Dr. R.F. Howard

14 April 2009

Senate Select Committee
Regional Remote Indigenous Communities
P.O Box 7100
Parliament House
Canberra ACT 2600

To the Committee,

I am writing to update my previous submission dated 16 May 2008, and attach as well a copy of a letter I wrote to the Northern Territory Emergency Response Review Board (22/7/08) . Unfortunately I will not be in Alice Springs when the Committee visits on the 1st of May, so I am unable to attend the Public Hearing.

There has been overall progress in the past 12 months, with the support of the management of the Central Australian Mental Health Service. The Alice Springs based urban Child and Adolescent Mental Health Team now has 2 (FTE) workers, supported by visits from an experienced Clinical Psychologist (1 week a month) and visits by 3 Child and Adolescent Psychiatrists (each doing 1 week every two months – both urban and remote work).Some of these positions are very recent developments. We are moving towards a nominated Team Leader to better coordinate services. The number of referrals has progressively increased (from many sources including Paediatricians, Dept of Ed, FAC's, GP's, Emergency Dept) and last year there were 130 referrals, about 50% of which were Indigenous young people. In fact this week we have had to put a one month moratorium on acceptance of new cases to allow staff to catch up with current case loads.So when a service is provided the demand is there. Many of these referrals are complex cases requiring intensive input and liason with multiple agencies. However if one of the fulltime clinicians were to leave, given the difficulty with recruitment, the team would struggle to maintain a reasonable level of service.

The Remote Mental Health Team currently has no Child and Adolescent Mental Health Workers. The visiting Clinical Psychologist is now providing a 1 day a month outreach to Tennant Creek and the 3 visiting Child and Adolescent Psychiatrists offer a consultation service to a few remote communities as part of their 2nd monthly visits. While this is better than nothing, it does not amount to anything like an adequate service. Large areas of remote Central Australia still have no effective Child and Adolescent Mental Health Service. There is a clear need for adequately trained and experienced Child and Adolescent Mental Health Workers on the Remote Team. These workers need to be able to operate independently so it is critical that a salary package designed to attract people with skills and experience be offered, if we are to have a well functioning and sustainable service.

Recruitment and retention of permanent staff remains an ongoing challenge that does not seem to have been addressed.

The pilot program involving collaboration between GP Network, Health Clinics, Western Aranda Health Aboriginal Corporation, and Child and Adolescent Mental Health has been operating in three clusters of communities. There have been staff changes in 2 out of 3 clusters and it is only recently that three Child and Adolescent Psychiatrists have been available, so it is early days. I understand that an initial evaluation will be completed sometime this year.

There has been no progress in the development of positions for Indigenous Child and Adolescent Mental Health Workers. There are currently no funded positions and no recognition from funding sources that this is critical to an effective service. These positions would need to have additional funding built into the package for training, travel, supervision and support etc. This needs to be a high priority.

I understand that Fahcsia is training 13 Remote Aboriginal Family and Community Workers, but do not know where this stands.

We have been unable to access resources for a systematic evaluation of our developing service. We have also been unable to access resources to quantify unmet service needs ,despite the Report of the NTER Review Board (October 2008) saying that this should be done, (e.g. updating the Menzies Report as mentioned in my previous submission) and the needs addressed. Unless funds are provided for these recommendations nothing is likely to change.

So overall, we have made progress in the development of a service in Alice Springs, although this remains fragile. We can only offer a minimal service in most communities in Remote Central Australia. There has been no progress in developing positions for Indigenous Child and Adolescent Mental Health Workers, which I believe is an essential component of an effective service.

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 and Families.

Many thanks for your consideration.

Yours sincerely.

Rosemary F Howard

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Child and Adolescent Psychiatrist

22th July 2008

Mr Peter Yu
The Chairman
Northern Territory Emergency Response Review Board

To the Review Board

I have enclosed a copy of a letter I wrote to the Senate Select Committee for Regional and Remote Indigenous Communities, which details my observations of the Federal Government Emergency Response from a Child and Adolescent Mental Health point of view (16/05/2008).

I wanted to add some thoughts about what may be helpful going forward, for your consideration.

Generally speaking, adequate funding for health, housing, education, employment and policing must continue, to bring standards to equitable levels and to address the endemic problems facing these communities and the families that live in them. This will require a long-term and large investment. Implementation with consultation and partnership with communities and community based organisations is crucial.

