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

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Introduction

This submission is authored by the two half-time child and adolescent psychiatrists (MC and SC) working in Alice Springs, in the Central Australia mental health Service and an adult psychiatrist (MT) who has worked in Central Australia for 19 years . We are making this submission because

- Many of our referred clients are of direct relevance to the scope of the Royal Commission, being either children in detention, in care, or at risk of both.
- We strongly feel that there are interventions which are possible to make which could alter the trajectory into and out of care and detention, but which are difficult to provide currently in Central Australia.
- These interventions require some additional resources, but even more some structural coherence in the approach to these young people.
- As is common in all jurisdictions, many of the children in detention are the same children who are in care, and who present to community mental health services, and are in trouble in education services. In the NT this group includes a much higher number of Indigenous children than other states and territories. There are a range of common factors impacting on these children - developmental trauma, including Foetal Alcohol Spectrum Disorder (FASD) and other biological challenges, transgenerational trauma, parenting gaps, exposure to domestic violence and substance use, accrual of a range of deficits in learning and prosocial competences which make it harder to remain in education and occupational settings, substance use and early criminal behaviour. Health interventions are one aspect of assisting these children, as part of an integrated approach with welfare, education, justice, family and community support in a multisystemic model. (Commonly referred to as a “wrap around model”)

We would like to be clear from the outset that we are not indigenous clinicians, and are acutely aware of the limitations this brings. We are offering this submission on the basis of our professional expertise and experience only, both in New South Wales and in the Northern Territory. This has included significant experience with children in care, working with the systems around them, and with indigenous children and families.

In addition, we are not experts on forensic child and youth within detention services, although we have experience working in those settings. However, our focus here is on the youth in Central Australia, and ways to approach service provision for those in often brief detention in the Alice Springs Correction Centre (ASCC).

Contents of this Submission:

1. The Child and Youth mental health Service (CYMHS) Context

The Child and Youth Mental Health Service (CYMHS) in Alice Springs sees clients relevant to the core business of the Royal Commission into the child protection and youth detention systems of the Northern Territory. Children and young people are referred to CYMHS when they are in detention, appearing in courts, on supervision orders, and when police and welfare services are involved. Children are also referred at earlier stages prior to involvement of police or welfare, when families and schools are having difficulties managing their behaviour.

While the Child and Youth Mental Health Service- Central Australia (CYMHS) has operated since ~ 1995, staffing has varied considerably. Currently the service has one FTE child psychiatrist, one team leader and five clinical positions. With this staffing level, referrals can be managed within Alice Springs, while service to remote communities is limited to telepsychiatry assessments for semi-urgent or crisis presentations and non-urgent assessments that rely upon families being able to travel to town via the NT 's Patient Assisted Travel Scheme. There is one child and youth mental health clinician position in Tennant Creek, plus visits from a senior psychologist (though under threat due to funding issues) and (recently commenced) three visits per year from a Child and Youth Psychiatrist.

Case managers have caseloads currently of 20-30 children and young people: the CYMHS team has around 25% of all case managed clients in the Mental Health Service of Central Australia. There has not been capacity to provide consultation and an effective service to the detention centre in Alice Springs, although known youth are offered appointments in town if detention centre staff can bring them to appointments. This service gap has been highlighted each year in Community Visitor Programme NT (CVP) reports and requests for enhancements have not been successful.

The CYMHS team exists in a network of small services that work with the same clientele. School counsellors and special education staff, therapists in NGO organisations (e.g. Relationships Australia), Territory Families caseworkers, Territory Families, therapeutic staff, paediatricians, General Practitioners, Central Australian Aboriginal Congress (CAAC), Intensive Support Services (Anglicare), the Child Development (allied health) Team, Intensive family support services, Headspace, and others. All these services have small numbers of staff who are transitory in the main, and who are variably skilled. Privacy [redacted]. The child and youth team similarly has to work to attract and retain staff, and adjust to a range of backgrounds and skills. This means that while there are numerous services involved with at risk young people, managing to develop and sustain case plans is difficult. Partnerships are always problematic to sustain, but more so when there is high staff turnover, and when all services are stretched both geographically and in terms of caseloads.

Footnote: Mental Health problems are common in children and adolescents. The second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015) found one in seven (13.9%) children and adolescents will experience a mental health disorder in a 12 month period of which 60% will be of mild severity; 25% moderately severe and ~15% severe. This prevalence figure of 13.9% is likely to be higher when one includes remoteness and Aboriginal and Torres Strait Islander populations. The Western Australian Aboriginal Child Health Survey (WA ACHS) conducted in 2005

gives us some indication of what this may be in the Northern Territory when it found that 24% of Aboriginal children aged 4-17 were at high risk of developing clinically significant emotional and behavioural disorders compared with 15% of the non Aboriginal population of the same age. A similar survey has not been carried out in the Northern Territory.

2. The Nature of CYMHS Clinical presentations, and the relevance of Developmental trauma

Overwhelmingly, the children and young people referred to this Child and Adolescent mental health Service (as to others all over the world) are the same children who struggle at school, who are involved in welfare services, and who may be involved in offending and youth justice services.

