21 April 2010

To: Senate Select Committee on Regional and Remote Indigenous Communities

Thank you for inviting my submission. I am a Child and Adolescent Psychiatrist employed by Queensland Health; I am the Clinical Director of the Townsville Child and Youth Mental Health Service (CYMHS) and also the psychiatrist for the North Queensland Adolescent Forensic Mental Health Service and the Cleveland Youth Detention Centre in Townsville. I am making this submission in a private capacity, and the views here are not intended to reflect the position of Queensland Health.

I have read the terms of reference of the committee, which are as follows:

"That a select committee, to be known as the Select Committee on Regional and Remote Indigenous Communities, be appointed to inquire into and report on:

1. the effectiveness of Australian Government policies following the Northern Territory Emergency Response, specifically on the state of health, welfare, education and law and order in regional and remote Indigenous communities;
2. the impact of state and territory government policies on the wellbeing of regional and remote Indigenous communities;
3. the health, welfare, education and security of children in regional and remote Indigenous communities; and
4. the employment and enterprise opportunities in regional and remote Indigenous communities."

I will address item (3) from the terms of reference, namely the health, welfare, education and security of children in regional and remote Indigenous communities

Mental health problems

Indigenous children in regional and remote communities have a high prevalence of mental health problems including disruptive behaviour disorders (i.e. conduct disorder), emotional disorders (depression, anxiety and post-traumatic stress disorder), developmental disorders (intellectual impairment) and substance use disorders (abuse of alcohol, volatile substances and cannabis). As a consequence, Indigenous children are over-represented in the Juvenile Justice system, are less likely to complete their education, and are more likely to develop severe mental health problems in adulthood.

The causes of these problems

1. Inadequate parenting (manifesting as inconsistent discipline and poor supervision), due to parental mental illness and drug/alcohol abuse, or due to parental inexperience and lack of support and role-modelling in the extended family. This can be traced back to social disruption resulting from historical government policies such as the 'stolen generation"
2. A high prevalence of psychological trauma resulting from child abuse and neglect (due to the above factors, and also unhelpful community values in

some communities); and also psychological trauma resulting from bereavement (due to high suicide and murder rates and excessive mortality due to "natural" causes)
3. Children being born with brain damage due to the mother's drug or alcohol use in pregnancy (e.g. foetal alcohol syndrome) or experiencing brain damage in childhood due to deliberate or accidental injuries
4. Older children and adolescents growing up in communities where they are exposed to poor role models such as peers and adults involved in crime or drug/alcohol abuse and who are unemployed with little prospect of finding employment
5. Community environments which have few safe recreational opportunities and few meaningful employment opportunities for young people

Current constraints

1. Perception of Government services by Indigenous communities. Partly for historical reasons, services may be seen as coercive and frightening and may be difficult to trust. This includes Health (especially Mental Health), Youth Justice and Child Safety. There is a perception in some communities that Government interventions are paternalistic "top-down" interventions that are implemented without adequate consultation and local "ownership". Communities may feel humiliated, disempowered and alienated as a result.
2. A perception of inadequate staff resources in rural and remote areas. Government agencies are sometimes not able to provide more than an occasional "fly-in" service. Youth Justice Orders cannot always be implemented or monitored. Child Safety services cannot always provide the necessary monitoring of vulnerable children or preventive or supportive interventions with vulnerable families. Specialist services in "hubs" such as Townsville do not always have adequate funding to provide the required "fly-in" services.
3. Where staff are available locally, there is a perception that the retention rates are poor. It is perceived that government agencies rely on financial incentives but do not always provide other necessary support, for example adequate budgets for travel and further education.

Potential solutions

1. Initiatives which are aimed at community capacity building seem to be well received. People want to be able to help and support those with mental health problems their communities, and have responded warmly to initiatives which give them the skills to do this. An example of this has been the delivery of "Mental Health First Aid" in Indigenous communities (see http://www.mhfa.com.au/)
2. The parents of current students have in many cases had negative educational experiences, so it is essential that schools should have deliberate strategies to engage Indigenous parents in the educational system, so as to support their children's engagement in education. Efforts should be made to include Indigenous parents in school governance for example PCAs. Parents can also engage with the Education system through programs such as PAFT (Parents as First Teachers; see for example http://www.det.nt.gov.au/parents-

community/early-childhood-services/at-home-with-child/families-as-first-teachers-program)

3. Mental Health services should develop and deliver therapeutic approaches which are culturally safe, and respectful of Indigenous culture. Culturally safe therapies would be mindful of the historical power relationship between service providers and Indigenous service users; would be focused on building strengths and resilience rather than focused on pathology and deficits; and would make use of approaches which are explicitly collaborative in nature. (see for example http://www.dulwichcentre.com.au/foundation.html).
4. Building healthy communities can be approached through the development of community leadership; development of local ownership of Health, Education and Police/Justice services; and facilitating collaboration among these services at a local level (an approach that has been applied internationally is described by Stuart Twemlow: Modifying Violent Communities by Enhancing Altruism: A Vision of Possibilities. Journal of Applied Psychoanalytic Studies, Vol. 3, No. 4, October 2001)
5. Schools can serve as a focus for community capacity building in remote communities (see http://www.westerncapecollege.eq.edu.au/51.html for initiatives in Weipa, Cape York)
6. The Cleveland Youth Detention Centre takes in young people from across North Queensland with the most complex and severe problems, and this poses an opportunity to intervene with youth with the most critical need, and who would otherwise be likely to progress to an adult life of crime, mental illness and drug and alcohol abuse. Increased resources for the Mental Health Service at the Detention Centre would allow the service to implement evidence-based interventions such as Multi-Systemic Therapy (see for example: Alternatives to Custody for High-Risk Young Offenders: The Multisystemic Therapy Approach, Leschied et al, European Journal on Criminal Policy and Research Volume 6, Number 4 / December, 1998). However, interventions such as this, having been developed in other countries, would require adaptation to the Australian context.

Yours sincerely

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