Chief Psychiatrist Review

Child and Adolescent Mental Health Services
APY Lands

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Contents

EXECUTIVE SUMMARY

On 26 October 2021 the Minister for Health and Wellbeing requested the Chief Psychiatrist to conduct an independent review of Child and Adolescent Mental Health Services (**CAMHS**) on the Anangu Pitjantjatjara Yankunytjajara (**APY**) Lands by 25 November 2021. This deadline was extended to 3 December 2021.

The Chief Psychiatrist is appointed as a Statutory Officer under Section 89 of the *Mental Health Act 2009*. The Chief Psychiatrist has, amongst other functions, the authority to monitor the delivery of mental health care and the standard of that care as well as providing advice to the Minister.

This report by the Chief Psychiatrist contains the findings and recommendations of this review.

Since 2010 CAMHS has delivered, through the Women's and Children's Health Network (**WCHN**), the Kunpungku Atunymankunytjaku Tjitji (KATU) program on the APY Lands. This program was designed to provide mental health services to children on the Lands, including those with complex trauma histories. It was established in response to the findings of the 2008 Mullighan Inquiry into child sexual abuse on the APY Lands.

KATU's core staffing profile has comprised of two lands-based clinicians (social workers), fly-in-fly-out (**FIFO**) mental health workers, visiting psychiatrists and Anangu staff members. In recent years, WCHN has been looking for opportunities to integrate KATU with the other services it delivers on the APY Lands, with the aim of developing and delivering a sustainable Integrated Model of Care (**IMOC**).

As neither of the two Lands-based clinicians are currently working on the APY Lands, WCHN has put in place interim, telehealth service arrangements ahead of the implementation of an IMOC currently being developed by a WCHN Working Group. FIFO services will be implemented but are yet to be restored.

The purpose of this review was to assess the adequacy of the interim service arrangements put in place following the unexpected departure from the Lands of both CAMHS Lands-based clinicians and to identify any additional services required to ensure access to WCHN clinical services on the APY Lands is maintained.

While this was a focussed review based on the limited Terms of Reference, in order to understand the level of clinical need for mental health services on the Lands, and the type of service required, fourteen interviews were conducted with relevant stakeholders, including CAMHS and WCHN. These were mostly held face to face, except for Alice Springs based staff. Time limitations for this review necessarily impacted the extent of consultation possible, and these limitations – in addition to the logistical challenges imposed by COVID-19 – also prevented a visit to the APY Lands communities being made. It is acknowledged that further consultation, particularly with APY Lands communities and people with lived experience, may be warranted and necessary in the future.

Documents relating to the planning, performance and review of CAMHS historical and current services on the APY Lands were reviewed, as were reports of previous enquiries that considered the level of need for therapeutic mental health services for children and young people on the APY Lands.

As is standard for any service review, several case notes (health care record) reviews have been completed, along with statistical analyses of service provision, referral processes and client demographic data.

From the evidence that was able to be considered, it can be concluded that there is a significant unmet need for child and adolescent mental health services on the APY Lands, and this need is acute. Culturally-appropriate mental health services are required on the Lands to respond to children with significant levels of unresolved intergenerational trauma and associated mental illness in the Anangu community in addition to other neurodevelopmental disorders. While this review did not investigate the contributors to this trauma, there was common agreement among interviewed stakeholders, as well as the findings of previous enquiries, that exposure to childhood sexual abuse, physical violence, substance abuse and unresolved mental illness and trauma arising from both colonisation and the Stolen Generations continue to significantly impact the mental health of young people on the Lands.

This review found that an effective mental health service on the APY Lands requires an evidence-based, therapeutic service adapted for the Anangu culture. The use of a FIFO model is beneficial in such remote settings, where the realities of staffing challenges must be faced. However, this investigation heard repeatedly that a FIFO model must be supported by Lands-based clinicians working with Malpas with established relationships of trust with families and children.

CAMHS' interim telehealth arrangements are insufficient to meet the unique and significant needs of children and young people on the APY Lands and steps must be taken as a matter of urgency to enhance service provision, including through the placement of Lands-based clinicians.

More detailed conclusions, and this report's recommendations can be found from page 32.
Finally, it is noted this review and final report was a collaboration between the Chief Psychiatrist and four staff members of the Office of the Chief Psychiatrist. Each team member's contribution to this report is acknowledged.

INTRODUCTION TO THE REVIEW

Terms of Reference

The Minister for Health and Wellbeing requested that the Chief Psychiatrist conduct an independent review of WCHN's CAMHS on the APY Lands.

The **Terms of Reference** for this review were to:

1. Review the adequacy of the interim arrangements to ensure access to therapeutic services on the APY Lands is maintained until the new Integrated Model of Care (**IMOC**) is established;
2. Identify any additional processes and services WCHN may need to put in place to ensure clients are able to access services on the APY Lands at this time; and
3. Consider the best way to engage key stakeholders in the design and development of the IMOC, including engaging people with lived experience on the APY Lands.

Independence of the Review

In South Australia, the Chief Psychiatrist is appointed as a Statutory Officer under Section 89 of the *Mental Health Act 2009*, and their functions outlined in Section 90. In broad terms, the Chief Psychiatrist role is to promote continuous improvement in the organisation and delivery of mental health services in South Australia, monitor treatment of patients and the use of restraint and seclusion, monitor the administration of the Act and the standard of psychiatric care as well as providing advice to the Minister on issues relating to psychiatry and any matter of concern relating to the care of patients.

In addition the Chief Psychiatrist can issue standards that are to be observed in the treatment and care of patients as well as having the authority to undertake inspections of any hospitals and to be taken to be an inspector under the *Health Care Act 2008* for that purpose. The Chief Psychiatrist has the capacity to delegate these powers under Section 91 of the Act.

The APY Lands

The Aṉangu Pitjantjatjara Yankunytjatjara Lands (**the Lands**) are part of the Western Desert in the far north-west of South Australia, covering 102,360 square kilometres in and around the Musgrave Ranges. The Aṉangu people own and administer the Lands. The population of the Lands varies from time to time, but the Australian Government's Centre for Population data shows the APY Lands total population as 2,590 as at 30 June 2020 with approximately 31 per cent of that population aged below 19 years (16 per cent aged below 10 years, and a further approximately 15 per cent aged between 10 and 19 years).[1]

The main communities on the Lands comprise Iwantja (Indulkana), Mimili, Kaltjiti (Fregon), Pukatja (Ernabella), Yunyarinyi (Kenmore Park), Amata, Nyapari and Kalka. A map of the Lands is included as **Attachment 1**.

The Lands are very remote, primarily accessed by unsealed dirt roads, and have basic services. Primary health services on the Lands are provided by Nganampa Health Council (**Nganampa**). Pitjantjatjara and Yankunytjatjara are the most dominant languages spoken, and English language skills are often at the conversational level only with literacy in both English and Aboriginal languages being limited among Aṉangu people.[2]

[1] Australian Government, Centre for Population, "Population in Local Government Areas", accessed at: https://population.gov.au/data-and-forecasts/
[2] CAMHS APY Lands Therapeutic Model, August 2018, p.4

Child and Adolescent Mental Health Services (CAMHS)

CAMHS provides community-based tertiary mental health services through WCHN. CAMHS APY has been providing a visiting clinical service to children and adolescents on the Lands since 2006,[3] and a Lands-based service – *Kunpungku Atunymankunytjaku Tjitji*, referred to as KATU – since 2010.[4] KATU provides therapeutic services to children who have experienced significant trauma, and extends to the inclusion of parents and extended families of the children, and capacity building in the community. It is understood that KATU has been the subject of various funding arrangements since its inception, initially funded through the COAG Indigenous Health National Partnership Agreement then, more recently, Lands-based staff were funded by WCHN and additional service delivery through South Australia's Closing the Gap funding.

As is further described below, in 2010, CAMHS and Child Protection Services (**CPS**) were involved in an intensive multi-agency response to concerns of sexualised behaviour and sexual abuse on the Lands, which led to an increased provision of all government services for a period of time. However, it is understood that, for various reasons, including staffing challenges associated with remote work conditions, WCHN and CAMHS APY has experienced difficulties maintaining a consistently staffed APY service.[5]

Most recently, the CAMHS APY model of service delivery has, until approximately June 2021, included two FTE Lands-based social workers (including a Manager) based in the Ernabella and Amata communities, with the term "Lands-based" variably referring to the clinicians living on the Lands for the school term and returning to Adelaide for the school holidays, or a seven week period. The CAMHS APY service delivery also included two lead Anangu Malpas (with additional Malpas engaged on a casual basis as required), and a visiting psychiatrist. Malpa is a Pitjantjatjara word; it means to come alongside and journey with – and they are Anangu people working alongside their community. The CAMHS APY services have included family-based therapy, assessments, counselling and delivery of a sexualised behaviours program.[6]

Due to unforeseen circumstances, since June 2021 neither of CAMHS two Lands-based social workers have been working on the Lands. Additionally, due to COVID-19 restrictions, travel to the Lands has been much reduced with the consequence that access to clinical services have further declined.

CAMHS APY interim service arrangements

In response to the unexpected absence of both of the Lands-based clinicians, WCHN has put in place interim arrangements for the delivery of CAMHS services on the APY Lands, ahead of the implementation of a proposed new IMOC (discussed below), which is currently at the development and consultation stage.

The OCP has been informed that under these interim arrangements:

- **Acute/urgent clinical referrals:** Nganampa Health service will contact the CAMHS Clinical Director directly via email. The Clinical Director, together with a CAMHS APY clinician located in Adelaide, will determine the most appropriate response to the child/young person's situation.

[3] See WCHN CAMHS Model of Care, "Who we are and what we do", 2016, accessed at: https://cdn.wchn.sa.gov.au/downloads/WCHN/camhs/CAMHS-Model-of-Care.pdf
[4] Annual Report of the Aboriginal Lands Parliamentary Standing Committee 2018-2018, Legislative Council, Parliament of South Australia, pg. 14.
[5] WCHN, "DRAFT APY Lands – Integrated Model of Care, Version 20" dated September 2020 (**Draft IMOC**), p.23.
[6] Royal Commission Report; see also Annual Report of the Aboriginal Lands Parliamentary Standing Committee 2018-2018, Legislative Council, Parliament of South Australia, pg. 14.

- **All other referrals:** will go through CAMHS Connect (the CAMHS referral and triage service), who will register the child/young person and take their details and inform the Clinical Director. Further follow up will be by the Adelaide-based APY Clinician.

This investigation was told there is telephone access on the Lands to enable access to the Adelaide-based APY Clinician at this time, should a community member wish to make a direct referral. However, CAMHS recognise the challenges they face in making direct contact with any child or young person who is the subject of a referral while CAMHS does not have a presence on the Lands, and suggest the involvement of Nganampa Health or the local schools may be needed to take any required action.

Comments as to the adequacy of these interim arrangements are made below.

The Need for CAMHS on the APY Lands – Child Sexual Abuse

The Mullighan Inquiry

In 2007, after considerable evidence was received by the Children in State Care Commission of Inquiry concerning the sexual abuse of Aboriginal children in communities, a separate, specialised commission was constituted to investigate these allegations. The Mullighan Inquiry was established under section 4A of the *Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004* (**the Act**).

In accordance with section 11 of the Act, the Commissioner, the Hon. E. P. Mullighan QC, presented the report titled, "Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report Into Sexual Abuse" (**Mullighan Report**) on 30 April 2008.

The terms of reference had required the Inquiry to "examine the incidence of sexual abuse of children on the APY Lands, the nature and extent of that abuse, and to report as to measures which should be implemented to prevent sexual abuse of the children and to address the consequences for the communities."[7]

Key Findings

In 2008, the Mullighan Inquiry visited each of the main communities on the Lands. A considerable body of evidence was received during these field trips about the sexual abuse of Anangu children even though there were no direct disclosure made by the victims of abuse.[8] Instead, the evidence accepted by the Inquiry as indicators that a child had been, or could have been sexually abused as a child, included underage pregnancies, sexually transmitted infections (STIs) in children and young persons, disclosures of sexual activity by them, direct evidence of young girls and boys living together, children and young persons exchanging sex for petrol, drugs or money, sexualised behaviour in children, and physical injury, particularly to genitalia of children.[9]

In summary, the Inquiry found on the evidence before it:[10]

- It was reasonably possible that 141 particular children had been sexually abused on the Lands, the majority girls (113 cases).
- From those cases, there were 269 allegations of sexual abuse of children, such that the incidence of sexual abuse of children on the Lands was widespread. Abused children were likely to be repeatedly abused over some years, and the number of allegations was not a true reflection of the extent of the sexual abuse.

