North Australian Aboriginal Justice Agency

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NAAJA Submission:

Senate Community Affairs References Committee Inquiry Foetal Alcohol Spectrum Disorder (FASD)

December 2019

About NAAJA

NAAJA provides high quality, culturally appropriate legal aid services to Aboriginal and Torres Strait Islander people throughout the Northern Territory. NAAJA was formed in February 2006, bringing together the Aboriginal Legal Services in Darwin (North Australian Aboriginal Legal Aid Service), Katherine (Katherine Regional Aboriginal Legal Aid Service) and Nhulunbuy (Miwatj Aboriginal Legal Service). From 1 January 2018 NAAJA has been providing legal services for the southern region of the Northern Territory formerly provided by CAALAS (Central Australian Aboriginal Legal Aid Service). NAAJA and its earlier bodies have been advocating for the rights of Aboriginal people in the Northern Territory since 1974.

NAAJA serves a positive role contributing to policy and law reform in areas affecting Aboriginal peoples' legal rights and access to justice. NAAJA travels to remote communities across the Northern Territory to provide legal advice, deliver community legal education and consult with relevant groups to inform submissions.

This submission draws on the cultural authority of an Aboriginal board which governs NAAJA as an Aboriginal Community Controlled Organisation. NAAJA staff are inspired by the strength and resilience of the Aboriginal people who are board members and come from across the Northern Territory including a strong focus and representation from regional and remote areas. We particularly acknowledge the Elders of our board and the contribution of Aboriginal and Torres Strait Islander people who developed and strengthened NAAJA over the years.

NAAJA provides criminal and civil legal services to Aboriginal youth and adults in the Northern Territory. NAAJA also provides an adult case management Throughcare program providing intensive support to Aboriginal people who have been incarcerated with the key focus on reducing recidivism once released. The organisation frequently deals with clients who have a complex range of needs and socio-economic challenges that result in coming into contact with the criminal justice system or government family services.

NAAJA also provides a number of services specific to youth, which are aimed to be holistic, trauma informed, and responsive to the different and often complex needs of young people in contact with the youth justice system. Our team of criminal lawyers includes youth lawyers who specialise in youth matters. We have Youth Justice Aboriginal Legal Support Officers who assist young clients at court. We also have Youth Throughcare teams in Darwin and Alice Springs, who work closely with young people in detention pre and post release with a view to facilitating engagement with necessary services and reducing the risk of reoffending. Our civil law team provides advice and representation to families in relation to care and protection matters. Additionally, our Law and Justice teams regularly deliver youth specific community legal education sessions, often in the detention setting.

Our Submission

We have reviewed the terms of reference, and our responses have been informed and guided by our frontline experience providing multidisciplinary assistance to Aboriginal clients who are interacting with the legal system, across the areas of criminal, civil or both. We have not addressed every term of reference and due to potential overlap and the breadth of this topic we have structured our response thematically.

As an Aboriginal Legal Service our response is informed by the insight gained through our work with Aboriginal clients, and framed accordingly. However, we wish to clearly state at the outset that we recognise FASD is not just an issue for Aboriginal people, but one that affects people of all cultural backgrounds.

The Northern Territory context: Compounding intersections of disadvantage

Appreciating the interconnected disadvantages experienced by Aboriginal people in the Northern Territory is crucial to understanding the exacerbating impact of poorly devised policies and practices that are ill-equipped to respond to the needs of those with FASD.

This situation is underpinned by:

- Our improved understanding of FASD from a clinical and evidence based perspective particularly in recent years and decades;
- The perverse nature of FASD where, for example, a person can have an IQ in the normal range yet their behaviors and decisions may be significantly affected by their disorder;
- Our lack of a broad understanding of the true extent and prevalence of FASD in the Northern Territory and particularly as it relates to all aspects of the justice system;
- The lack of access to diagnostic assessments and, for people diagnosed with FASD, appropriate services. Due to a lack of access to diagnostic assessments in many cases we are treating what is a health issue with a punitive, criminal justice response.

This situation requires systemic reform and the resources to match the scale and extent of our crisis.

The final report of the Royal Commission into the Protection and Detention of Children in the Northern Territory (Royal Commission) stated:

> “Children and young people with [FASD] have special needs that must be catered for in both the child protection and youth justice systems. They need a

> therapeutic environment that is structured, predictable, calm and nurturing in order to thrive."[1]

In his evidence before the Royal Commission Dr James Fitzpatrick cautioned that:

> '…FASD and early life psychological trauma truly are a sleeping giant within the child protection and justice systems in the Northern Territory and in other places, and they are a potent driver of engagement of young people in these systems.' [2]

NAAJA wholeheartedly agrees with these premises. The Royal Commission examined the issue of FASD as it affects children in the Northern Territory's youth justice and care and protection systems, and made a number of related findings and recommendations which we have sought to extract in the course of our submission. Aside from those specifically mentioned, NAAJA advocates for the implementation of all 227 recommendations of the Royal Commission as reforms that would benefit all children engaging with those systems, but especially children with FASD.

The prevalence and impact of FASD in the Northern Territory

Effect of FASD

Foetal Alcohol Spectrum Disorder ('FASD') is a health concern particularly pertinent to juvenile justice in the Northern Territory. In the *Doing Time – Time For Doing* report, FASD is described as "a range of physical, mental, behavioural and learning disabilities that are a direct result of alcohol use during pregnancy."[3] FASD is a lifelong disability and each individual with FASD is unique and has areas of both strengths and challenges.[4] The range of brain domains it can affect mean that FASD can be very difficult to identify. This means that people with FASD may go without a diagnosis and not receive proper support. Facial features of FASD may be present where there has been alcohol exposure early in the pregnancy.[5] However, research has indicated that only 1 in 8 people present with facial features of FASD out of those who have the disability.[6] People with FASD may also have normal IQ levels. Individuals with FASD will experience some degree of challenges in their daily living, and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential.[7]

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[1] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 1, p 140.
[2] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3B, p 173.
[3] Commonwealth, Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time—Time for Doing: Indigenous Youth in the Criminal Justice System* (2011), 94.
[4] CanFASD, 2019
[5] Prue Walker, *FASD Case Review for Youth Justice, Hume region, Department of Justice and Regulation*, 2018, 6.
[6] Prue Walker, *FASD Case Review for Youth Justice, Hume region, Department of Justice and Regulation*, 2018, 6.
[7] CanFASD, 2019

Prevalence of FASD: Tip of the Iceberg

A 2007 national review on children diagnosed with FASD across Australia revealed that 60% of those children were in care and 65% were Aboriginal.[8] There continues to be a paucity of data available on FASD. However, in March 2017, in an Australian-first study, researchers found that one in three young people at Banksia Hill detention in Western Australia had FASD.[9] Although the findings are not directly transferable to the Northern Territory, it suggests that a significant number may also suffer from this disorder in detention. In a submission to the *Doing Time – Time For Doing* report Heather Douglas estimated "60% of adolescents with FASD have been in trouble with the law."[10]

The lack of data in relation to FASD in the Northern Territory makes estimating the prevalence of FASD difficult. In evidence to the Royal Commission, the Northern Territory Department of Health indicated a view that FASD was not particularly prevalent in the Northern Territory due to the high proportion of Aboriginal people who live in remote communities where alcohol restrictions apply; whilst acknowledging that FASD may be an issue for those Aboriginal people residing in regional centres where alcohol is more freely accessible."[11] The Royal Commission found that this position was "not consistent with the expert evidence given to the Commission".[12]

NAAJA staff recently undertook in-house training with FASD consultant Prue Walker. When asked to share anecdotal observations about the prevalence of FASD amongst NAAJA youth clients, frontline staff who had attended the training expressed the following views:

> "I believe that many of our youth clients display signs of FASD"
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> "Multiple youth clients have been diagnosed with FASD. However, this often occurs after they have become significantly involved in the criminal justice system"

Staff further indicated that some youth clients who may have FASD may have been diagnosed with an intellectual disability because of a lack of investigation into whether or not the mother engaged in pre-natal alcohol consumption. It was noted that during some assessments the mother may deny drinking during pregnancy because of the associated shame of drinking while pregnant. This is a significant limitation in proper

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[8] E, Elliot, Payne, J et al. 'Foetal alcohol syndrome: a prospective national surveillance study', (2007) 93, *Archives of Diseases in Childhood*, 732-737.
[9] '1 in 3 young people in detention has alcohol related brain damage', *Telethon Kids Institute*, 2 March 2017 <https://www.telethonkids.org.au/news--events/news-and-events-nav/2017/march/1-in-3-young-people/>.
[10] Commonwealth, Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time—Time for Doing: Indigenous Youth in the Criminal Justice System* (2011), 94.
[11] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2A, p 353.
[12] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2A, p 353.

diagnoses of FASD and is one of many reasons why the number of those diagnosed is simply the tip of the iceberg.

