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Leading For Change: Barriers to Implementing Evidence Based Reform in Youth Justice, and the Critical Role of Leadership

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ABSTRACT

A series of reviews and inquiries into the quality of youth justice services have drawn attention to the need for substantial reform. And yet, there is little evidence to suggest that progress is being made towards implementing change. In this paper we review recommendations made to Australian youth justice agencies, identifying common themes and those recommendations that are most likely to result in reform. We apply learnings from quality assurance and clinical governance in healthcare to identify some ways forward for the sector, as well as acknowledging some of the specific barriers to change that arise in justice sector reform.

KEYWORDS: Leadership, Reform, Root Cause Analysis, Safety and Quality, Quality Assurance

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INTRODUCTION

The need to improve the quality of youth justice systems, both across Australia and globally, is widely recognized (Case & Hazel, 2023; Clancey et al., 2020), with recent years seeing repeated calls for the development of more compassionate, developmentally appropriate, and culturally responsive

service delivery models (e.g., Butcher et al., 2020). And yet despite the many recommendations that have been put forward - from a series of Royal Commissions, inquiries and audits – substantive progress does not appear to have been made. In fact, dissatisfaction continues to be expressed about the quality of current services, with calls for reform growing ever louder (see submissions to the Senate Inquiry, 2025). Perhaps most tellingly, it is now over thirty years since the landmark Royal Commission into Aboriginal Deaths in Custody handed down its 339 recommendations for change, many of which have only been partially implemented or remain unaddressed (see Anthony et al., 2021; Department of Prime Minister and Cabinet, 2018). Similarly, despite the Northern Territory Government accepting the 227 recommendations in response to the Royal Commission into the Protection and Detention of Young People in the Northern Territory (2017), progress in achieving action against these recommendations remains slow, and some completed recommendations have effectively been undone by successive governments (such as re-raising the age of criminal responsibility; see Law Council of Australia, 2019). In their submission to the Australian Government's Senate Inquiry into Youth Justice, the National Aboriginal and Torres Strait Islander Legal Service (2025) draw attention to a range of recommendations over 30 years that have not been implemented. These include: a recommendation for the development of national youth justice standards (1997 National Inquiry into the Separation of Aboriginal and Torres Strait Islander Child from their Families), Law Reform inquiry into the disproportionate rate of incarceration of Aboriginal and Torres Strait Islander people, and 24 recommendations from the national Children's Commissioner's 2024 '*Help Way Earlier*' report (with no announcement to formally respond to these recommendations). The conclusion drawn many is simply that "Australia continually fails to implement evidence-based reform to our child justice systems which would reduce offending behavior and make our communities safer" (Australian Human Rights Commission, 2024 p.9)

The purpose of this paper is to present an analysis of why multiple recommendations to improve Australian youth justice systems have proven so difficult to meaningfully and sustainably action. We present an analysis of recommendations made to agencies involved in the care of children and young people who are involved with the justice system, applying a novel approach (derived from models of quality assurance developed in healthcare) to determine the likelihood, effectiveness, and sustainability (or 'strength') of suggested improvements to service quality and safety. In this way we seek to leverage multi-sectoral expertise by drawing upon decades of lessons learnt from reforming healthcare regulatory systems. Our key findings can then be used as a springboard for discussion about how specific conceptual models and pragmatic frameworks can help the sector to build a systemic culture of quality governance, to make recommendations more actionable, and to better engage with a process of service reform.

The Australian Youth Justice System

Australia has a federal system under which responsibility for youth justice services in Australia is devolved to each of the eight States and Territories. Although the processes are comparable across the country, there is some variation in the philosophical approach adopted, such as in relation to the age of criminal responsibility, presumption of bail, sentencing regimes and the administrative positioning of departments (see Malvaso et al., 2024). Despite these differences, common factors in the youth justice system across Australia is the

significant and substantial over-representation of First Nations young people (who are 27 times more likely to be in detention and 19 times more likely to be under community supervision than their peers), rural over-representation, and a growing number of young people in detention (see AIHW, 2024). Approximately 2 in 3 (65%) of young people under youth justice supervision also had involvement with child protection services within the previous10 years.