[7] *Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004* (SA), Schedule 2.
[8] Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry, A Report into Sexual Abuse, April 2008, Government Publishing SA, Adelaide (**Mullighan Report**), p. XI.
[9] Mullighan Report, p. XIII.
[10] Mullighan Report, p. XIII.

- The abuse experienced by children (including children well under 10 years of age) included extra-familial men abusing girls, extra-familial men abusing boys, extra-familial children abusing children and intra-familial abuse.

The Inquiry was informed that girls accept they will be sexually abused: "*many do not consent, but believe it is expected of them and resistance is futile*".[11]

The Inquiry found that there are clear, harmful consequences of child sexual abuse. The Inquiry emphasised the evidence shows: [12]

- A clearly established need for a prompt and appropriate therapeutic response to child sexual abuse and without such a response, it is likely that many sexually abused children will suffer lifelong adverse consequences.
- The number of perpetrators of sexual abuse is increasing as some victims become perpetrators either immediately or later in life.
- Serious consequences of child sexual abuse to the communities on the Lands if the experience of abuse is not met with the required therapeutic response. These consequences include physical and mental health issues, increased alcohol and drug abuse, increased vulnerability to further abuse and, ultimately, increased community dysfunction and poverty.
- The effects of the abuse, if untreated, have the capacity to "effectively destroy a generation of children", putting at risk the long-term viability of the communities.

With respect to the provision of welfare, social services and mental health services on the Lands, the Inquiry found:

- There must be sufficient resourcing for the placement of child protection and health care (including mental health care) staff on the Lands: "*Many people who were sexually abused as children require mental health services and counselling from time to time during their lives. Their good health and wellbeing is essential to limit the adverse consequences to communities from sexual abuse of children*."[13]
- There are clear limitations to outreach/remote service delivery models. With respect to CAMHS' services, the Report noted the challenges of relying solely upon a remotely delivered mental health service for children in the context of the need for ongoing, long-term therapeutic services for many children, especially teenagers.[14]
- There is a need for effective information-sharing between different government agencies and non-government organisations with respect to at-risk young people so each can effectively perform its role.[15]
- In summary, the Report noted:[16]

> There are serious mental health issues in the communities on the Lands that require the provision of appropriate and continuing services, including therapeutic intervention and ongoing counselling and treatment to resolve these issues. As has been mentioned they are needed by children soon after they have been sexually abused and by all people who have been sexually abused.

<u>Mulligan Inquiry Report Recommendations</u>

The Mulligan Report made 46 wide-ranging recommendations, including the expansion of child protection services and other initiatives on the APY Lands, improvements to service standards, and establishing infrastructure to support services and the housing of communities. For the purposes of this review, these recommendations included the following that are relevant to the delivery of therapeutic services on the APY Lands:

[11] Mullighan Report, p.XIII.
[12] Mullighan Report, p. XIV.
[13] Mullighan Report, p. XVIII.
[14] Mullighan Report, p. 166.
[15] See Mullighan Report Recommendations 6, 7, 10; see also Mullighan Report, p. 141.
[16] Mullighan Report, p. 172.

Recommendation 5
That the initiative to place social workers on the Lands be expanded from the proposed three to at least six and some of them to be female. That each of the six social workers be aligned to one school, so that each of the six major schools on the Lands has one dedicated social worker involved in early prevention strategies/training to help prevent child sexual abuse and to minimise its effects in the communities.

Recommendation 7
That CAMHS and Families SA (now the Department for Child Protection, **DCP**) review the protocols that govern their working relationship with a view to providing better assistance to children who have been, or may have been, sexually abused on the Lands.

Recommendation 8
That the necessary long-term funding be provided to allow Families SA (now DCP) to provide the required therapeutic services to children and young people on the Lands who have been sexually abused.

Recommendation 9
That the staff of the Children's Protection Services (CPS) at the Women's and Children's Hospital be increased to enable timely and effective investigation of allegations of sexual abuse of young children on the Lands. That resources be provided to enable the training of sufficient Aboriginal medical practitioners, psychologists and social workers to undertake forensic assessments of Anangu children alleged to have been sexually abused.

Recommendation 16
That there be a substantial increase in services on the Lands for persons with mental health issues and for persons who have been sexually abused as children who require therapeutic services.

Implementation of the Mulligan Inquiry Recommendations

As required by section 11A of the Act, the responsible Minister (at this time, the Minister for Aboriginal Affairs and Reconciliation) delivered a formal Response to the Mullighan Report, dated July 2008, accepting all of the relevant recommendations.

Section 11A of the Act also required the Minister, for five years following the Response, to provide a further annual response describing progress on the implementation of the Mullighan Report recommendations. In November 2013, the Minister for Education and Child Development (at that time, the responsible Minister) delivered the fifth and final Annual Report on the implementation of the Mullighan Inquiry recommendations (**Fifth Annual Report**). This Report is **Attachment 2**. In brief, the Fifth Annual Report states that the Government's implementation of the Mullighan Inquiry recommendations is complete. It is understood that a range of the recommendations were not funded or not fully funded.

In June 2017, Aboriginal Affairs and Reconciliation, within the Department of State Development was tasked with coordinating a current audit of the implementation of the Mullighan Inquiry recommendations. An internal audit was conducted by SA Health on 1 June 2017 with respect to the status of the recommendations for which SA Health is responsible (Recommendations 7, 8, 9, 11, 15, 16, 17 and 29) (**2017 Recommendations Audit**).

Attachment 3 is a table which summarises the Government's implementation of the relevant Mullighan Inquiry Recommendations, as found in the Fifth Annual Report, and the status of this implementation as at 1 June 2017, as found in the Children on the APY Lands Recommendations Audit. Most relevantly, CAMHS work on the APY Lands (together with that of CPS) is identified as central to the implementation of the Mullighan Inquiry Recommendations with respect to increasing the mental health therapeutic services available to young people who have experienced significant trauma and sexual abuse.

The 2018-2019 Annual Report of the Aboriginal Lands Parliamentary Standing Committee (tabled in the Legislative Council on 23 June 2021) notes that:[17]

> In 2010, the size and complexity of problem sexual abuse and intergenerational trauma became clearer to CAMHS following a number of disclosures in one of the communities. An intensive therapeutic, community-wide response was funded for about eighteen months and allowed CAMHS staff to build relationships with, educate and support families to be better able to acknowledge and respond to issues.

CAMHS and WCHN CPS received additional State funding between 2013 and June 2015 to continue to respond to the significant issues of sexual abuse allegations and sexualised behaviour in a number of the communities on the APY Lands by providing an additional 2.5FTE staffing capacity for CPS to respond to requests for forensic interviews across the APY Lands for the period July 2013 to June 2015 … "*within the context of an expanded sexual abuse and sexualised behaviour assessment and treatment service by CAMHS in three communities on the APY Lands*". The Fifth Annual Report noted in 2013 that child protection referrals on the Lands "*have continued to increase since 2009-10 with CPS participating in 143 strategy discussions in 2012-13, an increase of 22% over the previous year*".

Continued need for CAMHS on the APY Lands: 2016 to present

Despite the recommendations of the Mullighan Inquiry and the significant work done to implement those recommendations to improve the health and safety of young people on the Lands, the Report of the Child Protection Systems Royal Commission, delivered in August 2016, found "*there is no reason to believe that the incidence of child sexual abuse in the APY Lands has reduced since the APY Lands Inquiry*".[18] Further, the Commissioner, the Hon Margaret Nyland AM found: [19]

> [I]t is plain that despite significant changes to service provision since the APY Lands Inquiry, many children remain highly vulnerable and continue to experience all forms of maltreatment.

With respect to CAMHS caseload concerning child sexual abuse on the Lands, the Report of the Royal Commission noted (citing a letter to the Royal Commission from CAMHS' former Clinical Director, Dr Prue McEvoy, dated 30 November 2015):

> CAMHS does not keep records of sexualised behaviour and sexual abuse. **However, for a time in 2013/14, it categorised referrals for the presence and seriousness of sexualised behaviour. About 80 per cent of referrals involved either concerning or extreme sexualised behaviour. At that time, CAMHS had about 230 open cases**. CAMHS told the Commission:
>
> We are aware of examples where girls aged 11 having been targeted by groups of boys up to the age of 15 years, being anally and vaginally penetrated by more than one adolescent and performing oral sex on others in a single incident and boys from eight years of age having anal sex with each other. Adolescents target younger girls and boys often in group situations while encouraging younger boys to watch, hold others down or masturbate … Adolescents frequently describe peer relationships where forced sex is the norm: girls saying things like 'at least if you have a partner the others can't have you'. Our clinicians are aware of many disclosures made by victims or [their] peers of sexual abuse within family, sexual assault and rape by adults, masturbation in front of children and exposure [to children], [performing] sexual acts for drugs or being forced to participate in such behaviour after being given drugs.
> (Emphasis added.)

[17] Annual Report of the Aboriginal Lands Parliamentary Standing Committee 2018-2018, Legislative Council, Parliament of South Australia, p. 14.
[18] Child Protection Systems Royal Commission Report, "The Life They Deserve", August 2016, Part V, "Children with Diverse Needs", (**Child Protection Royal Commission Report**), p. 470.
[19] Child Protection Royal Commission Report, pg. 470.

Even more recently, the Aboriginal Lands Parliamentary Standing Committee noted that:[20]

> CAMHS staff estimate [to the Committee] that 80% of children in the APY Lands have exposure to or continue to experience problem sexual behaviour. This behaviour occurs in the context of intergenerational trauma, domestic and family violence, substance misuse, poverty and overcrowding. It is a complex interplay of trauma, neglect, abuse, peer to peer engagement and self-soothing behaviours.

Documents received by the OCP from the Department for Child Protection (**DCP**) for the purposes of this review explain that child protection notifications for children living on the APY Lands are captured in the reporting for the Far North area, which includes the APY Lands, Coober Pedy, Oodnadatta, Marla and surrounding districts.[21] The following table shows the number of screened-in child protection notifications for this area, including the APY Lands, from 2018 to present:

Financial year	Screened-in notifications
2018/2019	456
2019/2020	491
2020/2021	555

The following additional table identifies how many of the total number of child protection screened-in notifications for the Far North (including the APY Lands) were made for primary allegations of sexual abuse:[22]

Financial year	Screened-in notifications
2018/2019	50
2019/2020	56
2020/2021	45

Finally, in response to a written request for information and documents relating to the APY Lands made by the Chief Psychiatrist to the Department for Education, the Department's Chief Executive, Mr Rick Persse, emphasised to the Chief Psychiatrist the importance of CAMHS' work on the Lands:[23]

> In regard to mental health, suicidal behaviour and self-harm among children, young people and families remains a concern [on the Lands]. I have also been advised that when CAMHS staff were based on the APY Lands, they possessed deep relationships and understandings of the complexity of cultural practice, parenting capacity, self-regulation, and traumatised experiences in remote Aboriginal communities. CAMHS workers provided prevention, early intervention, and treatment services to children on the APY lands and their carers/families. Both of these elements remain key requirements.

The sum of the above history (some of which is very recent), combined with increasing rates of child protection referrals, demonstrates a high and ongoing level of clinical need for effective therapeutic mental health services for children and adolescents to address issues of abuse, including child sexual abuse – both historical and current – on the Lands.

[20] Annual Report of the Aboriginal Lands Parliamentary Standing Committee 2018-2018, Legislative Council, Parliament of South Australia, pg. 14.
[21] Letter from Ms Cathy Taylor, Chief Executive, DCP to the Chief Psychiatrist, dated 11 November 2021.
[22] Ibid.
[23] Letter from Education Department CE, Mr Rick Persse, to the Chief Psychiatrist dated 10 November 2021.