Impact of FASD

The impact of FASD extends beyond the individual who has the condition. The impact on families is enormous. Considering the layers of disadvantage that many Aboriginal families face in the Northern Territory, the needs of a child with FASD can amount to an added pressure in daily realities that are already extremely high-pressure. Environmental factors leading to FASD may exist across multiple pregnancies over a period of time and it is possible that several children in a family may have FASD. Although NAAJA has observed this occurring in some instances, this is not always the case.

A NAAJA staff member with a social work background, and who has extensive professional experience in the Northern Territory, observed an intergenerational impact whereby FASD affected parents are having FASD affected kids. This is partly due to the higher likelihood of a person living with FASD developing drug and alcohol issues because of their extensive use of drugs and alcohol as a coping mechanism.

Importantly, FASD is not a 'female issue' that women are responsible for. It is crucial that partners, family and the broader community assumed a greater role in supporting expecting mothers care for themselves and their babies. Stigmatising mothers is extremely problematic. It adds to the barriers preventing expecting mothers access therapeutic assistance. NAAJA is concerned by public health educational brochures about FASD that do not feature images of men. A NAAJA social worker has reported anecdotally that clients have described instances of being pressured by their families and partners to drink with them, and of the difficulties remaining sober when the whole family might be drinking with no regard for the mother's need not to drink. Men can support their partners by abstaining and/or engaging in drug and alcohol rehabilitation to support their partner. This goes to the importance of effective and culturally appropriate education and health-based responses that go to the responsibility of men and families. It also goes to the importance of rehabilitation services that are culturally competent in a genuine way and consistent with Aboriginal led perspectives of cultural competency.

NAAJA understands that residential drug and alcohol rehabilitation options are extremely limited for pregnant women, and that the Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD) Pregnancy Program is the first alcohol rehabilitation program that will take women at any stage of their pregnancy. There is a need for increased options for pregnant women to engage in residential rehabilitation treatment, and for treatment options postpartum as well, whereby a mother can go to rehabilitation with her baby.

NAAJA is concerned about the impact of FASD on access to education. A NAAJA staff member highly qualified and experienced in this area has observed that, because children with FASD are often unable to link action and consequence, they have

difficulty learning to make good choices and this manifests in trouble at school, disengagement, suspension or expulsion in some cases. NAAJA observes that, whilst suspension should be a last resort for a child with a disability, it sometimes occurs as the first response. We are concerned that this may amount to discrimination on the basis of disability. Children with FASD are entitled to a full-time educational placement, with adjustments that are inclusive and enable them to fit in. NAAJA observes that this often does not occur in practice and that the accessibility of education for some children is very limited in practice. We are aware there are protocols in place to ensure expulsions from school are small in number, we observe in practice due to a lack of resources and supports many young people are actively discouraged from attending school because of behavioural issues. It is possible many of the young people involved in the justice system may have FASD that is not diagnosed because there is no access to assessments. This situation places considerable pressure on limited school resources and schools should be resourced and equipped to respond more appropriately to these circumstances.

A staff member from NAAJA's Katherine office expressed a view that many of the behaviours associated with FASD can generate conflict between the individual and their community, which can have many consequences including making the completion of non-custodial sentences difficult. The interconnection between FASD and the justice system is significant: as discussed in the following section, FASD acts as both a prompt and a prejudice in this setting.

We acknowledge and support the broader reform efforts of the Northern Territory Government as it relates to the justice system and alcohol policy and legislation.

The 2019 Pathways to the Northern Territory Aboriginal Justice Agreement report refers extensively to the relationship between health and alcohol related issues with the criminal justice system. With respect to FASD, the AJA Report refers to the ALRC's findings that indicate Indigenous Australians who do drink are more likely than non-Indigenous Australians to drink at harmful levels. Similarly, the report notes that Aboriginal people with cognitive disabilities like FASD are at an increased risk of coming into contact with the criminal justice system. NAAJA is preparing a submission to the draft Aboriginal Justice Agreement and will emphasise the importance of systemic reform and increased investment to deal more effectively with FASD.

The Northern Territory embarked on significant policy and law reform following the recent Alcohol Policies and Legislation Review ("Riley Review"). The Riley Review provides general comments about the possible prevalence of FASD noting the difficulty of understanding its prevalence due to the paucity of reliable data. The review notes that higher rates of FASD among Aboriginal Australians have been observed in several studies. The Riley Review has considered, and endorses, the Northern Territory Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder recommendations with slight variations. Following the release of the Riley Review's final report, the Northern Territory Government committed to adopting 219 of the

review's 220 recommendations. In October 2019, more than 75% of the review's recommendations have been implemented.

NAAJA observes that, in practice, there continues to be significant issues with the accessibility of FASD diagnostic tools and services for individuals even in circumstances where medical opinion strongly suggests that the individual may have FASD. NAAJA has proactively sought financial assistance and grants to improve the accessibility of FASD screening services for individuals who are in regular contact with the criminal justice system, however these have not been successful.

The Riley Review presents a sobering re-evaluation of the regulatory framework of alcohol in the Northern Territory and presents considered recommendations to address alcohol misuse. Although the review's recommendations are a step in the right direction, it is vital that the liquor industry assumes greater responsibility for alcohol-related harms. The recent understanding of the perverse nature of FASD and its impacts requires a shift in public discourse and levels of responsibility that we as a community take to effectively respond to the damage caused by FASD.

Similarly, punitive responses to justice issues like FASD should be replaced with measured and health-informed justice reforms.

FASD and Youth Justice

The Northern Territory has the highest rate of children and young people in detention in Australia.[13] Despite making up 45% of the population of 10-17 year olds in the Northern Territory, 96% of children and young people in detention are Aboriginal.[14] Recent census data at the time of writing has frequently indicated that 100% of the children in detention in the Northern Territory are Aboriginal. Since 2006-07, the number of children and young people entering detention has more than doubled in the Northern Territory.[15] Of the children in juvenile detention, 70% of these children were on remand.[16] The data in relation to care and protection is similarly bleak. On the night of 30 June 2016, 89% of the 1020 children and young people in out-of-home care in the Northern Territory were Aboriginal.[17] In 2015 approximately 60% of children in detention were in the care of the Department of Children and Families (now known as

[13] Australian Institute of Health and Welfare, 'Northern Territory: youth justice supervision in 2015–16' (2017) 2.
[14] Ibid.
[15] Joe Yick, Statement to Royal Commission into the Protection and Detention of Children in the Northern Territory, 14 October 2016, 55, <https://childdetentionnt.royalcommission.gov.au/public-hearings/Documents/evidence-2016/evidence9december/Exh-045-001.pdf>.
[16] Northern Territory Government, Northern Territory Department of Correctional Services, *2015-16 Annual Report* (2016) 56.
[17] Northern Territory Government, Office of the Children's Commissioner Northern Territory, *Annual Report 2015-2016* (2016) 37.

