

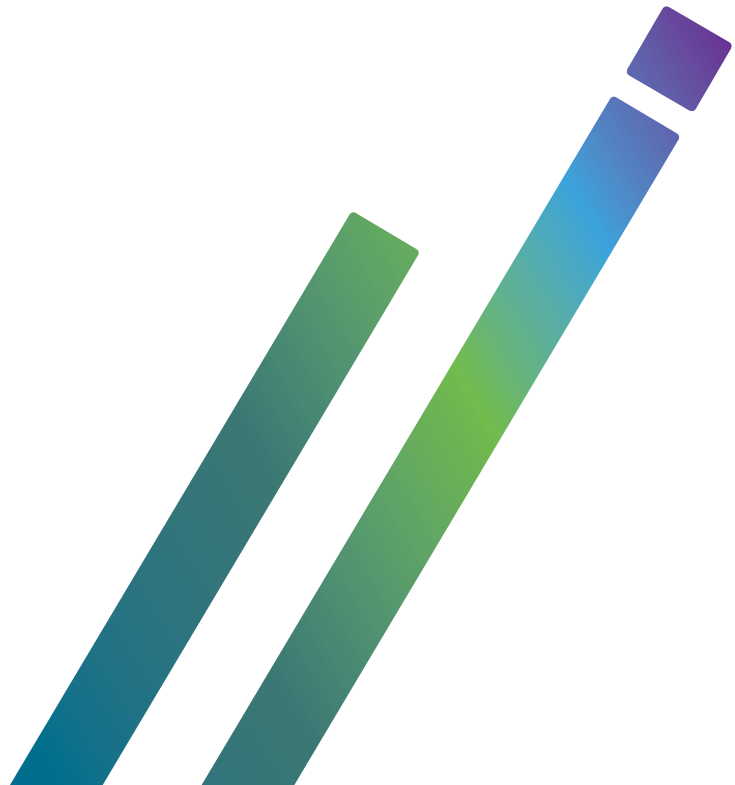


Australian Government

**Australian Institute of
Health and Welfare**



National data on the health of justice-involved young people: a feasibility study 2016–17



AIHW



Australian Government

**Australian Institute of
Health and Welfare**

National data on the health of justice-involved young people

A feasibility study

2016–17

Australian Institute of Health and Welfare
Canberra

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisations
AHRC	Australian Human Rights Commission
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AJJA	Australasian Juvenile Justice Administrators
AMS	Aboriginal Medical Service
COAG	Council of Australian Governments
FASD	fetal alcohol spectrum disorder
JJ NMDS	Juvenile Justice National Minimum Data Set
MBS	Medicare Benefits Schedule
NAGATSIHID	National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NATSIHSC	National Aboriginal and Torres Strait Islander Health Standing Committee
NDCMP	National Deaths in Custody Monitoring Program
NPHDC	National Prisoner Health Data Collection
NYJHAG	National Youth Justice Health Advisory Group
PBS	Pharmaceutical Benefits Scheme
RACP	Royal Australasian College of Physicians
SCATSIH	Standing Committee on Aboriginal and Torres Strait Islander Health
SHS	specialist homelessness services
SLK	statistical linkage key

Summary

The Australian Institute of Health and Welfare (AIHW) has reported against the National Prisoner Health Indicators for adult prisoners since 2009. However, little information currently exists, at the national level, about the health of young people under youth justice supervision (also known as juvenile justice supervision) in Australia—either in detention or in community-based supervision.

Addressing this data gap has been recognised as a priority in reports from multiple cross-jurisdictional bodies between 2011 and 2017. The importance of developing a national data collection focused on the health of young people under youth justice supervision was explicitly stated in the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) *Strategic Plan 2016–2020*. Improving national information in this area also supports the agreed standard for practice to be delivered by juvenile justice administrators, as set out by the Australasian Juvenile Justice Administrators (AJJA) in the *Juvenile Justice Standards 2009*.

The National Youth Justice Health Advisory Group (NYJHAG) was established in August 2016 to assist the AIHW to conduct a feasibility study during 2016–17 into potential data developments. The NYJHAG was set up as a time-limited group, with representatives from the statutory agencies responsible for the health of young people under youth justice supervision in the Australian States and Territories; a selection of subject matter experts in the fields of adolescent health and youth justice; and a representative each from the AJJA, the Australian Bureau of Statistics (ABS) and the AIHW. This report records the results of the feasibility study.

At the inaugural meeting of the NYJHAG in August 2016, the long-term agreed aim of the development work was articulated as:

...the creation of a national youth justice health data collection to monitor the health of young people under youth justice supervision and inform the planning, delivery and quality of youth justice health services.

Methodology

Consultations were undertaken with the state and territory departments responsible for the health of young people under youth justice supervision between October and December 2016. The goal of these consultations was to determine what information was currently available at the jurisdictional level; whether and how young people in community-based supervision should be included in a data collection; whether the existing National Prisoner Health Data Collection (NPHDC) might be a suitable template for a youth justice health collection and; if so, what changes would be required to make the collection more appropriate for young people.

A review of Australian and international literature on the health of justice-involved young people under youth justice supervision was also completed in January 2017. The literature review aimed to identify what is currently known about the health of young people under youth justice supervision.

Data issues

The feasibility study indicated that the NPHDC methodology is not a suitable template for a youth justice health collection. Differences between the youth and adult prison populations—including the size of the populations; the length of time under supervision; the inclusion of community-based supervision; and the capacity to effectively engage with, and respond to, a lengthy self-report survey—make the use of administrative by-product data a better option for supporting the aims of a national youth justice health collection.

In addition, stakeholders expressed a strong preference to include those under community-based supervision in any new data collection, due to the high level of overlap between these two population groups, and to increase the size and usefulness of the resulting data set.

Consultations with relevant stakeholders identified that some administrative by-product data relating to the health of young people in detention are available (or will be in the next 1–2 years). Although typically limited to data on clinic visits and medications taken by young people, the range of data available is increasing as changes to database systems are implemented in various jurisdictions.

The existence of the Juvenile Justice National Minimum Data Set (JJ NMDS) provides an opportunity to capture data about the health of young people—both in detention and under community-based supervision—through data linkage. This creates a different potential starting point for the development of a data collection than is possible in the prison sector, where such linkable administrative data were not available nationally.

Data linkage using the JJ NMDS could provide data on the health of young people while under community-based supervision; before and after detention; and while under community-based supervision. This could be supported by administrative by-product data from detention centres, to provide data on the health of young people while in detention. The resulting set of indicators would be likely to be less comprehensive than that derived from the NPHDC in terms of health status and health behaviours information, but could provide more complete information on service usage and health changes before and after detention, and on the continuity of care for young people.

The literature review identified that the most important health-related issues for justice-involved young people are mental health; disability including FASD; substance misuse; sexual health including sexually transmitted infections; and trauma. There was general agreement during the consultations that these issues are directly relevant to the Australian youth justice population and should be prioritised in the development of a national data collection and associated indicators.

Recommendations

This feasibility study identified significant gaps in available national data and current knowledge about the health status and risky behaviours of young people under youth justice supervision, and about the health services provided to them. Jurisdictions agreed that it would be both worthwhile and feasible to seek to establish a methodology, including data sources, for national reporting.

