ANNEXURE A

BUSHMOB ABORIGINAL CORPORATION
Indigenous Corporations number ICN 8470
www.bushmob.org.au

SUBMISSION TO THE ROYAL COMMISSION INTO THE PROTECTION AND DETENTION OF CHILDREN IN THE NORTHERN TERRITORY
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### ABBREVIATIONS

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<tr>
<td>CA</td>
<td>Central Australia</td>
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<tr>
<td>DoC</td>
<td>NT Department of Corrections</td>
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<tr>
<td>DCF</td>
<td>NT Department of Children and Families</td>
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<tr>
<td>DoH</td>
<td>NT Department of Health</td>
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<tr>
<td>High risk</td>
<td>Children and Young People with one or more risks including physical, medical, sexual, or emotional abuse, neglect, homelessness, societal, economic and educational disengagement, suicide, self-harm, antisocial behaviour and criminal activity.</td>
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<tr>
<td>Intentional practice</td>
<td>Model of practice operationalised across multiple settings including in foster care, youth justice and residential program settings. It refers to any intervention where the practitioner (or supporting adult) brings moment-to-moment awareness (mindfulness) of the desired outcomes (&quot;what&quot;) and associated processes (&quot;how&quot;) within the intervention. It does not prescriptively define what the intervention should be or what the outcomes are. ¹</td>
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<td>NT</td>
<td>Northern Territory</td>
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<td>NTDE</td>
<td>NT Department of Education</td>
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<td>VSA</td>
<td>Volatile Substance Abuse</td>
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<td>VSAP</td>
<td>Volatile Substance Abuse Prevention Act</td>
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<td>Children and Young People aged 12 – 24</td>
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Contact Details

For further information

Will MacGregor
CEO
Bushmob Aboriginal Corporation

Privacy
INTRODUCTION

About this Report
The information contained in this report concerns a significant cohort of Young People aged 12 – 24 years of age in the Northern Territory who, in the view of Bushmob Aboriginal Corporation (Bushmob), are at high risk.

This report includes case studies of Young People over the past two years. These case studies demonstrate failings by the child protection and youth detention systems of the Northern Territory Government. These case studies raise questions regarding the effectiveness and adequacy of the existing youth justice and welfare systems in the NT, oversight mechanisms and safeguards that are intended to ensure appropriate responses. They further demonstrate limited foresight by the Northern Territory Government to take appropriate measures to prevent the reoccurrence of inappropriate treatment.

About Bushmob
Bushmob has a substantial interest in the matters being considered by the Royal Commission.

Bushmob has been operating from Alice Springs since 1999. It was the first organisation to deliver programs in the Northern Territory, that therapeutically engaged children and Young People (aged 12-24) who were sniffing solvents, using other drugs or at risk of doing so, and at risk of entering or had already entered the criminal justice system.

Bushmob started by way of an outreach model, using intentional practice as its therapeutic basis by taking highly transient and hard to reach population groups on bush journeys and to engage significant families, and key Aboriginal family members, where it was possible for Bushmob.

Bushmob took the unprecedented step of going into the so called ‘sniffer’ houses in the Alice Springs Town Camps to initiate change. At this time Young People were encouraged to try to access adult alcohol and other drug services as there were no youth treatment services available.

Bushmob has grown into one of the few programs in Australia to work with Young People experiencing substance misuse, and possibly the only service in the NT employing holistic, medical, psychological, socio-cultural intentional therapy and case management. This approach enables Bushmob to comprehensively assess, treat and begin to resolve the complex, and significant needs of high risk Young People experiencing trauma and substance misuse.

During the period since the commencement of the Youth Justice Act, Bushmob has provided support to approximately 500 Young People on an annual basis. This includes approximately 110 Young People annually referred into the 16 week residential treatment program under youth justice, or volatile substance abuse treatment orders. The majority of these Young People are Aboriginal and Torres Strait Islander; and have virtually universal
involvement and/or issues relevant to the child protection and youth justice systems of the
Northern Territory Government.

The case studies contained in this Report
The tight time frame allowed for this investigation, and the lack of resources at Bushmob has made it difficult to retrieve and collate the large amounts of factual information contained on Bushmob’s files. This has limited Bushmob’s ability to present to the Commission an exhaustive list of our concerns regarding the inadequacy of the juvenile justice and child protection systems in the NT.

The case studies referred to in this Report are drawn from Bushmob’s case files, emails and staff recollections for the two (2) year period from 30 August 2014 – 30 August 2016. The case studies are indicative of the treatment of Young People, coinciding with the commencement of the *Youth Justice Act*.

The case studies are presented in such a way as to protect the privacy and confidentiality of individuals, families and communities. If the Commission requires further particulars, Bushmob will endeavour to furnish the Commission with the information it seeks.

Note, the information contained in this Report necessarily includes related information arising from the Department of Health’s administration of the *Volatile Substance Abuse Prevention Act*.

Responding to Youth Concerns
Although the case studies contained in this Report are limited to events during the last few years, the learnings of Bushmob have been gained over the 17 years Bushmob has operated in Alice Springs. These experiences inform and underpin the recommendations in this Report.

Bushmob aims to highlight, in this Report, the significant cohort of Young People in the NT who are at extreme to high risk and who have been systematically failed, over their life trajectories by successive Governments of the Northern Territory in child protection and juvenile justice. As will become clear through the case studies, the circumstances impacting on these Young People are exacerbated by the failings of the health and educational systems.

Young People who are the clients of Bushmob are frequently and systematically dislocated from safe and supportive family networks. The majority suffer significant emotional trauma, and have extremely poor physical and mental health. They are marginalised from educational, work opportunities, access to basic health care and social services.

If Young People at risk are to have the opportunity to make meaningful and productive life changes, the primary response must be trauma informed, include a long term residential component, and provide holistic physical, mental, and socio-cultural therapy that is consistent with the evidence base, and meets all legal and moral obligations on providers to a highly vulnerable population. Prevention and early intervention programs are important,
but in isolation of broader trauma informed responses, they are an inadequate response to
the significant and complex needs of the existing cohort of Young People that utilise the
services of Bushmob, or those who are at risk of entering the juvenile justice system.

Bushmob has since 2002, consistently raised the circumstances and issues affecting
Young People to the Northern Territory and Australian Governments through liaisons,
involve in review processes, by making mandatory child protection notifications, and
by advocated at community meetings, conferences and in the media.
CASE STUDY 1

A 12 year old Indigenous child was referred to Bushmob in late 2011 by DoC under the Youth Justice Act for stealing food from a supermarket. The referral was supported by the mother. The child had been living at various locations around Alice Springs that were unstable and unsafe. He was known to other youth service providers and to DCF for hazardous use of volatile substances.

There had been previous notifications to DCF for physical and medical neglect.

He arrived in a state of emaciation, and hunger. He told Bushmob staff that he sniffed because he was not fed and it stopped his hunger. He said he did not want to be with his mother because she did not feed him and she drank alcohol. He was in clothing donated from another youth service.

This boy was a genial child who related well to Bushmob staff and other clients. After a month, he fell into pattern of absconding for short periods to seek volatile substances which resulted in five (5) notifications made to police and DCF. On no occasion did the DCF notification result in a safety response. On one occasion DCF asked Bushmob not to contact them as the child was not their client. Police responded with assistance to locate and return the child to Bushmob.

Due to the unsustainable resourcing demands from frequent absconding, Bushmob was unable to continue to maintain responsibility for this child, as a residential client, and the child was discharged from residency, in early 2012. Bushmob notified DCF of the residential discharge and its concern about physical neglect and risk of serious harm. DCF did not provide feedback to Bushmob in relation to the notification. Bushmob retained this child as a client for outreach follow-up.

