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# THE TRAINING CENTRE VISITOR

AND

# THE OFFICE OF THE CHIEF PSYCHIATRIST

# Inspection Report

## Department of Human Services

## Adelaide Youth Training Centre

*Joint Inspection of the Mental Health and Wellbeing of children and young people detained at the Adelaide Youth Training Centre*

Status: Public Report

**October 2025**

Training Centre Visitor

Government of South Australia
Office of the Chief Psychiatrist

# Contents



**Content Warning**

Caution: Some people may find parts of this report confronting or distressing.

Please carefully consider your needs when reading the following information as it contains discussion about intentional self-harm, mental ill-health, detention settings, and distressing content related to child experiences of detention. If this material raises concerns for you contact Lifeline on 13 11 14 or see other ways you can seek help.

The Office of the Chief Psychiatrist (OCP) and the Training Centre Visitor respectfully acknowledge the individuals, families, and communities in South Australia who are impacted by intentional self-harm each year.

Aboriginal and Torres Strait Islander readers are advised that information relating to Indigenous intentional self-harm is included.

# 1. Executive Summary

This Joint Inspection examines systemic conditions and practices at the Adelaide Youth Training Centre (AYTC) that impact the mental health and wellbeing of children and young people, through the lens of the:

- Training Centre Visitor's legislative oversight functions under Part 3 of the *Youth Justice Administration Act 2016* (SA); and
- Chief Psychiatrist legislative oversight function under section 90 of the *Mental Health Act 2009*

## Training Centre Visitor Summary

The Training Centre Visitor's work and focus is grounded in legislative compliance, the Charter of Rights for Youths Detained in Training Centres and relevant international instruments including the United Nations Convention on the Rights of the Child and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules).

Children and young people detained at AYTC present with complex needs shaped by histories of trauma, cultural displacement, systemic racism, and adverse childhood experiences. It is therefore unsurprising that their mental health challenges can be more pronounced than their peers. Despite this, the custodial environment itself, inclusive of frequent lockdowns, prolonged isolations, and limited access to therapeutic, educational, and cultural supports compounds distress for this population and further marginalises already vulnerable children and young people. In particular, the report identifies that:

- Prolonged or repeated use of isolation and segregation continues to be a practice, including in cases involving children with psychosocial disability.
- Access to meaningful daily routines, including education, cultural support, recreation, and family contact, is inconsistent and often curtailed by staffing and operational constraints.
- Aboriginal children are disproportionately affected, both in the rate of detention and in the intensity of restrictions experienced, exacerbating the legacy of intergenerational trauma and systemic harm.

Legislative and policy protections have not always been consistently implemented or recorded in a way that allows for effective oversight.

While some operational reforms have been undertaken since the commencement of the *Youth Justice Administration Act*, significant gaps remain in the AYTC's ability to provide a rehabilitative and child-centred environment that is mindful of the mental wellbeing of children and young people detained at AYTC. This report calls for systemic attention to these matters, and for urgent workforce cultural and operational shifts that uphold the rights, dignity, and developmental needs of children and young people in detention. This cannot solely be systems or procedural shift for AYTC, it requires strong leadership, investment in staff and implementation of the strategies and interventions recommended by expert mental health practitioners.

The findings underscore the importance of independent oversight in bringing to light practices that are harmful to children and young people's wellbeing and contrary to law and human rights standards. They also reinforce the need for a child-focused, trauma-informed and culturally safe youth justice system that sees mental health not solely as a clinical matter, but as a shared responsibility tied to the care, treatment and control of young people under the State's authority.

Shona Reid
Training Centre Visitor

## Office of the Chief Psychiatrist Child Mental Health Summary

The Office of the Chief Psychiatrist has a focus on supporting best practice mental health care for all South Australians. It has a role in reviewing care for those who are receiving public mental health care and specifically in the Mental Health Act Legislation Section 90 (1) to promote continuous improvement in the organisation and delivery of mental health services in South Australia. Children and adolescents in custody are a particularly vulnerable group who rely upon the adults around them and the facilities provided to live well and live safely while in custody.

Mental health envelopes the entire experience of the child in this setting and is not only related to the delivery of health care services. Mental health is a foundational component of a child's overall well-being and development. It influences how children think, feel, respond to others and behave, shaping their ability to cope with stress, relate to others, and make healthy choices.[1] The primary goal is always to keep children out of a detention environment. In parallel with efforts to keep vulnerable children out of detention, the provision of high quality, evidence-based, trauma-informed, culturally appropriate, and age- and gender appropriate healthcare in all places of detention is critical to optimising health outcomes and ensuring that these children can reach their full potential and enjoy the highest attainable standard of health.[2]

Many South Australian children in youth detention have experienced significant family and life disruption before coming to the attention of the justice system. These Adverse Childhood Experiences (ACEs), such as abuse, neglect, or household dysfunction, have been linked to significant negative effects on child development.[3] ACEs also disrupt normal brain development and increase the risk of mental health disorders such as anxiety, depression, and post-traumatic stress disorder (PTSD). The toxic stress caused by ACEs can impair the child's ability to regulate emotions and respond to challenges effectively.[4] Children in our justice systems carry these effects with them when they enter detention, and their symptoms often heighten due to their surroundings.

Early mental health challenges and adverse social settings also impact academic performance. Many children with engagement with justice services have had fractured school enrolment, multiple education gaps and this has greatly impacted their social skills, and physical health, making early intervention critical to support positive outcomes.[5] Early intervention including recognising and acting on this when a child is in care or in detention is essential to avoid deterioration and to improve their outcome.

There are great risks for ongoing deterioration in mental health in those children who have been in detention. One study of 2849 children released from detention in Victoria, Australia between 1988 and 1999, and followed for an average of 3.3 years, found that the rate of death for males was 9.4 times higher than among the age- and sex-matched general population, and 41.3 times higher for females. In this cohort, most deaths were due to drug overdose (46%) or suicide (24%).[6]

The South Australian youth training centre can provide a space where mental health, health and education interventions can be provided to assist these children with complex needs. It provides a single space where a shared professional review of a child's health, educational and mental health state can occur. The forensic child and adolescent mental health team and the other health providers at AYTC are clearly working to support the vulnerable children and adolescents in the centre and work within this complex and multi-barrier

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[1] World Health Organisation (2024). Mental health of adolescents. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

[2] R M, J F, N K, et al (2022). Comprehensive Clinical Paediatric Assessment of Children and Adolescents Sentenced to Detention in Western Australia. Journal of Fetal Alcohol Spectrum Disorder; 4(1): 16-31.

[3] Felitti, V. J., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine, 14(4), 245-258.

[4] Shonkoff, J. P., et al. (2012). The lifelong effects of early childhood adversity and toxic stress. Pediatrics, 129(1), e232-e246.

[5] Centers for Disease Control and Prevention (CDC). (2020). Child and Adolescent Mental Health. https://www.cdc.gov/childrensmentalhealth/index.html

[6] Kinner S A, Calais-Ferreira L; Young JT, Borschmann RB; Clough A; Heffernan E. Rates (2025). Causes and risk factors for death among justice involved young people in Australia; a retrospective, population-based data linkage study. *Lancet – Public Health* Vol 10 Issue 4, E 274 – E 284.

environment to advocate and provide care to the children. There are opportunities to examine the pathway that a young person takes through the training centre, their access to services including health services and where changes could be made to meet their complex developmental and health needs.[7] It is also a place where plans can be built to lower their risk of reoffending and also be discharged to a safer and developmentally appropriate location on leaving detention.

The OCP was welcoming of the opportunity to work with the Training Centre Visitor and her team to allow a broader input by our team in this child and adolescent setting. We continue to support positive change for best mental health outcomes for these children.

Associate Professor Melanie Turner
Deputy Chief Psychiatrist

### Joint Recommendations Summary

The recommendations in this report reflect areas, that if changed, can greatly improve the mental health of children and young people in the AYTC. These include:

- Strengthen Therapeutic Service Access and Oversight.
- Transform the Physical and Procedural Environment.
- Reform Behavioural Management and Restrictive Practices.
- Address Equity, Inclusion, and Cultural Safety.
- Promote Rights-Based Participation and Accountability.

## 2. Legislative and Rights Framework

### 2.1 Mandate

2.1.1 Mental health and wellbeing of children and young people detained at the Adelaide Youth Training Centre is protected by a framework of **South Australian legislation** and **international human rights standards**, which together require the provision of therapeutic, trauma-informed, and developmentally appropriate care.

2.1.2 ***Youth Justice Administration Act 2016*** **(SA)**: Establishes the statutory obligations of the Chief Executive and staff in youth detention. It requires that services provided to young people promote their development, wellbeing, and reintegration, with special regard to mental health, disability, and cultural identity (Sections 3 and 20).

2.1.3 ***Youth Justice Administration Regulations 2016*** **(SA)**: Mandates that decisions made in relation to children take into account their best interests, health needs, cultural identity (especially for Aboriginal children), and capacity to participate (Regulations 5-7).

2.1.4 ***Mental Health Act 2009*** **(SA)** and ***Consent to Medical Treatment and Palliative Care Act 1995*** **(SA)**: Governs consent, access to treatment, and rights to appropriate and least restrictive care in cases of mental illness or psychiatric intervention.

[7] Additional references for the Office of the Chief Psychiatrist Child Mental Health Summary:

Anda, R. F., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174-186.

Masten, A. S. (2014). Global perspectives on resilience in children and youth. *Child Development*, 85(1), 6-20.

National Institute of Mental Health (NIMH). (2023). Child and Adolescent Mental Health. https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health

R M, J F, N K, et al (2022). Comprehensive Clinical Paediatric Assessment of Children and Adolescents Sentenced to Detention in Western Australia. *Journal of Fetal Alcohol Spectrum Disorder*; 4(1): 16-31.

Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). *From Neurons to Neighbourhoods: The Science of Early Childhood Development*. National Academies Press.

2.1.5 *The Charter of Rights for Youths Detained in Training Centres* ('The Charter of Rights'): Section 22 of the *Youth Justice Administration Act 2016* (SA) provides that there will be a Charter of Rights for Youths Detained in Training Centres. A person exercising functions or powers related to young people in detention (including staff members of AYTC) must have regard to, and seek to implement to the fullest extent possible, the terms in the Charter.[8]

### 2.2 International obligations

2.2.1 UN Convention on the Rights of the Child (UNCRC): Affirms the rights of children to the highest attainable standard of physical and mental health (Article 24), protection from harmful treatment (Article 19), and recovery from trauma in environments that uphold dignity (Article 39).

2.2.2 Mandela Rules (UN Standard Minimum Rules for the Treatment of Prisoners): Require that all prisoners, including children and young people, receive health care equivalent to that available in the community, including mental health services provided by qualified professionals (Rules 24-27, 109).

2.2.3 Havana Rules (UN Rules for the Protection of Juveniles Deprived of their Liberty): Prohibit practices harmful to mental health such as prolonged isolation, excessive use of force, and denial of psychological care (Rules 50, 64-67).

2.2.4 Beijing Rules (UN Standard Minimum Rules for the Administration of Juvenile Justice): Emphasise the importance of care, education, and treatment that promotes rehabilitation and avoids stigmatisation (Rules 5, 26.4).

2.2.5 Bangkok Rules (UN Rules for the Treatment of Women Prisoners): Provide guidance on mental health care for detained girls and young women, including protection from coercive or harmful practices (Rules 6, 12, 25, 29).

2.2.6 Paris Principles (Principles relating to the Status of National Institutions): Highlight the role of independent monitoring bodies, such as the Training Centre Visitor, in preventing ill-treatment and ensuring rights compliance.

## 3. About the Adelaide Youth Training Centre (AYTC)

### 3.1 Purpose and Function

3.1.1 South Australian legislation allows for the establishment of 'training centres' as 'necessary or desirable for the care, rehabilitation, detention, training or treatment of children and young people.[9]

3.1.2 AYTC as South Australia's sole youth detention facility, for young people aged 10-17 (and older if under YOA provisions).

3.1.3 AYTC provides secure care for children and young people on detention orders imposed by the Youth Court or on remand awaiting a hearing.

3.1.4 While detained, children and young people are under the custody of the Minister for Human Services. The Chief Executive of the Department of Human Services (DHS) is responsible for ensuring that there are adequate arrangements in place in the AYTC to maintain young people's physical, psychological and emotional wellbeing, and promote their social, cultural, educational and vocational development.[10]

[8] See The Charter of Rights in Appendix to this report.

[9] Youth Justice Administration Act 2016 (SA), s 21.

[10] Youth Justice Administration Act 2016 (SA), s 21, 24.

3.1.5 The primary purpose of youth detention in South Australia is rehabilitation and supporting children and young people to reach their full potential as members of the community.[11]

## 3.2 Location and Infrastructure:

3.2.1 Physical layout

i. AYTC is situated on a 7.7-hectare greenfield site in Cavan, South Australia.[i]

ii. This physical layout reflects AYTC's dual functions of custodial containment and rehabilitative care.

iii. Facility design is shaped by legislative standards under the *Youth Justice Administration Act 2016* and relevant regulations, with a focus on safety, security, access to education, health care, and reintegration supports.

iv. AYTC is comprised of multiple accommodation (five) units, each operating as a distinct living area within the overall secure perimeter of the site.

v. Each unit includes individual sleeping rooms (referred to operationally as "bedrooms"), shared common areas, meal service areas, and access to outdoor courtyards for exercise and recreation.

vi. The facility also includes administration buildings, health clinic, and dedicated spaces for psychological and case management services.

3.2.2 AYTC is divided into five separate units, each accommodating a maximum of 12 children and young people.[12]

i. Children and young people in these units are grouped by age, gender, and requirements arising from risk assessments, including any 'non-associations' they may have with other young people.[13]

ii. Populations may move around over time; however, certain units always house the same cohorts of children and young people, because of their specific location or facilities.[14]

iii. As a general rule, units accommodate groups of children and young people with the same or similar routines, balancing staffing needs and managing experiences/needs for young people.

iv. A 'protective actions' response may be required for children and young people at the AYTC. This is generally where children and young people are separated from the 'general population'. Protective Actions provide a 'range of additional actions and supports available to support a resident in consideration of both their static and dynamic risk factors. Protective Actions are tailored to a resident's individual needs in consideration of their safety, the safety of others and the security of [the Centre]'.[15]

v. Boys and young men are separated into groups that align with age-based routines.

vi. Girls and young women are separated from boys and young men. Their unit is located at the rear of the property and surrounded by specially constructed fencing to limit visibility between girls/young women and boys/young men.[16]

3.2.3 Medical, mental health and relevant internal DHS services:

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[11] Youth Justice Administration Act 2016 (SA), s 3(2).

[12] Accommodation for up to 60 beds across five units.

[13] 'Non-associations' (or 'no mixes') are when young people are not allowed to be in the same unit or classes, usually because they have been in conflict either in the community or while in detention. This may be based on information the Centre has obtained from the community, young people, or SAPOL. Young people do not always agree with non-associations in place.

[14] Frangipani has 'hardened' rooms with steel panels covering TV controls and light switches.

[15] Government of South Australia, DHS, Adelaide Youth Training Centre – Operational Order 69: Use of Restricted Routine (v 2.2, 26 September 2018), p 17.

[16] Ordinarily, all girls/young women are accommodated together, regardless of age group or their type of routine.

i. AYTC contains a dedicated health centre[ii] equipped for primary health care delivery and access to allied health, mental health, dental, GP, and substance use services.

ii. Clinical consultations typically occur in designated consultation rooms, separate from accommodation units, to ensure privacy and medical confidentiality.

iii. At the time of the inspection, Child and Adolescent Mental Health Service (CAMHS) Forensic Services provides a specialist service within AYTC. This tertiary mental health service is provided through the Women's and Children's Health Network (WCHN). CAMHS Forensic Services (all services) is staffed by a Psychiatrist (1.0FTE), Psychiatry Registrar (0.3FTE), Clinical Coordinator (1.0FTE), Administrative Support (1.4 FTE), Aboriginal Social and Emotional Wellbeing Workers (4.0FTE), Senior Aboriginal Social and Emotional Wellbeing Worker (1.0FTE), Social Worker (1.0FTE), Senior Allied Health Professionals (2.0FTE), Psychologist (1.0FTE), Clinical Nurse (1.0FTE), Clinical Nurse Consultant (2.0FTE), Nurse Practitioner (1.0FTE), and multiclassified (0.75 FTE).[17]

iv. At the time of the inspection, DHS Youth Justice Assessment and Intervention Service (YJAIS) and Enhanced Support Team (EST) are small multidisciplinary allied health teams that support young people and work with operational staff. YJAIS is a specialised allied health service that provides assessment, intervention, and consultancy services for eligible young people in custody and in the community. EST also works with operational staff to equip operational staff with tools to respond therapeutically to complex behaviours in the custodial environment. YJAS and EST share a Principal Psychologist (1.0FTE). In addition, YJAIS is staffed by a Lead Psychologist (1.0FTE, currently 0.8), Senior Speech Pathologists (2.0FTE currently 1.2), Senior Occupational Therapist (1.0 FTE, currently vacant), Senior Youth Justice Psychologists (1.6FTE). YJAIS is currently funded for 1.0 FTE Speech Pathologist; the additional resource is a temporary measure to help fill service some gaps. EST is staffed by a Clinical Manager (1.0FTE), and Senior Behaviour Support Practitioners (3.0FTE currently 1.4). Itis important to note that EST is only funded for 2.0 FTE Behaviour Support Practitioner. The service has been temporarily topped up to 3.0FTE, though this is currently vacant. At the time of the inspection, the services are transitioning to a new service model, where YJAIS and EST will merge to form Youth Justice Clinical Services (YJCS). There are no changes to FTEs as part of this shift, and not new positions are being created at this stage.

v. At the time of the inspection, Metropolitan Youth Health (MYHealth) health service in AYTC is provided by WCHN and staffed by a small Nursing (2.0FTE), Medical (0.3 FTE), Aboriginal Clinical Health Practitioner (0.4 FTE) and Admin staff (0.1 FTE) within limited hours Monday-Saturday.

vi. MYHealth nurses provide primary care, including health assessments, sexual health screening, hearing screening, immunisations and minor injury treatment.

vii. They coordinate medication management, including prescribing, ordering, and charting for pre-existing conditions; manage triage and clinic access, determining which young people require GP review in the onsite clinic; respond to acute health concerns, including sleep issues, infections, drug withdrawal, and mental health symptoms; facilitate diagnostic and specialist referrals, including virtual health services, Priority Care Centres, and Emergency Departments; coordinate with visiting specialists and outpatient departments, and provide advocacy and follow-up care.

viii. There is no capacity for urgent medical monitoring or short-term inpatient care onsite.

