

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

Original Public Report was Submitted on 8 May 2017

Final Edited Public Report on 5 August 2017

(Date of original report to the Royal Commission was on 9 April, 2017)

Associate Professor/Dr Peg LeVine, PhD, EdD

Medical Anthropologist and Clinical Psychologist

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Associate Professor at the University of Melbourne, School of Global and Population Health; Monash University, School of Psychiatry; Senior Research Fellow at the Center for Advanced Genocide Studies in Los Angeles

This document was prepared and submitted during a contracted position (January to July 2017) as the Clinical Trauma Psychologist and Medical Anthropologist within the Central Aboriginal Congress in Alice Springs for Royal Commission-impacted clients. The impetus for submitting this report came after observing and chronicling a pattern of unsafe practices of developmental neglect and harm being implemented by public health and justice system personnel. (This report is a private submission by the author.)

Three Supreme Goals of this Submission

- (1) To increase culturally responsive, consistently safe and developmentally enhancing treatment to Aboriginal children who are placed in detention and Northern Territory care.
- (2) To break down the systemic cycle of neglect and complex re-traumatisation for Aboriginal children during their engagement with police, justice, and health and mental health professionals.
- (3) To bring forward a public forum on the developmentally damaging use of psychotropic medication (including antipsychotics and major tranquilisers) for children and youth in detention and State care, which is documented in medical records as “chemical restraint” or “behavioural management”. A forum needs to advance the design of therapeutic environments that assist children to thrive, while modeling non-violence in words and actions.

Professional Synopsis of Author

Dr Peg LeVine is a medical anthropologist (PhD), clinical psychologist (EdD), trauma-torture international specialist, Associate Professor and senior researcher with over thirty years of experience working with children (into adulthood) in trauma and torture services globally, including Indigenous communities, refugees and refugees seeking asylum across Australia, New Zealand, North America, Nepal, Cambodia, and Laos PDR. She has published broadly in the field of trauma, mental health and justice, and genocide studies. She serves on medical teams and consults with legal teams in both domestic and international court hearings (including the United Nations) for survivors of genocide, child abduction, government deportation, refugees seeking asylum, and survivors of human trafficking. (CV attached).

Dr LeVine was contracted from January to 23 July 2017 by the Central Aboriginal Congress in Alice Springs (Social and Emotional Wellbeing) during the Royal Commission proceedings for Aboriginal Youth in Detention and those under Territory Family guardianship. She has recently accepted an on-going contract with the Northern Health Schools in Auckland, New Zealand to advance culturally and developmentally enhancing care to Maori vulnerable children, families and communities.

Report Based on the Following Observations

(1) Clinical case reviews and population health considerations of Aboriginal child and youth clients who have been in detention or State agency care (recently renamed as Territory Families); (2) direct therapeutic case formulation based on histories of Aboriginal children's displacement from their Country and livelihoods for extensive periods of time in their formative developmental lives; (3) use of culturally-responsive assessments (including the use of visual data regarding safe and unsafe places/treatments to children across their lifespan); (4) consistent observations of low standards of reliable assessments and therapeutic safe care for children with complex trauma by mental health and health providers inside and outside the Aboriginal Congress; (5) direct observations of clients before and after their transitions between detention centres (Darwin and AS); (6) direct observations of State-based interventions being delivered to Aboriginal children residing inside the detention centre in Alice Springs (AS); (7) engagement of clients upon release from detention and while awaiting court hearings; and (8) engagement with lawyers who represented my child and young adult Aboriginal clients in court and direct observations of their patchy representation.

Goals of Submission

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(2) To break down the systemic cycle of neglect and complex re-traumatisation for Aboriginal children during their engagement with police, justice personnel, and health and mental health professionals.

(3) To bring forward a public forum on the developmentally damaging use of

psychotropic medication (including antipsychotics and major tranquilisers) for children and youth in detention and State care, which is documented in medical records as “chemical restraint”.

(4) To increase the Australian ethical standards of care (to global standards) for prescribing psychotropic medications to Aboriginal and non-Aboriginal children living in licensed residential settings and detention systems.

In my case reviews, the misuse and overuse of psychoactive drugs was alarming (including the use of anti-psychotics and major tranquilisers, and over use of stimulants for children assumed to have attention deficits or aggressive behaviors, which are usual subset behaviours associated with trauma in childhood.