Recommendations from Youth Justice Inquiries

The last two decades have seen numerous public inquiries into youth justice systems across Australia, that have collectively put forward over 3,000 different recommendations (Stevens & Gahan, 2024). Some of the inquiries have been triggered by a high-profile safety or quality issue (e.g., the abuse or death of a young person in custody see for example Royal Commission into the Protection and Detention of Children in the Northern Territory, 2017; Queensland government's Review of Youth Detention Centers, 2016; 2023 Inspection of Banksia Hill Detention Centre and Unit 18 at Casuarina Prison, 2023), with others arising when public attention is drawn to the broader failings of the system (e.g., following a media focus on the problem of youth crime or on the extraordinarily high rate of incarceration of First Nations young people). Table 1 below provides a consolidated summary of the main themes that identified in three reports that have sought to synthesize these recommendations.

The sheer number of reviews and recommendations has created what is described as a 'decidedly crowded' and 'overwhelming' reform agenda (Clancey & Metcalfe, 2022, p.17), where stronger governance and accountability is identified as urgently needed to monitor the implementation of recommendations (Stevens & Gahan, 2024). Accordingly, our aim in this paper is to identify when calls for reform are most likely to have impact by applying a novel and transdisciplinary approach that has been widely used to strengthen the safety and quality of healthcare services after an adverse incident has occurred.

Table 1. A summary of key themes from reviews into Youth Justice across Australia

Author	Key themes
Stevens and Gahan (2024)	Strengthen prevention and early intervention; Supporting the needs of young people already in the child protection and youth justice systems through therapeutic and holistic approaches; Strengthening supports for those leaving youth justice supervision. Inadequate cross agency information sharing; collaboration and coordination; limited First Nations partnerships; lack of systems oversight; limited workforce support; and inadequate investment and limited opportunities for child voice.
Clancey et al. (2020)	Challenges in responding to vulnerable and complex needs, to young people known to child protection and youth justice; addressing the detrimental impacts of detention; reducing First Nations overrepresentation; the use of detention as a last resort (and the need to raise the age of criminal responsibility); the greater use of diversion; reduce remand populations, improve youth detention (including services and programs), increase access to education programs, and to properly train and supervise staff.
Clancey and Metcalfe (2022)	Detention center policy and infrastructure, staff, monitoring, accountability, and record keeping, audits, funding, availability of services and programs, cross sector collaboration, and review, evaluation, and research.

Learnings from Safety and Quality in Healthcare

The healthcare sector has a long history of improving the safety and quality of services through incident review, investigation, and outcome monitoring. Well-developed clinical governance processes have been developed that include service accreditation (see Australian Commission on Safety and Quality in Healthcare, 2021), and incident management processes to robustly examine when service and system processes have failed, to understand what went wrong and what can be done to prevent failure from occurring again (Australian Commission on Quality and Safety in Healthcare, 2025).

One tool often used to achieve this is Root Cause Analysis (RCA); an independent investigation that examines system and process failures in high risk and high impact matters (see Safer Care Victoria, 2021). RCA seeks to apply methods originally developed for use in engineering to identify 'lessons learnt,' as well as the contributory and causal factors that resulted in actual or potential patient harm. A RCA seeks, generally, under legal privilege, to identify linear cause and effect relationships between components of a system (people, equipment, processes) and adverse outcomes. It is widely used (and often preferred) despite criticism that it minimizes the importance of human factors (such as the variability of people working in complex systems). An example of a quality improvement that has resulted from this process is 'Ryan's Rule' – a means of escalating care and seeking second opinions when patients or their families are concerned that a person is clinically deteriorating and when feel that they are not being listened to by treating teams (Queensland Health, 2024). A range

of other investigation methodologies (such as RCA squared and human factors reviews; see Peerally et al., 2017) are also now available that identify ways to enhance the safety or quality of services and minimize the likelihood of an adverse incident occurring again.