3.2.4 Education and recreation facilities.

i. On-site education is provided through the Youth Education Centre by the Department for Education, which delivers curriculum-aligned learning programs to eligible children and young people.

[17] This does not include any current reduction in hours of any roles.

ii. Attendance and access to the onsite school is determined each day in consultation with AYTC management.

iii. Vocational training and programs are delivered in specialist classrooms and program rooms located within the AYTC grounds.

iv. Gymnasium, swimming pool, sports courts and oval[iii] are available for use at the AYTC.

3.2.5 Security and movement

i. Movement between areas is tightly controlled through a network of secure corridors, electronic locking systems, and monitoring technologies.

ii. AYTC operates a central control room responsible for surveillance and coordination of unit operations, as well as smaller 'observation/control rooms' in each accommodation unit.

3.2.6 External access and family contact

i. AYTC includes designated visiting areas, including contact and non-contact visit rooms, allowing for family and professional interactions under supervision.

ii. Legal and advocacy visits occur in secure private rooms designed to ensure confidentiality.

## 3.3 Population Profile

3.3.1 Children and young people in the Adelaide Youth Training Centre on the date of the inspection, 23 January 2025:

| | |
|---|---|
| **Total number of children and young people** | 55 |
| Aged between 10 years and 13 years | 5 |
| Aged above 14 years | 50 |
| **Gender: girls and young women** | 8 |
| **Gender: boys and young men** | 47 |
| **Gender: non-binary or other** | 0 |
| **Cultural identity[18]** | |
| Aboriginal | 34 |
| Non-Aboriginal | 21 |
| CALD | 8 |
| Proportion of Aboriginal and/or Torres Strait Islander children and young people in the AYTC | 34 out of 55<br>62%[19] of total population were Aboriginal children and young people |
| **Children and young people in care[20]** | 8 |
| **Legal status: CYP on remand[21]** | 52<br>95%[22] of total population were on remand |
| **Legal status: CYP sentenced to detention** | 2 |
| **Legal status: sentenced to imprisonment (18 years old)** | 1 |
| **Children and young people with disability** | unknown[23] |

[18] The cultural identity recorded here are based on the population reports that are provided to the TCV daily. These population reports use the language of 'ethnicity' and 'Aboriginal and Torres Strait Islander Status'. The TCV acknowledges the limitations in language and cultural identification during the admissions process, and that the cultural identity of individual children and young people may be different to, or more dynamic and personal than, what is recorded through the admissions process and in this population information.

[19] 61.818%.

[20] Children and young people under the guardianship of the Chief Executive of the Department for Child Protection.

[21] Accused and awaiting court hearing (and therefore no finding of guilt).

[22] 94.55%.

[23] The AYTC is unable to report upon children and young people with disability due to IT system limitations. However, the findings of DHS's Disability Screen Assessment Project illustrate a very high prevalence of complex disability-related needs which the young people detained at the AYTC live with and experience.

# 4. Methodology

## 4.1 Joint Inspection: The Training Centre Visitor including The Chief Psychiatrist

4.1.1 Under section 14 and 16 of the *Youth Justice Administration Act 2016*, the Training Centre Visitor's functions include; to conduct visits to, and inspections of, training centres.[24]

4.1.2 In undertaking a visit to the AYTC, the Training Centre Visitor may take "any other action required" to exercise her functions under s 16(1)(c) of the *Youth Administration Act 2016*.

4.1.3 The *Youth Administration Act 2016* anticipates that the Training Centre Visitor will undertake her functions and powers as reasonably necessary as to express independence under section 12.

4.1.4 As such, the Chief Psychiatrist (or his delegate) can accompany the Training Centre Visitor throughout a visit of the AYTC on the basis that it is necessary to have expert assistance provided by the Chief Psychiatrist or his Deputy in undertaking particular visits.

## 4.2 Joint Inspection: The Chief Psychiatrist including The Training Centre Visitor

4.2.1 The Chief Psychiatrist is appointed as a Statutory Officer under section 89 of the *Mental Health Act 2009*. The Chief Psychiatrist has, among other functions, the authority to monitor the delivery of mental health care and the standard of that care.

4.2.2 Section 90 of the *Mental Health Act 2009* provides context and guidelines for the Chief Psychiatrist, or delegates, to undertake inspections to monitor the safety, quality and effectiveness of South Australian mental health services, and to make recommendations to promote continuous improvement.

4.2.3 In the context of this joint inspection, the place of inspection is the forensic Child and Adolescent Mental Health Service (CAMHS) site located within the Adelaide Youth Training Centre. A separate Chief Psychiatrist Inspection Report for the CAMHS service was provided to WCHN and fact checked and confirmed by WCHN in July 2025.

4.2.4 Under section 91 the *Mental Health Act 2009*, the Chief Psychiatrist may delegate powers or functions of the Chief Psychiatrist to another person.

4.2.5 As such, the Chief Psychiatrist delegated the Training Centre Visitor and her identified staff who attended the joint inspection with powers and functions under sections 90(4) and 90(5) of the *Mental Health Act 2009* which enabled the Training Centre Visitor and her staff to visit CAMHS as delegates in the OCP inspection.

## 4.3 Process

4.3.1 Thursday 16 January 2025, the Training Centre Visitor sent correspondence to appropriate delegates[25] as notification of the inspection of AYTC on Thursday 23 January 2025.

4.3.2 Thursday 16 January 2025, the Chief Psychiatrist sent correspondence to the appropriate delegate,[26] as notification of the inspection of Children and Adolescent Mental Health Service - Forensic Service at AYTC.

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[24] Section 16 of the Act provides that, on a visit to a training centre, the Training Centre Visitor may-

(a) So far as practicable, inspect all parts of the centre used for or relevant to the custody of youths

(b) So far as practicable, make any necessary inquiries about the care, treatment and control of each resident of the centre; and

(c) Take any other action required to exercise the Visitor's functions.

[25] Ms Sandy Pitcher, Acting Chief Executive, Department of Human Services and Mr Sam Ledger, Acting General Manager, Adelaide Youth Training Centre.

[26] Ms Rebecca Graham, CEO of Women's and Children's Health Network.

4.3.3 Procedural fairness processes were afforded to both Department for Human Services and Women's and Children's Health Network.

## 4.4 Site Inspection and Engagement

4.4.1 Site visits and meetings:

i. Joint Inspection Team AYTC site visit and service provider meetings: 23 January 2025 from 9am to 5:15pm.

ii. Joint Inspection Team AYTC site visit and young person engagement: 10 February 2025 from 9.30am to 2.00pm.

iii. OCP Inspection Team meeting with Forensic CAMHS: 11 February 2025 from 3pm to 4.30pm.

iv. TCV Inspection Team meeting with AYTC Management, Youth Education Centre, DHS Enhanced Support Team (EST) and DHS Youth Justice Assessment and Intervention Services (YJAIS) on 12 March 2025 from 9am to 5pm.

4.4.2 Joint Inspection Team included:

i. The Training Centre Visitor; Principal Policy Advisor (OGCYP), Senior Policy Advisor (OGCYP).

ii. The Deputy Chief Psychiatrist; Inspection Coordinator (OCP).

4.4.3 The site inspection included a visit to: Forensic CAMHS; Health Service; AYTC units and bedrooms; 'Safe Rooms'; 'Reflection Room'; general grounds; educational areas and activity spaces.

4.4.4 Joint Inspection team met with: DHS staff; AYTC Centre Management; DHS EST; DHS YJAIS; CAMHS (including the medical, nursing, and Aboriginal cultural staff); and Metropolitan Youth Health (MYHealth).[27]

## 4.5 Data Sources

4.5.1 The Training Centre Visitor (TCV) reviews records to oversee the care, treatment, and control of young people at AYTC. These reviews include:

i. Incident reports and internal reviews.

ii. Feedback from young people.

iii. Medical attendances.

iv. Participation in, or cancellation of, programs and activities.

v. Behavioural monitoring tools such as phase scores and DRMPs.

4.5.2 This data is analysed by the TCV and staff as part of the TCV's statutory functions, alongside insights from young people, staff, and stakeholders. Data obtained through this function is used in this report.

4.5.3 Every effort has been made to ensure accuracy at the time of publication. Some discrepancies may exist due to limitations in data collection, reporting differences, or departmental counting rules.

4.5.4 Where DHS holds comparable data, variation may occur due to differences in methodology or interpretation. Differences may also appear when comparing with national datasets published by the Australian Institute of Health and Welfare.

4.5.5 Where known, significant discrepancies are noted in the text or footnotes. Caution is advised when comparing this report to national or cross-jurisdictional datasets. Some totals may not align due to rounding.

[27] All staff were very helpful and generous with their time. We thank the staff for their invaluable contribution and clear dedication to young people in their care.

# 5. Admissions and Assessments

## 5.1 Admissions and Assessment: Rights Requirements

5.1.1 Upon admission, all children and young people must be treated in a manner that upholds their inherent dignity and ensures their physical and psychological safety.[28]

5.1.2 International instruments require that, immediately upon admission, each child or young person undergoes a comprehensive intake assessment.[29] This assessment must address:

i. Physical and mental health.
ii. History of trauma or abuse.
iii. Disability and developmental needs.
iv. Risk of self-harm or suicide.
v. Cultural identity and religious needs.
vi. Educational status and learning needs.

5.1.3 This inspection focussed on initial physical and mental health screening, cultural and disability needs assessment and suicide/self-harm risk screening.

5.1.4 Children and young people who arrive at AYTC are admitted in the following manner:[30]

i. Transported to AYTC by SAPOL or a secure transport contractor.
ii. Enter through the 'Sally Port', a purpose-built entrance to the AYTC facility.[31]
iii. Have their property collected by staff (including any piercing or jewellery).
iv. Secured in a holding cell.
v. Searched (primarily via scanning machine, rare occurrences where non-clothed searches are undertaken).
vi. Recording of their height, weight, and distinguishing features.
vii. Photo taken.
viii. Directed to shower and issued with anti-lice treatment if appropriate, potentially medically isolated.
ix. Provided with a fresh change of clothing.
x. Interviewed for a custodial intake.
xi. Medically assessed by a MYHealth nurse 'as soon as practicable'.[32]

## 5.2 Admissions and Assessment: Observations

5.2.1 The admissions and assessment environment[iv] is harsh, sterile, and security-driven, creating a distressing and unfamiliar first experience for children and young people entering detention.[33]

[28] UNCRC Article 37(c); Mandela Rules, Rule 1; Havana Rules, Rule 1.

[29] *Youth Justice Administration Act 2016* (SA) s 23; Mandela Rules, Rule 30; Havana Rules, Rule 31–32; Bangkok Rules, Rule 2.

[30] Government of South Australia, Adelaide Youth Training Centre – Security Order 20: Admission Transfer and Release (v2.1, December 2016), para [3.4.3].

[31] Built to ensure children and young people in custody entering and departing from the AYTC do not have the opportunity to escape custody.

[32] Government of South Australia, Adelaide Youth Training Centre – Security Order 20: Admission Transfer and Release (v2.1, December 2016), para [3.4.9].

[33] The TCV acknowledges that since the date of inspection, Security Order 20: Admission Transfer and Release has been reviewed and updated with positive changes and inclusions. Approval date of updated Security Order 20: 29 August 2025.

5.2.2 Children and young people commonly arrive at the AYTC in a heightened state of distress, often following traumatic experiences such as alleged offending, arrest, drug use, police watchhouse detention, isolation from supportive adults and family, sleep deprivation, or exposure to violence.

5.2.3 The admissions process includes procedures that children and young people report as depersonalising, such as removal of personal items, photographing, physical assessments, lice treatment, and medical isolation (rarely, but can include strip searching), all potentially contributing to loss of dignity and autonomy.

5.2.4 Although individual admissions staff may work to build rapport, initial health and risk assessments are conducted in a non-therapeutic environment by non-clinical staff, asking deeply personal questions in a setting with an inherent power imbalance that may not be responsive to the child's potential trauma history or considering cultural safety.

5.2.5 Information exchange during the admission process is one-sided, with a clear expectation of data collection from the child or young person through direct questions from an adult. Although flexible approaches may exist, there is no guaranteed process for communicating key information to the child or young person in a way they can understand or retain and that could assist them with their stay.[34]

5.2.6 There can be significant delays[35] in completing health assessments ('HEADSS' assessments). This can lead to children not being able to physically attend the clinic for an arranged health assessment appointment.

5.2.7 Until these health and medical assessments are completed, children and young people are placed on restricted routines, excluding them from going to school and attending programs, which are key elements of social life within the AYTC.

## 5.3 Admissions and Assessment: Findings

5.3.1 The admissions process at the AYTC is not provided in a trauma-informed way and may exacerbate psychological distress, particularly for children and young people entering custody for the first time or those with recent exposure to traumatic events.

5.3.2 The physical and procedural design of admission reflects a custodial, rather than therapeutic model, failing to safeguard the dignity, mental health, or emotional safety of children and young people.

5.3.3 Mental health needs are unlikely to be appropriately identified during admissions, given the environment, timing, and method of initial assessment, which does not support disclosure or trust-building.

5.3.4 Delays in medical assessment, which are noted to have occurred with AYTC residents, have the potential to leave physical and mental health needs unmet for extended periods, increasing risk and compounding trauma, especially for children and young people with pre-existing conditions.[36]

5.3.5 Restricted routines imposed until medical assessment create additional psychological and social harm, isolating children and young people from peer interaction, educational access, and basic rehabilitation supports.

[34] Government of South Australia, Adelaide Youth Training Centre – Security Order 20: Admission Transfer and Release (v2.1, December 2016), para [3.4.10].

[35] The TCV acknowledges that operational orders suggest that delays over 24 hours should be rare and subject to leadership intervention. See Government of South Australia, Adelaide Youth Training Centre – Security Order 20: Admission Transfer and Release (v2.1, December 2016), para [3.3.9].

[36] DHS notes that "the majority of medical assessments upon admission are completed within the first three days." - comments received from DHS in response to draft joint report, dated 20 August 2025.

5.3.6 Notwithstanding the implementation of an Assessment Tracker to provide AYTC operational management with an overview of a young person's assessment status,[37] the serious concerns above remain.

5.3.7 Children and young people entering AYTC are denied an age and developmentally appropriate introduction to their custodial environment, which can reinforce a sense of powerlessness. This potentially prevents the building of a positive relationship with staff.

# 6. Physical Space and Custodial Environment

## 6.1 Physical space and custodial environment: Rights Requirements

6.1.1 The design and physical layout of the AYTC facility is not a neutral experience for a child/young person. It exerts a profound and ongoing psychological influence, as described to the teams during their inspection.

6.1.2 Custodial architecture, as noted in research literature, can either reinforce trauma and institutionalisation or actively support recovery, development, and dignity.

6.1.3 International instruments call for facilities that detain children and young people to:

i. Be fundamentally different from adult prisons, with design and routines that reflect their age, needs, and vulnerabilities.[38]

ii. Have access to fresh air, exercise, natural light, adequate ventilation, and clean and safe living conditions.[39]

iii. Safeguard children and young people from harm and uphold their right to privacy, particularly in bedrooms, toilets, and during personal care.[40]

iv. Support positive sensory experiences (natural light, colour, sound, texture) and opportunities for safe social interaction.[41]

v. Affirm and accommodate cultural identity, spiritual expression, and connection to Country where relevant.[42]

## 6.2 Physical space and custodial environment: Observations

6.2.1 The AYTC custodial environment is fundamentally risk-oriented, with a physical design and operational culture that centres on control, containment, and restriction.[43] This includes reinforced furnishings, concrete and metal infrastructure[v], and tight regulation over movement, contact, and daily routines.

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[37] During the procedural fairness process, DHS advised the TCV that an Assessment Tracker was implemented in October 2024 to provide operational management with an overview of a young person's assessment status. DHS advised that the Assessment Tracker is available to DHS Youth Justice/AYTC staff, and tracks the date of Case Coordinator Screenings, Youth Education Centre Education Assessments and Health Assessments (HEADSS) for young people from the date of admission and is considerate of custody statues. The inspection team has not observed the Assessment Tracker in practice.

[38] UNCRC, Article 37(c); Havana Rules, Rule 28; Mandela Rules, Rule 12.

[39] Havana Rules, Rule 32; Mandela Rules, Rule 23(1); Bangkok Rules, Rule 5.

[40] Havana Rules, Rule 87(e); Mandela Rules, Rule 51(2); UNCRC, General Comment No. 24 (2019), para 99.

[41] Havana Rules, Rule 47; Mandela Rules, Rule 42.

[42] Havana Rules, Rule 12; Bangkok Rules, Rule 54; *Youth Justice Administration Regulations 2016* (SA), Regulation 5.

[43] The custodial environment includes minimal issue clothing, controlled access to supports and anything which could be perceived as a risk reinforced furnishings and surroundings, high use of concrete and metal in both inside and outside environments, metal enclosures around 'courtyards', and restrictions in daily life.

6.2.2 Bedrooms ('rooms') resemble detention cells more than therapeutic spaces, featuring fixed furnishings, surveillance equipment (viewing window,[44][vi] CCTV, cuff traps[45], intercoms), shoulder-height bathroom walls, and limited access to natural light. Some rooms were observed in poor condition, with food on walls, graffiti, and toilet paper stuck to ceilings. [vii]

6.2.3 *"It is sometimes hard for my thoughts [in here]."* - young person in AYTC in reference to the echoey nature of the indoor environment of the accommodation unit.