Following, Bushmob staff picked the child up from the police station, and he was returned by police to Bushmob on a number of occasions when he was in a state of extreme hunger and physical neglect. He was provided with a shower, food and in some instances a bed overnight (although contrary to Bushmob’s funding agreement). The child was also involved in daytime Bushmob adventure therapy activities.

On each occasion Bushmob notified DCF, receiving no feedback.

On 16 December 2012, a Bushmob employee who was also related to the child stated that the child had been found unresponsive in a carpark, and that he had died later that day at the Alice Springs Hospital. Bushmob was never contacted by any authority in relation to the circumstances of the death.

It is understood the Coroner’s Report determined that the child died as a direct result of sniffing inhalants.

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2 If required Bushmob can provide further information privately to the Commission.
CASE STUDY 1 Continued

**A responsible government led response to CASE STUDY 1**

It is Bushmob’s view that the death of this child could have been prevented.

His inhalant use was well known and should have resulted in a referral for assessment for a volatile substance abuse treatment order prior to him committing an offence.

There were multiple points at which his circumstances could have been investigated by DCF and action taken.

For example, at the time of his admission to Bushmob, DCF could have obtained a short term protection order, and provided additional staffing resources to Bushmob specifically to supervise the child to the extent he required, while DCF completed a risk assessment and developed a child safety plan.

This could have included DCF conducting a family conference involving the child and the child’s advocate, the child’s safe family, DCF and other services.

Had this occurred, a safe Aboriginal family placement could have been identified, supported by a comprehensive case plan involving services, and the resources to support him and his family.

Note: A successful model of Aboriginal family group conferencing was developed in Alice Springs by DCF in 2012. Bushmob staff participated as service providers and as child advocates. Large numbers and intergenerational family members of children independently travelled from throughout the NT to be involved in conferences. Over 40 conferences were conducted with universally positive outcomes, including many children being reunited with families, with appropriate safety and care plans in place.

The trial was favourably reported in a Report by the Menzies School of Health. This document was never released.

It is Bushmob’s belief that the program was cut by the then Minister based on erroneous advice about its efficacy and outcomes.

DCF advise that family conferencing is integrated into practice. Bushmob is not aware of any case, since the disbanding of the family conferencing unit, where this has occurred.
CASE STUDY 2

In early [redacted] a 14 year old young Indigenous man was bailed to Bushmob for 16 weeks arriving directly from the Don Dale Juvenile Detention Facility (Don Dale). He had DCF involvement from the aged of 3 years, and was under a long term placement order until he reached 18 years of age.

He had multiple previous incarcerations at Don Dale where he had spent the best part of his youth. After minor settling in behaviours he actively participated in the Bushmob program including by attending school.

His primary concern was about what was going to happen to him when he left Bushmob and where he was going to live. He was not aware that DCF had a plan for him on finishing the program.

Bushmob staff contacted the DCF case worker in Darwin on [redacted] to inquire about the plan, to facilitate the involvement of the young man in reviewing the plan and asked for the involvement of a case worker from the Alice Springs office to facilitate more effective communication.

A phone conference was not conducted until two weeks later. It was attended by the Darwin based DCF case worker along with the young man and Bushmob staff. The DCF worker was unable to produce a care plan, and did not engage with the young person’s views about his placement. This caused the young man considerable anxiety, and he was frustrated with the lack of engagement by his case worker. It resulted in a written complaint to the regional manager of DCF in Darwin on [redacted] about his treatment and to request a change of case worker. DCF did not provide a response.

Bushmob then requested an urgent face to face meeting with DCF staff in Alice Springs. This was the first face to face contact by DCF with the young man since his admission to Bushmob. DCF committed to find a suitable post Bushmob placement and took steps to do so. He was advised his preferred placement with his mother was not suitable, and he told DCF his grandmother was his preferred alternative option.

Two days before his completion with Bushmob, DCF in Darwin had still not resolved his placement and the young man was told he would be temporarily placed with Lifestyle Solutions in Darwin until a suitable longer term placement could be found. Bushmob staff reported to DCF that the young man did not intend to stay in the temporary placement as it placed him in a situation of stress which he believed would result in his further offending and that he wanted to stay with his grandmother where he did not think this would be the case.
CASE STUDY 2 continued

After he left Bushmob DCF placed this young man at temporary accommodation, from which he absconded and self-placed with his mother. Within days he had offended and was in custody. Bushmob asked the court to order him back to the program, however due to the serious nature of his offences, this did not happen, and he was sentenced to a further months at Don Dale.

On the young man was paroled to Bushmob where he has participated in the program, finishing it on He told Bushmob staff that when he was in Don Dale he was subjected to physical and verbal abuse by the staff. Since making his treatment in Don Dale known, he has become fearful about retaliation.

Bushmob staff asked DCF for the leaving care plan as he was due to turn 18 years of age. This resulted in a series of constructive meetings involving DCF, the young man, and other services. This includes visiting his mother, before returning to Alice Springs to work with Bushmob to develop skills, and role model for other Young People. Appropriate accommodation has been provided by Anglicare and he is continuing his schooling, part time with Alice Outcomes.

A responsible government led response to CASE STUDY 2

Bushmob believes this young man need not have reoffended after leaving Bushmob for the first time. Had the DCF case worker engaged the young man and his family in the development of a care plan he may have committed to a supported placement and further life choice changes.

Had he been placed at Bushmob, rather than to Don Dale when he did reoffend he would not have been subjected to inappropriate treatment, and been provided with an environment to further develop his life skills and where contact with his family is facilitated and encouraged.

DCF do not appear to have an effective or accessible child centric care planning framework to Young People and their families.

The placement of Young People away from their homes is not accompanied by adequate systems to enable at location support by DCF, or by DoC officers. This imposes unnecessary barriers to effective engagement with Young People, and communication between service providers.

Complaints by Young People to DCF are rare because they do not feel empowered to do so. When Young People do complain, they are generally ignored.

The dislocation of Young People from service supports leads to a lack of trust in DCF, feelings of rejection, feelings that no one cares for them, isolation, anger, confusion and hopelessness. It sets Young People up to fail.
CASE STUDY 2 continued

It is common for Young People to arrive at Bushmob in a state of trauma after being held at Don Dale. They are tense, untrusting, hypervigilant and on edge.

It is common for Young People to vehemently declare they do not wish to return to Don Dale, and to express fear and hatred for the workers within it.

Since the Commission was announced, Young People have told Bushmob staff that some workers in Don Dale single out individuals for no reason, swear at them, lock them up for no reason, and tell them to bash each other, physically push them around and try to get a reaction out of them to justify staff punishing them. The Young People have also told Bushmob staff that this behaviour is from some guards and that there are guards who treat them fairly.

In the past Young People have described to Bushmob staff the intense heat inside of the high security cells at Don Dale where they have been locked for the majority of the day. They described a complete lack of ventilation resulting in stench and heat especially in summer. The have told staff this drove them ‘crazy’.
CASE STUDY 3

A CII year old child from a remote community in the top-end of the NT entered Bushmob following a DoH referral under a Volatile Substance Abuse treatment order on CII and Confidential. The assessment for the treatment order itself contained information from five (5) months prior that primarily related to the original referral to the Council for Aboriginal Program Services (CAAPS) in Darwin in CII and Confidential.

A mandatory notification had been made to DCF regarding risk of harm arising from volatile Substance use on CII and Confidential. He was under a current juvenile diversion order. The documentation indicated the VSA treatment order had expired. There was no evidence of a new order.

The accompanying clinical assessment of the child was formed from verbal reports and was also over five (5) months old. It did not contain information from CAAPS with whom the child had attended for some months. Nor did it include a health examination being conducted at any time, including immediately prior to the referral to Bushmob although the child was fully accessible at CAAPS. The referral indicated there were no medical problems or current mental health concerns other than volatile substance use.