Territory Families).[18] Whilst we understand these numbers as a total of young people in detention are trending downwards in the Northern Territory following recent reforms and an expansion of non-detention options, for young people diagnosed with FASD it is necessary to explore the suitability of the conditions and environment that they located and as it relates to their circumstances.

The Northern Territory youth justice system is ill-equipped and presently fails to accommodate the needs of children with FASD at all junctions of the youth justice system, including the first point of contact with police, bail determinations, Court, supervised orders and detention

Children who come into contact with the youth justice system as a consequence of behaviours associated with FASD are often prejudiced due to the lack of responsiveness and understanding within it. One NAAJA staff member described FASD as a double edged sword when it comes to bail, in the sense that if a child is known to have difficulty following the rules this may work against them in a bail application to the perceived likelihood of reoffending whilst on bail. It was further observed that children with FASD have trouble comprehending the consequences of their actions, yet still receive harsher punishments every time they offend, coming out of detention angrier with the world and not understanding why they have been locked up.

Contact with Northern Territory Police and bail

The majority of children in detention in the Northern Territory are on remand. For the period 2015-16, the Northern Territory Department of Correctional Services reported this figure to be 70% of children in detention.[19] The data is not available to say how many of these children have FASD. We are aware recent reforms by Territory Families has significantly improved this situation and with more appropriate supported accommodation in community for young people on remand. This is a positive step.

Aside from communication approaches in relation to bail conditions, it is essential that the conditions themselves are appropriate to the circumstances of the young person and the alleged offending. The primary focus of an undertaking of bail should be ensuring that a young person attends court. The conditions of bail should not be punitive in nature, however unfortunately NAAJA staff continue to see onerous, inappropriate and confusing bail conditions being imposed upon Aboriginal young people across the Northern Territory. This is particularly the case in Alice Springs.

NAAJA observes that problematic bail conditions imposed by police contribute to high rates of breach of bail offences in Alice Springs and the Barkly. Conditions that have been identified by lawyers as problematic include curfews, which are not always

[18] Jared Sharp, 'Does the Northern Territory Youth Justice deliver justice to vulnerable young offenders or their victims?' (Paper presented at Criminal Lawyers Association of Northern Territory, Bali, June 2015) < https://clant.org.au/wp-content/uploads/the-bali-conference/2015/Sharp_ppt.pdf>
[19] Northern Territory Government, above n 10, 56.

necessary, and vague conditions such as abiding by the lawful direction of a worker. Whilst the premise of conditions is to ensure monitoring of young people and assessing their ability to comply with the standards of an authority, if these conditions do not adequately take into account their disability then they may compound existing challenges. Young people in Alice Springs also faced a hugely disproportionate number of breach of bail offences. During the 2018/19 financial year, there were 321 new case files for breach of bail in Alice Springs as opposed to 97 in Darwin. NAAJA has observed a steady rise in breach of bail offences in Alice Springs in 2019.
The Royal Commission made the following recommendation in its final report:

> Recommendation 25.1 – Excerpt:
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> - (5) All Northern Territory Police receive training in youth justice which contains components about childhood and adolescent brain development, the impact of cognitive and intellectual disabilities including FASD and the effects of trauma, including intergenerational trauma.[20]

NAAJA is of the view that the above training would be a positive step towards improving the engagement of Northern Territory Police with vulnerable Aboriginal youth. In our view, training relating to health and especially trauma and trauma-informed approaches should be delivered with the direction of Aboriginal Community Controlled health organisations so that Aboriginal perspectives are integrated into the delivery. Whilst some of this work is taking place and especially for lawyers and other staff working in youth matters, more can be done to ensure it is appropriately supported and with resources and dedicated program support in place.

FASD and the Youth Justice Court

NAAJA has observed distinct differences between practices between courts in the Top End and Central Australia in relation to FASD and its effects on those diagnosed with FASD. NAAJA believes such disparity is attributable to the lack of a specialist Youth Court with a designated Youth Court Judge in Alice Springs.

Whilst the number of assessments for FASD for relevant young persons before the Youth Court is gradually increasing, in our direct experience there are challenges associated with costs and accessibility of assessments that continue to impact the justice process.

In its final report, the Royal Commission made the following observations in relation to the benefits of a dedicated Youth Justice Court:

> "The Commission heard that there have been positive changes to youth justice in the Northern Territory since the dedicated Youth Justice Court opened in Darwin in March 2016, including an increased focus on the issues facing

[20] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2B, p 223.

> children and young people. Expert reports on a young person received by the court are now being collated for reference so that if a young person comes before the court again, '*vital information about issues such as trauma, exposure to violence or abuse, cognitive issues, FASD* [Foetal alcohol spectrum disorder] *is not lost*'."

In contrast, in Alice Springs, NAAJA is concerned about the general lack of training for people involved in all levels of the youth justice system as to the effects of FASD and how best to understand and engage with those diagnosed with it. The effect is that people with significant power over the lives of young people with a permanent intellectual disability - such as judges, police officers, care and protection workers, lawyers, detention centre staff, social workers, youth justice officers - often do not have the adequate skills to understand, engage with and make informed decisions about those young people.

Even where FASD is diagnosed, findings and recommendations are not always appropriately integrated into the justice system's response. For example, Territory Families' (TF) Youth Outreach and Re-Engagement Teams (YORETs) provide reports to the Court regarding a young person's bail prospects (bail and supervision assessments) and pre-sentence reports. The considerations in these reports can be fundamentally swayed by a diagnosis of FASD, as an ability to understand action and consequence and impulse control are factors that are crucial to both multidisciplinary FASD assessments and TF reports for the court. However, TF reports regularly do not consider a multidisciplinary report to diagnose FASD or consider FASD in adequate detail. This is a clear indication of inadequate training.

NAAJA recommends that where a MTD assessment exists stating that a young person has FASD, it must be considered as a fundamental aspect of any report made to the Court. Where an MTD assessment does not exist but has been requested, efforts should be made to delay decisions until it can be properly considered, or at the least require that interim enquiries be made as to the effects of a potential diagnosis.

In contrast, a NAAJA Darwin practitioner observed that in the youth space there has been a growing recognition of how FASD impacts offending and the ability to comply with court orders and conditions. This is shown through Judges being open to accept submissions on how FASD lowers moral culpability for offending conduct and the need for simple conditions when imposing orders. The level of recognition of FASD is reflected in Youth Justice Judges in Darwin being very open and willing to order FASD assessments. Unfortunately such receptiveness is not replicated in Alice Springs. NAAJA observes a reluctance by the Court at times to order a multidisciplinary FASD assessment.

NAAJA submits that the establishment of a Youth Court in Alice Springs, along with a designated Judge, would assist with facilitating the specialist response required.

Concerns were also raised by NAAJA staff in Darwin in relation to the significant lack of recognition by the Territory Families Youth Justice Officers as to how FASD can

impact on a young person's behaviours resulting in unrealistic expectations with bail supervision suitability, compliance with conditions and a lack of flexibility in breaching young people for non-compliance.

In addition to recommendation 25.1(5), NAAJA recommends the introduction of FASD training for court-based officials and lawyers.

FASD in the youth detention setting

The Royal Commission made scathing findings in relation to the youth detention setting in the Northern Territory, and in relation to FASD specifically found that "the environment of youth detention in the Northern Territory on the whole did not provide the structured, regular, predictable and therapeutic environment required for children and young people with FASD."[21]

NAAJA is concerned that more than two years since the Royal Commission handed down its final report, the detention setting is still extremely poor at appropriately supporting, and responding to, children with FASD. Whilst we understand progress is being made to build a suitable centre in Darwin there are currently no plans for a centre in Alice Springs. Further, we are concerned that the Commonwealth Government's decision not to fund the Royal Commission's recommendations places considerable pressure on the Northern Territory Government to provide resources and in the current economic climate.