The following case examples (amalgamated real cases) describe some of the young people our service sees who are at risk of entering or have had contact with the justice system:

1. A 9-year-old Indigenous boy referred because of absconding from and failing to attend school, spending a lot of time 'on the streets', having difficulties with learning, and using volatile substances with an older peer group. His grandmother carer was concerned but helpless, and felt unable to protect her grandson. The school was concerned but unable to engage him. He had many relatives who used substances at times, and although his grandmother tried to keep him away from adults when they were using substances, he was increasingly exposed. Intensive support was eventually available to this boy and his grandmother (after 12 months), which helped with health assessment and treatment, and supporting grandmother to protect him. He is not yet effectively back in school and is on a court order.
2. A 6-year-old Indigenous girl in the care of non-Indigenous foster carers, referred because the placement was about to break down. She had been significantly traumatised for some years, and this was her third placement. She required constant supervision from her carer and teachers, could not sit still, could not concentrate in school, was on part-time attendance (1 hour each day only) at school, and was often violent and unable to play with other children. She was significantly assisted by CYMHS with therapy and medication, but her placement remained unstable and stressful and under threat of change. Her schooling improved but concerns remained about cognitive deficits, which were unable to be assessed. It was predicted that her gains may be lost if there was sudden change in care arrangements, and as she gets older she would remain vulnerable to exploitation by others (as had already happened even with supervision). Holistic planning for care, education and therapy support, and carer support were needed to enable her to have a stable childhood, with planned reconnections to a range of family members.
3. A 15-year-old indigenous boy from a remote community, referred due to a serious suicide attempt on a background of forensic problems and substance use. He could be seen while in hospital after the serious attempt, but consistent follow up after discharge was not feasible due to distance and family movements. He required active follow up, but resources were not available and the CYMHS team has no capacity for remote outreach. He was likely to reoffend when unwell, and remote community services (primary health clinics, NGOs, Territory Families staff) have limited training in assessment and treatment for mental health and substance use problems.
4. A 13-year-old indigenous boy referred because his carers were struggling to manage his erratic behaviour. He was in and out of detention, had been through relative placements, foster placements with indigenous families, and was now in residential care. It became clear that he had significant confusion about which world he belonged to, he recurrently left his placement and other accommodation provided, he was in and out of town, had a failed

attempt at boarding school, and was increasingly using substances. Services were unable to do cognitive testing (there was confusion about capacity in the school setting), and could not provide the intensity needed to connect with him and his family, especially with remote components. This boy was identified as having major struggles several years prior to contact with CYMHS.

Further to these case examples we have categorised or 'staged' the development of at-risk behaviours in young people into four broad groups (not to be interpreted as a linear progression)

a. Children (under 12 years) in the care of their biological families, but who are unsupervised for long periods recurrently, drifting between households, not attending school regularly, often experimenting with substances. Carers often feel they are unable to control them or keep them safe. These children come to the attention of Territory Families at times, but often do not meet criteria for ongoing case management. They are highly vulnerable to the influences of antisocial adults or adolescents on the streets.

   Intermittent substance use can be a precursor to entrenched substance abuse and related harmful behavior including criminal activity. These children have experienced unreliable or frightening parental care as well as chronic neglect, their parents often have histories of trauma complicated by transgenerational trauma. The children are often difficult to 'see', as families, schools, Territory Families, support agencies and health services, struggle to keep track of their activities, relationships and development.

   Children in this group, as with all the groups, may have undiagnosed or untreated health and developmental problems such as trauma-related symptoms, FASD, Attention Deficit Hyperactivity Disorder, sexualised behaviour, developmental delay and Learning Disorders. They are at risk of experiencing further trauma while living itinerantly, which can 'trigger' past trauma responses and have profound impacts on behaviour and functioning. They tend to struggle at school despite efforts to engage them, often their learning difficulties are not properly identified, and they experience little or no success educationally and socially at school.

b. Young children, often Indigenous, in foster placement with Indigenous or non-Indigenous carers, who have severe emotional and behavioural problems.

   The greatest difficulty for these children and their carers is to manage challenging emotional and behavioural problems, including all too often aggression and violence. The risk of carer burnout and placement breakdown is high, potentially leading to further loss and trauma, and erosion of developing self-esteem. Children in this group can have many foster placement breakdowns and changes, interspersed with residential care experiences, all of which occur during important stages of development. Behaviour patterns that are formed when children are chronically neglected and cumulatively traumatised reflect the biological and brain mechanisms used for survival. These children often demonstrate very negative developmental trajectories that may be difficult to shift. They are at high risk of educational failure, substance use disorders, depression and anxiety, conduct disturbance, aggression and other antisocial behaviour. Their care systems require sustained intensive support and targeted interventions for optimal outcome.