It is recommended that a national data collection on the health of young people under youth justice supervision be developed, using a combination of data linkage with the JJ NMDS, and administrative data available from youth detention centres.

The next steps required to progress this work include:

- continuing the NYJHAG by renewing membership and updating the terms of reference for 2017–18
- establishing a technical working group under the NYJHAG to support the development of national technical specifications
- liaison with relevant cross-jurisdictional bodies (for example, the AJJA and the NAGATSIHID, which was absorbed into the National Aboriginal and Torres Strait Islander Health Standing Committee in August 2017)
- creating a set of national indicators for the health of young people under youth justice supervision
- identifying priority national data sets (and associated items) capable of being linked to the JJ NMDS for reporting against indicators
- mapping available administrative by-product data to create a picture of current national capabilities and capacity for reporting against indicators
- identifying remaining data gaps
- undertaking a pilot project.

Subject to appropriate resourcing, this work should commence as soon as possible.

1 Introduction

Those involved in the justice system are a vulnerable group, with significant and complex health needs. Compounding this is the over-representation of other already vulnerable groups, such as Indigenous Australians, within this population (AIHW 2015; AIHW 2016a; AIHW 2017). With the use of community detention models throughout Australia, and the extent to which those under supervision move between the justice system and the general community, the health concerns of this population are not relevant only to the management of individuals' health within the justice system, but also to broader community health-management practices.

The justice systems for young people and adults are separate in Australia, each with specific legislation. After a period of national consultation and development work (AIHW 2006; AIHW 2009; AIHW: Belcher & Al-Yaman 2007; Grau 2001), a series of national indicators for the health of Australia's adult prison population were established. These indicators were first reported against in 2009 (AIHW 2010) with the scope of reporting further expanded in 2012 (AIHW 2013). In contrast, little information currently exists at the national level about the health of young people under youth justice supervision in Australia—either in detention or in the community.

Currently the only nationally available information about the health of this population comes from the Australian Institute of Criminology (AIC) National Deaths in Custody Monitoring Program (NDCMP). Since 1992, the AIC has reported on deaths of all young people who, at the time of their death, were in police custody or youth detention or attempting to escape police custody or youth detention. In addition, these NDCMP reports include those young people whose death was caused, or contributed to, by traumatic injuries sustained, or by lack of proper care, while in such custody or detention, or in the process of police or corrections officers attempting to detain them (Baker & Cussen 2015). The *Report on Government Services Youth Justice Services*: chapter 16 does not currently report on any indicators relating to the health of young people under youth justice supervision (Productivity Commission 2016). There is one relevant indicator noted for future development and reporting on secure housing—the proportion of young people exiting youth justice detention to a stable, permanent housing arrangement—however, it is not clear when data on this indicator would be available.

Addressing the paucity of national data on the health of young people under youth justice supervision was recognised as a priority in various key reports between 2011 and 2017, including by the Council of Australian Governments (COAG), NAGATSIHID, the Australian Human Rights Commission (AHRC) and Royal Australasian College of Physicians (RACP). With the over-representation of Indigenous young people evident both in detention (where it was 25 times higher) and in community-based supervision (15 times higher) (AIHW 2017), the importance of developing a national data collection focused on the health of young people under youth justice supervision was explicitly stated in the NAGATSIHID *Strategic Plan 2016–2020* as one of the 6 strategic priorities necessary for supporting the Australian Government's health goals for Aboriginal and Torres Islander people to improve health outcomes and achieve health equality by 2031 (Department of Health 2013). Strategic priority 4 states:

While available data suggest that Indigenous over-representation in youth detention is increasing, there are major gaps in data and information on the health of young Australians in youth detention centres. NAGATSIHID has identified the need to develop data on the health of young people in detention. These data will inform policy and programme development in prevention and health care in relation to Indigenous youth in detention.

Improving national information in this area also supports the agreed standard of practice for juvenile justice administrators, as set out by the AJJA in the *Juvenile Justice Standards 2009*. Standard 10 recognises the need for services that optimise the health and wellbeing of young people under youth justice supervision, including the administration of health assessments on admission to custody; access to a continuum of health care; and access to a range of programs that promote development and wellbeing.

Given the significance of this data gap and its noted importance, the AIHW concluded that a feasibility study that explored available data and the most appropriate methodology for a national youth justice health dataset would provide a clear understanding of what would be required to set up a nationally consistent youth justice health data collection early in the life of the NAGASIHID strategic plan.

The AIHW allocated internal funds to undertake the feasibility study during 2016–17. To assist the AIHW in conducting this work, the NYJHAG was established in August 2016. Drawing on the successful advisory group model used to support the NPHDC work, the NYJHAG was setup as a time-limited group, with representatives from the government agencies responsible for the health of young people under youth justice supervision in the Australian states and territories; a selection of subject matter experts in the fields of adolescent health and youth justice; and a representative each from the AJJA, the ABS and the AIHW. At the inaugural meeting of the NYJHAG, the ultimate aim of the development work was articulated as:

...the creation of a national youth justice health data collection to monitor the health of young people under youth justice supervision and inform the planning, delivery and quality of youth justice health services.

The feasibility study was to support this aim by investigating the options for establishing the national collection and by reviewing (via consultation with the state and territory authorities responsible for the provision of health services to young people under youth justice supervision) what data are currently collected. Consultations were held from October to December 2016 in each state and territory in Australia, and a literature review was completed in January 2017. Further direction was provided by the NYJHAG through to June 2017.

This report outlines the results of those consultations, and ends with some recommended 'next steps' in the development of a national youth justice health-data collection.

2 Background

This section of the report reviews information about what we currently know about the health concerns of justice-involved youth; why addressing this data gap is important; and the governance arrangements for youth justice health services at the time of the 2016 consultations.

In Australia, state and territory governments are responsible for dealing with young people who have committed, or who are alleged to have committed, criminal offences. Young people can be charged with a criminal offence if they are aged 10 and over, and there are separate justice systems for young people and adults. The upper age limit for treatment under the youth system is 17 (at the time of the offence) in all states and territories except Queensland, where the age limit was 16 until recently. Legislation to increase Queensland's age limit to 17 was passed in November 2016, and enacted in February 2018.

Youth justice supervision is a major component of the youth justice system. There are 2 main types of supervision:

- **community-based supervision**, for young people who reside in the community who are supervised by the youth justice department. Young people in community-based supervision may be unsentenced (before a court hearing or while awaiting the outcome of a trial or sentencing) or may have received a sentence of community-based supervision from a court. Community-based supervision also includes young people who have been released from sentenced detention on parole or supervised release
- **detention**, for young people who are detained in a youth justice centre or detention facility. As with those under community-based supervision, these young people may be unsentenced or may have been sentenced to a period of detention by a court.

Young people who are in the youth justice system may also be unsupervised in the community (for example, on unsupervised bail).

Information about young people under youth justice supervision in Australia is collected in the Juvenile Justice National Minimum Data Set (JJ NMDS). Under an agreement with the Australasian Juvenile Justice Administrators (AJJA), data for the JJ NMDS is provided each year by the state and territory government departments responsible for youth justice and compiled and analysed by the Australian Institute of Health and Welfare (AIHW).