Other mental health services on the APY Lands

As mentioned above, for the purposes of conducting this review, the OCP contacted the Department for Education, the Department for Child Protection, Nganampa Health Council, Ngaanyatjarra Pitjantjara Yankunytjatjara (**NPY**) Women's Council and non-profit Skylight Mental Health (which maintains a presence on the Lands) for information regarding what mental health services, if any, their Departments and/or organisations offer to children and adolescents on the APY Lands.

In response, the OCP was informed of the following other services currently provided on the Lands:

- The Department for Education's Student Support Services Lands Team has a staffing allocation of 6 FTE. These services are provided on a FIFO basis and include speech pathology (2FTE); behaviour support coach, special educator and special educator (hearing) (3FTE); and an educational psychologist (1FTE). Relevantly, the psychologist's role is to provide consultative and educational assessments of students and service to schools; this role does not provide therapeutic mental health interventions.[24]
- Skylight has four Lands-based local staff based in Ernabella, including a team leader. The service offered is neither a traditional nor psychosocial service, and the staff are best described as support workers.
- Nganampa Health Council employs mental health nurses who link with three visiting psychiatrists for adult mental health services (two from Adelaide and one from Alice Springs). The mental health nurses and social workers are qualified, and they are mentored and trained on the Lands. They can access a psychiatrist for their patients when they need to. Dr Martin Kelly of Nganampa Health told this investigation that two clinicians on the Lands are needed to provide mental health services, and they should be full time; remote / FIFO doctors can only work if you have full time Lands-based staff.[25]
- The NPY Women's Council (**the Council**) is an Aboriginal organisation incorporated under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (Cth) with approximately 460 members. Membership is open to any women who is at least 16 years of age and who is an Aboriginal woman from the NPY region (or with sufficient cultural or family connection to the region).[26]

  The Council runs health, educational, therapeutic and support programs across the lifespan and reach almost all families on the Lands. Relevantly, these programs include a child nutrition program for growth faltering children up to 6 years, an intensive family violence service (0-17 years) which receives referrals from CPS, and a youth program (10-24 years) which adopts a holistic, multifaceted approach to working with young people, incorporating sport, recreation, case management, and work with senior Aṉangu men and women to educate young people around health relationships and lifestyles.

  The Council offers another program with a focus on evidence-based mental health and mindfulness resources, which develops and implements culturally sensitive resources to allow Aṉangu to not just understand trauma, but also how to heal from it. This program is based in a strong theoretical framework and uses a narrative therapy approach, adopted for Aṉangu culture, which has been traditionally more effective with Aṉangu children than one-to-one clinical counselling (as that term is understood in Western culture).[27] For example, the Council recently delivered a "visual meditation"

[24] Ibid..
[25] Meeting via Teams with Dr Martin Kelly in Alice Springs on 23 November 2021.
[26] NPY Women's Council Annual Report 2019-2020.
[27] Meeting with Ms Liza Balmer on 22 November 2021.

program with young children (who, due to trauma histories, are often uncomfortable closing their eyes in a group). This culturally adapted mindfulness technique produced very beneficial results for young, school-age Anangu children.[28]

REVIEW PROCESS: CONSULTATION

Stakeholder Engagement

For the purposes of conducting this independent review and to effectively respond to the three Terms of Reference, the Chief Psychiatrist sought input from a range of people and organisations involved in service delivery in the APY Lands. Invitations to meet with the Chief Psychiatrist and his staff were extended to the following:

- [redacted] CAMHS APY Lands-based social worker and Manager
- [redacted] CAMHS APY Lands-based social worker
- Dr Martin Kelly, Medical Director of Nganampa Health Council
- Mr John Singer, Executive Director of Nganampa Health Council
- Ms Liza Balmer, CEO of the NPY Women's Council;
- Ms April Lawrie, Commissioner for Aboriginal Children & Young People
- Dr Roger Thomas, Commissioner for Aboriginal Engagement
- Ms Tanya McGregor, Director of Aboriginal Health, DHW
- Dr Prue McEvoy, DCP (formerly, Clinical Director of CAMHS)
- Dr Jon Jureidini, Child and Adolescent Psychiatrist
- Mr Paul Creedon, Skylight Mental Health
- Dr Adriana Lattanzio, Rural and Remote Mental Health

Of those persons listed above, the Chief Psychiatrist and his staff consulted (either in-person or via video conference) with all but Mr Singer of Nganampa Health who was unavailable and, due to time limitations, the OCP was unable to speak with his suggested delegate. The Chief Psychiatrist and one staff member also met with CAMHS leadership, Dr Mohammed Usman, Clinical Director, and Fiona Margrie, General Manager of Community, Primary and Population Health at WCHN on two occasions.

Time limitations for this review necessarily impacted the extent of consultation possible, and it is acknowledged that further consultation, including with those persons listed above as well as APY Lands communities and people with lived experience, may be warranted and necessary in the future.

The content of each consultation discussion was primarily focused on determining the current level of clinical need on the Lands, what existing mental health and wellbeing services are available, views on the existing CAMHS service and planned IMOC, and what else may be required to best support the mental health needs of children and adolescents on the Lands, including those with complex trauma histories. Additional service-based questions, primarily related to administration, training and record-keeping of case notes, were also directed towards current and former CAMHS staff.

A copy of the consultation questions which informed stakeholder meetings is **Attachment 4.** (These questions were a guide. Not all questions were asked of all parties, and in depth questions originally prepared on administration and record keeping were not used as the interviews focussed more on referrals and the questions in earlier sections.)

[28] Meeting with Ms Liza Balmer on 22 November 2021.

Key Themes From Consultation

The following key themes arose over the course of discussions with the stakeholders listed above. Stakeholder comments have been anonymised, except where otherwise stated, in which case permission for attribution was obtained.

1. There is a need for Lands-based clinicians to support a FIFO model

In particular, given the geographic size of the Lands, a suggestion was made that two Lands-based teams are required to service the East and West of the APY Lands. The investigation heard that the referral system "does not work" on the Lands, and that CAMHS clinicians have historically needed to drive to communities to proactively seek out cases. This both underscores the importance of having clinicians on the Lands, and the need to limit the geographic distance each team of clinicians must drive to reach these cases.

[redacted] CAMHS Manager and Lands-based clinician, explained that developing trust with local Anangu takes a long time and this requires ongoing contact and repeat visits; CAMHS credibility in the community stemmed from their on-the-ground work.[29]

Ms Liza Balmer, the CEO of the NPY Women's Council, also emphasised that it is very difficult (if not impossible) to build sufficient trust to receive disclosures of abuse from children with a FIFO model and noted language is a significant barrier for FIFO clinicians. Ms Balmer said that it was "the informal nature of what [CAMHS Lands-based staff] offered" that has historically been the most beneficial element of the CAMHS APY service:[30]

> Children and young people felt very comfortable with them. Often the reason they would receive disclosures is because they a provided safe place for kids to go. That part is really important. [But] there is also a need for more specialist therapeutic interventions, so we don't continue to see the passage of intergenerational trauma continuing.

Ms April Lawrie, Commissioner for Aboriginal Young Children and Young People visited the Lands in June 2021. Having previously worked in Aboriginal health for many years, she was aware of the CAMHS program and observed that that it has taken several years for the trust and relationships to develop between the Community and the two CAMHS workers, and upon her June visit it was apparent to her that the planned changes to the CAMHS services worried and concerned Anangu families and youth.[31] The Commissioner also noted that it is unfair that any decision to move from an on-Lands service to a FIFO service had been made without informing Anangu of the reasons for the change or what the new plan is.

We heard there was a need for two CAMHS workers on the Lands, and that these workers had been needed since July.

The most common view put forward was that FIFO has a significant role, but benefits from support from residential staff as well as Malpas. The limited role of telehealth was also noted because of the difficulty establishing relationships and rapport this way.

[29] Meeting with [redacted] on 19 November 2021.
[30] Meeting with Ms Liza Balmer on 22 November 2021.
[31] Meeting with Ms April Lawrie on 19 November 2021.

2. There remains significant unmet need for child and adolescent mental health services on the Lands

Dr Roger Thomas, South Australian Commissioner for Aboriginal Engagement noted the current high level of urgency needed in delivering services to the community required for the safety, wellbeing and mental health of children on the Lands.[32]

Ms April Lawrie said that the need had been clearly established, and the recommendations from the Nyland Royal Commission and the Mullighan Inquiry would still inform the need and approach today.[33] She, like others, noted the gaps that existed with the level of need, even when the two Lands-based workers were present. This includes a geographic gap, as the CAMHS service was not able to cover every community, and the need to cover the sheer level of clinical need. She said that the APY warranted a dedicated service by virtue of the number of mental health concerns on the Lands that go mostly unreported.

[redacted] described the challenge of responding to the need with the limited staffing.[34] This is reflected in the high numbers of clients. It could take up to three school terms to get to know some families and therefore complete an initial assessment. She estimated that at any time there would be a third of the clients on the book with whom they were actively working, a third who were in effect on a "waiting list", and another third with whom they were not actively engaging – they could attend the clinic, or were being referred to the NDIS. This situation became more difficult in 2020 when it was no longer possible, due to staffing and workload, to maintain regular visits to the East and the West, although extra visits were made to Indulkana and Mimili to respond to concerns of sexual assault and suicidal ideation. Additional staffing would allow smalls teams (of two clinicians) to go East and West, which is a model that has worked in the past.[35]

It is clear that all stakeholders, including WCHN and CAMHS, agree there is significant unmet need for services on the Lands. Of this issue, Dr Martin Kelly of Nganampa Health said:[36]

> [T]here are acute and urgent mental health problems on the Lands, [including] adolescents with acute psychotic illness … Child abuse and witnessed violence are a big part of many children's lives. Many have behavioural difficulties with psychiatric pathology, which are not being addressed by psychiatrists at the moment. A small proportion come to the attention of visiting paediatricians, managing ADHD with stimulant medication treatment or foetal alcohol syndrome. Schools [also] don't have enough support workers to assist with these kids … There are vulnerable people, an increase in personality disorders, depression, PTSD. They need care and it needs to start with adolescence. The majority of psychiatric illnesses start in adolescence.

3. The IMOC will be beneficial if it leads to increased collaboration between services and a clearer distinction of roles: the role of CAMHS clinicians providing therapeutic services on the Lands must be separate and distinct from the role of CPS.

The investigation was told that it was not uncommon for Aṉangu people to be wary of, or unwilling to seek clinical help from, CAMHS clinicians out of fear their children would be taken away. The investigation heard there is a need for CAMHS' role to be more clearly defined in the community, and that this role must be distinct from CPS. This sentiment was supported by [redacted] who told the investigation that part of the challenge for CAMHS clinicians

[32] Meeting with Dr Roger Thomas on 22 November 2021
[33] Meeting with Ms April Lawrie on 19 November 2021.
[34] Meeting with [redacted] on 19 November 2021.
[35] Meeting with [redacted] on 19 November 2021.
[36] Meeting via Teams with Dr Martin Kelly in Alice Springs on 23 November 2021.

in building trust with Anangu was reassuring the local community they were “not welfare”, and that this process can take many visits.[37]

In general, sentiment toward the proposed IMOC was positive, and it was agreed that an integrated service that addresses multiple areas of community need, including mental health, is required. However, it was also suggested that resources for clinical service provision should be directed towards Aboriginal Community Controlled Health Services, which are “on the ground and community-led”.

4. **Engagement on the development and implementation of the IMOC should occur with Anangu. A number of community stakeholders were suggested.**

To facilitate further consultation, it was suggested that consulting with a handpicked, select group on the APY Lands who are engaged with the topic would be beneficial.

Another suggested involving a number of people who could assist in drawing the community together and, in particular suggested the Regional Anangu Services Aboriginal Corporation (RASAC) and APY Executive Council.