It has been established that recommendations for reform in health care are more likely to be effective when they are written in a way that is easy for stakeholders to understand and that focusses attention on underlying causes (such defective processes and systems) rather than administrative tasks (see Australian Commission on Quality and Safety in Healthcare, 2025). This principle has enabled critical reviews of different health care recommendations against their relative 'strength' – based on type, effectiveness, and sustainability (Hibbert et al., 2018; Safer Care Victoria, 2025). Recommendations that are considered 'strong' are those that rely less on people's actions, memory aides/reminders and are therefore more sustainable in efforts to achieve lasting change (e.g., replacing revolving doors to reduce patient falls), whereas 'weak' recommendations are those such as reminders, training, policy changes which - although often necessary to establish proficiency - are considered less likely to bring about behavioral change and therefore unlikely to provide sustained improvements in safety (e.g., issuing reminders to staff to check intravenous pumps every two hours).

In what follows, we apply this approach from health care to youth justice services to assess the relative strength of recommendations that have been put forward and the likelihood that they will result in sustained improvement to service quality and safety. To our knowledge, this is the first paper to have applied this approach from health care to germinate new ways of understanding the intransigent barriers and available enablers to implementing recommendations to reform youth justice services.

METHOD

The data used in this analysis were derived from publicly available 'grey' literature published between 2020 and 2024 and included reports from independent, statutory bodies across three different Australian jurisdictions – New South Wales, Queensland, and South Australia. The websites of each jurisdiction's children's commissions, audit offices, prison inspectorates, human rights commissions, ombuds, and youth justice agencies were initially searched to identify any reports that may have made recommendations about the provision of services to justice-involved children and young people. Eligible reports included those relating to young people who may have received services from other agencies (such as those under the care of police or child protection). Academic literature and reports from non-statutory organizations (such as consultancy firms) were excluded, as were internal practice reviews and service planning documents.

The recommendations from each eligible report were then extracted and coded in terms of which agency was identified as accountable for implementing reform. A thematic analysis was then undertaken to understand the types of recommendations that were issued. This involved a familiarization process based on reading the recommendations several times over, generating initial codes, and then searching, reviewing, and defining themes and cross referencing for internal consistency and validity (see Maguire & Delahunt, 2017). A total of 32 thematic codes were initially identified which, after review, were then consolidated into 26 codes. The codes and were validated through iterative conversations amongst the authors, bringing a multidisciplinary lens to the analysis.

Table 2. Recommendations per accountable agency

Accountable Agency	n (%)
Youth Justice	102 (61)
Police	18 (10.77)
Multiple agencies	16 (9.58)
Commonwealth Government	4 (2.4)
Ministers of the Crown	3 (1.8)
Health	2 (1.20)
Corrective Services	1 (0.6)
Central agencies	1 (0.6)
Other (e.g., child protection, non-specified state government)	19 (11.38)

Finally, the strength of the recommendations was mapped against the action hierarchy for patient safety, a widely used tool to examine health care recommendations (see US Department of Veteran's Affairs, 2016; Wood & Weigman, 2020) and matched against examples provided in the Institute of Healthcare Improvement (2019) patient safety toolkit.

A total of twenty-three reports were identified as eligible for inclusion. Seven of these were subsequently excluded as they did not make any recommendations (or made recommendations that were not relevant or specific to youth justice). One duplicate review was also identified and thus excluded, leaving a total of 16 reports for the analysis. These included custodial inspections (n = 10), reviews into police watchhouses (n = 2), annual reports (n = 2), a service review (n = 1), and a policy position paper (n=1). A total of 167 recommendations were made across these reports, ranging from 1 (minimum) through to 51 (maximum) per report.

FINDINGS

Accountable agencies

Youth Justice agencies were identified as accountable for 102, or just under two thirds (61%), of all recommendations. Slightly under 10% of all recommendations listed more than one accountable agency (Table 2).