The health of justice-involved youth

Youth justice supervision

Data on the number of young people under youth justice supervision are available from the JJ NMDS. In Australia in 2015–16, there were about 5,500 young people under supervision on an average day, consisting of almost 900 young people in detention and about 4,600 under community-based supervision (AIHW 2017). During 2015–16, a total of 11,000 young people were under supervision at some point during the year, with periods of community-based supervision lasting for an average of about 24 weeks and detention for almost 10 weeks.

On an average day, most (84%) of young people under supervision were in the community and the remainder were in detention. However, over 40% (about 4,800) of young people supervised during 2015–16 were in detention at some time during the year.

Youth justice, homelessness and child protection data linkage

The JJ NMDS includes some information on the demographic characteristics of the young people, but does not include any health-related data. Recent data linkage work by the AIHW has linked national child protection, homelessness and youth justice datasets. This work has provided some insights into issues that are relevant to the health and wellbeing of justice-involved youth. Young people under youth justice supervision were 15 times as likely as the general population to be in the child protection system in the same year (AIHW 2016b).

Young people who were under youth justice supervision between 2011–12 and 2013–14, and who received specialist homelessness services (SHS) at some point between 2011–12 and 2014–15, had a number of vulnerabilities that were more pronounced than for other young people who also required these services. Given that those receiving SHS are already a vulnerable population, those in the youth justice cohort appear to be particularly vulnerable. They were more likely than young people not involved in youth justice to be receiving SHS; to require assistance with challenging social/behavioural problems (39% compared with 20%); to be seeking SHS due to lack of family and/or community support (38% compared with 21%); to live alone on presentation to SHS agencies (38% compared with 15%); to experience substance misuse issues (32% compared with 7%); and, for those whose housing situation at the end of SHS support was known, to return to sleeping rough (6% compared with 4%) (AIHW 2016a).

National deaths in custody monitoring program

The AIC NDCMP also provides limited data relevant to the health of justice-involved youth. Since 1992, the AIC has reported on deaths of all young people who, at the time of their death, were in police custody or youth detention, or attempting to escape police custody or youth detention.

The NDCMP reports also records the deaths of all young people:

- whose death was caused by, or contributed to, traumatic injuries they sustained—or by lack of proper care—while in such custody or detention
- who died or were fatally injured in the process of police or corrections officers attempting to detain them (Baker & Cussen 2015).

Other data sources

Outside these sources of national data, current knowledge about the health issues of this vulnerable group is reliant on the few state- and territory-based studies that have been done, such as the Young People in Custody Health Survey (Indig et al. 2011) in New South Wales, as well as from research studies in Australia and internationally. The existing literature highlights a number of areas of concern in the health of this population, which are summarised below. While these studies provide some valuable insights, they do not provide national data, and the infrequency with which they are conducted limits their usefulness for outcomes monitoring.

Mental health and trauma

Mental illness often appears for the first time during adolescence and those involved in the youth justice system are a population at increased risk for developing serious and chronic mental illness (Casswell et al. 2012). Risk factors for the development of mental health problems among young offenders include parental incarceration or death; a history of abuse or neglect; being in out-of-home care; social isolation; and living with someone with physical

or mental disabilities (Kenny 2014). In a Victorian study, young offenders screening positive for psychotic symptoms were more likely than other offenders to have unstable housing, school expulsion and a family history of alcohol and other drug and mental health problems (Degenhardt et al. 2015). Similarly, not being engaged in education, employment or training; frequent drug use; and experience of multiple adverse life events were found to be associated with police contact for young people accessing mental health services (Shepherd & Purcell 2015). Studies both in Australia and internationally have found higher rates of mental health problems among young people in detention than on community-based orders, which may be because the experience of being in detention exacerbates symptoms (Degenhardt et al. 2015; Kinner et al. 2014; Reich 2014).

A meta-analysis of the prevalence of mental health issues among youth in detention found rates of psychosis 10 times those found in the general community (Fazel et al. 2008). Despite high levels of need, mental health service use is often low in this population, particularly when released back into the general community (Barrett et al. 2006; Burke et al. 2015). A New South Wales study found that treatment of antipsychotic diagnoses helped keep an individual in a non-custodial community setting for longer. That is, for each month of antipsychotic treatment in detention, a young person spent an extra 23 days, on average, in the community (that is, not under supervision) following release (Kasinathan 2015).

Traumatic brain injury, which is associated with mental health and behavioural problems, is also significantly more likely among those involved in youth justice than for the general community, usually acquired from sports injuries, falls, motor vehicle accidents or fights (Farrer et al. 2013).

One in 6 young people under youth justice supervision report having deliberately harmed themselves in the previous 6 months and are more likely than other young offenders to have other mental health problems; alcohol and other drug issues; and social risk factors (Borschmann et al. 2014). The rates of mental health diagnoses and suicidal behaviour increase with an increase in youth justice supervision, with higher rates for those in detention than those in the general population and for those in solitary confinement compared with those in mainstream detention (Alcorn 2014; Borschmann et al. 2014; Scott et al. 2015). One quarter of those in youth detention who had ever had thoughts of suicide or self-harm reported an increase in those thoughts after entering custody (Moore et al. 2015).

Disability

Little is known about the disability status of young people under youth justice supervision, with the few studies that have been done pointing to disability being an area of significant concern for this population. A New South Wales study found that almost half (46%) of young people in detention had 'borderline' or lower intellectual functioning, indicating significant impairment, and one quarter (25%) had left school before the age of 14 (Haysom et al. 2014). The cognitive functioning of young people in detention is worse than for those in the general community, particularly for receptive verbal skills (the ability to understand what someone is saying). Speech, language and communication problems are significantly higher among those involved in the youth justice system than in the general population (Bryan et al. 2015).

Fetal alcohol spectrum disorder (FASD) is difficult to diagnose, and often not diagnosed correctly (Freckleton 2016). It is associated with problems with memory; learning; attention; understanding abstract concepts; reasoning; understanding cause and effect; learning from past experiences; information-processing; decision-making; and comprehending social skills or expectations (Passmore et al. 2016). Children with FASD have significant deficiencies with

social skills and empathy, such as understanding what another person feels or believes (Stevens et al. 2015). These difficulties often lead to disrupted education; unemployment; substance misuse; homelessness; mental health problems; early and repeated engagement with the law; problems adhering to conditions of community-based orders; increased risk of entering detention; and poor or easily misinterpreted behaviour while in detention (Passmore et al. 2016). The ability to understand and navigate formal criminal justice procedures is substantially poorer among young offenders with FASD than with other young offenders (McLachlan et al. 2014).

Prevalence estimates for FASD in Australia are based primarily on state- and territory-based studies, and range from 0.01 to 0.68 per 1,000 people (Burns et al. 2013). However, estimates for remote Indigenous communities are as high as 120 per 1,000, which is similar to high-risk populations internationally (Fitzpatrick et al. 2015). Prevalence among justice-involved young people in Australia is not known, but a study to estimate prevalence in the youth detention population in Western Australia was conducted in 2016 (Passmore et al. 2016). Currently, there is a lack of suitable community support services to reduce the risk of re-offending, for those with FASD (Freckleton 2016).

