data. Diagnosis of: depression, sleep disorders, unspecified mood disorders, disruptive behaviour disorders, traumatic stress disorders, attention deficit/ hyperactivity disorder, bipolar disorder, and anxiety.	Youth in the juvenile court who have experienced child sexual exploitation and who use substances are significantly more likely to have experienced child protection involvement, out-of-home care placement, and a greater number of placements, as well as general mood disorder and sleep disorders compared with those who do not use substances. The combination of mood disorder and child welfare placement was observed to lead to a high risk of substance use in this JJ sample.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Bodiford (T) (YJ)	2015	US	To assess whether mental health diagnosis moderates the relationships between delinquency and community poverty and between delinquency and family poverty.	Cross-sectional.	Random selection of juvenile court files from offending that occurred in between 1998-2013 in Alabama (n=254).	Administrative data. Child welfare system interaction – investigation, OOHC placement, physical/ sexual abuse or neglect, parental custody disrupted.	Juvenile justice sample. Amount of general offending, age of first offence,	Administrative data. Documented presence of a mental health (Axis I) diagnosis, excluding Conduct Disorder, Oppositional Defiant Disorder, Intermittent Explosive Disorder and Disruptive Behaviour Disorder, N.O.S.	**Effect of child welfare involvement on offending:** After controlling for family poverty, both child welfare involvement and mental health diagnosis significantly predicted a greater amount of general offending in the sample. It was found that mental health diagnoses did not moderate the relationship between community poverty and amount of general offending after taking into account child welfare system involvement. **Effect of child welfare involvement on age of first offence:** After controlling for family poverty, child welfare involvement predicted a significantly younger age of first offence, but mental health diagnosis did not. It was found that mental health diagnoses did not moderate the relationship between family poverty and age of first offence after taking into account child welfare system involvement.
Campbell et al. (J) (YJ)	2004	Canada	To evaluate the clinical, psychosocial and criminal correlates of psychopathic traits among incarcerated adolescent offenders.	Cross-sectional.	Case record review of 226 adolescents (12–19 years old) in Nova Scotia.	Administrative data. History of foster care.	Juvenile justice sample. Administrative data – criminal history.	Youth self-report. Psychopathy Checklist – Youth Version, Youth Self Report – Internalising and externalising behaviour, Beck Depression Inventory, Depressive Experiences Questionnaire, Aggression Questionnaire.	**Foster care and psychopathy scores** - A history of placement in non-parental living arrangements/ foster care was associated with significantly higher PCL-YV scores, in the sample ($p < 0.05$) and was the only significant psychosocial predictor in the multivariate model ($p < .0001$).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Casiano et al. (J) (YJ)	2016	Canada	To examine demographic and forensic risk factors for self-harm in youth in juvenile detention.	Cross-sectional.	Youth aged 12-18 at offending who were in custody in a Manitoba youth correctional facility between Jan 2005-Dec 2010 (n=5,102).	Administrative data. Child and family services involvement.	Juvenile justice custodial sample.	Administrative data. Case file notes suicide attempts/ self-harm in custody.	**Child welfare involvement and self-harm -** Child welfare involvement was associated with 5.7 times the odds of self-harm/suicide attempt in custody.
Corrado & McCuish (J) (YJ)	2015	Canada	Explore developmental and offending outcome differences between FASD and non-FASD youth.	Cross-sectional.	Canadian FASD (n=58) and non-FASD (n=456) youth 12-19 years incarcerated between 2005-11.	Youth self-reported foster care placement.	Juvenile justice custodial sample. Criminal versatility, times arrested, age of first incarceration.	Youth self-report or administrative file listed diagnosis of FASD, 'Other' behavioural disorders e.g. ADD/ADHD, ODD, and CD.	**FASD in custody -** FASD youth offenders were significantly more likely to have a history of foster care placement (85.7% vs 52.9%, χ 2 (1) = 21.89, $p < .001$, $\Phi = .207$). Youth with FASD and Aboriginal youth were significantly more likely to have been placed in foster care (OR 4.5 and 2.0 respectively) and to have a comorbid behavioural disorder (OR = 3.2 and 0.7 respectively). Having FASD significantly was also associated with other factors such as increased scores on the youth's low self-control scale and earlier initial age of alcohol use. In stepwise OLS regression models, placement in foster care contributed uniquely and significantly to predicting the number of times arrested, and younger age of first incarceration. Once foster care placement and other factors were considered (e.g. self-reported abuse, low self-control), FASD no longer significantly predicted these offending outcomes.
Dimond & Misch (J) (YJ)	2002	UK	To establish the psychiatric morbidity in children remanded to prison custody using an age appropriate instrument.	Cross-sectional.	Cohort of 15- and 16-year-olds successively admitted on remand to the juvenile wing of a youth offending institution (n=19).	Youth self-report -history of being "looked after" in child welfare system.	Juvenile justice (remand) sample.	Youth self report – diagnoses of conduct disorder, major depressive disorder.	**Conduct disorder in remand population -** Youth who were looked after were significantly more likely to have a diagnosis of conduct disorder (87.5 % vs 19.2%, p=.005), major depressive disorder (62.5% vs 9.1%, p = .041).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Finlay (T) (YJ)	2010	Canada	To understand the relationship between importation and deprivation factors and the perception of safety by incarcerated youth in youth justice custodial settings in Canada.	Cross-sectional.	In-depth interviews with youth sentenced to custody at the age of 16-17 years, in secure custody facilities in Canada (n=93).	Youth self-report - involvement in the child welfare system (Y/N), number of out-of-home placements.	Juvenile justice (custodial) sample. Age at first charge, total time in the study site, number of previous youth justice placements, total time in previous youth justice placements.	Self-reported trauma history.	51.1% of the sample had a history of child welfare system involvement, and one-quarter (24.7%) of all youth participants reported current involvement in the child welfare system. forty-two percent (42.4%) of all youth participants had been placed in an out-of-home residential setting by child welfare authorities. **Trauma history impacts on experience of custody** - Crossover youths trauma histories were impacted their experiences of traumatic incidents in custody (e.g. sexual violations perpetrated by staff, lack of staff intervention in assaults perpetrated on them or others). Trauma histories were described by youth as related to their heightened vigilance, reactivity (e.g. “flipping out”), or withdrawal (“keeping it in”) in response such experiences. Child welfare-involved youth also described dissociation in custody (“watching from the outside”). Similar experiences were not described by non-child welfare involved youth living in the same institutions. Crossover youth were more likely to be in Less Safe institutions, being faced with the trauma of actual victimization coupled with the stress of potential victimization.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Garcia et al. (J) (YJ)	2021	US	To 1. Determine whether the MH service provision between two cohorts of JJS-involved youth. 2. Identify whether individual and contextual case characteristics associated with MH service use and dosage of services differ between the two cohorts of JJS-involved youth. 3. Determine if use of MH services among JJS youth influences whether they cross over to child welfare services.	Longitudinal.	Comparative study of two cohorts of youth involved in juvenile justice in 2003 (n=4973) and 2012 (n=2044).	Administrative data. CWS involvement & Placement type.	Juvenile justice samples.	Administrative data. Receipt of any type of MH service within 3 years. Dosage of MH service was also calculated for both cohorts as a total of the number of months each child received any MH services during the 3-year study tracking period.	**Receipt of MH services -** Youth who crossed over into the CWS during the study period, including those who experienced out-of-home placement ($B = 1.20$, $p < 0.001$) or remained at home ($B = 0.63$, $p < 0.001$), were more likely to receive MH services compared to JJS-only youth. The number of placement moves was positively associated with receipt of MH services ($B = 0.35$, $p < 0.001$). **Dosage of MH services -** Length of time receiving CWS services ($B = 0.02$, $p < 0.001$) was associated with increased rates of MH service use, while crossover experience was associated with decreased dosage if youth remained at home. **Predicting crossover experience by MH service receipt -** Receipt of MH services in the 1st year of the study period was positively associated with the odds of CWS involvement in the 2nd or 3rd year of the study period ($B = 0.47$, $p < 0.001$), controlling for age ($B = -0.50$, $p < 0.001$), gender ($B = 0.73$, $p < 0.001$), race/ethnicity (non-significant), and cohorts (non-significant).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Giallella (T) (YJ)	2015	US	To identify and compare the mental health and substance use characteristics of crossover youth and of delinquent-only youth.	Cross-sectional.	Youth committed to New Jersey's Juvenile Justice Commission during 2011-12 (N=419). Youth were classified as crossover youth (n = 206, 49.2%) if they had ever been involved with the child welfare system in NJ. 37 (8.8%) youth had open cases, 169 (40.3%) had closed cases, and 213 (50.8%) had no history with the child welfare system.	Administrative data. Any New Jersey child welfare system involvement (Y/N), current open case (Y/N).	Juvenile justice sample.	Youth self-report (administrative data). MAYSI-2 mental health screening instrument (7 domains). Substance use risk, feelings of anger and frustration (i.e., Angry-Irritable), depressive and anxiety symptoms, physical symptoms (i.e., Somatic Complaints), suicide risk/ ideation), psychotic and derealisation symptoms and lifetime trauma experiences.	**Mental health by crossover status** - Crossover youth and delinquent-only youth did not statistically differ in the MAYSI-2 scales,. Crossover youth with open cases demonstrated significantly higher levels of suicidal ideation and thought disturbance than did youth with closed cases or with no history of child welfare system involvement. Controlling for gender and race, dichotomous classification as crossover or delinquent-only youth was not significantly related to a score in the clinical range on any MAYSI-2 scale. An open case with child welfare was significantly associated with the likelihood of scoring in the Warning range on the Depressed-Anxious scale when compared to no history with child welfare. An open case and a closed case with child welfare was significantly related to the likelihood of scoring in the Warning range of the Suicidal Ideation scale. An open case with child welfare was significantly associated with the likelihood of scoring in the Warning range on the Thought Disturbance scale among boys. There was a significant interaction between child welfare involvement and traumatic experiences on the Suicidal Ideation and Thought Disturbance scales. Youth with open DYFS cases and high traumatic experiences scores reported the highest levels of suicidal ideation and thought disturbance on the MAYSI-2. **Effects of number of placements** - number of out-of-home placements did not significantly mediate the relationship between child welfare involvement (i.e., open case, closed case, no history) and any MASYI-2 scale score.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Go-re-Felton et al. (J) (YJ)	2001	US	To examine the relationships of sexual, physical and emotional abuse to emotional (internalizing) and behavioural (externalizing) problems among incarcerated girls and boys.	Cross-sectional.	Youth remanded to the correctional facilities within a statewide juvenile correctional system in a southern state in the US.	Administrative data. Lifetime experience of sexual abuse, physical abuse and emotional abuse.	Juvenile justice sample.	Youth Self-Report. Internalizing & externalizing scales.	**Abuse and internalizing problems** - Emotional abuse was significantly and positively related to YSR internalizing scores. **Abuse and externalizing problems** - Youths with physical or sexual abuse history reported significantly greater externalizing problems compared to youths without a history of reported physical or sexual abuse.
Hodgdon (T) (YJ)	2009	US	To examine: 1. The relationship between maltreatment and aggression in adolescence. 2. The impact of mediational factors (emotional regulation, moral disengagement, and emotional callousness) on the maltreatment-aggression relationship.	Longitudinal.	Adjudicated adolescents in Philadelphia aged 14-17 years at the time of their committing offense (n=1,354).	Administrative data. All allegation narratives of child abuse and/or neglect, date report was made to DHS, source of report, outcome of investigation (including whether report was substantiated or unsubstantiated and classification of the maltreatment), dates of DHS involvement with the family, and services recommended.	Juvenile justice sample. Youth self-report – Aggressive Offending Variety score.	Youth self-report. Children's Emotion Regulation scale, impulse control sub-scale of the Weinberger Adjustment Inventory, Callous-Unemotional dimension of the Youth Psychopathic Traits Inventory.	**Maltreatment and IQ** - Maltreated youth in the study were younger and had lower IQ scores. **Maltreatment and aggression** - Maltreated youth reported significantly higher average variety of aggression than the non-maltreated youth. When examining individual maltreatment types, only youth with a history of physical abuse or emotional maltreatment had significantly higher average variety of aggression scores. In addition there was a significant interaction between physical abuse and emotional maltreatment. Additionally, individuals with either a history of emotional abuse or emotional and physical abuse had significantly higher average variety of aggression than individuals who were either not maltreated or only physically abused.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Predicting aggression using maltreatment severity- A linear regression examining the impact of the five confounding factors and average maltreatment severity on average variety of aggression was significant ($F(6, 441)= 7.19$, $p < .01$), accounting for 9% of the variance in aggression. SES, proportion of time spent in a facility, and maltreatment severity were all significantly predictive of aggression among youth in this sample. When individual maltreatment types were examined, only emotional abuse severity predicted aggression. **Predicting aggression using maltreatment frequency** – A regression model, including gender, age, IQ, SES, average proportion of time in a facility, and maltreatment frequency was significant ($F(6, 441)= 6.53$, $p < .001$), accounting for 8% of the variance in youths' aggression. SES, proportion of time spent in a facility, and maltreatment frequency were all significantly predictive of aggression among youth in this sample. When individual maltreatment types were examined, only emotional abuse frequency predicted aggression.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Predicting aggression using maltreatment severity and frequency – A linear regression model, including gender, age, IQ, SES, average proportion of time in a facility and maltreatment severity x frequency score was significant ($F(6, 441)= 6.46$, $p < .05$), accounting for 8% of the variance in youth's aggression. SES, proportion of time spent in a facility, and maltreatment severity x frequency score were all significantly predictive of aggression among youth in this sample. When individual maltreatment types were examined, only emotional abuse severity x frequency predicted aggression **Impact of maltreatment on emotional regulation, impulse control, and callous-unemotional traits** - there were no significant differences between maltreated and non-maltreated participants on emotion regulation, impulse impulse control, or callous-unemotional traits. However when individual maltreatment types were examined, there was a near-significant trend indicating that sexually abused youth reported lower levels of emotion regulation ($M = 2.66$, $SD = 0.12$) than non-sexually abused youth ($M = 2.89$, $SD = 0.04$; $F(1,428) = 3.72$, $p = .05$). Further mediation models suggested that moral disengagement partially mediated the impact of emotional abuse on aggression, while impulse control fully mediated the impact of physical abuse on aggression.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Johansson et al. (J) (YJ)	2009	US	To assess the independent effect of certain risk factors on girls' and boys' involvement in serious, violent, and chronic offending.	Cross-sectional.	Youth referred to a metropolitan juvenile court in Texas and tracked from 1997 to 2003 (n=10,405).	Administrative data. Any indication of child abuse or child welfare involvement (Y/N).	Juvenile justice sample. Juvenile justice involvement – secure detention from 1997-2001; offence type(s) including if violent; chronic offending = 5+ court referrals in study period; prior dispositions.	Youth self-report via MAYSI-2 instrument.	**Effect of risk factors on serious or violent offending –** Among males and females, experiences of maltreatment appeared protective against serious and violent offending, while for males, mental health problems increased the risk of serious and violent offending by 22% (no impact for females). **Effect of risk factors on chronic offending (no serious or violent)** – Maltreatment had no impact on chronic-only offending for either males or females, however mental health problems increased the risk for both groups. Having mental health problems increased the odds of chronic offending, as compared to occasional offending, with 67% for females and 72% for males, holding other variables constant. **Effect of risk factors on chronic and serious/violent offending** - For females and males, mental health problems increased the risk of serious, violent, and chronic offending, as compared to less frequent nonserious offending. Abuse and maltreatment was not statistically significant. For mental health problems, the odds of serious, violent, and chronic offending were 2.2 times higher for females and 2.0 times higher for males.
Krischer et al. (J) (YJ)	2008	Germany	To examine the relationship between early emotional, physical or sexual trauma and neglect and psychopathy in incarcerated delinquent female and male juveniles.	Cross-sectional.	Cases - detained delinquent juveniles (96 boys and 89 girls) 14-19 years who were incarcerated in two German jails in the Cologne-Bonn area (n=185). Controls - school juveniles of 15 to 17 years of age (n=98).	Number of stays in foster care.	Juvenile justice (custodial) sample.	The Psychopathy Checklist—Youth Version (PCR-YV)	**Foster care and psychopathy** - For justice-involved girls, the number of foster homes and emotional neglect were associated with various dimensions of psychopathy scores. For justice-involved boys, traumatisation (particularly physical abuse) was a more important predictor of psychopathy scores, along with parental drug abuse.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Mallett (J) (YJ)	2009	US	To identify disabilities and corresponding court supervision, detention, and incarceration outcomes for a 48-month period for a sample of probation-supervised youth.	Longitudinal.	All probation-supervised youth in Cuyahoga County Ohio from 2003-06 (n=397).	Administrative data. Child welfare involvement.	Juvenile justice (probation) sample.	Administrative data. Special Education/ Developmental Disabilities including categories of severely behaviourally handicapped, learning disabled, severely emotionally disturbed, and developmentally handicapped; mental health disorders.	**Crossover status and probation completion -** Youth involved in all four systems (JJ, MH/AOD, special education & child welfare), comprised 9.4% of the full sample and 7.3% of those who were incarcerated. This group were least likely to successfully complete probation (21%) compared with youth involved in 3 (27.7%), 2 (34.4%) or solely juvenile justice systems (63.7%).
Mallett et al. (J) (YJ)	2009	US	To test for associations between specified mental disorders or maltreatment and later delinquency adjudication.	Cross-sectional.	Random sample of youth before juvenile courts in two Northeast Ohio counties (n=555) over 4-years (2003-06).	Administrative data. Child welfare intake, assessments, and child investigation findings.	Juvenile justice (court) sample.	Administrative data. Diagnosed with ADHD or mood disorder.	**Predicting adjudication of delinquency** – both mood disorder and number of maltreatment types significantly predicted adjudication of delinquency (as opposed to youth who remained under probation supervision only). Prior diagnosis of any kind of depression was associated with six times the likelihood of subsequent delinquency adjudication. Number of maltreatment types appeared protective, with youths adjudicated delinquent being three times less likely to have experienced any one form of abuse, and six times less likely to have experienced any two kinds of abuse. Diagnosis of ADHD in the cohort was not significantly associated with being adjudicated delinquent in the model.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Mallett (J) (YJ)	2011	US	To explicate factors which predict detention length among youth adjudicated delinquent.	Longitudinal.	Random sample of youth adjudicated delinquent from 2006-08 from one large, urban Midwestern county in the United States (N=342).	Administrative data. Child welfare involvement and maltreatment type(s).	Juvenile justice sample.	Administrative data. 'Emotional and behavioural issues' - diagnosis of oppositional defiant personality disorder, attention deficit hyperactivity disorder, bipolar disorder, or conduct disorder.	**Predictors of detention length –** Youth with histories of child welfare involvement, neglect or physical abuse, mental health disorders, and court dispositions for mental health, had significantly longer periods of detention. Other factors predicting longer stays in detention were sociodemographic (African American race) or legal (violation of court order, personal crime offense).
Mallett (J) (YJ)	2012	US	To examine correlates of suicidal thoughts and behaviours in youth who have been adjudicated delinquent.	Cross-sectional.	All youth under juvenile court supervision over a distinct period of time in two counties within a U.S. Midwestern state (n=433).	Administrative data. Child welfare involvement and substantiated maltreatment.	Juvenile justice sample.	Administrative data. Any mental health diagnosis, diagnosis of ADHD, conduct disorder, oppositional defiant disorder, bipolar disorder, depression, adjustment disorder, posttraumatic stress disorder (PTSD), anxiety disorder, alcohol dependence, and substance use disorders; Any MH service use prior to JJ involvement (any, psychiatric hospitalization, psychiatric medication); Any prior suicide attempt.	**Prior suicide attempts** - Among youth adjudicated delinquent, a history of child welfare involvement was associated with increased odds of prior suicide attempts (2.2-2.7 X depending on controls for poverty, any mental health diagnosis etc.).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Malvaso, Delfabbro, Day & Nobes (J) (YJ)	2019	Australia	To ascertain differences in family background, individual, & social characteristics of young people in youth justice detention by child protection history.	Cross-sectional.	Young people (10-18 years) in South Australian youth justice secure custody / detention from 1995-2012 (n=2045).	Administrative data: all CP notifications and substantiations for abuse and neglect & details of any OOHC placement. Excluded those who had not reached 18th birthday by date of data extraction.	Juvenile justice (custodial) sample. Administrative data: Conviction type, age at first conviction, number of different types of convictions.	Youth self-report. Secure Care Psychological Screening Assessment (SECAPS). Intellectual ability, reading difficulties, mental health problems (depressive mood, suicidal ideation, suicide attempt).	**CP history and disability -** Detained youth with no CP history were less likely to score below the borderline ranges for possible intellectual disability and to have reading difficulties. Children with CP reports plus placements were more likely to score below the borderline ranges (this only approached significance, p = .02). Furthermore, these individuals were more likely to have difficulties reading. **CP history and mental health -** Detained youth with No CP history scored lower on the chronic depression and hopelessness measures and were less likely to report suicidal ideations or attempts. Those in the CP reports plus Placement group scored higher on the depression and hopelessness measures and were more likely to report suicide ideations and attempts.
McFarlane (J) (YJ)	2018	Australia	To investigate the relationship between the child welfare and justice systems among a cohort of court-involved children.	Cross-sectional.	Representative sample children who appeared before the criminal jurisdiction of a primary Children's Court in NSW, between 2008-10 (n=160).	Administrative data. Any OOHC placement.	Juvenile justice (court) sample.	Administrative data. Mental health impairment, intellectual and cognitive impairment, case dismissed under MH Act, suicide and self-harm.	**OOHC history and mental health/ disability -** Compared with other children before the Court, those with an OOHC history were more likely to have mental health impairments (48% vs 22%), intellectual/cognitive impairments (16% vs 4%), a history of suicide/self-harm (18% vs 5%), and to have their case dismissed under the MH Act (20% vs 6%).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Modrowski (T) (YJ)	2021	US	To examine the roles of attachment- and nonattachment-related trauma, emotion dysregulation, PTRS, and other PTSS in predicting offending behaviour	Cross-sectional.	Youth aged 12-19 years who were involved in the juvenile justice system in Utah in 2013-17.	Administrative data. Child welfare system involvement.	Juvenile justice sample.	Youth self-report. Trauma exposure and posttraumatic stress symptoms (PTSS), post-traumatic risk seeking (PTRS), emotional dysregulation.	**Mental health differences by crossover status** – Crossover youth evidenced greater levels of attachment-related trauma relative to JJ only youth. **Mental health factors and self-reported offending -** For crossover youth, there was only a significant relation between attachment-related trauma exposure and self-reported offending; on the other hand, for JJ-only youth, there was only a significant association between nonattachment-related trauma and self-reported offending. **Mental health and recidivism -** There was a significant association between PTRS and the number of recidivism charges for crossover youth, and PTRS appears to be a risk factor for continued involvement in the JJ system.
Moore, Gaskin & Indig (J) (YJ)	2013	Australia	To explore trauma and PTSD among incarcerated young offenders.	Cross-sectional.	Youth in custody in one of eight juvenile justice custodial facilities in NSW, Australia between Aug-Oct 2009 who participated in the YPiCHS survey and who had a diagnosis of PTSD (N=291).	Self-report data. Childhood trauma questionnaire (25 items): physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. Placed in care < 16 years old.	Juvenile justice (custodial) sample.	Youth self-report. Psychiatric disorders-Kiddie Schedule for affective Disorders for Children–Present and Lifetime Version. Intellectual functioning – Wechsler Adult Intelligence Scale.	**Correlates of PTSD –** While experiences of childhood maltreatment (sexual abuse, physical abuse or neglect, emotional abuse or neglect and severe multi-type maltreatment) were associated with as diagnoses of PTSD in the sample, being placed in OOHC prior to age 16 years was not.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Pasko & Mayeda (J) (YJ)	2011	US	To examine Native Hawaiian and other Pacific Islander (NHOPI's) backgrounds and pathways to delinquency and youth corrections, ascertaining gender differences in such pathways, and analysing factors impacting incarceration.	Cross-sectional.	Case file analysis of random sample of NHOPI children drawn from the Hawai'i state tracking system database of juvenile probationers in 2003–04 (n=150).	Case file data. Any record of sexual abuse (including self-report), CPS record of physical abuse, CPS record of neglect, foster care placement.	Juvenile justice (probation) sample.	Case file data. Psychological assessments.	**Risk of commitment (incarceration) –** In a multivariate model which controlled for child protective services record of abuse or neglect (significant), suicidal ideation/depression did not predict commitment in the sample.
Ruffolo & Savas (J) (YJ)	2003	US	To examine characteristics of young males identified with mental health problems and differences between young people identified with mental health problems and the general population in an adjudicated juvenile justice residential centre.	Cross-sectional.	Case file review of young males in juvenile justice residential placements during 1997 in Michigan and Ohio (n=381) + survey of second sample of young males (n=458) in juvenile justice residential placement in October 2000.	Administrative data. Foster care history.	Juvenile justice (residential care centre) sample.	Administrative data. Identification of mental health problems at intake.	**Foster care and mental health -** More young persons identified with mental health problems had been in foster home placements prior to juvenile justice placement when compared to those not identified with mental health problems (14% vs 5%, p = .01).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Ryan et al. (J) (YJ)	2013	US	To determine whether neglect is associated with recidivism for moderate and high risk juvenile offenders.	Cross-sectional.	All moderate and high risk juvenile offenders screened by juvenile probation in Washington State between 2004-07 (n=19,833).	Administrative data. Child welfare neglect history.	Juvenile justice (moderate-high risk) sample.	Administrative data. Mental health diagnosis.	**Crossover status and mental health** – Dually involved youth (concurrently involved in both systems - 33%) were more likely to have a mental health diagnosis than crossover youth (ever involved in both systems – 27%), and youth only involved in the juvenile justice system (20%). **Crossover status and impulsivity –** Dually involved youth (60%) were more likely to exhibit impulsivity than crossover youth (54%) or juvenile justice only youth (43%). **Recidivism -** After controlling for neglect and crossover status, and a range of other child and family variables, mental health problems did not predict recidivism in the sample, however impulsivity did.
Smith (J) (YJ)	2019	US	To investigate the narratives of female juvenile offenders to assess the utility of Khantzian's self-medication theory in this population.	Exploratory.	Convenience sample of female juvenile offenders in Utah's Division of Juvenile Justice System from 2002–03 (n=30).	Youth self-report – foster care history.	Juvenile justice (secure care & residential) sample	Youth self-report – experiences of childhood trauma.	**Youth narratives support self-medication hypothesis** – 93.3% of the female JJ sample had child welfare system involvement. Female narratives support hypothesis of self-medication of childhood trauma, including experiences of abandonment and instability in placement in foster care. Use of substances for self-medication escalating to addiction and justice system involvement.
Snow & Powell (J) (YJ)	2011	Australia	To describe the nature and extent of oral language impairment in an incarcerated sample of young male offenders & its relationship to offending.	Cross-sectional.	Consecutive sample of male offenders aged 17–21 years completing custodial sentences at a youth detention centre in Victoria, Australia (n=100).	Youth self-report – OOHC placement.	Juvenile justice (custodial) sample.	Youth self-report – Test of Language Competence, Depression, Anxiety & Stress Scale, Kaufman Brief Intelligence Test, lifetime diagnosis of ADHD, traumatic brain injury, psychotic illness & hearing impairment.	**Language impairment and OOHC –** Youth with OOHC placements were more likely to be language impaired (62% vs 42%).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Tidefors & Strand (J) (YJ)	2012	Sweden	To understand how adolescents with ADHD who had sexually offended described their childhood experiences and spoke about their diagnostic symptoms.	Exploratory.	Adolescent males aged 14-17 who had committed sexual offences and been diagnosed with ADHD (n=11).	Youth self-report – foster care experience.	Juvenile justice sample.	Administrative data. ADHD diagnosis.	**Early relations** - characterised by neglect, abandonment & betrayal. **Foster care** - Several boys had been placed in foster homes at an early age; made life seem unpredictable; described further abuse in care & further abandonment by foster carers. **Symptoms** – Difficulties sitting still, concentrating, restlessness, impulsiveness, fights with peers. Viewed as manifestations of ADHD or consequences of being reared in chaotic environments with maltreatment and abuse. Resulted in difficulties at school & negative associations with school. **Strategies to manage symptoms** – Use other students to calm themselves down, breaking things, offending, exploding, using anger to express sadness & frustration.
Wylie & Rufino (J) (YJ)	2018	US	To examine reoffending for youth with reported experiences of victimization, as well as mental health symptoms at the time of diversion intake.	Cross-sectional.	Justice-involved juveniles referred for diversion in a large Midwestern city (n=2792).	Administrative data. Abuse/ neglect victimisation.	Juvenile justice (diversion) sample.	Youth self-report/ administrative data. The DISC Predictive Scales – assessed likelihood of mental health conditions.	**Predictors of time to recidivism** – in a multivariate model, experiences of abuse/neglect predicted shorter time to recidivism, while measures of mental health did not. Other predictors of shorter time to recidivism included male gender, non-white race, higher recidivism risk scores, person or property crime victimisation, and substance use symptoms.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Baidawi (J) (CO)	2020	Australia	To examine the nature and context of crossover children's initial police charges.	Cross-sectional.	Criminal court-involved crossover sample aged 10-17 years at offending with current/ historical statutory child protection involvement (n=300).	Administrative data. Statutory child protection system involvement (Order type, OOHC placement (Y/N)).	Administrative data. Age at first police charge, charge type, timing of first charge relative to any OOHC placement.	Administrative data. Case file indicated diagnoses of mental health diagnoses, intellectual disability, borderline intellectual functioning, learning/ communication disorder, attention deficit hyperactivity disorder, autism spectrum disorder, conduct disorder, foetal alcohol spectrum disorder or Tourette's Syndrome.	**Entry to residential care -** Breakdown in living arrangements with parents or kinship carers often precipitated relinquishment and entry to residential care. Breakdown was often observed to arise in the context of caregivers being unable or unwilling to manage the child's behaviour, mental health, or neurodisability needs. Some caregivers refused to collect children due for discharge from hospital settings, or who had presented to police stations seeking help. Children were often transient, moving between family, care placements, friends, and partners, or to homelessness during this period; school exclusion and failed family reunifications were also common. Oftentimes parents were also struggling with their own needs at these times, particularly mental health and substance abuse difficulties. **Initial police charges in residential care -** Placement around the time of initial offending was often to residential care, after which many children's initial charges were acquired (particularly children with complex trauma and neurodisability), commonly assault and property damage in the placement environment, or co-offending with other residential care-placed children outside these settings.