Current service provision to the remote communities in the broad sense is patchy, poorly co-ordinated, and often with short-term funding that has been stitched together from multiple sources. There appears to be no over arching leadership and support for development of programs across Central Australia.

Response across all levels of Government is necessary to address the social determinants of health and disadvantage. To be effective, minimise duplication and optimise referral pathways, this needs to be well co-ordinated. To my observation, co-ordination between Federal Intervention initiatives and Mental Health Services in Central Australia has been minimal and could easily be improved.

The Indigenous Child Health Checks have become a key plank of the Intervention. They aim to standardise health screening for Indigenous Children from birth to 14 years of age. The concept pre-dates the emergency intervention in the Northern Territory and is supposed to include an assessment of child'physical,psychological and social well-being. "The broad scope of the child health check is consistent with recent international research that identifies the key risks for poor child development in developing country settings and for recurrent maltreatment.Families social conditions,the social and emotional well being of parents, parenting skills, adequate nutution, and prevention and early treatment of infection should be important aspects of any intervention. The investigations of these conditions within the scope of the child health check reflects a view that primary health care services have responsibities in all these areas"("Delivery of Child Health Services in Indigenous Communities: Implication for the Federal Governments Emergency Intervention in the Northern Territory" – MJA. VOL 188NO10. 19th of May 2008) This paper went

on to describe delivery of child health services in Australian Aboriginal Communities (NT, N.S.W, W.A.) Documentation of inquiry regarding social conditions was poor (3-11%). Only 11 to 13% of children with identified social problems had an assessment report on file. This is consistent with my observations that the current Child Health Checks are making only a token effort towards identifying issues related to social and emotional well-being of parents and children and if problems are flagged, there is virtually no response and no capacity for follow-up.

There is no effective screening for Mental Health / Emotional / Behavioural Problems, although we know it is highly likely that there are high rates of unrecognised and untreated Mental Health problems in this population of Children and Adolescents. (Western Australian Aboriginal Child Health Survey – Social and Emotional Well-Being volume 2005) Development of systems for identification and ongoing sustainable responses to these problems should be a priority.

This will require the development of broad-based community programs to facilitate optimal child development and alleviate risks – a preventative and early intervention approach at the Primary Care level. Some of the Intervention budget is already geared towards this eg $101.5million for extra Maternal and Child Health Services (under 5 years targeted) and $3.4million for "Early Childhood Development Services to support learning and development opportunities for children" (this funding was for 5 playgroups and 10 crèches). Given the promise to provide all Indigenous 4 year-olds in remote communities with access to a quality pre-school program within 5 years, there is a big job ahead.

The "Little Children are Sacred" report (Rex Wild and Pat Anderson) pointed out the overall lack of community based family support facilities, especially culturally appropriate ones. This was identified as a significant gap as usually there were no child focussed support systems to which FAC's could refer families identified as maltreating children, for assistance and support. This left out of home care as the only option in serious cases. However, the problem is broader than clearly identified child protection cases and includes mental health and substance abuse issues for parents, carers and children, family dysfunction, parenting practices, etc. Where frank mental health problems or broader social and emotional well-being issues are evident, there is also no community based services for treatment, assistance and support. Community based family support and case management services are needed to assist identified high-risk families or groups eg families where a carer has a mental illness, drug and alcohol problems, domestic violence, chronic physical illness or where a child has identified developmental problems, hearing and speech difficulties, emotional or behavioural difficulties etc.

This year, the Central Australian Division of Primary Health Care has been funded by the Department of Health and Aging to employ three community workers, each serving a small cluster of communities to "provide greater access to mental health services". It is an attempt to link the Aboriginal Health Organisations, Central Australian Mental Health Service and the local Health Clinics to enable a co-ordinated approach to mental health service delivery with a strong emphasis on prevention and early intervention with high-risk families. Having a worker based in the communities (at least Monday to Friday) will facilitate trust and development of

relationships with Indigenous families and allow for ongoing and if needed intensive intervention.

Specialist Mental Health Services can provide specialist psychiatric or psychological assessment, offer consultation around case planning and review, work with adults and children with a serious mental health disorder and support other staff. This is a model that is attempting to tie in on the ground community case management with specialist Mental Health Services, to address the mental health needs of children and families. However, it is clearly a small program, with funding granted until December 2009. This is being evaluated and if successful could provide a model that with significant extra resources could be rolled out across many remote communities. It is important to note that the specialist Child and Adolescent Mental Health backup, even for this limited program consists of one Child and Youth Mental Health Clinician covering the entire area of remote Central Australia (850,000sq km). It is blindingly obvious that this is inadequate.