NAAJA observes that Territory Families routinely transfers young people detained at the Alice Springs Youth Detention Centre (ASYDC) to Don Dale Youth Detention Centre (DDYDC) on the grounds that ASYDC do not have the resources to manage a young person with behavioural issues. Of these, some have been diagnosed with FASD, with their assessments noting that behavioural issues as a consequence of their diagnosis. ASYDC, by their own admission, do not have sufficient resources to support young people with behavioural issues, which has implications for young people with FASD including the practical consequence of being transferred 1500kms away from their family, country and support networks.

When a young person is in a detention setting where their needs are not being appropriately met, the behavioural issues that ensue can also lead to further offences being committed whilst in detention. NAAJA has seen multiple examples of this, where detention centre staff who do not have effective de-escalation skills respond to a disturbance in a forceful manner, attracting an equally forceful response from the youth which often leads to charges being laid.

Further detail about the severe shortcomings experienced by children with FASD in detention is provided later in the submission when support services are discussed. For

[21] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2A, p 351.

the purpose of this section, it is useful to note the recommendations and findings that the Royal Commission made in relation to FASD in the detention setting:

Screening:

> It is accepted that FASD diagnosis can be intensive and expensive. Hwever, the effective use of a screening tool is achievable and essential to assist in appropriate referral for formal diagnosis.[22]
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> FASD screening of detainees is not undertaken despite the likelihood that a significant number of detainees are affected.[23]
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> Recommendation 15.1 – Excerpt:
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> - The comprehensive medical and health assessment required to be carried out, should include … (b) a behavioural questionnaire to determine whether a formal assessment for Foetal Alcohol Spectrum Disorder should be conducted, and if so determined and if the detainee has not previously been the subject of a formal assessment, that assessment to be conducted.[24]
> - If the need for a formal FASD assessment is identified, that this be funded through Medicare or the NDIS as appropriate

Recommendation 81: That consideration be given to establishing a process whereby a behavioural questionnaire be administered when a young person comes into contact with the justice system, to screen for FASD or other cognitive difficulties.

NAAJA calls for the implementation of these recommendations, so that the improvements envisaged by the Royal Commission can be fully recognised for our clients.

Sentencing options and alternatives to detention

There is a need for a greater number of culturally appropriate alternatives to detention to address the underlying causes of a young person's interaction with the youth justice system. The *Doing Time – Time For Doing* report identified healing programs as important measures for Aboriginal people in the justice system, especially those with FASD. June Oscar AO, Aboriginal and Torres Strait Islander Social Justice Commissioner submitted to the Inquiry:

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[22] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2A, p 353.
[23] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2A, p 356.
[24] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2A, p 356.

> We need collaboration between governments and Aboriginal communities on community based justice for FASD sufferers as an alternative to imprisonment or detention. We would like the committee to support the recognition of Aboriginal people with nurturing and traditional learning expertise in education, justice, health and early childhood development fields. Answers and solutions cannot be found in Western models. We need to incorporate Aboriginal ways of healing and managing family members.[25]

The *Youth Justice Act 2005* (Northern Territory) states that programs established under the Act should "be culturally appropriate".[26] Evidence demonstrates that western and mainstream mental health interventions are ineffective in responding to the complex needs of Aboriginal people.[27] As such, it is imperative that programs are Aboriginal led.

In its final report, the Royal Commission noted that "Specialist intervention may be required for children and young people suffering from neurological conditions that may lead to offending behaviours, such as Foetal alcohol spectrum disorder (FASD) or acquired brain injury. They also need to be referred to programs that have been designed specifically for their condition."[28]

NAAJA welcomes the additional supported bail accommodation options that have been made available in the Northern Territory since the Royal Commission, noting that there are still gaps in this regard. In short, there are some positive movements afoot in relation to alternative detention settings for our clients. However, much more must be done especially with respect to alternative detention options on country and at a location taking into account the cultural circumstances of the young person..

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[25] Commonwealth, above n 24, 91.
[26] *Youth Justice Act 2005* (Northern Territory) s 4(p)(i).
[27] B Fan, 'Intervention model with Indigenous Australians for non-Indigenous counsellors', 3(2), *Counselling, Psychotherapy and Health, Indigenous Special Issue*, (2007), 14-15.
[28] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 2B, p 275.

1. FASD and Care and Protection

Aboriginal children are overrepresented in the Northern Territory care and protection system, and the reasons behind these notifications are overwhelmingly a direct result of the impoverished circumstances in which many Aboriginal families live. *Growing Them Stronger, Together* identified 'neglect' as the primary maltreatment type experienced by Indigenous children in the Northern Territory occurring in 43% of child protection notification substantiations.[29] Neglect is characterised as the failure to provide "for a child's basic needs, including failure to provide adequate food, shelter, clothing, supervision, hygiene or medical attention."[30] The Inquiry highlighted the link between neglect and the poor socio-economic conditions experienced by Indigenous communities, which includes "overcrowding, unemployment and a lack of services."[31] The report also noted that the "socio-economic factors which give rise to child abuse and neglect are more prevalent in the Northern Territory than in any other State or Territory."[32] The Royal Commission's *Interim Report* acknowledged the connection between intergenerational trauma, child protection and youth justice on Indigenous children in the Northern Territory:

> Aboriginal people have experienced trauma stemming from the results of colonisation and the loss of culture and land, as well as government policies such as the forced removal of children. This trauma has had a negative impact on cultural identity, which consequently has reduced the capacity of Aboriginal people to participate fully in their own lives and community. The fact that so many Aboriginal children and young people enter out-of-home care and youth detention in the Northern Territory is a consequence of these factors.[33]

For many Aboriginal children, care placements may aggravate these traumas and/or expose them to further disadvantage and neglect. For a child with FASD, the impact will be exacerbated. A reduced ability to cope with change creates an additional difficulty for Aboriginal children with FASD in care in the Northern Territory as they are "moving between family of origin, kinship care and foster care involves changes in

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[29] As a point of contrast, non-indigenous substantiations of abuse are broken down as physical 37%, sexual 11%, emotional 32%, and neglect 20%: M. Bamblett, H. Bath and R. Roseby, Board of Inquiry into the Child Protection System in the Northern Territory, Northern Territory Government, *Growing them Strong, Together: Promoting the safety and wellbeing of the Northern Territory's children,* (2010) vol 1, 165.

[30] M. Bamblett, H. Bath and R. Roseby, Board of Inquiry into the Child Protection System in the Northern Territory, Northern Territory Government, *Growing them Strong, Together: Promoting the safety and wellbeing of the Northern Territory's children: Summary Report* (2010) 21.

[31] Ibid.

[32] M. Bamblett, above n 16, 108.; M. Bamblett, H. Bath and R. Roseby, Board of Inquiry into the Child Protection System in the Northern Territory, Northern Territory Government, *Growing them Strong, Together: Promoting the safety and wellbeing of the Northern Territory's children: Summary Report* (2010) 21.