Risky behaviour

In this group of vulnerable young people, risky behaviour is common. The 2009 NSW Young People in Custody Health Survey showed that almost 4 in 5 young people reported being current smokers and consuming alcohol at risky levels, with 2 in 3 reporting illicit drug use in the week prior to custody (Indig & Haysom 2012). These results are similar to the results for prisoners across Australia (AIHW 2015). Internationally, rates of substance use and substance-use disorders among those in the youth justice system have been found to be high—and significantly higher than the general community (Ahmad & Mazlan 2014; Smith & Saldana 2013; Welty et al. 2016). Within the youth justice system, a Victorian study found higher rates of alcohol and other drug issues, including injecting drug use, among those in detention than among those on community-based orders (Kinner et al. 2014).

Justice-involved young people have higher rates of sexually risky behaviours than those in the general community (Golzari et al. 2006). A Swedish study on sexual risk-taking behaviours found that young people in detention were significantly more likely than those in the general community to have had their sexual initiation before 15 years of age; their most recent sexual encounter to have been unprotected and while affected by alcohol or other drugs; to have had more than 6 sexual partners in the last year; to have paid for or been paid for sex; to have been sexually assaulted; to have been pregnant; and to have lower knowledge of—but higher risk for and actually having—chlamydia (Lindroth et al. 2013). Young offenders also have poor knowledge of hepatitis C transmission, and a custodial sentence doubles the risk of infection compared with a community-based supervision order (van der Poorten et al. 2008).

Mortality

The poor health and risk-taking behaviours of justice-involved young people increases their risk of mortality—including when released back into the general population. A data linkage study done in the USA looking at records from initial police arrest of young people through to detention and adult prison over a 13-year period found an overall mortality rate 1.5 times that of the general community, with the rate increasing as the involvement with the criminal justice system increased (Aalsma et al. 2016). Consistent with this, a data-linkage study in Australia found the mortality rate of young people under community-based orders or in detention was 4 times higher than for young people in the general community, with substance misuse being a significant risk factor (Kinner et al. 2015).

Complexities/co-morbidity

The health issues and risk factors highlighted above are often not found in isolation for justice-involved young people. While most young people in the general community have no history of abuse or neglect, disabilities, mental health issues, or substance misuse, most young people in the justice system have more than one of these issues (Mallett 2014). Young people on remand (awaiting trial or sentencing) have poorer mental and physical health; higher prevalence of suicidal thoughts and behaviours; greater family adversity; poorer school attendance; and emotional and behavioural problems interfering with schooling and social activities (Sawyer et al. 2010). Many of these health and social needs have been unrecognised and unmet (Lennox 2014). There is a clear need for services, especially in the community, to be equipped to respond to this co-morbidity and to engage with justice-involved young people, who are often excluded on the basis of risk assessments and have difficulties keeping appointments (Kretschmar et al. 2016; Krieg et al. 2016; Mallett 2014; Stathis et al. 2013).

Studies suggest that, while the needs of young offenders are higher than those of the general community, within the young offender population, the needs of those in detention are higher still. A study in Victoria found that young people in custody were more likely than those on community-based orders to have unstable housing; to have left school by Year 9; to have been expelled from school by age 14; to have multiple youth justice orders; to have substance misuse, including injecting drug use; to have mental health issues including depression, psychosis and self-harm; and to have a family history of substance misuse and incarceration (Kinner et al. 2014). However, the health services available in youth detention centres may be beneficial, with suggestions that unmet need may be higher among those on community-based orders (Kinner et al. 2014) and that health literacy (the capacity to obtain and understand information about health and health services) increases in detention (Holstein et al. 2014).

Issues limiting a national picture

In the absence of an ongoing national data collection, there is no regular national monitoring of the health and risky behaviours of justice-involved young people, or of the health services provided to them. Contrasts and comparisons between different states and territories are problematic, with no national data standards in this area to ensure consistency of data when they are available. Much of the data included in the literature review provided above come from international sources, rather than from Australia, and may not be directly relevant to the Australian context. Equally, with different legislation and policies at state and territory level, there is no certainty that results found in one Australian jurisdiction are generalisable to the rest of Australia.

Why youth justice health data are important

Requests for information about the health of justice-involved young people and the health services provided to them—and intentions to collect data on this topic—have been evident since early 2000. In 2003, the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) responded to the high rates of Indigenous incarceration in Australia by commissioning work to ensure that the health needs of prisoners and young people in youth detention were being met. This work aimed to develop policy guidelines and operational standards for the provision of health-care services to Aboriginal and Torres Strait Islander people held in prisons and youth detention centres (AIHW 2009).

In 2005, the ABS National Information Development Plan for Crime and Justice included 2 relevant priorities to develop statistics on:

- juvenile contact with the crime and justice system including sharing information across sectors such as health (Priority 6)
- health, including mental health, as it relates to crime and justice (Priority 10).

Since then, national data on the health of prisoners has been developed in the form of the NPHDC to report against the National Prisoner Health Indicators (AIHW 2009). However, the health of justice-involved young people has not been included in these national data developments—a fact reflected in the increasing calls for these data more recently.

In 2011, the RACP recommended that the governments of Australia and New Zealand monitor and evaluate health and social outcomes for adolescents during and after incarceration, through annual reporting. Specifically, the RACP recommended collection of data on health-screening and assessment outcomes; recidivism tracking and risk factors; and health and social outcomes; as well as appropriate evaluation and monitoring to ensure policies and programs are effective in meeting the health needs of incarcerated adolescents (RACP 2011).

The House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs included a chapter on the link between health and the criminal justice system in their 2011 report on the Inquiry into Indigenous youth in the system. That report identified alcohol and other drugs; FASD; mental health and emotional wellbeing; and hearing loss as key health factors for Indigenous youth. The recommendations of the report included that the Australian Government, in collaboration with the states and territories, ensure all Indigenous youth who enter the criminal justice system are provided with:

- comprehensive health screening, including for FASD
- access to intensive holistic intervention programs which involve family, mentors and Indigenous leaders and include support for mental health, hearing loss and drug and alcohol reform (from Recommendation 15) (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs 2011).

Building on this work, the Senate Community Affairs Reference Committee (2016) report on the indefinite detention of people with cognitive and psychiatric impairment in Australia recommended that:

...the COAG (Council of Australian Governments) develop and implement a disability screening strategy (including hearing assessments) for all Australian jurisdictions. This screening strategy would apply to all people (adults and minors) who engage with the criminal justice system. The strategy would be applied at multiple points throughout the criminal justice system such as first contact with police, courts, prisons and related facilities (Recommendation 10).

A 2015 report by Amnesty International into Indigenous youth in detention made several recommendations that would rely on health data to implement. These included developing justice indicators to be disaggregated by disability status; identifying the national data required to implement a 'justice reinvestment' approach; and identifying unmet need for bail accommodation—particularly of young people with mental health issues and cognitive impairments including FASD (Amnesty International 2015).

The AHRC recently recommended:

...that the Australian Institute of Health and Welfare (AIHW) and the Australasian Juvenile Justice Administrators (AJJA) work together in 2017 to generate additional publically available data on characteristics of [youth justice] detainees, their treatment and conditions (Recommendation 4).

Noting the potential benefits of the AIHW's data-linkage capabilities, the Human Rights Commission advised that it would be highly desirable to broaden the collection of the JJ NMDS to include information about children and young people within this population with disabilities; to seek to link these data to other relevant national health and social determinant datasets; and to pursue development work to facilitate the collation and reporting of national data on the health of young people under youth justice supervision (AHRC 2016).