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									Age of initial police charges - Compared to crossover children first charged after 14 years of age, those charged by police before 14 years were more likely to be Indigenous (37.9% vs 17.5%, p< .01) and to have a neurodisability (57.8% vs 41.1%,p< .01).). Earlier first police charges were also associated with children's cumulative number of challenges, including: intellectual disability, other neurodisability, mental health diagnoses, self-harm or suicidality, substance misuse, sexual exploitation risk, and challenging, absconding or sexualised behaviour **Gender differences in neurodisability** - Males were more likely to have a neurodisability diagnosis compared to females (58.9% vs25.3%,p< .001) **Initial charges by neurodisability status** - Crossover children with neurodisability were less likely to be initially charged with offending against the person (29.1% vs 44.1%,p< .05), and more likely to be charged with property offences (44.8% vs 32.4%,p< .05). However, by the time of first adjudication, there were no differences in the most serious charge seen among crossover children with and without neurodisability. **Placement of at initial offending by neurodisability status** – Compared with other crossover children, crossover children with neuro-disability were more likely to be in out-of-home care (36.1% vs 24.5%,p< .05), and to have a history of care placements (61.7% vs 49.3%, p< .05).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Baidawi & Piquero (J) (CO)	2021	Australia	To examine differences in childhood adversity, child protection involvement, and offending among crossover children by neurodisability status.	Cross-sectional.	Criminal court-involved crossover sample aged 10-17 years at offending with current/ historical statutory child protection involvement (n=300).	Administrative data: Statutory child protection system involvement (Order type, OOHC placement (Y/N)), neurodisability status (Y/N) and type, mental illness status (Y/N) and type, adverse childhood experiences (ACE) (individual prevalence and cumulative number).	Juvenile justice (court) sample.	Administrative data: **Neurodisability** - Case file indicated diagnoses of intellectual disability, borderline intellectual functioning, learning or communication disorder, attention deficit/ hyperactivity disorder, autism spectrum disorder, Tourette syndrome, foetal alcohol spectrum disorder, organic acquired memory disorder, acquired brain injury, or epilepsy. **Mental illness** – case file indicated a formal diagnosis of mood, conduct, personality, trauma and attachment-related, psychotic, and other mental illness.	**Prevalence and types of neurodisability** – Nearly one-half (48.0%, n=134) of crossover children had a recorded neurodisability, most commonly ADHD (29.0%), learning and communication disorders (22.6%) and intellectual disability (17.2%). Where data were available, for 34/38 children (89%) intellectual disability was classified as mild, while the remaining 11% were classified as moderate. Of crossover children with neurodisability, similar to the general population, 55% (n=74) had more than one diagnosis (2-5 unique neurodisabilities). **Underdiagnosis** - The prevalence of neurodisability and mental health in the sample are likely to be underestimates due to the lack of assessment of many children, including some suspected of having a neurodisability. Casefile information demonstrated several assessment barriers including a lack of service availability, transience and instability in children's lives, and some children's refusal of assessment. **Gender differences in neurodisability** - Neurodisability was significantly more prevalent among male compared to female crossover children (58.9% vs. 25.3%, $p < 0.0001$), and crossover children with neurodisability were significantly younger on average (16.0 vs.16.4 years, $p = 0.021$). **Comorbidity with mental illness -** Crossover children with neurodisability were significantly more likely to have a mental health diagnosis compared with crossover children without neurodisability (72.4% vs. 50.3%, p=0.0002). Crossover children with neurodisability were more likely to have been diagnosed with conduct disorder (34.3%vs. 7.6%, $p < 0.0001$), and trauma and attachment-related disorders (posttraumatic stress disorder and reactive attachment disorder) (29.9% vs. 11.0%,$p< 0.0001$), they were less likely to be diagnosed with personality disorder(0.7% vs. 6.2%,p=0.02) compared with other crossover children. No differences were observed in relation to mood disorders or psychotic disorders by neurodisability status