[33] Commonwealth, above n 4, 35.

culture, language and location. All of these are a challenge for a child with FASD to manage."[34]

In Volume 1 of the Final Report of the Royal Commission, NAAJA lawyer Brianna Bell's evidence was referred to:

> 'While removal of a child is sometimes necessary, it must be acknowledged that removal itself can cause a form of trauma both to the children and the parents. In this context, it is critical to ensure that families have the right to hear the allegations, safety plans and any proposal to remove the child, and respond to these, in the language they are best able to express themselves in.[35]'

NAAJA is concerned that the lack of support and education for families to meet the needs of a child with FASD could be a contributing factor to involvement with the child protection system. NAAJA staff have observed that children are often removed from parents on the basis of a perceived lack of parenting capacity and insight. Whilst there may be a number of factors cited as contributing to this, such as alcohol abuse or domestic and family violence, NAAJA believes that the lack of education for parents around the complex needs of their children is also a significant factor. During supervised visits, NAAJA is aware of instances where a parent has been judged as being unable to control their FASD-affected after the child has had a temper tantrum that has been challenging for the parent. Education for parents about how to read the signs their child will show would go a long way towards alleviating Territory Families' concerns about parenting capacity

A social worker at NAAJA observed that:

> "There is a huge gap in education (especially culturally appropriate) for Aboriginal parents about FASD. Many people are confused about what FASD is and how it affects children/young people. Often parents will be told "it's a problem with how the child's brain grows and functions and it's caused by mums drinking alcohol during pregnancy". This is a very vague description and it doesn't offer any real information about supporting a child living with FASD. There are no education classes or courses that provide ongoing learning about what the condition is and which provide practical examples of how to assist and support a child with FASD. Most of the time parents hear from Territory Families or a GP once or twice about their child's FASD. It's not realistic to expect a parent to understand what FASD is and acquire the specialist skills to support their kids with FASD if they haven't had appropriate education. These are also parent who may speak English as a 2nd or 3rd language, may possibly have limited education, are from socio-economic disadvantage, may possibly have an intellectual impairment or disability."

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[34] Ibid.
[35] Vol 1, page 36. Exh.678.001, Statement of Brianna Bell, 26 May 2017, tendered 30 June 2017, para 36.

Section 10 *Care and Protection Act 2007* (Northern Territory) states that the "best interest of the child is the paramount concern" in child protection matters. However, when there are no options for Indigenous parents to educate themselves and better understand FASD this becomes a difficult obstacle for parents to overcome and to demonstrates to the Courts that they can adequately care for the child.

Undiagnosed parents also face difficulties accessing the appropriate services to enable them to meet expectations of Territory Families or the Child Protection Court Judge in child protection matters. A NAAJA social worker further observed that:

> There are parents who know their mums drank alcohol during pregnancy and after but have never been assessed for FASD. Territory Families will pay for children to be assessed but there is no funding available for parents. Territory Families will often not consider parents as potentially having FASD so there is no understanding about the difficulties some parents are facing with having to meet Territory Families expectations.

NAAJA staff have frequently observed that clients who may have been in the care and protection system from a very young age may not have been assessed for FASD despite clear red flags as to its possible presence. Many of these children end up being involved in the youth justice system, due to behaviours that are likely attributable to FASD and which could have been mitigated through appropriate assessment, diagnosis and treatment plans. The removal of a child from their family will always be an unfortunate instance, all the more so when that unfortunate instance is not least used as an opportunity for positive interventions in the child's life and an appropriately thorough analysis of what the child needs to thrive.

Where a child in the care and protection system has been diagnosed with FASD, shortcomings may also occur in the departmental response to that child. A NAAJA staff member shared the following example:

> NAAJA assisted a 15 year old youth, who was diagnosed with FASD as a child. Territory Families have worked with the child throughout 15 different placements with extended family. At the time the child was diagnosed, there should have been a focus on stabilising family. Too often the system waits until the situation is at crisis point until taking action, which is too late. The youth requires a specialist care placement, which is possible but resource intensive; and not something done as usual practice as Territory Families is overloaded and has limited capacity.

NAAJA recommends that Territory Families establish a dedicated FASD unit. We acknowledge that coordination of a FASD diagnosis is a massive workload, and understand that caseloads of Territory Families workers may present challenges in this regard. There is a need for a specialised, adequately resourced team with all children with FASD being managed by that team given it is such a specialised area.

The Royal Commission made a number of findings and recommendations in relation to FASD and care and protection as follows:

> "Children with FASD who enter the child protection system are likely to require complex care. In her evidence to the Commission, a former departmental officer noted that change and instability are particularly difficult for those children. She recommended specialist services be developed to provide expert services for these children and that carers receive training and support to manage their care."[36]

Screening

> Recommendation 33.14: Territory Families standardise screening for these children for FASD when entering out of home care.[37]
>
> "Children who enter out of home care have a range of needs that should be supported. To ensure the needs of children with disabilities are met in out of home care, adequate screening and assessments must be undertaken when these children enter care. It is recommended that Territory Families standardise and improve screening for children with FASD and other disabilities when they enter care and provide automatic referrals to relevant medical professionals."[38]

Rehabilitation services

> "Some of the rehabilitation programs and services that were available were not able to cater to children and young people in out of home care who had complex needs. For example, DG was deemed unable to participate in one volatile substance abuse program due to her cognitive impairment. Given the prevalence of FASD in the Northern Territory, discussed in Chapter 3 (Context and challenges), there is a clear need for rehabilitation and counselling services that target children and young people with cognitive impairments."[39]
>
> Recommendation 33.15: Territory Families improve access for children and young people in out of home care to effective rehabilitation and

[36] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3A, p 441.
[37] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3A, p 441.
[38] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3B, p 274.
[39] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3A, p 443.

counselling services including the prevention and treatment of substance abuse.[40]

Training for carers

- "The Chief Executive Officer of Foster Carers' Association Northern Territory told the Commission that foster and kinship carers may require specific training to manage particularly complex behaviours, including those relating to FASD. The Commission heard that Territory Families does not currently offer comprehensive training for carers living in remote locations."[41]

  Recommendation 33.19: Territory Families provide support to foster and kinship carers, including through implementation of training targeting specific populations in out of home care. This training should be accessible to all foster and kinship carers, including: those in remote communities, and those who cannot attend training during business hours.[42]

The Northern Territory FASD Strategy referred to a pilot study commissioned by Territory Families looked at a sample of children involved with child protection services in the Northern Territory during 2011-12. The study found that prenatal alcohol exposure was associated with children entering care, and that these children experienced more significant behavioural and health issues than others. As result, the Northern Territory FASD Strategy Identified children in out of home case as a priority group. The Strategy further acknowledged that early assessment for neurodevelopmental impairment and linking these children with support services may prevent future contact with the juvenile justice system. NAAJA welcomes the move to identify children in out of home care as a priority group, and calls for this to be meaningfully reflected in practice.

2. Assessment and Diagnosis

There are significant barriers to obtaining a FASD assessment in the Northern Territory, including cost, gaps in service provision, and the length of the process which is onerous for clients and their families. There are regional differences between the options available in the Northern Territory. In Alice Springs, Central Australian Aboriginal Congress have limited resources to undertake FASD assessments and devise treatment plans for youth that are diagnosed. In Darwin, in NAAJA's experience the options for assessment are more limited and require engagement of interstate

[40] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3A, p 443.
[41] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3A, p 446.
[42] *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report, November 2017) Vol 3A, p 446.

organisation PATCHES who conduct the assessment on a fly-in, fly-out basis with visits on a monthly basis.