At the health check at Bushmob the child was diagnosed with schistosomiasis which was notified to DCF and the VSA clinician at the DoH as CII and Confidential. On CII and Confidential, when the child was discharged from Bushmob following behaviours that placed other clients at risk, he was clear of CII and Confidential

On CII and Confidential, he re-entered Bushmob under a referral by the VSA clinician. No referral documentation was provided. The child appeared frightened, disoriented, and was emaciated. He had not eaten or had adequate drinks during the 24 hour bus trip from his remote community in the top-end to Bushmob. He had not been provided with food, drink or money to purchase them, and he had travelled alone.

His medical assessment at Bushmob showed CII and Confidential, and he exhibited behaviours warranting referral to the Bushmob psychologist and psychiatrist, and to the DoH child and adolescent mental health consultant in Alice Springs.

He continued to exhibit difficult and at times self-harming behaviours. He also absconded overnight on two occasions.

Throughout Bushmob staff made notifications to DCF (and DoH). These were in addition to separate mandatory notifications that were also made to DCF from the Bushmob GP, and staff from the mental health service. They were regarding proven physical neglect, proven educational neglect, and proven health neglect.

He was discharged following a violent incident. Prior to discharge senior Bushmob staff and the Bushmob psychologist met with DCF on CII and Confidential to relay concerns about the welfare of the child, and need for adequate supervision.
CASE STUDY 3 continued

DCF placed him in a youth accommodation service which program did not provide the level of supervision required. In the following days Bushmob staff saw the child unsupervised at night, and he presented at Bushmob extremely hungry. This resulted in further notifications made to DCF.

DCF did not provide Bushmob with feedback about what response if any was being taken in relation to any of these notifications.

A responsible government led response to CASE STUDY 3

It is Bushmob’s view that the harms to which this child was exposed could have been prevented. There was active involvement of a senior clinician of the DoH, the child was under a juvenile justice order, and there was a DCF referral. Any of which could have instigated a safety and case management response.

Had a health assessment been conducted as part of the first VSA referral the Child Identifying could have been notified earlier to DCF and medical treatment could have been instigated at that time. This could also have identified underlying behavioural issues which could have informed the care planning and supported his placement at Bushmob.

Had DCF instigated a safety response, a child safety assessment could have been conducted, and a child safety plan put in place that also involved his family. This could have been conducted at his home, close to his support networks.

Observations

There are inadequate systems to support complex shared and sequential case management of Young People across government agencies, and the processes for the assessment of children vary between agencies. No referring agency, provides adequate or effective psychosocial or medical assessments of high risk Young People.

In the absence of these processes, Bushmob appears to be the only point in the system where high risk Young People can adequately access their basic rights to health care.

Having identified his health needs at Bushmob the agencies of the Government of the NT appear to lack the systems and processes to enable continued health care.

Additionally, it is common for DCF to appear to do nothing to respond to notifications made by Bushmob concerning confirmed serious risks to Young People.

Bushmob has established procedures for notifications to DCF with regard to children at risk that align with its legal, moral and ethical obligations. In the last two years alone, Bushmob has made notifications regarding 57 individual children, of up to six (6) notifications per child regarding confirmed sexual, physical, social, psychological and medical risks.

The DCF response has been inadequate and at times this includes by denying risk although Young People have met risk definitions sufficient to warrant state intervention to compel treatment at Bushmob (as has been confirmed by the child commissioner’s office).
RISK PROFILE OF YOUNG PEOPLE IN BUSHMOB

Each year approximately 110 Young People enter the Bushmob residential program. They have at least one, but generally multiple orders which are under the Youth Justice Act, the Care and Protection of Children Act and the Volatile Substance Abuse Prevention Act.

Data extracted from Bushmob records indicates that about 70% of these Young People are referred from the juvenile justice system, 20% from health under a volatile substance abuse treatment order, and 10% are from other sources that includes from DCF.

Approximately 95% of the Young People engaged in any one of Bushmob programs are Indigenous, and nearly all arrive in a traumatised state. All Young People entering the residential program have one, and often all of the following characteristics:

1. **Unsafe:** Young People are in transient living situations with ongoing exposure to physical and medical neglect and to sexual, physical and emotional abuse.

2. **Social vulnerabilities:** Young People are dislocated from their families and communities, have unstable living arrangements, limited or no post primary education, and limited access to training or work. They have limited coping mechanisms and limited access to supports to prevent their engagement in high risk behaviours which includes alcohol and other drug abuse, recidivistic criminal and anti-social activities.

3. **Inaccurate official identities:** Young People’s names are often recorded inaccurately in official documents and their living arrangements not tracked with impacts on their access to basic health and social services.

4. **Unrecognised mental health and behavioural needs:** Young People have unassessed and untreated issues. Issues commonly detected at Bushmob include depression, anxiety, stress, behavioural and learning disorders; addictive disorders; suicide risk, ideation and attempts; personality disorders, foetal alcohol syndrome and other acquired brain injuries; and less frequently, mental illnesses such as bipolar or schizophrenia. Young people display challenging behaviours which includes repressed, oppositional, sexualised, violent, and self-harming behaviour.

5. **Untreated health needs:** Young People have conditions that have become chronic and that cause chronic pain and discomfort. The common conditions detected at Bushmob include iron deficiency (due to strongyloidiasis), eye conditions, dental caries, incomplete immunisations, middle ear diseases, underage pregnancy, rheumatic heart disease, sexually transmitted infections, skin infections, boils, sores, abrasions and other untreated wounds, failure to thrive, underweight, undernourished, pre-diabetic, overweight and other infections including hepatitis B cases that are lost to follow-up.

6. **Outstanding legal issues:** Young People have inadequate access to legal support because of stretched resources and limited funding for youth advocates.
BUSHMOB PROGRAM METHODOLOGY

Bushmob is a non-custodial community based service. Due to funding limitations it is able to operate only fifteen (15) of a potential twenty (20) residential places in Alice Springs. It is currently operating a further ten (10) of a potential fifteen (15) residential places at Loves Creek Station. It also operates community programs such as media, schooling, and the signature Bushmob adventure therapy. Bushmob programs are integrated and so have the ability to provide residential and community based preventative, and therapeutic support to Young People.

Bushmob has developed a unique model of working effectively and efficiently with high risk Young People to ameliorate the complex interplay between the developmental, physical and psychosocial factors impacting on them. It has developed from the priorities expressed by Indigenous people about strengthening youth. The Bushmob practises are rooted in the community it serves and this community development ethos enables Bushmob to draw on the cultural and community assets and strengths that exist within Indigenous families and in the Indigenous cultural context. Bushmob has intergenerational support and is a sought after option by Young People, families, community and government referrers in the NT, and nationally. It uses a wide range of partnerships that integrate western and traditional Aboriginal knowledge that bridge Government constructed program boundaries.

Bushmob applies Intentional therapy within a Bush Adventure Therapy framework as the primary therapeutic approach. All elements of the program enable Young People to make behavioural and life transitions by building their repertoire of constructive responses to life stressors through therapeutically supported experiential learning. Safety is provided as the first intervention. The self-efficacy of Young People and their families is supported through child centric, non-judgemental and family inclusive practices. The dignity of Young People is preserved by providing clothing, clean, comfortable, restful physical environments, good nutrition, and choice. The Bushmob programs include comprehensive health care, school attendance, activities of daily life and adventure therapy delivered through an expansive program including weekly horse culture healing, and a signature annual horse trek.

The Bushmob positive behavioural approach maintains the balance between retaining Young People in the program, and supporting their right to exercise choice including to leave, and return to the program. This mechanism allows some Young People to dip in and out of the program as an integral step to building trust and confidence. The resulting positive association with the Bushmob program is for many high risk traumatised Young People, their first positive attachment with authority.