   Foster carers of Indigenous children in Alice Springs are often respectful of Indigenous culture and the child's need for contact with community and family. The child psychiatrist authors have observed that in Central Australia more so than in NSW (where we have also worked extensively), carers encourage and enable contact with biological families, while Territory

Families does attempt to incorporate cultural activities and contact with community in care plans. As the children approach adolescence they are particularly vulnerable to identity dilemmas, and even stable placements are vulnerable, and the young people may enter an antisocial peer group and leave home.

c. Young people often in residential care on diversion programs such as police cautions, supervision regimes, drug rehabilitation programs, boot camps.

   Young people in this category generally have trajectories emanating from (one of) the groups above. Substance use is common, the costs of which often motivate young people to steal and engage in other criminal activity. Parents, carers and schools have struggled to provide stable environments.

   By this stage there are many operators - Territory Families caseworkers, program operators, community project teams, lawyers and magistrates - striving to keep the young person out of detention. The authors are uncertain as to the level of Aboriginal consultancy or Elder involvement in the courts. Diversion programs are generally chosen according to the young person's needs, such as drug rehabilitation programs (Bush Mob is an Alice Springs example). Some programs are based in remote communities (such as the Warlpiri Youth Development Aboriginal Corporation WYDAC operating in Yuendumu, Willowra, Nyirripi, Lajamanu and Mt Theo Outstation), and have Aboriginal community governance, involve Elder leadership, cultural teachings, and aim to instill respect for culture and community.

d. Young people, most often Indigenous, who are in detention and will be released on bail or parole orders into the care of their families or carers or residential homes.

   These young people also have histories such as those outlined above and may have several diagnoses related to developmental trauma. Their behavior in detention may be characterized by distrust of adults, poor emotional control, reactive anger and difficulties expressing their needs appropriately. Isolation and loneliness are significant, especially for those sent to Darwin for long periods. Disconnection from families can increase so that when released there are few strong connections in place, and reoffending is more likely.

3. Developmental Trauma

In all of these cases and with the majority of young people in detention in the NT, the phenomenon of Developmental Trauma is vital to understand.

Throughout the world, there has been an increased awareness of, and research into the group of children who appear in an overlapping group of services - mental health, special education, disability, juvenile justice, and welfare (van der Kolk 2005, Perry 2009, Cook et al 2005, Boivin et al 2012). These children have multiple things in common - early neglect, poverty, exposure to a range of developmental traumas, including domestic violence, family and care instability and disruptions and losses, a range of physical health issues, and early contact with the justice system.

Over the last 20 years especially there has been an increasing focus on this group of children and young people, partly fuelled by

- Recognition of poor outcomes in most jurisdictions, with poor educational and employment outcomes, high levels of substance use and early pregnancy, high levels of detention,

difficulty in stabilising care placements. Outcomes for indigenous youth are consistent with these.

- Recognition that these children and young people are difficult to help, with most services struggling to meet their needs with any consistency, due to the complexity, chronicity and multiplicity of concerns.

The research has focused on a range of areas of need, including

- Awareness of biological components to the children's problems (notably an awareness of FASD, the impact on the developing brain of chronic stress and arousal, and chronic neglect). In addition, the range of genetic influences and epigenetic effects is much larger than previously acknowledged.
- Awareness of the consequences of disrupted and abusive attachments. These are consequences to the children's development, sense of self and capacity to self regulate, to form satisfying mutual trusting relationships and their capacity for caring and empathy with other people.
- Awareness of the frequency of Chronic Post Traumatic Stress Disorder, on children and young people exposed to abuse, neglect, domestic violence and multiple losses. This results in chronic hypervigilance and states of hyperarousal, which adds to self-regulation difficulties. In addition it often results in the avoidance of situations that might trigger fear responses, including situations that are frightening, shameful or humiliating (e.g. school), or threatening (e.g. intimacy with adults, control by adults).
- Awareness of the impact of these stressors on learning, social functioning and capacity to be in employment. Executive functioning difficulties, similar to those with children with ADHD, combined with chronic anxiety and hypervigilance decrease learning even for children attending school regularly.
- The Adverse Childhood Experiences (ACE) literature (e.g. Campbell 2016, Fellitti 1998) demonstrates a graded dose-response relationship between the number of ACE's a child experiences and intensity of risk of subsequent adverse outcomes for adolescents and adults in multiple domains such as poor educational attainment and productivity; more likely to engage in high risk behaviours such as smoking, binge and heavy drinking; early sexual activity (with multiple partners and increased risk of sexually transmitted illnesses); have impaired mental (for example depression and suicide attempts) and physical health (for instance diabetes and Coronary Artery Disease); more impairment in relationship functioning such as intimate partner violence, teenage pregnancy and a higher risk of sexual violence (see Figure 1).