FASD assessments require a paediatric review to identify whether the facial features are present, and to review the young person's records from birth including the presence of any growth deficits, intrauterine growth retardation and/or microcephaly (small head circumference). Assessments by a neuropsychologist and/or educational or developmental psychologist; occupational therapist; physiotherapist; and speech and language pathologist are required to cover the 10 domains. A social worker may be required to investigate the child or young person's prenatal history which may involve interviews with parents, family members, or a review of child protection files, to determine whether there is evidence of prenatal alcohol exposure.[43]

The sequence of events that generally leads to an assessment, as described by a Darwin based NAAJA Youth Throughcare worker, is as follows:

- Youth comes into contact with Families or Youth Justice
- NAAJA lawyer has contact
- Social worker undertakes psycho social assessment (as requested by a lawyer)
- Social worker Identifies signs of FASD and/or other issues (eg complex trauma)
- Forms completed for consideration by Youth Court to have assessment undertaken (Patches)

Based on enquiries by a NAAJA social worker, we understand that the following assessment options are currently available in the Northern Territory:

- Royal Darwin hospital – requires referral from a GP to the paediatric clinic. 6-8 months wait for first appointment. Then several months for next appointments if needed. Assessment is free and follow up support provided through allied health services.
- PATCHES – private agency from WA. Costs approximately $8000 with a 2-3 month wait. Assessment report and recommendations made. No follow up specifically but can provide coordination if allocated as the provider by NDIS.
- Central Australian Aboriginal Congress (Alice Springs) – 18 month wait at least (for young people not in detention)
- Outlook psychology (Nhulumbuy based) Approx $4500 – The youth justice court are looking into this option at present
- The Northern Territory Government have undertaken, as part of their 'Addressing Foetal Alcohol Spectrum Disorder 2018-2024' policy that they will support coordinating FASD interventions and assessments with Aboriginal

[43] Prue Walker, *FASD Case Review for Youth Justice, Hume region, Department of Justice and Regulation*, 2018, 6.

> controlled health organisations. It isn't clear if there has been any progress with this. Getting FASD assessments is very difficult.

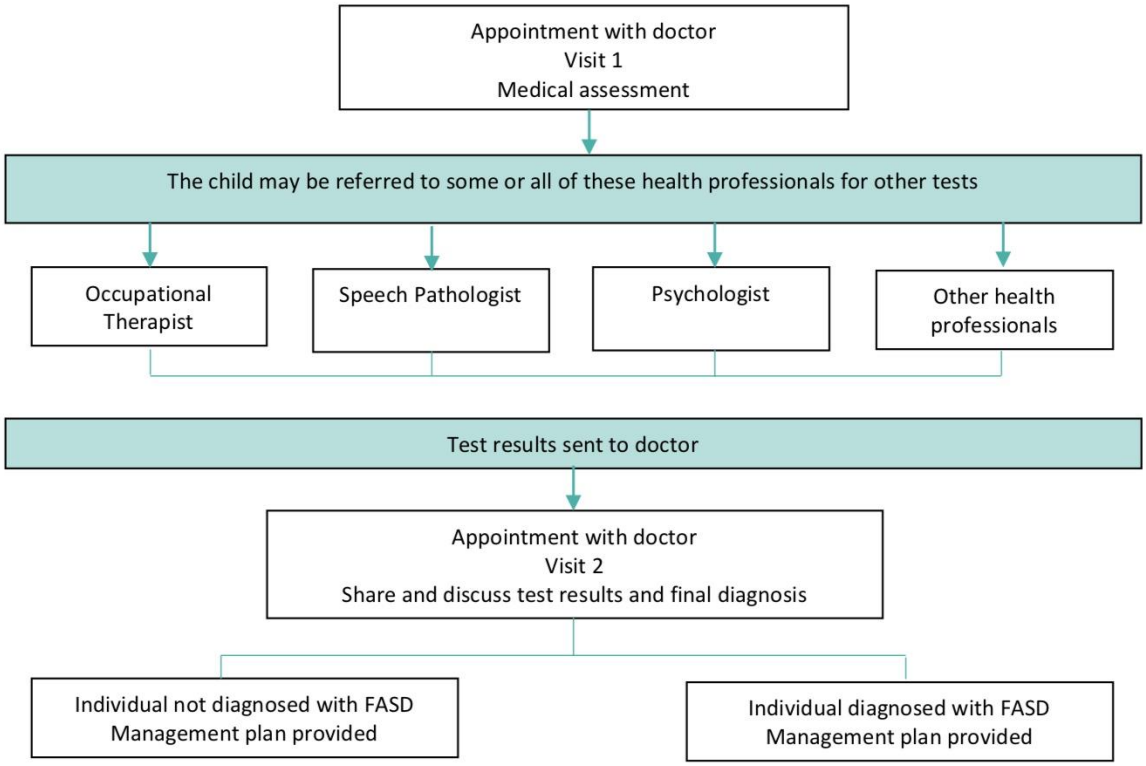
Notwithstanding the renowned expertise of PATCHES, difficulties can arise as a result of the fly in, fly out nature of assessors including reduced flexibility of appointment times. For young people who are not in custody, this can lead to a lot of time being spent by local service providers locating the client and assisting them to attend the appointment. If the assessors were Darwin based, there may be more flexibility in this regard. NAAJA notes that as part of the 'Addressing FASD 2018-2024' policy, the Northern Territory Government has indicated that they will support coordinating FASD interventions and assessments with Aboriginal controlled health organisations. NAAJA supports the increased resourcing of Aboriginal Community Controlled Health Services to perform this function.

PATCHES are a registered therapy provider through the NDIS and offer FASD-specific therapy and support programs. PATCHES use a three stage assessment program: (1) Neuropsychology testing, (2) speech therapist or occupational therapist, and (3) Pediatrician. The appointments occur over three days and may take up to six months to finalise a diagnosis. Occasionally, a report may be completed within 2-3 months.

The consequences of the FASD court report requiring several months to complete often means that the young person's proceedings are delayed and extends the time the individual is in contact with the system. For children remanded in custody, this can significantly extend their time in detention.

In the absence of a FASD Diagnostic team, the Guidelines propose a process whereby an identified medical practitioner conducts an assessment, refers the child or young person for the other required multi-disciplinary assessments, then reviews the outcomes and makes a final diagnosis.[44] The process is outlined as follows:

[44] Prue Walker, *FASD Case Review for Youth Justice, Hume region, Department of Justice and Regulation*, 2018, 6



Australian Guide to the Diagnosis of FASD, 2016

NAAJA staff have emphasized that evidence of prenatal drinking can be difficult to locate, and that enquiring directly with the mother has its limitations due to the shame and guilt associated with drinking during pregnancy. For this reason, it is important that primary documentation from police, child protection, and health services is considered as contemporaneous material that could indicate whether drinking during pregnancy did occur.

Whilst it is important for full investigations to be conducted (with the required consent), NAAJA cautions against an over-zealous approach that may see assumptions being made that a child has FASD because of the mother's current alcohol issues, with no consideration or knowledge if she drank during her pregnancy. In our direct experience we are aware of instances where the inference is an Aboriginal mother consumed alcohol during pregnancy and denies doing so and the results of FASD assessments find the child does/did not have FASD.

Obtaining a diagnosis is but one of many steps that are required. According to Prue Walker:

> The specifics of the diagnosis need to be translated into knowledge for those who need to know – for example, in a speech and language assessment, it might be identified that the young person's working memory can hold only one thing at a time, or that the young person takes about a minute to process verbal information. This is important knowledge for those working with the individual.

> It is of benefit for a young person to understand their diagnosis as it can assist the young person not to 'feel stupid' or to blame themselves when they don't understand something. The young person's strengths also need to be identified so that planning can be strength-based.
>
> Family members and those supporting a young person with FASD need psycho-social education about the disability and what it means for the young person. Education needs to be specific to the young person, their environment and their networks. Family members who are asked to support a young person need to understand how the young person's brain works, so they can understand and even predict their behaviour in different circumstances.[45]

Having outlined some of the complexities in relation to assessment and diagnosis, we now turn our attention to the issue of support services – or the unfortunate lack thereof.

3. Support services

Even if someone is able to overcome the barriers that may present when engaging with the assessment process, unfortunately they will face a real lack of specialist supports in response to a diagnosis of FASD. The lack of support services occurs in both the custodial and community settings. The lack of services can adversely impact clients in a number of ways, including prejudicing their legal options and leading to time in detention in lieu of community based supports.