The call for increased data linkage across sectors was echoed in the 2016 COAG *Prison to Work Report*, which included a recommendation that the Australian Government, together with state and territory governments, conduct a project linking the data for persons moving through the child protection, justice, health, welfare and employment systems (COAG 2016).

The impending Royal Commission into the Protection and Detention of Children in the Northern Territory also identifies the significant role that issues of health and health-service access play in the interaction between young people and youth justice systems. The Royal Commission indicates in the interim report that health issues for children and young people will form a significant part of the Commission's considerations as it moves towards final recommendations (Royal Commission into the Protection and Detention of Children in the Northern Territory 2017).

National and international standards

Internationally, Australia is signatory to mandated minimum standards of health-care provision for young people in detention:

- *United Nations Standard Minimum Rules for the Administration of Juvenile Justice* ('the Beijing Rules')
- *United Nations Convention on the Rights of the Child*
- *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*
- *Optional Protocol on the Convention Against Torture* (OPCAT).

Nationally, the AJJA have agreed juvenile justice standards, including a standard on health and wellbeing. The stated purpose of that standard is to 'provide services that optimise health and wellbeing', and includes:

- 10.1 Health assessments on admission to custody identify urgent health needs
- 10.2 Children and young people in custody have access to a continuum of health care.

Currently, there are no available national data by which these standards and obligations can be judged or reported.

Governance of youth justice health in Australia

The governance of youth justice health in Australia is broadly similar to that of prisoner health: a state- and territory-based responsibility that is primarily, but not exclusively, delivered through the relevant health department, with models varying among the states and territories (AIHW 2015).

Youth justice services are governed by either the justice-related department (in New South Wales, Victoria, Queensland and Western Australia) or the community services-related

department (in South Australia, Tasmania, the Australian Capital Territory and the Northern Territory) (Table 2.1). In all jurisdictions except Western Australia, health services are provided to young people in detention by the relevant state or territory health department. In Western Australia, these services are provided through the youth justice section of the Department of Corrective Services. Some jurisdictions (such as Victoria) contract a health-service provider and, in the remaining jurisdictions, the services are provided directly by the health department.

Table 2.1: Governance of youth justice health services, 2017

State/territory	Youth justice services	Youth justice health services
New South Wales	Department of Justice	Justice Health and Forensic Mental Health Network
Victoria	Department of Justice Health Services	Department of Justice Health Services
Queensland	Department of Justice and Attorney-General	Queensland Health
Western Australia	Department of Corrective Services	Department of Corrective Services
South Australia	Department for Communities and Social Inclusion	South Australia Health
Tasmania	Department of Health and Human Services	Tasmanian Health Service
Australian Capital Territory	Community Services Directorate	Health Directorate
Northern Territory	Territory Families	Department of Health

Young people under community-based supervision orders access health services in the general community, rather than having them provided through the departments responsible for youth justice.

Each jurisdiction uses different databases, for both custodial information and health information (Table 2.2). In some jurisdictions there is a common identifier across the different systems (such as in New South Wales). In jurisdictions without a common identifier, there are varying degrees of integration of the systems.

Table 2.2: Administration of youth justice health services, 2017

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Detention centres	6	2	2	1	1	1	1	2
Community offices	34	19	26	31	13	n.a.	1	n.a.
Average daily population in detention	299	168	187	138	56	9	9	49
Average daily population in community-supervision	1,202	921	1,285	594	253	132	71	139
Health provider	NSW Justice Health & Forensic Mental Health Network	Youth Health & Rehabilitation Services (contracted)	West Moreton & Townsville Hospital & Health Services Lady Cilento Health Services	Youth Justice Services	Women's & Children's Health Network	Correctional Health, Tasmanian Health Service	Justice Health	Top End Health, Central Australian Health Services
Custodial database ^(a)	OIMS	CRIS	ICMS & DCOIS	TOMS	C3MS	Community Services data warehouse	CIS	IOMS
Health databases ^(b)	JHeHS; PAS; iPharmacy	Mastercare	HBCIS	EcHO	eCHIMS	Prison Health Pro; WebsterCare	MAJICER	PCIS
Custodial identifier ^(c)	AUID	CRIS	n.a.	TOMS	n.a.	n.a.	CIS	IJIS
Health identifier ^(d)	AUID	Mastercare	n.a.	TOMS	n.a.	n.a.	ACTPAS	PCIS

(a) Custodial databases: OIMS (Offender Information Management System); CRIS (Client Relationship Information System); ICMS (Integrated Client Management System); DCOIS (Detention Centre Offender Information System); TOMS (Total Offender Management System); C3MS (Connected Client and Case Management System); CIS (Client Information System); IOMS (Integrated Offender Management System).

(b) Health databases: JHeHS (Justice Health electronic Health System); PAS (Patient Administration System); HBCIS (Hospital Based Corporate Information System); EcHO (Electronic Health Online); eCHIMS (electronic Child Health Information Management System); MAJICER (Mental health, Alcohol and other drug, Justice health integrated data system); PCIS (Primary Care Information System).

(c) Custodial identifier: AUID (Area Unique Identifier); CRIS (Client Relationship Information System); TOMS (Total Offender Management System); CIS (Client Information System); IJIS (Integrated Justice Information System).

(d) Health identifier: AUID (Area Unique Identifier); TOMS (Total Offender Management System); PCIS (Primary Care Information System).

3 Feasibility study outcomes

This section of the report summaries the work undertaken during the 2016–17 feasibility study.

Methodology

Information for this study was gathered in 2 stages:

1. **a literature review** of Australian and international literature on the health of justice-involved young people under youth justice supervision (a synopsis of which is presented in Section 2)
2. **a series of consultations** with departments responsible for youth justice and the provision of health services to young people under youth justice supervision in each state and territory (presented below).

The literature review identified what is known about the health of young people under youth justice supervision; provided supporting evidence for the health issues relevant to this population; and reinforced the lack of available, regularly reported national data in Australia. The literature review was completed in January 2017.

The consultations, held during the period October 2016 to January 2017, were used to canvas support for the development of a data collection, and to identify suitable data-collection methods. Attendees from different jurisdictions varied, depending upon governance arrangements; whether there were projects in place to upgrade or establish electronic health records databases; and availability. Overall, the consultations included representatives from departments and sections responsible for:

- the provision of health services in youth detention
- the operation of youth detention centres
- supervision of young people on community-based orders
- electronic health records.

The consultation phase identified in-principle support for a data collection and possible options for data-collection methods. The results of the consultations are outlined below.

Support for a youth justice health data collection

Consultation undertaken as part of the feasibility study identified significant gaps in available national data and current knowledge about the health status and risky behaviours of young people under youth justice supervision, and about the health services provided to them. Jurisdictions agreed that it would be both worthwhile and feasible to seek to establish a methodology, including data sources, for national reporting.

Agreement on priority data items

The literature review identified that the most important health-related issues for justice-involved young people are mental health; disability including FASD; substance misuse; sexual health including sexually transmitted infections; and trauma. There was general agreement during the consultations that these issues are directly relevant to the

Australian youth justice population and should be prioritised in the development of a national data collection and associated indicators.

Issues of mental health, disability, substance misuse and sexual health broadly align with indicators under the NPHDC; however, the NYJHAG noted that the scope and focus of indicators related to these issues would likely differ between the youth and adult populations. Further, with a number of indicators under the NPHDC reliant on self-reported data, differences in methodology between the NPHDC and a future youth justice health collection would create additional disparities in indicator sets.

