

9<sup>th</sup> October 2016

Royal Commission into the Protection and Detention of Children in the Northern Territory

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Dear Commissioners,

I am a registered nurse and midwife, endorsed as a Nurse Practitioner. Qualifications include; Bachelor of Nursing with Distinction, Bachelor of Science 1<sup>st</sup> class Honours, thesis "Kaltukatjara Children: child rearing practices in a remote Central Australian Aboriginal community", Graduate Diploma Midwifery, Graduate Diploma Mental Health Nursing, Master of Remote Health Practice: Nurse Practitioner and Graduate of Australian Institute Company Directors. For the past 15 years I have worked in remote Central Australia as a Remote Area Nurse and Primary Health Care Manager. I am a fellow of CRANApplus the peak body for remote health clinicians. Until May 2016 I worked in clinical practice in remote Central Australian communities. I am currently employed as a topic coordinator at the Centre for Remote Health, in the Remote Health Program – Nursing.

I would like to draw your attention to the inconsistencies in service delivery for remote children. This document presents the case of one child; however the resource and structural impediments to his care are common to many children in the Northern Territory.

*Illustrative Case Overview:*

As a Remote Area Nurse Child A first came to the attention of clinic staff in a remote community at CII of age for routine health care. The name of his mother was listed but she was not resident in the community. In the paper records used at that time, there was no information as to where the child had been previously or who his current carers were.

Eighteen months later, aged CII, the next recorded encounter documents clinic staff requested a visiting adult psychiatrist to review the child as he had exhibited behavioural problems for probably the last 9 months. The clinic had not been able to engage with him. There was still no record as to who cared for him. The issue at the time was a recent mandatory report to the Department of Children and Families (DCF) as well as the Volatile Substance Abuse (VSA) unit, that he had been sniffing petrol. Concerns were also raised that he did not attend school, did not appear to be supervised and no one could state who was caring for him.

The psychiatrist report from this request notes that it seemed the child had not had any clear or stable parenting figures through much of his life. CII

. The teachers at the time advised his school attendance had been minimal

during his time in the remote community and he was therefore essentially functionally illiterate. The teachers felt this was due to lack of time in an educational environment. They also raised concerns about his home environment. The psychiatrist felt the most likely explanation for bad behaviour was that Child A has had no real structures in his early life and no sustained attachment figure. The recommendation was that he needed to be placed with a stable responsible carer who could provide both positive emotional investment and some structure.

At [redacted], Child A was again seen at the remote clinic by a visiting paediatrician. His behavioural problems had continued and he was with different community members as his “carer”. He was now involved with the justice system. He could no longer be managed at the school. His behaviour was noted to be worse when he was in [redacted]. He had been referred to [redacted]. His medical problems now included [redacted]. A referral was made for child and youth psychiatrist and audiology review.

Five months later Child A was reviewed in the remote clinic by a visiting paediatrician. His behaviour had worsened. He was expelled from school. He remained involved in the justice system. His medical needs had increased. He was referred to [redacted] for assistance.

I saw Child A roaming around the [redacted] at 9.30 – 10.00 pm at night, happy to engage but unable to tell me where he was staying or who was looking after him.

There was no feedback to the remote clinic from [redacted] service as to their engagement with Child A (if any) and progress or suggestions for management.

The child and youth mental health service [redacted] was extremely flexible in making appointments for Child A, often at short notice, none of which he attended.

He attended [redacted], on an ad hoc basis for medical review – however those taking him to such reviews do not appear to be clear about what is needed and what has already been done. [redacted]

#### *Issues:*

1. Unable to source information about the first [redacted] years of his life –given his current challenges it is surprising he did not come to any services attention prior to [redacted], and his care co-ordinated at a much earlier age.
2. Dis-connect between expectations of service providers in the remote setting versus the urban setting. Remote communities are small places and clinics provide the co-ordination of primary health care. Unfortunately once a child moves from the [redacted] this co-ordination seems no longer available to them. Urban service providers seem to struggle to ensure primary health care needs are met for their clients and there is no clear lead provider that relevant information can be sent to. Given that [redacted] has a much greater range of services than any remote community it seems incredible that there is such disconnect in care.

A simple example is that whilst in the remote community visiting service providers expected clinic staff to actively follow up his needs, proactively locating him for vaccinations, medical reviews etc; and provide this information back to other services. Similar expectations were also placed upon educational staff by external providers. It is apparently acceptable for remote clinic and educational staff to have to make home visits and pressure individuals to comply with services directives. However when Child A moves to CII [REDACTED] it is apparently not the business of any service provider to proactively follow him up, ensure he attends relevant appointments and that carer's understand the need and outcome of these appointments. It was extremely difficult to find any CII [REDACTED] based service who could try to locate Child A as services are office based and do not do home visits. His case had been closed by DCF.

3. Communication between visiting service providers to remote communities is fragmented and relies on relationships between staff. Few visiting services acknowledge that they are in fact "visiting" and therefore cannot co-ordinate care, in the same way a service provider permanently based in the community can. Conversely, should a child move to CII [REDACTED] there is no central point to send relevant information ensuring appropriate follow up of their various needs; medical, social, educational, cultural.

For example, CII [REDACTED] do not provide feedback about the progress and well-being children in their care, although they expect to receive information from other service providers. CII [REDACTED] also does not provide feedback about children referred to them. At a very basic level, for both services, the referrer usually does not hear whether the referral has been accepted or not.

CII [REDACTED]. It is not always clear how children have entered their programs and what they can offer. Generally I have found staff are willing to have case discussions about individuals and families to ensure co-ordination of care, however this is person dependant rather than a formal process. Without these informal interactions it is unclear which families they are involved in and what support they offer individual families.

Within the Department of Health, specialist reviews such as audiology and mental health assessments are sent to the primary health care clinic. All remote clinics in the Northern Territory now use electronic data systems. Child A was registered with CII [REDACTED], which should have ensured his health needs were met regardless of whether he attends a clinic in CII [REDACTED] or the remote setting. He has on-going medical needs as well as psycho-social requirements. However those involved in his psycho-social care displayed little understanding of his medical needs and the relationship between psycho-social and physical well-being.

#### *Summary:*

Child A is a CII [REDACTED] year old boy who first came to the remote clinic's attention at CII [REDACTED] years old, with difficult behaviours and lack of a stable care structure. Despite input from many service providers in the intervening years his medical, psycho-social and educational needs worsened. The goodwill and strenuous efforts of many service providers, notably education and health staff, to have these matters addressed, has not resulted in any tangible benefit for Child A.

I feel he would have benefited from having a clear “lead” provider, who could co-ordinate his care regardless of his geographical location. Such a provider would require the authority to seek and receive feedback from all involved agencies, regardless of Department, as well as family members. This information would then be used to best inform Child A needs, across the entire spectrum of medical, psycho-social, educational and cultural. He could then be referred to appropriate services without duplication, there would be a clear understanding of the role of each service in Child A life, care could be transferred to appropriate agencies as he changed geographic location and family members would have a clear central point of contact regarding services.

Although this letter uses Child A’s case as an illustration of the challenges involved in providing care for transient children, it should be noted that he is just one of many children **CII** who are falling through the gaps. The fragmentation, resource limitations and structural constraints to service delivery for remote and transient children are common throughout remote Central Australia. I look forward to your findings regarding these issues and can be contacted on the below numbers.

Yours sincerely,

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