NAAJA has observed a lack of follow-up support and coordination, and if case management and support is provided it is on an ad-hoc basis by different agencies incidentally involved. If a child is in the care of Territory Families, Territory Families should be providing that case management. NAAJA is concerned that there do not seem to be any specialist or specific teams that case manage the children and young people who have or are suspected to have FASD. FASD practice principles do not appear to be at the forefront of planning for children who does have FASD. A NAAJA social worker commented that it is not uncommon to receive a section 51 report for a young person with FASD that does not even mention that they have FASD. We are also concerned that in the residential care setting, there is a lack of training about how to appropriately support children and young people with FASD. Through our discussions with staff in residential care, we are aware of staff from numerous services who have not received any FASD training.

Unfortunately, NAAJA has observed that young people at the Alice Springs Youth Detention Centre are not receiving the limited treatment that is available in Alice Springs due to no clear lines of responsibility in relation to who should fund these services. Service providers such as Headspace then indicate that they can only see youth clients if they attend appointments in town. However, TF do not generally facilitate this due to not having enough staff to transport young people to town for

[45] Prue Walker, *FASD Case Review for Youth Justice, Hume region, Department of Justice and Regulation*, 2018, 7

appointments. As a result, young people in detention with diagnoses, or potential diagnoses, of FASD and requiring specialist mental health support are not receiving the little treatment that is available in Alice Springs.

At the DDYDC there are serious shortcomings with respect to the qualifications of staff and their knowledge of FASD. We understand that there is no occupational therapist in that setting, and social workers have varying knowledge of the condition.

NDIS

NAAJA acknowledges the expertise of Aboriginal Community Controlled Health organisations in relation to NDIS, and endorses the submissions of AMSANT and Danila Dilba Health Service in this regard. We also note the expertise within Darwin Community Legal Service as to the legal issues experienced by clients when seeking to access supports through NDIS.

In his evidence to the Joint standing committee on the National Disability Insurance Scheme, David McGinlay of the Darwin Community Legal Service DCLS stated:

> "Much has been reported about the underspend of the NDIS. NDIS plans for remote communities at the Top End of the Northern Territory are funded; however, participants do not draw down on the funds to access disability support services. The question is: why? The answer is predominantly that there are limited to no disability support services available in remote communities.
>
> As mentioned previously, the Northern Territory government previously provided disability support services in remote communities prior to the NDIS. They've since handed all responsibility for disability support services provision to the NDIS. Due to the remoteness of the locations and costs associated with establishing a service provision, disability support service providers have made a logical business decision—that it is not worth it for them to fill the service gap. This has then created the situation of thin to non-existent services being available for NDIS participants, who are left with limited, if any, choice of disability service support.
>
> Many NDIS plans are left with unspent funds, and participants are going without essential services. The underspend is a fiction. It is not an underspend; it's an inability to spend. It is a failure in the market economy created by the NDIS. This is a postcode lottery that results in an inequality of service provisions based on where you live. [46]

[46] David McGinlay, Darwin Community Legal Service, Joint standing committee on the National Disability Insurance Scheme – Tuesday 19 November 2019, p45 (accessed at <https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/NDISPlanning/Public_Hearings>)

Gaining a FASD assessment through the NDIS can be a difficult process for young people. It is important to identify the compounding disadvantages a young person may experience trying to navigate through the system when they also have FASD.

> Of most significance has been the dramatic reduction in offending and his willingness to engage with a broader range of people and services than he had previously.

Support for parents of children with FASD

We have identified a huge gap in education for Aboriginal parents about FASD. A NAAJA social worker commented:

> "Many people are confused about what FASD is and how it affects children/young people. Often parents will be told 'it's a problem with how the child's brain grows and functions and it's caused by mums drinking alcohol during pregnancy'. This is a very vague description and it doesn't offer any real information about supporting a child living with FASD. There are no education classes or courses that provide ongoing learning about what the condition is and which provide practical examples of how to assist and support a child with FASD. Most of the time parents hear from TF or a GP once or twice about their child's FASD. It's not realistic to expect a parent to understand what FASD is and acquire the specialist skills to support their kids with FASD if they haven't had appropriate education. These are also parents who may speak English as a 2nd or 3rd language, may possibly have limited education, are from socio-economic disadvantage, may possibly have an intellectual impairment or disability."

This lack of education means that parents are not supported to develop the specialist skills to meet the needs of their children or discipline them appropriately, and that parents do not understand why their children are misbehaving. There is a public education deficit not just in relation to FASD, but all disabilities generally. The following case study highlights this issue:

> A parent was scrutinized by Territory Families for not understanding autism and knowing how to respond to their child. The parent was given no support to understand or learn about the disability, other than being sent to their GP to be informed. This is inadequate. A longer session than a short discussion during a GP visit is needed, and education must also be recurring as children change as they grow and there will be differences between how to manage FASD at the stages of infancy, toddler, child, adolescent and adult. Some isolated appointments with a GP is not enough support or education.

Education must also be culturally appropriate. In this regard, NAAJA recommends that Aboriginal Community Controlled Health Organisations are resourced to have a neurodevelopmental specialist on site to deliver support and education sessions.

4. Adults experiencing FASD: a significant unknown

The submission has noted the lack of Northern Territory specific data to estimate the prevalence of FASD amongst young people. This dearth of information is even more pronounced where adults are concerned, partly due to the lack of assessment options but also due to the other intervening factors that may be present in adulthood that can make it difficult to isolate issues and identify which behaviours are attributable to which condition or circumstance.

In the course of our discussion about the intersection of FASD and the care and protection system, we discussed the way in which parents of FASD affected children can be prejudiced by the lack of education and support available during their dealings with that system. This is even more so for parents who themselves may be experiencing FASD. In Darwin, NAAJA understands that PATCHES does not conduct assessments of parents who may have FASD, and that these assessments have to be arranged independently with significant cost and difficulty. NAAJA is aware of instances where adult clients know that their mothers consumed alcohol whilst pregnancy and after, but have never been assessed for FASD. When interacting with a family, we understand that Territory Families will pay for children to be assessed for FASD but will not cover this cost for parents. Given that the best interests of the child would be better served by supporting the capacity of parents to care for their own child, this gap is most unfortunate.

The lack of assessment options also present a barrier to accessing NDIS supports, due to the requirement of a diagnosis for eligibility purposes. It would be a positive step if NDIS could extend to the assessment stage where FASD is suspected but requires proper investigation.

NAAJA is aware of a lack of services for adult clients, even after they have gone through the process of being assessed and diagnosed. A NAAJA lawyer from Darwin spoke of his efforts to assist an adult client to try to access supports after being diagnosed with FASD:

> "The client was not diagnosed until he was an adult and he is currently serving a lengthy prison sentence. Despite persistent advocacy, there has been very little support provided by Northern Territory Corrections. There is very little mental health support for individuals in Darwin Correctional Centre, and no programs in place for those diagnosed with FASD. As a result, the support the client has received since diagnosis is extremely limited."

In the course of preparing our submission to this inquiry, NAAJA has also had contact with the Darwin Indigenous Mens Service (DIMS). DIMS was created to provide support services to Aboriginal adult men in the Darwin region, and sees approximately 200 males every 12 months. DIMS has indicated that 25% of these clients show indicators of FASD, including short attention spans and limited memory retention. DIMS focusses on using pictures and "narrative" education for clients with these difficulties. We understand that many clients presenting with FASD symptoms also

have drug and alcohol issues, and that FASD indicators are at times identified partly through clients engagement with rehabilitation at Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD) and Council for Aboriginal Alcohol Program Services (CAAPS); albeit not through any specifically targeted programs for FASD itself.

It is NAAJA's view that the assessment and treatment options for adults who are, or are suspected to be, affected by FASD require investigation. We expect that grave shortcomings will be identified, and would welcome the resourcing of further options in this area.