These adverse life experiences include:

- ABUSE (emotional, physical and sexual);
- HOUSEHOLD CHALLENGES (mother treated violently, mental illness in household, substance abuse present, parental separation or divorce and household member who has gone to prison) and
- NEGLECT (Emotional and physical)

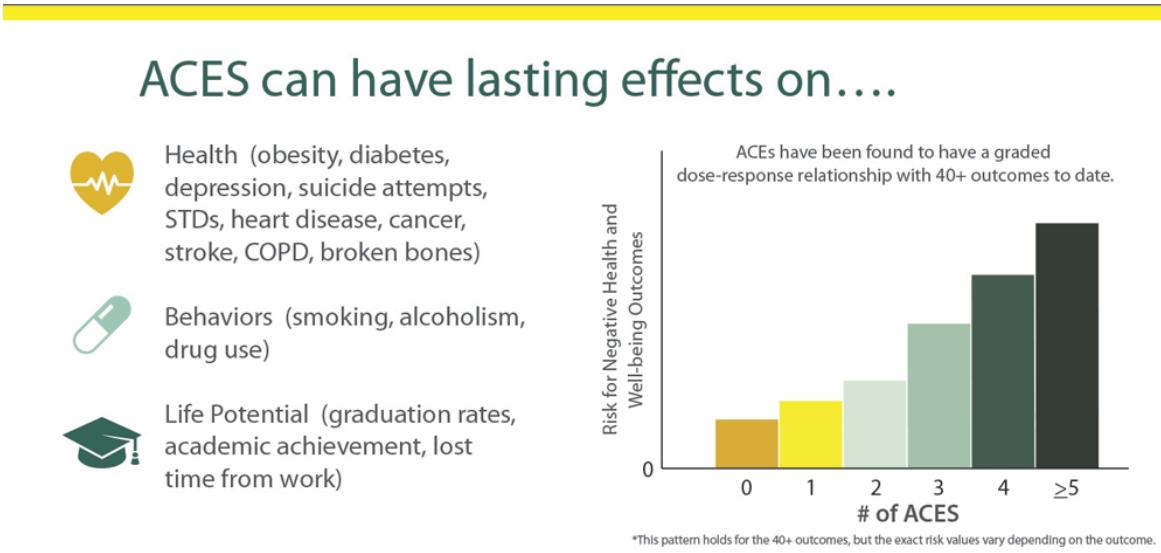
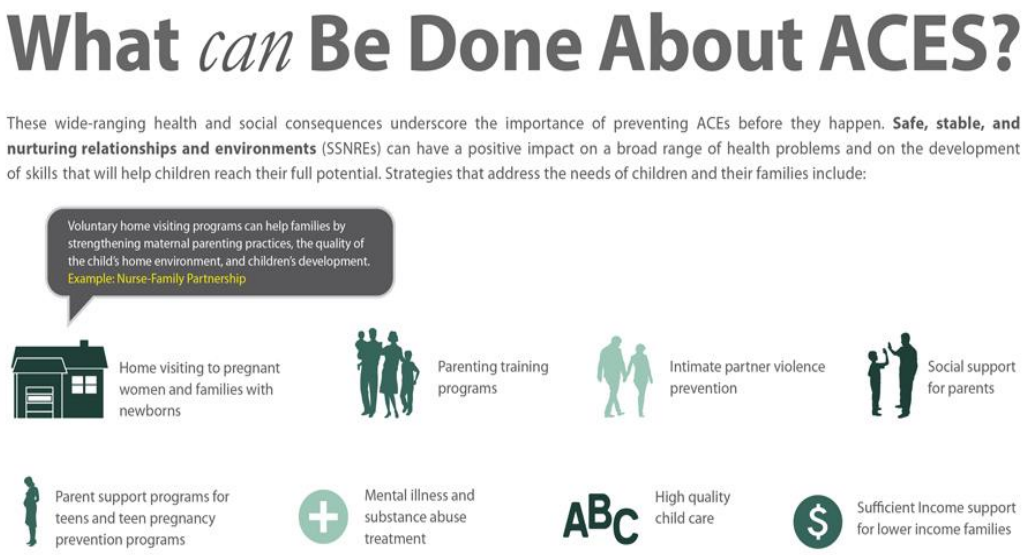


Figure 1.

- We include a diagrammatic representation of some of the evidence based programs that can mitigate these outcomes (see Figure 2).



(Figure 2)

The frequency of past trauma among youths in detention in the US is extremely high (over 90%) (Soulier and McBride 2016). In the NT it is likely to be similar, and with high numbers of Indigenous youth in detention the issue of **transgenerational trauma** is often an additional component cause of developmental trauma in this group. Much has been written about transgenerational trauma due to colonisation of Indigenous groups, where historical trauma such as forced removal of children from their families, is embedded in collective memory and passed from adults to children within a community or cultural group (Atkinson 2002, 2013). This kind of secondary trauma is a reality for many Indigenous children.

4. Implications of Developmental Trauma for treatment and intervention services.

These and other findings have meant that when considering how to improve the outcomes for these children and young people, all service settings need to

- Be aware of the above factors (biological, psychological, social, cultural, historical)
- Have a holistic approach to the children and young people which takes into account their specific needs and vulnerabilities (bio-psych-social-cultural)
- Have a **long-term recovery of function approach**, so that the aim of intervention is to enable the child's best functioning in school and in family and relationships, and in development of an integrated and competent sense of themselves.
- Sustain involvement over time - recovery is not quick or simple, and is different at different ages. Continuity of care, and sustaining long-term relationships is essential for better outcomes.