6.2.4 Blinds in rooms are controlled by staff, meaning children and young people cannot access natural light or privacy without requesting assistance.[46]

6.2.5 Televisions are available but tightly regulated, switching off automatically at a set time, which can be distressing for children and young people who rely on background noise to manage sleep issues.

6.2.6 Strictly enforced bedtimes and close room proximity can exacerbate sleep disruption, particularly for children and young people with disordered sleep or anxiety, and disturbances often affect entire units.

6.2.7 Children and young people comment on the poor quality of food and food options.[47] Some food practices (such as stockpiling toast and Milo before being secured) may contribute to disordered eating habits.

6.2.8 Prolonged isolation in rooms is common, particularly during restricted routines, with contact limited to staff via intercom or adjacent peers yelling through doors. This isolation occurs for a variety of reasons and is often not reflective of behaviour concerns or risk concerns about a child. Aboriginal children and young people have identified this isolation as especially distressing and described as a 'trigger'.

6.2.9 Movement across the Centre is tightly restricted, typically requiring two operational unit staff to accompany each child. Children/young people and health staff described many instances when staff were not available, and children and young people were then not able to go to health appointments or school due to a lack of staff to escort them.

6.2.10 The outdoor 'courtyard' spaces[viii] attached to each unit are fully enclosed, with cement flooring, wired caged walls, and solid roofing. They therefore offer minimal therapeutic or environmental benefit. These areas create an institutional atmosphere devoid of natural elements or sensory relief. The absence of greenery or open sky was described by one young person as *"anything that could be grown in here would just die,"* reflecting the psychological toll of such sterile, restrictive outdoor environments. Many young people talked about being placed in the outdoor area for a part of each day, even when very hot or very cold, as a way to manage movement of young people in the unit.

6.2.11 Access to indoor 'living areas'[ix] is dependent on staff discretion, and these spaces are functionally institutional. While these areas include basic amenities such as weighted furniture, carpet or linoleum flooring, televisions with restricted channels, and limited recreational options (e.g. a games room with playing cards available or a table tennis table in some units), their design and access remain controlled, with limited capacity to provide comfort or autonomy.

6.2.12 Sleep disruption is a systemic feature of the custodial environment, contributing to dysregulation and undermining mental wellbeing. This includes:

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[44] It was discussed that many young people, particularly those new to the AYTC, find this level of observation unnerving and report feeling exposed.

[45] Cuff traps are small, secure openings in doors which allows floor staff to put on or remove handcuffs without fully opening the door. During modified routines food and drink may delivered this way. The inspection team have also heard that psychology and psychiatric appointments have had to occur by talking to children and young people through the cuff trap in their room door.

[46] AYTC staff advised the blinds in rooms are on timers, children and young people are not able raise blinds on their own. Children and young people do not have the capacity to open the blinds in their room to allow natural light.

[47] DHS notes that "[F]ood is a topic regularly raised through the feedback process and the Youth Advisory Committee, and this feedback is acted upon." – comments received from DHS in response to draft joint report, dated 20 August 2025.

i. Enforced bedtimes and removal of televisions or other self-regulation aids, which disproportionately impact children and young people with trauma histories, neurodevelopmental conditions, or disordered sleep patterns.

ii. The design of units, with rooms in close proximity, means a child in distress (calling for assistance or having sleep disturbances such as night waking or terrors) often affects others, compounding collective dysregulation.

iii. Significant time spent in rooms[48] with no or few in-room activity options during the day frequently results in disrupted circadian rhythms, with children and young people sleeping during daylight hours and struggling to sleep at night.

## 6.3 Physical space and custodial environment: Findings

6.3.1 The physical and operational environment at AYTC is poorly compatible with therapeutic care and is more aligned with adult correctional practices than child development or rehabilitation needs.[49]

6.3.2 The current layout, materials, lighting, acoustics, privacy, and aesthetics make for a generic, completely shared, artificially lit space with little privacy and few positive activities. This negatively affects:

i. Mood regulation and emotional stability.

ii. Sleep and restfulness.

iii. Trust, safety, and relational capacity.

iv. Capacity to engage in rehabilitation or education.

v. Risk of self-harm or withdrawal.

vi. Long-term effects on neurodevelopment and identity formation.

6.3.3 Custodial infrastructure and surveillance measures undermine privacy and autonomy, contributing to distress, hypervigilance, and feelings of exposure, particularly for new arrivals or those with trauma histories.

6.3.4 Children and young people are subject to institutional routines that deny them meaningful control over fundamental aspects of daily life, such as when they sleep, eat, move, or connect with others (conditions that can erode mental health and a sense of agency).

6.3.5 Restricted twenty-minute phone calls were mentioned by most children and young people as a distressing feature of being at AYTC. Many spoke of wanting to talk to more people or talk to them for longer periods due to their feelings of loneliness and isolation.

6.3.6 Living conditions in bedrooms have basic standards of care, with poor cleanliness, damaged surfaces, and blocked views contributing to a degrading and demoralising environment.

6.3.7 Isolation, particularly long hours in their bedroom, limited social interaction, and lack of access to movement or stimulation compound psychological risk, particularly for children and young people already managing trauma, disability, or mental ill-health.

6.3.8 The custodial environment is structurally dehumanising, framed through a lens of 'risk', and its restrictions on autonomy, comfort, and dignity directly undermine the mental wellbeing of detained children and young people.

6.3.9 The AYTC physical environment fails to meet child-centred or trauma-informed standards and presents a serious risk to the psychological health and emotional development of children in custody.

[48] Due to isolations, staff operational need, risk management tool, child or young person request.

[49] The TCV and OCP acknowledge the development of two new units at AYTC (not operational at the time of the inspection so not within scope) that, although still custodial in nature, are designed with the intention to provide more therapeutic spaces for young people. These units will be an important upgrade in facilities for the children and young people in custody who are able to be accommodated in these units.

An environment that assists in feeling safe, both physically and psychologically, is needed to allow a child with developmental trauma to be able to work with the onsite team.

6.3.10 Cumulative institutional sleep disruption is contributing to poor capacity for emotional regulation, behavioural incidents, and mental health recovery.

6.3.11 The custodial environment can replicate or intensify trauma symptoms, particularly for children and young people with histories of neglect, violence, or institutionalisation.

6.3.12 The accommodation units offer natural lighting through glazed windows; however, this is not direct sunlight and does not meet the intent of international instruments direction on natural lighting.

6.3.13 There is little meaningful opportunity for self-initiated movement within the living areas with recreation each day facilitated by operational unit staff.

6.3.14 Living conditions do not accommodate cultural identity, disability, and trauma-informed needs in physical layout.

# 7. Accessing Mental Health Care

## 7.1 Accessing mental health care: Rights Requirements

7.1.1 Access to timely, culturally safe, and developmentally appropriate mental health care is not optional, it is a core human right for all children and young people deprived of their liberty.

7.1.2 AYTC must provide proactive and therapeutic mental health supports that not only respond to crises but promote healing, continuity of care, and dignity.

7.1.3 Children and young people in detention are at significantly heightened risk of mental ill-health due to the trauma that precedes, and is often compounded by, their incarceration.[50]

7.1.4 The National Mental Health Commission has endorsed the Mental Health Safety and Quality Engagement Guide.[51] It is a priority national action involving and recognising the importance of consumer and carer engagement in the development of mental health services. Having children and young people who have been in youth detention contribute to development of the AYTC mental health supports provided by both clinical and non-clinical team would support this recommendation.

7.1.5 International instruments consistently affirm that governments have a heightened duty of care toward children in custody, particularly in safeguarding their mental wellbeing. These include:

i. The right to the highest attainable standard of mental health.[52]

ii. Prompt access to qualified mental health professionals.[53]

iii. Mental health care must be culturally safe and child appropriate.[54]

iv. Ongoing care and continuity across detention and release.[55]

v. Protection from harmful or coercive practices.[56]

[50] Underwood, L. A., & Washington, A. (2016). Mental Illness and Juvenile Offenders. International journal of environmental research and public health, 13(2), 228.

[51] National Mental Health Commission, *Mental Health Safety and Quality Engagement Guide*, Mental Health Commission, 2024.

[52] UNCRC, Article 24; UNCRC, Article 39; Mandela Rules, Rule 24(1).

[53] Mandela Rules, Rule 25(1); Havana Rules, Rule 49; Beijing Rules, Rule 26.4.

[54] Havana Rules, Rule 27; Mandela Rules, Rule 2(2); Youth Justice Administration Regulations 2016 (SA), Regulation 5.

[55] Mandela Rules, Rule 26; Bangkok Rules, Rule 9; UNCRC, General Comment No. 24 (2019), para 104.

[56] Havana Rules, Rule 67; Mandela Rules, Rule 31.

## 7.2 Accessing mental health care: Forensic Child and Adolescent Mental Health Service - FCAMHS

7.2.1 FCAMHS is a specialist service within the Child and Adolescent Mental Health Service (CAMHS) governed by the Women's and Children's Local Health Network.

7.2.2 The team provides a service to a highly complex and vulnerable population in the AYTC facility, an environment that is not health led. The lack of shared documentation and communications between a number of different services, engaged with different aspects of a child or young person's period of time at AYTC, complicates mental health care.

7.2.3 Most children seen by FCAMHS have a history of developmental trauma, undiagnosed or newly diagnosed learning disorders and have significant education gaps. Many have been clients of community CAMHS previously.

7.2.4 FCAMHS review the admission list to AYTC daily to determine which of the young people have been referred or who are already known CAMHS consumers. Young people reflected that they were happy to see CAMHS staff for appointments.

7.2.5 Psychiatrists and CAMHS team staff do attend the AYTC, however, it was reported that their access to children and young people is limited and determined by referral processes and AYTC operations.

7.2.6 They accept referrals from most people who have had contact with the child and adolescent and who have concerns, including at intake assessment. Many referrals are not documented by referrers in writing.

7.2.7 FCAMHS is referred to as CAMHS within the AYTC by children, young people and AYTC staff, and as such this report uses that terminology.

## 7.3 Accessing mental health care: Observations

7.3.1 Direct mental health service provision is delivered by CAMHS and DHS staff from the EST and YJAIS to eligible children and young people, with indirect support also provided by MYHealth clinicians and allied health professionals embedded within DHS.[57]

7.3.2 The mental health and disability-related needs of children and young people at AYTC have become increasingly complex and acute. During the inspection, staff and service providers reported a noticeable rise in:

i. Presentations of psychosis, including drug-induced and early onset forms.

ii. More severe and persistent mental ill-health with symptoms present much of the time.

iii. A higher number of young people presenting with disability-related needs, requiring targeted therapeutic and clinical support. The disabilities include intellectual impairment, learning disorders, neurodevelopmental disorders, foetal alcohol spectrum disorders as well as a smaller number of physical disabilities.

7.3.3 Efforts to improve access to mental health support have been introduced in recent years.[58] These include:

i. A consistent cultural presence onsite seven days per week.

ii. Increased involvement of CAMHS in day-to-day operations of the AYTC and CAMHS offering a weekend onsite clinic.

iii. Improved communication processes regarding medication between MYHealth and CAMHS services.

[57] The TCV and OCP acknowledge the skills, passion and dedication of the workers within these teams.

[58] As advised by: DHS staff and centre management from AYTC; DHS Enhanced Support Team (EST); DHS Youth Justice Assessment and Intervention Service (YJAIS); CAMHS (including the medical, nursing, and Aboriginal cultural staff); Metro Youth Health (MYHealth).

iv. EST and YJAIS team are now physically closer to operational staff responding to incidents. Noted improvements in informal sharing of information.[59]

v. YEC and Behaviour Support Team (BST) are physically closer and share more information, operationally more responsive (noted, that more progress to be made).

vi. Positive anticipation for the new Enhanced Support Model (which is under development) as an overarching framework for positive behaviour support that is informed by trauma informed principles.

7.3.4 Despite these efforts, children and young people report limited access to mental health support, and this was reinforced through observations made during the inspection.

7.3.5 Children and young people described that a way to see someone for mental health care was to approach a CAMHS worker when the CAMHS staff member was physically on their unit.

7.3.6 CAMHS have a clinic on site, however, it was noted to the visiting team that these appointments can be missed due to AYTC operational and staffing constraints.

7.3.7 CAMHS staff described trying to attend units when this occurs but noted that there are no confidential spaces to speak.

7.3.8 CAMHS staff noted that the high turnover of residents and unknown discharge days or times makes it difficult to plan for follow up with children and young people.

7.3.9 The challenges in providing a CAMHS service with shortened and missed appointments, and difficulty in follow up, is seen in clinical documentation.

7.3.10 Children and young people described that they felt reassured that mental health support was available when they saw CAMHS staff at AYTC in person.

7.3.11 Consistent messaging from interviewed stakeholders was that not all children and young people who would benefit from accessing mental health support, in particular an ongoing therapeutic intervention, are eligible for services or able to access support.

7.3.12 Access to psychological support is also limited, with CAMHS, YJAIS, and EST onsite but constrained in capacity. Despite worker's observations of great need, these teams are only able to support the highest-risk children and young people and unable to work with all children and young people in the AYTC who have mental health concerns.

7.3.13 Several young people expressed distress at the quality and availability of therapeutic resources available in the residential units, including:

i. "We're getting treated like animals, and the toys they give us to calm us down are dog toys."

ii. "I just feel fucking helpless."

iii. "I like seeing the health staff, nurse and stuff. But then I just sit here all day."

7.3.14 Mental health concerns can go unidentified on admission, which means children and young people may not receive necessary medication due to missed information during intake.[60]

7.3.15 Operational unit staff are the primary mental health gatekeepers, frequently assuming responsibility for monitoring and responding to the emotional and psychological needs of multiple children and young people in the absence of consistent clinical presence. This model places significant pressure on a workforce not clinically trained to assess or respond to complex mental health presentations.

[59] The TCV notes that DHS therapeutic staff can formally share information with DHS operational staff through the Connected Client and Case Management System.

[60] The TCV is aware of an example where a young person spent several days in the AYTC before it was identified they should have been taking an ADHD medication, unknown to AYTC staff. Details have been provided to DHS on their request. Advocacy was undertaken by the TCV and medication was reinstated.

7.3.16 There is no clear self-referral pathway to CAMHS, requiring children and young people to often disclose distress and request support through operational unit staff to request an appointment with clinicians. This introduces a structural barrier that may delay or inhibit timely access to mental health care.[61]

7.3.17 The response a child or young person receives is generally shaped by subjective operational unit staff interpretation, with some behaviours characterised as "manipulative" or "attention-seeking", while others are met with empathy and care. This inconsistency may result in unequal access to therapeutic support and undermine the identification of risk. It also provides a confusing scenario for a child or young person when very different responses, to the same behaviour, occur from different operational staff.

7.3.18 Containment-oriented training (e.g. MAYBO) remains the dominant framework for intervention when a young person is potentially at risk to themselves and others. This means that children and young people in distress may be supported in that setting by the same operational unit staff involved in previous physical restraints, potentially compounding trauma and eroding trust.

7.3.19 While an 'Incident Feedback Form' is offered to children and young people post-incidents to complete,[62] it is noted that a trauma informed debrief conversation is not routinely offered post restraint to the young person. It is recognised within mental health and health services that trauma informed post incident conversations are best practice. Although the AYTC is not a designated mental health or health service, the inspection team note that processes and responses considered best practice for mental health and wellbeing should still be afforded to young people in the custody of the Government, regardless of their location or youth justice mandate.

7.3.20 Clinical advice in support plans (e.g. DRMPs[63]) is inconsistently implemented. This is often due to operational limitations, lack of specific training, lack of perceived validity of this advice by operational unit staff, or practical constraints during incidents.

7.3.21 Clinicians also raised concerns that there was a general lack of clinical governance and oversight of how DRMPs and any clinical advice within them is managed.

7.3.22 Atypical presentations of dysregulation or self-harm are inconsistently recorded or recognised, particularly where behaviours fall outside common clinical markers (e.g. repeated headbanging or wall punching), increasing the risk of under-identified harm.

7.3.23 Behavioural escalation is frequently interpreted through a compliance lens, rather than as a manifestation of emotional distress,[64] potentially leading to overly restrictive or punitive responses and reducing the likelihood of referral to appropriate support services.

7.3.24 It is acknowledged that many operational unit staff do demonstrate commitment to the care of young people within a highly constrained system and often challenges with staffing numbers.

7.3.25 Health professionals noted the urgent need for expanded training for staff around child development, trauma informed care and responding to mental health distress, reflective supervision, and clinical partnership to build capacity in trauma-informed practice and therapeutic engagement.

7.3.26 Mental health professionals reported concerns that their clinical recommendations were not consistently implemented by operational AYTC staff. It was described that there was a large variety of interest from operational AYTC staff around clinical advice and recommendations.

[61] The inspection team note that a referral to CAMHS can be initiated by MYHealth staff during the young person's initial health assessment or during other visits to the health centre.

[62] With a support person offered if required.

[63] Dynamic Risk Management Plans (DRMPs) are signed, official plans which the AYTC puts in place when they take a Protective Actions response to a young person under the Behaviour Support Plan (BSF).

[64] The inspection team notes that behaviour escalation can also be a clinical manifestation of drug/alcohol withdrawal, which ought to be escalated to MYHealth/CAMHS staff in a time-sensitive manner.

7.3.27 There was a prevailing view that mental health supports were at times devalued or disregarded in practice, resulting in children and young people not being engaged with or supported in alignment with clinical guidance. This disconnect between therapeutic intent and operational delivery risks undermining care plans and the wellbeing of vulnerable young people.

7.3.28 Appointments with internal and external providers (e.g. NDIS therapists) are frequently delayed or cancelled, with an estimation of missed appointments provided to the inspection team as up to 50%.[65]

7.3.29 Different agencies at AYTC operate separate information systems, which risks delays or failures in information sharing across CAMHS, DHS, Education, and MYHealth.

7.3.30 Insufficient information sharing can lead to a lack of complete understanding of the child/young person and places that child/young person as the only person who can give a narrative of what other staff or services have said or recommended for them.

7.3.31 It is noted that if the child is the only person holding the information on what interventions work for them that this is a large responsibility for a child/young person. This is particularly the case for a child with complex mental health and developmental background.