Bushmob incorporates multiple entry and exit points spatially, and over time in response to changing developmental and situational needs. This extends the period of the therapeutic engagement beyond the generally sixteen (16) week residential program\(^3\). Unless a young person wishes otherwise, Young People leaving the residential program continue to have access to all of the Bushmob programs including to return to the residential program, and to access face to face and phone outreach follow up in the community.

\(^3\) Program modelling is discussed further in the systems observations section of this document.
CASE STUDY 4

A 21 year old young man was referred to Bushmob by DCF directly from CAAPS in Darwin. He had been in DCF care since 2 years of age, under a long term protection order. He was due to turn 18 years of age in 2 days later on the 25th. He was listed on a public housing waiting list. There was no evidence of a DCF transition from care plan.

The referral identified significant substance abuse, and medication for anxiety but did not include a mental health assessment. The Danilla Diba medical service was listed as involved in his care, but no other medical information was provided.

DCF indicated there was limited family involvement. Detailed family history or contact information was not provided.

On arrival at Bushmob he had violent outbursts, paranoia and psychosis which indicated it was an obviously inappropriate referral and due to the risks to the safety of others, there was a planned discharge within a week.

DCF staff initially refused to become involved in his placement as he had turned 18 years of age. A response was provided by DCF after Bushmob advocated with more senior staff of DCF. A worker collected the young man from Bushmob, however the staff declined to provide information about where he would be placed.

The following day, the young man presented at Bushmob intoxicated from alcohol. He had been dropped off by DCF at a backpackers in Alice Springs and given $20 for food.

Bushmob notified the case to the Child Commissioners office.

Observations

Although being in care and potential known to at least two departments of the Government of the Northern Territory, this young man had never had a proper medical or mental health assessment.

The 21 years this man had been under the care of DCF, had proven insufficient time for a psycho-social assessment to be conducted, or for the engagement of his family or for the development of a transition from care plan.

It is an example of a significant number of Young People who are inappropriately referred to Bushmob by referrers providing incomplete, inaccurate, or misleading information including in relation to serious mental health issues, dangerous behavioural patterns and subnormal IQ levels.

It is indicative of a significant number of Young People with entrenched violent and dangerous behavioural issues which have likely developed, or at least perpetuated, for want of proper assessment and treatment.

It is highly likely that this young man has now come to the attention of the adult criminal justice system.
CASE STUDY 5

In the Northern Territory, a 12 year old boy from a remote CA community was referred to Bushmob by DoC. He was unable to speak English, with poor hygiene, skin sores, dental cares, mumps and needing all his adolescent immunisations arrived at the Bushmob.

He was terrified and would not allow even the simplest medical examination. The GP was unable to give him catch up immunisations or to take bloods to determine his health status.

He did not understand how he had ended up at Bushmob or what he was doing there. He had evidently had minimal engagement with the health system as was evidenced by his fear, poor health and lack of willingness to co-operate. He ran away two days later.

The police are looking for him and if they find him again he will presumably go back to Corrections where he will be detained again.

Observation

This indicates a stark failure early on in the education and health system that failed to engage a child in the most basic of primary health care, and is indicative of similar cases seen at Bushmob on a weekly basis.

A prerequisite to admission to Bushmob is informed consent to ensure Young People are willing to attend the program, and understand where they are being referred. This case is indicative of the poor communication that is a feature of referrals. It shows a lack of active and genuine engagement with the child.

Despite language differences, the use of interpreters is rare. There are cases where the referrals have responded to the question regarding language as indicating 'Aboriginal language'. This information shows a lack of basic understanding about Aboriginal socio-cultural systems and in particular of language and identity.
CASE STUDY 6
A 11 year old girl had been incarcerated by DoC for 11 months, with one week free before spending another 11 days incarcerated before she came to Bushmob when she was first seen by the GP.

The girl did not have a Medicare number available. When she first arrived to Bushmob the girl’s surname was “Goods” (pseudonym) and had no record at Medicare. The GP asked if she was named after her father (Frampton, a pseudonym) and was found. This allowed for a link to her legal records at DoC with her Medicare records. She was found to have had several months earlier before entering DoC but the could not find her as she was by then returned to the DoC and was incarcerated under a differed name.

From reviewing of the medical records she had not had a test the first spell in corrections. This is unusual but happens occasionally. So she had been languishing in DoC for 11 months with untreated while were looking for her. She had had a test the second time she visited prison which the GP could see using My-e-health records once the name differences were resolved. She was treated at Bushmob.

A full medical review by the Bushmob GP revealed she was also and . These were picked up from the tests done in DoC under the different name as well as our own test done at Bushmob.

The girl was aware that she was using different names in the medical and legal systems but did not understand the full implications. If DoC had access to Medicare this situation would not have arisen.

In order to write up this case study, the patient’s My-e-health records were reviewed but those from DoC appeared to have been lost from the system. This adds another layer of hopelessness to the entire situation.

Observations

Clinicians within the juvenile justice system do not appear to access Medicare and associated recording systems. This inhibits Young People from receiving an appropriate level of care when incarcerated.

There is an underlying lack of acknowledgement of the extent of the health care failure to high risk Young People whereby health care systems have not been adequately prioritised and supported as Young People traverse the health, education, corrections and child protection systems.
SYSTEMIC FAILURES

Services like Bushmob which take holistic and community embedded approaches, are required to undertake major amounts of advocacy to navigate the separate pathways of multiple government agencies; in their efforts to ensure high risk Young People are receiving basic human rights.

Bushmob is described by its primary DoH funder, as a youth alcohol and other drug service. It is more accurate, however, to describe Bushmob as a therapeutic service for high risk Young People whose complex needs generally include alcohol and other drug use.

The categorisation of Bushmob according to administrative and funding expediencies reflects the mismatch between the NT Government policy frameworks available to Young People and the needs and best interests of Young People and their families.

Full comprehension of this distinction is a vital precursor to the design of responses, such as those attempted by Bushmob, which are capable of systemically responding to the full range and depth of needs experienced by high risk Young People in the NT.

Policy and Program Development

There is no single point of accountability and responsibility for services for high risk Young People in the NT.

This lack of a centralised point of accountability impedes effective policy and programmatic decisions for the highly vulnerable cohort of high risk Young People.

It serves to restrict the adequacy responses by the Government of the NT to meet the basic human, ethical and legal rights of Young People and their families.

It enables government agencies to abrogate responsibility by transferring risk onto services such as Bushmob.

There are inadequate residential placements for high risk Young People.

Bushmob is one, if not the only residential service in the NT attempting to provide holistic therapy for high risk Young People in the community. Only 15 of the potential 20 beds at Bushmob in Alice Springs are adequately funded.

Policy decisions about the establishment of residential places have been taken without proper consideration about the contemporary needs of high risk Young People.

From referral trends and expressed need, Bushmob estimates there is an immediate need for 25 fully funded additional beds in Alice Springs to meet demand for voluntary placements, and provide additional scope to safely accept additional referrals via court and legal systems, as orders or bail options.
Responses to high risk Young People are inadequate: No program model in the NT for high risk Young People exists.

Programs targeting offending Young People do not fully engage with the needs outlined in this Report, and tend to be designed based on advice taken outside of the evidence, and external to the expertise within the NT.

Bushmob is funded inadequately. It can only safely operate 15 of the 20 beds in Alice Springs. No funding is provided commensurate with the complex needs, and complex health care needs of the client population. Funding provided for virtually identical programs are funded at different levels by different administrations of the Government of the NT.

Bushmob has resolved the moral and ethical dilemma to meet basic human right of Young People to primary health care by developing a clinical model based on a private GP, psychiatrist and psychologist who access Medicare. This model is contrary to the funder’s categorisation of Bushmob as a non-clinical service.

