Supplementary submission to Royal Commission into the Protection and Detention of Children in the Northern Territory - Child Safety

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Recommendation 2: That specialist child and adolescent psychiatry services, where required, assess and treat all children and adolescents with mental health needs, without exclusion. Innovative models to provide these services, including the use of telehealth in conjunction with Social and Emotional Wellbeing teams, should be explored to provide services to remote areas as well as in town.

Recommendation 3: That support, including counselling for victims of sexual assault and sexual abuse of children in remote areas be adequately funded and provided as a specialist NT-wide service by the Sexual Assault Referral Centre (SARC).

Recommendation 4: That prevention strategies both at individual child and community levels be funded, including education on appropriate sexual behaviour for young people and community.

Recommendation 5: That highly specialised treatment for adolescent perpetrators of child sexual abuse and young people/children with inappropriate sexual behaviour be funded and available, including to young people in remote areas. Any treatment model should follow family therapy principles and be tailored to both the family and community involved.

Recommendation 6: That Recommendations 23, 24, 25, 38, 40, 57, 94 (see Appendix 1 for these recommendations) from the Little Children are Sacred report be implemented without delay.

Introduction

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) is the peak body for Aboriginal Community Controlled Health Services (ACCHSs) in the Northern Territory (NT). Our members provide comprehensive primary health care all over the NT from urban centres to the most remote parts of the NT. AMSANT has already made a submission to this Commission which responded to the Terms of Reference in detail and made a number of recommendations, from the perspective of the social determinants of health.

This supplementary submission deals more narrowly with service provision, and the clear gaps in the provision of child and adolescent mental health services, therapeutic healing and counselling services for child sexual abuse. It also addresses the lack of prevention and early intervention programs for identifying and managing child sexual abuse and inappropriate sexual behaviour. This subject matter is highly emotive and this submission acknowledges that this is a highly sensitive and specialised area. It is nevertheless an urgent priority.

This supplementary submission has particular relevance to item (8) in the Plain English version of the Letters Patent Terms of Reference, i.e.

- What improvements could be made to the child protection system of the Northern Territory, including the identification of early intervention options and pathways for children at risk of engaging in anti-social behaviour.

It is also relevant to items (1) and (9), i.e.

- Failings in the child protection and youth detention systems of the Government of the Northern Territory during the period since the commencement of the Youth Justice Act of the Northern Territory.
- The access, during the relevant period, by children and young persons detained at the relevant facilities, to appropriate medical care, including psychiatric care.

This supplementary submission and its recommendations are consistent with the recommendations in AMSANT's prior submission to this Commission, should be read in conjunction with that document and should be implemented in line with the principles outlined in that document, i.e. that system reform should be:

a. Trauma informed and trauma integrated
b. Community led
c. Incorporating Aboriginal worldviews
d. Focussed on family approaches
e. Child-centred.

Child and adolescent mental health services

Levels of mental health issues and trauma

The burden of disease and injury among Aboriginal Australians is higher than for other Australians of all ages. For Aboriginal young people, this burden is largely attributable to the high rates of mental health issues, such as anxiety and depression, substance use, and injuries (Begg et al. 2007).

According to the Australian Bureau of Statistics 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), an estimated 33% of Aboriginal young people aged 18-24 years had high or very high levels of psychological distress, compared with 14% of non-Aboriginal young people in this

age group. Among Aboriginal young people aged 16-24 years, in the 4 weeks prior to the NATSISS, 12% had one or more days in which they were unable to carry out normal activities due to feelings of psychological distress. Of those Aboriginal young people who had in the last year experienced high or very high levels of psychological distress, the most common personal stressor reported was the death of a family member or close friend in the previous year (32%), not being able to get a job (24%), serious illness or accident (20%) and alcohol or drug-related problems (15%).

The experience of childhood trauma can impact on mental health over the entire life course, contributing to depression, post-traumatic stress disorder, suicidality and substance abuse. A substantial proportion of cases go unreported and the impact of these experiences, if untreated, may be serious.