(5) To increase reliable and safe standards for assessing and treating children with “complex trauma” by employing on-going specialists in trauma, culture and remote health as part of any intervention program.

It is noted that the current practice wherein existing professionals (including psychologists and GPs) are authorised to attend a group workshop in trauma treatment or posttraumatic stress disorder may be perpetuating the lack of responsive assessment and therapeutic mapping for Aboriginal children.

(6) To review “how’ Aboriginal children’s diagnoses and medical interventions are linked to the ‘Medicare” system of referral, which requires mental health care plans and particular diagnoses for treatment-payment plans that can compromise cultural validity.

Currently, there is an increased trend in employing clinical psychologists over counselors, Aboriginal specialists, or social workers as a way of gaining access to Medicare mental health plans for funding. As an artifact, I observed directly the standard practice of assigning Western diagnoses to Aboriginal children by psychologists, physicians, paediatricians and psychiatrists without due consideration of complex trauma and developmental histories -- inside and outside Aboriginal Community Controlled Organisations. Research is needed to advance reliable population and community health data in this regard.

Documents Supporting the Report

(1) *Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in License Residential* The Ontario Expert Panel (July 2009). It is noted that these recommendations followed as a response to the Canadian Federal government’s apology for abuses to Aboriginal children in residential school care. http://www.children.gov.on.ca/htdocs/English/documents/specialneeds/residential/summary_report.pdf

(2) *Facts about Foster Care Children Abused with Psychotropic Drugs*. Citizens Commission on Human Rights.

(3) Attachment of de-identified hospital summary record regarding ‘chemical restraint’.

Introduction

This submission follows the findings in the Interim Report of 31 March 2017 for the Royal Commission into the Protection and Detention of Children in the Northern Territory.

- (1) 94% of children in detention in the Northern Territory are Aboriginal.
- (2) 28% are 15 years or under. First offending children 11-13 years of age are housed with multiple offenders 16-17 years of age; the adverse developmental implications are obvious.
- (3) 89% of children are placed in out-of-home care. Underlying this statistic is the social fact that children placed in care are usually removed from Aboriginal homes, Country, language and kin. Herein, their human attachment needs and rights to thrive culturally, emotionally, psychologically, socially, and within their Indigenous cultures and spirit-based places are often compromised.
- (4) The Northern Territory has the highest rate of children and young people receiving child protection services, nationally.
- (5) Health status and 'mental illness' terminology: "There are high rates of mental illness among children and young people in the Northern Territory, particularly among Aboriginal children and young people." Application of the term "mental illness" implies that pathology is in the individual, which increases the chances of medication being used to treat the illness purported to be encased in the child's mind, particularly when children are living in unsafe and chaotic care contexts.

To date, the advance of therapeutic environments is undermined by overuse of psychoactive drugs and methods of punishment for 'behavioural management'.

Aboriginal organisations nationally have worked tirelessly for decades to advance a whole person wellness model of assessment and care, while challenging the term "mental illness" in literature and treatment planning. Obstacles to a 'wellbeing' perspective sit in the national Medicare system of funding criteria. Fundable mental health plans require an assignment of a mental disorder to a person seeking services. Such a practice decreases funding potential for preventative-based services and confounds our reliable population health data. For example, while in detention, a child that was my client was told of his mother's death. Not only was he placed in seclusion (lock down) for fear he was 'at risk', his grief reaction (sadness with crying spells and agitation) was pathologised; his need for kindness with family-cultural contact and nurturing care was neglected.

- (6) Foetal Alcohol Spectrum (FASD) was considered in the report from a neuro-biological framework with primary attention to brain abnormalities. The report notes that effected children are challenged in attention capacity as well as "learning and controlling their emotions and urges, and placing them at significant disadvantage in the context of the criminal justice system".

Evidence-based research on this topic points to the complexity of FASD and the need to extend our foci outside neurobiological interventions and to maximise

socio-cultural and geographic factors. The child's sensory-motor and social adaptation systems are compromised further when consistent, predictable and nurturing therapeutic systems of care are absent or minimal during their developmental years. Early assessment and early therapeutic intervention is critical as pervasive developmental delays often accompany FASD. Therefore, reliable assessments are critical to increased advantages for children's social, cultural, imaginative, educational and psycho-emotional development.