Ms April Lawrie commented on her June 2021 Youth Engagement Forums across the Lands schools. The Commissioner spoke with Anangu children and with young Anangu men and women who indicated it was the first time anyone had asked for their opinion about what was important to them and what may work well for them. In two separate communities, the Commissioner heard a sense of abandonment voiced amongst some Anangu youth with changes in the way service run and the changes in workers.[38]

The review heard that Anangu elders also need to be engaged about what they want and need in their communities, and this cannot be presumed.

WCHN and CAMHS indicated that consultation is ongoing, particularly with the APY Executive Council, and that additional consultation with Anangu community and lead Malpas was planned for late 2021 and early 2022.

CAMHS ON THE APY LANDS

CAMHS APY: Historical notes

In response to a request from the Chief Psychiatrist for documents relating to the planning, performance and review of the CAMHS services on the Lands, WCHN provided this review with quarterly project and budget reports for the KATU (CAMHS APY) program dating from 2010 to 2020.

While it does not assist in answering the Terms of Reference to relay these reports in full, the following key points provide some context and assist in identifying key challenges and advantages of the CAMHS APY service as it has been at various times since its inception in 2010:

- Staff recruitment to clinical positions (particularly Lands-based roles) is extremely challenging. For example, the CAMHS Lands-based service began in July 2010 with one Lands-based worker after recruitment for the second position was unsuccessful. This second clinical position was not filled until July 2012, and this successful recruitment was possible due to the applicant’s pre-existing familiarity with the Lands. A report dated 17 October 2012 notes, *“[The new clinician’s] previous experience with*

[37] Meeting with [redacted] on 19 November 2021.
[38] Meeting with Ms April Lawrie on 19 November 2021.

the APY Visiting Service and the Amata Response project enabled a seamless transition into her new role as a Lands-based clinician and manager".[39]

It is apparent that one factor affecting the ability of CAMHS to employ and retain Lands-based staff is the psychological impact on APY staff of living and working on the Lands, particularly the impact of regular exposure to traumatic incidents and violence. WCHN also provided the OCP with a July 2020 Risk Assessment document which describes the risk to staff due to "*frequent and unpredictable exposure to trauma and violence, including but not limited to, attempted hangings and violence between community members, without an appropriate mechanism for systematic debriefing*".[40] The inherent risk rating (the rating if no controls are in place) is assessed as "Extreme" with "almost certain" consequences. The WCHN Risk Assessment recommends, in addition to enhancing communications infrastructure and debriefing systems, changes to both funding models and recruitment processes. Specifically, the historical cyclical funding model, which did not offer permanent employment positions, for CAMHS APY "*limits the pool of potential applicants therefore limiting the ability to attract the most suitable candidates*", with applicants who often have no training or experience working in remote areas with direct exposure to trauma and violence.[41]

Recommendations include supporting CAMHS to recruit beyond government, seeking exemptions to current recruitment methodology to require potential employees travel to the Lands for a weeklong orientation prior to contract-acceptance, and including additional recruitment strategies to identify high levels of resilience.[42] It is notable that the Lands-based Manager/clinician role successfully filled in July 2012 was with a person [redacted] with pre-existing experience on the Lands.

- The Lands-based clinicians played important roles in developing relationships with local communities, including to develop a local Aṉangu workforce and more culturally appropriate therapeutic practices (the "KATU CAMHS APY Lands Therapeutic Model", described further below) to convene community meetings, and to engage with Aṉangu Elders regarding CAMHS role on the Lands. These clinicians also regularly conducted training with teachers and students at local schools, in addition to ongoing clinical outreach to young people on the Lands.[43]
- As recently as 2015, three CAMHS programs were operating on the Lands: (1) The CAMHS APY service (including the Lands-based clinicians), (2) the Visiting Service (funded by Closing the Gap to provide a Drive-in-Drive-out service three times per school term), and (3) the Problem Sexual Behaviour (**PSB**) Program. The PSB program was established in October 2013 and staffed with a half-time coordinator (one of the Lands-based clinicians), four clinicians (three FIFO based in Adelaide to visit Amata and Ernabella fortnightly, with the other to be based in Marla).[44] It is apparent that ongoing challenges associated with staff retention and funding meant that at various times each of these CAMHS APY programs had staff vacancies.

It is noted that the last of these quarterly reports, dated 23 July 2020, includes comments that clinical services have been reduced due to COVID-19 flight restrictions (meaning FIFO services did not occur) and long-term sick leave of one of the Lands-based clinicians. It is

[39] Report titled "COAG – Indigenous Health National Partnership Agreement: Healthy Transition to Adulthood – CAMHS in APY Lands", Appendix A, Jan-March 2013, dated 17 October 2012.
[40] WCHN document, Risk Assessment, Issue/Risk 7841, dated July 2020.
[41] Ibid, pp.4-5.
[42] Ibid, p.6.
[43] See Reports titled COAG – Indigenous Health National Partnership Agreement: Healthy Transition to Adulthood – CAMHS in APY Lands", Appendix A, from April 2010 to 2016.
[44] See Report titled COAG – Indigenous Health National Partnership Agreement: Healthy Transition to Adulthood – CAMHS in APY Lands", Appendix A dated 1 November 2013.

noted that one FIFO position remains vacant and *"[i]nsecure funding continues to impact on recruitment and retention for both Aṉangu and clinical staff. CAMHS was only advised in May 2020 that funding had been committed for a further year for 2020-21*."[45]

In an interview with the Chief Psychiatrist, [redacted] CAMHS' Lands-Based Manager, explained that every year, around mid-June, CAMHS' staff would begin the school holiday leave period unsure of the tenure of the job they would return to in the new financial year once Closing the Gap funding was re-allocated.[46] [redacted] said that each year staff would be assured of employment until Christmas but beyond that was unknown, and this uncertainty was not good for the Community or the staff themselves.[47]

The staffing challenges identified above reflect a significant component of why WCHN has "struggled to implement a sustainable model" of care on the APY Lands, despite providing services for over 10 years.[48] It is due to the deemed unsustainability of the current WCHN CAMHS APY model that has led to the development of the proposed integrated model of care (IMOC).

The Integrated Model of Care

SA Health, through WCHN, delivers other specialist services to children on the APY Lands through Child and Family Health Services (CaFHS) and Child Protection Services (CPS).[49] CaFHS provides nursing and support services for children under five, including developmental health checks, education and nutritional advice on a FIFO basis. It is understood there is an accepted need to enhance this service delivery, however, the service is currently on hold pending the development of the proposed IMOC. Currently, to the knowledge of the OCP, CaFHS are not providing a service in the APY Lands.

CPS psychologists, social workers and medical officers provide therapeutic work, training and consultation, and forensic psychosocial assessments of young children aged below 12 years where there are concerns about sexual abuse and/or neglect. CPS receives referrals from SAPOL and DCP and its services are delivered to the APY Lands community on a FIFO basis.

In order for CAMHS to transition away from Closing the Gap funding (2019/20 funding was $926,000) to core funding, WCHN are developing an integrated model of care that proposes a new way forward to integrate the three health services (CAMHS, CaFHS and CPS) it currently provides to the APY Lands. It is understood this integrated model would seek to coordinate all services into an integrated unit, under the governance of CAMHS. It is understood the model seeks to enhance partnerships, build the capacity of the local APY community and deliver efficiencies in providing services to such a remote community.

The OCP was informed that, as at July 2021, WCHN had developed a business case to secure budget for this integrated model of care for the APY Lands, and the Department has confirmed funding for the 2021-22 financial year, while recurrent funding is confirmed. It is not anticipated there should be any interim loss in positions or services over the coming year.

WCHN provided the OCP with a document titled "DRAFT APY Lands – Integrated Model of Care", marked Version 20 and dated September 2020. It is relevant to the Terms of Reference to consider what is proposed by the IMOC – including its intended purpose, aims, governance model and staffing – and this is done below. However, the OCP has more recently been

[45] Half-yearly report titled "Closing the Gap in Aboriginal Health Outcomes: KATU (CAMHS APY)", Appendix B dated 23 July 2020.
[46] Meeting with [redacted] on 19 November 2021.
[47] Meeting with [redacted] on 19 November 2021.
[48] Draft IMOC, p.23.
[49] CAMHS Model of Care, 'Who we are and what we do', 2016

informed by CAMHS and WCHN that, following a visit to the Lands in early 2021, thoughts surrounding the proposed direction of the IMOC have now changed. While the WCHN working group tasked with developing the draft IMOC will not meet again until mid-December 2021, it is understood that the new direction being taken is focused on Lands-based care being delivered by a local Anangu workforce and will move away from CAMHS clinical staff being on-Lands.

The comments which follow are, therefore, made with respect to the draft IMOC in its present, documented form, and the OCP recognises that some elements may be subject to considerable change in the near future, particularly those that concern Lands-based staffing. As a consequence, this review cannot comment conclusively on the benefits or otherwise of the IMOC as its final form is still being developed by WCHN.

First, it is apparent that the draft IMOC (in its present iteration) recognises that, as a result of significantly reduced social determinants of health on the APY Lands (compared to the rest of South Australia as a whole) and the collective and cumulative burden of historical and intergenerational trauma, the Aṉangu people on the APY Lands are at greater risk of adverse health outcomes, including mental health outcomes. In particular, children are at greater risk due to the small size of the communities, lack of housing and/or overcrowding and the capacity of parents and the community to protect children and young people given their own experiences of abuse and trauma.[50]

Second, the overriding purpose of the IMOC is to see the development of a coordinated, multi-focused clinical team comprising three designated areas: (1) child and family health/developmental support (CaFS); (2) child and adolescent mental health assessment and intervention (CAMHS); (3) assessment and intervention in relation to child protection concerns (CPS).[51]

Third, the expressed aims of the IMOC include:[52]

- to build on "*KATU CAMHS APY Lands team's established relationships and trusted culturally appropriate service delivery*", with a set KPI to measure this level of trust as being community referrals to the IMOC services at or above 70%.
- to provide specialist clinical services and integrated care as "value adds" and not as a duplication of the work occurring in other organisations, such as Nganampa Health and NPY Women's Council.
- to build the capacity of and partner with the Aṉangu community to support community-based responses. The IMOC notes, "*[t]here has been considerable work by the current WCH CAMHS team in developing and supporting the Anangu workforce … the APY IMOC supports further development … towards a sustainable community-based response*". An "immediate and medium term" deliverable of this aim includes building the capability of Nganampa Health and NPY Women's Council to "*deliver priority child and family health supports that would enhance their own service delivery to families on the APY Lands*".

Fourth, and with regards to operational governance, the draft IMOC notes this will be co-led between "the Cultural Leader (likely to be Adelaide-based with FIFO arrangements) and the CAMHS Manager (currently Lands Based with FIFO)".[53] Local level and WCHN governance of the IMOC will be achieved through the development of an APY Lands Steering Committee,

[50] Draft IMOC, p.5.
[51] Draft IMOC, p.9.
[52] Draft IMOC, p.11.
[53] Draft IMOC, p.17.

to include Aṉangu community and local level key service providers. This Committee will report to the CAMHS Divisional leadership Committee.[54]

Regarding staffing, the IMOC (as presently drafted) is predicated upon the existence of both Lands-based and FIFO staff. With regards to the latter, the IMOC notes that, given geographic size of the Lands:

> [A]ccess to this area is most efficiently achieved by air travel followed by driving to the APY Communities on unsealed roads in properly equipped vehicles. This requires staff, not residents of the APY Lands, to participate in a FIFO schedule.[55]

For CAMHS-specific staff, a draft staffing plan is included:[56]

- 0.3 FTE Psychiatrist FIFO
- 1.10 FTE AHP4 Lands Based Clinical Lead
- 1.00 FTE AHP3 Lands Based Senior Clinician
- 1.0 FTE AHP3/RN3 FIFO clinician
- 1.0 FTE AHP2/RN2 FIFO Clinician

The IMOC envisages all FIFO team clinicians will meet with APY Lands based staff to receive updated local information. It is also intended the schedule of the FIFO visiting team will be expanded to support service delivery during the school holiday periods, and will "*work to ensure service provision provides access to the eastern, central and western aspects on the APY Lands on a regular basis*".[57] The draft document does not currently explain how it is envisaged this will occur. The capacity building of the Aṉangu and Aboriginal workforce is a focus of the IMOC, and Appendix 2 details the proposed expanded role of the Malpa workforce, including the appointment of a lead or senior Malpa role to "provide overall advice and leadership, ongoing support and supervision for the Malpa workforce".[58] It is envisaged the IMOC will support the specific employment of Aboriginal staff in both administrative and clinical roles to over 50%.[59]

As noted above, it is understood these details with respect to proposed CAMHS staffing are now outdated and CAMHS does not intend the final IMOC will include Lands-based roles for CAMHS clinical staff, focussing instead on developing the therapeutic and administrative capabilities of the local Anangu workforce who, CAMHS acknowledge, require further training in these areas to be able to provide this service with support from FIFO CAMHS clinicians.