Thematic analysis

The most common theme for the recommendations related to 'case management' or 'custodial procedures' (13.17%), followed by 'care of young people' (9.58%), and 'staff training' and 'record keeping' (6.58%). The recommendations that were coded as relating to the 'closure of, or inappropriate, services' included recommendations to decommission two custodial units, to provide basic amenities (ablutions and running water) in seclusion or separation rooms or watchhouses, and about young people generally being held in police watchhouses (Table 3).

Strength of recommendations

Twenty-three (13%) of the 167 recommendations were assessed as 'strong', with the most common of these coded as 'tangible involvement by leadership'. These related to legislative change, system level leadership tasks (such as establishing and regularly attending youth justice task forces), and the development of strategic plans. There were 7 recommendations made that related to architectural change (in physical detention spaces or watchhouses, including privacy for toileting). Over half of the recommendations were assessed as 'medium' strength, with the most common of these relating to policy/guideline enhancements and audits. Under one third of the recommendations were 'weak,' with new procedures and training and education being the most common (Table 4).

Table 3. Thematic analysis of recommendations (alphabetical order)

Theme	n (%)	Example
Assessment and treatment spaces	3 (1.78)	YJ NSW ensure that psychologists have access to a confidential space to facilitate consultations with young people
Care of young people	16 (9.52)	YJNSW ensure young people are provided with new underwear
Case management or custodial procedures	22 (13.10)	That DHS review end-to-end case management to consider the post-custody needs of detainees in order to reduce reoffending and maximize opportunities for post-release success and community reintegration
Cleanliness	1 (0.6)	YJNSW develop a system of regular checks and compliance recording sheets for the cleaning and maintenance of reception holding rooms at Frank Baxter Youth Justice Centre.
Closure of or inappropriate services	7 (4.16)	The Queensland Government and the DJY provide funding to improve the center's separation rooms and holding cells to ensure that they have basic facilities in them, including a toilet, running water, and a bed or seat
Complaints management	2 (1.2)	The QPS reviews its complaints-handling policies and procedures to ensure it has an effective, transparent and confidential process in place for children held in a watch-house. The complaints system should be user-friendly for children with low levels of literacy, those with disabilities and those for whom English is an additional language or dialect
Cross agency engagement	1 (0.6)	That DCP, SAPOL and the Youth Court collaborate to investigate and address the relationship between bail-related offences, residential care, remand and detention
Cross referencing other recommendations	1 (0.6)	That DCP accelerate implementation of Nyland Report recommendations 145 and 149 and provide quarterly implementation progress reports to OGCYP.
Cultural security/safety	9 (5.36)	The QPS ensures admission discussions with children are culturally appropriate and conducted in a confidential and non-threatening environment

Data and record keeping	11 (6.54)	YJNSW establish a system to capture digital records of all searches and ensure that the Ombudsman has live access to these records and related reports.
Healthcare	4 (2.39)	YJNSW provide occupational therapy and speech pathology services to all youth justice centers in NSW.
Investment	9 (5.36)	Within 12 months, all Australian governments provide appropriate and ongoing funding to enable all NPMs to undertake their OPCAT mandate.
Legislative reform	8 (4.76)	The Queensland Government amends the Youth Justice Act 1992 to include mandatory prerequisites for the use of separation, and requirements for the humane treatment of children in separation. The amendments should include minimum conditions for separation, and external review rights.
Local environment	6 (3.57)	YJNSW create a sensory space for young people at Riverina Youth Justice Centre.
Organizational culture	2 (1.19)	YJNSW address staff culture at Orana Juvenile Justice Centre and provide support to the ensure to effect necessary change
Public accountability and reporting	5 (2.98)	That DHS publish an annual public report on its implementation of the Aboriginal and Torres Strait Islander Youth Justice Principle
Restrictive practices	3 (1.78)	YJNSW reduce high levels of use of force and restraints in Acmena Youth Justice Centre.
Safety to young people	10 (5.95)	The broader review of watch-houses announced by the QPS in July 2024, and the review of the QPS building design manual, both include an assessment of issues arising from watch-house infrastructure that create risk of harm to children, and develop strategies to address them
Security	6 (3.57)	YJNSW provide access to a body scanning machine for visits.