5. International Best Practice

This section will outline some of the best features of the youth justice and care and protection systems in Manitoba and British Columbia (Canada), and New Zealand. It is worth considering some of the exceptional advances that have been made in juvenile justice globally which acknowledge and account for the relationship between social disadvantage, health, trauma and youth offending and also provide sophisticated alternatives to detention. Any adoption of these approaches will need to sensitively and carefully tailored to the Northern Territory context.

Healing and holistic approaches as pathways to success

Aboriginal children in the youth justice system who have FASD present a particularly difficult kind of vulnerability. New Zealand and Canada have all gone to lengths to acknowledge the impact of a young person's circumstances on their offending and have subsequently resourced alternate options to detention. These options give full effect to the Northern Territory *Youth Justice Act* principle that detention is used only as "a last resort".[47] Aboriginal leaders have identified that the experiences of trauma and disadvantage are so severe that for some child offenders healing programs are essential for lasting behavioural change. The success of early intervention and diversionary options addressing such needs have been demonstrated by New Zealand.

New Zealand's Child, Youth and Family youth justice supervisor Ange Couch credited the success of Family Group Conferencing (FGC) in New Zealand to greater family involvement in managing the offending of their child and addressing "underlying factors like drug and alcohol issues".[48] New Zealand is a model for reform due to its emphasis on and respect of Maori forms of care and the requirement to consult with family in regards to child offending and protection. As part of a FGC, whole families may agree to attend Functional Family Therapy or Multi Systemic Therapy and work

[47] *Youth Justice Act 2005* (Northern Territory) s 4(c).
[48] Adele Redmond, 'Drop in crime reflects better collaboration in youth justice', *Stuff* (online, 14 March 2016) <http://www.stuff.co.nz/national/crime/77807338/Drop-in-child-crime-reflects-better-collaboration-in-youth-justice>.

together to address the offending behaviour.[49] New Zealand has noted the importance of a greater availability of Maori informed rehabilitation programs for better youth justice outcomes.[50] These measures avoid punishing children for historical and structural disadvantages and seek to address the underlying causes of offending. It is in such a structure that creative solutions can be devised to deal with a young person's complex needs as someone suffering from FASD.

The suspected high presence of FASD in child protection cases and youth detention detainees in the Northern Territory warrants particular attention in how to better manage this condition. Canada appears to be one of the most progressive jurisdictions in the world in terms of its actions on FASD and youth justice. In a one-year study of youth remanded in an inpatient psychiatric assessment unit in British Columbia, 23.3% were diagnosed with FASD.[51]

The development of the Manitoba FASD Youth Justice Program is underpinned by an understanding that "FASD affected children need to be identified as early as possible if therapy and interventions are to make a difference in their long term prognosis, and screening programs need to be introduced to afford early detection."[52] Based on preliminary research NAAJA understands that this Program essentially enables a FASD-specific Court to be accessed by youth who have been diagnosed with FASD, and adults up to age 25 where they have been diagnosed before 18.[53]

Manitoba's regime to screen for FASD prior to court sentencing is crucial to ensure fair and just decisions are made. The *Youth Criminal Justice Act* requires courts to hand down sentences which are "meaningful for the individual young person given his or her needs and level of development".[54] These measures understand that perpetrators can only be accountable for their actions to the extent that they have the capacity to be accountable. If eligible for the program, the Court will be informed about the severity of the accused's condition after they have undergone assessment by health and other professionals. Manitoba Legal Aid also have a specialised 'FASD Youth Accommodation Counsel' and provide lawyers to FASD affected-youth who have an expertise in the area. These measures ensure a quality of service and improved outcomes for clients.[55] Although it is a condition that has no cure, evidence

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[49] Judge Andrew Becroft, 'It's All Relative: the Absolute Importance of the Family in Youth Justice (a New Zealand Perspective)', (Paper presented at World Congress on Juvenile Justice Geneva, Switzerland, 26-30 January 2015) 28, 31-32.
[50] Davies, above n 9, 13.
[51] Julianne Conroy, Kwadwo Ohene Asante, Asante Centre, *Youth Probation Officers' Guide to FASD screening and referral* (2010) 9.
[52] Sally Longstaffe et al., 'The Manitoba Youth Justice Program: Empowering and Supporting FASD Affected Youth in Conflict with the Law' *Biochem Cell Biology* (2017) 5.
[53] *Youth Criminal Justice Act*, SC 2002, c 1, s 3(c)(iii); For more information, see https://www.thelawyersdaily.ca/articles/10177
[54] Ibid, 9.
[55] Ibid, 29.

demonstrates that early interventions is the best method to manage, prevent and reduce anti-social behaviour.

In Manitoba there are also innovative supports available to parents and carers with FASD children, including the following:

- The Building Circles of Support is an 8 week parenting information series offered by the Manitoba FASD Centre in person and through Tele health video conferencing to parents, caregivers, family members and professionals who support children and youth diagnosed with FASD. The purpose of the group is to help educate and empower families and other key individuals in the child's life about FASD; learn about the best practices in parenting a child with FASD; connect and network with other families; and link to FASD resources and services in their area.
- The FASD Family Support, Education and Counselling 6-14 Program is offered by New Directions for Children, Youth and Families. The program works in partnership with parents and professionals to develop programs that are individualized to meet the needs of children and youth with FASD, ages 6-14, living in Winnipeg. The program also provides home-based services and counselling to families and helps to access family advocacy and other services.
- **The FASD Family Network** is co-sponsored by the Manitoba FASD Centre and the Rehabilitation Centre for Children. It provides an opportunity for parents and caregivers of children affected by FASD to meet with other parents and caregivers. Participants are asked to share ideas, develop connections and provide knowledgeable input into developing new services for families. The program also offers recreation opportunities for youth with FASD, such as summer and winter camps.
- **The Manitoba Key Worker Program**, offered through the Interlake-Eastern Regional Health Authority provides support and personalized information to families of children and youth, ages 0-21, with FASD or confirmed prenatal alcohol exposure. Key Workers assist families in accessing supports, community resources, and health and education information that reflects the specific needs of the family. Key Workers work in collaboration with parents, family members, adoptive parents, caregivers and service providers to assist children and youth with FASD experience less frustration and more success. Key Workers supplement and enhance, but do not replace existing community resources.[56]

British Columbia's program is known as the 'Through an Aboriginal Lens' Project ('TAL') and offers a more comprehensive support to youth and families referred through the Youth Justice FASD Program, including assistance to young people

[56] For more information see: https://www.gov.mb.ca/healthychild/fasd/supports.html

transitioning back into the community after custodial sentences.[57] This support incorporates Aboriginal values of patience, care, respect and love to their rehabilitation services.[58] Central to the program is collaboration between the Aboriginal community and FASD health experts. TAL takes a strengths based approach and provides young offenders "the opportunity to experience spiritual cleansing ceremonies, time on the land and Indigenous foods, medicines and arts."[59]

Since 2016, Australia has had its own diagnostic tool for identifying FASD.[60] This tool ought to be used in conjunction with the multidisciplinary interventions used in Manitoba. Targeted research ought to be carried out about FASD prevalence in youth detention and the juvenile justice system more broadly to better understand these issues. These approaches are imperative to fairly and adequately manage the offending of FASD-affected children from the child protection system.

CONCLUSION

NAAJA thanks the Committee for taking the time to consider our feedback. We would be happy to provide further information as required, to assist the Committee with its work.

We look forward to the outcome of this inquiry.

[57] Asante Centre, *Through An Aboriginal Lens Program*, (2017) <http://www.asantecentre.org/Through_an_Aboriginal_Lens.html>.
[58] Through an Aboriginal Lens, *Youth Justice* (2017) <http://throughanaboriginallens.ca/yj.php>.
[59] ibid.
[60] 'FASD diagnostic guidelines', *Telethon Kids Institute* (Web Page, 16 May 2016) <https://alcoholpregnancy.telethonkids.org.au/resources/fasd-diagnostic-guidelines/>.