Links between untreated mental health and trauma and juvenile offending

Young people who are involved in the youth justice system have higher levels of mental health issues than non-offenders with research suggesting around 60% of incarcerated young offenders demonstrate significant mental health problems (Lennings, 2003). These mental health issues include depression, anxiety, attention deficit hyperactivity disorder (ADHD), developmental disabilities, and prodromal psychotic disorders. Studies of young people in detention have consistently identified high rates of co-occurring mental health issues, with a NSW study identifying an average of 3.3 past and/or current psychological diagnoses (Indig et al, 2011). Aboriginal young people in custody had an average of 3.7 psychological diagnoses. The two most common mental health issues in this study were attention or behavioural disorders (75% of Aboriginal young people in custody) and substance use disorder (69% of Aboriginal young people in custody).

While mental health issues may emerge during or develop as a consequence of young people's experience with the youth justice system, many mental health issues predate and contribute to the young person's entry into the system.

Childhood trauma is also thought to have an impact on the development of antisocial and aggressive behaviour in adolescence, especially in young men (Krischer & Sevecke, 2008) and multiple pathways between trauma and juvenile offending have been identified (Kerig et al, 2009; Malinosky-Rummell & Hansen, 1993; Maschi et al, 2008).

Access to child and adolescent mental health services

Despite the high levels of trauma and mental health issues among Aboriginal young people, there are currently no specialist child or adolescent psychiatry services available in remote areas of the NT.

Child and Adolescent Mental Health Services (CAMHS) within the Top End Health Service explicitly exclude children and adolescents in regional and remote areas who have issues related to the child protection system or who have been sexually abused (see "Not Accepted: do not meet criteria for Mental Health Services" in the Top End Health Services Child and Adolescent Mental Health Services rural and remote areas flow chart attached). CAMHS Top End also excludes children with isolated alcohol and drug issues, neurodevelopmental disorders including ADHD and autism spectrum disorder, and those with developmental problems. The flow chart directs these referrals to local primary care providers or paediatricians.

Those children and adolescents in rural and remote areas in the Top End who do meet the strict referral criteria for CAMHS (e.g. depression, severe anxiety, post-traumatic stress disorder), are managed by adult mental health teams, with CAMHS providing a secondary consultation/liaison

service. As per the attached flow chart "CAMHS is unable to routinely offer case management or ongoing therapy to rural/remote areas – will support and liaise with local providers if this is needed. In some cases, outreach by CAMHS can be provided, or patient travel organised for client to travel to Darwin for assessment if deemed appropriate and necessary by CAMHS team".

The situation is similar in Central Australia. The Child and Youth Mental Health Service (CYMHS) in Central Australia are not funded to accept remote referrals and do not provide any outreach services to remote areas. Clinicians from the team do accept referrals on a case-by-case basis if the case is deemed severe, and will provide assessment and recommendations to the primary health care team or school provided the child or adolescent is able to be transported into town by some other means. The Barkly Mental Health Service has one full time child and adolescent social worker who is able to see children or young people in Tennant Creek only.

The CYMHS team are more inclusive and flexible in the referrals that they accept from Alice Springs, seeing any child or young person with moderate to severe mental health difficulties. They do not exclude children or young people on the same basis as the Top End Service (i.e. they will see children or young people who have issues with the child protection system, who have been sexually abused, who have neurodevelopmental disorders and who have developmental problems) however this means that they have a long wait list and are often stretched beyond their capacity.

CAMHS provided some outreach services to selected Top End and Central Australian remote areas until 2016. When these outreach services were in place, AMSANT's member services identified that they were often not culturally appropriate. Providers worked within a predominantly medical model, did not routinely use interpreters and were unwilling to engage with Social and Emotional Wellbeing Services (SEWB) teams that work within member services. From the perspective of Aboriginal young people, mental health and social and emotional wellbeing are part of an holistic understanding of life that encompasses not only the wellbeing of the individual but also the wellbeing of their family and community (National Aboriginal Health Strategy Working Party 1989; Swan & Raphael 1995). A model where child and adolescent psychiatrists simply provide an outreach service from tertiary hospitals in this way is not acceptable. However, specialist child and adolescent mental health services are integral to addressing the mental health and trauma issues of at risk children. These services have not been replaced, and local primary health care providers including ACCHSs have not been funded to provide these services within existing SEWB teams.