Accounting Formally for “Complex Cumulative Trauma” in Childhood

The Royal Commission hearings highlighted the potential to fund and develop mental health resources and to increase staff in youth detention centres, as well as improve responsive services for children and youth in Territory Family care.

This author calls for a review of the *United Nations International Covenant on Economic, Social and Cultural Rights* with regard to institutional systems of justice and guardianship in order to enhance children's developmental capacity related to the rights of the child. The following articles are relevant: *Right to Family Life* (Article 10), the *Right to Health* and the highest standard of physical and mental health care and the right to freedom from fear (Article 12), and the *Right to Participation in Cultural Life* (Article 15).

In this century, we have the evidence-based findings to increase an understanding of trauma-eroding contextual factors across the child's developmental years. By attending to childhood trauma studies, we refrain from classifying a child as harbouring a mental illness when he or she is doing the best she/he can while living inside developmentally harmful contexts.

It is essential to review all we know about trauma from the Stolen Generation as a way of minimising further displacement, cultural exile and institutionalisation of today's children. Overall, the interim report falls short of addressing “complex cumulative trauma” as a primary contributing factor to childhood and adolescent developmental progression and regression (as discussed in the recommendation section of this report).

Findings Related to this Submission on Misdiagnoses of Children:

I conducted a longitudinal review of primary psychiatric diagnoses assigned to a cohort of children in detention and Territory Family care in Alice Springs in the Northern Territory between February and May 2017. Youth I reviewed were/are under consideration for Royal Commission review as part of my brief. I found that 80% of those youth have been diagnosed with Conduct Disorder (Oppositional and Defiant Disorder) and/or ADHD (Attention Deficit Hyperactive Disorder) as their primary diagnoses by local paediatricians, psychiatrists and mental health practitioners. I noted developmentally eroding psychotropic medications being administered to children who were nine years of age. (It is noted that defiant and dissociative behaviours for middle-age boys are normed indicators that something is wrong in a child's life, such as childhood violence, severe neglect, sexual abuse. These are first indicators of complex trauma that often go misevaluated and mistreated).

I found no consideration being given to the historical violations perpetrated to some of my child clients while they were/are in detention. For example, some of my child clients who witnessed or directly experienced sodomy and rape as a young boy or girl were at

risk regularly when being disrobed by justice staff. The trauma trigger is obvious, and a child's aggressive response (to spit, hit, lash out in words) is a survival reaction of fight or flight, which is rarely if ever considered by health professionals in the case records I reviewed.

In my case reviews, I found that NO Aboriginal child had been assessed with Complex Trauma or PTSD as the primary influencing diagnosis, despite living in chaotic and developmentally eroding contexts. Most alarming, I found a patterned schedule of psychotropic medications (anti-psychotic tranquilisers) being prescribed by paediatrician(s) and psychiatrist(s) in Alice Springs who are in positions of high influence and authority. More than 50% of the children and youth I reviewed were prescribed high doses of stimulants and/or antipsychotic spectrum of medication before the age of thirteen; in evidence-based journals this practice is not advised before that age; if initiated, children are required to have extensive peer review with consistent checks for side-effects every three months. In my case reviews of children with histories of being in detention, those reporting serious side effects from medication and treatment appear not to be taken seriously (especially if they are intellectually impaired); they are not routinely invited into a dialogue about their experience and history; they are not interviewed routinely in their first language.

CASE EXAMPLE: One of my Aboriginal clients (who is now an adult whom I continue to see privately) reported an alarming incident of 'chemical restraint' by psychotropic drugs that were administered to him without his consent. He signed a 'freedom of information release form' in order to review the hospital records. He had been a former detainee at Don Dale detention centre and gave private testimony during the Royal Commission. He has given consent for his name to be identified if the Royal Commission wants to interview him with my presence as his advocate, whom I'll call Mr B. (De-identified hospital letter attached).