FASD and trauma do not form part of the NPHDC, and have been identified as being specifically relevant to the youth justice population in Australia. Complexities associated with identifying FASD would mean that any reporting on this issue would be an undercount of the prevalence of the issue, and caution would need to be exercised if indicators for FASD were to be included.

In addition to those issues identified above, consultations also indicated that structural and social determinants (disengagement with school; housing; employment; relationships; and disruptions) were highly relevant to the health of young people under youth justice supervision. These determinants are identified throughout the literature review in Section 2 as risk factors for a variety of health issues within this population. While socioeconomic indicators are present in the NPHDC, again the scope and focus of these indicators would need to be revised for the youth justice context. Parenthood and carer responsibilities, post-release mortality and morbidity issues, and continuity of care and health outcomes were also identified by the NYJHAG as priority areas.

Scope

The NYJHAG agreed that those in detention (sentenced and remand) and those serving community-based orders should be considered 'in scope' for a national collection on youth justice health (noting that this is also the scope of the existing JJ NMDS). However, it was noted that, during indicator development, there would need to be further careful consideration of those considered 'in scope', and that the population for specific indicators may vary. (Remand, for example, can create difficulties for capturing meaningful health data, particularly discharge data as presented in the indicators under the NPHDC, due to the high 'churn' for this supervision type, which can be as short as a couple of hours).

Support for inclusion of community-based supervision

From the consultation process it was determined that any national data collection should include information on the health of young people under community-based supervision. Community-based supervision models are used throughout Australia, and young people in detention are a small minority of the number under supervision on an average day (16%) (AIHW 2017). In addition to the limitations arising from small numbers, there is good evidence that data obtained solely on those in detention would not be representative of the youth justice population (Kinner et al. 2014).

The inclusion of young people under community-based supervision raises a number of ethical and methodological issues. The departments responsible for the provision of health services to young people in detention do not have similar responsibility for such provision to young people under community-based supervision. Community-based supervision orders may sometimes include health-related conditions, such as attendance at an alcohol or other drug counselling service—however, the primary aim is usually to reduce re-offending rather than to address health issues. Therefore, departments responsible for supervision of young

people on community-based supervision orders rarely have responsibility for ensuring health needs are met. Young people under community-based supervision access community-based health services which are separate from youth justice health services. This means that obtaining data on the health of young people under community-based supervision will require a separate data collection methodology.

Further, while it is feasible that self-reported survey data could be collected by case officers during routine visits with those under community-based supervision, this would create a significant additional resource burden. In addition to the added demands on case officers created by such an approach, with this population consisting of minors, the sensitivity of some areas of interest (for example, trauma or self-harm) can create significant concerns around the ethics of collecting data in this fashion, if suitable supports are not able to be provided.

The NPHDC methodology is unsuitable

The NPHDC provides information on the health of people entering the adult prison system (prison entrants); conditions and problems managed by prison health clinics; medications taken by prisoners; the health and prison health clinic experiences of people due to be released from prison (prison dischargees); and the operation of the prison health clinics. Most data are collected during a two-week data collection period with the medications form completed on a single day as a snapshot. This enables a reasonable amount of data to be collected whilst minimising the disruption to the prison clinics.

There are 5 collection forms used for the NPHDC:

- **prison entrants form**—completed for prisoners entering prison during the data- collection period. It includes questions relating to demographics of the prison entrants; mental health; chronic diseases; disability; substance and alcohol use; use of health services; and pregnancy
- **prison discharge form**—completed for prisoners who were scheduled to be released from prison within the two-week collection period and up to 4 weeks from the data-collection period. It includes questions relating to demographics of the prison dischargee; mental health; chronic diseases; substance and alcohol use; use of prison health services; injuries in prison; and preparation for release
- **clinic form**—completed for all visits to the clinic during the data collection period. It includes questions about demographics of the prisoner; who initiated the visit; the problems managed at the visit; and the type of health professional involved
- **medications form**—completed for all prisoners in custody who were administered prescribed medications. It includes questions on the demographics of the prisoner and medication types administered
- **prison establishments form**—completed once for each prison clinic. It includes questions about whether health services were provided by Aboriginal Community Controlled Health Organisations (ACCHOs) or Aboriginal Medical Services (AMSs); discharge planning, immunisation; full-time equivalent staffing; and hospital transfers.

Supplementary administrative by-product data are also collected on notifications of sexually transmissible infections and the number of prisoners received into and released from prison.

The NPHDC is conducted over a 2-week census period every 3 years. The majority of the data collected for the entrants and dischargee sections are self-reported data. Surveys can be a simple and efficient method of collecting data: advantages include not needing specialised training for interviewers; being generally quicker than diagnostic interviewing

(for health conditions); and that it provides the direct perspective of the person being interviewed. The main disadvantage of self-reported data is that there is no independent validation of the responses. This may lead, for example, to deliberate under-reporting of illegal activities. Self-reported data may be compared with other self-reported data, but may not be directly comparable with reports and studies that use other data collection methods.

The feasibility study found that there are several important differences between the youth justice and adult prison populations which are relevant to the development of a data collection. Consultations indicated that the methodology and structure of the NPHDC is not a suitable template for a national youth justice health collection.

Flow of those under supervision

There are differences in the flow of adult prisoners and the flow of young people through detention centres, with youth detention having a higher proportion on remand and very short stays. Consultations indicated that stays in remand could be as short as a matter of hours. Further, data from the JJ NMDS for 2015–16 indicate that the national median length of a completed individual period of detention was 8 days (AIHW 2017).

The short stays for some types of supervision create difficulties for a survey-based data-collection methodology, such as the one used in the NPHDC. The high rate of entries and exits in youth detention centres means that substantial resources are required to complete the required data collection forms during a census period.

In addition, shorter periods of supervision mean that discharge indicators are potentially less informative and relevant. The prison discharge form used in the NPHDC was designed to collect information on health services provided in custody; health changes in custody; and preparation for release. Shorter stays in detention within the youth justice population, by definition, mean fewer opportunities to visit the clinic, and less time for health changes to take place. Relevant questions from the prison discharge form may be limited to those relating to preparation for release.

Inclusion of community-based supervision

As noted under the 'Scope' section above, strong support was expressed during the consultation for those under community-based supervision to be included in a national youth justice health data collection. The way community-based supervision is used in the youth justice context makes reporting on this group highly relevant to the development of indicators for youth justice health. Further, including data on young people under community-based supervision, as well as on those in detention will increase the size of the sample and allow for more meaningful analyses.

However, as noted above, the inclusion of those young people under community-based supervision raises a number of resource issues in using a data-collection methodology such as the one used for the NPHDC. While a survey-based data collection for young people under community-based supervision would be technically possible, it would be very difficult to achieve, and would be likely to require researchers to be employed to administer the survey. This is likely to be beyond the scope and resources of an ongoing monitoring data collection.

Issues with literacy, attention and capacity for self-reporting

Advice received during the consultation period was consistent with research literature (Lansing et al. 2014) that indicates that young people in detention are likely to suffer impairments in areas of receptive vocabulary, oral reading and cognitive functioning.

Consultations indicated that those under youth justice supervision are unlikely to be able to complete a long health assessment due to poor literacy levels, and issues with attention/distractibility and mental health.