Prior to the introduction of the VSAP Act in 2009, Bushmob primarily accepted self-referrals from Young People, and their families. The limited beds and requirement to preference DoC and DoH referrals has restricted self-referrals. This excludes and undervalues the voluntary engagement of Young People and their families in treatment.

The value of family and community has been further eroded by a lack of resourcing to support Aboriginal family engagement models, and incorporate post discharge reintegration back to home.

**COMMON SCENARIO 1**

Young People are coming to Bushmob from DoC with incorrect diagnosis regarding for example, scabies and streptococcal infections. There have been cases where skin sores have been treated with steroid cream, due to being seen by nurses instead of doctors.

It is common for Young People to come out of DoC without having been fully vaccinated.

There appears to be no attempt to provide dental care. Free dental treatment is a right for all children in Australia until the age of 18. Very severe caries is often seen when Young People arrive at Bushmob from DoC, and from DCF and DoH.

Minor ailments such as iron deficiencies are noted but not investigated or treated.

In the rare instances where a doctor within DoC has conducted what could be considered a full Indigenous health assessment, looking at the records from DoH the only tests routinely done are urine STI checks and blood tests for HIV and syphilis. Self-examination of the testicles seems to have been added recently.

Young People coming from DoC seem to have had no examination into their early childhood experiences, their problems, their educational or health needs. There seems to be little or no analysis as to what led to the behavioural dysfunction or to remedial help for their specific problems.
There is inadequate and iniquitous resourcing of services for high risk Young People.

The Alice Springs based component of Bushmob is primarily funded by the DoH, with additional funding from the Australian Government Department of Prime Minister and Cabinet, Indigenous Advancement Strategy.

The DoC does not contribute to funding, despite being the primary referrer.

The DCF does not contribute any funding although it is a significant direct, and indirect referrer. This distances DCF from its client and service development responsibilities in relation to high risk Young People.

The quantum of funding provided to Bushmob is inadequate to maintain a safe minimum 1:5 staffing model for its entire twenty (20) beds at the Alice Springs facility. All representations made by Bushmob to funders to resolve this funding shortfall have been unsuccessful.

In the absence of ongoing additional funding, Bushmob has also tried to seek a means of accessing once-off funding to increase staffing ratios to accommodate high behavioural needs of individuals including Young People at high risk if discharged. This has also been unsuccessful.

The level of funding provided to the Alice Springs Bushmob is iniquitous when compared to adult AOD treatment services. It is also about 50% less than funding provided to Bushmob by the DoC for the beds at Loves Creek.

It is common for government agencies to use geographic containment as a primary response to Young People.

It is common for Young People referred to Bushmob to have been placed away from their homes and in some instances for Young People to be placed, by DCF, at interstate boarding schools over years.

Referrers routinely send Young People whose homes are in Central Australia to the top-end of the NT. This includes where a referral to Bushmob has been specifically requested by the young person concerned and is supported by their families.

This practice appears to have developed as a means of providing safety through containment in preference to adequate investment in appropriate service models for high risk Young People in the Northern Territory.
Service Delivery

**Government agencies have conflicting child at risk response parameters.**
Bushmob staff make mandatory notifications to DCF, according to Bushmob policy and procedures and obligations of the *Care and Protection of Children Act*. DCF rarely, if ever, provide adequate responses to notifications made by Bushmob including in instances of proven actual physical, medical or psychological harm or risk of harm.

Advice from the Child Commissioners office is that the referral of a child to Bushmob is in and of itself proof of a child at risk, warranting a response from DCF. This view is contrary to clarification provided by DCF.

Additionally, there appears to be ineffective child notification responses between agencies and in particular advocacy by DoH and DoC when making child protection referrals.

**Families are inadequately engaged in the care and protection of Young People.**
The NT Government has not systematically provided effective mechanisms, through programs or staff preparation, to genuinely engage Young People and their families in justice and child protection processes. This leads to the false assumption that safe and supportive family networks do not exist for Indigenous Young People.

During 2014 / 2015 the AODP provided Bushmob with once-off repatriation funds for a staff member to accompany Young People home, meet with families and service providers, to facilitate re-integration / relapse prevention plans; and to check on other Young People at various communities on route. Although there were significant benefits, the funds were not continued. Similarly, during 2012 the highly effective Aboriginal Family Group Conferencing Unit in DCF in Alice Springs was disbanded without explanation, and the Report prepared by the Menzies school of public health was never released.

**High risk Young People are not receiving basic health care.**
Young People who enter Bushmob have usually never previously received adequate primary health care including GP, psychiatric, and psychological assessments. There has never been a young person referred to Bushmob who had previously received adequate dental care.

DoC referrals tend to be accompanied by risk and health assessments, however the quality of the assessments vary considerably depending on the availability of GP’s and whether access has been gained to health care records. Referrals received from DoH and DCF are never accompanied by adequate health assessments or properly recorded such as in the shared record.

All Young People at Bushmob receive a medical assessment, with associated psychiatric assessment and psychological support. Clinical information is documented in the Bushmob case file and uploaded in the shared electronic health record. This informs individual care plans, which are regularly reviewed as part of Bushmob’s multidisciplinary case management processes.
Referral processes for high risk Young People are inadequate.

As indicated in the common scenario 1 below, high risk Young People with almost identical characteristics are dealt with differently depending on the legislative regime and agency protocols under which they happen to be managed by either DoC, DCF or DoH.

Referrals of Young People received by Bushmob from the DoC generally include some form of health examination and assessment of risk and are accompanied by a case plan. It is rare however for these referrals to be of a standard considered to meet age appropriate primary health care assessments and treatment instigation, or adequate psychosocial assessment. Referrals of Young People received by Bushmob from the DoH while generally including completed referral documentation and a care goal never include a health examination, or adequate psychosocial assessment.

Referrals of Young People received by Bushmob directly from DCF are rarer. These do not show evidence of health, or psychosocial assessments. Referrals from any pathway have not been known by Bushmob to include detailed cross program information or evidence of active joint case managed between government agencies. This includes cases where there has been long term DoC and DCF involvement.

This means that all high risk Young People entering Bushmob have some form of deficit in receiving their basic rights such as health care, and family engagement, and in the provision of professional services, particularly, in relation to their complex behavioural needs.

**COMMON SCENARIO 2**

Young person A is referred via the DoC under the *Youth Justice Act* to prevent recidivism.
Young person B is referred via the DoH under the VSAP to prevent inhalant harms.
Young person C is referred via DCF to reduce alcohol and other drug use.

A, B and C are assessed at Bushmob as being 15 year old males, with untreated sexually transmitted diseases, dental caries, ear infections, current outstanding legal issues, never attended secondary school, multiple DCF placements, a history of absconding, trauma related behaviours and distrust of authority.

Bushmob makes notifications to DCF regarding A, B and C, informs each involved agency of the assessment outcomes, establishes a risk and care plan, and starts the process of making case management referrals and assisting with health, legal and other issues. There is no follow up by DCF regarding the notifications.

A receives regular follow-up visits from community corrections staff and has access to a 1:5 staffing ratio because he was referred to the DoC funded beds at Loves Creek Station.

B and C, can only have a 1:10 staffing ratio because the beds in Alice Springs are DoH funded.

All of the Young People settle into a behavioural program which incorporates gradually increasing expectations. Building on incremental achievements by Young People so as to build their confidence in their own abilities. This includes through day to day living skills, schooling, horse riding, media, and other activities.
COMMON SCENARIO 2 continued

The discharge plan that Bushmob staff commenced preparation with the young person at admission is refined during the course of the young person’s stay.

A wants DCF to change the placement plan but this requires a lengthy process to engage DCF that may not be concluded before discharge.

B wants to continue to develop his new found talent for mathematics but his school enrolment is proving difficult because it is outside the VSA workers scope to release the contact information to complete the guardian permission required for school enrolment.