Serious offenders	2 (1.19)	Recommend YJ and QPS agree on a uniform, evidence-based approach to identifying those young offenders with the highest risk of reoffending and ensure this information is shared with relevant stakeholders across the system.
Service planning	4 (2.38)	DYJ develops an infrastructure strategy for the Cleveland Youth Detention Centre to ensure its infrastructure supports a therapeutic operating environment.
Staff training	11 (6.54)	CSNSW officers who may deal with young people under the MOU receive training about conducting searches in line with YJNSW's search policy and procedure.
Statewide service development	5 (2.97)	YJNSW endorse the Men's Group and Pasifika programs as state-wide intervention programs and explore program adaptations for young people of differing cultures.
System governance	9 (5.35)	Recommend DYJ and QPS, in collaboration with other relevant stakeholders, strengthen their leadership and governance of the youth justice system (the system). This should include ensuring relevant leadership committees, including the youth justice taskforce, are attended by appropriate delegates with appropriate decision-making authority, identifying and prioritizing key challenges across the system and implementing appropriate strategies and actions, improving cross entity collaboration…
Workload and workforce	8 (4.76)	The Queensland Government and the DYJ give priority to the Cleveland Youth Detention Centre when developing strategies to meet the government's April 2024 commitment to increase staff at youth detention centers
Young people and family engagement	2 (1.19)	Family members or significant others, including relevant community organizations, are engaged in young people's transition/reintegration case planning, and where this has been unable to occur, the reasons why are clearly recorded in ICMS

Note: Youth Justice NSW (YJNSW), Queensland Police Service (QPS), DHS (Department of Human Services), DCP (Department of Child Protection, CSNSW (Corrective Services NSW), Department of Youth Justice (DYJ)

Table 4. Strength of recommendations.

Strength	Type	n
Strong	Tangible involvement by leadership (including establishing clinical governance)	8
	Architectural/physical plant changes (including checking for hanging points)	7
	Standardize equipment or process, including benchmarking against other organizations	6
	New devices with usability testing	1
	Simplify process	1
	Engineering control (forcing function)	0
	Subtotal	23
Medium	Review of existing policy/guideline/documentation or enhancement	19
	Audit undertaken	20
	Increase in staffing/decrease in workload	8
	Enhanced documentation, communication	8
	Review rostering/appropriateness of staff mix	8
	Re-evaluate use/appropriateness of equipment	6
	Standardized communication tools	5
	Implement a new team	3
	Software enhancements, modifications	2
	Checklist/cognitive aids	1
	Education using simulation-based training, with periodic refresher sessions and observations	0
	Eliminate/reduce distractions	0
	Redundancy	0
	Eliminate look- and sound-alikes	0
	Subtotal	80
Weak	Introduce new procedure/memorandum/policy	25
	Training and education (including counselling)	14
	Informing/Notifying/Warning	7
	Formal discussion/taken to meeting	4
	Double checks	0
	Warnings	0
	Subtotal	50

DISCUSSION

In this paper we have presented an analysis of recommendations made to reform youth justice services across three Australian states as a way of advancing our understanding of why reform to the sector has proven so challenging. Drawing on a total of 167 recommendations put forward in 16 separate reports published between 2020 and 2024, we were able to demonstrate the breadth of advice that has been offered, with the key themes resonating with those identified in previous work by both Stevens and Gahan (2024) and Clancey and Metcalf (2022). However, our assessment of the strength of the different recommendations offers additional insight into which of these are most relevant or can be prioritized, with the majority classified as either 'medium' or 'weak' strength.