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									Neurodisability and adverse childhood experiences (ACE) – crossover children with any neurodisability had a greater average number of ACEs compared with crossover children without any neurodisability (m=5.9 vs. 5.2, p=0.01). Differences between diagnoses were evident. Crossover children with intellectual disability and learning/communication disorders displaying significantly higher average ACE scores compared to crossover children without these diagnoses, however children with ADHD did not display higher ACE scores than crossover children without that diagnosis. Females with neuro-disability had significantly higher ACE scores compared to males with neurodisability (6.7 vs. 5.7, p=0.04). While females with any neurodisability had significantly higher ACE scores than females without neurodisability (p=0.01), the difference in ACE scores for males with and without neurodisability was not quite significant (p=0.07). Males and females diagnosed with each of intellectual disability and learning/ communication disorders displayed higher ACE scores than males and females, respectively, without each of these diagnoses. However, similar disparities were not observed among crossover children with and without ADHD.

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									Crossover children with any neurodisability were more likely to have been exposed to household substance abuse and mental illness. Family violence, household substance abuse, and household mental illness were higher among crossover children with learning/ communication disorders and intellectual disability, compared with children without these diagnoses. Crossover children with ADD/ADHD were also significantly more likely to have a household member affected by mental illness, though they were less likely to have experienced parental death. On the other hand, crossover children with any neurodisability were no more likely to have been exposed to any single form of maltreatment (physical, emotional/psychological, and sexual abuse, or neglect) than other crossover children, though these figures do not account for maltreatment severity, recurrence or chronicity. **Neurodisability and child protection involvement -** crossover children with neurodisability were, on average, notified to protective services and substantiated in relation to risk of harm more than two years earlier than crossover children without neurodisability (4.3 vs 6.8 years). Crossover children with neurodisability had more protective notifications (particularly children with intellectual disability), and more placement in residential care. Crossover children with an ADHD diagnosis were significantly more likely to have experienced relinquishment by caregivers, including parents, kinship caregivers, or foster carers, often resulting in their entry to residential care environments. A greater likelihood of experiencing relinquishment also approached significance for children with learning/ communication disorder (p=0.06).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Neurodisability and police charges - younger onset of offending characterised crossover children with neurodisability compared to those without neurodisability, as well as a greater number of total charges at the time of their court matter. No differences were observed in the prevalence of violent offending (after controlling for age) for children with any neurodisability, however crossover children with ADHD diagnoses were 2.6 times more likely have charges related to violent offending compared to other crossover children. Crossover children with any neurodisability were more than twice as likely to have charges of criminal damage and motor vehicle thefts, and to have evidence in their casefiles of engagement in adolescent family violence, and to have received residential care placement-related charges. Neurodisability and residential care-based charges - The odds of acquiring charges relating to residential care placement were significantly higher for children with ADHD and intellectual disability, but not for those with learning/ communication disorder, though this approached significance (p = .06). Increased risk of residential care-based charges for children with intellectual disability was not significant after controlling for placement in residential care. Conversely, the increased risk of acquiring residential care-based charges for children with ADD/ADHD diagnoses persisted after controlling for placement in residential care (OR=2.108, 95% CI [1.029,4.321],p=0.042). This indicates that crossover children with ADD/ADHD are more likely to acquire residential care-based charges compared with other crossover children placed in these care settings. Conversely, children with learning/communication disorders or intellectual disability faced elevated risk of acquiring these charges due to their greater propensity to be placed in residential care relative to other crossover children