With respect to this element of the proposed new direction of the IMOC, it is difficult for the OCP to comment on its merits without reviewing a detailed, documented plan, and speaking directly with the Malpas themselves. However, in the usual course, it would be expected that there would be substantial training, support and on-Lands mentorship to oversee the supplementation of the Anangu workforce's existing critical roles with new roles. These existing roles encompass cultural supervision and education of clinical workers, the provision of community therapy approach alongside clinicians and they are the facilitators of community engagement. Potentially with this proposal they would then also be offering an on-site crisis response and administrative presence for CAMHS in lieu of, and not alongside, Lands-based clinical staff. If this is to occur, this would seem to be a more natural development from the pre-existing service structure (featuring at least two Lands-based clinicians), rather than a direct replacement of it.

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[54] Draft IMOC, p.18.
[55] Draft IMOC, p.18.
[56] Draft IMOC, Appendix 3.
[57] Draft IMOC, p.18.
[58] Draft IMOC, Appendix 2.
[59] Draft IMOC, Appendix 2.

Finally, the IMOC notes that some consultation between WCHN and the Aṉangu community with respect to service delivery and the development of the IMOC, occurred at Ernabella on 26 August 2019 in the form of a focus group. Earlier, in 2016, CAMHS had established an Aṉangu Steering Committee with "*representatives from across all Communities and Non-Government Organisations on the APY Lands*". With 20-30 representatives that continue to meet quarterly, the purpose of the committee is to improve children's safety and wellbeing outcomes.[60] The IMOC states this Steering Committee was consulted on the development and design of the IMOC but does not state when this consultation occurred.

Relevantly, it was apparent that the NPY Women's Council has not been involved in the development of the IMOC, and the Women's Council is not a member of the Aṉangu Steering Committee. This is notable because the IMOC recognises the importance of developing service delivery in conjunction with Nganampa Health and the NPY Women's Council and, in fact, key aims and KPIs of the IMOC are premised upon the involvement of these organisations.[61] To this end, CAMHS informed this investigation that CaFHS will be overseeing consultation with the Women's Council into the future, due to an existing working relationship.[62]

As neither of CAMHS's pre-existing Lands-based social workers [redacted] are currently on the Lands – and it is unknown to the OCP if and when these workers will return – it is also notable that the IMOC (as presently drafted) appears to be premised on at least one of these two social workers (likely the Manager, [redacted] returning to the Lands. It is these two social workers who have the longstanding trust and relationships with the community that are referred to throughout the draft IMOC. As the OCP has heard multiple times over the course of this review, the "CAMHS" acronym is without meaning to the local Aṉangu people. The "established relationships and trust" upon which the IMOC is premised[63] lies with the individual social workers, not with the CAMHS APY organisation itself. In contrast, this review heard that staff of Lands-based Aboriginal Health Organisations, such as NPY Women's Council, "have a 50% head start" in developing relationships on the Lands simply by association with these trusted organisations.

CAMHS APY Data: referrals and client contacts

Referrals to CAMHS APY Lands: October 2020-21
Using data extracted from CBIS by the Information Management & Performance Monitoring Unit (IMPMU) and provided to an OCP safety quality officer, an analysis of referrals made to CAMHS APY over the preceding 12 months was conducted:

The CBIS record of each referral was reviewed for quantitative and qualitative information which was gathered in relation to each referred client.

The information collected comprised of client demographics, referral reason, referral source, referral acceptance or non-acceptance, mention of current or historical alleged CSA and/or PSB, and follow-up services provided by the CAMHS APY Lands workers.

<u>Dates of Referrals</u>

[60] Draft IMOC, p.8.
[61] Draft IMOC, p.21 See, e.g., the KPI of building a broad Anangu workforce in the immediate and medium term is measured by an "identified increase in Nganampa Health Service and/or the NPY Women's Council service delivery".
[62] Meeting with Ms Fiona Margrie and Mr Mohammed Usman of CAMHS on 1 December 2021.
[63] Draft IMOC, p.11 See, e.g., Aims of the model 6.1, "Using KATU CAMHS APY Lands team's established relationships and trusted culturally appropriate service delivery as the platform, the APY IMOC will strengthen families and build community capacity to achieve the vision…".

- ranging from February 2020 to August 2021
- entered into CBIS 1 Oct 2020 to 28 October 2021

Number of Referrals

- Total referrals = 106 (involving 101 children)
  - Accepted = 15 (14%)
  - Not Accepted = 62 (58%)
  - Unknown status 29 (27%)
    - No referral action = 7
    - Current consumers / open episodes (but have no listed contacts) = 4

Current consumers (open episodes) as of 4 Nov 2021 from the 106 referrals above = 13.

Children Age Range (as of 4 November 2021) – grouped by 3 years

Age Range	Number	Percentage
0-2 yrs	16	14.8
3-5 yrs	24	22.2
6-8yrs	15	13.9
9-11yrs	14	13.0
12-14 yrs	18	16.7
15-17yrs	19	17.6
18 yrs	2	1.9
TOTAL	**108**	**100**

Locations/Communities

Location	Number	Percentage
[redacted]		
TOTAL	**106**	**100**

Referral Source

Referral Source	Number	Percentage
Family	41	38.7
DCP	20	18.9
School	17	16.8
SAPOL	9	8.5
NGO	5	4.7
WCH Mallee Ward	3	2.8
WCH ED	2	1.9
Child Protection Agency	3	2.8
Aboriginal Health Service	2	1.9
Friend	2	1.9
Community member	1	0.9
Self	1	0.9
TOTAL	**106**	**100**

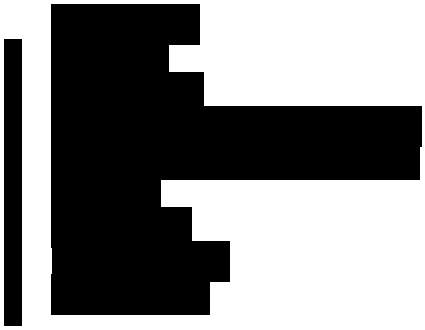
Reasons provided for Referrals Not Accepted:

- Child and/or family moved outside of APY Lands = 15
- Child placed into care outside of APY Lands = 13 (1 child had 3 referrals)
- Concerns resolved = 13
- Other agencies involved, MH no longer required = 8
- Child placed into care with other family / no further concerns = 5
- Reason unclear = 5
    - "No Planned Visits to Indulkana 20/21 Fin year due to resources" = 1 [redacted]
    - "CAMHS unable to follow up as no service on lands due to COVID restrictions" = 1 (388913)
- Parents (or older teen) challenging/difficult to engage = 3

Mention of current or history of alleged child sexual abuse and/or problem sexual behaviour

- 23 referrals (22%) involving 21 children
- Ages:

- Loc tions:



- Referral status:
    - Accepted = 4
    - Not accepted = 10
        - 7 of the 10 had follow-up/contact entries documented in the Referral Comments section
    - Unknown status = 9
        - 3 of the 9 had follow-up/contact entries documented in the Referral Comments section

Follow-up / Contact documented in Referral Comments Section:

- Many referrals that were 'Not Accepted' or status 'Unknown', had multiple entries of follow up completed with family/child/agencies that would normally (should be) entered as contacts under an Open Episode. However, it appears to be the practice of this service to enter this information in the Referral Comments section of CBIS (see example in Figure 1 below).
- This means that some referrals were accepted in principle where the child/family had follow-up, contacts, meetings/liaising with other agencies, etc, but this work has not been captured in a CBIS 'episode' of care (as a current consumer) as a participating or non-participating 'contact', and then these referrals were then 'not accepted' or left marked 'unknown'.
- 44% of referrals (47 of the 106 referrals) had documented evidence of CAMHS follow-up and/or contact with family/child/agencies that has not been captured in an open episode as a contact.
- There was a total of 155 follow-up/contact entries documented in the Referral Comments section for the 47 referrals, with a range of 1-14 per referral, and an average of 3.3 entries per referral.
    - Not accepted:
        - 52% of the Not Accepted referrals (32 of 62) had a total of 114 follow-up/contact entries (range 1-14 per referral) documented in the Referral Comments section.
    - Unknown status:
        - 31% of the Unknown status referrals (9 of 29) had a total of 25 follow-up/contact entries (range 1-6 per referral) documented in the Referral Comments section.
    - Accepted:
        - 33% of the Accepted referrals (5 of 15) had a total of 16 follow-up/contact entries (range 1-7 per referral) documented in the Referral Comments section, which were additional (different dates) to the follow-up/contact entries documented in the Open Episode section

Follow-up / Contact documented in Open Episodes (from accepted referrals)

- 15 referrals were accepted (of the 106).
- There was a total of 143 follow-up/contact entries documented in the open episodes, with a range of 0-51 entries, and an average of 9.5 entries per episode.
- These entries are captured in the CBIS contact data.

System gap found

- 18yo male. [redacted] Referral not accepted due to age. Plan to handover to adult services. No referral to adult services. [redacted]

An extract of a clinical record illustrating the significant contacts that can occur in the referrals section of the record is on file with this report in the OCP, but not included in this final report as it might identify individuals.

CAMHS APY Lands Client Contacts: 2008-2020

Using data provided to the OCP by WCHN, an analysis was conducted of the number of APY Lands clients receiving services from CAMHS between 2008 and 2020.

Most recently, CAMHS contacts were recorded in the APY Lands under two teams in the CBIS records, APY Lands Team and APY Lands Guardianship Team. The Guardianship team records began in 2014.

'Services' is a term used to describe follow-up or contacts with the client, family or other agencies that is provided by the CAMHS workers, and are individually counted in CBIS as 'participating' services (with the client) or 'non-participating' services (with family or others agencies).

CAMHS APY Lands Team

The number of clients who received services from the APY Lands Team from 2008 to 2020 ranged from 73 to 363 children per year, with an average of 252 children per year.

The number of total services provided by the team per year ranged from 152 in 2008 to 8,019 in 2014, with an average of 2,619 services provided per year. This consisted of an average of 802 participating services and 1,625 non-participating services per year.

The average number of services provided per client ranged from 2.1 services in 2008 up to 22.1 services in 2014.

CAMHS APY Lands Guardianship Team

The number of clients who received services from the APY Lands Guardianship Team from 2014 to 2020 ranged from 1 to 13 children per year, with an average of 4 children per year.

The number of total services provided by the team per year ranged from 12 in 2014 to 94 in 2019, with an average of 50 services provided per year. This consisted of an average of 21 participating services and 29 non-participating services per year.

The average number of services provided per client ranged from 5.8 services in 2020 up to 33.0 services in 2016.

Overall more children were seen with more contacts per child five to six years ago. While this has not been correlated with staffing levels, we understand that the higher contact levels occurred when extra staff were available. As noted in previous sections we do not consider that the need for services have dropped so the reduction in numbers and clients is a trend that should be addressed. This reduction would now be even more dramatic since mid-2021, and the loss of the on-Lands services.