7.3.32 Formal discharge summaries[66] are not provided to children and young people on exit, despite many children and young people engaging with multiple in-centre health services. Access to documentation that helps describe the health care received while in AYTC, for health professionals engaged in their community care, is also very challenging to locate when outside of AYTC and can cause disruptions in care.[67]

7.3.33 Referrals to community-based mental health services are limited, reducing continuity of care post-detention.

7.3.34 CAMHS is not routinely notified of seclusion, restraint, or isolation incidents involving their clients. This is the case even though restrictive practices are known to have a negative impact on mental health.

7.3.35 Mental health support is sometimes delivered through cuff traps or in non-private settings, due to either staffing and operational constraints or risk assessments.

7.3.36 Children and young people report having to choose between accessing care for themselves, which would take operational staff away from their unit - causing the rest of the unit residents to be in lock down - or the whole unit being able to attend school. This creates a disincentive to seek help and places children and young people in a challenging position when wanting to advocate for their own health care.

7.3.37 Therapeutic services are often provided in visible, communal areas, compromising confidentiality and therapeutic safety.[68]

[65] This figure was provided as an estimation, during stakeholder interviews.

[66] Discharge summaries are critically important to ensure that any information or diagnostic assessments undertaken becomes available to the child or young person on exit or provided to their guardian or community supports.

[67] The inspection team acknowledges that health professional engaging in community care can be sent a health summary on request and with consent of the young person.

[68] It was also reported that psychological support is often provided to a young person in their unit space (either in the Games room or courtyard) frequently in full view of staff and other young people, and even in ear shot. This was because otherwise it would not be possible to have the appointment due to staffing constraints. YJAIS staff noted that there was a missed appointment rate of approximately 50%, and a late appointment rate of approximately 100% due to staffing or operational issues. It was also noted that staffing constraints sometimes see appointments with NDIS therapy providers cancelled for children and young people with disability.

## 7.4 Clinical documentation review of CAMHS (by OCP)

7.4.1 OCP inspected clinical documentation; five randomly selected five young people (from CAMHS team caseload of 72) who were registered to the Women's and Children's Hospital Forensic Secure Care service on the day of inspection.

7.4.2 Clinical documentation review was limited to the Computer Based Information System (CBIS) entries of the CAMHS Forensic Secure Care Team. CBIS is the main electronic medical record of the CAMHS services in South Australia. No paper documentation or any notes written within AYTC were reviewed.[69]

7.4.3 Details of these clinical records are in the separate and confidential Forensic CAMHS OCP inspection report, for the purposes of this report the following summary is provided:

i. All five young people, randomly selected, were First Nations young people. All five received support from Aboriginal Health Workers within the Forensic Secure Care Team. For two young people the majority of contacts from the team were for Cultural Support.

ii. Referrals were generally unclear regarding why a specialist CAMHS service was requested or considered required for the young person.

iii. Three referrals to the team were from AYTC staff and two were self-referrals from young people held in custody within AYTC.

iv. One young person had a detailed mental health assessment completed whilst the remaining four had details regarding their cultural background and support networks but very little recorded about their mental health needs. One young person was given a mental health diagnosis.

v. According to CBIS only one young person was seen by the Consultant Psychiatrist- this was the young person who received a detailed, documented mental health assessment. Other health notes are kept in different record systems however and not accessible the OCP reviewers. That documentation may include other aspects of care for the other young people however these are maintained by non CAMHS services and are not available through the SA Health medical records systems.

vi. It was not possible to identify from the mental health notes why the young people were in custody or the length of time they were being held (although this information is documented within AYTC records but not available to the health practitioners).

vii. Finally, three sets of CBIS notes ended suddenly mid-way through December with no explanation. It is not possible to determine if the young people had been released on bail, transferred or simply closed to the team. It was noted by the inspection team that young people can be released from AYTC in evenings and on weekends and that the CAMHS team may not be aware of this occurring.

## 7.5 Accessing mental health care: Findings

7.5.1 Notwithstanding the existence of important screening processes during admissions,[70] mental health needs are often not adequately identified or addressed upon admission, exposing children and young people to delays in care, inappropriate placement, and increased psychological risk in the early days of detention.

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[69] OCP reviews of clinical documentation of a team or service is acknowledged to be limited. However, it is generally possible to gain an understanding of the mental health and care of people receiving care/support from services. In this case it was challenging to get an overall impression of the young people as documentation was limited to the Forensic Secure Care Team. It would appear this team provide in-reach support to young people in custody within AYTC of which no remote access to documentation was possible, therefore the following points relate purely to the CAMHS service provision. **Note that there was no entry marking safe room or reflection room events unless in a clinician's note from an appointment.** Notes or details from other co located health services were not available and not visible in the CAMHS notes.

[70] Including the Custodial Intake Screening Form, HEADSS assessment by MYHealth, and Safety Risk Assessment which aim to identify support needs.

7.5.2 The current mental health service model is fragmented, risk-gated, and unable to meet demand, leading to inequitable access to therapeutic supports and over-reliance on operational unit staff to interpret and respond to complex mental health presentations for which they are not clinically trained.

7.5.3 Clinical recommendations are inconsistently implemented once young people are in an AYTC unit and not subject to clear governance, weakening the impact of care plans and compromising trust and collaboration between health and operational teams.

7.5.4 Whilst limited formal protocols that promote interagency communication exist, concerning gaps remain in interagency coordination, resulting in missed opportunities for trauma-informed, wraparound care. Each service aims to communicate and share information with each other, however, their ability to do this is impeded by small staff numbers and different documentation systems which contain different referral and follow up pathways.

7.5.5 Staffing and operational constraints impact access to care, contributing to missed or cancelled appointments, rushed interventions, and therapeutic sessions conducted in environments that undermine privacy, safety, and dignity.

7.5.6 Children and young people are not empowered to seek support, with no clear self-referral pathway to CAMHS and access mediated by operational unit staff, creating structural barriers to disclosure and perpetuating a custodial rather than therapeutic culture.

7.5.7 Therapeutic engagement is shaped by subjective interpretation and containment-based responses, where staff distinguish between "genuine" and "manipulative" distress, and training remains focused on behaviour control and intervention rather than trauma-informed care.

7.5.8 Signs of psychological distress are sometimes misunderstood or overlooked by operational staff and behavioural escalation is interpreted as defiance rather than emotional dysregulation.

7.5.9 Despite individual commitment, staff operate in a system ill-equipped to support complex mental health needs, with limited access to training, reflective supervision, and clinical partnership, leaving both staff and children/young people at increased risk of harm.

# 8. Accessing General Health Care

## 8.1 Accessing general health care: Rights Requirements

8.1.1 Children and young people in detention remain entitled to the same standard of health care available in the community.

8.1.2 Their vulnerability, due to disrupted developmental, social, and health histories, requires not only equal access but *enhanced, proactive, and trauma-informed* health care.

8.1.3 Denial, delay, or inadequacy of care in a custodial environment constitutes a breach of their fundamental human rights to:

i. Equal access to the highest standard of care.[71]

ii. Timely, confidential and respectful health services.[72]

iii. Special attention to vulnerabilities.[73]

iv. Health promotion and preventive care.[74]

[71] UNCRC, Article 24; Mandela Rules, Rule 24(1); Havana Rules, Rule 49.

[72] Mandela Rules, Rule 26(1); UNCRC, General Comment No. 24 (2019), para 99.

[73] Mandela Rules, Rule 27; Bangkok Rules, Rule 6.

[74] Havana Rules, Rule 49; Mandela Rules, Rule 28.

v. Continuity of care across custody and community.[75]

## 8.2 Accessing general health care: Observations

8.2.1 Children and young people at AYTC often have complex health needs due to poverty, neglect, untreated illness, and disconnection from primary health care before detention.

8.2.2 Health services are not available 24/7, with nursing coverage six days per week and limited medical presence (e.g. three times weekly medical staff present on site), leaving non-medical staff to triage health concerns outside clinic hours.

8.2.3 Children and young people are unable to consistently access general practitioners, nurses, dental services, optometry, immunisations, and sexual and reproductive health care as a matter of routine, not just in emergencies.

8.2.4 Medical issues after hours are triaged by non-clinical staff, who escalate to supervisors for locum or hospital support, although locum attendance is rare.

8.2.5 Children and young people cannot easily self-refer to health services, creating reliance on staff referrals and limiting opportunities for confidential or discreet disclosure of health concerns.

8.2.6 Health care responses are prioritised for physical injuries, with limited recognition or care pathways following episodes of distress or self-harm without visible injuries.

8.2.7 Children and young people are treated with empathy and involvement in decision-making as it relates to their interactions with MYHealth. However, it was reported to the inspection team that there are appointment back logs due to AYTC operational and staffing constraints. MYHealth nursing staff do their best to alleviate this by attending the units for reviews where possible.[76] .

8.2.8 No health workers are present on units, meaning medication administration, recording and pre/post administration observations are the responsibility of operational unit staff, who dispense PRN[77] medications without clinical oversight.

8.2.9 It is noted, in general, CAMHS staff do not prescribe PRN medication to avoid operational unit staff, who are not health workers, determining when it would be given. Clinical incidents reviewed by OCP found instances where youth workers had administered medication to residents that had not had a medical officer review nor was the medication ordered for the resident and blank paper used to document medication administration times.[78] Overall the SA Health Safety Learning System showed 10 instances of medication errors including wrong dispensing and doses missed from Jan 2024 to Jan 2025.

8.2.10 Medication charts are handwritten, and systems are fragmented, with medication ordered through local pharmacies and managed manually by operational unit staff.

8.2.11 Post-restraint assessments are ad hoc and focused only on physical health, lacking standardised or trauma-informed follow-up for psychological impacts of restraint or seclusion.

8.2.12 Young people are screened for pre-existing conditions, medication requirements and recent medical care during initial health assessments with the team collecting information and arranging follow up. However, delays in these essential assessments due to operational constraints may mean that

[75] Mandela Rules, Rule 26(2); UNCRC, Article 25.

[76] Comments received from WCHN in response to draft joint report, dated 19 August 2025.

[77] PRN is a medical term that comes from the Latin phrase “pro re nata,” meaning “as needed.” Such medications are meant to be taken on an as-needed basis, to address acute conditions like pain or nausea, or to aid in managing ongoing ailments, such as allergies and asthma.

[78] Cited by OCP in the Safety Learning System. 26 January 2024 to 13 January 2025 logged as prescribing or administration of medication; patient information, access/discharge; information technology or supply of medication incidents. All related to medication-based treatment for a young person in AYTC.

children and young people with pre-existing health conditions, drug use or untreated injuries may have to wait for these issues to be identified or addressed.[79]

8.2.13 Information sharing across health services is fragmented, with separate systems used by DHS, MYHealth, and CAMHS limiting visibility and continuity of care.

8.2.14 Medical records are incomplete and dispersed, with treatment information held across IT systems, manual logs, or verbal requests, impairing oversight and accountability.

8.2.15 Staffing constraints directly impact access to health services, with reports of appointments cancelled or missed due to inadequate staff availability or unit lockdowns.

8.2.16 Due to multiple systems and unclear governance structures for staff it was unclear if an error in medication, appointment planning or care occurred for a young person - who would report this to a senior staff member, what remediation or learning would take place and how the need for any systemic change would be identified.

8.2.17 AYTC and other DHS staff suggest systemic reform, recommending a 24-hour health model with unit-based clinicians, centralised information sharing, and an onsite inpatient unit to reduce ED transfers and improve clinical oversight.

### 8.3 Accessing general health care: Findings

8.3.1 The absence of a 24/7 health service undermines timely and appropriate clinical care, particularly after hours when non-clinical staff must make complex medical decisions.

8.3.2 Operational unit staff are inappropriately relied upon to manage and monitor health issues, exposing children and young people young people to avoidable risks due to lack of clinical training.

8.3.3 Limited access to physical and mental health care compromises health, with service access determined more by operational feasibility than clinical need.

8.3.4 The inability of children and young people to self-refer to health without having to speak to operational staff creates a structural barrier to care, reducing autonomy and increasing reliance on discretionary staff referrals.

8.3.5 Medication management lacks clinical oversight, raising risks related to accuracy, safety, and appropriate administration of psychiatric and general medications.

8.3.6 Dispersed and incomplete health records hinder oversight, preventing accurate tracking of medical care, follow-up needs, and statutory compliance.

8.3.7 Health care can be disrupted by staffing and operational constraints.

8.3.8 Interagency communication is inadequate, which risks limiting coordinated and comprehensive responses to young people's complex physical and mental health needs.

8.3.9 Existing models do not meet the scale or complexity of need at AYTC, and staff across disciplines have identified that a more intensive, integrated health model is urgently required.

## 9. Accessing Family and Support Networks

### 9.1 Accessing family and support networks: Rights Requirements

9.1.1 Preservation of family and cultural relationships is a fundamental human right for all children, including those deprived of their liberty.

[79] The inspection team acknowledges the important and dedicated work of health teams to provide children and young people in AYTC with support with health issues, especially when young people have not been able to access health support in the broader community.

9.1.2 For many children and young people in detention, particularly Aboriginal and Torres Strait Islander children, family connection is not only about emotional wellbeing but about survival, cultural identity, and healing.

9.1.3 International law recognises that ongoing connection to family and support networks is essential to a child's wellbeing, emotional regulation, identity formation, and successful reintegration. Detention should never sever the bonds of kinship, culture, or care.

9.1.4 International instruments are clear:

i. The right to maintain family contact is absolute.[80]

ii. Family engagement must be actively facilitated, not restricted.[81]

iii. Cultural and kinship connections must be respected.[82]

iv. Children in care have dual entitlements to family and support.[83]

## 9.2 Accessing family and support networks: Observations

9.2.1 Loss of connection to the outside world significantly impacts children and young people's mental health, with children and young people reporting that the absence of normal supports (e.g. friends, walks, social media) contributes to emotional distress and behavioural escalation.

9.2.2 Children and young people have no control over who they can contact, with approval of phone contacts and visitors managed by guardians or the Department for Child Protection (DCP), which may result in blocked or delayed contact with key support people.

9.2.3 Children and young people in care report feeling forgotten, with concerns that DCP carers and caseworkers disengage once a child/young person enters detention.

9.2.4 Children and young people on restricted routines (e.g. DRMPs) are particularly vulnerable to feeling isolated. Some rely on phone calls as their only external contact.[x]

9.2.5 Non-English speaking children and young people face additional isolation, as phone calls may be their only opportunity to communicate in their language and connect with someone who understands them.

9.2.6 Children and young people who are parents face complex emotional and logistical challenges, including shame, operational barriers, and dependence on others to facilitate visits with their children, which further isolates them from their families.

9.2.7 In-person visits are limited by geography, cost, and AYTC requirements, disproportionately affecting Aboriginal children and young people from remote communities and those who are culturally and linguistically diverse with overseas or regionally based families.

9.2.8 A phone call allocation is provided to children and young people each week, with the number of calls allocated per week dependent on their routine or phase level.[84][85]

i. "That's 20 minutes [a day] to talk to our families." - young person in AYTC.

ii. "I have to work out who to call, and I can't talk too long. That's not right." - young person in AYTC

[80] UNCRC, Article 37(c); Havana Rules, Rule 5; Mandela Rules, Rule 58(1).

[81] Havana Rules, Rule 60; Mandela Rules, Rule 106.

[82] UNCRC, Article 30; Havana Rules, Rule 12; *Youth Justice Administration Regulations 2016* (SA), Regulation 5.

[83] UNCRC, Article 20; Havana Rules, Rule 80.

[84] Each child or young person is allocated a minimum$1.40 per week for the purposes of using the phone system (each call to a personal number deducts a nominal 10 cents from their weekly call allocation). The allocation is figurative only. Children and young people can be allocated additional phone calls outside of phase progression according to their individual needs.

[85] Government of South Australia, Adelaide Youth Training Centre – Security Order 55: Monitored Phone System (v3, February 2022), para [3.1.3].

9.2.9 Phone call availability is constrained by operational unit staffing, with limited time windows and too few phones per unit, leading to competition and conflict between young people.

9.2.10 Children and young people are entitled to personal visits and can only be visited by people who have been screened and approved.[86] Unless there are exceptional circumstances, no visitor will be permitted entry unless a booking has been made.[87]

9.2.11 The administrative process for visits is burdensome, with restrictive booking procedures, requirements for accompanying adults for child visitors, and subjective staff assessments (e.g. on appearance or behaviour) that may unfairly restrict access.

9.2.12 Children and young people also described that they were unsure of why some of their family or friends were turned away and were unsure how to 'reapply' for them to come and visit.

### 9.3 Accessing family and support networks: Findings

9.3.1 Disconnection from family, community, and culture has a profound impact on mental health, contributing to emotional dysregulation, self-harm, and heightened distress for detained children and young people.

9.3.2 The current system for approving and facilitating contact is disempowering, particularly for children and young people in care, non-English speakers, and those on restrictive routines, limiting their access to essential emotional supports.

9.3.3 Limited call availability, shared phones, and restricted visiting hours fail to meet the developmental and relational needs of children and young people.

9.3.4 The visit booking process and AYTC visitation rules create additional barriers, particularly for low-income, regional, or culturally diverse families, reducing meaningful contact and continuity of relationships.

9.3.5 The absence of trauma-informed and child-centred systems for communication and connection risks further isolating already vulnerable children and young people, particularly those with existing mental health concerns, disabilities, or histories of disconnection.

9.3.6 The system lacks flexibility to support the diverse familial, cultural, and linguistic needs of young people, contributing to an environment that compounds relational loss and detachment.

## 10. Accessing Education

### 10.1 Accessing education: Rights Requirements

10.1.1 In South Australia, children's rights to education are protected under both national and state legislation.

10.1.2 The *Education and Children's Services Act 2019* (SA) provides the framework for compulsory schooling and access to educational services. According to this Act, all children and young people from the age of 6 to 16 must attend school, with an expectation to participate in education, training, or employment until they turn 17. This legislation is aligned with the United Nations Convention on the Rights of the Child (UNCRC), which Australia has ratified. The convention asserts every child's right to a quality education regardless of their background, circumstances, or legal status.