> *Recommendation 1:* That culturally responsive child and adolescent mental health services be provided in remote areas, as in reach within Aboriginal Community Controlled Health Services Social and Emotional Wellbeing teams where possible.

> *Recommendation 2:* That specialist child and adolescent psychiatry services, where required, assess and treat all children and adolescents with mental health needs, without exclusion. Innovative models to provide these services, including the use of telehealth in conjunction with Social and Emotional Wellbeing teams, should be explored to provide services to remote areas as well as in town.

Inappropriate sexual behaviour and child sexual abuse

Levels of underage sexual activity and child sexual abuse

While it remains difficult to accurately estimate the extent of child sexual abuse in the Northern Territory's Aboriginal communities, the Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse found clear evidence in 2006 that child sexual abuse was a significant problem, as documented in its report, Ampe Akelyernemane meke Mekarle "Little Children Are Sacred". Concern has again been raised by AMSANT's member services about high levels of underage sexual activity and behaviours and what may lead to potential child sexual abuse and behaviours. Some of this has become evident due to a recent syphilis outbreak in the NT. The outbreak has led to increased sexually transmitted infection (STI) testing among young people, demonstrating a concerning number of syphilis cases among children aged 14 years and under. This is not new, however, and surveillance reports from the Centre for Disease Control show a steady number of cases of chlamydia and gonorrhoea in children aged 14 years and under over the past five years (CDC Surveillance Reports).

AMSANT responded to member services' concerns by convening two high level meetings about child safety to determine if other agencies shared these concerns. Relevant agencies participating in the meetings included representatives from the AMSANT, Commonwealth Department of Health, the NT Department of Health, NT Primary Health Network, Territory Families, NT Police, and the Office of the Children's Commissioner.

In follow up to these meetings, AMSANT met with the Sexual Assault Referral Centre (SARC), a service within the NT Department of Health. SARC has offices based in Darwin, Katherine, Alice Springs and Tennant Creek, and is the intake service for medical and counselling assistance for those who have been sexually assaulted. SARC reported similar concerns regarding levels of underage sexual activity and potential child sexual abuse, and are making their own submission to this Commission.

Evidence of links between child sexual abuse and juvenile offending

There is clear evidence of the links between child sexual abuse and a number of adverse outcomes for many children in adolescence and adulthood, including long term harm to brain development, interpersonal and social functioning, mental health, health risk behaviours including substance use, and physical health (Cashmore & Shackel, 2013).

There is also evidence of a greater likelihood of behavioural problems, running away, vandalism and juvenile offending among those who had been sexually abused than those who have not been sexually abused (Chandy, Blum & Resnick, 1996; Smith & Thornberry, 1995; Widom, 1996; Ogloff, et al, 2012). Child sexual abuse victims are more likely to have been charged with an offence than those in the general population, with women 6.71 times more likely and men 4.34 times more likely to have been charged. Further, child sexual abuse victims are more likely to receive a custodial sentence (Ogloff, et al, 2012)

While the vast majority of those who have been sexually abused do not go on to abuse others, retrospective self-report studies of child sex offenders indicate that possibly as many as 75% of offenders were sexually abused as children, with rates generally reported in the range of 41-43% (Johnson et al., 2006; Nathan & Ward, 2002; Ogloff et al., 2012).

Lack of counselling services for victims of child sexual abuse in remote areas

Despite the levels of child sexual abuse and evidence of adverse outcomes, including increased likelihood of juvenile offending among victims, there are no support or counselling services available for victims of child sexual abuse in remote areas of the NT. Children who are identified as victims can be evacuated out of community for initial medical treatment and assessment at the Sexual Assault Referral Centre (SARC) in Darwin, Katherine, Tennant Creek or Alice Springs. However, while SARC is able to provide ongoing counselling services in these towns, they are not currently funded to provide ongoing services to children who return to remote communities. This means that children are sent back to their communities without ongoing follow up, or are removed from home and thus doubly victimised.