Chart 1: APY Lands Number of Clients Receiving Services by Team by Year

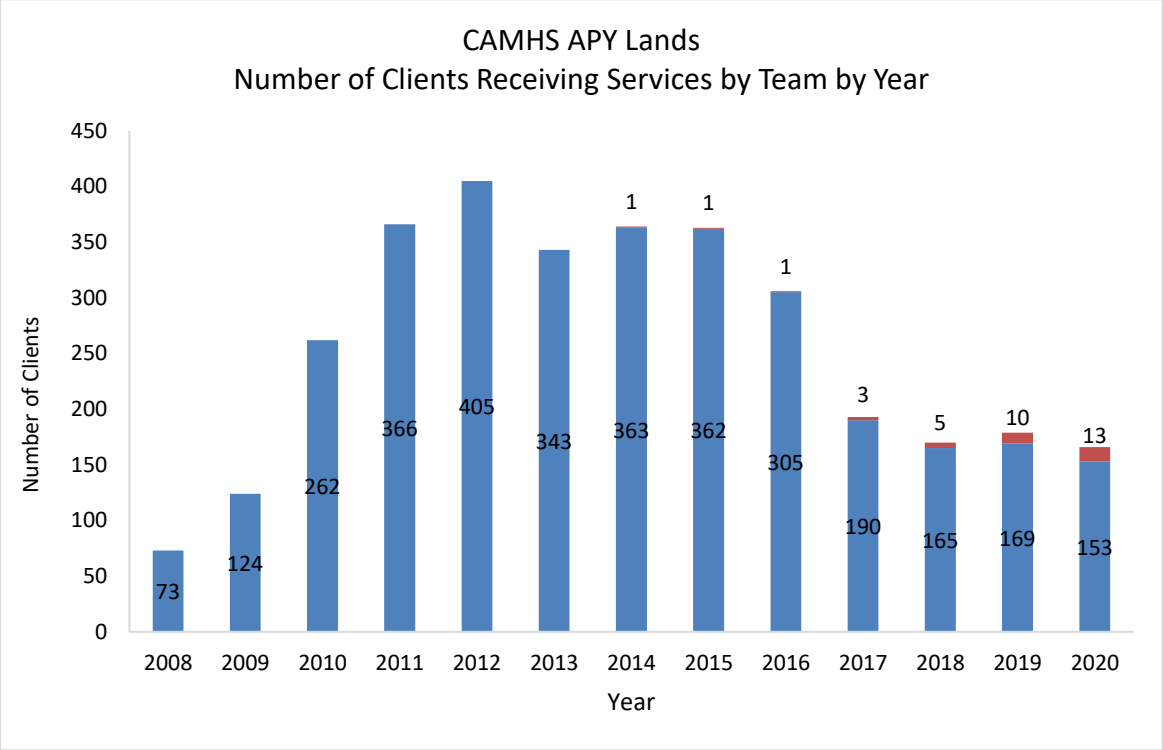
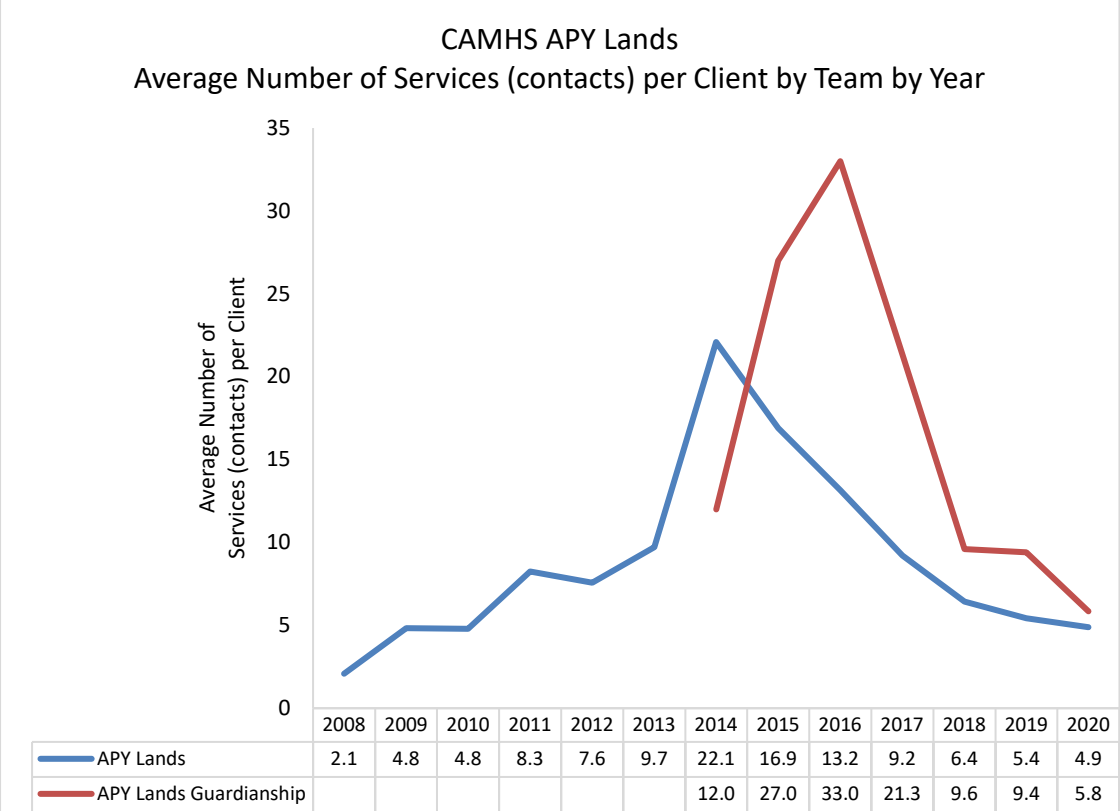
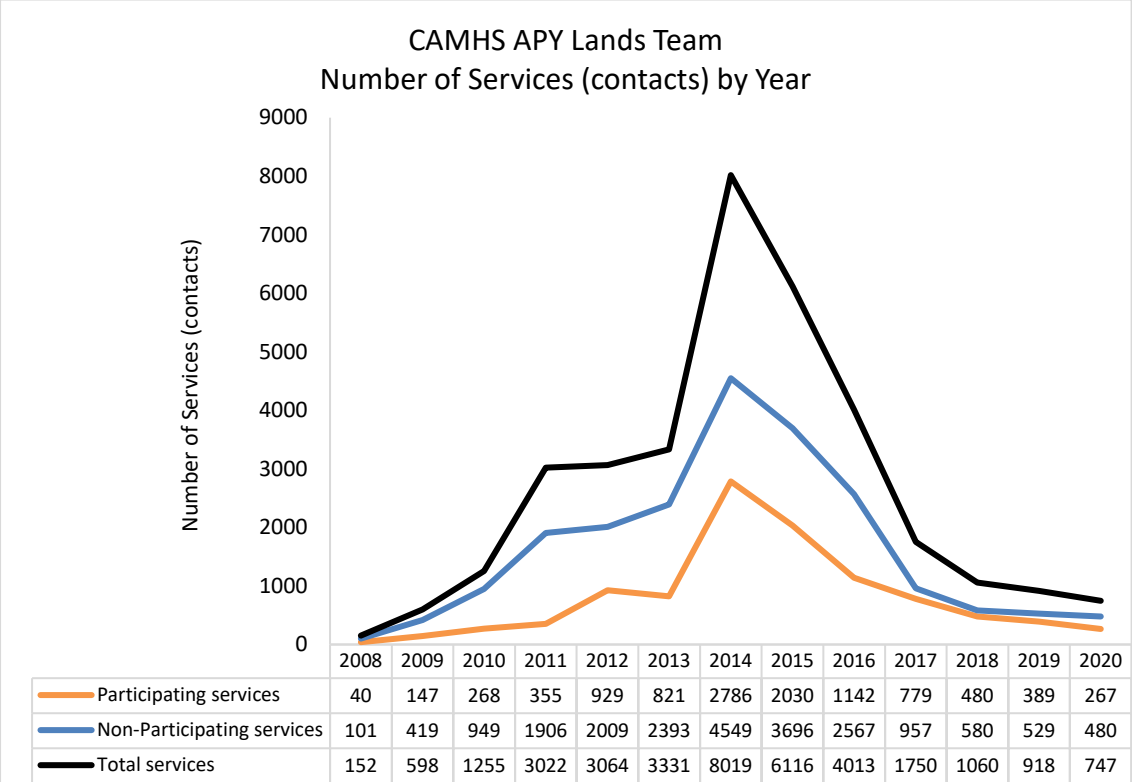


Chart 2: APY Lands Average Number of Services per Client by Team by Year



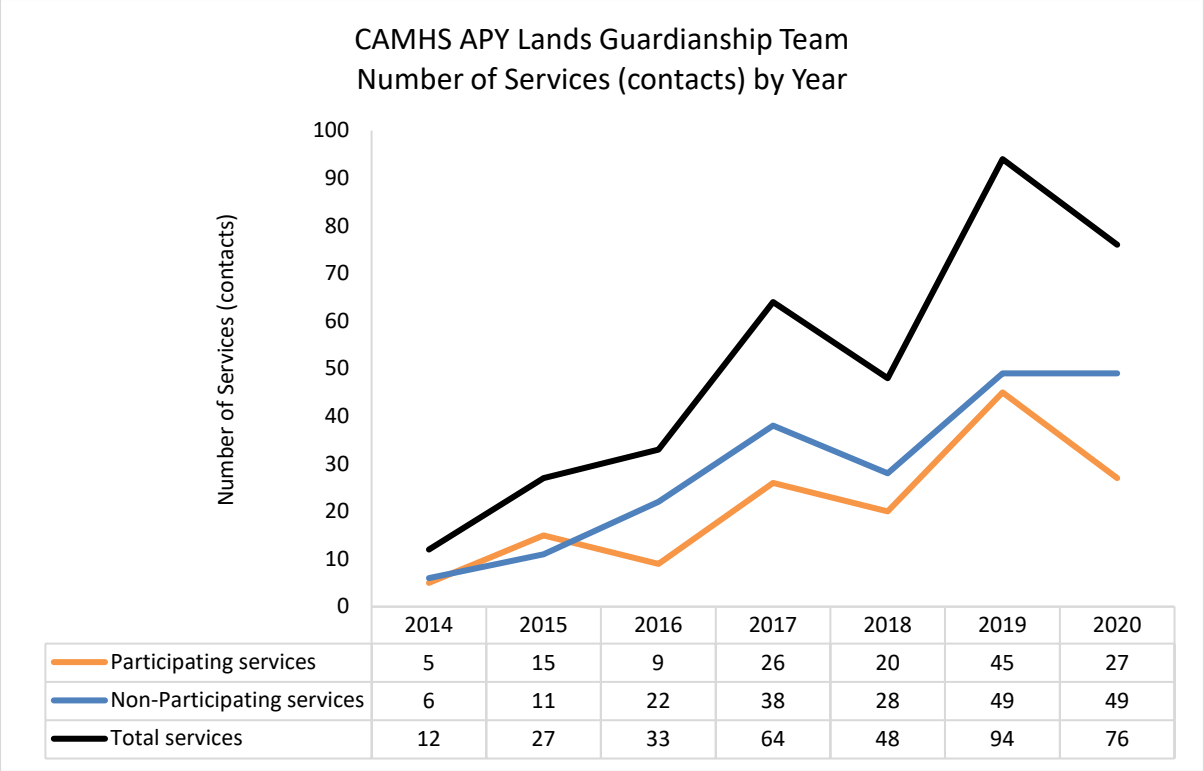
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
APY Lands	2.1	4.8	4.8	8.3	7.6	9.7	22.1	16.9	13.2	9.2	6.4	5.4	4.9
APY Lands Guardianship							12.0	27.0	33.0	21.3	9.6	9.4	5.8

Chart 3: APY Lands Team Number of Services (Contacts) by Year



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Participating services	40	147	268	355	929	821	2786	2030	1142	779	480	389	267
Non-Participating services	101	419	949	1906	2009	2393	4549	3696	2567	957	580	529	480
Total services	152	598	1255	3022	3064	3331	8019	6116	4013	1750	1060	918	747

Chart 4: APY Lands Guardianship Team – Number of Services (contacts) by Year



	2014	2015	2016	2017	2018	2019	2020
Participating services	5	15	9	26	20	45	27
Non-Participating services	6	11	22	38	28	49	49
Total services	12	27	33	64	48	94	76

