Central Australian Aboriginal Congress

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Submission to the

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

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Background

Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of our people. Since the 1970s, we have developed a comprehensive model of primary health care that includes:

- multidisciplinary clinical care;
- health promotion and disease prevention programs; and
- action on the social, cultural, economic and political determinants of health and wellbeing.

Congress delivers services to more than 16,000 Aboriginal people[1] living in Alice Springs and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna. For further information about Congress visit our website: www.caac.org.au

As a result of the processes of colonisation (see paragraph 10 below) Aboriginal people in Central Australia have very high levels of disability (7% of those aged 15 or more report having a profound or severe disability). Families provide much of the care needed, with 19% of Aboriginal people in the region report providing unpaid care to family members, while their capacity to do so is challenged by poverty, isolation and lack of services [1][2].

This submission follows the Royal Commission into the Detention and Protection of Children in the Northern Territory, initiated after revelations of abuse of children and young people in youth detention in the NT. Given the high rates of cognitive disability of children and young people within criminal justice system, the Royal Commission highlighted the need for a therapeutic, rather than punitive approach, for these children.

Congress has concurrently increased our focus on early childhood development and early intervention on developmental delay, which if unaddressed, leads to cognitive disability. This is reflected by the number of young people with cognitive disability within the criminal justice system.

[1] Congress uses the term 'Aboriginal' as the most appropriate term in the Central Australian context to refer to Australia's First Peoples.

[2] Note that the figures in this paragraph are from the 2016 Census and are certainly underestimates of the scale of the problem.

This submission focuses on how to address these high rates of disability, in particular through:

- principles for action on disability in the Aboriginal context
- how cognitive disability arising from early childhood disadvantage can be prevented and/or addressed
- addressing disability for Aboriginal people within the context of the criminal justice system and cognitive disability.

Recommendations

Recommendation 1

That any approach to meeting the needs of the high numbers of Aboriginal people with disabilities must be based upon their rights under the *United Nations Convention on the Rights of Persons with Disabilities* and Aboriginal peoples' rights to self-determination as established under the *United Nations Declaration on the Rights of Indigenous Peoples*. This is alongside agreeing to the structural reform needed to claim rights of self-determination, as called for in the *Uluru Statement of the Heart.*

Recommendation 2

That all programs for addressing disability in the criminal justice system must be founded on a positive attitude to Aboriginal culture and ways of being, and resourced to be trauma-informed and healing-focused.

Recommendation 3

That any approaches to preventing and addressing disability includes acting on poverty and disadvantage; unemployment, overcrowding and inequality.

Recommendation 4

That, as a key primary prevention measure to address the developmental vulnerability and disability arising from harmful alcohol use, the Australian Government provides leadership for the national adoption of objectively evidenced policy approaches to reducing alcohol-related harm at a whole-of-population level, which include action on price and availability similar to those contained in the successful and world-leading Northern Territory Alcohol Policies and Legislation Reforms.

Recommendation 5

That government supports universal implementation of evidence-based early childhood development programs as the most cost effective long-term strategy to offset the effects of adverse early childhood experience of Aboriginal children and

reduce the very high rate of disability in Aboriginal communities in general and the criminal justice system in particular.

Recommendation 6

That government supports and resources culturally secure assessment and primary prevention/early interventions services delivered by Aboriginal Community Controlled Health Services for children and young people.

Recommendation 7

That government supports and sufficiently resources neurodevelopmental assessment and therapeutic services, alongside primary health care, delivered by ACCHSs within youth detention centres.

Recommendation 8

That the minimum age of criminal responsibility be raised to 14 years, in line with a therapeutic approach to child and youth justice, rather than a punitive approach.

Recommendation 9

That government recognises the time needed to support behaviour change including therapies to manage and improve disability outcomes, and that programs are given substantial time to work (i.e. years), and are independently evaluated before considering disinvestment.

Recommendation 10

That the police and courts are informed of and understand the prevalence and causes of neurodevelopmental conditions and related behaviours in young Aboriginal people, and modify processes and procedures to better meet the needs of these young people.