For service systems, this means

a) Incorporating biological, psychological, social and cultural components. This is a multisystem approach, found to be effective now in a range of jurisdictions where other single system approaches are not effective.

b) Assessment needs to be biological, psychological, social and cultural. This means that the children's health needs and developmental needs are clarified including speech, hearing and OT assessments, nutrition and growth, cognitive functioning and academics, mental health, relationship and cultural connections and family ties, current and past losses, current social and peer functioning. These are all areas that need awareness and will impact on the child's outcome if not addressed.

c) Planning for recovery needs to include provision of sustainable care and relationships, strong family knowledge and connections and identity, a focus on educational recovery and opportunities for peer prosocial functioning. Physical recovery and the use of medication and behavioural strategies and therapy may be needed for the specific problems identified e.g. post traumatic stress disorder, executive functioning difficulties, self regulation difficulties, substance use.

d) Planning for recovery should include treating problems as well as making up deficits, and developing competences and strengths (providing opportunities to excel and develop skills)

e) **The service system around these children and young people must be conceptualised as having multiple components that are integrated**. The components will vary in specifics with the age of the child but essentially the components are the same:

Assessment components - paediatric, mental health, speech therapy, occupational therapy, psychology

Treatment components for the individual child, including speech therapy, occupational therapy, therapy for PTSD

Informed carers who are able to parent in a way that helps recovery. Foster carers, residential care staff, and relatives often need assistance to parent children who may be more disruptive and dysregulated, with decreased capacity to trust others and used to losses and change.(Important to note that there are specific psychoeducational and support group programmes available for carers and relatives)

Educational support with a focus on recovery and opportunities. This often means individual or small group programmes, and opportunities for alternative programmes with a focus on activity and practical skill acquisition to increase confidence.

Intensive case management that allows for individualised services and monitoring, and the capacity to repair after failure. Sustainability requires intensive case management, and also for older children this may need to be supported by a legal framework of monitoring and

supervision and capacity to work in an ongoing way with children as the structures around them changes.

5. Implications of trauma for children and young people in detention

Young people with histories of abuse, neglect, multiple losses and attachment disruptions, learning difficulties, FASD and Post traumatic Stress Disorder are over-represented in youth detention populations, in western parts of the world (Soulier and McBride 2016, Popova et al 2011, Shufelt 2006, Abram et al 2004, Teplin et al 2002).

In Central Australia, the vast majority of young people in detention are Indigenous, have suffered developmental trauma, been exposed to multiple ACE's as previously defined and their families have suffered transgenerational trauma. This has a range of implications for the young person's management in detention:

- Severe distress will be triggered easily for many young people, which may present as acute 'at risk' periods. This will occur when the young person feels threatened, overwhelmed, coerced and alone. Distress will only settle as the young person feels safe, and connected to relatives and trusted other adults within the staff of the detention centre. Acute 'at risk' assessment needs to be able to differentiate distress from major illness, so that the appropriate safety-focused responses can be implemented. Too often the young person is deemed 'not mentally ill' while the distress is not recognised and arousal is not reduced by appropriate interventions.
- Many young people in detention will be easily aroused and overstimulated, with poor executive functioning and problem solving skills, and deficits in language ability and learning that can make it hard for the young person to understand and be understood, and manage the experiences of detention. Peer relationship difficulties, a tendency to distrust others and low frustration tolerance are associated problems.
- Many young people in detention have a poor capacity to interact with adults in authority and will react to them with challenge and distrust. This creates a confrontational interaction, difficult for either youth workers or young people to avoid. Both of these issues are improved by education of the adults in the nature of trauma.
- Many young people in detention will have problematic relationships with their families - these relationships may be lost, stressed, coercive or impacted by a range of parental health or substance use problems. This increases the arousal and sense of lack of connection of many of the young people.

Detention centres can function in a way that recognises these issues, and reduces distress for the young person, while still functioning for the purpose of detention, by:

- Respecting the young person's need for safety, by clarity and predictability and fairness of processes, making sure that family connections are enhanced, facilitating every young person having an advocate/ case manager/ communicator, creating opportunities for communication.
- Enhance capacities for recovery, of educational opportunities, social skills and peer interactions
- Offer therapeutic assessment and treatment of traumatic disorders, depression and anxiety and substance use disorders, psychotic disorders.

6. Suggested approaches that may alter the trajectory of children 'at risk' and in detention

For each of the four groups outlined earlier, there are potential approaches for effective intervention, which can alter the trajectory of a child's development. However, some of the interventions are not possible currently in Alice Springs, in part because the resources are simply not available, but also due to other barriers such as geography, heavy case loads, high levels of trauma in multi-generational families, and the cultural complexities of non-indigenous service providers trying to provide services to indigenous people.