Chart 5: APY Lands Team Number of Clients Receiving Services by Age Group

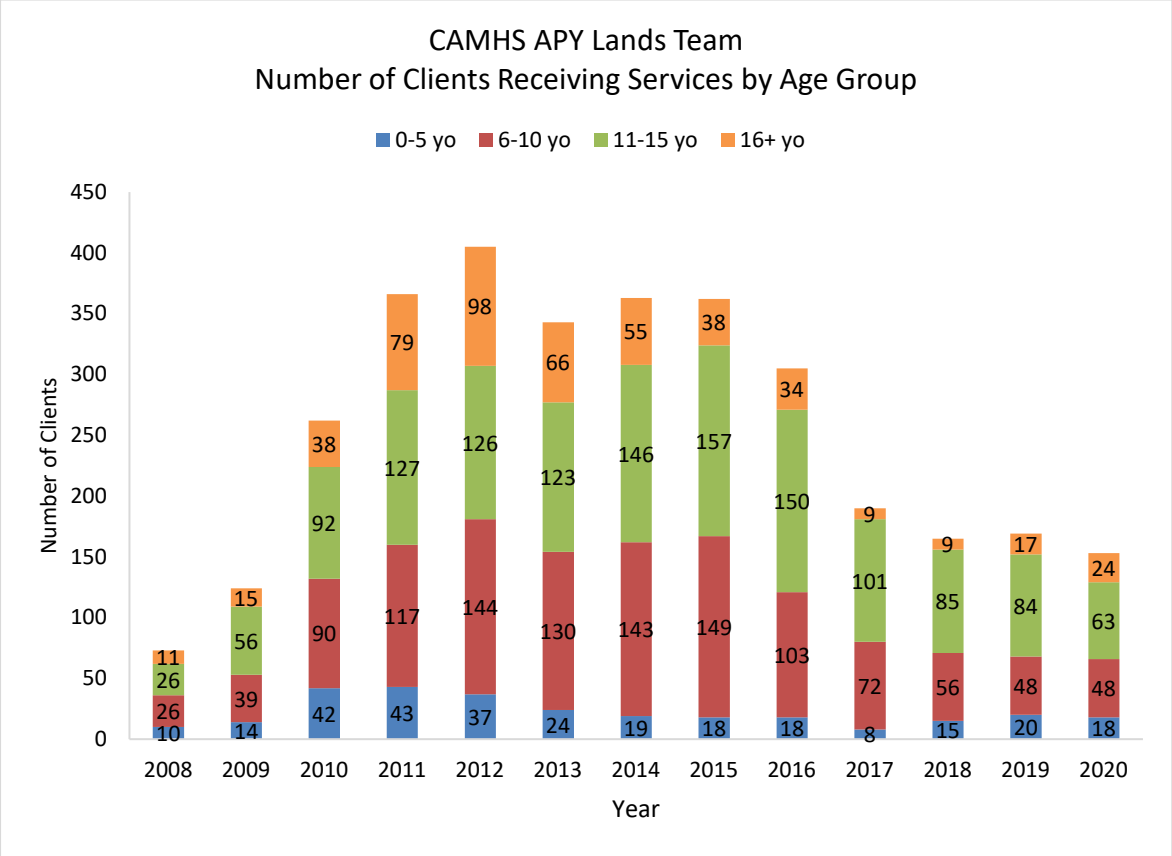
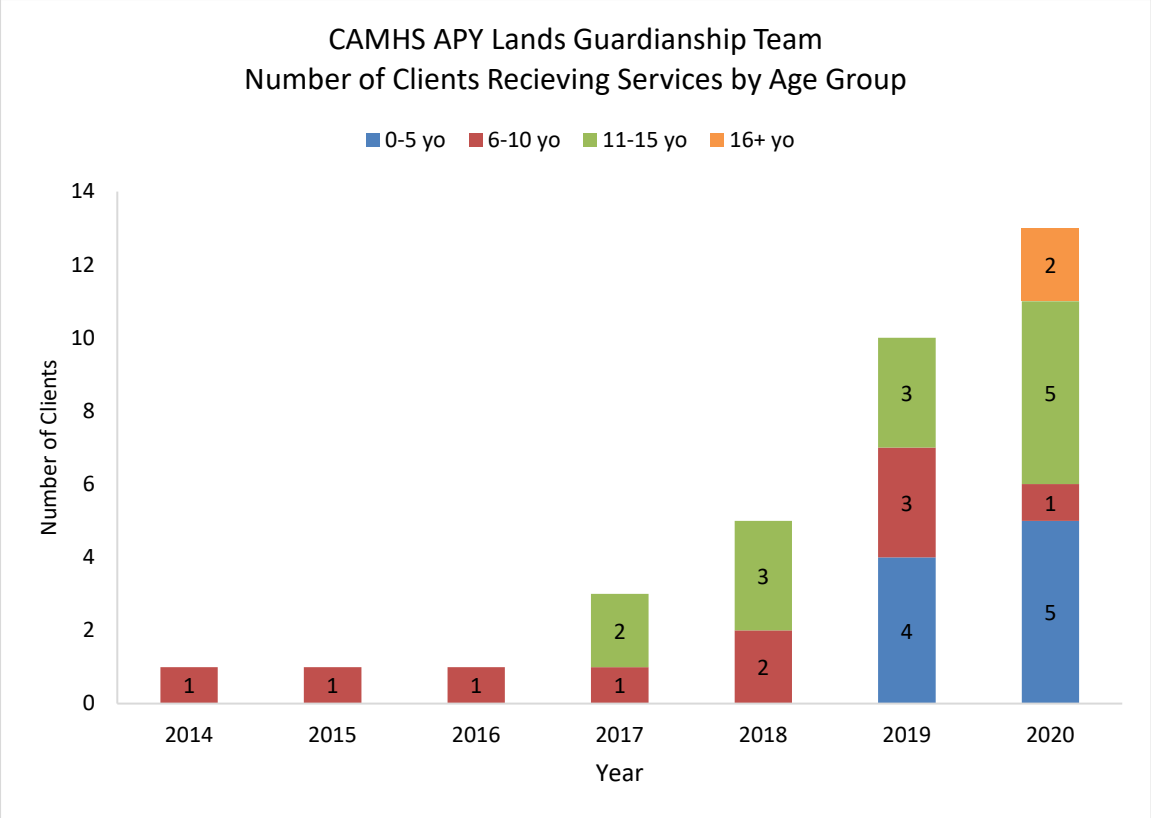


Chart 6: APY Lands Guardianship Team Number of Clients Receiving Services by Age Group



Audit of CAMHS APY Clinical Case Notes

Approach to the audit

As a part of the review of CAMHS APY the Office of the Chief Psychiatrist undertook a review of clinical notes that were identified on CBIS as clients allocated to the CAMHS APY team also referred to as KATU. The entire list of clients was located and a purposive sampling of files, both those accepted by CAMHS and not accepted as CAMHS clients was completed. The files represent a range of ages, gender and residing location on the Lands. Client notes are a mixture of handwritten notes, genograms and CBIS electronic records. Elsewhere in this report is documented the use of CBIS in the KATU team. As much of the KATU CAMHS work is not done in an office it is likely that staff documented some work on paper and some electronically. The use of CBIS records varied for each child, and some entries were in different areas of CBIS than would usually be used.

To place the notes in a context for the reader it is important to note that the work with children and families in the APY lands is complex. Much of the general 'Western' style therapeutic approaches are based on a child being in a consistent physical location of residence, having parents who speak the first language of the therapists, having carers who have few of their own educational and mental health difficulties and who are able to navigate a health care system. In the APY lands, as outlined elsewhere in this report, this is not the picture of most families. The work that is designed to be offered to those with trauma histories is also generally a long term and at times intense process. This pattern of work is also not one that is designed with the APY communities' structure and story. It is with this in mind that the files have been reviewed.

KATU (CAMHS APY) Lands Therapeutic Model

In 2018, the CAMHS KATU team drafted their Lands Therapeutic Model. This was written to represent "the organisational memory of 12 years of practice experience".

This document explains the concept of "Community therapy":[64]

> While this descriptor is problematic in terms of being confused with community development, which it is not, it does allow APY Lands clinicians to differentiate their approach from mainstream Western mental health treatments which focus on diagnosing and treating individuals , and from mainstream conceptions of 'family therapy' which assume a nuclear family model.
>
> …
>
> The need to address systemic issues is not seen as separate from everyday therapeutic interventions in a Community Therapy Approach. Working together with other agencies across the continuum of Child Protection Services to keep children safe is at the centre of the KATU CAMHS APY Lands model.
>
> …
>
> Community Therapy as an approach has evolved in the APY Lands in respect of the Anangu concept of persons being inseparable from their kinship networks and their country, and is characterised by:
>
> (i) Community genograms
> (ii) Consistent collaborative relationship building across the APY lands
> (iii) Well-developed understandings of cultural safety.
> (iv)

In half of the reviewed files an intergenerational genogram was noted. Initiating and building on a genogram is noted as *"a powerful and therapeutic way to start to engage families".*

Introductions are also important in Anangu culture and the team noted that '*the CAMHS clinician needs to offer Anangu an introduction that is meaningful to them.'* There is a strong

[64] KATU (CAMHS APY) Lands Therapeutic Model dated August 2018, p. 16.

focus in the KATU therapeutic model of building relationships. This is noted in the contacts that are made between CAMHS and the family of the referred child, as well as with other agencies.

The KATU therapeutic model outlines four stages of care:[65]

1. **Referral and triage**

All of the notes reviewed had been referred to CAMHS by a range of referrers including SAPOL, DCP, schools, family and self-referral. There were files opened under a child's name but with work done with a parent and focussed on a parent. Often contact and liaison work was done after referral, which is supportive and productive work, but is not documented as work with an accepted client.

2. **Assessment**

This is an ongoing process and requires the worker to listen and work gradually with the person. This is not noted in all reviewed cases. The documentation is unclear at times of whether an assessment has been completed. If this was completed gradually over time, there is often missing an overview of the assessment and the goals of CAMHS input.

It is then outlined in the KATU Therapeutic model that Community consultation occurs '*Once a community genogram is studied, family movements tracked, kinship networks identified, and family histories explored, the CAMHS APY lands clinician needs to consider which family members, and/or community consultants would be best placed to assist with therapeutic meetings'.*

There are no clear notes related to therapeutic meetings occurring (using that specific wording), however there is wide liaison at times between different community members and CAMHS. This may represent the 'therapeutic meetings' mentioned above.

3. **Therapy**

The team outline that building trust and safety and working in family group therapy are goals. There was therapeutic work in a small number of reviewed cases, many did not receive a clear therapeutic input. It was limited and some clients were not taken on as CAMHS clients due to lack of resources to do so.

4. **Transition from CAMHS**

This is the planned exit from CAMHS services. However, Anangu clients were documented as still in contact at times with the CAMHS services, including coming to the CAMHS workers house.

The notes reviewed show that a broad community approach is taken to accumulate information to enable an assessment of what is occurring for the child and their family. However, documentation of the wellbeing of the child or sessions with the child are not present. It is difficult to know from the CBIS or handwritten notes if the clinicians set eyes on the children or if the work was with the adults who engage with them.

The notes show the team are trying to work in a cultural framework while also having a health structure to work within. Having staff on the Lands is clearly beneficial with comments made in each case of people in the community approaching and talking to CAMHS staff at different times and places about concerns. This approach appears to have enabled a better understanding of a number of families and their stories and enabled positive and helpful CAMHS engagement.

[65] KATU (CAMHS APY) Lands Therapeutic Model dated August 2018, p. 25.

CAMHS APY clinical notes review
Eleven files were requested from WCHN from the CBIS patient list. Paper files were received by the OCP for most of the patients. Files for patients 1,2, and 3 were not provided as no CAMHS file was created although clients were entered on CBIS:

A short summary of 9 client files was created which is on file in the OCP, but not included in this report (although deidentified this summary has been kept confidential as clinical details of individual children might be identifiable in small communities).