Recommendation 11

That government supports the development of different models of alternatives to youth detention, that: aim to achieve long term health and development outcomes; are implemented over sufficient periods of time, with strong community involvement in their development; and are independently evaluated.

Principles for action

A human rights approach

1. In traditional times, Aboriginal people's access to the land and its resources and their cultural practices ensured that they were healthy and that those who needed were cared for by networks of kin. However, the processes of colonisation including the dispossession and impoverishment of our communities; the forcible removal of children from their families and its

intergenerational effects; the suppression of culture and language; and the ongoing experience of racism and discrimination have had profound effects on the health and wellbeing of our Nations. This includes both high levels of disability and extreme rates of incarceration.

2. Given this context, any approach to addressing the needs of Aboriginal people with disabilities must recognise, in addition to the rights under the *United Nations Convention on the Rights of Persons with Disabilities*, the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples* [2], which states:

   Article 22: Particular attention shall be paid to the rights and special needs of … persons with disabilities in the implementation of this Declaration.

   Article 23: Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

3. Additionally structural reform is needed for Australia's first sovereign Nations to claim their rights of self-determination, as called for in the Uluru Statement of the Heart:

   Our Aboriginal and Torres Strait Islander tribes were the first sovereign Nations of the Australian continent and its adjacent islands, and possessed it under our own laws and customs.

   We believe this ancient sovereignty can shine through as a fuller expression of Australia's nationhood.

   When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.

Intergenerational trauma and culture

4. The historical and ongoing experience of colonisation for Aboriginal people is now recognised as resulting in 'intergenerational trauma' whereby traumatic experiences

   … can be transferred from the first generation of survivors that have experienced (or witnessed) it directly in the past to the second and further generations of descendants of the survivors … this intergenerational trauma … is passed from adults to children in cyclic processes as 'cumulative emotional and psychological wounding' [3]

5. Culture and spirituality are important in addressing intergenerational trauma through supporting resilience, positive social and emotional wellbeing, and living a life free of addiction to alcohol and drugs [4]. In addition, services provided to populations carrying a large burden of trauma – and this includes

all programs in a criminal justice context – must have the skills and resources to recognise the different ways that unresolved trauma can manifest (for example, in mental health issues including suicide, addiction, or violence) and be able to address presenting issues in a way that promotes healing [3].

Recommendation one:

That any approach to meeting the needs of the high numbers of Aboriginal people with disabilities must be based upon their rights under the *United Nations Convention on the Rights of Persons with Disabilities* and Aboriginal peoples' rights to self-determination as established under the *United Nations Declaration on the Rights of Indigenous Peoples*. This is alongside agreeing to the structural reform needed to claim rights of self-determination, as called for in the *Uluru Statement of the Heart.*

Recommendation two:

That all programs for addressing disability in the criminal justice system must be founded on a positive attitude to Aboriginal culture and ways of being, and resourced to be trauma-informed and healing-focused.