[86] Government of South Australia, Adelaide Youth Training Centre – Security Order 54: Visitor and Contact Approval (v3, February 2022), para [3.3].

[87] Government of South Australia, Adelaide Youth Training Centre – Operational Order 23: Visits for Children and Young People (v3.0, February 2022), para [3.1].

10.1.3 Children's rights to education remain intact even when they are in forensic custody. The right to education is not paused at the "sally port" gate, it remains a fundamental and inalienable right for every child and young person, including those deprived of their liberty.

10.1.4 Denying or limiting this right further compounds the disadvantage and exclusion that many detained children and young people have already experienced.

10.1.5 The Department for Education, in partnership with the Department of Human Services, are the agencies tasked with providing tailored educational services to meet the needs of young people in custody.

10.1.6 The *Youth Justice Administration Act 2016* (SA) and the *Children and Young People (Safety) Act 2017 (*SA)[88] further emphasise the responsibility of the state to ensure the safety, wellbeing, and development of children, including their educational needs. Under these Acts, education is considered a key aspect of rehabilitation and personal development, especially for those in custody.

10.1.7 As such, the curriculum and educational resources provided in detention settings are required to be comparable in quality to those in mainstream education, adapted where necessary to meet individual learning needs.[89]

10.1.8 International instruments make clear that education in detention must be of equal quality, responsive to individual needs, and aimed at supporting full social reintegration and development.

i. Education is a fundamental and non-negotiable right.[90]

ii. Education must be delivered within the facility by qualified educators.[91]

iii. Education must be personalised, trauma-aware, and culturally safe.[92]

iv. Education must support reintegration and future pathways.[93]

v. Exclusion from education must never be used as punishment.[94]

## 10.2 Accessing education: Observations

10.2.1 Providing education in detention is complex and resource-intensive, with the Youth Education Centre (YEC)[95] required to cater for students from Year 5 to Year 12, sometimes within a single classroom, contributing to isolation for some learners.

10.2.2 There is no clear separation between school and unit life, meaning that behaviour or emotional regulation challenges in one setting effect a child/young person's experience in the other, such as school disruptions resulting in consequences back on the unit, and vice versa.

i. "I cracked the shits in school, and it's fucked my unit life. If you're at school in the real world, it doesn't affect your home life." - young person in AYTC.

[88] Along with the newly introduced *Children and Young People (Safety and Support) Act* 2025.

[89] For research on importance of assessments, learning gaps and school outcomes for young people in custody see:

Thomas G. Blomberg, William D. Bales, Karen Mann, Alex R. Piquero, Richard A. Berk (2011), Incarceration, education and transition from delinquency, *Journal of Criminal Justice*, Volume 39, Issue 4, 2011, 355-365

Griller Clark; Unruh (2010), Transition practices for Adjudicated Youth with Related Disabilities. *Behavioural disorders*, 36 (1) 43 – 51

Kippin NR, Leitao S, Finlay-Jones A, Baker J, Watkins R. (2021) The oral and written narrative language skills of adolescent students in youth detention and the impact of language disorder. *Journal of Communication Disorders*. Volume 90, 2021 Mar-Apr; 90.

[90] UNCRC, Article 28; UNCRC, Article 29; Havana Rules, Rule 38.

[91] Havana Rules, Rule 39; Mandela Rules, Rule 104(1); Beijing Rules, Rule 26.6.

[92] UNCRC, Article 23; Havana Rules, Rule 39.

[93] Mandela Rules, Rule 104(2); Havana Rules, Rule 38.

[94] Mandela Rules, Rule 43(2); UNCRC, Article 28(2).

[95] The Youth Education Centre is a Department for Education school and has two campuses, one of which is located within the AYTC. This is referred to internally as the 'Goldsborough Road Campus'.

10.2.3 Access to education is restricted for some children and young people due to routines, placement, or staffing and operational constraints, particularly for those in the Protective Actions Unit, or those awaiting health assessments or under modified plans.

i. “[Going to school,] it depends on unit staff and school staff. So today, we are one staff down. So we couldn’t go [to school]” - young person in AYTC.

ii. “Operational issues impact everything to do with education” - YEC staff member.

10.2.4 Children and young people report frustration and educational loss, particularly where they are not offered alternative education while excluded from the classroom environment.

i. “Everyone was at school, and I was just doing nothing” - young person in AYTC.

10.2.5 The impact of inconsistent education varies depending on pre-detention engagement, with disengaged learners becoming further isolated from schooling, and previously engaged students experiencing heightened anxiety, difficulty with reintegration, and educational regression.

10.2.6 Staffing and operational constraints directly affect attendance, with classroom access dependent on unit staff availability for supervision and escort, leading to cancelled or reduced lessons.

10.2.7 Repeated school cancellations contribute to long-term disengagement, as children and young people lose motivation and connection to education over time.

10.2.8 Notwithstanding current formal protocols, information sharing between DHS, Health, and Education is underdeveloped, which risks preventing the YEC from receiving relevant information (e.g. clinical updates, reports related to intellectual disability and language and learning impairments, incident reports and support plans) in a timely manner to inform safe, trauma-informed, and individualised teaching approaches.

## 10.3 Accessing education: Findings

10.3.1 The educational experience at AYTC is inconsistent and vulnerable to disruption, with operational and systemic barriers preventing children and young people from accessing regular and meaningful learning.

10.3.2 The absence of a consistent boundary between education and detention contributes to confusion and penalisation, with behavioural dysregulation affecting a child or young person’s experience across both environments, undermining engagement and motivation and impacting mental health.

10.3.3 Some children and young people are effectively excluded from education, either due to health-related delays, restrictive placement, or staff decisions, with no guaranteed provision of alternative or compensatory learning.

10.3.4 Inconsistent education access reinforced existing disadvantage, particularly for children and young people with limited educational history, compounding disengagement and reducing rehabilitation opportunities.

10.3.5 Operational capacity, not educational need, determines access, which contradicts principles of equity and children's rights to education under both domestic and international standards.

10.3.6 Insufficient cross-agency information sharing limits trauma-informed education planning, reducing the ability of teaching staff to adjust practice in response to health, behavioural or emotional needs, and excluding education voices from broader care planning.

10.3.7 System-level barriers are contributing to long-term disengagement from learning, with frequent class cancellations diminishing educational confidence and reducing the likelihood of post-release school or training re-engagement.

# 11. Operational Responses

## 11.1 Operational responses: Rights Requirements

11.1.1 The way the AYTC responds to the daily behaviour, distress, needs and growth of children and young people in custody is a critical test of its legitimacy and lawfulness.

11.1.2 Children and young people in detention are often survivors of trauma, loss and systemic failure. Their distress may be expressed through behaviour that challenges adults or rules, but this must be met with care, not punishment.

11.1.3 Detention environments must model emotional regulation, fairness, and respect, providing consistent support that builds trust, not fear.

11.1.4 International standards are clear: every operational response must uphold the child/young person's dignity, be proportionate to their developmental stage, and aim for rehabilitation, not control:

i. Behavioural responses must be guided by human dignity, not control.[96]

ii. Responses must be proportionate, individualised and trauma-informed.[97]

iii. Use of incentive and behaviour programs must uphold rights, not undermine them.[98]

iv. Emotional distress must not be met with punishment.[99]

v. Trusting relationships must be prioritised in day-to-day operations.[100]

## 11.2 Operational responses: Observations

11.2.1 The Behaviour Support Framework (BSF) operates as a reward and punishment system, where access to basic privileges (e.g. family phone calls, snacks, radios, later bedtimes) is contingent on staff-assessed behaviour via a phased scoring system i.e. Phase 1,2 or 3.

11.2.2 Each child spoken to during the inspection were aware of their 'phase' and were unsure if they would ever get to 'Phase 3' and those on a higher phase were worried about 'keeping' their phase level.

i. "I have to be perfect, or I drop down a phase, I can't cause any problems' - young person in the AYTC.

11.2.3 The BSF does not sufficiently accommodate disability, intellectual impairment or neurodevelopmental related needs. Nor does it accommodate the trauma and adverse childhood events likely experienced by children and young people in detention[101] which impact their responses to situations and environments. [102]

11.2.4 Children and young people report distress at how scoring decisions are made, with them describing that staff at times focusing on minor behaviours, leading to lowered phase levels and reduced access to supports that are beneficial to mental health.

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[96] UNCRC, Article 37(c); Mandela Rules, Rule 1; Havana Rules, Rule 66.

[97] Beijing Rules, Rule 5.1; Havana Rules, Rule 87(c); Mandela Rules, Rule 36.

[98] Mandela Rules, Rule 103; Havana Rules, Rule 63.

[99] UNCRC, Article 39; Mandela Rules, Rule 109.

[100] Havana Rules, Rule 81; Mandela Rules, Rule 76(1).

[101] Malvaso, C., Day, A., Cale, J., Hackett, L., Delfabbro, P. & Ross, S. 2022, *Adverse childhood experiences and trauma among young people in the youth justice system*, Trends & issues in crime and criminal justice No. 651, Australian Institute of Criminology, viewed 22 April 2025, https://www.aic.gov.au/sites/default/files/2022-06/crg_1218_19_adverse_childhood_experiences_v8.pdf

[102] Wright, S., & Liddle, M. (2014). *Young offenders and trauma: Experience and impact – A practitioner's guide.* Beyond Youth Custody, viewed 15 April 2025, https://www.beyondyouthcustody.net/wp-content/uploads/BYC-Trauma-experience-and-impact-practitioners-guide.pdf

11.2.5 The framework assumes the child and young person has behavioural control. This is within a context where trauma and adversity affect cognitive functioning, and where children and young people may not have full capacity to regulate behaviour under stress.

11.2.6 Protective Action responses under DRMPs impose significant restrictions, with structured or restricted routines leading to long periods of isolation, limited peer interaction, and withdrawal from education and programs.

11.2.7 Children and young people on DRMPs often spend most of the day confined to their single bedroom, with only limited periods of out-of-room time, contributing to reported feelings of isolation and despair.

i. "I don't see anyone. They don't let me communicate with anyone." - young person in the AYTC.

11.2.8 Staff to child/young person relationships are characterised by a complex dynamic of care and control, with operational unit staff having the authority to support or sanction, including through restraint or influence over phase levels, impacting a child or young person's wellbeing and sense of trust.

i. "Why are they responsive when a resident cracks up at a staff member but [the other way around] it's not the same"? - young person in the AYTC.

ii. "I behave good and hope I go up in my phase, but they all think different and I don't know if I'll go up." - young person in the AYTC.

iii. "[Staff] affect over all our shit. Our scores.... Literally everything they affect" - young person in the AYTC.

11.2.9 Operational and staffing pressures shape behavioural responses, limiting the ability to use calming or therapeutic alternatives (e.g. taking a walk, engaging in sport) when children and young people are in distress.

11.2.10 DRMPs are not consistently informed by multidisciplinary input, with health, education and allied health staff noting they are not routinely involved in the design, approval, or review of these plans.

11.2.11 There are concerns about the duration and review of DRMPs, particularly where children and young people remain under restrictive regimes beyond the period of acute need, without sufficient clinical oversight. This is a particular risk when a multidisciplinary approach hasn't been taken and the ability to view progress or deterioration through a trauma informed consideration is therefore not available.

## 11.3 Operational responses: Findings

11.3.1 "Trauma is chronic and widespread in both young people and staff" - DHS staff member.

11.3.2 The BSF has a disproportionate impact on the mental health of young people, especially those with trauma histories or disability-related needs, due to its rigid, compliance-based structure.

i. "...I struggle already, why can't you adjust my scores?...Cos they've been like trying to pick at the most littlest things and they've been scoring me right down for it too." - young person in the AYTC.

11.3.3 Behavioural management practices were noted by many stakeholders to conflate distress with misconduct, leading to punitive responses rather than therapeutic or rehabilitative ones, undermining the psychological wellbeing of vulnerable children.

11.3.4 Access to privileges tied to behavioural scoring creates inequities, as support and connection (such as phone calls to family) are denied to those most in need, compounding isolation.

11.3.5 Protective Action responses under DRMPs significantly restrict participation and connection, and the conditions under which they are implemented risk breaching rights to education, social contact, and developmental engagement.

11.3.6 The lack of clinical governance and cross-disciplinary input into DRMPs undermines their legitimacy, applicability and safety, with important therapeutic, developmental, and cultural considerations often not considered or excluded.

11.3.7 Operational responses are shaped by systemic staffing constraints, leading to greater reliance on restrictive practices and fewer opportunities for proactive, trauma-informed alternatives.

11.3.8 The dual role of staff as carers and enforcers creates power imbalances, where young people's trust in staff can be undermined by inconsistent responses, perceived unfairness, or the discretionary use of punitive measures. It also is a challenging role for staff who do not have sufficient training in being a support for children and young people with complex developmental, educational and mental health needs.

11.3.9 Extended use of DRMPs beyond the immediate period of crisis is a concern, particularly where reviews lack clinical oversight or multidisciplinary consideration and timely revision.

11.3.10 The BSF, as currently operationalised, does not support long-term rehabilitative outcomes, as it incentivises short-term behavioural compliance to access activities, tasks or items; over meaningful development of emotional regulation or social skills.

# 12. Incident Management

## 12.1 Incident management: Rights Requirements

12.1.1 The way the AYTC responds to, documents, and learns from incidents (especially those involving harm, risk, or use of force) speaks directly to its human rights culture.

12.1.2 Incident management systems are not simply about compliance: they are an essential safeguard against abuse, neglect, and institutional harm. They are also a mechanism for learning and systemic improvement. For children and young people, especially those with histories of trauma, how adults respond in moments of crisis can either reinforce harm or build trust and restoration.

12.1.3 International instruments are clear: every incident involving a child or young person must be managed with transparency, accountability, and an unwavering commitment to that child's safety, dignity, and recovery. These include:

i. Children must be protected from harm and treated with dignity.[103]
ii. Every incident must be accurately recorded, reviewed and investigated where necessary.[104]
iii. Children must receive immediate support and follow-up after incidents.[105]
iv. Use of force must be exceptional, proportional and the last resort.[106]
v. Oversight, transparency and accountability are essential.[107]

## 12.2 Incident management: Observations

12.2.1 TCV reviewed 353 incident files (in the 1 July 2023 to 30 June 2024 year)[108]. With 467 children and young people involved across these incidents[109] with 102 unique individual children and young people.[110]

[103] UNCRC, Article 19; UNCRC, Article 37(a); Mandela Rules, Rule 1 & 43.

[104] Mandela Rules, Rule 34; Havana Rules, Rule 87; Bangkok Rules, Rule 25.

[105] UNCRC, Article 39; Mandela Rules, Rule 35(2).

[106] Mandela Rules, Rule 82; Havana Rules, Rule 64.

[107] Mandela Rules, Rule 36; Havana Rules, Rule 87; Paris Principles (NHRIs).

[108] Please note, that this time period is different from the time period used for the *Special Report into the use of Isolation at the Adelaide Youth Training Centre published in August 2025*. Therefore data is not comparable between the two reports.

[109] Multiple children and young people could be counted within a single incident reviewed.

[110] A total of 102 individual children and young people were involved across the 353 incident files.

12.2.2 The following are recorded incidents by category (as reported by AYTC):

| Category Type | Number | Percentage of total[111] |
|---|---|---|
| Behavioural | 280 | 79.3% |
| Threat | 93 | 26.3% |
| Assault to staff | 52 | 14.7% |
| Self-harm (no injury) | 48 | 13.6% |
| Assault to youth | 38 | 10.8% |
| Property damage | 34 | 9.6% |
| Self-harm (injury) | 25 | 7.1% |
| Other | 18 | 5.1% |
| Injury to staff | 12 | 3.4% |
| Illness | 10 | 2.8% |
| Substance misuse | 8 | 2.3% |
| Injury to youth | 8 | 2.3% |
| Contraband | 2 | 0.6% |
| Security threat | 1 | 0.3% |

12.2.3 Incident responses did escalate to children and young people experiencing harm. The following provides insight:

i. **Physical force** was used on young people on 321 occasions in incidents or 68.7% of the time that young people were involved in incidents.[112]

ii. **Mechanical restraints** were used on young people on 84 occasions in incidents, or 18.0% of the time that young people were involved in incidents.[113]

iii. **Prone restraint** was used on young people on 114 occasions in incidents, or 24.6% of the time that young people were involved in incidents.

iv. On 28 occasions[114] there was no self-harming identified until **after** the initial incident/code was called, indicating that self-harming occurred as a result of the incident/code response. This is evidenced by self-harming occurring:

(1) when the child or young person was isolated in the safe room or their own room, including post restraint;

(2) during a restraint;

(3) after the young person is ordered to return to their room.

12.2.4 The **Safe Room** was used 80 times in 1 July 2023 to 30 June 2024, to detain 36 individual children and young people.

i. 1 in 6 occasions (17.1%) for children and young people involved in incidents

ii. More than 1 in 3 individual young people who were involved in an incident were detained in the Safe Room (35.3%)

iii. The longest period of safe room use was 3 hours and 12 minutes

iv. The average safe room duration was 52 minutes

12.2.5 Use of **isolation** was recorded by AYTC on 813 occasions in 1 July 2023 to 30 June 2024. Isolations are categorised as Staff-ordered (n:601) and Resident-requested (n:188)

[111] Percentages are calculated as a proportion of all incident files for 1 July 2023 to 30 June 2024. As multiple incident categories may apply, percentages do not add to 100%.

[112] Physical force ranged from placing a hand on a young person's arm and physically escorting them to their room; up to highly restrictive restraints such as prone restraint.

[113] Mechanical restraints include handcuffs and leg wraps.