An important initial finding is that the largest number of recommendations identified as 'strong' related to the need for tangible involvement by leadership to establish stronger clinical governance processes. Whilst the need for more effective leadership in youth justice has been previously identified (e.g., Butcher et al., 2023), our analysis reinforces the need for youth justice agencies to focus their attention on this area. To put this in simple terms, effective leadership is not only repeatedly identified as lacking, but improvement in this area is considered most likely to result in lasting change. Of those recommendations that fall in the 'medium' strength category, a need to strengthen policy and guidelines and to routinely audit current practice was most frequently identified. Both areas warrant attention and have also been identified in recent Australian research as key to any improvement process (Boyd et al., 2025; Butcher et al., 2025). However, other than suggesting that those who lead inquiries into youth justice systems should focus on identifying stronger recommendations (i.e., those that are most likely to drive sustainable reform), this analysis still tells us relatively little about why recommendations have proven so hard to implement.

The reasons for implementation failure have been the subject of some discussion in the health care literature (e.g., Westerlund et al., 2019). This tells us that it may occur for several reasons, including because of policy that fails to take account of the practice context, the difficulties that inevitably arise in changing any behavior, and when learning remains in silos and is not generalized across an agency. Hughes (2023) has, for example, recently written about the reasons why commitments to 'learn lessons' are not always realized in practice. She notes that inquiries and reviews – and their recommendations - vary significantly in format, process, and outcomes (depending on the terms of reference and the preferences of the chair), and how the absence of specific guidance (i.e., discretion inevitably remains with the Minister) can lead to a lack of transparency about what is implemented. In addition, Hughes argues that there is often a lack of a 'joined up' approach when responding to recommendations, with frameworks rarely put in place to assess effectiveness (or even to allocate responsibility to ensure that recommendations have impact). In our view, however, the problems extend beyond 'implementation gap' challenges and should also be understood in relation to two related issues that are specific to this context. The first of these is that youth justice is simply a 'wicked problem,' where simple solutions are unlikely to address the complexity involved, leaving agencies feeling largely impotent to effect change. The second is that there is often little political will for change, as youth justice systems strive to maintain the status quo and feed into 'tough on youth crime' political narratives that continue to dominate the sector.

It is simply a wicked problem…

The recurrence of inquiries into similar (or the same) issues, and the similarities found across their resulting recommendations, may illustrate the complexity of the issue (Prasser, 2021). For Tamatea et al. (2024), Rittel and Webber's (1973) typology of 'tame' and 'wicked' problems provides a helpful way to assess whether a problem is 'reasonably solvable' in the context of current knowledge and practices. Tame problems are those that not necessarily simple but can be resolved through routinised actions due to the likelihood of the situation having occurred before (e.g., when the introduction of a new process or a standard operating procedure is effective). Wicked problems, on the other hand, cannot be solved without impacting the whole environment as there is no discernible relationship between cause and effect (as is often assumed in root cause analysis) and where finite resources come up against infinite demand. In an important sense, youth justice systems are complex, nonlinear systems that represent a melting point of such problems. At a 'machinery of government' level, Australia's federated system has resulted in differing service and policy responses to children and young people who are involved with criminal justice system, whilst at the jurisdictional level a complex array of administrative arrangements and working arrangements are in place with other parts of government. When we also consider that justice-involved children and young people are often disadvantaged, victims of maltreatment and neglect, entrenched in both child protection and criminal justice systems, and yet often excluded from education and other health and social services, it is perhaps unsurprising that recommendations made to youth justice agencies are often not straightforward to implement.

Solutions to wicked problems require, as a starting point, some level of understanding of the interconnectedness between the different parts of the system (what Tamatea et al., 2024 refer to as the 'ecosystem' or 'ecology'). Constellation diagrams are a tool used in health care to examine and visually represent the complex, non-linear, and interconnected factors that contribute to an incident and then to identify the best leverage points for building more precise and robust recommended actions (Incident Analysis Collaborating Parties, 2012). This approach assists in differentiating between 'complicated' and 'complex' scenarios – whereby the relationships in a complicated scenario are simulated and clarified (which increases predictability), while in a complex scenario they interact and influence each other continuously (making predictability impossible). For complex scenarios, the goal is to identify actions to address local factors based on a snapshot, rather than systemic, view. Diagramming is used to assist teams to visualize these relationships and make recommendations that are more credible, reliable, and effective by not being too linear or overstating the importance of single contributing factors.