Disability, early childhood development and alcohol

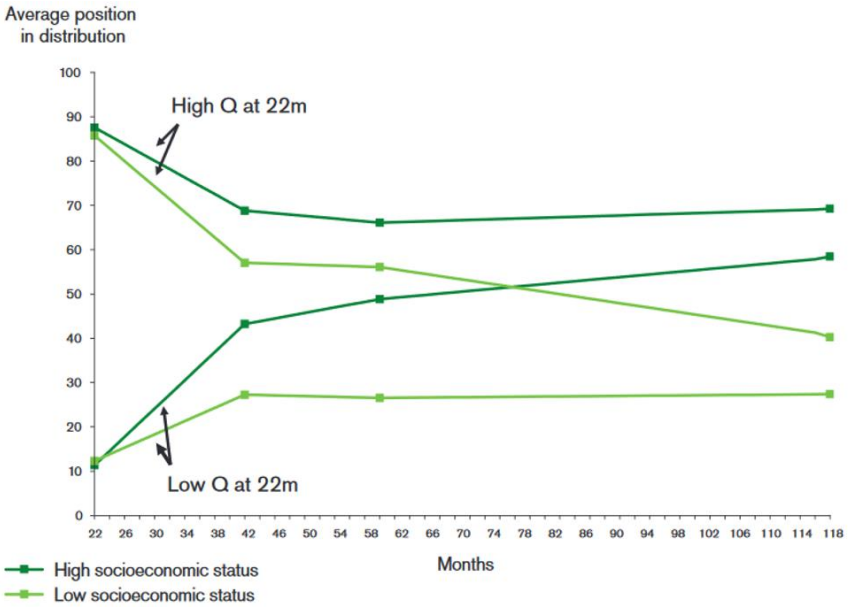
Disadvantage and brain development

6. During the first few years of life, interactions between genetic make-up, environment and early experience have a dramatic impact on how the brain forms. During these critical first few years, children need stimulation and positive relationships with care givers to develop neural systems crucial for adult functioning [5]. By the age of five, many of the developmental gateways for language acquisition, self-regulation and cognitive function have been passed, and a child's developmental trajectory already set [6].

7. Children who grow up in a disadvantaged environment do not develop the brain capacity to do well in education and, even though they attend primary school, will on average do less well and often drop out as soon as they are old enough. Traits such as impulsivity, poor concentration, lack of self-control and self- discipline are more likely [7].

8. The following graph shows how much the early childhood environment impacts on cognitive development. The difference in outcomes for children from low income families is likely due to children's experiences in the first three years of life in their homes. The things that make a difference include: daily one on one interactions and talking with young children; daily reading; going to bed at regular times; being physically active; and having a good playgroup of children of similar age. Without these critical early childhood experiences of responsive care and stimulation children lose cognitive potential even to the point of having an intellectual, emotional or other disability by age three [8].

Figure 1: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



Reproduced from [8]

Aboriginal children in Central Australia at higher risk of cognitive disability

9. The nurture and care of children is at the heart of Aboriginal culture. For tens of thousands of years, our diverse peoples raised healthy, resilient and creative children. Today, many of our families still do. As noted above in par. 5 contemporary Aboriginal families have been profoundly affected and disrupted by the processes of colonisation.

10. As a result, too many Aboriginal children in Central Australia grow up in an environment marked by poverty, substance abuse, and lack of responsive care and stimulation, with low levels of formal education and school attendance coupled with economic marginalisation and social exclusion. This does not apply to all families: there are many who are working, and able to care for their children well. Nevertheless, the overall picture for Central Australia shows that [1]:

    - the median individual income for Aboriginal people over the age of 15 is $281 per week, less than one third of that for non-Aboriginal people in the town ($1,080 per week);
    - 83% of Aboriginal adults did not complete schooling to Year 12; 8% did not go to school at all;
    - only 25% of the Aboriginal population over the age of 15 are employed (81% for non-Aboriginal residents);
    - 12% of babies born to Central Australian Aboriginal mothers in 2016 were of low or very low birth weight [9] (similar to Congress' own data which shows 11% in 2016/17).

11. As can be expected, the high level of disadvantage that these figures describe has a significant effect on child development and disability. The most telling figures are from Australian Early Development Census (AEDC) where the results for 2015 show that by the time they start school [10]:

    - Aboriginal children in the Alice Springs region are *six times* as likely to be vulnerable on two or more of five developmental domains compared to their non-Aboriginal classmates (43% of Aboriginal children, 7% of non-Aboriginal children)
    - 60% of Aboriginal children in the region are developmentally vulnerable on at least one domain (22% for non-Aboriginal children).

12. Broadly speaking, addressing the social and economic determinants of health will have a population level impact in the reduction of cognitive delay and disability in the Aboriginal population.

13. Addressing poverty and disadvantage; unemployment, overcrowding and inequality are integral to children's health and developmental outcomes, and preventing children and young people entering the criminal justice system.