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Baidawi & Sheehan (J) (CO)	2020	Australia	To identify the contexts in which crossover children offend and factors associated with children being charged in each context.	Cross-sectional.	Criminal court-involved crossover sample aged 10-17 years at offending with current/historical statutory child protection involvement (N=300).	Administrative data: Statutory child protection system involvement (Order type, OOHC placement (Y/N)), neurodisability status (Y/N) and type, mental illness status (Y/N) and type, adverse childhood experiences (ACE) (individual prevalence and cumulative number).	Juvenile justice (court) sample. **Key offending contexts** - categorised through the repeated observation of social and environmental milieu in which children were charged with crime, currently or historically. Relied on specific charges (e.g. adolescent family violence) and qualitative data from e.g. police briefs or youth justice reports.	Administrative data: **Neurodisability** - Case file indicated diagnoses of intellectual disability, borderline intellectual functioning, learning/ communication disorder, attention deficit/ hyperactivity disorder, autism spectrum disorder, Tourette syndrome, foetal alcohol spectrum disorder, organic acquired memory disorder, acquired brain injury, or epilepsy. **Mental illness** – case file indicated a formal diagnosis of mood, conduct, personality, trauma and attachment-related, psychotic, and other mental illness.	**Adolescent family violence (AFV)** – Neurodevelopmental, mental and behavioural health disorders were more prevalently diagnosed amongst those children displaying AFV (40–53 per cent of children with AFV incidents). This includes diagnoses of any neurodisability, ADHD, neurodisability excluding intellectual disability, any mental health disorder as well as specific diagnoses of trauma/ attachment related disorders (e.g. reactive attachment disorder, C/PTSD), and behaviour disorder (e.g. conduct disorder). **Residential care-based charges** - Children's history of challenging behaviours, mental health concerns and specific diagnoses of 'emerging' personality disorder, trauma/ attachment-related disorders or behavioural disorders were each significantly correlated with having residential care-based charges. Children with an intellectual disability were no more likely to receive residential care-based charges compared with other children in residential care. However, children with intellectual disabilities were over-represented amongst children placed in residential care, and overall were twice as likely to have received residential care-based charges compared to other children sampled (31.3 per cent versus 15.6 per cent, $p = 0.014$). **Motor vehicle theft charges** – Significant correlates of motor vehicle theft charges included any neurodisability ($p = 0.012$), and specific diagnoses of intellectual disability or borderline intellectual functioning ($p = 0.013$).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Baidawi & Sheehan (R) (CO)	2019	Australia	To understand the extent to which children and young people before the Criminal Division of the Children's Court of Victoria are also clients of the child protection system; To identify factors that distinguish children and young people who 'cross-over' between the child protection and youth justice systems; To understand the factors that contribute to the entry of those children and young people into the criminal justice system; to identify factors that keep crossover children and young people entrenched in these systems.	Mixed methods. Cross-sectional case file analysis & key stakeholder consultations.	Criminal court-involved crossover sample: aged 10-17 years at offending with current/historical statutory child protection involvement (N=300). Professionals sample: 25 interviews and focus groups with 82 key stakeholders including the Magistracy, child protection and youth justice professionals, lawyers, police officers and police prosecutors, child and family welfare professionals, specialist child and family welfare mental health clinicians, and alternative education specialists.	Administrative data: Statutory child protection system involvement (Order type, OOHC placement (Y/N)), adverse childhood experiences (ACE) (individual prevalence and cumulative number).	Juvenile justice (court) sample.	Administrative data: **Neurodisability** - Case file indicated diagnoses of intellectual disability, borderline intellectual functioning, learning/ communication disorder, attention deficit/ hyperactivity disorder, autism spectrum disorder, Tourette syndrome, foetal alcohol spectrum disorder, organic acquired memory disorder, acquired brain injury, or epilepsy. **Mental illness** – case file indicated a formal diagnosis of mood, conduct, personality, trauma and attachment-related, psychotic, and other mental illness.	**Case file data findings** **Disability and school exclusion** - Transience and school exclusion in primary and secondary school often in the context of children's emotional and behavioural regulation challenges. Challenges regulating behaviour and emotion in school settings were seen for one half of children, sometimes commencing from primary or preschool. • At least 36% of children had experienced school exclusion (suspensions and expulsions); • School exclusion typically emerged in high school (e.g. 13-15 years); for 7.7% of crossover children exclusion commenced in primary school; • Males were more likely be excluded from school than females (44.9% vs 16.7%) there was no difference in the proportion of Indigenous (32.7%) and non-Indigenous (40.4%) children in terms of file evidence of school exclusion; • There was no significant difference in school exclusion between children with (43.8%) and without (35.3%) intellectual disability, or those with borderline intellectual functioning (47.4%); • Children with learning and communication disorders (54%), ADHD (56%), trauma/ attachment-related disorders (51%) and behavioural disorders (62%) were more likely to experience school exclusion; • Children with a mental health diagnosis (45.6%) were more likely to experience school exclusion compared to those without a mental health diagnosis (24.5%).

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									Incidents leading to school exclusion - Poor attendance (e.g. late attendance or truancy); not completing schoolwork, oppositional behaviour towards staff, disruptive behaviour (e.g. interrupting or walking out of class), sexually inappropriate or aggressive behaviours (e.g. threatening, assaulting or attempting to harm staff or students,); and other dangerous, destructive or illegal behaviour at school (e.g. using substances at school, bringing weapons to school, theft or destruction property). **Escalation in school behavioural and emotional regulation challenges -** often coincided with adverse social and relational difficulties including: escalating family violence at home; parental separation; placement changes, particularly transitions into and out of OOHC; fractured child-parent relationship, including parental rejection or relinquishment; parent/ parent figure death (expulsions often occurred soon after parental death); current sexual abuse or assault; and, disclosure of abuse (e.g. sexual abuse), particularly where disclosure was disbelieved or otherwise not responded to helpfully (i.e. secondary trauma). **Difficulties re-enrolling -** Secondary structural form of school exclusion occurred for some children who faced difficulties in reenrolment after school exclusion or disengagement. Barriers to school enrolment were often, but not always related to disability, e.g.: • Wrong time of year for new enrolments; classes full; school lacking appropriate program; child lacking birth certificates or other evidence required to enrol the child (e.g. current address); schools unable to adhere to safety requirements for child; schools unable to subsidise level of support (e.g. classroom aides) required for child; child too young for available alternative education options; and, schools refusing to enrol child due to child's educational history or criminal charges.

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									School supports and alternative and special education – Disability-related challenges affected children's schooling, e.g. developmental delay, language disorder, intellectual disability, mental health problems including attachment disorders, complex post-traumatic stress disorder, ADHD and autism; many children linked to non-mainstream educational options and provided with other educational supports: 12% of children had classroom aide, or funding for education-related behavioural support; 56% engaged in alternative education (e.g. alternative schools, home schooling, one-to-one tutoring, specialist disability schools, and education delivered in youth justice custody); 18% engaged in specialist educational programs for children in OOHC. **Prevalence of neurodisability -** 48% of crossover children had a neurodisability diagnosis and more than 25% had two or more neurodisability diagnoses. No significant differences were observed by Indigeneity; males were more likely to have diagnosed neurodisability than females (59% vs 25%). Gender differences were statistically significant for all conditions, with the exception of intellectual disability and 'other' disorders. In addition: 29% of children received an ADHD diagnosis; 22.6% had specific learning difficulties and communication disorders; 17.2% had diagnosed intellectual disability, and data on severity were available in 81% of cases (38/47 children); for 89%, ID was classified as mild, while 11% were classified as moderate.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									ID diagnosis vs offending onset - data were available for 34 children. For 71% the ID was diagnosed prior to offending behaviour emerging; for 29.4% ID was diagnosed after offending commenced, sometimes as part of children's criminal court assessments. **Mental health disorders -** 61.2% of crossover children had a recorded mental health diagnosis, including mood disorder (28%), behavioural disorder (20.1%), trauma and attachment-related disorder (19.4%), psychotic disorder (5.3%) and personality disorder (3.5%). Not prevalence estimates as some mental health diagnoses not articulated, but these provide an overview of the types of diagnoses commonly seen in this cohort. • 35.2% of crossover children had a history of self-harm, suicidal ideation/ attempts. • 13.7% had been treated in an inpatient child/adolescent psychiatric unit, or were subject to an involuntary mental health treatment order (excluding children who used outpatient hospital mental health services, and those who spent time in hospital-based schools or behavioural units). **Self-harm and suicidal behaviours -** Often commenced from young ages; included threatening suicide, multiple suicide attempts, persistent and distressing suicidal thoughts; children scratching, biting, cutting, gouging, punching, strangling and cutting themselves; overdosing on medications, head-banging behaviours, from as young as infancy; intentionally ingesting toxic substances/objects; stepping in front of traffic/train tracks. Children's self-harming behaviours were at times characterised as indicators of emotional and psychological distress, while at other times were depicted as behavioural issues, or attempts at manipulation. • No significant difference by gender or Indigeneity in proportion of children with any mental health diagnosis. • Females (49.4%) were significantly more likely to have a history of self-harm, suicidal ideation, or suicide attempt listed in their files compared to males (28.6%).

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									• Diagnosed mental health issues did not always reflect the psychological and emotional distress apparent from qualitative data in children's files; distress tended to be attributed to 'underlying trauma', 'attachment issues' and 'complicated/ traumatic grief and loss', and not to any specific mental health diagnosis. Distress often manifested as the cluster of 'emotional regulation challenges', 'self-harm/suicidality' and 'challenging behaviour'. **Behavioural challenges -** 72.4% of crossover children were described as displaying behavioural challenges, including: verbally or physically aggressive abusive behaviours (e.g. at school, with family, in placement, including 'aggressive outbursts' or threats to harm others); throwing and damaging property (e.g. punching walls, breaking windows, causing significant property damage in residential care and other institutional environments); racist, sexist or bullying behaviours; fire-lighting; and, spitting or yelling. Challenging behaviours were significantly more likely among: Males vs females (82.7% vs 51.1%); children with learning/communication disorder (84.1% vs 69.4%); children with Intellectual disability (87.5% vs 69.7%); other neurodevelopmental/ neurological disorder (92.3% vs 70.8%); mood disorder (82.5% vs 68.8%); trauma/attachment disorder (85.5% vs 69.6%); ADHD (90.1% vs 65.7%); and behavioural disorder (91.2% vs 68%)

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									Maltreatment and disability – Positive correlations were observed between the number of maltreatment types children experienced and their likelihood of experiencing self-harm, suicidal ideation, or attempts; trauma and attachment-related disorders; and challenging behaviours. **Diagnostic revisions & disagreements -** Diagnostic disagreements and revisions were apparent in relation to disability, including mental health diagnoses, often resulting in a lack of clarity. (E.g. ADHD diagnoses were often later revised by other clinicians in later childhood or adolescence to other diagnoses such as complex post-traumatic stress disorder, developmental trauma disorder, reactive attachment disorder, conduct disorder, learning disorder). **Clinical service utilisation –** 12.6% of crossover children had formally engaged with a disability service (Overall 68.8% of children with an intellectual disability diagnosis had some evidence of contact with disability services), 48.6% had engaged with clinical mental health services, 44.6% had engaged with generalist psychology/counselling; 30.6% had engaged with trauma-specific services; 6.1% had engaged with speech therapy or occupational therapy. **Offending contexts and relationship to disability**

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Adolescent family violence - 32.7% of children had incidents of adolescent family violence (AFV) described in case files, though these did not always result in criminal charges; AFV was more commonly observed among crossover children with neurodisability, mental health diagnoses (specifically trauma/attachment-related disorders or behavioural disorders), and a history of challenging behaviours. A key concern was the limited availability of therapeutic, mediation and support programs to respond to the complex contexts in which adolescent family violence occurs, including children's diagnosed/undiagnosed disabilities and histories of maltreatment. **Residential care-based charges -** 35.7% of crossover children ever placed in residential care had residential care-based charges. Residential care-based charges were more common among children placed in residential care who had a mental health diagnosis (43.9% vs 12.1%), a history of challenging behaviours (42.2% vs 8.7%), emerging/ personality disorder (75% vs 34.1%), trauma and attachment-related disorder (55.6% vs 29.8%), behavioural disorder (48.9% vs 30.5%).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Intellectual disability and residential care-based charges - Children with any neurodisability were no more likely to receive these charges compared to other children placed in residential care. However, children with intellectual disabilities were over-represented among children in residential care, and overall were twice as likely to have received residential care-based charges compared to children without an intellectual disability; suggests a need for attention to children with intellectual disability placed in residential care, who may require specialised placements, staffing or approaches. Findings reinforce the need for trauma-informed and disability-informed mental and behavioural health expertise among adults working with children in these care environments. **Qualitative data of good practice in residential care -** Examples were seen where children were better-supported to regulate behaviour in residential care via detailed assessment, effective care teams, specialist therapeutic placements, placement routine and stability, reduced client numbers, enhanced matching of co-residents, increased staffing, reduced staff rotation, and disability expertise. **Theft of motor vehicles –** 34.1% of crossover children had theft of motor vehicle charges; children with borderline intellectual functioning were significantly more likely (57.9%) to have such charges compared to children with no intellectual disability (ID) (32.1%), as were children with challenging behaviours (40.5% vs 23.1%). Children with emerging/ personality disorder were less likely to have theft of motor vehicle charges.

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									Disability Court Reports - Disability Client Services (DCS) engagement was noted for 9.3% of children, and a DCS report was requested in 7.4% of current criminal matters (e.g. assessment of the child's eligibility for receiving DCS services, comprehensive client overview reports, and service plans to integrate disability supports into the sentencing plan). Waiting times of up to five months were noted for some children to access disability (Target Group) assessments. Children at times were held on remand for these assessments to inform sentencing and service planning. **Disability-related factors associated with early offending onset -** A younger age of first police charge was significantly associated with intellectual disability, any mental health diagnosis, trauma/attachment-related disorder, and behavioural disorder. **Disability-related factors associated with offending volume –** A greater number of charges were associated with having a neurodevelopmental disability, mental health diagnosis (particularly trauma and attachment-related diagnoses), and behavioural challenges (behaviour disorder diagnosis and presence of challenging behaviours). **Disability-related factors associated with offences against the person –**Greater likelihood of violent charges was seen among crossover children with mental health diagnoses, and those with a history of challenging behaviour.

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									Criminalisation of welfare concerns – Many cases were identified where child's offending behaviour was assessed by youth justice and mental health professionals as relating to unmet welfare needs, including mental health or disability needs. Professionals expressed concerns about children becoming entrenched in the criminal justice system. **Key regional differences -** Compared to crossover children coming before metropolitan Courts, those before the regional Court were significantly: younger, more likely to be First Nations children (42% vs 20.9%), more likely to have a diagnosed intellectual disability (25.7% vs 14.1%), and to have contact with Disability Client Services (19.2% vs 10.2%). **Key stakeholder findings** • **Framing of crossover children's emotional and behavioural regulation challenges –** behavioural difficulties were understood as responses to the cumulative impact of children's traumatic and challenging circumstances (e.g. instability, maltreatment and poverty). Links between lower verbal communication capacities and children's reliance on behavioural communication strategies were outlined. • **Mental health and disability -** mental health concerns were seem as prevalent and acute, even at young ages. A moderate prevalence of intellectual disability, language disorder and foetal alcohol spectrum disorder was observed among crossover children. Cases were outlined of substance-induced acquired brain injuries at young ages. • **Challenges acquiring diagnosis -** Participants outlined difficulties in obtaining intellectual and neurodevelopmental disability diagnoses for crossover children. This was attributed by professionals to challenges in engaging young people and families, or a lack of attention by child protection services. Neurodisability was often uncovered as a consequence of criminal justice system proceedings.