C has been reconnected with safe family during his admission, however, a placement variation is proving difficult because the DCF family maps are incorrect, and the workers are reluctant to be involved in liaisons with DoC staff regarding a variation to a community service order that is discovered after admission.

High risk Young People are ineffectually managed.

The different models of approach, and expertise of DoC, DCF and DoH results in an overall lack of the systems and capabilities required to effectively manage high risk, complex Young People. There has never been a referral to Bushmob showing evidence of effective joint and/or sequential case management between government agencies, nor a referral that has demonstrated the effective involvement of other service providers, families and Young People themselves.

The deficit in cohesive care permeates all phases of the case management process from assessment, through case planning, reviews, and post discharge / relapse care planning and reintegration. This creates gaps and delays in the basic health and social care provided to Young People as they traverse different part of the services system. Bushmob starts the case planning process at intake by developing the case plan which includes the aftercare / relapse prevention plan. This includes liaisons with safe family members, and service providers.

The involvement of DCF and the DoH in joint case management processes with Bushmob generally occurs at the instigation of Bushmob, and after intensive advocacy. It is common for clinical information provided to DoH and DCF referrers by Bushmob not to be acted upon post discharge. Community Corrections officers, however, regularly participate in joint case management by attending Bushmob and by regular contact with Bushmob staff to review the progress of referred Young People.

It is common for a young person to return to Bushmob for a second time without receiving ongoing health care for conditions identified and communicated to referrers at the first admission.
CASE STUDY 7
A 11 year old Indigenous young man was bailed to Bushmob to complete the 16 week program on CII and Confidential. Since CII and Confidential, he had been under a long term protection order with DCF. He actively participated in all of the activities at Bushmob, enjoying going to school and was proud to have completed his youth diversion community work hours whilst at Bushmob. He also volunteered to support the Riding for the Disabled program.

In accordance with Bushmob protocol, staff initiated and maintained regular contact with the DCF case worker via email and phone. This included a request to the DCF worker to develop the exit plan one month prior to the planned exit from Bushmob. This was known to be CII and Confidential and a return to country trip to leave Alice Springs had been arranged for that day. At the time Bushmob had once off funding from DoH to return Young People to their post discharge placements. DCF did not respond to the request.

Bushmob contacted the DCF case worker days before the planned exit. DCF was unable to clarify the placement. Bushmob spoke to another two staff in DCF but this also did not illicit an adequate response. Bushmob then contacted the child’s lawyer. This resulted in an urgent court sitting at which Bushmob attended by phone. DCF were allowed several days to find a suitable placement in Katherine. Immediately after the court sitting, DCF contacted Bushmob to advise a placement had been secured at CII and Confidential in Katherine and Bushmob was given permission for staff to leave that day with the child.

When staff arrived at the placement with the child, however, CII and Confidential, staff were unaware of any arrangement or contact from DCF, and refused entry the premises. After urgent advocacy with DCF a place was provided.

This sequence of events caused the child considerable anxiety, and undermined the gains made during his time in Bushmob, including in his confidence that others had his best interests at heart.

This case resulted in Bushmob making a complaint to the child commissioner’s office.

Observations
Responsibility for case planning when Young People have concurrent DoC and DCF, and/or VSA orders is not clear.

It is common for DCF to be unaware of the whereabouts of individual Young People, and to lack the consistent focus to review and update care plans, including for children under long term protection orders.

Bushmob is not aware of any young person arriving at Bushmob with a current, effective and appropriate care plan in place, or a plan that adequately incorporates sequential and shared care arrangements. These arrangements are required as a minimum to ensure
adequate and appropriate cross department involvement and consistently identified case manager with responsibility for the coordination of complex care needs.

CASE STUDY 8
A 31 year old child from a Top-end community self-referred to Bushmob on CII and 
This was her second placement with Bushmob, the first being a temporary out of home care placement by DCF to Bushmob in CII. 

This child was under a current DCF order. Bushmob notified DCF of her presentation. DCF advised they had trouble locating this child because she was highly transient.

At Bushmob she was referred for examination at the CII and program on CII and found to be CII.

On CII and , Bushmob notified DCF and reported the case to the police. It is not known what action resulted from the police report.

This young woman said she was CII and to which she had recently been placed by DCF.

She subsequently discharged herself from Bushmob to stay with her sister who was CII and recently CII. This was also notified to DCF.

Observations

Despite being under the care of DCF, this young person’s whereabouts are regularly unknown to DCF and in consequence, there is inadequate supervision which places Young People at risk. This includes medical risk, but it also leads to young person engaging in anti-social or criminal behaviour.

There appears to be a culture where DCF are reverting to the lesser of the inadequate protective options for some high risk Young People. This includes the use of geographic containment either across the territory, or through interstate placements. It may also include tacit support of offending resulting in incarceration. In the face of a system that is otherwise incapable of effectively ameliorating risk.

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4 This case is just outside the two year data range for the submission. It has been included as relevant to demonstrate the issues noted, including issues affecting young women.
CASE STUDY 9

A 13 year old Indigenous young person was admitted to Bushmob from a Top-end community in mid January under a VSA order.

The health assessment at Bushmob identified scabies, major dental caries, trench foot and athlete’s foot and treatment provided.

He told staff that he had never been to school. At Bushmob he participated in a work readiness program and basic literacy training.

Observations

Young People in Bushmob have infrequent engagement with their education after leaving primary school. Bushmob has encountered instances where Young People have never been to school.

Immunisations are generally completed at secondary school age but this is not the case for Young People who enter Bushmob.

Commonly there are significant levels of undiagnosed learning needs which are not being picked up at the primary level of education.

All Young People of school age attend school as part of the Bushmob program. Where Young People do not attend school, it is because a school place is not available.

It is Bushmob’s strong view that the assumption that Young People do not want to go to school is incorrect. Young People go to school, and enjoy learning when they have adequate assessments and support, and they have supportive and safe learning and living environments.
REPORTS AND NOTIFICATIONS

High risk Young People have significant trauma, extremely poor physical, and mental health, suffer extreme marginalisation from educational and work opportunities, as well as from health and social services; and they are systematically dislocated from safe and supportive family networks.

Bushmob has reported these circumstances to Australian and NT Government funders, by making mandatory child protection notifications, complaints to the NT Children’s Commissioner, at health and community services community meetings, at conferences and other forums; in the media, and through NT government review processes including in relation to the juvenile justice system, the Department of Health and Department of Children and Families.

The information provided has been in varying levels of detail and specification, however, it has been blunt and unambiguous in describing systematic failures, and their effects on the safety and care of high risk Young People, and that these failings are getting worse. This information has not translated into changes in how high risk Young People have been treated in the NT.

Notifications to DCF

Taken from the 2 years of data analysed for the Report

In the period covered by this Report Bushmob has made notifications to DCF regarding 57 individual children. This includes multiple notifications for some children. It has been regarding confirmed sexual, physical, social, psychological and medical risks.

There has never been an adequate response by DCF.

Bushmob has sought to clarify what responses can be expected from DCF. The information provided to Bushmob by DCF is that DCF does not assume risk to have been confirmed by admission to Bushmob.

This advice, however, is contrary to information provided to Bushmob from the Child Commissioner’s Office that admissions to Bushmob as the result of intervention by the state is in itself confirmation of child at risk criteria having been met.

Complaints to DCF

Taken from the 2 years of data analysed for the Report

Bushmob staff regularly, on a daily, or weekly basis complain to individual case workers within DCF about the lack of response to Young People, and notifications regarding children.