Addressing disabilities caused by alcohol

14. Parental alcohol dependence is a major cause of child neglect and developmental disability, both before and after birth. The harm caused by alcohol to children is recognised in tools for the assessment of the needs of children and families such as the Family Strengths and Needs Assessment tool (FSNA) used by Congress. In addition, Foetal Alcohol Spectrum Disorder (FASD) is estimated to be between 3 and 7 times as common in the Aboriginal community as it is in the non-Aboriginal population [11] with one study concluding that 15.6% of avoidable intellectual disability in Aboriginal children is attributable to maternal alcohol use – twelve times the rate for non-Aboriginal children [12].

15. Reducing the consumption of alcohol amongst all women of child-bearing age and their partners is the key primary prevention approach to reducing developmental disabilities caused by alcohol consumption. This is because:

    a) the developing child is most vulnerable to exposure to alcohol in the first three to six weeks after conception, which is often before many women are aware that they are pregnant [13];

    b) the relatively high proportion of women who continue to drink at risky levels during pregnancy [14];

    c) the risk factors for having a child with FASD includes a woman having a male partner who drinks [15];

    d) the significant developmental harms done to children in the years after their birth into families where alcohol misuse is frequent [16].

16. For these reasons, and in line with key studies [17], reducing the prevalence of cognitive and other disabilities caused by alcohol must include broad-based public health measures to reduce consumption amongst the whole population, including women of child-bearing age.

17. In October 2019 the Northern Territory Government introduced a package of reforms to deal with the jurisdiction's long-standing issue with high levels of alcohol-related harm. The reforms included [18] a floor price to prevent the sale of cheap alcohol; a Banned Drinkers Register (BDR) to reduce the access to take-away alcohol by problem drinkers; and Point of Sale Interventions at bottle shops; risk-based licencing and greater monitoring of on-licence drinking; and a commitment to high quality, ongoing independent evaluation.

18. The first full year of the operation of the alcohol reforms from October 2018 to September 2019 showed very significant reductions in alcohol related harm including a reduction of 1,000 alcohol-related assaults (down 24% from 4,105 to 3,105) and a reduction of 525 domestic violence assaults where alcohol was involved (down 20%) [18].

19. These results provide objective evidence for population-level reductions in harmful drinking as a result of the reforms. They can be expected to lead to significant reductions in the prevalence of FASD and other developmental disabilities related to adverse childhood experiences such as trauma from exposure to domestic violence in the Northern Territory.

Recommendation 3.

That any approaches to preventing and addressing disability includes acting on poverty and disadvantage; unemployment, overcrowding and inequality.

Recommendation 4.

That, as a key primary prevention measure to address the developmental vulnerability and disability arising from harmful alcohol use, the Australian Government provides leadership for the national adoption of objectively evidenced policy approaches to reducing alcohol-related harm at a whole-of-population level, which include action on price and availability similar to those contained in the successful and world-leading Northern Territory Alcohol Policies and Legislation Reforms.

The importance of early diagnosis and intervention: Congress' multidisciplinary approach to childhood cognitive disability

20. Quality early childhood development programs are a key, cost-effective intervention to address and offset the effects of adverse early childhood development. Such programs are proven to support cognitive, social,

communicative, physical and emotional development and thereby improve long term health, education and employment outcomes for young children from disadvantaged families. They also have been shown to prevent the onset of significant cognitive disability [19-22].

21. In line with this evidence, Congress provides evidenced-informed, culturally appropriate early childhood development programs within our child and family services. The Abecedarian Approach Australia (3a) is used as a strategic population health approach with specific interventions to improve the health and developmental trajectory for developmentally vulnerable children. Congress operates:

    - a Child Health and Development Centre, *Arrwekele akaltye-irretyeke ampere*. Congress believes that Centres such as this have a major role to play in the primary and secondary prevention of disability. The centre accepts children from disadvantaged, non-working families from the age of 6 months until the child enters pre-school. For a full description of the program logic of this centre please see **Attachment 1** and the first, independent evaluation of the centre is available at **Attachment 2.** Congress negotiated with the NDIA to at least partly fund centres such as this both in Alice Springs and remote Aboriginal communities as a key approach to the original Early Childhood Early Intervention (ECEI) program. After gaining final agreement the funding did not eventuate due to a change in senior staff and policy direction. Please read our letter of concern addressed to the CEO of the NDIA at **Attachment 3** and the email response that was received from the NDIA at **Attachment 4**. No further response has been received to date and it remains the view of Congress that some of the most disadvantaged children in Australia are yet to get any access to the envisaged potential of the NDIS in the early childhood early intervention area. This is in spite of intensive negotiation and advocacy over more than 3 years.