Mr B detailed allegations made by police about an incident that was later heard in court with a just outcome to my client. The incident began after he was tear gassed by police and transported in handcuffs in a paddy wagon vehicle by police to Alice Springs hospital. Outside the emergency room when in the wagon, he stated that he was administered that which he called, "the settlement needles" (another colloquial term for 'chemical restraint'). As described in the hospital records, a medical attendant without consent had injected him with a major tranquiliser. While in a comatose state handcuffed in the emergency room, he was administered another dose of a psychoactive drug whereupon he required heart monitoring as his vital signs were compromised. After his vital signs returned to safe levels, he was transported to the 'Watch House' in the paddy wagon where he claims he was held for approximately 14 hours. He reports suffering multiple side effects for days following the injection. There was never any formal follow-up by the hospital or any medical personnel. When I wrote my court report and included this event, the representing public lawyer requested firmly that I exclude the contextual data; I did not comply. The judge's attendant thanked me for this inclusion as it assisted his understanding for case determination.

My review of fourteen children revealed a pattern whereby attending practitioners in Alice Springs prescribed anti-psychotic medication to boys in mid-childhood (age 9-12 was usual), which was sustained often into their late adolescence. Risperidone and Olanzapine were being prescribed mostly with other multiple interacting psychotropic medications being prescribed simultaneously for depression, attention-deficit disorders,

mania, and epilepsy without impartial peer review regarding diagnostic evidence, best practice and duty of care to children. Complex trauma was not reviewed formally in any of these cases.

The overriding rationale for prescription cocktails has been “behaviour management” of aggressive symptoms; again, once prescribed, youth are typically maintained on these substances during all of their developmental years. When guardianship moves from parental and kinship care to Territory Family care to the justice system’s custodial care – cultural and mental health is compromised exponentially. One of my former clients who was in detention told me that he received medication from the guards for his “depression” and “home sickness”. Upon formally reviewing his medical records, he was being administered an antipsychotic spectrum of medication, Risperidone.

I note that medical specialists routinely based their diagnoses on reports by guardians and/or institutional carers and/or teachers who highlight ‘unruly’ behaviours in children, or reference them as devils (‘not angels’) or bad kids. One of my client’s case notes made by an attending physician who was working at the Central Aboriginal Congress who had prescribed psychotropic medication to my client wrote, “ratty kid”. I made a photocopy of that record for my files.

To date, diagnoses are given most often in offices, with few observations collected across culture-specific or outdoor settings by the clinician. I note that Aboriginal children and youth are usually administered psychological tests that focus on cognitive and intellectual functioning as normed on Western urban populations. Test results are used often for school placements, with no attention to the ‘thriving’ capacity of the educational or care environment.

Not one child or youth in my sample had been given long-term or short-term sensitive child-oriented therapy, access to a trauma specialist outside of court evaluations, or provided with Indigenous healing ceremonies, or responsive play therapy by a culture-trauma specialist. I found that some had been provided sessions by a local artist who is not trained in art therapy.

Most youth accumulated trauma more complexly by moving between and across homes, communities and geographic places and languages and skin groups, detention centres and schools. I found no evidence of “complex case formulation” regarding childhood fears, over active or defiant behaviours, and insecure attachments, of which all are primary symptoms common to the trauma spectrum in childhood.

National Non-partisan Review Panel Required

The overriding impetus for this submission came when I unearthed medical collusion in harm through unethical and developmentally harmful use of psychoactive medications, (antipsychotic drugs to children). In fact, now formally recorded, one of my male clients (who has been in Territory Family care for much of his life) was growing breasts due to long-term use of the antipsychotic, Risperidone, and related hormone disruption; in fact, advocating testosterone suppression in boys requires review. I initiated consultation with a psychiatrist and an Aboriginal specialist to review the child’s diagnoses and treatments. The psychiatrist (following our trauma-based review) withdrew the antipsychotic medication that was prescribed initially by a pediatrician.

While at the Central Aboriginal Congress, my specialist role sat outside the psychologist team, which meant that I was free from increased pressure to diagnose clients in ways that assists agency compliance for Medicare reimbursement, whereupon, complex trauma tends to take a back seat to depression, anxiety, conduct disorder and ADHD despite the cluster of symptoms that are subsets of trauma. The tendency is to prescribe medication for each category of disordered symptoms.

The trends in mental health practices that are being institutionalized by our Medicare system of funding services within Indigenous community-controlled organisations require formal review to reduce the over labeling of Indigenous children by Western-derived systems of assessment and over use/misuse of psychotropic interventions.