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									<u>Offending contexts related to disability</u> **Adolescent family violence-** Intervention orders, charges relating to family violence and removal of children from the home and placement in residential care were often seen in response to behaviours constituting adolescent family violence. Professionals described these behaviours as often occurring in the context of children's chronic exposure to maltreatment and family violence. Professionals were concerned about the use of legalistic, rather than therapeutic responses to AFV for crossover children. A shortfall of AFV programs was described. **Residential care-based charges-** Residential care staff utilising police to manage children's behaviour was seen as an inappropriate, lacked efficacy to support behaviour change, and often inconsistently applied. Residential care-based charges were commonly usually acquired: • When a child was emotionally and physiologically heightened, which was often amplified by police presence, or the threat of police attendance; • Through further charges in relation to children's interaction with police; Criminalisation was seen to damage relationships between children and residential care staff, and were believed to contribute towards children running away from placements. Other participants suggested there was a need for natural consequences to behaviour harming others or property, and the need to protect staff in residential units. Suggestions for non-criminalising responses to behavioural difficulties in residential care included:

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									• Implementing a State-wide protocol with Departmental (DHHS) oversight; • Adopting collaborative interagency responses; and, • Undertaking therapeutic skill-building work with young people. **Averting the pathway to youth justice –** Stakeholders suggested families involved with child protection, particularly where children had known disabilities, required increased 'whole-of-family' support, that was provided earlier, and more intensively. Additionally, protective intervention with older adolescents was also seen to be a service gap. **Needing a range of home-based care options -** There are minimal foster care options available for adolescents with more complex support needs, including those with emotional and behavioural regulation difficulties. Trauma and disability-related behaviours typically emerge and/or escalate in early adolescence, triggering breakdown in family or foster/kinship care arrangements, and the child's entry to residential care. **Challenges in residential care settings –** Aside from the criminalising responses, the co-location of vulnerable children and placement instability were identified as barriers to more therapeutic, relational practice in residential care. Genuinely therapeutic residential care with high levels of staff expertise and support were observed to support better outcomes for children.

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									Disability and educational disengagement/exclusion - Some cross-over children experienced behavioural, emotional, and other neurodevelopmental challenges (sometimes undiagnosed) which contributed to educational disengagement and exclusion. Strengthening the mainstream education system's capacity to support young people with neurodevelopmental, behavioural, emotional, mental health and welfare needs was a recommended by stakeholders. Alternative education providers described mainstream schools refusing to enrol crossover children who had more complex needs. At the same time, alternative education environments sometimes supported greater flexibility and responsiveness to children's needs, including challenges with emotional or behavioural regulation. **Therapeutic service access -** Cross-over children were observed to experience limited early therapeutic interventions and barriers to accessing therapeutic services (e.g. adolescent family violence, youth mental health and youth drug and alcohol services, specialist therapeutic services to address trauma-based emotional and behavioural needs). Participants outlined the need for: • A secure therapeutic facility to meet the needs of crossover children that community and hospital-based mental health services were unable to meet. • Services that are trauma-informed and relationally-based; crossover children were seen to as notoriously challenging to engage and support, lacking in trust, and easily excluded from service systems due to their challenging presentations, or need for specialist approaches.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									• Availability of early intervention services • Availability of therapeutic services able to work with children on a long-term basis • Equity of access to therapeutic services (including assessments) in rural/regional areas • Statutory definition of disability and intellectual disability under the Disability Act (2006) are ill-suited to capturing the needs of crossover children and seen to create barriers to service access. **Service coordination including children's court processes** • Designation of responsibility, and staff turnover acknowledged as key concerns in often large care teams of crossover children (including disability and mental health services). • Children's Courts seen to be able to provide accountability and coordination of services involved with crossover children (e.g. requiring service access), but this may require different court models (e.g. crossover court lists, docketing systems for consistent judicial officer to hear a child's matters, non-adversarial, problem-solving, holistic models seen as good examples). • Important for youth criminal courts to be provided with information regarding disability/mental health to provide context of crossover children's behaviour. • Service delivery seen as fragmented for crossover children, both in court settings, and community-based service provision (e.g. court requiring therapeutic engagement at odds with current care team direction); system is not child-focused or coordinated.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									• Improved support required for crossover children with disability to understand and navigate court and legal processes, and to access timely assessments as required • Therapeutic diversion and restorative justice options seen as possible avenues for early, non-criminalising and therapeutic response. **Policing with crossover children –** Police often see crossover children in contexts of behavioural challenges, and when children are in heightened physiological and emotional states; need for police to have greater understanding of both histories of trauma and neurodisability among crossover youth to give context to behaviours.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Dierkhising et al. (J) (CO)	2019	US	To examine juvenile justice and child welfare histories, psychosocial characteristics, and predictors of rearrest among the dually involved population in Los Angeles County as well as the services youth are referred to and utilize among a subsample of dually involved youth tracked postdisposition (n = 152).	Longitudinal.	Dually involved youth in Los Angeles County (N = 718) from Oct 2013-July 2014; postdisposition follow up subsample (n=152)	Administrative data. Crossover youth with open child welfare cases. Number of child welfare referrals; length of stay in the system; number and type of placements; the youth's permanency goal at the time of referral.	Administrative data. Crossover youth – arrest history; type of current charge; preadjudication detention decision, where the arrest occurred; multidisciplinary team's recommendation to court; court disposition.	Administrative data. Any indication of youth receiving mental health services at arrest; has a history of substance abuse; has a mental health diagnosis; was described (and taking) psychotropic medications; Accessing mental health services in 6 months post-disposition (all Y/N).	**Crossover youth and mental health -** Majority of crossover youth had a diagnosed mental health problem at time of arrest (74.5% all youth, 78.9% tracked youth). Approximately half were receiving mental health services at the time of the referral (44% all youth, 53.3%tracked youth); approximately one quarter were prescribed psychotropic medications (26.4% all youth, 27% tracked youth). Of those who were prescribed psychotropic medications, about half (55%all youth, 53.7%tracked youth) reported actually taking the prescribed medication. **Mental health and recidivism-** Crossover youth receiving mental health services had nearly double the odds of rearrest (OR = 1.9), however youth with a diagnosed mental health issue were overall no more likely to experience rearrest. Other factors predicting rearrest included a higher number of prior arrests (OR=1.2), number of placement changes experienced in child welfare (OR=1.03), having a substance abuse issue (OR=3.6). **Mental health referrals -** On average, youth were referred to 2.56 services in the mental health domain, and 64.5%accessed mental health services. Youth who experienced a placement change during their probation period were significantly less likely to access mental health services.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Herz et al. (B) (CO)	2009	US	To explore: 1. Demographic and background characteristics of crossover youth, and if these differ across nonviolent and violent youth. 2. Risk and treatment need levels, and differences across violent and nonviolent crossover youth. 3. The extent to which need for mental health treatment met with the provision of treatment services, and if these relationships differ across nonviolent and violent. 4. If risk levels, treatment need, and treatment history impact recidivism, and differences across nonviolent and violent youth.	Cross-sectional.	First-time offenders from data previously collected from all joint assessment reports completed between April and December 2004 (n=226)	Crossover sample. Administrative data. Length of time in DCFS care, placement history, and treatment history.	Juvenile justice (crossover) sample. Whether the youth was detained in juvenile hall at the time of the arrest.	Administrative data. Presence of a mental health problem. Receipt of treatment (Y/N).	**Prevalence of mental health problems -** Over three-quarters of crossover youth had problems with mental health, substance abuse, or both. The differences were not significant across nonviolent and violent offenders, but the pattern for mental health /substance abuse problems was slightly different across groups. Violent offenders were most likely to have mental health problems only (40.8%), whereas nonviolent offenders were equally as likely to have a mental health problem only or co-occurring problems (30.9%). The prevalence of substance abuse among nonviolent offenders was also noticeably higher than among violent offenders. **Mental health problems and recidivism risk -** For both violent and nonviolent offenders, approximately one-quarter of offenders fell into the low-risk /mental health and into the low-risk /no mental health problem categories. Differences were noticeable when prevalence of mental health problems was considered for moderate- and high-risk offenders. Less than 10% of offenders were classified in the moderate-risk /no mental health group, but approximately one-third of offenders were classified in the moderate risk/mental health group. The same pattern was found among high-risk offenders. Only 1% (n = 1 in each group) of offenders were placed in the high-risk/no mental health category, whereas slightly less than 10% were found in the high-risk/mental health group.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Mental health problems and receipt of treatment - Most nonviolent (66.7%) and violent (75.7%) offenders received some type of mental health treatment while under the care of child protection services. Approximately one-quarter of youth did not receive any treatment. Slightly more than three-quarters of the youth with a need for mental health treatment received some type of mental health treatment, and approximately 20% of youth had a need but did not receive treatment. None of these findings differed significantly across nonviolent and violent offenders. **Mental health and recidivism -** Recidivism within each risk group is increased with the presence of a mental health problem. **Authors' conclusions -** Crossover youth are predominately low risk, but a substantial portion of them have mental health problems that may contribute to recidivism. Mental health problems seem to be more problematic as criminogenic risk increases. High-risk offenders have the greatest need for behavioural /social interventions followed by moderate-risk and low-risk offenders, respectively. Significant needs for treatment relate to child abuse/neglect, exposure to traumatic events (domestic and likely community violence), depression /anxiety, conduct problems, possible learning disabilities, impulse and attention problems, and substance abuse. The majority of youth had received some type of mental health service, and many had several episodes of treatment. Yet these interventions did not reduce the likelihood of recidivism, but rather correlated with an increase in delinquent behaviour. The treatment offered appears ineffective as an intervention to reduce the likelihood of recidivism