    - A 55 place long day care centre for children from working families which also incorporates the Abecedarian approach with the limits of its funding model; and

    - a Preschool Readiness Program.

22. Additionally, we provide an Intensive Family Support program to support vulnerable families to keep children safe at home and for families involved with the child protection system, in addition to providing support for parents more broadly through the Parenting Under Pressure Program.

23. Our multi-disciplinary team approach within comprehensive primary health care ensures all children have access to best practice including:

    - routine and systematic child health checks and developmental screening through all of our clinics (using the ASQ-TRAK assessment tool) for

children 0-5 years old, with support provided to parents and carers to attend appointments. This includes following up recalls when appointments are due to ensure children are able to attend;

- further developmental assessments for delay and disability provided through our Child and Youth Assessment Service (CYATS) of allied health professions in collaboration with Alice Springs paediatricians and community health services. This includes the capacity to diagnose (FASD) along with other neurodevelopmental disorders in collaboration with paediatricians from Alice Springs hospital
- To date the team have completed assessments on around 120 unique clients. Approximately a third of these children have been diagnosed with FASD, and another third with Attention Deficit Hyperactivity Disorder (NB some of these diagnoses will be on the same child as we are finding many children have multiple diagnoses).
- However, demand for neurodevelopmental assessments and therapies far outstrips our resources. CYATS is relatively small compared with the need, employing an Occupational Therapist, a Speech Pathologist, a Neuropsychologist, an Aboriginal Family Support Worker, a social worker and a coordinator. CYATS is funded by a number of different sources with varying conditions, multiple reporting requirements and limited timeframes without ongoing certainty.
- Assessments are extremely complex and labour intensive, and require significant engagement and work with families and other institutions and agencies. Consequently there is still a waiting list of over 160 for initial assessments with an estimated waiting time of 24 months. This is a critical time for development of children.

24. Early identification of neurodevelopmental disorders and intervention can change the trajectory of children, reducing the risk of permanent or more severe disability, increasing the likelihood of achieving optimal health, educational and employment outcomes.

Recommendation 5

That government supports universal implementation of evidence-based early childhood development programs as the most cost effective long-term strategy to offset the effects of adverse early childhood experience of Aboriginal children and reduce the very high rate of disability in Aboriginal communities in general and the criminal justice system in particular.

Recommendation 6

That government supports and resources culturally secure assessment and primary prevention/early interventions services delivered by Aboriginal Community Controlled Health Services for children and young people.

Aboriginal people with a disability in the criminal justice system

25. Aboriginal people within the criminal justice system, particularly young Aboriginal people, are likely to have a neurodevelopmental delay or disability. For instance a study in Western Australia found that one third of young people detained had a diagnosis of FASD, and almost all (97%) had at least one complex neurodevelopmental disorder [23].

26. Furthermore, these diagnoses were only made when the young person was in detention, meaning access to assessments and treatments have only been made through this avenue. If a young person is assessed prior to involvement with justice, it is easier for a young person to transition back to supportive services they used previously than to learn how to use disability support services they have never had access to before. Neurodevelopmental assessments and treatments are undertaken by Congress in Alice Springs Youth Detention Centre. However as noted, identification of disabilities and appropriate supports should happen long before a young person enters the justice system. Well supported young people are less likely to enter the justice system in the first place.