Services have previously been available in remote areas. Following the Northern Territory Emergency Response in 2007, funding for SARCs were increased, and a mobile outreach service known as SARC-MOS was funded to deliver services and to victims of child sexual abuse in remote areas from July 2008. In November 2009, additional funding from the Closing the Gap NT budget measure expanded the scope of SARC-MOS to provide therapeutic services for trauma associated with all forms of child abuse and neglect. It was renamed MOS Plus and initially serviced 90 remote communities. In July 2012, there was recognition that the scope of the program was impacting on its ability to deliver the depth of services required in communities. MOS Plus was shifted from the Department of Health into the Department of Children and Families in July 2012 and reduced its service to 30 remote communities with some scope to visit other communities if there was a clear need that other services could not meet. The Australian Government committed to fully funding MOS Plus for ten years from July 2012 as part of the National Partnership Agreement on Stronger Futures in the NT. MOS Plus was defunded in early 2016, and has not been replaced.

AMSANT's member services identified significant issues with MOS Plus, including a lack of cultural safety, high staff turnover and very infrequent visits to communities. Services of this type can cause more harm than help. AMSANT maintains that MOS Plus was not an appropriate model to address child abuse, however it is not acceptable that this service has been defunded without replacement. SARC has not received any additional funding to provide services to remote areas in the wake of this program's closure, however they have been attempting to provide an ad hoc service to selected communities when they are able to piggyback on other services' transportation. SARC should be adequately funded to provide ongoing counselling services in remote areas. The NT does not have the population to support two separate services providing sexual abuse counselling.

> *Recommendation 3:* That support, including counselling for victims of sexual assault and sexual abuse of children in remote areas be adequately funded and provided as a specialist NT-wide service by the Sexual Assault Referral Centre (SARC).

No prevention strategy including community education on appropriate sexual behaviour

There is currently no prevention strategy in place to reduce underage child sexual activity and potential child abuse in remote areas. The program MOS Plus (described above) was previously funded to provide community education about child abuse, including child sexual abuse. MOS Plus was an inappropriate vertical model to provide this community education, and was not culturally appropriate nor evidence based. However, since its defunding in 2016, no program has replaced it and there is no community education about appropriate sexual behaviour in place in remote communities.

The multi-agency Child Safety Meetings convened by AMSANT in 2016 recommended development of community education on appropriate sexual behaviour and laws regarding child sexual abuse.

Actions from the meetings primarily focused on increasing training around, and awareness of mandatory reporting requirements for underage sexual activity among staff at all NT health services, and developing community education on the laws regarding sexual activity and abuse of young people (including age of consent, age gaps and power imbalance). The group suggested that education be developed and implemented in collaboration with community elders, AMSANT services, and the NT Government. However, there is no clear funding source for this training.

In addition, there is no sexual education aimed at young people in remote communities. A program called Adolescent Sexuality Education Program (ASEP) was previously funded by the Commonwealth Department of Health and implemented by the NT Department of Health from 2012. ASEP provided culturally appropriate sexual education in schools, and also engaged young people not attending education regularly. This program covered both health and social issues regarding sexuality, including appropriate sexual behaviour. An evaluation by Health Outcomes International in 2014 found that knowledge across both biological and social aspects of sexuality had improved. Unfortunately, funding for this program ceased in 2015 and this program has not been replaced.

> *Recommendation 4:* That prevention strategies both at individual child and community levels be funded, including education on appropriate sexual behaviour for young people and community.

No treatment for adolescent perpetrators and children with inappropriate sexual behaviours.

There are currently no treatment options for adolescent perpetrators of child sexual abuse, or education programs for children with inappropriate sexual behaviour available in the Northern Territory. Causes and drivers of inappropriate sexual behaviour are understood as occurring for a range of reasons, but often these behaviours are a symptom of other forms of abuse and neglect (Saunders & McArthur, 2017). Literature suggests that high risk sex offenders tend to begin offending in their adolescence (Manderville-Norden & Beech, 2004).

Child and adolescent sexual behaviour occurs on a spectrum – from healthy curiosity and experimentation to inappropriate behaviour to abuse. Where the behaviour sits on the spectrum can also depend on the age and cognitive abilities of the child or young person. Yellow and red flags for concerning behaviour exist, however this is a very complex area that requires sensitive and expert input to determine the appropriateness of the behaviour, the safety needs of families involved, and the treatment needs of the child or young person. This is obviously a highly emotive issue for families, and can involve a lot of shame. As such, it must be dealt with by highly trained health professionals who follow best practice, such as that recommended by the Secretariat of National Aboriginal and Islander Child Care and the National Framework for Protecting Australia's Children 2009-2020, but are also able to tailor the treatment to the family and community involved.