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Herz et al. (J) (CO)	2010	US	To examine: 1. Which characteristics predict whether a crossover youth in Los Angeles County will become a ward of the delinquency court? 2. Which characteristics predict whether a crossover youth in Los Angeles County will incur a new arrest (i.e., recidivate)?	Cross-sectional.	Crossover youth cases processed in LA County from April-Dec 2004 (n=581).	Crossover sample.	Juvenile justice (crossover) sample. Whether youth detained at juvenile hall following arrest and prior to adjudication; whether youth had prior offenses; and whether offense was violent (Y/N) or related to a warrant/ probation violation (Y/N). In the recidivism model, whether the youth was made a delinquent ward was also included.	Administrative data. Any mental health problem.	**Prevalence of mental health problems -** 56% of crossover youth had indication of a mental health problem. Mental health problems did not predict becoming a ward of the dependency court, or recidivism.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Hirsch et al. (J) (CO)	2018	US	To examine education-related risk factors, recidivism, referrals for services, and service access among dually-involved youth in Los Angeles County	Longitudinal.	Crossover youth whose justice cases were processed in LA County from Oct 2013- July 2014 (n=131).	Crossover sample.	Juvenile justice (crossover) sample.	Administrative data. Mental health referrals received and services accessed (Y/N).	**Mental health needs and service access -** Among crossover youth, an average of 2.56 mental health referrals were received and an average of 1.76 mental health services were accessed. **Education and mental health service access -** Educational risk scores (sum of scores around school attendance, credit deficiency, school behaviour, and current grades), were negatively associated with mental health services accessed (i.e. greater risk = fewer mental health services accessed). Education referrals were associated with more referrals to mental health and substance abuse services and education services accessed was associated with mental health service access. **Recidivism and service access -** There were no significant differences between those that recidivated and those that didn't on mental health service access.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Kim et al. (J) (CO)	2020	US	To investigate the rates and predictors of mental health service use among dual system youth.	Longitudinal.	Youth aged 13–17 who were dually involved in the CW and JJ systems in a large Mid-Atlantic city in 2003 (Cohort 1; n=781) and in 2012 (Cohort 2; n=486).	Crossover sample. Youth whose child welfare case remained open after investigation. Placement type, placement instability.	Crossover sample. Youth convicted of crime.	Administrative data. Receipt of MH services beyond assessment within 3 years of involvement in the CW and JJ systems, date of MH services, and diagnostics.	**Mental health service use among crossover youth -** roughly 75% of crossover youth received MH services within the 3 years of tracking period. The MH service recipients, 70.9% of whom had co-occurring MH problems, received MH services for an average of about one year (11.9 months). The MH service recipients, compared to those who did not receive MH services, stayed longer in the CWS and JJS, and were more likely to experience out-of-home placement and placement instability. The proportion of female youth was higher among the MH service recipients. In a regression analysis, greater odds of MH service receipt was detected for: • female youth (OR = 1.69, p < .01) • younger youth (OR = 0.77, p < .001) • placement in an institutional setting (cf remaining in their homes of origin) • those experiencing placement instability • those with a longer length of stay in the CWS (OR = 1.03, p < .001) and JJS (OR = 1.07, p < .001). **Dosage of MH services –**Older youth (IRR = 0.84, p < .001) and African American youth (compared to Caucasian youth; IRR = 0.65, p < .001) received a lower dosage of MH services. With regard to case characteristics, placement type was predictive of the amount of MH service use, with those in group home (IRR = 1.32, p < .05) or institutional settings (juvenile detention centres) (IRR = 1.47, p < .001) receiving increased rates of MH services. In addition, placement instability (IRR = 1.07, p < .05) and length of stay in CWS (IRR = 1.03, p < .001) and JJS (IRR = 1.03, p < .001) were associated with increased rates of MH service use. After controlling for co-occurrence of MH disorders, placement instability, which was significant in the NB model 1, lost its significance, (IRR = 1.03, p > .05). It was noted that female crossover youth, while accessing services more, did not have a greater dosage of services.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Kim et al. (J) (CO)	2021	US	To explore the proportion of dual system youth who re-enter the CW and/or JJ systems after receiving MH services, and the association between individual and case characteristics and the likelihood of system re-entry.	Longitudinal.	Youth aged 13–17 who were dually involved in the CW and JJ systems and who received mental health services in a large Mid-Atlantic city in 2003 (Cohort 1; n=206) and in 2012 (Cohort 2; n=194).	Crossover sample. Youth whose child welfare case remained open after investigation; placement type, placement instability.	Crossover sample. Youth convicted of crime.	Administrative data. Receipt of MH services beyond assessment within 3 years of involvement in the CW and JJ systems, date of MH services, and diagnostics).	**Mental health disorders:** The vast majority of the total youth in the sample (90%) were diagnosed with disruptive behaviour disorders, while mood (42%), adjustment (36%), and substance-related disorders (32%) were also prevalent. Over 80% of the dual system youth, as a result, were found to have co-occurring MH problems. **System re-entry:** Most dual system youth (85%) became involved with the CW and/or JJ systems again, even after receiving MH services. In a regression analysis, older youth experienced greater odds of JJ system re-entry. Specifically, 15-year-old dual system youth were nearly 3 times more likely to experience JJ system re-entry than 13-year-old youth (OR = 2.87, $p < .05$). Gender was also found to be a significant predictor, with female dual system youth being less likely to experience subsequent JJ system re-entry (OR = 0.19, $p < .001$) and CWJJ re-involvement (OR = 0.38, $p < .05$). Experiencing out-of-home placement increased the likelihood of subsequent CW re-entry (OR = 2.70, $p < .01$). Fifth, dual system youth who were diagnosed with disruptive behaviour disorders (OR = 5.83, $p < .05$) and anxiety disorders (OR = 6.17, $p < .05$) had greater odds of subsequent CWJJ re-involvement than those without such disorders, even after receiving MH services. Finally, race/ethnicity and comorbidity had a non-significant effect on the likelihood of subsequent system re-entry.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Malmgren & Meisel (J) Malmgren & Meisel (J) (CO)	2004, 2002	US	To examine service delivery and risk factors for youth with emotional and behavioural disorders who were involved in one jurisdiction's child welfare, juvenile justice and special education agencies.	Cross-sectional.	Youth with emotional and behavioural disorders who were involved in one jurisdiction's child welfare, juvenile justice and special education agencies (n=93).	Crossover sample. Youth known to the child welfare system.	Crossover sample. Youth known to the juvenile justice system.	Sample were all receiving special educational services for emotional or behavioural disorders (EBD).	**Average age at first agency contact –** 8.2 years **First agency contact** – special education (48.9%), child welfare (31.9%) and juvenile justice (19.1%). **Eligibility for special education services** – Identified on average at 10.2 years of age. Gender and ethnic differences apparent (Hispanic youth and females identified as eligible at older ages). **Special education referral –** behaviour problem (55.1%), behaviour+ academic difficulties (22.5%), academic problems only (5.6%), speech and language (10.1%); most youth (79.5%) were placed in programs in general education schools upon entry to special education. **Initial category of disability** - serious emotional disturbance (55.6%), learning disabled (16.7%), need of assessment (13.3%), speech/language impaired (10%). **Involvement in juvenile justice** – Average age of 12.9 years; females significantly older. First offences mostly property (58.4%), crimes against people (31.5%), status offenses (5.4%). JJ placed half of youth in OOHC at some point (49.4%). **Involvement in child welfare –** Average age of 10.9 years, entry to foster care at 11.9 years; no significant gender or ethnicity differences; 84.9% 3rd party referral, 7.5% by parent/ guardian self-referral. **Child maltreatment –** physical abuse (49%), sexual abuse (29.4%), neglect (75%). Rates of neglect higher among African American children. **Parent or sibling incarceration –** 23 youth, disproportionately African American children. **Substance abuse –** 43.3% (disproportionately higher among African American children).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Academic or attendance problems – 48.8% multiple difficulties (reading, math, language) prior to diagnosis. 16.7% in a single area. Only 3.6% had school attendance problems. After referral 63% were noted to have attendance problems in special education files. **Conduct problems at school -** 91.7% prior to special education referral. 38.9% attended more than one school in an academic year, which continued after special education referral. **Retention -** 35.2% were retained in grade at least once during their academic careers up to the point of data collection. Of these youth, 59.1% were retained in the primary grades (i.e., Kindergarten—grade 3). **Suspension & expulsion –** 27.5% suspended and 9.8% expelled prior to being identified for special education (no gender or ethnicity differences).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Trejos-Castillo & Noriega (J) (CO)	2020	US	To gather insights about mental and reproductive needs and challenges of multisystem youth.	Exploratory.	Convenience samples of multisystem youth 14–17 years (n=15) and parole and probation officers (n=20).	Child welfare/ crossover (foster care) sample.	Child welfare/ crossover (juvenile justice) sample.	Conceptualised as mental health needs.	**Criminalization of behaviours** – All youth reported that behaviours conceptualised as stress/anxiety bring provoked for non-system youth were treated as offences in their situations; not provided with counselling or support instead. Similarly treated in school settings – given out-of-school suspensions as opposed to support. **Lack of support to navigate justice system** – Professionals believed this also propelled criminalisation. **Concerns about screening/intake** – Concerns as to whether mental health assessments were being undertaken by sufficiently skilled professionals in JJ system; youth also particularly anxious in these scenarios - query impact on assessment. **Challenges in MH service provision** – (a) Unstandardized services and protocols across multiple systems – some youth not provided certain services once they enter JJ (e.g. can't access same medication) (b) Lack of data sharing across systems –lack of background information which would support more targeted/appropriate service provision; youth having to repeat their stories. (c) Lack of trauma-trained care providers – youth felt misunderstood, dismissed, and lacking safe spaces and relationships; professionals noted some lacked the framework to understand youth in context of traumatic histories. (d) lack of continuity of services - youth building a connection with service providers and having to change; foster placement changes disrupt continuity of therapeutic services; youth observed as often either receiving too many/insufficient services; (e)Overuse of "crisis" procedures (f) Need for developmentally appropriate prevention services.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Baidawi, Sheehan & Flynn (J) (P)	2020	Australia	To examine the relationships, processes, and criminal activity related to child criminal exploitation among crossover children, and to canvass current legal and welfare responses to this phenomenon.	Exploratory.	Interview and focus group consultations (n=25) were undertaken with 87 child welfare, legal, justice, and education key stakeholders + analysis of crossover children court files (n=300)	Defined as children experiencing statutory child protection involvement.	Defined as children experiencing police involvement (e.g. cautions, arrests or youth justice involvement).	Conceptualised as neurodisability.	Key stakeholders identified children with neurodisability involved with child protection as particularly vulnerable to criminal exploitation by older youth and adults, alongside children in residential care placements. Supply of illicit substances to children by adults, leading to the child's later offending to repay drug-related debts, or otherwise appease exploiters was described as a common trajectory of criminal exploitation by key stakeholders. This pathway was also the most commonly seen type of exploitation across the case files, the victims of which were all male, and half of whom had diagnosed intellectual disabilities.
Gerard et al. (J) (P)	2018	Australia	To examine the mechanisms of criminalization of children in residential care in the Australian context.	Exploratory.	Semi-structured interviews with professionals working contact with young people in residential care settings in New South Wales, Australia - police officers, residential care providers, legal aid lawyers and juvenile justice workers (n=46).	Defined as children in residential out-of-home care.	Defined as children experiencing police involvement (e.g. cautions, arrests).	Behaviours often related to disability as described by professionals.	**Criminalisation of children in residential care -** Young people in residential care are observed to be charged with criminal offences for behavioural problems that might have been managed less punitively in other environments. **Behaviour management in residential care -** Criminalisation results from use of police as a behavioural management tool. Police respondents were frustrated about, and reported frequent and unnecessary contact with children in residential care. Residential care providers however reported a carefully planned process of intervention and support in cases of misbehaviour. Lack of clear institutional behavioural management policies (e.g. for "challenging behaviour"), combined with deficient staff training, support, staff numbers, and remuneration, were perceived to lead to unnecessary criminalisation. An example was provided of criminalisation of a child with cognitive impairment who was believed by residential care staff to require "consequences" for behaviours. While there were findings related to the criminalisation of Aboriginal and Torres Strait Islander children in residential care, none of these specifically related to concepts of disability.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Greig et al. (J) (P)	2019	Australia	To gain insight into factors contributing to the criminalisation of children with cognitive impairment in OOHC.	Exploratory.	Semi-structured interviews with 11 senior strategic officers and service providers to this cohort.	Defined as children in out-of-home care.	Defined as children experiencing police involvement (e.g. cautions, arrests).	Behaviours often related to disability as described by professionals.	**Increased vulnerability** **Intersectional challenges -** cognitive impairment seen to compound the challenges facing children with a history of trauma, abuse and neglect, making criminal behaviour "an almost inevitable outcome". Professionals' difficulties reconciling ideas of disability and criminal justice system involvement together; tendency to view young people as either having disability or being justice-involved; reinforced by funding systems which regard these as separate needs, ignoring the complexity of the relationship between the two. **Vulnerability to exploitation** – Ability of children with cognitive impairment in OOHC to assess risk is lower and so they can be "abused and exploited by others". **Barriers to engagement in protective factors –** e.g. reliance on communication skills to engage with protective factors such as prosocial peers, counselling & academic achievement. **Lack of belonging and security** Due to in-care and pre-care factors, including disorganized/insecure attachments, lack of consistent caregiver and placement instability; seen to drive association with pro-criminal peers. **Neglect** – Lack of care and protection when this group of children get into trouble with police. **Criminalisation of challenging behaviour** – lack of recognition of disability, and understanding that behaviour is a response to trauma and/or a function of cognitive capacity results in school exclusion and criminalisation.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Barriers to identification **Lack of diagnosis –** Lack of diagnosis or recognition of disability facilitates criminalisation of behaviours. "Hidden disabilities" e.g. receptive language skills less developed than expressive language skills. **Lack of staff training –** Facilitates the lack of diagnosis and criminalisation of behaviour. Particularly lack of disability expertise in OOHC sector. **Resistance to identifying –** Youth in OOHC not wishing to identify as having a disability also compounds above factors. Facilitates hidden nature of disability (e.g. learned behaviours to compensate).
Marshall (T) (P)	2012	US	To examine why African-American youth are disproportionately represented in those who cross over from involvement in the child welfare to the juvenile justice system.	Exploratory.	Individual, semi-structured, interviews with child welfare, law enforcement and court professionals.	Defined as children involved with child welfare system.	Defined as involvement with juvenile justice system.	Behavioural issues related to trauma as described by professionals.	The author noted that none of the participants discussed the known association between maltreatment and disabilities, especially subtle cognitive and behavioural disabilities relevant to school functioning. **Contribution of emotional/ behavioural problems -** Participants noted children with trauma backgrounds are easily excluded from school due to zero-tolerance behaviour policies, which jeopardizes the chances for academic success among this cohort. Many participants saw emotional and behaviour problems of the child (49%, n=16) as contributing to crossing over. **Child level contributors** – experiences of trauma leading to low self-esteem and school failure, lack of healthy attachments, bonds and adult attention leading to unhealthy attention-seeking behaviours. Unprocessed anger and trauma. **Systems level contributors -** 15% (n=5) Were significantly younger, younger when ageing out of care problems as a result of problems at the macro level—specifically, a shortage of mental health resources in the community. **Contribution of foster care system –** zero tolerance policies in congregate care placements leading to criminalisation of children's behaviours such as fights in placement (p. 73). Also: multiple placements, lack of caregivers willing to go the extra mile.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
McElvaney et al. (J) (P)	2016	Ireland	To explore professionals' experiences of working with young people in the care and youth justice context in Ireland, focusing on the issue of mental health need.	Exploratory.	Focus groups and interviews with purposive sample of professionals from 14 disciplines (psychiatry, psychology, social work/care, OT, SLT, education, police/justice and other) (n=26).	Defined as children in the care system.	Defined as children in the youth justice system.	Mental health needs.	**Complex needs –** children in these systems seen to have multiple difficulties and complex needs; professionals were concerned about taking responsibility of meeting children's needs, feeling 'bewildered' 'frustrated' 'embarrassed' and lacking confidence in their ability to respond. **Diagnosis & medical model -** Professionals suggested an over-reliance on medical models of diagnosis, however there was pressure from wider systems to classify children diagnostically (e.g. to access services). Yet labelling seen to interfere with how YP are viewed, and may delay intervention. **Multiple assessments** of children and young people seen to interfere in ability to engage young people in meaningful therapeutic work. Conversely, complexity of presentation could lead to impulsive decision-making. **Systemic shortcomings** – Limited resources to respond to YP needs (services, suitable placements); services gatekeeping due to lack of resources; disparities geographically and in service quality. Also by age with late teens seen to be a service gap. Causal link between inadequate mental health service provision and children's negative trajectories – justice system being used to fill gaps in mental health service provision. **Barriers to collaboration –** Professionals' differences in opinion about conceptualisation of children's needs, and direction/timing of interventions; unrealistic expectations of other services.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Mendes et al. (J) (P)	2014	Australia	To identify factors that present challenges to successful transitions from care.	Exploratory.	Focus groups and interviews with convenience sample of professionals from child protection, youth justice and associated support services (n=77).	Defined as children in out-of-home care.	Defined as children involved with the youth justice system.	Disability and mental health needs.	**Crossover children and disability** - Respondents in 15/23 consultations stated that many of the dual order young people involved in both the CP and YJ systems have a disability, whether or not formally diagnosed. Further, a significant number of this group of young people were said to be from indigenous backgrounds. Disability seen to compound challenges of transitioning from care for crossover youth. **Lack of diagnosis** - Many of the young people whose disability is not formally diagnosed were seen to have significant learning and literacy difficulties, but informants noted that they receive little if any appropriate support when they leave care **Lack of service access in the transition from care** – due to unwillingness of adult services to intervene until age 18 years, and some young people not wishing to engage with services, due to a stigma/not identifying as having a disability. **Crossover children and mental health** - Workers in 20/23 consultations identified trauma-related mental health issues as prevalent within the dual order population. These included forms of depression and anxiety, and in some cases, instances of self-harm and attempted suicide. It was suggested that residential care environments may worsen existing problems by failing to provide a therapeutic response. **Challenges accessing MH services** – Difficulties accessing mental health assessments and ongoing specialist adolescent forensic health support services. Some good mental health teams appear available on an outreach basis, engaging in ongoing assessment and treatment, (not just secondary consultation). A number of services only available until the young people turn 18 years of age; some regions had established Child and Youth Mental Health Services to 25 years. **MH challenges and transition from care** – MH problems seen to complicate transitions from care; respondents believed these issues correlated with substance abuse as self-medication. Limited supported housing options for those with challenging behaviours.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Shaw (J) (P)	2016	UK	To gain insights into the criminalisation of young people in response to children's residential, home-based challenging behaviour.	Exploratory.	Focus groups and interviews with convenience sample of professionals from child welfare and youth justice systems (residential care staff and managers, field social workers, Youth Offending Service (YOS) workers, leaving care workers; youth court magistrates, legal advisers, solicitors and police officers) (n=40).	Defined as children in residential care.	Defined as police involvement.	Defined as challenging behaviours.	**Frequency & seriousness of incidents** – residential care staff reported police only called as last resort to deal with genuine risk & violence to staff/other YP. Others conveyed it was frequency rather than seriousness that led to police involvement, examples given of minor property damage. **Criminalisation to provide consequences -** Youth justice seen as recourse when young person not responding to staff sanctions, staff unable to "contain" YPs behaviour, to "wake up" and provide "consequences". Criminalisation also observed to preserve authority of staff and unit, send a "message" to other YP. **Criminalisation due to lack of other sanctions –** staff reported lack of other consequences able to be applied to YP. **Consideration to disability and history -** Impact of child's history (abuse/neglect) on behaviour not at forefront of decisions to involve police. **Lack of consistency –** Lack of consistency in use of police described. **Police seen as positive presence by staff** – used to calm unit down, to familiarise police with YP and their circumstances; Police seen to encourage staff to deal with behaviours in house.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Shaw (J) (P)	2012	UK	To examine professionals' perceptions of the factors that contribute to young people in residential children's homes coming to the attention of the criminal justice system.	Exploratory.	Interviews with professionals from the care and criminal justice systems between Oct 2008-Jan 2009 (n=31).	Defined as children in residential care.	Defined as police involvement.	Defined as challenging behaviours.	**Individual disposition and family background** – workers believed YPs behaviour in residential care a continuation of that in the family home; attributed to family background and individual psychosocial deficits. **Individualisation and choice** – Behaviour seen as conscious choice and/or refusal of individual child to take advantage of support offered. **Staffing in residential care setting –** Staff seen to have limited capacity to impose boundaries and consequences on YP. Lack of relationship with YP also limits influence of staff on YPs behaviours. Some participants believe staff do good job in difficult circumstances; others observed some staff more skilled. **Social environment of residential care** - Peer pressure in the residential care context to become involved in offending seen as contributor, alongside wanting to avoid being lower in pecking order. Additionally, some children struggle to adjust to rules of the home, which are characterised as a "preoccupation". **Nature of behaviour –** Some respondents (social workers, residential care staff) believed criminalisation of some behaviours warranted, others (e.g. Court/legal professionals, including magistrates, youth offending teams & leaving care workers) viewed as unnecessary and harsh. **Criminalisation and placement instability –** other than criminalisation, a further response to challenging behaviour was often to move the YP, resulting in further instability. Placement moves for other administrative reasons also contributed to instability.