From these summaries, key points were developed as follows:

- The APY CAMHS KATU service provided mental health care for a range of children and their families with a focus on community therapy and communication. It is not clear if all of the children who were registered as patients received therapy in the way that may be expected from a CAMHS service.
- All benefitted from a local service with clinicians in the community who knew the connections with the people and country. It was through this knowledge that the team were able to locate, support and connect with children and families
- It is unclear if the team saw all of those who fit the CAMHS remit as the documentation can be difficult to follow or appears to be missing.
- Some files were closed for children who were at high risk of mental illness, lived with families with severe mental illness or substance abuse and violence. However, from the files it is also noted that the level of violence, sexual abuse, sexualised behaviour and alcohol use was very high in the community. Therefore children, even when with caring families, are exposed to this degree of trauma in the APY Lands despite CAMHS intervention. Due to this environment, CAMHS were working within a community that required a community-wide service who were able to work across generations with trauma and with other services. Therefore, direct work with a child that may be seen in other, non APY, communities is not likely to be helpful for all of the children in this population.

CULTURAL DELIVERY OF CARE

As in many Aboriginal and Torres Strait Islander communities around Australia, most Anangu families live in poverty and/or are completely welfare dependant, some for second and third generations:[66]

> Most houses are very overcrowded, poorly maintained, and often without the most basic essentials and provisions. Poverty is related to very limited opportunities for employment, and those jobs that do exist are often unattainable for Anangu due to the limited literacy, or lack of the child and vulnerable persons clearances that are required.

Social and emotional wellbeing are subsequently significantly compromised, leading to higher levels of substance abuse, domestic violence, sexual abuse, gambling, neglect and self-harm behaviours. These stressors have impacted Anangu communities across several generations culminating in complex intergenerational trauma and complex grief and loss.

Aboriginal cultural delivery of care is an important aspect when caring for Anangu. Reflective of and responsive to their cultural identity and need, applying an Aboriginal-centred approach, can improve the quality of care and understanding among Anangu people, in this case Anangu children, youth and service providers.

Connection between culture, healthcare and Anangu can directly improve and enrich daily life through better informed and culturally appropriate management and practice:[67]

[66] KATU (CAMHS APY) Lands Therapeutic Model dated August 2018.
[67] Ibid.

> An important factor to keep in mind when working in Indigenous mental health is that individualised mental health care, no matter how efficient, will always fall far short of its aim to improve mental health if it is not linked in with broader social and structural improvements in strength of family and quality of life for the whole community.

Strong leadership is required to address and respond to individuals experiencing mental ill health, including depression/anxiety arising due to exposure to violence, physical/sexual abuse, historical and transgenerational trauma, the ongoing effects of past and present social and systematic racism, disconnectedness from place, land, kinship, and spirit along with the limited access to health and other supportive services.

Redesigning effective and sustainable Aboriginal mental health care must include services being supported with good principles and practice that includes culture at its core, culturally appropriate tools, engagement with family and community, flexibility and an on-land based central coordinated service.

The APY Lands communities are geographically very isolated. Placing a metropolitan service with metropolitan thinking and management will only disempower the service required and lose any progress in improving Anangu mental health and wellbeing.

RESPONSE TO TERMS OF REFERENCE AND RECOMMENDATIONS

By considering evidence collected via the review of previous APY Lands inquiries, internal service planning documents, stakeholder engagement, recent CAMHS referrals, as well as casenotes disclosing the clinical service being provided by CAMHS with pre-existing staffing levels, this review has attempted to consider both the historical and ongoing level of need for mental health services for children and young people on the APY Lands. It is against this background that the following conclusions and recommendations are made with respect to the Terms of Reference:

TOR1: Review the adequacy of the interim arrangements to ensure access to therapeutic services on the APY Lands is maintained until the new Integrated Model of Care is established.

- The evidence (both documentary from referral data and case notes, and that arising from verbal discussions with the OCP) shows both historical and ongoing high levels of need for child and adolescent mental health services. Culturally-appropriate therapeutic services are needed on the Lands to combat the intergenerational trauma being suffered by young people in the Anangu community.
- While this review did not investigate the contributors to trauma leading to this clinical need, there was common agreement that exposure to sexual abuse, physical violence, substance abuse and unresolved mental illness and trauma are significant factors in this ongoing need. There was no suggestion that interventions such as the CAMHS 'community therapy' approach were any less required now than they were at the times of the Mullighan and Nyland reports.
- The CAMHS 'community therapy' approach offered until June 2021 provided an evidence-based approach to trauma that responded to the wishes of the Anangu community, depended on high levels of engagement and follows key principles that recognise an Aboriginal view of health, cultural understanding, experiences of trauma and loss since European invasion and human rights, amongst other principles as described in the draft 2018 KATU (CAMHS APY) Therapeutic Model.[68]

[68] Ibid, pp. 6 -7

- In this investigation we have heard and seen evidence that the CAMHS service was addressing this need, but had difficulty responding to the volume of referrals it received. There were sufficient commendations for this work from external parties not linked to the provision of this service to conclude that the service was effective in engaging community, and likely to have improved the outcomes of the young people and families it assisted, acknowledging that the objective measurement of outcomes – particularly those related to preventing future distress and trauma – can be difficult to gauge.
- The IMOC model in turn seeks to use *"…KATU CAMHS APY Land's team's established relationships and trusted culturally appropriate service delivery as the platform, the APY IMOC will strengthen families and build community capacity to achieve the vision…"*[69].
- Currently, CAMHS is providing remote support for the care of a small number of clients who have neurodevelopmental needs and is not providing a response to the broader concerns secondary to trauma and abuse and requiring a psychosocial therapeutic response.
- Given that the evidence we heard and read points towards the benefit of using Lands-based clinicians and connection to community being essential components of any meaningful therapeutic response for children and young people on the Lands, it is clear that the interim arrangements put in place by CAMHS to maintain service delivery to the APY Lands are insufficient to meet the need. It should be noted, however, that as described, the current arrangements offer a limited backup and it is understood by CAMHS that the addition of extra workers is required.
- Given recent estimates (including by CAMHS clinical workers) of significant numbers of the young APY Lands population being exposed to sexual abuse or trauma, and the previous experience of CAMHS APY clinicians needing to travel to family homes to proactively identify children in need, it is likely the interim approach will result in the majority of children and young people in need of therapeutic services slipping through the cracks.
- It is likely that the addition of FIFO workers alone will be insufficient to restore the service to the same capability and capacity previously achieved.

For these reasons we recommend.

1. The engagement and experience of [redacted] and [redacted] should be utilised, if at all possible, in the development of the next phase of the service. This might involve them returning to Lands-based work for a period of time or providing handover and advice in the development of the service and assisting with succession planning.

2. The service should be provided with a regular funding source. Past reviews, and direct stakeholder feedback, indicate that recruitment is difficult and hampered by the temporary nature of funding which precludes the advertising of ongoing roles.

3. The level of funding for the service should be commensurate with the need. A formal analysis of demand and workloads was not undertaken, but the referral and case note analyses both identify the need for more referrals to receive a response and interview, and suggest that a necessary level of staffing would correspond to at least the levels put in place post Mullighan inquiry and those levels available to respond to issues arising in communities after surges. This would double the workforce from the 3 staff for much of 20-21 to 6 staff, in addition to Malpas.

4. The IMOC approach has broad support, however this should not prevent the full funding of the CAMHS component which might then subsequently be absorbed into the service.

[69] Draft IMOC, page 9.

5. While awaiting the development and implementation of the IMOC, CAMHS gaps should be addressed as soon as possible given the minimal service delivery currently in place.

TOR2: Identify any additional processes and services WCHN may need to put in place to ensure clients are able to access services on the APY Lands at this time.

- Staffing of Lands-based clinical staff, and providing support for those positions on the Lands, may require an alternative approach. For example, it is possible to conceive that the service is delivered not by CAMHS alone, but by CAMHS in collaboration with an Aboriginal Controlled Community Organisation, such as NPY Women's Council and/or Nganampa Health. For example, the community organisation could employ and support Malpas, as well as potentially employing on-Lands clinicians undertaking the KATU clinical therapy model or an updated evolution of this model as part of the IMOC. CAMHS could support this with FIFO CAMHS workers including psychiatrists. This may provide a sustainable model, as well as address some of the challenges CAMHS faces with respect to on-Lands staffing, such as recruitment (a community organisation may have access to a broader recruitment pool), staff safety (Lands-based organisations have the people and structures in place to better support on-Lands staff) and succession planning (as unlike the recent CAMHS service it would not rely upon specific individuals if there is a larger on lands organisational base.).
- An alternative model would be for Malpas and local "community therapy" staff be embedded in the Department for Education. They could operate on a matrix model receiving line supervision through Education and professional supervision through CAMHS. In undertaking this investigation, it became apparent the significant role that Education has for young people on the lands, and the broad role of schools in the community.

Therefore, with respect to additional processes and services, we recommend:

6. The return of an on-Lands service as soon as possible. This would benefit from the assistance of the former Lands-based workers who might return to the Lands or assist with transition.

7. If a Lands-based solution is not possible in the short term, seek to implement a continuous presence during the school term time through FIFO workers, while working to restore Lands-based workers.

8. That a decision be made for funding over the next 4 years to give certainty to both community, possible clients and their family, and to potential workers seeking employment.

9. That early contact is made with organisations such as, but not limited to, NPY Women's Council who have an on-site presence on the Lands and could act as collaborators in the delivery of the services.

TOR3: Consider the best way to engage key stakeholders in the design and development of the IMOC, including engaging people with lived experience on the APY Lands.

- It was suggested to the review that a consultation group be formed on the APY Lands of people who are engaged with the topic or had experience of services. Key community and provider organisations on the lands could help identify members.

- The importance of extensive Anangu consultation in the development of the IMOC was stressed by all stakeholders who spoke to this review, with “key stakeholders” identified as the APY Executive Council, Anangu elders, Anangu youth, the Regional Anangu Services Aboriginal Corporation and Aboriginal Community Controlled Services including Nganampa Health and NPY Women’s Council.
- It is noted that CAMHS informed this investigation that extensive further consultation is planned with APY Lands stakeholders before the end of 2021 and into early 2022. CAMHS have been working with the APY Executive Council to determine the best way to engage the APY Councils. Lead Malpas, who have been working with Lands-based clinical staff, are also attending consultation meetings planned for December 2021 which aim to further develop the role of Anangu Lands-based staff in the next iteration of the proposed IMOC.

Therefore, with respect to stakeholder engagement, we recommend:

10. Early, broad and meaningful consultation be undertaken with APY Lands communities, including with young people and representatives of those with lived experience.

11. The WCHN Working Group tasked with responsibility for drafting the IMOC be expanded to include representatives from the APY Lands communities and representatives from the Lands-based Aboriginal Health Organisations with whom partnerships are envisaged, such as Nganampa Health and NPY Women’s Council.

SUMMARY OF RECOMMENDATIONS

1. The engagement and experience of [redacted] and [redacted] should be utilised, if at all possible, in the development of the next phase of the service. This might involve them returning to Lands-based work for a period of time or providing handover and advice in the development of the service and assisting with succession planning.

2. The service should be provided with a regular funding source. Past reviews, and direct stakeholder feedback, indicate that recruitment is difficult and hampered by the temporary nature of funding which precludes the advertising of ongoing roles.

3. The level of funding for the service should be commensurate with the need. A formal analysis of demand and workloads was not undertaken, but the referral and case note analyses both identify the need for more referrals to receive a response and interview, and suggest that a necessary level of staffing would correspond to at least the levels put in place post Mullighan inquiry and those levels available to respond to issues arising in communities after surges. This would double the workforce from the 3 staff for much of 20-21 to 6 staff, in addition to Malpas.

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ATTACHMENTS

1. Map of the APY Lands
2. Fifth Annual Report by the Minister for Education and Child Development to the Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry, A report into sexual abuse, dated November 2013.
3. Table summarising the implementation of the Relevant Mullighan Inquiry Recommendations, as found in the Children on the APY Lands Recommendations Audit, as at 1 June 2017.
4. Copy of interview questions used in consultation meetings with the Chief Psychiatrist.

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