A review of five treatment programs designed for young people who sexually offend in Australia and New Zealand showed the programs had positive outcomes in reducing recidivism (Macgregor, 2008). None of these programs worked specifically with Aboriginal young people, and it is difficult to determine if Aboriginal-specific programs in Australia are effective, as most have not been properly evaluated. However, Canadian programs that have been effective use Aboriginal healing models and use a holistic approach to involve the offenders, victims and the families of both (Young, 2007). Any program introduced in the NT would need to follow similar principles as the Canadian program to promote success (Macgregor, 2008):

- Involving families and communities of offenders in the treatment process

- Employment and training of Aboriginal staff
- Co-development and facilitation of the program by Aboriginal and non-Aboriginal staff
- Consultation with elders to provide guidance of program delivery
- Implementation of the program within communities.

Recommendation 5: That highly specialised treatment for adolescent perpetrators of child sexual abuse and young people/children with inappropriate sexual behaviour be funded and available, including to young people in remote areas. Any treatment model should follow family therapy principles and be tailored to both the family and community involved.

Recommendations from previous inquiries have not been implemented

Ampe Akelyernemane meke Mekarle or the "Little Children Are Sacred" Report made 97 recommendations with regard to reducing child sexual abuse. Many of these recommendations are relevant to this submission, but have not yet been implemented ten years on from its release.

Recommendation 6: That Recommendations 23, 24, 25, 38, 40, 57, 94 (see Appendix 1 for these recommendations) from the Little Children are Sacred report be implemented without delay.

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Appendix 1 Recommendations from Ampe Akelyernemane meke Mekarle "Little Children Are Sacred" Report

23. That victim and community support programs be developed in remote Aboriginal communities as well as urban settings that

a. reduce the risk of a child subsequently acting out sexually

b. prevent re-victimisation and/or the likelihood of the child subsequently offending at a later time

c. provide case coordination for those children who require ongoing support.

24. That appropriate guidelines and training on the management of sexual health of children and young people be provided to government and non-government primary health care providers and relevant FACS staff on a regular basis.

25. That, in respect of mental health services, consideration be given to putting in place comprehensive child and adolescent mental health services with a focus on the provision of increased services for young people with a mental illness whose behaviour is indicative of significant trauma and distress resulting from the abuse.

38. That the government provide youth-specific, culturally appropriate rehabilitation programs for juvenile sex offenders in detention, and for those on parole or subject to community-based orders.

57. That the government drives a fundamental shift in family and community attitudes and action on child sexual abuse by:

a. developing appropriate resource information on sexual abuse and conducting regular media campaigns that explain sexual abuse as described in Recommendation 94.

b. expanded delivery of mandatory reporting training to professionals including school staff.

c. high profile Aboriginal men and women to provide positive, proactive leadership on the prevention of sexual abuse and the setting of appropriate community norms for sexual behaviour.

d. expansion of parenting education and parenting skills training for young people (the next generation of parents) and those already caring for children

e. engaging in a dialogue with communities to discuss the particular education that might be needed in a specific community and how that education can best occur

f. recognising the appropriateness of messages being in language and delivered through a number of mediums

g. ensure sexual health and personal safety programs are in all schools as part of the curriculum.

94. That a public awareness campaign for Aboriginal people be introduced forthwith to build on the goodwill, rapport, and awareness of the problem of child sexual abuse which now exists in Aboriginal communities, and that this campaign:

a. include public contact, meetings and dialogue with the communities and service providers with the government to be represented by a suitably senior officer or officers

b. acquaint leaders of communities and, as far as possible, all members of those communities with the key elements of mainstream law in relation to such issues as the age of consent, traditional or promised brides, rights of the parties within marriage, individual rights of men, women and children generally, rights of parents and/or guardians to discipline children, and of the recommendations contained in this Report and the proposed implementation of it.

c. be conducted with advice being sought from community leaders as to the most effective and culturally appropriate manner in which to convey the messages, utilising local languages wherever appropriate.