The following suggestions could assist in overcoming these barriers:

- **Capacity for comprehensive assessment of all of the children in these groups.** Assessment would encompass physical, mental health, speech and language development, and cognitive capacity. This would require increased speech therapy, occupational therapy and psychologist time, as well as some extra specific hours of a paediatrician and child psychiatrist. This would significantly assist the clarification of diagnoses of FASD, other developmental problems, and other treatable diagnoses, and would enable proper plans for school and family behaviour management. It would allow identification of vulnerabilities that can influence outcomes such as poor frustration tolerance, and poor emotion regulation (identified as a major prognostic factor relating to future violence). Comprehensive assessments would assist the court. Some of these assessments are done currently within existing resources, but they are always delayed, overbooked and may be years later than initially needed.
- **Capacity for multidisciplinary treatment approaches** that flow from these assessments and which are well coordinated, made practical for remote contexts (e.g. with use of telehealth), trauma-informed, sensitive to the age of the young person and their cultural needs. Treatment is sometimes necessarily delayed by the need to manage acute or high-risk situations such as suicidality, violent behaviour, threatened placement breakdown. Plans need to be reviewed regularly because circumstances and priorities of treatment may change. For adequate treatment provision there would need to be more allied health resources (as for above), as well as more mental health clinicians for assertive follow up, delivery of therapies, and coordinating remote outreach.
- **Capacity for specific parenting support, for both biological and foster families.** There are parenting programmes available, e.g. the 'Reparative parenting programme', which has been developed for foster and relative carers of traumatised children, and has been adapted for carers of indigenous children; training is available for this program. It educates carers about developmental trauma and also functions as a support group enhancing capacity to stabilise placements and share solutions.
- **Capacity for intensive case management, by both** Territory Families **and other intensive services**. Intensive case management allows the case manager the time and resources to persist with mobile and non-compliant young people, and to keep re-establishing solutions for them rather than allow them to 'disappear' in the system. There may need to be a number of iterations in plans to keep a young person housed safely and in education or training. These intensive services exist in other states as models for high needs young people (e.g. those with case loads of only six cases).
- **Capacity to provide therapeutic case management in detention centres, and coherent case management outside detention over a period of time.** This includes the capacity to involve families, both in visiting the detention centres and after detention. In addition, education plans based on the comprehensive assessment previously described allows for remediation.
- **A TRAUMA-INFORMED APPROACH by all the services involved**, including the corrections staff, legal and welfare personnel and therapeutic agencies. This trauma-informed approach would facilitate the recognition of distress in the young people in detention and in the court system, and the recognition of the need to provide first and foremost safety for all - cultural safety, the provision of safe people and family contact, the provision of language speakers, the provision of

clear explanations and safe connections. Distress is the biggest source of self-harming and aggressive behaviour, and a more common problem than mental illness.

- **Many of the specialist services need to exist in partnership with Indigenous workers and services, to promote trust, acceptance and appropriation by clients and their families**. In Alice Springs there are a number of Indigenous health and welfare services that work with the Child and Youth mental health team. Service provision with these agencies could be facilitated by proper partnerships and clear pathways, and joint service provision
- **Services to remote youth remain difficult**. A capacity for intensive case management would help this - many of the children and youth go between town and community settings, and coherent care needs to be provided. Young people can be "placed' out of town as a way of decreasing offending; however they may be sent to communities where they have no language, no real connections and nothing to do. They then drift back into town and often reoffend.
- **Capacity for comprehensive mental health assessment and treatment of young people in detention,** with particular attention to trauma-related symptoms, mood and anxiety disorders, ADHD, psychotic disorders, cognitive and learning problems, and substance use disorders. This would require additional child psychiatry hours.
- **Capacity for case management of young people in detention with the aim of liaising closely with families,** linking with services outside the facility to ensure coherence before and after detention, and providing therapeutic interventions, and education of staff and families. Young people in detention in Alice Springs almost all come from Central Australia. They need connection to families, community and culture, and to education, employment and leisure activities in their communities. While a territory-wide youth forensic service may be important for long periods in detention, those going in and out more quickly need local case management that is connected and able to provide knowledge and coherence. This would require a local child and youth forensic clinician.

7. Current service capacity and system gaps

Health Components
Currently general health assessments occur in primary health in a predictable way. Referrals can then be made from primary health services (both GPs and AMS providers) to Department of Paediatrics and to Child and Youth Mental Health. Referrals are also made by school councillors, by Territory Families case workers, by legal representatives and by therapists working for NGOs.

This system however has flaws as follows-

- It is a reactive referral system. This means that the child or young person must have difficulties identified by someone. They may be small if the person is aware and educated about likely concerns, or they may be quite severe before the young person is referred for assessment e.g. on the brink of failing at school, or placement about to break down.
- The child is likely to be assessed in a limited framework i.e. depending on who they are referred to, that will be the type and scope of assessment. This means that a comprehensive assessment is less likely to happen. In particular, relationship issues and the sustainability of the placement and family connections may not be considered. School functioning may be difficult to clarify.
- Assessment is limited by the resources available. In particular there are key aspects, which are very difficult to access e.g. cognitive assessments are particularly hard to obtain, as most services do not have the capacity for this.
- Sometimes when the young person is very distressed or acutely disturbed, assessment is hard to complete. If it was done as a routine, not is a crisis, there would be a greater chance of completing a meaningful review.