This author recommends that a National Expert Advisory Panel be established with non-partisan interdisciplinary panel of experts in Childhood Complex Trauma, Indigenous kinship systems and history, Medical Human Rights, Cultural Rights and the United Nations Rights of the Child. The overriding aim of the panel is to develop protocols for safe, culturally responsive and informed practices, while mapping therapeutic and developmentally enhancing environments of service for children who are victims of cumulative harm and neglect.

The Commissioners are invited to consider the serious nature of this report on Aboriginal children's mental health treatment and *chemical restraint*; this term was referenced regularly to me at the Alice Springs detention centre, Bush Mob, and Central Aboriginal Congress. One supervisory professional said to me, "You just get used to it over time". I allege that this matter is a serious human (child) and cultural rights matter in need of investigation.

These issues must be urgently investigated and rectified formally before mental health funding is advanced by the Royal Commission recommendations and distributed for services in detention centres and Territory Family State homes.

Urgent needs for safeguarding vulnerable Aboriginal Children:

- (1) To increase and safeguard duty of care for children currently in detention and care.
- (2) To guard against medical collusion in "chemical restraint" and other exclusive 'mental' and 'behavioural management' methods, which compromise the developmental and cultural wellbeing of children and youth.
- (3) To mandate long-term case-based *advanced* training of health professionals who assess and treat Aboriginal children in detention and care. To date, introductory knowledge in trauma rarely goes beyond PTSD (Posttraumatic Stress Disorder) symptom-based criteria.
- (4) To increase confidential support systems as a way of increasing mandatory reporting by professionals who currently feel disempowered.
- (5) To move from a treatment and behavioral management culture to a therapeutic and safe-practice culture in our justice and in-care systems for Aboriginal and non-Aboriginal children and youth.

CHILDREN'S DEVELOPMENTAL AND CULTURAL SAFETY: RECOMMENDATIONS

These recommendations are directed to Aboriginal children and youth, since they comprise the overriding majority of young people in detention. Also, there is a strong carry over impact between those in detention and children in Territory Family care since they live in insecure care systems, often with displacement from family and/or Country and language. The recommendations set below are intended to increase culturally reliable assessments inclusive of trauma criteria for Aboriginal children, alongside safe practices.

This author uncovered a grave trend whereby some medical practitioners (inside and outside the Aboriginal Health centres) are routinely complicit in 'chemical restraint' through their administration of psychotropic drugs with Aboriginal children without peer reviews or safe monitoring. This trend now runs through two generations of young people; my sample ranges from 9 to 21 years of age.

Of all reviewed, children were enduring violent and/or chronically neglectful home and education contexts at time of diagnoses. And while Posttraumatic Stress Disorder was sometimes mentioned, it was not the main presenting disorder and the youth had on-going cumulative trauma, not just "post" trauma. The International Classification of Disorders (ICD-10) accounts for complex trauma criteria and is better suited to Indigenous people globally with fuller scope for therapeutic planning, when compared to the American system of the DSM-V.

Key recommendations

(1) To increase the capacity of clinicians to comprehensively assess the impact of neglect, trauma, chaotic and unsafe attachment patterns, and removal from Country, kin, language and culture in young people who present with symptoms of self-harm or aggression (as these symptoms are consistent subset features of trauma in childhood and adolescence).

(2) To mandate *advanced* long-term training of medical and allied health professionals who assess and treat Aboriginal children in detention and care. To date, introductory knowledge in trauma rarely goes beyond PTSD (Posttraumatic Stress Disorder). There is an immediate need for professionals to increase their research and practice knowledge of Complex Trauma criteria in childhood and adolescence, and maintain reliable supervision in this regard.

Briefly, complex trauma is featured in the ICD-10, International Classification of Disease and has relevance for Indigenous populations globally when compared to the DSM-5 category of Posttraumatic Stress Disorder. PTSD has three categories of trauma symptoms, while the ICD-10 has five categories of trauma-clustered symptoms with formal inclusion of oppositional and defiant responses.

As a correlation, the more children live without kindness, self-agency, and experiences of consistent-secure care, the more they are prone to a flight or fight survival mechanisms, which get misdiagnosed as conduct disorder rather than complex trauma.

As restated in the discussion section below, to date, medical and educational and

social service providers are diagnosing conduct disorder and attention deficit disorder excessively, with little to no attention to complex trauma children have endured from neglect and harm. All children I assessed have extreme cumulative histories of emotional and developmental neglect and cumulative violence, including witnessing or directly experiencing rape and sodomy during early developmental years.