There is little political will for change…

It has been suggested that the primary focus of government agencies when participating in external reviews and inquiries is to 'reduce their blame, reaffirm their capabilities and authority, and promote themselves as solutions for future transformations' (Stanley et al., 2024 p.438). In doing so the aim is to simply increase institutional power and purposefully avoid reform. This is illustrated in the work of Stanley et al. (2024) which present an analysis of evidence provided by State agencies to the 2019 Royal Commission of Inquiry into Abuse in Care to

investigate the abuse and neglect of children, young people, and vulnerable adults in Aotearoa/New Zealand. Their analysis identified 10 different strategies that, they argued, the State used to minimize responsibility and to maintain institutional legitimacy. These included abnegating responsibility for change (the organizational defense of 'not knowing or not having sufficient evidence or data'), the evasion of culpability ('don't blame us, blame them'), arguing that they are simply constrained by their statutory mandate ('the law and bureaucracy made us do it'), attributing responsibility to individuals ('blaming bad apples, not systemic failings'), or arguing that the problem has now been resolved ('it's all in the past') or soon will be ('we are partnering, we are reforming, we are strengthening'), or that it is all somehow now in hand ('we are the solution'). For these authors, these are strategies that reflect a defensive, risk-averse, and reactive culture that lacks openness and accountability and thus can only result in change occurring at a 'glacial pace' (see also Desmarais, 2023). In short, commissions and inquiries are viewed primarily as a means for State agencies to restore public confidence and to reaffirm existing institutional and social structures.

The implication here is that Youth Justice agencies will often seek 'closure' on adverse events or external criticism by denying that there is any substance to them, or by presenting problems as only temporary aberrations. This is a view that resonates with most recent annual report of Training Centre Visitor (TCV) in South Australia (OGCYP, 2023) which notes that only two of ten recommendations from a June 2020 inspection of the youth justice center were completed, despite them all being accepted by the State government. For the Training Centre Visitor this indicates "a lack of commitment [by the Department of Human Services] to the recommendations and the feedback provided by the TCV as an oversight body" (p.119; emphasis added).

Ways forward?

We would argue that a key focus of efforts to encourage the sector to accept and act on the advice of external reviews and quality assessments should be on the quality of leadership provided. There is a widely held view that leadership in youth justice services remains fragmented and inconsistent, particularly in relation to how public sector managerialist responsibilities are balanced against the need for critical professionalism and the development of system level readiness. This, we would suggest, is likely to be a result of what is known as 'new public management' which emphasizes private sector management approaches to improve the efficiency and effectiveness of public services (Haynes, 2003), rather than traditional public service management approaches that prioritize values (expertise, impartiality, and equity), and capacity. New Public Management achieves this in three key ways: incentivization which emphasizes rewards for specific performance (e.g., performance-related pay systems), competition as a dynamic for action (e.g., outsourcing tasks and responsibilities to non-government organizations) and the disaggregation of public agencies into narrowly focused, mission based agencies with a narrow focus on implementing and delivering services (see Goldfinch & Halligan, 2023; Lapuente & de Walle, 2020). Although service efficiency is relatively easy to quantify (e.g., price per unit, delivering within budget and full-time equivalent positions), what constitutes a quality (or effective) youth justice service is more challenging to assess. Thus, optimal leadership is demonstrated by that which is administratively efficient, rather than by improvement in service quality that are proposed in external assessments. The implication is that there is need to develop and recognize the key role of leadership in quality assurance and clinical governance across youth justice.