- Currently assessments are done at times by outside agencies or clinicians paid to assess a few children. This is expensive, but also recommendations are likely to be separate from the agencies needing to implement them.
- The usefulness of an assessment is related to both clear communication of strengths and difficulties of the child, and the development of a clear plan to assist them. This is difficult in terms of resources available in different services, and the fact that interventions are often required in multiple areas outside health e.g. an education remediation plan, classroom management strategies, parental support and training, family cohesion.
- The above steps are even more complicated for children and young people living in remote areas. Recognition of difficulties may be delayed, assessments are harder to conduct, implementation of plans is more difficult, there is a dearth of specialist support (apart from some communities that have paediatric visits) and the existence of family support services, youth programs and telehealth facilities are inconsistent at best.

Therapy Components

Currently there are a range of services delivering various therapeutic interventions to this group of children and young people. These include

- Services who treat traumatised children e.g. Children's Therapeutic services through relationships Australia, who deliver individual therapy and some support to carers. This programme suffers from resource constraints, and over the last 2 years has cut the number of children it sees significantly.
  Territory Families has a service to treat traumatised children in their care. Over the last few years this service had difficulty with staff continuity and has reformed. There are now three clinicians who look after some children in Alice Springs. There are other counselling and therapy services - Holyoake, Headspace and SARC.
- There are less intensive support services, working with children and families currently with the Intensive Family Support program no longer funded and the Targeted Family Support program funded for only 10 families compared with 30 in the recent past . This has changed in terms of service providers over the past few years. Congress has some capacity, as does Tangentyere: and Anglicare is currently the service provider for that specific service.
- For younger children, the Child Development Unit does assessments and interventions: however the waiting list is long, resources are few, and after the child is 7-8 years, they are no longer eligible for that service.

There is a range of limitations with these services, principally the potential for fragmentation, collapse when there are vacancies or a change in funding, separateness from others involved. In addition, these services, like health services, are often stretched and not able to do the communication and case integration needed.

Case management processes

Currently almost all the case management of these children is with Territory Families. Some children are in the total care of their families, others are in joint care between relatives or foster carers, and Territory Families. The difficulty arises with the capacity for intensive involvement, and involvement sufficient to act as integrators and implementers of a case plan. Most case managers have very large caseloads, and there is high staff turnover so that coherence and long term planning and partnerships are difficult to develop. Many case managers are crisis driven, as young people in crisis consume most of their time.

Education processes

Schools are a major system that can assist children and young people, especially in giving them skills and opportunities to move into adult life. Indeed education is really the largest single public health

intervention in the world given the importance of educational attainment (both cognitive and social skills) to future health and broader wellbeing. Schools have tried to approach these young people with a trauma focus, and to implement individual management plans, in small groups and with a range of options. However, they are often handicapped by inability to conduct cognitive assessment, and other limited resources. In particular, alternative options in the younger age group (primary) are not available if the child is not significantly delayed.

A fuller exposition of the work of Professor James Heckman (Nobel Laureate Economics 2000), though apposite to this discussion, is however beyond the scope of this submission though we would like to emphasise the role of appropriate and targeted investment in early childhood (such as nurse led home visits to pregnant mums and mothers with newborns, the Child and Family Centres in Tasmania and Abecedarian programs) as an evidenced based approach to reduce the likelihood of adverse outcomes into adolescence and adulthood. The Heckman Equation that demonstrates early investment produces a greater return on capital investment than in later years proving the proverb that "a stitch in time saves nine" is set out in Figure 3 below (Doyle et al 2009).

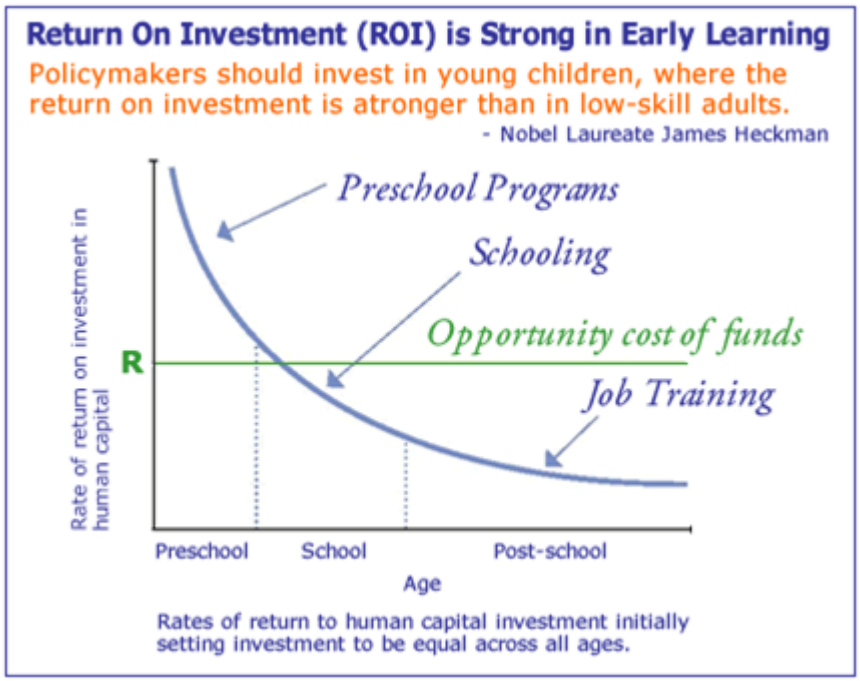


Figure 3.