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Other child and adolescent samples (n=2)									
Chen (T) (P)	2008	US	To investigate the predictive links between multifaceted factors in childhood and short- and long-term behavioural problems for students with high-incidence disabilities.	Longitudinal.	Economically disadvantaged students from the Chicago Longitudinal Study who attended school from 1985-86 (n=1370).	Administrative data. Child welfare history (Y/N) - child or family received child protective services or received other child welfare services due to abuse or neglect reports at ages 0-3.Child abuse/ neglect (Y/N) - based on the report of the Child Protective System in Illinois Department of Child and Family Services and/ or petitions to the Cook County juvenile system at ages 7 to12.	Administrative data. Arrest (ages 10-18) in Cook County or two mid-western locations.	Administrative data. Number of years in special education between age 7-12 years. Disability status – recorded presence of Learning Disability (LD) - significant difficulties in listening, thinking, speaking, reading, writing, spelling, or mathematical abilities due to the deficits in one or more of the basic psychological processes involved in understanding or using language or Emotional Disturbance (ED) - inability to learn, relationship problems, inappropriate behaviour, unhappiness or depression, and physical symptoms or fears over a long period of time.	**Disability and juvenile delinquency controlling for child welfare involvement -** After controlling for child welfare involvement, disabilities in grades 1-12 were associated with juvenile delinquency, with a marginal effect of .097 ($p < .01$). Students with disabilities in grades 1 through 12 had a rate of 24.7 % compared to 14.9% for students without disabilities, indicating a 9.7 percentage point difference on juvenile delinquency. Effect size for relationship between disabilities and juvenile delinquency was .37. (p.67) After controlling for child welfare involvement, disabilities in grades 1-6 were significantly associated with juvenile delinquency. The marginal effect of disabilities in grades 1 through 6 in this model was .075 ($p < .05$). Students with disabilities had a 7.5 percentage point higher rate of juvenile delinquency compared to students without disabilities (22.9% vs. 15.5%). Effect size for relationship between disabilities and juvenile delinquency was .30. (p.68) After controlling for child welfare involvement, reading comprehension/ juvenile delinquency associations were significant for students with later-identified disabilities. The marginal effect for reading comprehension was -.029 ($p < .05$), suggesting a one-unit increase in reading comprehension for students with later-identified disabilities was associated with a 2.9% decrease in juvenile delinquency. For students with high-incidence disabilities (diagnosed before grade 6), no significant reading comprehension/ juvenile delinquency association existed. (p.85).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
									Child maltreatment and juvenile delinquency for students with disabilities - A significant child maltreatment/juvenile delinquency association existed for the entire study sample in one model, with a marginal effect of .109 ($p < .05$). Any child maltreatment in the elementary grades was associated with a 10.9 percentage point increase in juvenile delinquency. However, child maltreatment had no discernible relationship with juvenile delinquency for the separate subgroups. For students with high-incidence disabilities, child maltreatment was not statistically associated with juvenile delinquency, with a marginal effect of .169. For students with high-incidence disabilities, parent involvement was not significantly associated with juvenile delinquency. On the other hand, the predictive effects of child maltreatment on juvenile delinquency was generally in the positive direction. Child maltreatment had distal effects on juvenile delinquency for the entire study sample. (p.97) **Relative importance of Individual, family and school factors on juvenile delinquency –** For students with high-incidence disabilities in grades 1 through 6, school level factors had more influence on juvenile delinquency, relative to individual and family level factors (p. 123). For students with high-incidence disabilities in grades 1 through 12, covariates also accounted for a similar amount of the variance in juvenile delinquency (.081). School level factors explained more of the variance in juvenile delinquency than individual and family level factors (p. 123). For students with high-incidence disabilities, individual level factors were less important than school level factors in predicting juvenile delinquency (p 130). A significant main moderator effect for child maltreatment in predicting juvenile delinquency was found for students with high-incidence disabilities in grades 1-12 (p. 132).

Study	Year	Country	Aims/ purpose	Methods	Population & sample	Child protection measures	Offending measures	Disability measures	Relevant findings
Narendorf, et al. (J) (P)	2020	US	To examine historical risk and resilience characteristics of young adults experiencing homelessness (YAEH) by systems involvement (foster care, juvenile justice, both systems (dual status), and no system involvement).	Cross-sectional.	Convenience sample of YAEH aged 18-26 years enrolled from drop-in centres, shelters & transitional housing programs in 7 US cities (n=1426).	Youth self-report. Exposure to foster care system: ever been in foster care.	Youth self-report. Exposure to juvenile justice system: juvenile court, probation, detention, or diversion.	Youth self-report. Mental health- Lifetime diagnosis of ADHD, ODD/CD, bipolar disorder, depression, schizophrenia or psychotic disorder, or PTSD. Psychological distress – Kessler Psychological Distress Scale.	**Rates of mental health diagnoses-** Dual status youth reported significantly higher rates of mental health problems than those solely involved with the juvenile justice or foster care systems. **Levels of psychological distress** – there were no significantly differences among YAEH groups by systems involvement in the level of psychological distress reported.

Note. (C) – Book Chapter (J) – Journal Article (T) - Thesis (CP) – Child Protection sample (YJ) – Youth Justice sample (CO) – Crossover sample (P) – Professionals sample

Appendix C. Survey Instrument

Care criminalisation of young people with disability in child protection systems

PARTICIPANT INFORMATION SHEET

Project title

Care Criminalisation of Young People with Disability in Child Protection Systems

HREC Reference Number

1896/21

Chief Investigator

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Institution Responsible:

Monash University

Project Funder:

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

You are invited to take part in this study. Please read through this participant information statement in full before deciding whether or not to participate in this research. If you would like more information regarding any aspect of this project, you are encouraged to contact the researchers via the phone number or email address listed above.

Who is involved in this project?

We are a group of researchers from three different organisations, working in partnership. The research team consists of social work researchers from Monash University, Aboriginal and/or Torres Strait Islander researchers from Western Sydney University and an implementation researcher from the Centre for Evidence and Implementation.

Background to the research topic

Young people in the child protection system, especially those in out of home care (OOHC), are at increased risk of coming into contact with the criminal justice system, both while they are still in the child protection system and in the period following their transition out of the system. The relationship between trauma, abuse and neglect and involvement with both the child protection and criminal justice systems is well-established. The cohort of young people who have been in contact with both the child protection and criminal justice systems are sometimes referred to as “crossover children”. Aboriginal and/or Torres Strait Islander young people, who are greatly overrepresented in both systems, are up to 18 times more likely to fall into this group. Young peoplewith disability are overrepresented in both systems, yet there is limited research into what factors impact the chance of young people with disability in the childprotection system entering the criminal justice system. There is also limited information about what are the best responses for preventing and addressing criminal justice system contact among children with disability in child protection systems.

The research project

This research has been requested by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability (the Royal Commission). The Royal Commission wants to know more about children with disability in child protection systems, and their pathways into criminal justice systems. They also seek to understand effective interventions that can interrupt these pathways and improve outcomes for young people with a disability. There is little existing research about this area, and this project intends to fill that gap in knowledge.

Why were you invited to participate in this research?

We want to hear from direct service providers and other professionals who are involved in the delivery of services and programs to young people with a disability in child protection systems at risk of justice system involvement. This includes anyone who works, or has worked with this cohort of young people.

Our project partners who are Aboriginal Community Controlled Organisations have invited their affiliates to be part of this research.

What does the research involve?

You will respond to an anonymous survey that consists of scaled and short answer questions. The survey questions ask for you to share your experiences working with young people with disability in child protection systems who are at risk of justice system involvement. This includes questions around what factors impact their pathway from child protection to justice systems, what works to prevent their involvement in justice systems, and any ideas you have for improving service delivery and support.

By completing the survey, you are consenting to take part in the survey component of this research. You have the right to withdraw from participation at any time prior to submitting the survey. Once you have submitted all your responses, it will not be possible to withdraw the data, as the data is anonymous and can no longer be identified.

The survey will take approximately 10 to 15 minutes to complete

There is no reimbursement or payment for participation in this research. The survey is anonymous, and no personal details are requested.

Possible benefits and risks to participants

Many participants will experience no direct or immediate benefits, however there are broader beneficial impacts for the community. This research will benefit young people with disabilities who have child protection system contact and are at risk of justice-system involvement, including Aboriginal and/or Torres Strait Islander children and young people and those from a culturally and linguistically diverse background.