Apart from this new and small program, a model for effective delivery for mental health services for children and adolescents in Central Australia has yet to be developed. Currently, there is a fly in – fly out consultation and liaison services to the APY lands (the Northern Area of South Australia and the Southern Area of the Northern Territory) from Adelaide, which offers one or two visits per school term to communities and which liaises primarily through schools. This team includes one Child and Adolescent Psychiatrist, one Social Worker and two Aboriginal Mental Health Workers.

A consultation/liaison model of service delivery is offered by the Mark Sheldon Remote Mental Health Team in Central Australia with mental health clinician's based in Alice Springs. It has psychiatrist back-up from Dr Marcus Tabart (Consultant Psychiatrist in Alice Springs) and a number of psychiatrists from other states who fly in under MSOAP (Medical Specialist Outreach Administration Program). It has been difficult to support and retain staff working on this team. Feedback to the one Child and Youth Clinician on that team (recently left) is that communities want a more available on the ground presence, capable of offering more direct service and emergency intervention if required. This has not been possible with existing staffing.

Mental Health Services in the Northern Territory have put in a proposal for additional funding for Child and Adolescent Services from the budget allocation for primary health care in phase 3 of the intervention (Mental Health and Early Childhood were identified as priority areas). It is important that this be supported but also that it is recognised that this in itself is just a beginning and not a sufficient response. The Menzies School of Health Research from the Northern Territory produced a well researched and detailed report in 1999 – "Shifting the Balance – Services for People with Mental Illness in Central Australia – a framework for planning and resource allocation". It studied population based resource allocation formula from several other systems and attempted to build in realistic loadings for remote practise. This report documented the "critical shortfall" in Child and Adolescent Mental Health especially in Indigenous Communities outside Alice Springs. It recommended a total of 14 staff including 3 clinician's, one specialist Child and Adolescent Psychiatrist and 10 Aboriginal Mental Health Workers who could be community case managers. It noted that there were no specialist services in terms of residential beds for

assessment of complex severe problems and intensive treatment in the whole of the Northern Territory for Children and Adolescents. These young people either do not receive adequate treatment or have to be sent interstate, hardly conducive to family involvement and good follow-up and often unacceptable to remote indigenous families.

This report has largely been ignored. It is important to remember that it was written in 1999 (based on population estimates from the 1996 census). The Aboriginal population is growing and is young. About 33% are in the 0 to 14 year age group, compared to about 20% in the rest of Australia. In addition, since the Western Australian Aboriginal Child Health Survey, we are now more aware of the higher prevalence rates of disorder among Indigenous Children, than we were in 1999. Clearly the proposed staffing numbers and resource allocation in the "Shifting Balance" report would need to be increased to be considered adequate today.

In summary, significant long-term investment in community based family support services capable of offering broad and intensive case management, backed up by an adequately resourced specialist Child and Adolescent Mental Health workforce would appear to be a way forward.

The other very obvious component that is largely missing is the availability of Indigenous Mental Health Workers to work alongside non-indigenous staff to facilitate overcoming the significant cultural and language barriers. There are no Indigenous Mental Health Workers with training or experience in Child and Adolescent Mental Health currently working in the Central Australian Mental Health Team. It is difficult to see how any of the family support services or mental health teams can be truly effective without the employment of Indigenous staff as co-workers. While there has been a lot of talk about the need for this over the past 10 years, very little progress has been made in recruiting, training and supporting such staff, in what is clearly a very difficult role. It is not realistic at this point to think that we can recruit 10 Indigenous people willing to train as community based case managers. In the short to medium term, more non-indigenous clinician's will be required who can over time support and train Indigenous workers to take on these roles.

In general terms, recruiting, training, supporting and retaining staff in Central Australia is a constant battle and needs to be seriously addressed. This is currently left largely to over-worked managers, whose direct responsibility for service provision leaves inadequate time. Central Australia is a challenging environment to work in, with many stressors not present in urban work places, eg remote isolated practice, extremes of temperature, long-distance travel, poor quality accommodation, huge cultural differences, language barriers etc. There needs to be excellent support systems and financial incentives if adequate and reliable staff levels are to be achieved. Private sector businesses seem much more creative about this than Government Departments and non-Government organisations. Unless this is addressed, it will be difficult, if not impossible to sustainably fill any newly created positions.

Once again, 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

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