While sectors such as healthcare have well-developed patient safety cultures, that are underpinned by evidence-based models of leadership (for example transformational leadership) and are supported by a range of bespoke resources such as Leader Rounding (Murray et al., 2024), or Speaking Up For Safety (Cognitive Institute, 2025), similar advice is not as forthcoming for youth justice leaders (see also Butcher et al., 2024). There is a need to supporting youth justice leaders to balance their public sector managerialist responsibilities with their professional identity (expertise) in a model of 'integrated professionalism' if reform is to occur (Timor-Shlevin et al., 2021).

This may be achieved through two ways:

1. Leadership development: Leadership is essential in bringing about reform, as reflected in this paper's analysis of recommendations. Despite this, there is a dearth of advice related to how people should lead youth justice services and what styles of leadership (such as adaptive leadership or transformational leadership) should be engaged to bring about quality improvement (see Butcher et al., 2024; Heiftez et al., 2009). This is particularly important in contexts where concerns have been raised that old practice is simply being replaced with new rhetoric, or where practitioners feel they are currently conducting their practice in a way that already aligns with reform priorities, so do not change (Parosanu et al., 2025). Further, there are conceptual issues of how leadership is described in youth justice services, with some authors calling for future research examining what leadership interventions are likely to be successful in this context (Ressong-Wildschut et al., 2023). This stands in contrast to other professional fields (such as medicine), where leadership styles, functions and engagement are well developed (Spurgeon et al., 2015).

2. System management and system coherency: There have been on-going calls for the youth justice system to become more child-focused, developmentally appropriate, trauma-informed, and culturally responsive (see Case & Hazel, 2023; Day et al., 2023). Despite widespread agreement with these general principles, implementing them in practice has proven more challenging – partly because of what is characterized as a lack of clarity and absence of direction (Senate, 2025). In this respect, Haines and Case (2019) have described the need for leadership to set an "over-arching, coherent and cohering policy context that is simultaneously bold and flexible enough to facilitate local areas responding to their local circumstances in evidence-based and integrated ways that support children towards pro-social maturation" (p. 143). This approach has been described in other areas, such as health care, as system management – where health services are generally delineated between the provider of health services (such as hospital boards) and a co-ordination function (generally departments or ministries) who are responsible for the oversight of an entire macrosystem view including performance oversight, resourcing, quality development and benchmarking, policy development, practice frameworks, and co-ordination between local agencies, adjacent agencies and across various levels of government in order to achieve (as far as possible) an integrated, connected system logic. Adopting a system management lens (rather disaggregated services focused on delivery) will likely provide a governance platform to realize stronger reform through sharing innovations and benchmarking safety and quality.

CONCLUSION

It seems clear to us that finding solutions to the challenges faced by youth justice services is much more difficult than formulating recommendations. There is certainly a need for those who are recommending reform to carefully consider the strength of the advice that they are put forward, and to prioritize those recommendations that are most likely to facilitate the process of reform (Travaglia et al., 2008). It is also important, of course, to recognize that there may also often be other (legitimate) reasons beyond the 'wickedness of the problem' or the need to avoid 'embarrassing the minister' that reduce the ability of the public service to reform. These may relate to the everyday challenges of the work, such as a lack of power to influence the political agenda of the day, an inability to navigate industrial relations, and, of course, limited budgets. It may also relate to a lack of confidence in staff and a fear of further harms occurring is they are afforded greater discretion. Nonetheless, greater effort should be put into conceptualizing the broader issues and identifying and responding to 'preventable harms' drawing on the methods and learnings from healthcare. Stronger leadership is needed from agency managers so that the spotlight is shone firmly on the quality of care provided rather than service efficiency; whether this involves introducing methods (such as problem mapping or constellation diagrams), developing a set of quality indicators and outcomes (and then putting in place targets in areas of key performance; see Day et al., 2023), methodologies for responding to critical incidents, and/or strategic planning and continuous improvement processes (see Butcher et al., 2025). This paper challenges us to consider how we might build a system for healing, rather than containment.

DECLARATION OF INTEREST

On behalf of all authors, the corresponding author states that there are no conflicts of interest to disclose.

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