There are no expected risks of survey completion. The survey will be anonymous and delivered online, and participants can discontinue at any point by exiting the survey.

Confidentiality

The information in this research project will be confidential and engagement in the survey will be anonymous.

Storage of information collected

Electronic data will be stored on a university networked drive. This is secured by password protection and multi-factor authentication. Only the researchers involved in this study will have access to this data. Data will be kept for five years.

Results or queries

If you would like information about the research results, or have any further queries, please contact the Chief Investigator.

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact The Chairperson, AH&MRC Ethics Committee:

The Chairperson
AH&MRC Ethics Committee
35 Harvey Street
Little Bay NSW 2036
Email: ethics@ahmrc.org.au
Telephone: (02) 9212 4777

Thank you

Dr Susan Baidawi

Your participation in this survey will provide valuable information that will be used to formulate future policies and inform ongoing research by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability (the Royal Commission).

By choosing 'I agree' below, you will provide your consent to participate in this survey. Your participation is voluntary and you can choose to withdraw from the survey at any time by closing the browser window. All responses will be confidential and no identifying information (names, occupation, etc.) will be reported in the survey findings.

The survey will take approximately 10-15 minutes to complete.

- I agree to participate

Background and Definitions

For the purposes of this survey and the project, the following definitions are in use:

Disability refers to any physical, sensory, cognitive or neurological disability (e.g. intellectual disability or ADHD); mental illness (e.g. PTSD) or complex trauma. For the purposes of this survey, disabilities may be formally diagnosed or suspected.

Criminalisation refers to any contact with police, courts, or youth justice.

Child Protection involvement includes any reports or notifications to child protection, any case management or orders through child protection or placement in out-of-home care.

Professional Information

What is your area of current or most recent work?

- Child protection (statutory service)
- Youth justice (including youth justice provider or youth justice support worker)
- Out of home care (non-government organisation)
- Legal practitioner
- Disability justice service
- Youth disability service
- Non-government advocacy group
- Aboriginal Community Controlled Organisation (non-government)
- Health/mental health
- Child and family support services
- Other (please specify)

How long have you been working in this sector?

- Less than 1 year
- 1-5 years
- More than 5 years

In the past five years have you worked in any of the following sectors? Select all that apply

- Child Protection (statutory service)
- Youth Justice (including youth justice provider or youth justice support worker worker)
- Out of Home Care (non-government organisation)
- Legal Practitioner
- Disability justice service
- Youth disability service
- Non-government advocacy group
- Aboriginal Community Controlled Organisation (non-government)
- Health/Mental Health
- Child and family support services
- Other (please specify)

Do you work in a program that provides services exclusively to Aboriginal or Torres Strait Islander children and young people?

- Yes
- No

Children and Young People, Child Protection & Disability

In your work with criminalised children in the child protection system, what types of disabilities do you encounter? Select all that apply.

- Cognitive disability (e.g. intellectual disability, borderline intellectual disability, challenges with memory or planning)
- Neurodisability (e.g. ADHD, Autism Spectrum Disorder, FASD, ABI, epilepsy)
- Learning and communication disability (e.g. dyslexia, language disorder, speech disorder)
- Physical disability (e.g. Cerebral palsy, spina bifida or other spinal impairments, limb deficiencies)
- Sensory disability (e.g. Visual impairment, hearing impairment)
- Severe mental health issues
- Complex/developmental trauma
- Suspected/undiagnosed/unknown disability (e.g. Children displaying challenges with emotional or behavioural regulation)
- Anything we have missed? Please specify

In your work with criminalised children in the child protection system, what disability do you encounter **most often**? Choose **one** from the list below.

- Cognitive disability (e.g. intellectual disability, borderline intellectual disability, challenges with memory or planning
- Neurodisability (e.g. ADHD, Autism Spectrum Disorder, FASD, ABI, epilepsy)
- Learning and communication disability (e.g. dyslexia, language disorder, speech disorder)
- Physical disability (e.g. Cerebral palsy, spina bifida or other spinal impairments, limb deficiencies)
- Sensory disabilities (e.g. Visual impairment, hearing impairment)
- Severe mental health issues
- Complex/developmental trauma
- Suspected/undiagnosed/unknown disabilities (e.g. Children displaying challenges with emotional or behavioural regulation)
- Anything we have missed? Please specify

In your experience, how many of the criminalised children and young people with whom you have worked had **official/formal diagnoses** of disability?

- Very Few
- Few
- Many
- Most
- All

In your experience working with criminalised children and young people in the child protection system, are there any disabilities that are either missed or not formally diagnosed?

- Yes - please add details
- No

Children and Young People, Child Protection and Justice System

For the questions that follow, please consider the work you have done with children and young people **with disabilities** in the child protection System

For those children and young people with disabilities who end up involved in the justice system, have any of the following been relevant factors in their criminalisation?

- Placement in out of home care
- Placement in residential care
- Age (please add detail of how age is a factor)
- Lack of family involvement
- Family justice system involvement
- Education exclusion
- Location, e.g. metropolitan vs regional (please add detail of how location is a factor
- Placement instability
- Substance use
- Cultural or ethnic background (please add detail of how culture/ethnicity is a factor)
- Individual characteristics or support needs of the child (please specify)
- Other (please add details)

For children and young people with disabilities in Child Protection who do not become criminalised, what are some possible protective factors? Select all that apply.

- Children remaining with family
- Children placed with siblings
- Children in kinship placement
- Children with certain types of disability (please specify)
- Younger children
- Children in metropolitan areas
- Therapeutic supports
- Therapeutic placement
- Individual characteristics of the child (please specify)
- Individual characteristics of the family (please specify)
- Other

Aboriginal and Torres Strait Islander children and young people

In your work, have you had experience interacting with Aboriginal and Torres Strait Islander children and young people in the child protection system?

- Yes
- No

Are you aware of any programs targeted at reducing and/or preventing the criminalisation of Aboriginal and Torres Strait Islander children and young people with disability in child protection systems?

- Yes
- No

What is working well with these programs?

What **challenges** have you faced in preventing and responding to criminalisation of Aboriginal and/or Torres Strait Islander children with a disability in child protection systems? (Consider assessment, service provision, etc.)

What are potential **solutions** to the challenges you have faced in working with Aboriginal and/or Torres Strait Islander children and young people with disabilities at risk of criminalisation in child protection systems?

Culturally and Linguistically Diverse children and young people

In your work, have you had experience interacting with Culturally and Linguistically Diverse (CALD) children and young people in child protection systems?

- Yes
- No

Are you aware of any programs targeted at reducing and/or preventing the criminalisation of CALD children and young people with disability in child protection systems?

- Yes
- No

What is working well with these programs?

What **challenges** have you faced in preventing and responding to criminalisation of CALD children with a disability in child protection systems? (Consider assessment, service provision, etc.)

What are potential solutions to the challenges you have faced in working with CALD children and young people with disabilities at risk of criminalisation in the child protection systems?

Policies and Practices

The following questions will ask you about your experience with certain policies and practices that relate to children and young people in the child protection and youth justice systems

In your work, have you observed or experienced collaboration between the following programs:

Youth justice and disability/mental health/trauma therapeutic services

- Yes
- No

Youth justice and the child protection system

- Yes
- No

Disability services and the child protection system

- Yes
- No

What was the nature of this collaboration? Select all that apply

- Disability Justice Plans
- Disability Justice Services

- NDIS or other disability/mental health providers
- Participation in care team meetings
- Information sharing
- Shared decision making
- Joint case planning
- Other

How effective were these collaborations in preventing or reducing the criminalisation of children and young people with a disability in child protection systems?

- Very Ineffective
- Largely ineffective
- Neither effective nor ineffective
- Somewhat effective
- Largely effective
- Very effective

Please tell us what worked well.

Please tell us why the collaboration was ineffective. Select all that apply.

- Child was ineligible for services
- Child not wanting/refusing assessment
- Child not wanting/refusing services
- Child did not identify as having a disability
- Poor service collaboration (please describe)
- Services not successfully engaging children/families
- Ineffective service models (insufficient intensity, not culturally responsive, etc.) Please describe
- Difficulties with communication
- Difficulties with information sharing
- Lack of role clarification

- Different priorities or agendas
- Lack of disability/mental health/trauma expertise (please describe)
- Time constraints
- Workload constraints
- Other (please describe)

In your opinion, how could collaboration between youth justice, child protection and/or disability mental health services be improved to better support children and young people with disability in youth justice and child protection systems?

Block 8

Do you work in Queensland, New South Wales, or Victoria?

- Yes
- No

In your work, have you encountered protocols between residential care providers and police?

- Yes
- No

How effective were these protocols in preventing or reducing criminalisation of children and young people with a disability in child protection systems?

- Very ineffective
- Largely ineffective
- Neither effective nor ineffective
- Somewhat effective
- Largely effective
- Very effective

Please tell us what worked well

- Residential care providers implementing more therapeutic/non criminalising responses to children with disability
- Residential care providers utilising behavioural management plans outlining a child's

disability/mental health needs to consider non criminal justice responses

- Greater communication between residential care and police regarding the needs and appropriate responses to children with disability
- Less criminalising responses by police to children with disability in residential care

Please tell us why the protocol is ineffective. Select all that apply.

- Residential care provider lack of knowledge about how disability relates to children's behaviour of concern
- Police lack of knowledge about how disability relates to children's behaviours of concern in residential care
- Lack of policy implementation or application by residential care providers
- Lack of supervision for policy implementation in residential care
- Lack of supervision for policy implementation within police
- Policy is insufficient to prevent criminalisation of children in care
- Lack of preventative supports
- Insufficient guidance in the protocol (e.g., minor behaviours still attracting police consequences)
- Police lack disability/mental health knowledge and training

What other policy or practice changes could reduce the criminalisation of children and young people with disability in residential care?

Criminalisation of young people with disability

The following questions ask about the criminalisation of young people with disability in child protection systems.

What are the specific pathways by which children with disability in child protection systems become criminalised? Select all that apply.

- Adoption of criminal justice response to disability/mental health-related behaviours in residential care
- Adoption of criminal justice response to disability/mental health-related behaviours in other contexts (e.g. adolescent family violence, other - Please describe)
- Vulnerability to influence of offending peers

- Vulnerability to criminal exploitation by older youth or adults
- Other (Please describe)

Which of the following barriers have you observed or encountered when trying to access assessment for children in child protection systems who may have a disability? Select all that apply.

- Children refuse assessment
- Assessments are too expensive
- Assessments are too lengthy/unable to be completed
- Waiting time to access assessments
- Unclear referral pathways for assessments
- Children being transient or missing
- Unable to collect collateral information for assessments (e.g. from family, child protection and out-of-home-care services, schools, support networks)
- Relevant services unavailable
- Lack of culturally appropriate assessments
- Other (please describe)

What helps support the process of disability/mental health assessment of child protection involved youth at risk of criminalisation? (e.g. programs that have assisted, particular practices you have utilised)

Block 10

This final section of the survey invites you to contribute any remaining comments or reflections.

What is working well to prevent or reduce the criminalisation of children and young people with a disability in child protection systems? Consider assessment services, service provision, cultural supports, community supports, diversion, etc.

What challenges have you faced in preventing or responding to criminalisation of children and young people with disability in child protection systems? Consider assessment services, service provision, culturally safe practices, programs, etc.

What are the potential solutions to the challenges you have faced in working with children and young people with disability in the child protection system at risk of criminalisation?

Block 11

Do you have anything else you would like to share about how children and young people with disability in child protection systems can be better supported **before** they enter the youth justice system?

Do you have anything else you would like to share about how children and young people with disability in child protection systems can be better supported **after** they enter the youth justice system?

[END OF SURVEY]

Appendix D. Consultation (Semi-Structured Interviews) Data Collection Instrument

Researchers to begin by outlining aims of project:

- identifying risk and protective factors for justice system entry
- identifying interventions programs or models
- analysing effectiveness of current policy and practice
- focusing on the experiences and needs of Aboriginal and/or Torres Strait Islander children with disability and CALD children

Researchers to then outline definition of 'people with disability' as defined by Royal Commission: 'people with disability' is defined as people with any kind of impairment, whether existing at birth or acquired through illness, accident or the ageing process, including cognitive impairment and physical, sensory, intellectual and psychosocial disability. For the current study, this includes things like complex/developmental trauma, attachment, mental and behavioural health difficulties, as well as things like intellectual disability, FASD or ADHD.

Outline that the discussion/interview/focus group/yarn relates to Aboriginal and/or Torres Strait Islander or Culturally and Linguistically Diverse children with child protection involvement and who live with a disability (whether formally diagnosed or not), and who become criminalised/experience police or youth justice involvement.

Semi structured interview questions/topics:

1. What things have you found helpful in preventing this group of children from becoming involved in the criminal justice system?
2. What things have you found useful for helping this group of children after they already have criminal justice system involvement?
3. How do you support and assist in gaining access to disability services for Aboriginal and/or Torres Strait Islander and CALD children in child protection? What changes would you like to see within services working with this group of children who have child protection and youth justice?
4. What barriers do Aboriginal and/or Torres Strait Islander/CALD children with disability, who have child protection involvement, and who are at risk of criminal justice system involvement, face in accessing the right help or support?
5. What important needs are not being met by current services for this group of children? Are there services needed that you think, in your experience, in order to be more responsive to Aboriginal and/or Torres Strait Islander and CALD children and young people?

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