[114] Incident report numbers: 26866, 27919, 25958, 26942, 27146, 26353, 26812, 28781, 29160, 27918, 28799, 28802, 27815, 28888, 28781, 28434, 26878, 26896, 26121, 27007, 27424, 29386, 26758, 28622, 29443, 28756, 28761, 28475.

i. Location of isolation were:

(1) Young persons bedroom n:520 (64.0%)

(2) Education 'reflection room' n:293 (36.0%)

ii. Longest recorded isolation period was 5 hours[115]

iii. Average recorded isolation period was 19:07 (mm:ss)[116]

12.2.6 Some groups of young people are over-represented in incidents, isolation, safe room use and prone restraint:

| | % of average **daily population** | % of all young people involved in **Incidents** | % of all **Safe room use** | % of all **Isolation use** | % of all **Prone restraint use** |
|---|---|---|---|---|---|
| **Aboriginal young people** | 52.3% | 58.2% | 61.3% | 57.6% | 60.0% |
| **Girls and young women** | 19.1% | 29.3% | 37.5% | 20.4% | 32.2% |
| **Young people with care experience** | 22.1% | 48.2% | 57.5% | 45.8% | 55.7% |
| **Young people under 15 years** | 14.8% | 25.1% | 31.3% | 13.9% | 28.7% |

12.2.7 There is inconsistency in:

i. Clear and timely documentation of incidents, including use of force, injury, threats, self-harm, and near misses.

ii. Having an incident report reviewed by senior staff for consistency and proportionality.

iii. Recording efforts by unit staff to de-escalate, provide trauma-informed care or ensure that use of force was proportionate to risk posed by actions of the child.

12.2.8 There is no documentation regarding:

i. Incidents where actions, words or environments that are known to escalate a child or young person's behaviours are still used, or investigations where rights may have been breached.

ii. The involvement of young people in trauma-informed post-incident debriefing and adequate and accessible opportunities for voice and redress.[117]

12.2.9 Incident management is viewed by AYTC as recording what occurred and does not aim to ensure that children are safe, supported, and not retraumatised in the aftermath.

12.2.10 Follow-up is inconsistent in regard to:

i. Physical and mental health assessment by a qualified clinician.

ii. Emotional support and restorative opportunities.

iii. A clear record of the child's own account and wellbeing.

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[115] The TCV acknowledges that this period of isolation was classified as "resident requested". Resident requested isolation is recognised as a form of isolation in Operational Order 68 – Use of Isolation. The TCV notes that isolation categorised as 'resident requested' does not recognised that young people may request to spend time in their room without requesting to be locked inside their room.

[116] This average recorded isolation time was calculated including the longest recorded isolation discussed in the footnote above. The TCV maintains that this is appropriate as isolations categorised as 'resident requested' are recognised as a form of isolation, see above.

[117] Notwithstanding the existence of Incident Feedback Forms as per our comments in 7.3.19. For an example of a trauma informed post-incident conversation guide, see Office of the Chief Psychiatrist 2025 *Trauma-informed post-incident conversation guide*, Government of South Australia, viewed 9 May 2025, https://s3-ap-southeast-2.amazonaws.com/sahealth-ocp-assets/general-downloads/Trauma-Informed-Post-Incident-Conversation-Guide.pdf.

12.2.11 There is reported training and support for staff with regards to de-escalation, and that incident data is used to prevent recurrence and strengthen safety.

12.2.12 There are complaints mechanisms following incidents for children and young people, however, there is a level of distrust about how seriously children and young people's complaints are managed.[118]

12.2.13 There is **not** an independent (non-DHS) review where harm, excessive force or breaches of duty are alleged to have occurred.

12.2.14 The inspection team is aware that individual incidents are reviewed by the Incident Triage Panel, who then escalate incidents categorised as major/critical or serious to the Incident Review Committee. However, the inspection team notes no clear systemic analysis of incident trends to inform safer practices.[119]

## 12.3 Incident management: Findings

12.3.1 Incident management practices at AYTC do not meet legislative or rights-based standards for transparency, accountability, and child-centred care. Incidents involving harm, restraint, or risk are not consistently responded to in ways that prioritise safety, recovery, and the prevention of further trauma.

12.3.2 Documentation of incidents is inconsistent and lacks critical detail. There are gaps in recording de-escalation efforts, injuries, near misses, and self-harm behaviours. Incidents are often viewed as discrete events rather than opportunities for review, learning, and systemic improvement.

12.3.3 There is limited evidence (which does not mean it does not happen) of follow-up care or restorative support for children and young people post-incident. Access to timely clinical assessment, emotional debriefing, and opportunities for children and young people to provide their account or raise concerns is inconsistent and undocumented.

12.3.4 Incident reviews are not subject to independent non-DHS oversight While the Incident Triage Panel and Incident Review Committee review incidents, there is no external process to investigate use of excessive force, breaches of rights, or systemic analysis of incident trends.

12.3.5 There is insufficient trend analysis of incident data to inform safer practices. Without routine monitoring of incident patterns, including who is involved, why incidents escalate, and what supports were or were not offered, opportunities for prevention and reform are missed.

12.3.6 While complaints mechanisms exist, children and young people express distrust in their efficacy. Many do not believe their concerns are taken seriously, especially following incidents involving physical intervention or emotional harm.

12.3.7 Despite some training in de-escalation, incident response remains largely reactive and custodial in nature. Trauma-informed approaches are not consistently evident in frontline practice, and there is no clear framework for ensuring that crisis responses prioritise child safety and wellbeing.

[118] Children and young people have identified that when they make a complaint, "[m]anagement come down and find a way to tell me off for what's happened, even though I was complaining about their staff… what's the point."

[119] The inspection team acknowledges DHS comments that "The ITP recommends actions to address service gaps and improve future incident responses and takes any critical corrective or improvement actions, where considered necessary by the ITP, through appropriate delegations, and gives notification of these actions to the IRC and any other appropriate party." (DHS comments in response to draft joint report, dated 20 August 2025). The inspection team acknowledges this important work. However, the inspection team notes that to understand trends in practice incident data must be monitored in the long-term.

# 13. Management of Acute Mental Health Crises

## 13.1 Management of acute mental health crises: Rights Requirements

13.1.1 Children and young people in detention are at heightened risk of acute mental health crises: including suicidal ideation, self-harm, panic attacks, psychotic episodes, and severe dysregulation.[120] [121]

13.1.2 These moments of crisis are not behavioural issues to be managed: they are health emergencies requiring immediate, compassionate, and clinically informed responses.

13.1.3 International human rights law makes clear that the duty of care owed by detention authorities is never more critical than in these moments:

i. Mental health emergencies must be treated as health events, not misbehaviour.[122]

ii. Staff must be trained to recognise and respond to mental health crises.[123]

iii. Children in crisis must be immediately supported by qualified mental health professionals.[124]

iv. Isolation, force or punitive responses must never be used in lieu of clinical care.[125]

v. Children in crisis must be treated with respect, dignity and care.[126]

## 13.2 Management of acute mental health crises: Observations

13.2.1 Children and young people experiencing acute mental ill-health are accommodated in units not purpose-built for therapeutic care.[127]

i. "Some people hurt themselves in here. I hurt myself in here when I'm angry. Staff will help and talk about what we can do better." - Young person in the AYTC.

13.2.2 Operational unit staff are the default first responders during mental health crises, despite lacking clinical training; their interventions prioritise risk containment rather than therapeutic care.

13.2.3 **Self-harming** accounted for a significant number of incidents in the 1 July 2023 to 30 June 2024 year.

i. AYTC count: 73 self-harming incidents (20.7%) with 7.8% of the 73 self-harming incidents resulting in injury

ii. TCV count: 109 self-harming occasions[128] within 104 incidents (29.5%) and an additional 26 incidents indicating a risk of self-harm, either through chid/young people's expression of self-harm or suicidal ideation, or other circumstances indicating risk (such as the possession of sharp implements or excess medication, on a known background of self-harm)

iii. Safe Room was used on 47 occasions where young people self-harmed (43.1%); the most frequent use was for self-harm incidents involving ligature (n: 33) or head banging (n: 20)

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[120] Meurk, C., Steele, M., Yap, L., Jones, J., Heffernan, E., Davison, S., Nathan, S., Donovan, B., Sullivan, L., Schess, J., Harden, S., Ton, B. & Butler, T. 2019, *Changing direction: Mental health needs of justice-involved young people in Australia,* Kirby Institute, UNSW, Sydney.

[121] This is likely impacted by the high rate of children and young people in detention who have experienced adverse childhood events which can exacerbate or instigate mental health conditions including depression, anxiety, schizophrenia-type conditions, and psychosis. See Russell, A. E., Ford, T., Williams, R. & Russell, G. 2023, 'Prospective longitudinal associations between adverse childhood experiences and adult mental health outcomes: A systematic review and meta-analysis', *Systematic Reviews*, vol. 12, no. 1, p. 64.

[122] UNCRC, Article 24; Mandela Rules, Rule 109; Havana Rules, Rule 50.

[123] Mandela Rules, Rule 76(1); Bangkok Rules, Rule 29.

[124] Mandela Rules, Rule 25(2); Havana Rules, Rule 51; UNCRC, Article 39.

[125] Mandela Rules, Rule 43; Havana Rules, Rule 67.

[126] Mandela Rules, Rule 31; UNCRC, Article 12.

[127] The TCV and OCP acknowledge the development of two new units at AYTC (not operational at the time of the inspection so not within scope) that, although still custodial in nature, are designed with the intention to provide more therapeutic spaces for young people. These units will be an important upgrade in facilities for the children and young people in custody who are able to be accommodated in these units.

[128] Multiple incidents occurred where more than one young person self-harmed.

13.2.4 For 20.7% of all incidents recorded by AYTC in the 1 July 2023 to 30 June 2024 period (73 incidents in total) 25 of these incidents resulted in injury from this self-harm (7.8%).

13.2.5 Self-harm is commonly responded to through containment measures to prevent or decrease physical harm. These interventions include use of Safe Rooms[xi], canvas clothing, physical restraint including leg wraps[129], and isolation. These interventions may retraumatise and escalate the cycle of distress, in particular for children and young people who have been victims of physical abuse and harm.

13.2.6 On 28 occasions[130] there was no self-harming identified until **after** the initial incident/code was called, indicating that self-harming occurred as a result of the incident/code response. This is evidenced by self-harming occurring:

i. when the child or young person was isolated in the safe room or their own room, including post restraint;

ii. during a restraint;

iii. after the young person is ordered to return to their room.

13.2.7 Some self-harm incidents are extreme and prolonged, involving repeated ligatures, headbanging, and self-inflicted injuries such as attempted limb-breaking.

13.2.8 Follow-up care after release is inconsistent, with reports of missed handovers to community-based services and interrupted access to mental health supports or medications.

13.2.9 The Women's and Children's Hospital was reported by stakeholders to be reluctant to admit detained children and young people from the Training Centre, even for acute mental health needs. Emergency Departments are not viewed as welcoming or clinically suitable alternatives for these children. WCHN has both a Clinical Procedure to manage admissions from AYTC to Mallee ward (the acute inpatient unit at WCH) and an "Information Sheet" re AYTC for WCH PED staff to provide information on AYTC in general, AYTC scope, and requirements for discharge back to AYTC.

13.2.10 CAMHS service delivery occurs primarily within clinic spaces when possible as there are no private interview spaces on a residential unit. Therefore, early signs of distress may be missed due to lack of residential unit in-situ observation by trained clinicians.

13.2.11 Staffing and operational constraints can impact crisis responses and limit therapeutic options, including impacting transport to hospital or access to clinicians, which may also disrupt other essential services like education and healthcare.

13.2.12 There is no 24/7 onsite mental health or in-patient service, leaving operational unit staff to manage acute episodes without immediate clinical support, particularly outside business hours.

13.2.13 Information sharing between services is inconsistent, especially after-hours and during shift handovers, impacting continuity of care and clinical oversight in acute cases. DHS and health services at AYTC use different record keeping systems which means that information sharing is not automatic and needs to be arranged across the multiple teams to be effective.

13.2.14 Staff and leadership express strong support for a more intensive onsite health model, including a dedicated space for assessment, suicide prevention, and a reliable option for short-term in-patient care.

[129] Any use of a leg wrap is at the prior approval and direction of the Duty Supervisor. See Government of South Australia, Adelaide Youth Training Centre - Security Order 26 – Use of Mechanical Restraint (v3.1 , June 2020). para [3.4].

[130] Incident report numbers: 26866, 27919, 25958, 26942, 27146, 26353, 26812, 28781, 29160, 27918, 28799, 28802, 27815, 28888, 28781, 28434, 26878, 26896, 26121, 27007, 27424, 29386, 26758, 28622, 29443, 28756, 28761, 28475.

### 13.3 Management of acute mental health crises: Findings

13.3.1 The current model of care places operational unit staff inappropriately at the centre of acute mental health responses, which increases risk for both staff and children/young people and does not meet clinical or human rights standards for care.

13.3.2 The use of Safe Rooms and restrictive responses to self-harm risk further harm, particularly for young people with trauma histories, and may reinforce or escalate cycles of suicidal or self-injurious behaviour.

13.3.3 Lack of integrated, trauma-informed therapeutic environments compromises the safety, dignity, and psychological wellbeing of children and young people experiencing mental health crises.

13.3.4 Inadequate follow-up care on release, a lack of a comprehensive document outlining health care provided in AYTC and no health discharge plan given from AYTC to the child's GP, family or guardian fractures post detention follow up. Poor interagency communication risks continuity of mental health support, heightening vulnerability during transitions back to community or other placements despite any positive input that may have occurred in AYTC.

13.3.5 External health services are not always accessible or responsive to the needs of detained children and young people, leading to missed opportunities for clinical intervention and reliance on containment instead of care.

13.3.6 The absence of 24/7 mental health care provision constitutes a critical gap in crisis management, resulting in delays in response and escalation of distress without timely therapeutic support.

13.3.7 Information silos and communication breakdowns reduce the quality and consistency of care, particularly during and following emergency mental health incidents.

13.3.8 Staffing and operational pressures hinder appropriate escalation, intervention, and post-incident care, while also limiting children and young people's broader access to health, education, and rehabilitative opportunities.

13.3.9 There is a strong case for, and requests from staff for consideration of, a dedicated 24/7 accessible and assertive mental health care team, to provide appropriate care, reduce reliance on restrictive practices, and alleviate pressure on operational unit staff.

## 14. Use of Physical Restraint

### 14.1 Use of physical restraint: Rights Requirements

14.1.1 The use of physical restraint on children or young people is a grave and serious intervention that engages multiple human rights protections.

14.1.2 Its use must be exceptional, not routine, and never as a substitute for skilled, therapeutic, or trauma-informed care.

14.1.3 Children and young people in detention are among the most vulnerable members of society. Many have experienced violence, abuse, and systemic neglect: contexts in which the use of restraint can retraumatise, degrade, and inflict long-term psychological harm.

14.1.4 Facilities that rely on physical restraint risk violating children's rights to dignity, bodily integrity, and protection from ill-treatment.

14.1.5 International law is unequivocal: physical restraint must only ever be used as a last resort, for the shortest time necessary, and solely to prevent immediate harm. Critically:

i. Restraint must be used only as a last resort and to prevent harm.[131]

ii. Method, duration, and impact must be closely monitored.[132]

iii. Restraint must never be used on children with mental illness to manage distress.[133]

iv. All staff must be trained in de-escalation and safe holding practices.[134]

v. Use of restraint must be transparent, reviewable and subject to oversight.[135]

## 14.2 Use of physical restraint: Observations

14.2.1 Physical force and restraint are routinely used in the AYTC, permitted under legislation to prevent harm, property damage, maintain order, or preserve security.[136] While most incidents do not result in 'serious' injury (although injuries do occur), all restraint carries physical and psychological risk.

i. "[Staff] just kept on going, they kept on pushing my head into the ground." - young person in the AYTC.

ii. "They put that leg wrap on, to stop you leaving, you lie on the ground and by the time you take it off they've slammed the door. I'm just in there screaming."- young person in the AYTC.

14.2.2 Prone restraint was used on young people on 114 occasions in incidents, or 24.6% of the time that young people were involved in incidents in the 2023/24 financial year.

| | No. of prone restraints | No. of recorded incidents | % of incidents where prone restraint used |
|---|---|---|---|
| Threat | 93 | 93 | 100.0% |
| Behavioural | 87 | 280 | 31.1% |
| Assault to staff | 25 | 52 | 48.1% |
| Self-harm (no injury) | 16 | 48 | 33.3% |
| Assault to youth | 14 | 38 | 36.8% |
| Self-harm (injury) | 11 | 25 | 44.0% |
| Injury to staff | 8 | 12 | 66.7% |
| Injury to youth | 4 | 8 | 50.0% |
| Other | 2 | 18 | 11.1% |
| Security threat | 1 | 1 | 100.0% |
| Substance misuse | 1 | 1 | 12.5% |
| Contraband | 1 | 1 | 50.0% |

[131] UNCRC, Article 37(a); Mandela Rules, Rule 82(1); Havana Rules, Rule 64.

[132] Mandela Rules, Rule 33 & 47; Havana Rules, Rule 65.

[133] Mandela Rules, Rule 109(2); UNCRC, Article 23.

[134] Mandela Rules, Rule 76(1); Havana Rules, Rule 82.

[135] Havana Rules, Rule 87; Mandela Rules, Rule 34.

[136] *Youth Justice Administration Act* 2016 (SA), s 33.

14.2.3 Some groups of young people are over-represented in the use of prone restraint

| | % of average **daily population** | % of all **Prone restraint use** |
|---|---|---|
| **Aboriginal young people** | 52.3% | 60.0% |
| **Girls and young women** | 19.1% | 32.2% |
| **Young people with care experience** | 22.1% | 55.7% |
| **Young people under 15 years** | 14.8% | 28.7% |

14.2.4 Medical assessment post-restraint focuses on physical impact and may be delayed due to staffing availability. Psychological impacts are not consistently assessed or addressed. Stakeholders described that not all children or young people who are restrained are referred for medical or nursing review. It was unclear if there was a record of who was offered a health assessment.

14.2.5 Operational staff use the Maybo technique for physical restraint, promoted as a non-pain-inducing and preventative approach. However, incident reports occasionally reference the use of "non-Maybo" or "outside Maybo" techniques, which are undocumented and lack transparency.