The existing NPHDC prison entrants and prison discharge forms would take too long to complete, making them unsuitable for the youth justice population. It would be more feasible to restrict any survey-type data collection to a very short and focused prison entrants form. Such a form could supplement other data collection methods and fill significant gaps if required.

Relevant health concerns

As noted previously, while there are common areas of health needs between adult prisoners and young people under youth justice supervision (such as mental health, substance misuse and sexual health), there are areas relevant to the health needs and outcomes of young people that are not included in existing adult prisoner health indicators (for example, issues of trauma and abuse). Further, the focus of indicators for a youth justice cohort are likely to differ from the focus of existing indicators under the NPHDC, and the scope of indicators in areas of structural and social determinants will differ for the 2 populations. In addition, some indicators from the NPHDC would not be applicable to young people under community-based supervision.

The tendency of young people to have a relatively brief period of contact with youth justice services would also need to be carefully considered when scoping indicators.

Selected data items

While a more detailed analysis of the relevance of existing NPHDC indicators to a youth justice cohort was recommended as part of the development work following the feasibility study, the NYJHAG provided specific feedback in relation to a number of items in the NPHDC (listed here in alphabetical order). It is important to note that, in addition to the differences between youth justice and adult prisoner populations, the focus, scope and relevance of data items may also differ between those under community-based supervision and those in detention within the youth justice cohort.

Health-related data items

Assistance with quitting smoking

The relevance of data in relation to assisted quitting would vary across states and territories based on jurisdictional policies in this area. While other jurisdictions indicated that data on nicotine replacement therapy were not pertinent, Victoria and the Australian Capital Territory indicated that these data would be useful.

Cancer, cardiovascular disease and arthritis

Data on cancer and cardiovascular disease were considered to be relevant to the youth justice population. Data on arthritis were not considered to be relevant.

Diabetes

In relation to diabetes, the NYJHAG indicated that data should seek to capture if the young person is insulin-dependent.

Health service use in the community

Noting that data on reasons for not using services would be difficult to capture through administrative by-product or linked data, the NYJHAG indicated that access to a Medicare

card and the level of engagement/concern of the young person's carer with the young person's health were relevant factors when considering the perceived accessibility of health services.

Hospitalisations

The NYJHAG noted that 2 additional focus areas in relation to injuries sustained by a justice-involved young person—stabblings and whether the injuries resulted in a hospitalisation—were not found in the NPHDC. It was also emphasised the importance of data on self-harm, noting that a compounding issue for collecting data in this area is extensive under-reporting by young people themselves.

Methadone, suboxone and naltrexone programs

The NYJHAG generally agreed that data in relation to these programs were not relevant in the youth justice context.

Medications

In relation to medication types provided to young people while in detention, in addition to categories listed in the existing NPHDC item, stimulants (Ritalin) and prescribed amphetamines were considered relevant. Likewise, data on 'immunisation catch-ups' including varicella, pneumococcal and influenza should be captured in a dataset on youth justice health. Drugs used to treat opioid dependence, Parkinson's disease, nicotine dependence, benign prostatic hypertrophy, and diuretics were not considered relevant for the youth justice cohort.

Oral health

In relation to oral health, the NYJHAG considered that the frequency with which oral health examinations are provided by detention facilities was important, but so too were data on the timeframes for accessing oral health services and on the need for oral health services.

Pap smears and mammograms

The NYJHAG saw no need to seek to collect data on these topics for the population of interest.

Pregnancy

In addition to seeking to collect data on whether a young person had ever been pregnant, and related data on the age at first pregnancy, the NYHAG agreed that it would also be important to try to obtain information on whether justice-involved males had ever been responsible for a pregnancy.

Sexual health education programs

Collecting data on the frequency with which sexual health education programs are run by detention facilities was considered relevant.

Personal and social data items

Abuse

It was acknowledged that administrative data on substantiated cases of abuse or neglect for young people under youth justice supervision would be important for informing the picture of the young person's wellbeing, but would also under-report of the prevalence of these issues for justice-involved youth. However, other forms of data collection would also likely result in under-reporting and potentially raise significant ethical concerns.

Children in the home vs. dependants

The NYJHAG indicated that data collected on the ‘number of children living with’ a young person (prior to detention) should seek to distinguish between the ‘number of children in the residence’ and the ‘number of children dependent on’ the young person.

Concerns of the young person

The NPHDC captures data on a range of concerns held by prisoners, including the degree to which prisoners are worried about:

- current imprisonment
- family or relationships in the community
- relationships in prison
- mental health issues
- physical health issues
- alcohol, tobacco and drug issues.

While it would be difficult to capture data on the current concerns of the young person outside a self-report survey instrument, the NYJHAG noted that concerns about education, housing and employment are relevant to the youth justice population, in addition to categories captured in the NPHDC.

Indigenous health-care worker (ACCHO or AMS)

Looking at whether young people had contact with an Indigenous health worker while in detention, and whether there was an Indigenous service providing in-reach to detention centres were considered to be appropriate data items to seek to collect.

Out-of-home care

The AIHW noted that there is an established annual project that already links national child protection data with youth justice data. The NYJHAG agreed that collecting data on the placement of justice-involved youth in out-of-home care was very important for informing the picture of the young person’s wellbeing.

Sex

The NYJHAG considered that the collection of ‘gender’ would be more appropriate than ‘sex’, but acknowledged the need to align with any established national metadata standards. Specific questions related to transgender individuals were considered a lower priority, with a preference for these questions to be incorporated into a subcategory of the ‘Sex/Gender’ response options.

Schooling

In relation to schooling, it was considered important to include data related to ‘current schooling’ in addition to ‘highest level of completed schooling’ and whether school had been attended in the last 30 days. Questions about ‘exclusion’ from school were also considered to be valuable for a youth justice cohort—noting that a date of (or time since) last exclusion would provide valuable context.

It was also recommended that data be collected on whether the young person re-engaged with schooling while in detention, and whether this continued after their release.

Work and government payments

Collecting data on whether the young person had/was expected to have paid employment within 14 days of leaving detention was considered relevant. Likewise, it was considered appropriate to seek to monitor the extent to which government payments were received.

Alternative data collection methodologies

The feasibility study indicated that the NPHDC methodology is not a suitable template for a youth justice health collection. The differences between the 2 populations of interest, including the size of the populations; the length of time under supervision; the inclusion of community-based supervision; and the capacity to effectively engage with, and respond to, a lengthy self-report survey, make the use of administrative by-product data a better option for supporting the aims of a national youth justice health collection.

As part of the consultation process, states and territories were asked about the feasibility of using administrative by-product data to report on the health of young people under youth in detention, and alternative data collection methodologies for gathering data on those under community-based supervision.

Administrative by-product data collection

There are no states or territories that regularly and routinely collect and report on the health of young people under youth justice supervision in their jurisdiction. However, most jurisdictions have some form of electronic health record, either existing or under development, from which some data could be extracted for a national data collection. Consultation in relation to available administrative by-product data indicated that some data on the health of young people in detention would be available (or would be likely to become available soon) as administrative by-product data and could thus be collected for every young person in detention over a 12-month period. This was considered to be a more feasible way of collecting data for those in detention than a survey. The capacity to collect data for a full 12-month period would also help to address potential issues regarding the size of the youth justice detention population.