During the period covered by this report this includes three (3) formal complaints about central intake and inappropriate responses to staff try to make notifications.
Complaints about DCF to the Child Commissioners Office

Taken from the 2 years of data analysed for the Report

In the same period Bushmob has also complained to the Child Commissioners Office regarding the treatment of three (3) children by DCF. One complaint resulted in court intervention to ensure a child under an existing DCF order was placed. This case resulted in an investigation being undertaken by the Commissioner’s Office. The others were regarding the refusal of a DCF worker to accept a child at risk notification, and inadequate response to the needs of a child in care. These resulted in internal DCF investigations.

Reports to Review Processes

Cross section of examples from 2009

The Review of the Northern Territory Youth Detention System conducted in 2015 did not include an interview with Bushmob staff or provide for submissions, this, unfortunately means that the review has excluded important information.

Bushmob has however, provided written submissions and participated in interviews related to other review and inquiry processes with respect to the issues and circumstances surrounding high risk Young People in the NT. The following are some examples.

2015

Leading up to and after 08 Oct 2015 Mr MacGregor had a series of conversations with Correctional Services Commissioner Mr Ken Middlebrook regarding more effective models for the management of Young People in detention. During which he described the circumstances of Young People and expressed concern about current programs and in particular the use of ‘boot camps’.

2014

During the DoH review of residential rehabilitation services and of bush adventure therapy undertaken in 2014, detailed information was provided about the circumstances of Young People, and program deficits and needs.

As part of the written submission to the Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities. Best Practise Treatments and Support for Minimising Alcohol Misuse and Alcohol Related Harm, published on 19 March 2014, Bushmob stated:

“There is a lack of Youth AOD service provision around Australia... In the NT there is Bushmob, Mt Theo, Brahminy (private) and CAAAPS. In Central Australia youth services at Ipolera, Injartnama, Ilpurla have all ceased functioning.

All Young People who enter Bushmob are complex high needs clients with significant primary health care issues. We estimate that 30% of our clients are affected by Foetal Alcohol Spectrum Disorder (FASD) issues. There is no relevant FASD training in the NT at this time to manage these issues other than word of mouth and off the internet.
We also have a growing concern for the number of Young People with significant comorbid issues including FASD, who either already have or will end up in the correctional system as opposed to secure care or assisted environment, and incarcerated without charges due to being unfit to plead and magistrates having no other placement options.

We have seen a growing number of Young People engaging in harmful levels of substance misuse, the youngest so far being 6 years old…"

2011
On 19 July 2011 Mr MacGregor, CEO of Bushmob, met with the reviewers during the review of the Youth Justice System that was conducted under the chair of Ms Jodeine Carney. Mr MacGregor described, at length, the full range of health, social, and related issues (as described in this submission) that were impacting on Young People and his perceptions of the system failings and in particular of health and DCF. He described the inadequacy of interventions and practices that were inappropriate for high risk Young People with complex needs and in particular inadequate health care and interventions undertaken by justice / corrections. He expressed the National Bush Adventure Therapy Association policy position, as shared by Bushmob, of opposition to the use of short term so called ‘boot camps’ or ‘youth camps’ as outdated for the management of this population group in the community and in the Corrections settings.

2009
Bushmob provided detailed information about the circumstances of Young People and policy deficits and needs during the DoH review of the scope range and effectiveness of alcohol and other drug treatment services in Alice Springs in 2009. Indicating definition issues regarding mismatch funding source, and actual services provided.

Bushmob has also provided reviewers with copies of the independently conducted Evaluation Report. Bushmob: A socio-cultural approach to youth service delivery in Central Australia, completed on 17 August 2009, by Dr Anita Pryor; from which the following is extracted:

Bushmob provides seamless service across the spectrum of public health needs, including in prevention, early intervention, maintenance, and recovery … tailored to the need of participating individuals… service delivery is both cultural and social.

Bushmob participants have experienced the spectrum of health risks, across nine wellbeing domains (including physical, mental, behavioural, social, cultural, spiritual, environmental and economic domains. In general participants tend to have experienced early life trauma, and many experience ongoing (daily) trauma due to the effects of poverty, substance abuse, lack of access to services, cultural isolation, and the effects of intergenerational grief and loss …
Participants may attend Bushmob with extremely high needs – for example, in chaos, perhaps with wounds – and may have little energy or ‘readiness’ to bring about change. Bushmob is often a vital ‘safe space’.

Given the breadth and depth of needs of Young People attending with, Bushmob has had to tailor specific risk management practices to match their target group and context. Bushmob have developed a range of strategies to manage the health risks of individuals in their care, and to support the improvement of health.

Bushmob works alongside other human and social services that are considered ‘essential for survival’ by those individuals living in high risk settings with minimal security and/or minimal material resources (including minimal access to health, economic participation and legal services)…

The nature of Bushmob’s seamlessly integrated services means pressure on one area of service delivery stresses other areas… [it] is one of the few … services in Australia that can be said to offer support across the full spectrum of public health needs in the area of mental health (including substance misuse)… and that can attest to meeting all of the best practice adventure therapy industry standards… On a national scale, Bushmob is considered a mature model of adventure therapy practice.

Due to the extent of potential impacts (across nine domains of well-being) Bushmob … practices appear to offer an incredibly cost-effective health intervention. It is possible the effects and effectiveness of Bushmob’s approach will compare favourably with any clinical health intervention.

Will (Will MacGregor, CEO of Bushmob) stated ‘Having a voice about key issues is considered our core business – we bring our core values to key decision-making bodies, equally to the Young People we are here to assist’. From social and cultural perspectives, now is potentially a good time to showcase distinct effects and effectiveness of Bushmob … approaches. By sharing these stories, this expertise, other individuals, families and communities, in a range of settings, may benefit.” Extracted from Evaluation Report. Bushmob: A socio-cultural approach to youth service delivery in Central Australia, completed on 17 August 2009, by Dr Anita Pryor

Information provided to senior staff of Government Agencies

Since 2002 Bushmob has provided detailed information about the circumstances of high risk Young People, and issues impacting on their safety and care and the deficits in the system, policy and funding to services such as Bushmob to officials of the Government of the Northern Territory.

While this has been most frequently to staff of the DoH, it also includes representations to officers of DoC and DCF and the Australian Government Department of Prime Minister.
This has been to advocate for policy changes, to ameliorate staff to child ratios and service barriers by describing the characteristics and issues impacting on high risk Young People and their families.

Since 2002, Bushmob staff have been regular members of various community agency and department forums and have provided information descriptive of the issues impacting on Young People and their families. This includes forums attended by senior staff of DCF, DoC, and DoH such as the Youth Justice Advisory Committee (YJAC).

Information reported in the Media

A cross section of examples from 2002

Mr MacGregor, the CEO of Bushmob has made the characteristics and issues impacting on Young People and their families in the NT known through the media. This has been in television, radio and print reports. The following are some examples of print media reports.

2016

[Mr MacGregor’s] seen firsthand how drug problems affect regional areas. He said if they were as bad in Sydney or Melbourne, much more would have been done. “But we’re out of sight, out of mind,” he said. “We’re not meeting any of the targets we’re supposed to and we’re not getting the funding.” NT News Fair Go campaigns, 10 April, 2016

… these kids needed more than a day away. They needed a safe haven where they could escape the trauma of their everyday lives. “They were really sick – spiritually, emotionally, physically,” he says. “There were significant health issues – STDs, scabies, head lice, diabetes, mental health. They really needed some help.” Inspired organisation, June 20916, http://inspired.org.au/2016/06/will-macgregor/

Mr MacGregor…said many youngsters arrived traumatised, and had multiple health problems such as diabetes, rheumatic heart disease, hearing loss and sexually transmitted infections…. Bush Mob offers a 16-week program for kids aged 12-15 years. Many are from disadvantaged urban Aboriginal communities, stuck on a merry-go-round between treatment, care and youth justice services…Mr MacGregor said pressure on the health and child-protection systems was exacerbating problems. “If we get approached with a referral for a known sex offender we will not generally take that person,” he said. “But what often happens is that people are quite desperate to get people into placements and they are leaving out information.”