14.2.6 Mechanical restraints are used, including handcuffs, leg cuffs, closeting chains, leg wraps[xii], and padded helmets, and are sometimes applied when children and young people are moved outside their rooms due to perceived risk.[137]

14.2.7 Canvas clothing is claimed to be used to reduce self-harm risks, but its use, especially without trousers/pants, has been described by children and young people as shaming and traumatising, particularly for those with histories of sexual abuse.

14.2.8 Post-incident processes lack therapeutic follow-up, with no requirement for trauma-informed debriefing or emotional support offered to children and young people following restraint.

14.2.9 The prone restraint position is still used at AYTC, despite well-established risks including restraint asphyxia and its prohibition in child mental health settings. The Training Centre Visitor has viewed footage of a 15-minute prone restraint.

14.2.10 The OCP Restraint and Seclusion Standard[138] relating to mental health settings[139] contrasts starkly with AYTC practice.[140] The Standard includes clear bans on prone restraint for children and young people in mental health settings, and requirements for clinical authorisation and post-incident review processes. Notably:

i. OCP provides clinical guidance for the use of restraint and seclusion, including standards aimed at reducing and eliminating restrictive practices, particularly for children with mental illness or disability.

[137] The use of mechanical restraints must be recorded and utilised in a manner consistent with Security Order 26 – Use of Mechanical Restraint (Version 3.1 – June 2020).

[138] Chief Psychiatrist 2024, Restraint and Seclusion Standard – A Standard to Reduce and Eliminate where possible the Use of Restraint and Seclusion applied under the Mental Health Act 2009 (Version 1.2), SA Health, viewed 16 April 2025, https://s3-ap-southeast-2.amazonaws.com/sahealth-ocp-assets/general-downloads/Restraint-and-Seclusion-Standard-Final-2024.pdf.

[139] The development of Standards provides the Chief Psychiatrist with a mechanism to carry statutory functions, such as monitoring the standard of mental health care, the treatment of patients, the use of restrictive practices and the administration of the Act. The 'Restraint and Seclusion Standard' (cited above) describes expectations in relation to the use of restraint and seclusion in health services where a patient with mental illness may be assessed and treated in a health setting under *Mental Health Act* 2009 (SA) powers.

[140] The inspection team acknowledges that AYTC staff are not bound by this Standard. However, the inspection team is of the view that prone restraint should not be used on children and young people, regardless of the setting. The inspection team highlights that prone restraint is considered a 'high-risk restrictive practice' in the NDIS Quality and Safeguards Commission *Practice Alert – High-risk restrictive practices* (January 2023) which states "unsafe physical restraint can lead to trauma, injury or death. The use of prone restraint for instance, can cause sudden death, due to risk of the restraint causing a cardiac event. Use of these types of restraints are further associated with the risk of postural asphyxiation, and asphyxiation by choking or vomiting and obstruction of a person's airways."

ii. The OCP Standard mandates that physical restraint be used only in emergencies, where all less restrictive interventions have been tried and failed, and only where there is an imminent risk of harm.

iii. The OCP explicitly prohibits prone restraint for children and young people, citing international guidance and evidence of associated risk of injury or death. If unit restraint is unavoidable, the preferred position is supine and only for the shortest possible time.

iv. Post-restraint, individuals must be offered debriefing, and records must be kept regarding whether it was accepted, how carers were notified, and how the emotional wellbeing of staff and the young person was followed up.

v. Every restraint incident must be reviewed by a clinical team within 24 hours, with the aim of reducing future use and preparing an individualised response plan.

vi. Clinical restraint events must be continuously observed and supported by a formal health protocol to monitor both physical and mental wellbeing.

vii. The OCP Child and Adolescent Restraint and Seclusion Guideline (2025) recently completed and in the last stages of consultation - states that restraint and seclusion of children and young people should be a decision made by an experienced clinician and occur after a trial of all other less restrictive means. The Guidelines notes that restraint and seclusion are traumatic experiences and the use of alternatives is recommended in all settings with children and young people.

14.2.11 Almost all children and young people at the AYTC have current or past engagement with CAMHS, and many present with neurodevelopmental, learning, or physical disabilities - groups recognised by the OCP as particularly vulnerable to harm from restraint.

14.2.12 Operational and staffing pressures reduce capacity for early intervention and de-escalation, increasing reliance on restrictive practices and reducing access to training opportunities for staff.

14.2.13 A sense of normalisation of extreme behaviours and responses was observed, contributing to a custodial culture where high-risk practices can be perceived as routine.

i. “I think we just accept more of that (aggression and violence) here. So when do you intervene? You sort of expect most of it to go badly and when there are only two of you (staff) you have to sort it quickly.” - staff member at AYTC

## 14.3 Use of physical restraint: Findings

14.3.1 Use of physical and mechanical restraints in AYTC is inconsistent with child-focused, trauma-informed standards, particularly those set out by OCP for mental health settings. In the TCV’s review of records for the 1 July 2023 to 30 June 2024 year:

i. **Physical force** was used on young people on 321 occasions in incidents or 68.7% of the time that young people were involved in incidents.[141]

ii. **Mechanical restraints** were used on young people on 84 occasions in incidents, or 18.0% of the time that young people were involved in incidents.[142]

iii. **Prone restraint** was used on young people on 114 occasions in incidents, or 24.6% of the time that young people were involved in incidents.

14.3.2 The continued use of prone restraint on children and young people is of serious concern, given its known risks and the fact that it is prohibited in child mental health care environments. Its use in AYTC may constitute a breach of human rights and clinical best practice.

[141] Physical force ranged from placing a hand on a young person’s arm and physically escorting them to their room; up to highly restrictive restraints such as prone restraint.

[142] Mechanical restraints include handcuffs and leg wraps.

14.3.3 Post-restraint processes do not adequately address psychological harm, with delayed or absent debriefing and a lack of mandated emotional follow-up for restrained children and young people.

14.3.4 Some restraint practices are undocumented or fall outside approved techniques, raising concerns about accountability, oversight, and safety.

14.3.5 Protective tools intended to reduce harm, such as canvas clothing and mechanical restraints, may contribute to shame, distress, and re-traumatisation, particularly for children and young people with histories of abuse or complex trauma. It is noted that these devices, if used in a health setting, would not receive approval for use in restraint and seclusion under the OCP standard.

14.3.6 The AYTC custodial environment prioritises containment over care, especially during times of operational and staffing pressures, leading to greater use of force and fewer opportunities for early intervention or therapeutic support.

14.3.7 There is a systemic gap between the standards applied in custodial and health settings, with children and young people in AYTC not afforded the same clinical safeguards or restrictive practice limitations required under the *Mental Health Act 2009*.

14.3.8 The current use of force regime lacks adequate clinical oversight, independent scrutiny, and procedural safeguards, placing children and young people at risk of harm and undermining rehabilitative and rights-based objectives.

# 15. Use of Isolation and Seclusion

## 15.1 Use of isolation and seclusion: Rights Requirements

15.1.1 The use of isolation or seclusion (removing a child from all meaningful human contact) represents one of the most severe forms of deprivation in youth detention.

15.1.2 Isolation should *never* be routine. It must be used only as an absolute last resort, for the shortest possible duration, and under strict safeguards.

15.1.3 For children and young people, especially those already affected by separation from family and community, isolation can be deeply damaging and may amount to cruel, inhuman, or degrading treatment.

15.1.4 International human rights law recognises that such practices carry a high risk of psychological harm, re-traumatisation, and rights violations, particularly for children and young people with mental illness, neurodisability, or a history of trauma. International instruments are clear:

i. Solitary confinement and prolonged isolation are prohibited for children and young people.[143]

ii. Isolation must be clinically justified, time-limited, and subject to oversight.[144]

iii. Isolation is incompatible with mental health support.[145]

iv. All use of isolation must be transparent and subject to independent scrutiny.[146]

v. Isolation disproportionately harms already vulnerable children and young people.[147]

[143] Juan Ernesto Méndez, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc A/HRC/28/68 (5 March 2015) [44]. Solitary confinement is defined in the Mandela Rules, Rule 44, as confinement of prisoners for 22 hours or more a day without meaningful human contact. Havana Rules, Rule 67; UN Committee on the Rights of the Child, General Comment No. 10 (2007), para 89.

[144] Mandela Rules, Rule 45(1); Havana Rules, Rule 87.

[145] Mandela Rules, Rule 109; UNCRC, Article 39.

[146] Mandela Rules, Rule 34; Havana Rules, Rule 78–87.

[147] UNCRC, Article 2; Youth Justice Administration Regulations 2016 (SA), Regulation 5 & 6

15.1.5 The Training Centre Visitor has recently released a Special Report on the use of isolation at the Adelaide Youth Training Centre (tabled in SA Parliament on 12 August 2025). A summary of this report highlighted:

i. That despite strong legislative protections under the Youth Justice Administration Act 2016, isolation at the Adelaide Youth Training Centre (AYTC) has been inconsistently applied and poorly recorded.

ii. Operational practices at times diverged from the legislative threshold for isolation, with insufficient documentation of de-escalation efforts and a pattern of vague rationales.

iii. Some isolations appeared punitive or administratively convenient rather than based on immediate risk, undermining safeguards intended to protect young people's rights.

iv. Unrecorded isolations and routine practices indistinguishable from isolation (e.g., late unlocks, hygiene lockdowns) further obscured the scale and impact of isolation at AYTC.

v. Young people reported feelings of injustice and distress, especially when isolation was perceived as unfair or inconsistently applied.

vi. The report calls for comprehensive reforms, including clearer guidance, rigorous oversight, better staff training, and authentic inclusion of young people's voices in decisions affecting them.

## 15.2 Use of isolation and seclusion: Observations

15.2.1 Isolation practices at AYTC occur across a spectrum, from routine room time to more restrictive placements such as Safe Rooms and extended in-room confinement under modified routines.

i. “I’d rather go [to the adult system] and get out of my room then sit here in one room and go mental.” - young person in the AYTC.

ii. “[Isolation] fucks with your mental health” - young person in the AYTC.

15.2.2 There is no clear or consistent legislative or operational definition of ‘isolation’ in South Australia, nor in the *Youth Justice Administration Act* or its Regulations. Operational Order 68 provides a working definition that explicitly excludes a range of isolation practices, including Safe Room use, lockdowns, segregation, and routine periods of scheduled isolation. [148]

15.2.3 Use of **isolation** was recorded by AYTC on 813 occasions in 1 July 2023 to 30 June 2024. Categorised as Staff-ordered (n:601) and Resident-requested (n:188).

i. Location of isolation were:

(1) Young persons bedroom n:520 (64.0%).

(2) Education ‘reflection room’ n:293 (36.0%).

ii. Longest recorded isolation period was 5 hours.

iii. Average recorded isolation period was 19:07 (mm:ss).

15.2.4 Reported isolation figures underestimate the full extent of occasions where isolation is used - noting that the Use of Isolation Operational Order expressly excludes a large range of isolation practices from formal reporting requirements.

15.2.5 Isolation may be miscategorised as ‘resident-requested’ when it is imposed and enforced by staff.

15.2.6 Isolation categorised as ‘resident-requested’ does not recognise that:

i. Children and young people may request to spend time in their room without consenting or requesting to be locked inside their room.

[148] Government of South Australia, Adelaide Youth Training Centre – Operational Order 68: Use of Isolation (v2.2, November 2019), para [3.1].

ii. Children and young people who ask to spend time in their room may be subject to extended and cumulative periods of isolation beyond their 'request', related to modified routines, lockdowns, staff discretion or other 'operational necessity' reasons.

15.2.7 Prolonged time alone in rooms is common, with children and young people reporting that isolation builds up anger, emotional overwhelm, and increases the likelihood of self-harm or explosive behaviours.

i. "[Time in rooms] builds up anger" - young person in the AYTC.

ii. "[Time in rooms] makes you want to riot" - young person in the AYTC.

iii. "We are left in our rooms with our emotions and thoughts and when we come out we just explode" - young person in the AYTC.

15.2.8 Children and young people with trauma histories or disability-related needs are particularly affected, especially those who rely on co-regulation strategies. During periods of isolation, access to self-regulation supports (e.g. fidget tools, music, nature, or exercise) is often restricted or unavailable.

15.2.9 Safe Rooms are frequently used in response to behavioural crises or self-harm, involving physical restraint, mechanical leg wraps, and seclusion.

15.2.10 The Safe Room is located at the unit entrance, meaning all children and young people pass it when entering or exiting.

15.2.11 Children and young people have described their experiences in the Safe Room to the TCV, including being restrained before being placed inside, left to self-regulate, and instructed to remove mechanical restraints (e.g. leg wraps) themselves after staff leave.

15.2.12 Safe Rooms are commonly soiled, damaged, or graffitied, and are used following distressing incidents, compounding the psychological impact on young people exposed to or confined in these spaces.

15.2.13 Conversations with young people revealed a heightened state of vigilance, with some expressing the need to always be "ready" for conflict or containment.

15.2.14 Restraint equipment (leg wraps) was left on the unit, despite signage instructing proper storage, and there are no additional formal policies or guidelines governing the use of leg wraps for children and young people with mental ill-health or neurodevelopmental disabilities.

i. "You can just take them (the leg wraps) off yourself when they let you go." - young person at AYTC.

15.2.15 There are no modified or trauma-informed policies in place for Safe Room or restraint use for children and young people with mental ill-health or neurodevelopmental disabilities.

15.2.16 One Safe Room[xiii] was noted as being significantly colder than other rooms, with graffiti on the walls and visible signs of distress (e.g. profanity), suggesting a neglect of therapeutic standards and environmental care.

15.2.17 Clinical review following Safe Room use can be delayed by 24-48 hours, as onsite health staff may not be present, and reviews rely on offsite services being notified and available.

15.2.18 CAMHS is not notified of clients being placed in Safe Rooms, nor are these incidents documented in shared clinical records.

15.2.19 There are no structured debriefing processes for staff, children and young people following use of the Safe Room, and trauma-informed care is not embedded in post-incident practice.

15.2.20 AYTC staff acknowledged they lack trauma-informed training and rely on containment measures, such as Safe Room placement, rather than clinical interventions, especially in the absence of health staff or PRN medication.

15.2.21 There is no policy ensuring access to basic needs (food, water, toilet, medication) for children and young people placed in Safe Rooms, nor are there protocols for managing these requirements during episodes of acute distress.

15.2.22 The Reflection Room[xiv], situated within the education space, is used to isolate children and young people who are removed from class. It is dark, sparsely furnished (single chair facing a 'blackboard' wall), and controlled solely by operational unit staff (including lighting).

15.2.23 Operational unit staff, not educators, determine the use and duration of time in the Reflection Room, which can escalate to Safe Room placement if behaviour deteriorates further.

## 15.3 Use of isolation and seclusion: Findings

15.3.1 Isolation practices at AYTC lack therapeutic purpose and carry a high risk of psychological harm, particularly for children and young people with trauma histories, mental ill-health, or disability-related needs.

15.3.2 There is no legislated or standardised definition of isolation, resulting in inconsistent practice, poor accountability, and inadequate oversight of restrictive environments including bedrooms and Safe Rooms.

15.3.3 Children and young people are frequently subjected to extended time alone without access to regulation supports, leading to emotional dysregulation, escalation, and increased risk of self-harm.

15.3.4 Safe Rooms are routinely used as containment responses to crisis, involving mechanical restraint and seclusion without clinical oversight or trauma-informed alternatives.

15.3.5 The visibility and condition of Safe Rooms contribute to a custodial culture of control, rather than care, reinforcing fear, stigma, and institutional trauma among young people in detention.

15.3.6 Children and young people report significant distress linked to time in isolation, and the absence of clinical input, debriefing, or restorative follow-up limits opportunities for recovery and rehabilitation.

15.3.7 The use of isolation and Safe Rooms at AYTC does not meet international human rights standards, including those articulated by the UN Special Rapporteur on Torture, which prohibit solitary confinement of any duration for children.[149]

15.3.8 The Safe Room environment and its proximity to everyday routines may normalise distress and reinforce punitive custodial culture, rather than promote therapeutic care or emotional recovery.

15.3.9 The lack of independent non-DHS oversight around the use of leg wraps and other restraint equipment presents significant risks, particularly for children and young people with complex trauma or disability.

15.3.10 The absence of clinical input, trauma-informed debriefing, and PRN medication in response to acute mental health distress leaves children and young people reliant on containment rather than care.

15.3.11 Delayed clinical assessments following Safe Room use undermine the safety and effectiveness of these interventions, particularly when distress is severe or ongoing.

15.3.12 Failure to notify CAMHS or integrate Safe Room use into shared care records fragments care and weakens clinical continuity, especially for children under active mental health treatment.

15.3.13 Environmental conditions in the Safe Room, such as cold temperatures, odour and graffiti, reflect neglect of basic standards for dignity, psychological safety, and therapeutic support.

[149] See 15.1.4.

15.3.14 Children and young people placed in Safe Rooms are expected to self-regulate without access to supportive care, basic necessities, or medication, which contradicts principles of child-centred and trauma-informed crisis response.

15.3.15 The use of isolation-like spaces in educational settings, without pedagogical or clinical frameworks, risks further stigmatisation and disengagement from learning.

15.3.16 Overall, current practices around Safe Room and Reflection Room use reflect a containment-driven model that fails to uphold therapeutic, rights-based, and developmental standards for children and young people in detention.

# 16. Medication Management for Mental Health Concerns

## 16.1 Medication management for mental health concerns: Rights Requirements

16.1.1 The administration of psychiatric or psychotropic medication to children and young people in detention must be grounded in clinical necessity, informed consent, and ongoing oversight.

16.1.2 These are not just medical requirements, they are obligations under international human rights law. The use of medication for mental health concerns must never be a substitute for appropriate therapeutic care or a response to behavioural management challenges.

16.1.3 Children and young people deprived of their liberty are uniquely vulnerable to the misuse of medication due to power imbalances, disrupted medical histories, and the closed nature of custodial environments.