Responses to requests for information during the feasibility study indicate that, in the short term, these data would be likely to be limited to data on medications, some information on visits to the detention centre health clinics (such as when, the type of health professional visited, reason for visit), and possibly some information on suicide or self-harm risk. In many jurisdictions, some data from the NPHDC entrants form are either currently available in equivalent youth justice administrative systems or included in planned upgrades or new database systems within the 12 months following 2016–17. The exception to this is South Australia, where available electronic data are very limited, and there are currently no state-wide upgrades planned that would expand these reporting capabilities.

There are no health-related data available from the departments responsible for youth justice health for young people under community-based supervision, because there are no health services specifically provided to this population. Data for this group would need to be sourced from regular community-based health services for the general population.

As part of ongoing development work in this area during 2017–18, the NYJHAG recommended that further consultation be undertaken to determine a national list of available data items.

Short entrants and discharges survey

The existing long entrants and discharges surveys used in the NPHDC were considered inappropriate for the youth justice cohort. However, a shorter version of these that focused on health issues not able to be addressed by other means was considered to be more feasible, in terms of young people's capacity to respond. This approach was still considered to be undesirable by the NYJHAG, due to concerns around resourcing, ethics and consent (particularly for those under community-based supervision).

Data linkage

The existence of the JJ NMDS provides an opportunity to capture data about the health of young people, both in detention and under community-based supervision, through data linkage with other relevant national health and welfare data collections. The JJ NMDS includes the AIHW's statistical linkage key (SLK), creating the potential for linkage to other AIHW data collections. The JJ NMDS includes data from each state and territory from 2000–2016, with some limitations to the available data from Western Australia and the Northern Territory. This creates a different potential starting point than the prison sector for the development of a data collection, where such administrative data were not available nationally at the time of development.

Consultations during the feasibility study indicated support for the use of data linkage as an appropriate methodology for collecting information on the health and wellbeing of young people under youth justice supervision. Data linkage using the JJ NMDS could provide data on the health of young people while under community-based supervision, and before and after detention and community-based supervision. This could be supported by administrative by-product data from detention centres, to provide data on the health of young people while in detention. The resulting set of indicators would be likely to be less comprehensive than those derived from the NPHDC in terms of health status and health behaviours information, but could provide more complete information on service usage and health changes before and after detention, and on the continuity of care for young people.

The resourcing required for this—and the feasibility of using data linkage in a national data collection for ongoing monitoring purposes—is unclear at this stage and requires further consultation. However, a number of related projects have already been completed or are underway. The AIHW already links national child protection data with the JJ NMDS annually. Work linking the JJ NMDS and national homelessness data has also successfully been completed.

In addition to providing valuable information on the incidence of abuse or neglect experienced by young people under youth justice supervision and on the care arrangements for these young people, national child protection data include data on the disability status of young people, and the requirement for, and conducting of, health checks for those placed in out-of-home care.

The national homelessness data also contain a number of variables of interest to the health of young people including:

- reason for seeking assistance:
 - domestic and family violence
 - sexual abuse
 - substance misuse issues
 - mental health issues

- medical issues
- disengagement from school or other education
- unemployment
- transition from custodial arrangements
- support services provided:
 - family and domestic violence services
 - family, relationship assistance
 - assistance for challenging social/behavioural problems
 - assistance for trauma
 - specialist counselling services
- experience of repeat episodes of homelessness
- participation in National Disability Insurance Scheme.

Further, the AIHW is involved in a demonstration project trialling linkage of hospitals, Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and National Death Index data. This includes admitted patient care, emergency department care and non-admitted patient care. Arising from this demonstration project, a national database is likely to be developed over time, starting in 2018. Some of the potential variables of interest to youth justice health from the national database are:

- funding source—which may include corrections (for hospitals data)
- urgency of admission
- diagnoses
- external causes of injury or poisoning
- MBS item code
- PBS medications
- underlying cause of death.

The AIHW is also engaged in scoping work exploring access to disability support services information through Centrelink payments data, which may yield relevant data that can be linked to the JJ NMDS cohort.

Other health- and welfare-related data collections held by the AIHW warrant further investigation in relation to how they may inform a national picture of the health and wellbeing of justice-involved youth. These include alcohol and other drug treatment services, disability services and mental health services.

Alcohol and other drug treatment services

The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) provides information on publicly funded government and non-government agencies providing alcohol and/or drug treatment services, including community-based ambulatory and outpatient services. As well as information about when treatment services were received, variables of interest to the health of young people include:

- injecting drug use status
- principal drug of concern
- referral source—includes correctional services, police and courts

- usual accommodation type prior to service episode—includes supported accommodation, hospitals and custodial accommodation.

A proof-of-concept project linking the AODTS NMDS with the JJ NMDS has already commenced.

Disability services

The Disability Services National Minimum Data Set (DS NMDS) includes information about disability services provided and the service users who received the services. As well as information about when various disability services were received, variables of interest to the health of young people include:

- activity and participation need for assistance
- effective communication indicator
- primary disability group
- principal source of cash income
- living arrangement (alone, with family or with others)
- residential setting accommodation type
- labour force status.

Mental health services

The AIHW collects data on a range of mental health services, including youth-specific services and forensic mental health services, in a number of data collections. These collections do not include the *Statistical linkage key 581* (SLK-581), which would facilitate data linkage, and there are no plans in the near future to include this linkage key in these data sets. There are, however, other identifying variables which may allow for data linkage to occur, and it is feasible that these data collections will undertake linkage with the linked health data set (including MBS and PBS data) currently under development by the AIHW. Direct linkage with these data sets is likely to be a longer-term goal for any youth justice health data collection.

4 Conclusions and recommendations

This feasibility study identified significant gaps in available national data and current knowledge about the health status and risky behaviours of young people under youth justice supervision, and about the health services provided to them. Jurisdictions agreed that it would be both worthwhile and feasible to seek to establish a methodology, including data sources, for national reporting.

The study found that it is feasible to establish a national data collection on the health of justice-involved young people in Australia, but that it is unlikely to closely resemble the NPHDC. Rather, the most appropriate methodology for the youth justice cohort would involve a combination of administrative by-product data available from youth detention centres and data linkage between the JJ NMDS and other identified national data sets.

The next steps required to progress this work include:

- continuing the NYJHAG through the renewal of membership and the terms of reference for 2017–18
- establishing a technical working group under the NYJHAG to support the development of national technical specifications
- liaising with relevant cross-jurisdictional bodies (for example, AJJA and NAGATSIHID—absorbed into the National Aboriginal and Torres Strait Islander Health Standing Committee in August 2017)
- creating a set of national indicators for the health of young people under youth justice supervision
- identifying priority national data sets (and associated items) capable of being linked to the JJ NMDS for reporting against indicators
- mapping available administrative by-product data to create a picture of current national capabilities and capacity for reporting against indicators
- identifying remaining data gaps
- undertaking a pilot study.

Subject to appropriate resourcing, this work should commence as soon as possible.

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List of tables

Table 2.1: Governance of youth justice health services, 2017 10

Table 2.2: Administration of youth justice health services, 2017 11



Currently, little information exists at the national level about the health of young people under youth justice supervision in Australia. This feasibility report outlines how this critical data gap might be addressed into the future through the use of currently available data and data linkage.

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