(3) To routinely screen for childhood trauma with appropriate culturally-reliable instruments and observations across outdoor and indoor environments as the majority if not all assessments occur in an office, with sketchy attention to culturally-responsive rapport building with Aboriginal children.

(4) To increase health promoting “therapeutic mapping” for children who have been consistently subject to chaotic, traumatising, and developmentally neglectful people and places.

(5) To decrease the over diagnosis of “conduct disorder” and ADHD (Attention Deficit Hyperactivity Disorder) by attending medical professionals by establishing a reliable system of review that accounts for the interaction between symptoms and trauma contexts (See Ontario Expert Panel Action Plan).

(6) To decrease depending on informants’ descriptions of ‘unmanageable behaviors’ or assuming the children’s homes are safe when the trauma symptom checklist indicates otherwise.

(7) To decrease the misuse of psychotropic medication in children and adolescents as “behavioral management” or “risk diversion” and shaming and cover-up methods of intervention.

(8) To formally investigate (through funded research) the high positive correlation between paediatrician/psychiatrist’s diagnoses of “conduct disorder” in middle childhood (ages 8-12) and their on-going prescriptions for antipsychotic medications for children who do NOT present with psychotic symptoms and who are often maintained on these drugs into adolescence and adulthood. (This same review is needed for use of stimulants for children diagnosed with attention deficits, as again, those behaviours are often subsets of complex trauma).

(9) To review the relationship between ‘conduct disorder’ labels and the entry of such in the Medicare system which determines population health data. The perpetuation of unkind treatment streamlines children into detention pathways (and “detention” diversion programs) once labeled, rather than advancing therapeutic pathways if trauma were addressed formally.

There is an urgent need to review the institutionalised trend across mainstream and Aboriginal organisations that have moved towards an exclusive use of Medicare-funded services for mental health care. This means that Aboriginal children, youth and adults are labeled with Western-determined ‘mental disorders’, which may require a formal and ethical review on ‘mission statements’ by stakeholders who invest in mental health services for Indigenous people, particularly when mental health statuses are uploaded into health service data banks, which risks lowering the social statuses of Indigenous people, and

diminishing their access to culturally-reliable services. Population health statistics on mental health statuses are at risk for under-reporting of trauma-based syndromes.

(10) To call for a formal investigation into the long-term side effects of psychotropic drugs that compromise young people's developmental, neurological and hormonal health. This alarming trend was found in this author's random sample review of medical files of youth in detention and observations and interviews with youth who report serious side effects with little to no responsive reassessment protocols.

(11) To increase the educational infrastructure and outdoor learning programs (inside and outside the justice system) for Aboriginal youth who have developmental and/or behavioural challenges due to cumulative and on-going trauma or developmental delays due to FASD and/or nutritional or genetic abnormalities. To date, there is no assessment protocol for visual, auditory or visceral learners in detention centres. Additionally, there are no accredited programs for one-on-one learning options for children in Alice Springs. Attention to engaging Aboriginal children's curiosity in learning environments is lacking.

(12) To develop 'release' pathways (such as the Bushmob in Alice Springs) that can decrease the rate of gang attachment and disengaging behaviours in youth who have been harmed by conventional systems of care. Having said this, the safety of Aboriginal traditional systems of justice for Aboriginal youth requires formal protocols and duty of care for long-term prospects of engagement if proposals are to move in this direction.

To reduce bootcamp-like programs for Aboriginal youth as such systems may well harden rather than soften children over time and decrease further their experiences of safe-place. (<http://theconversation.com/boot-camps-a-poor-fit-for-juvenile-justice-9208>)

There is a need to assess strengths, nurture resilience and natural talents in Aboriginal children routinely as assessments usually highlight deficits and prescribe remedial programs or punishment and shaming interventions.

Overall, it takes considered time to develop complex case formulations around the defiant attitudes and aggressive behaviours associated with complex trauma that present in children. There is an urgent need to break down the systemic cycle of neglect and complex re-traumatisation for Aboriginal children during their engagement with police, justice, and health and mental health professionals. In this regard, it is recommended that an expert panel be established before funds are moved forward for "mental health" facilities and culturally and developmentally responsive care systems.