16 May 2008

Senate Select Committee
Regional and Remote Indigenous Communities
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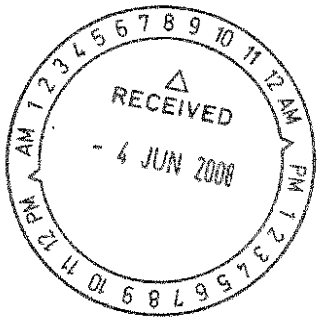
Parliament House
CANBERRA ACT 2600



To the committee

I am a child and adolescent psychiatrist based in Sydney. I have been working with the Central Australian Mental Health Service, based in Alice Springs since September 2006. I spend one week every two months supporting the Child and Adolescent Mental Health workers and members of the Adult Mental Services seeing adolescents. I do assessments, help with the development of management plans and offer case consultation. I see young people in both Alice Springs and in remote communities in Central Australia. There is no resident Child and Adolescent psychiatrist and I am the only regular visiting Child and Adolescent psychiatrist. There is only one full-time resident Child and Adolescent psychiatrist in the Northern Territory and he is based in Darwin. The Child and Adolescent Mental Health Team in Alice Springs has two full-time positions. In the time that I have been there, it is only since January this year, that both positions have been filled, due to long-standing difficulties the service has in recruiting permanent staff. The Remote Mental Health Team has one position for a Child and Adolescent Mental Health worker. This team has responsibility for numerous remote communities spread over 750,000 square kilometres, the bottom half of the Northern Territory. This is a relatively new position and predictably, it has been difficult to work out an effective role for this person. Currently we have no Aboriginal Mental Health Workers with training or experience in Child, Adolescent Mental Health. This is increasingly being recognised as an essential component of an effective and culturally appropriate service.

There appears to have been little consideration of the need for comprehensive Child and Adolescent Mental Health Services in the recent reports relating to Indigenous Health in the Northern Territory. The "Little Children are Sacred" report has one paragraph suggesting that the need for such services be considered. The Northern Territory government's response "Closing the Gap" makes no reference to Child and Adolescent Mental Health Services outside of the area of sexual abuse. Perhaps the reason this has been overlooked is that so few people are working in this field, that there has been no time or energy for advocacy to highlight both the unmet need as well as the lack of available services. Perhaps it has been considered and believed to be too difficult or expensive, or it is assumed such services are already in place and functioning well. Unfortunately this is not so.

The Australian Government Emergency Response so far has done nothing to address these issues. Physical health problems of remote Indigenous children in the Northern Territory have been well documented in the past. There has never been any attempt that I am aware of, to systematically survey the Mental Health needs of young people in

the Northern Territory. The best estimates we have come from the Western Australian Aboriginal Child Health Survey (Social and Emotional Well Being volume – 2005). This showed that 24% of Aboriginal children (for 4-17 years) were at high-risk of clinically significant emotional and behavioural difficulties (compared to 15% of the general child population in Western Australia). In NSW, 23% of aboriginal children were at high-risk, ie consistent data. In the WA survey, the same range of disorders, were seen in both Indigenous and non-Indigenous children, but Conduct Disorder, Hyperactivity and Self Harm occur at a much greater frequency. The broad range of difficulties including depression, anxiety, post-traumatic stress disorder, autism spectrum disorders and psychosis would be expected to occur and benefit from proper assessment and treatment. We know that abuse (sexual, physical and neglect) increases vulnerability. The survey identified a number of factors not surprisingly associated with high-risk – high number of life stress events, poor family functioning and poor quality of parenting, chronic medical or mental health problems in the carer and physical problems in the child (speech, vision and hearing). Suicide rates have increased dramatically over the last 3 decades in Indigenous populations from levels that were previously lower than the general Australian population. Rate of suicide for Indigenous young men in the Northern Territory (15 to 24 years) is 3.5 times higher than the general population (most by hanging). The pattern of suicide has continued to change with the emergence of child suicide in recent years. In some communities, children play pretend hanging as a game. Nearly 40% of the aboriginal population is in the 0 to 14 years age group, compared to 20% in the general Australian population. Obviously there are non - indigenous as well as indigenous children living in these communities.

We know that it is highly likely that there are high rates of unrecognised and untreated mental health problems in this population of children and adolescents. The Mental Health needs of adult (or teenagers) parents and carers are also crucial to support normal child development and resilience and adequate family functioning. Despite this, the services on the ground to address these issues are woefully inadequate. The basic level of resourcing is inadequate and this is further undermined by the enormous difficulty current services have in recruiting and keeping skilled permanent staff.

The Central Australian Mental Health Service is run by a group of dedicated and hard working people who struggle to provide the best service possible but are frequently exhausted by the demands. Burn out of staff is common and contributes to the difficulty of maintaining a stable and skilled work force who are a-tuned to the very particular difficulties of working in remote Central Australia. To be effective as a Mental Health Worker in a remote setting, considerable time and effort needs to be taken to develop relationships and consult with local people (Indigenous and non indigenous) and key organisations or groups in the community. This requires sustained contact and development of trust. This cannot be achieved in a one off visit or with a rapid turnover of staff. Adequate clinical and administrative support is essential but rarely available. Considerable logistic organisation for every visit is required – liaison with local services eg Medical Clinic or school, Transport (4 wheel drive or small plane), accommodation (usually very limited), food etc. This takes up a lot of clinical time.

The Child Health Check Teams are continuing to see children in Central Australia. Mental Health Screening is not included in the formal child health check apart from 3 questions out of 80. Up till March 2008, 1195 children had been seen. There have been 5 referrals for children to the Mental Health Service (1 for depression, 1 for

separation anxiety, 3 – non-specific) ie less than 0.5% referral rate. I understand there have been 4 referrals of adults as a result of the intervention – all intervention workers.

There has been no liaison between Intervention workers – co-ordinators and local Mental Health Services in Alice Springs that I know of. We arranged a meeting two months ago with the person responsible for organising the orientation of the Child Health Check Teams and hopefully some input highlighting the need for considering Mental Health issues and clarifying appropriate referral pathways will now be included – a small step forward.

I fully support the thrust of the Intervention to tackle issues of family violence, drug and alcohol abuse in both adults and young people, and sexual and physical abuse and physical health needs of Indigenous children. Underlying disadvantage must be addressed ie housing, poverty, unemployment and education. It is critical that early intervention and prevention be a major focus with the establishment of a broad range of family support services, with a high-level of community consultation. This supposes that adequate basic services for Mental Health assessment and treatment are in place which currently is not the case. Adult Mental Health services struggle to meet the need and Child and adolescent Mental Health services are minimal. Nevertheless, real change in the transmission of vulnerability and disadvantage across generations requires that we address the Mental Health needs of both the current generation of parents or carers, and the current generation of children and adolescents.

At this point in time, there is no comprehensive effective and timely Mental Health Service available to children and families in remote communities in most of Central Australia.

Please note that these views are my own and I write this in my private capacity and not on behalf of the Northern Territory Department of Health.

Yours sincerely

Dr. Rosemary F Howard