8. Current limitations within the child and youth mental health service

Current resources within the Child and Youth Mental Health Service are limited. To enable mental health services to properly contribute to the multidisciplinary comprehensive assessment and treatment of children and young people at risk, including providing assertive follow up, responding to acute and high-risk situations as they occur, delivering therapies and coordinating mental health remote outreach to young people and families, there would need to be

- Additional child psychiatry hours
- An increase in the number of mental health clinicians on the team
- including clinicians to specifically coordinate remote outreach

The Royal College of Psychiatrists (2013) and more recently the Royal Australian and New Zealand College of Psychiatry Faculty of Child and Adolescent Psychiatry (draft document 2016) have

grappled with developing a framework for what constitutes an adequate specialist workforce to meet the mental health needs of infants, children and adolescents.

According to their benchmarks our service should comprise the following components (based on a population of around 60000 in Central Australia; a role that encompasses subspecialty areas of intellectual disability; forensic mental health; provision of a specific child and adolescent consultation and liaison service (C/L Service) to the 40 bed general paediatric unit of the Alice Springs Hospital (currently this service is provided by the adult C/L Team); substance use; the provision of outreach to remote communities and finally the fact that a high percentage of clients are indigenous):

- Consultant Child and Adolescent Psychiatrists increase FTE from 1 to 3 (though the recruitment and retention of the extra FTE would be very challenging);
- The child and adolescent multidisciplinary team comprising specifically trained clinicians in child and adolescent mental health including therapists, child psychologists, social workers, Occupational Therapists etc. would need to increase from the present 6 FTE to 23.2 FTE!

Given the reality of current funding constraints and recruitment issues in Central Australia we believe the additional resource of 1 FTE Forensic Child and Adolescent mental health clinician will enable our team to provide inreach to current young people in detention in ASCC and an additional 2 FTE clinicians with the CYMHS team will enable an limited expansion of the team to begin to visit targeted remote communities in Central Australia.

The CYMHS team in Central Australia has historically seen young people in detention who are existing clients when they can be brought into the CYMHS offices. However proper case management is required with the aim of liaising with families and outside services, providing therapeutic interventions and education to corrections staff and families, and providing coherence before and after periods of detention. For the last few years, extra resources have been requested by CYMHS to enable assessment of a **wider** range of young people in detention, and to provide mental health intervention and case management as needed though these additional FTE's has been declined. These extra resources would include

- Additional child psychiatry hours (approximately one day per week)
- A child and youth forensic case manager

9. Potential Service System

It is important to highlight that while this submission is focused on the possible contribution that child and adolescent mental health services can make, in terms of understanding the challenges faced by the children and those looking after them and educating them, best practice requires a **multisystemic therapy (MST)** model of care, which recognises that risk factors for antisocial behaviour and emotional problems arise from many areas of influence including the family, peer group, school environment, community and neighbourhood (Henggeler et al. 1999; Burns et al 2000). The model is 'flexible' in terms of the intensity and number of sessions; it involves a number of systems around a child integrated by intensive case management, and persisting partnership relationships between service providers. The family system is always involved, while other systems that are usually involved include

- Welfare services
- NGO providers

- Education services
- Physical Health
- Mental health
- Youth Justice
- Families
- Communities

A recovery model involves both interventions to repair damage and make up deficits; and to help a young person to develop and thrive and have a range of opportunities. This involves coherent partnerships often sustained over time with different lead services at different developmental stages.

The MST model of care is not unknown: there are successful examples in the US, Sweden, Britain and Australia, with adaptations to different circumstances including for juvenile drug court (Balsamo and Poncin 2016). It requires commitments to work together, practical meeting and communication processes, clarity of expectations and capacity to co-operate. There are many examples of nascent attempts to do this, and Central Australia is a discreet area with largely centralised services. There are real difficulties involved because of staff turnover and shortages of resources: but there is also an enormous capacity to innovate! Specific service requirements would include

1 Agreed comprehensive assessment process, with sufficient capacity to assess all young people entering care, or identified as at risk. This would include the capacity for both urban and remote assessments.
2 Agreed service relationships, so that treatment plans are comprehensive and reviewed regularly by the whole system. Core services would look different for different age groups (groups of children and young people) e.g. under 7s, 7-11, over 12 years, those in/ entering the legal system.
3 Services are adequately resourced to provide for the numbers of young people actually needing help, and for the length of time required. This includes where the need for intensive case management is identified, either by Territory Families or by an NGO (but which is part of the discussion).
4 Remote service provision is separately considered.

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