27. Not every Aboriginal child or young person in youth detention has a disability. However behaviours (e.g. impulsivity, poor concentration, lack of self-control and self-regulation) are often linked to cognitive function coupled with social and economic disadvantage and trauma i.e. these young people are highly complex and vulnerable.

28. There is a need for qualified and skilled staff to manage complex behaviours within the youth justice system. These include clinical and forensic psychologists, neuropsychologists, as well as staff with expertise in behaviour management, disability, trauma or emotional regulation, alongside primary health care through general practice.

29. ACCHSs are best placed to provide these services for Aboriginal people as we work with these young people across their life span and are able to maintain continuity of care and culturally secure services. This includes the provision of primary care and General Practitioners and Aboriginal Health Practitioners who are able to claim Medicare items in youth detention. This would increase capacity of primary health care and provision of continuous culturally secure services both in and out of detention.

30. Last, children as young as ten years of age should not be in the imprisoned. The minimum age of criminally responsibility should be raised to 14. This is because children's brains are still developing, especially the part that

regulates judgement, decision making and impulse control. Children cannot foresee the consequences of any action and cannot fully understand the criminal nature of behaviour. When children as young as 10 are forced through the criminal legal processes at such a formative age, they can suffer immense harm to their health, wellbeing and future. For further information see: https://www.raisetheage.org.au/.

Recommendation 7

That government supports and sufficiently resources neurodevelopmental assessment and therapeutic services, alongside primary health care, delivered by ACCHSs within youth detention centres.

Recommendation 8

That the minimum age of criminal responsibility be raised to 14 years in line with a therapeutic approach to child and youth justice, rather than a punitive approach.

Time needed to reach intended outcomes.

31. In Congress' 2016 submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory we argued for a therapeutic rather than a punitive response to these behaviours. The Royal Commission was instigated due to the horrific scenes of abuse of children in detention.

32. The newly elected Northern Territory Government did make a number of significant reforms in response to the Royal Commission. This included moving the responsibility for children and young people in detention from the Department of the Attorney-General and Justice to Territory Families. It also established the Children and Families Tripartite Forum of government, non-government and Aboriginal organisations which advises and supports the implementation of a reform agenda to improve services to vulnerable children and young people.

33. However these are long-standing issues which need significant timeframes and ongoing resources before improvements will be seen. They are also politically and economically contentious. While numbers have dipped since the 2016 Royal Commission, children and young people remain in detention at much higher rates than any other state or territory [24].

34. Investment in therapeutic measures as alternatives to punitive measures must recognise the time needed to change complex behaviours, particularly highly traumatised young people with neurodevelopmental conditions. Programs cannot be conditioned on short term outcomes, and on political cycles.

Recommendation 9

That government recognises the time needed to support behaviour change including therapies to manage and improve disability outcomes, and that programs are given substantial time to work (i.e. years), and are independently evaluated before considering disinvestment.

Improving police and court experiences for young Aboriginal people with disability

35. A lack of knowledge about cognitive delay and disability within the criminal justice system, including rates and causes, underpins much mis-management of young Aboriginal people in contact with the police and courts. While there has been a shift towards considering cognitive delay and disability as a reason for the behaviour that results in young people entering the criminal justice system, there is a considerable need for more long term investment and resources to expertly assess and manage these complex behaviours.

36. A better understanding is needed by police, justice and corrections systems of the complex trauma and disabilities and how these present, and how best to approach people experiencing these conditions. Congress' CYATS team have been providing education sessions to police and courts however they are a small team and with a high clinical demand and limited capacity to provide education.

37. Currently NT police do not have access to the diagnostic information and recommendations about a child so that they are aware of any behavioural issues that may be related to disability. This could solved by having a system in place to receive and store assessment reports. There is also a need for greater capacity to undertake court-ordered assessments that need to be undertaken quickly.

38. Simplified language and less legalise in the court room would better support young Aboriginal people with a disability, particularly those who do not have English as a first language. Additionally it would be worth exploring alternatives to court rooms and consider environments that are less stressful and confronting.