16.1.4 International instruments therefore demand robust safeguards to ensure that medication is always in the child's best interests, administered by qualified professionals, and monitored with transparency. These include:

i. The right to health includes safe and informed mental health care.[150]

ii. Medication must be administered only on clinical grounds, never as control.[151]

iii. Informed consent and participation are essential.[152]

iv. Ongoing monitoring and review are obligatory.[153]

v. Access to alternative and complementary therapies must be provided.[154]

## 16.2 Medication management for mental health concerns: Observations

16.2.1 Medication charts are handwritten by medical officers working within AYTC once the medication needs of a child or young person are known and a review of their medication occurs.

16.2.2 Medications are ordered from a local pharmacist and returned in Webster packs. Operational unit staff are responsible for dispensing, recording, and managing medication refusals.

16.2.3 No health workers are based in the units, meaning there is limited clinical oversight for medication administration and review, and no ability to identify the need for PRN (as-needed) medication in a time-sensitive manner.[155]

[150] UNCRC, Article 24; Mandela Rules, Rule 25; Havana Rules, Rule 50.

[151] Mandela Rules, Rule 31; Havana Rules, Rule 67; UN Special Rapporteur on Torture (2013).

[152] UNCRC, Article 12; Mandela Rules, Rule 32(1); Havana Rules, Rule 53.

[153] Mandela Rules, Rule 27; Bangkok Rules, Rule 12.

[154] Havana Rules, Rule 50; Mandela Rules, Rule 26(1).

[155] MYHealth nursing staff do a once weekly review of all medication charts and blister packs. During this round the nursing staff check that the medication is being given regularly/at the correct time and review any missed or refused medication over the past week.

16.2.4 Operational unit staff, rather than qualified medical personnel, manage medication provision, in a setting characterised by high turnover, variable needs, and dynamic unit environments.

16.2.5 There are no clear guidelines or policies for administering medication while a child or young person is in the Safe Room or Reflection Room, and PRN medication is not available, even during acute episodes of distress.

16.2.6 Children and young people are expected to self-regulate during crisis periods, such as when placed in the Safe Room, without the support of pharmacological intervention commonly used in clinical mental health settings and by the carers of children in home settings. This is related to non-clinical staff being the core staff in the unit and not being able to use clinical judgment to determine when to use 'as needed' medication options.

16.2.7 AYTC does not operate a 24/7 health service, limiting medical access outside business hours and placing pressure on operational unit staff to make decisions related to medication under constrained conditions.

## 16.3 Medication management for mental health concerns: Findings

16.3.1 The absence of qualified health professionals on units creates a significant clinical gap, leaving the responsibility for medication management with untrained staff and increasing the risk of administration errors or missed treatment.

16.3.2 Medication governance at AYTC lacks appropriate safeguards, with handwritten documentation, variable dispensing practices, and limited capacity to respond to missed or refused doses.

16.3.3 The unavailability of PRN medication during mental health crises undermines safe and effective care, particularly in the Safe Room, where children and young people are left to self-regulate without clinical or pharmacological support.

16.3.4 Children and young people in distress are placed in containment settings rather than receiving therapeutic intervention, a practice that is inconsistent with standards in health settings under the *Mental Health Act 2009* (SA).

16.3.5 Current practices do not meet the medication management needs of a high-risk, high-needs population, many of whom have diagnosed mental illness or neurodevelopmental conditions requiring tailored support.

16.3.6 Operational limitations, including staff constraints and the lack of a 24/7 medical service, directly compromise safe and timely access to prescribed and necessary medication.

16.3.7 Medication administration at AYTC does not align with trauma-informed, child-centred, or clinically governed care standards, and places an inappropriate burden on operational unit staff without adequate training or support.

# 17. Findings and Recommendations

17.1 Together, legislative mandate and international rights instruments require that mental health and wellbeing in youth detention is not managed as a matter of behavioural compliance, but as a right, supported through therapeutic care, continuity with community services, culturally safe supports, and strict limitations on restrictive practices.

## 17.2 Summary Findings

17.2.1 The inspection findings paint a consistent picture of a custodial environment that is not fit for the therapeutic care and rehabilitation of children and young people.

17.2.2 While many staff demonstrate commitment and compassion, they are operating within a system defined by containment, institutional routine, and fragmented care.

17.2.3 Children and young people are subjected to conditions that undermine their mental health, violate their dignity, and fail to uphold their rights.

17.2.4 Systemic barriers to therapeutic care: Mental health services are risk-gated, inconsistently applied due to availability of staff to bring children and young people to appointments or limited access to a unit to see a child or young person, and fragmented across multiple service providers. Operational unit staff (without clinical training) are the gatekeepers of care. The absence of a clear self-referral pathway, and underdeveloped interagency coordination all reinforce a custodial rather than rehabilitative model. The inspection team note that the teams met with expressed a desire to increase information sharing and collaboration, and are working to the fullest extent of their capacity with good intentions.

17.2.5 Harmful and non-therapeutic physical environment: The custodial infrastructure of AYTC is rigid, surveilled, and austere, offering little opportunity for natural light, autonomy, or sensory relief. Children and young people sleep in rooms that resemble cells more than bedrooms, experience significant isolation (physical and mental), and have limited and inconsistent access to meaningful activity or comfort.

17.2.6 Restrictive and punitive operational responses: The Behaviour Support Framework and use of Dynamic Risk Management Plans foster a reward/punishment culture, disproportionately impacting children and young people with trauma histories or disabilities. The use of physical and mechanical restraints, Safe Rooms, and isolation practices reflect control rather than care.

17.2.7 Depersonalising admissions processes: Children and young people enter AYTC after distressing experiences in police cells and law enforcement processes and are then subject to potentially invasive and reportedly depersonalising intake processes that do not sufficiently support disclosure, therapeutic engagement, or cultural safety.

17.2.8 Disrupted access to continuity of care and education: Information silos, operational and staffing constraints, and disconnected systems prevent consistent continuity of mental and general health care, including post-release follow-up. Education access is impacted by operational pressures, and the environment often fails to support individual needs.

17.2.9 The cumulative effect of these issues is a system that increases, rather than mitigates, the psychological risk of detention. It fails to uphold key legislative obligations and rights protections under domestic and international law.

## 17.3 Recommendations

17.3.1 These recommendations aim to bring the AYTC into alignment with the *Youth Justice Administration Act 2016* (SA), *Youth Justice Administration Regulations* 2016 (SA), the UN Convention on the Rights of the Child (CRC), Havana Rules, Mandela Rules, Bangkok Rules, and Beijing Rules.

| Rec 1: | Strengthen Therapeutic Service Access and Oversight |
|---|---|
| **Rationale:** | Children and young people in detention have complex and acute mental health needs that cannot be met by a custodial workforce alone. Ensuring consistent, coordinated, and clinically governed care is essential to uphold their right to health and prevent avoidable harm. |
| **Method:** | a) **Establish a 24/7 accessible multidisciplinary health and mental health support team for the AYTC**, available for review and support of children, young people and staff.<br>b) **Implement a clearly documented self-referral pathway to CAMHS** to uphold young people's autonomy and remove structural barriers to care.<br>c) **Increase positions in YJAIS and EST (Youth Justice Clinical Services)** to enable greater access to services for more children and young people.<br>d) **Introduce an independent clinical governance framework** to ensure accountability for implementation of care plans and clinical advice.<br>e) **Operational practices are informed by and responsive to clinical advice** (across DHS and other health services).<br>f) **Improve interagency coordination and ICT system** with formal communication protocols between DHS, CAMHS, MYHealth, Education, and operational teams. This should include health services being notified of restraint and Safe Room and Reflection Room use. |
| *Linked to: CRC Articles 3, 12, 24, 39; Mandela Rules 25, 27, 32; Havana Rules 54; Beijing Rules 13.1; Youth Justice Administration Act 2016, s21.* | |

| Rec 2: | Transform the Physical and Procedural Environment |
|---|---|
| **Rationale:** | The current physical environment and admission procedures are institutional, non-therapeutic, and often retraumatising. A rehabilitative setting must foster safety, privacy, and dignity from the outset of a child or young person's time in detention. |
| **Method:** | a) **Redesign admissions processes** to be trauma-informed, culturally safe, and child-centred. Incorporate appropriate pre-assessment and welcome procedures.<br>b) **Upgrade the physical environment** to support privacy, sensory regulation, and wellbeing—e.g. rooms with operable blinds, access to unfiltered natural light, and removal of excessive surveillance.<br>c) Increase children and young people's **access to outdoor space, natural environments, and self-directed activity.** |
| *Linked to: CRC Articles 27, 37, 39; Mandela Rules 12, 13, 23; Havana Rules 19, 23, 87.* | |

| Rec3: | Reform Behavioural Management and Restrictive Practices |
|---|---|
| **Rationale:** | Containment-driven responses (such as restraint, seclusion, and phase-based privileges) undermine mental health recovery and disproportionately impact vulnerable children. A trauma-informed approach is needed to support wellbeing, reduce harm, and promote meaningful behavioural change. |

| | |
|---|---|
| **Method:** | a) **Replace the Behaviour Support Framework** with a therapeutic model that distinguishes between trauma-related dysregulation and behavioural misconduct<br>b) **End the use of prone restraint** and **develop detailed guidelines** for all forms of physical and mechanical restraint, with clear prohibition for use on children and young people in line with national and international standards.<br>c) **Eliminate the use of Safe Rooms and Reflection Rooms for mental ill-health related behaviours and self-harm or suicide related distress**, replacing them with clinical response spaces led by health professionals.<br>d) **Mandate post-incident debriefs including with operational staff and trauma-informed follow-up care** for children and young people after any use of force, seclusion, or restraint. |

*Linked to: CRC Articles 19, 24, 37, 39; Mandela Rules 33, 34, 39, 41, 47; Havana Rules 67 - 71; Chief Psychiatrist Restraint and Seclusion Standard.*

| Rec 4: | Address Equity, Inclusion, and Cultural Safety |
|---|---|
| **Rationale:** | Culturally unsafe and linguistically inaccessible systems exacerbate distress and marginalisation for Aboriginal and culturally and linguistically diverse children and young people. Tailored support is necessary to protect identity, uphold rights, and ensure equitable access to care and connection. |
| **Method:** | a) **Ensure culturally competent models** of care for Aboriginal and Torres Strait Islander children and young people, including connection to Country, family, and Aboriginal health professionals.<br>b) **Provide trained interpreters and culturally appropriate supports** for children and young people from culturally and linguistically diverse backgrounds. |

*Linked to: CRC Articles 2, 30; Bangkok Rules 2, 54.*

| Rec 5: | Promote Rights-Based Participation and Accountability |
|---|---|
| **Rationale:** | Children and young people thrive when their rights are protected. They must be empowered to understand and exercise their rights while in detention. Transparent systems, robust advocacy, and independent oversight are vital safeguards against abuse and neglect in closed environments. |
| **Method:** | a) **Ensure children and young people are informed of their rights in accessible formats,** including how to access support and raise concerns and ensure that these rights are known by workers.<br>b) **Charter of Rights for children and young people in detention to reflect the importance of accessible and appropriate mental health care** in scenarios requiring urgent care as well as overall wellbeing in the AYTC, including the right for a child, young person or guardian to lodge a complaint.<br>c) **Staff engaged in the care, treatment and control of detained children and young people engage in learning opportunities** that assist in their rights based decision making across youth justice system.<br>d) **Ensure that all service providers actively uphold** children and young people's rights to education and health related services.<br>e) **Strengthen external oversight and independent advocacy,** ensuring regular access to children by statutory bodies. |

*Linked to: CRC Articles 12; Mandela Rules 83; Havana Rules 24; CRC General Comment 10.*

# Photographs

## [i] Images of AYTC layout

Image 1: Aerial view of AYTC
Image taken from google images

Image 2: Front view of AYTC
Image taken from google images

Image 3: Grounds of AYTC

## [ii] Images of Health Centre

Image 4: Waiting area in the Health Centre

Image 5: Posters within Health Centre

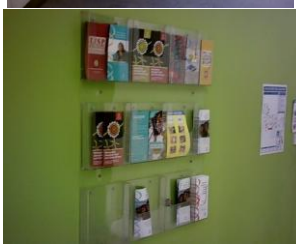

Image 6: Brochures available within Health Centre

Image 7: Information board within the Health Centre

## [iii] Images of Oval and Pool

Image 8: Football oval

Image 9: Pool

## [iv] Images of physical space in admissions

Image 10: Entrance for Young People coming into custody ('Sally Port')

Image 11: Scanning machine each child or young person goes through on admission

Image 12: Door to room where searches are undertaken in the admission area

Image 13: Toilet within the admission area

Image 14: Door to holding cells within the admission area

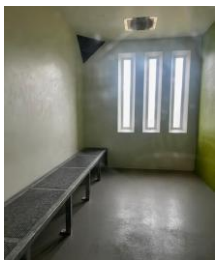

Image 15: Inside holding cells within the admission area

## [v] Images of concrete and metal used throughout grounds

Image 16: View of outside from a courtyard within a unit

Image 17: Concrete walls and basketball court

## [vi] Images of viewing windows on room doors

Image 18: View from bedroom at the viewing window


Image 19: Staff erected a sheet to cover viewing window for young persons comfort.

## [vii] Images of bedroom

Image 20: Bedroom view

Image 21: Food and stains on wall in bedroom

Image 22: Bathroom in bedroom

Image 23: Bedroom view

Image 24: Toilet in bedroom

Image 25: TV and desk in bedroom

## [viii] Images of courtyard attached to unit

Image 26: Unit outdoor courtyard view from inside the unit.

Image 27: Unit outdoor courtyard, view from the courtyard looking towards the outdoor space.

## [ix] Image of Common Area of a unit

Image 28: TV in common area

## [x] Image of the phone in a unit

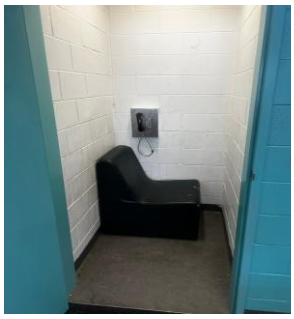

Image 29: Space that is used to make phone calls within a unit

## [xi] Images of Safe Rooms

Image 30: Safe room image from google

Image 31: Safe room on day of inspection

Image 32: Safe room entrance is the first door on the right when entering the unit. The first observation window is on the outer door.

Image 33: View of Safe Room through first door. The second observation window is on the second door. In the space between the two doors to the safe room is where leg wraps are stored.

## [xii] Images of Leg Wraps used in Safe Rooms


Image 34: Leg wrap sign advising leg wraps to be hung up after use.

Image 35: Leg wraps on the floor under sign.

## [xiii] Images of writing on walls of Safe Rooms

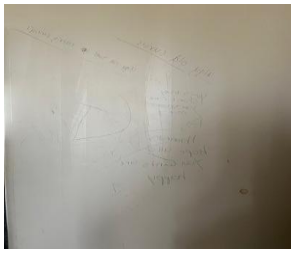

Image 36: Writing on Safe Room door: “ugly old cunts”, “yous truly don’t care”, “I honestly hope all of you cunts are happy”

Image 37: Writing on Safe Room door: “Fuck this place”

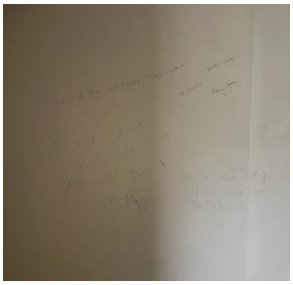

Image 38: Writing on Safe Room door: “Fuck you I want to die but you don’t care”

## [xiv] Images of Reflection Room

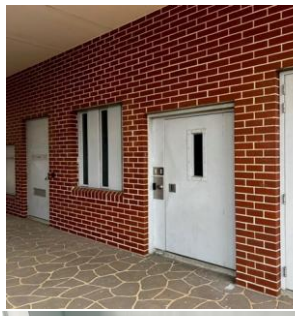

Image 39: Outside entrance to the Reflection Room

Image 40: Door open to Reflection Room. The seat in the room can be seen.

Image 41: Inside the Reflection Room. The seat and floor are covered in chalk dust.

Image 42: Inside the Reflection Room. Markings on the wall.

# APPENDIX: The Charter of Rights

This 'Charter of Rights for Children and Young People Detained in Training Centres' tells you what you can expect during your time in the Adelaide Youth Training Centre. The rights apply to everyone so you have to respect other people's rights.

You have the right:

- To be **treated equally**, and not treated unfairly because of your sex, sexuality, race, religion, disability or other status
- To be **treated with respect and dignity** by staff and to be kept safe while you are in the youth justice centre
- To be given a copy of and have explained to you the **rules of the centre**, and rights and responsibilities, in a language that you can understand
- To see a **doctor or nurse** whenever you need to, have your health assessed soon after you arrive, and receive proper healthcare
- To receive help for your **mental health** if you need it, and be transferred to a mental health facility for treatment if required
- To **get help** if you have problems with drugs or alcohol
- To have special care and **protection if you are vulnerable** or have special needs
- To have **regular contact with your family** and friends through visits and phone calls
- To get help **to see a lawyer** and talk to them privately
- To have an **interpreter** for formal meetings or medical examinations if you are not fluent in English
- To get information and **news** about what is happening in the world
- To **have a say** in decisions about your rehabilitation and other issues that affect you
- To participate in **activities and programs** that help your rehabilitation
- To continue your **education**, or do training to learn useful skills for work
- To get **exercise** every day, and to go outside every day except in bad weather
- To have enough **good food** (including food that is suitable for your culture or religion, or dietary requirements), and have drinking water available whenever you need it
- To have **clean clothes**, and to wear your own clothes if you go out of the centre
- **Not be punished unfairly**, and only in accordance with the rules of the centre or the law
- **Not have force used against you or restraints used on you unless absolutely necessary**, and never as a punishment
- **Not be isolated** from other young people **unless necessary** to keep you or others safe, and never as a punishment
- To practice your **religion** or express your **culture** and, whenever possible, to participate in cultural celebrations and see religious or spiritual advisers
- If you are Aboriginal or Torres Strait Islander, whenever possible, participate in **cultural activities** and celebrations with other Aboriginal or Torres Strait Islander people
- To **make a complaint** about your treatment to an independent person (like an official visitor) and to be told what happens with your complaint
- Before you leave the centre, get help with **somewhere safe to live and ongoing support**.