“We need to acknowledge the fact Young People are having a hard time in our country... I don't mean mainstream Young People, with roofs over their heads and food in their bellies… kids [at Bushmob], the future for them is living today, survival. These guys are in crisis and trauma, both white and black. The last national youth policy was under Rudd and it's got the bare bones of a good framework, but nobody ever asks the Young People having a hard time with drugs or crime what their opinion is." The Australian 12:00AM February 4, 2016 reported by Amos Aikman http://www.smh.com.au/national/australian-of-the-year-nominee-will-macgregor-lends-a-hand-to-troubled-youth-20160121-gmaph0.html
2010
There is one alcohol rehabilitation or treatment bed for every 485 adults in Alice Springs. There is one for every 2000 people aged between 12 and 25. Yet the need for a facility catering for young abusers …is acute, growing and uncharted territory…Bushmob is filling the gap, underfunded, stretched to its limits and inappropriately located, says its manager, Will MacGregor.

Mr MacGregor says the service … is meant to have five “funded” beds but in fact the average occupancy is eight…And that is pretty well as far as government interest goes: “We applaud that the government has had the foresight of starting an urban facility. “Apart from that, the funders give us money and then leave us to our own devices,” he says…. The clients are mostly Aboriginal, and from backgrounds where nothing is done “until there is a crisis”, says Mr MacGregor.

Some should, for a long time, have had treatment for schizophrenia or psychosis, but they didn’t. Their families “did not have the capacity to know about it,” says Mr MacGregor. The kids are being admitted to Ward One, the “psych ward” at the hospital. Beds there, too, are limited and so the Young People are released back to the family. “Medication goes out the window,” says Mr MacGregor… So the Young People “self-medicate with booze or drugs to take away the bad feeling”. Then it’s back to Ward One … and so on.

For another group of Bushmob clients, substance abuse, mostly practiced in public places, is the main way of dealing with life – neglect, boredom and hunger. They band together: “We’re tough kids. This is how we survive, look out for each other”, is their attitude, says Mr MacGregor….There isn’t a textbook in The Centre for dealing with kids from such extreme backgrounds…Often parents are unable to cope… Where will they end up? “I don’t know,” says Mr MacGregor, “probably in a further engagement with the criminal justice system.”

So Mr MacGregor and his staff of eight are finding their own ways, building rehabilitation in town… the picture is grim …there is no or little access in the bush to clinical treatment… Alice Springs News, March, 11, 2010, reported Erwin Chlanda

2002
Much of the petty crime in Alice Springs which is driving traders to distraction is being committed by street kids, numbering 30 to 50 by some official estimates. There are "lots more," says Will MacGregor, who with his Aboriginal partner Bruce Steen runs Bushmob. These kids are hungry, sleep rough, are constantly exposed to violent abuse, don't attend school circumstances that would ordinarily result in large scale intervention by child welfare authorities.

Their decisive action would be as much in the interest of the Young People as the community at large. But authorities are doing little at the moment occasional placements in foster homes clearly afraid to raise the spectre of another "stolen generation" of "taken away children". It's a fear that's "paralysing the public service," says Mr MacGregor. The government does acknowledge that the buck stops with it: the "ultimate guardian" is the Minister for Health who oversees Family and Children's Services (FACS), says Minister...
for Central Australia Peter Toyne, who has made fixing the problem his top priority. But for the moment the government is putting its trust in a coalition of private "service providers" (see report this edition), mainly publicly funded Aboriginal organisations. Key initiatives are still not in place; some players, such as Eddie Taylor and the Youth Night Patrol (Alice News, Nov 20) are still out of the loop; and collaboration between the organisations is recent, after a long history of bickering and rivalry. That’s got to stop, says Dr Toyne: In this “life threatening” situation there is no longer a place for "ancient feuds and tribalism”.

Mr MacGregor… With Mr Steen…has cobbled together resources from the Commonwealth Department for Family and Community Services, the Myer Foundation and Newmont Mining, operators of the gold mines in the Tanami. Bushmob, which operates under the auspices of DASA, has "one and a half staff", one demountable building, two silver bullets, a Toyota ute and a 25 year old Troopie "with 500,000 km on the clock". The main initiative, about once a fortnight, is taking kids who want to come out bush for one or two days. Mr MacGregor and Mr Steen make contact with the Young People aged 12 to 27 in the streets, shopping centres, town camps. Sometimes they are referred by other organisations.

The Young People are mainly Aborigines, but sometimes white youngsters join them, on their way "up north" to look for a job and stuck in Alice Springs for a couple of months. The typical "client" might not have had any sleep the night before. He might have been the victim of violence, sometimes sexual. "Do you want to go to hospital?" is often the first question Mr MacGregor asks. "They are hungry. They have no money for food. "One of the things they’re getting out bush is at least two good meals. "They might have had their gear ripped off, so clothing might be a problem. "Why can't they go to school? I can't because I can’t have a shower," they tell us. ADDICTION" They might be caught in an addiction cycle, alcohol or ganja. "Ganja is huge at the moment." Mr MacGregor says most have given up hope of ever being part of the mainstream society. "I'll never get a job. I'll never be working Ð why should I bother?" Some live on the dole, "arse money, because it's for sitting on your arse and they say this with a great deal of sadness". Mr MacGregor says they are desperately unsure about their place in the world. "What am I? "Am I a Nike kid? "Am I going into initiation this Christmas?" Frequently the parents have succumbed to alcohol and the grandparents are too tired for raising a second lot of kids. "However, they often do," says Mr MacGregor. The Young People if they sleep in a town camp would usually spend the night on the floor, maybe on a mattress, or " anywhere you're likely not to get hassled by someone, behind a bush, in an alley".

"There are always people around looking for money for grog, people off their face who want to rouse someone. "The kids eat junk food, chips, lollies, shoplifted from supermarkets, whatever is going". Mr MacGregor acknowledges his contribution is small but at least he's making one. "They are the kids who are forgotten and discarded. "Maybe we've become a lazy society which doesn't give a damn about its children." Meanwhile organisations spend a great deal of their time vying for public money. The street kids are painfully aware of this: "It's like mum and dad having an argument," says Mr MacGregor. Alice Springs News Nov 2002, STREET KIDS: ACTION NEEDED, NOT BICKERING. Report by ERWIN CHLANDA.
WHAT NEEDS TO HAPPEN

The characteristics and issues impacting on Young People in the juvenile justice system or at risk of entering the juvenile justice system are complex and significant.

If high risk Young People are to have opportunities to make meaningful and productive life changes, the primary response must be trauma informed, include a long term residential component, and provide holistic physical, mental, and socio-cultural therapy that is consistent with the evidence base, and legal and moral obligations to a highly vulnerable population.

The following are suggestions about how this could be achieved.

1. **Fully implement the Recommendations of the Royal Commission into Aboriginal Deaths in Custody.**
2. **Establish a single point of administration for high risk Young People.**
   a. Engaging services, Young People and communities in the development of a high risk youth response for the NT;
   b. Establish a new program category for high risk Young People supported by policy and case management frameworks with therapeutic specifications; and
   c. Report health, welfare and educational outcomes nationally for high risk Young People.
3. **Reform the juvenile justice system.**
   a. Cease all short term non-therapeutic programs such as ‘boot camps’ or ‘farms’;
   b. Establish youth justice advocates at Bushmob and similar catchment points; and
   c. Establish residential therapeutic treatment for high risk Young People - like Bushmob - as the preferred placement option.
4. **Connect children with their families.**
   a. Reinstate the Aboriginal family group conferencing unit in DCF; and
   b. Create ‘authorised child at risk notifiers’ for employees in designated community services whose recommendation compels a child safety response.