Recommendation 10

That the police and courts are informed of and understand the prevalence and causes of neurodevelopmental conditions and related behaviours in young Aboriginal people, and modify processes and procedures to better meet the needs of these young people.

Diversion programs

39. There should be an emphasis on preventative diversion programs, so young people with disabilities (or any young people) avoid youth detention and receive early interventions, ongoing family and cultural support. Youth diversion programs should be provided by Aboriginal Community Controlled services as a therapeutic measure and not used as a tool for seeking retribution and remorse from young people with delay and disability.

40. Many young people will not have capacity to undertake alternatives to detention such as vocational training and victim/offender conferencing as they may not have the cognitive capacity for learning, empathy and remorse, at least until they have undergone significant therapy.

41. Youth diversion programs should include pathways to therapies and NDIS with sufficient timeframes for therapies to work before engaging in education or vocational training and other measures such as victim conferencing.

42. Alternative pathways should also include gaining access to the NDIS if bail conditions can be culturally inappropriate – for example many youth in detention when released have a curfew such that they must be at a specific address after a specific time. If family have not returned home by that time or they don't have transport or they are living between the houses of different family members they can accidentally be in breach of bail. A person with a disability may struggle to problem solve this situation and feel helpless to effectively comply with bail conditions.

Alternatives to detention for vulnerable children and young people

43. Detention centres need to be rehabilitative centres instead of punitive centres. Especially for people with disabilities, they should encompass culturally safe therapies, healing and supports that will then translate to and follow them back into community.

44. Alternative models for youth detention, particularly for vulnerable populations, are required. For example the Diagrama Foundation focusses on educating young people and preparing them for release, supporting them to gain the social and formal skills needed to obtain employment and re-integrate into their local community.

45. The Diagrama model is centred on the themes of relationships and emotions, cognition, behaviour and progression. The philosophy is to re-educate children and the system is based on the children's best in interest, not punishment.

46. Staff in the facility are described as social educators – they are not teachers but people who are able to communicate with children and teach basic

relationship skill. Social educators are educated to a minimum degree level e.g. education, psychology. Other key staff positions are the technical team (psychologists, social workers, health care) and security (only need as a last resort in incident management).

47. Only 20 per cent of juveniles going through this program reoffend, as compared to 67 per cent in the UK.

48. There has been strong advocacy by Aboriginal organisations for the Diagrama model to be implemented in the Northern Territory. The model and its implementation aligns to the emphasis placed be the *Royal Commission into the Detention and Protection of Children in the Northern Territory* the importance of place-based solutions, and partnership working with Aboriginal Community Controlled Organisations in developing tailored responses to meet the needs of young people in their communities.

49. Proponents of the model in the NT, including Aboriginal Peak Organisations Northern Territory (APONT) and Danila Dilba Health Service, argue that its integrity must be maintained. Fundamentally this includes, committed workers who are able to talk with the children and develop a trusting relationships, as well as a period of 9-12 months detention in either secure or non-secure setting, depending on the risk (see https://www.diagramafoundation.org.uk/).

50. An alternative to detention model has also been proposed in the Barkly region of the Northern Territory, with a similar therapeutic focus though without secure accommodation and authority to keep young people on the premise and in the program, and generally over a shorter period of time, along the lines of supported bail accommodation.

51. Proponents of the Diagrama model argue that a longer detention term within a secure facility (not necessarily with fences) is needed for supportive relationships and sustainable behaviour change. None-the-less, the argument for a shorter period, non-secure facility in the Barkly has come from local organisations and communities, and is therefore a place-based solution.

52. It would be worth trialling both models as pilots established relevant to local conditions and with Aboriginal community buy-in. This would require sufficient time and funds to undertake independent evaluations that are able to demonstrate behavioural changes and recidivism outcomes, in addition to disability (e.g. access to disability supports) and psychological outcomes (improved mental health).

Recommendation 11

That government supports the development of different models of alternatives to youth detention, that: aim to achieve long term health and development outcomes; are implemented over sufficient periods of time, with strong

community involvement in their development; and are independently evaluated.

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