Submission to the Productivity Commission: Expenditure on Children in the Northern Territory

July 2019

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Recommendations

Recommendation 1: That the Productivity Commission continue to engage with a range of Aboriginal Community Controlled Health Services in the NT for the duration of this study, including consideration of case study sites.

Recommendation 2: That the Productivity Commission utilises the following NT Aboriginal Health Forum endorsed core services frameworks in mapping service provision for children and families:

- Progress and Possibilities: What Are the Key Core Services Needed to Improve Aboriginal Childhood Outcomes in the NT?
- Core functions of primary health care: a framework for the Northern Territory.

Recommendation 3: That culturally responsive child and adolescent mental health services be funded for remote areas, as in-reach within existing social and emotional wellbeing teams wherever possible.

Recommendation 4: That services be made available for victims of sexual abuse and children displaying inappropriate sexual behaviours, including as outreach to remote communities, as well as prevention strategies, including community education on appropriate sexual behaviour.

Recommendation 5: That there is increased investment in youth services, with a particular focus on universal, preventative services, and not just services funded for 'at risk' young people.

Recommendation 6: That the proposed Commonwealth/NT Coordinated Funding Framework be managed by the Tripartite Forum, with funding allocated through a process of nominal funds pooling.

Recommendation 7: That the design of programs and allocation of funds better align with the accepted public health and placed-based policy approaches.

Recommendation 8: That there be an overall increase in funding for children and family services, in line with level of need.

Recommendation 9: That funding mechanisms include generous allocations for training and support of Aboriginal staff across child and family services and youth justice.

Recommendation 10: That collaborative, needs-based planning which recognises Aboriginal organisations as the preferred providers of services to Aboriginal people, be the preferred mechanism for funds allocation, in preference to competitive tendering.

Recommendations 11: That contracting and procurement processes be reformed in line with the conditions as set out on pages 14-15 of this submission.

Recommendation 12. That long term funding is provided to support organisations and services to become culturally responsive and trauma informed.

Recommendations 13: That the Productivity Commission recognises that improvements in key determinant areas – including trauma and cultural disconnection, inadequate and overcrowded housing, disengagement from welfare, and alcohol misuse – are essential to improving outcomes for children and families in the NT.

Introduction

AMSANT is the peak body for the community controlled Aboriginal primary health care (**PHC**) sector in the Northern Territory (**NT**). AMSANT has been established for 20 years and has a major policy and advocacy role at the NT and national levels. We have 26 members providing Aboriginal comprehensive primary health care across the NT from Darwin to the most remote regions.

Comprehensive PHC includes a range of programs targeting the health and wellbeing of children and families, including: early childhood development, parenting and family support programs, and social and emotional wellbeing (**SEWB**) support for young people. Aboriginal Community Controlled Health Services (**ACCHSs**) are also required to provide responses in relation to statutory notifications of child abuse and neglect, and are subject to mandatory reporting requirements in relation to harm or exploitation of children and in certain circumstances of underage sexual activity. They also provide services and care for children in out of home care and detention as well as post-detention and care.

The ACCHSs sector in the NT is comparatively more significant than in other jurisdictions, being the largest provider of Aboriginal primary health care services to Aboriginal people in the NT. Around two thirds of all Aboriginal PHC services in the NT are provided by ACCHSs.

AMSANT would like to note the improvements that we are beginning to see since implementation of reforms by the NT Government in recent years, including those stemming from the NT Royal Commission into the protection and detention of children (**NT Royal Commission**), and the Review of NT Alcohol Policy and Legislation (**Riley review**).

Rates of substantiated child protection notifications have dropped from 30.5/1000 children in the NT for 2016-17 to 27.8 in 2017-18 figures[1]. Data presented to the Tripartite Forum indicated that there are more children in kinship care and less in non-kinship care.

The crime rate has dropped in Alice Springs substantially – crimes against the person are down by 24.2% compared to the same time in 2017-18, including a 33.7% reduction in alcohol related assault[2]. We have also seen a 24% reduction in alcohol related ED presentations in all NT hospitals[3].

More is being invested in diversion and youth activities, including:

- $4.6 million in 2018-19 and $8.5 million ongoing from 2019-20 for the Back on Track program, providing alternatives to detention and diversion programs to support young people and to engage in training and achieve successful employment outcomes
- $10.2 million in 2018-19, $16 million in 2019-20 and 2020-21 and $13.7 million ongoing to break the cycle of crime in Darwin, Palmerston and Alice Springs, including better pathways

[1] AIHW (2019). *Child Protection Australia 2017-18*. Retrieved from: https://www.aihw.gov.au/getmedia/e551a2bc-9149-4625-83c0-7bf1523c3793/aihw-cws-65.pdf.aspx?inline=true

[2] NT Police Fire and Emergency Services. *NT Crime Statistics.* Retrieved from: https://www.pfes.nt.gov.au/Police/Community-safety/Northern-Territory-crime-statistics/Alice-Springs.aspx

[3] Dec 2018 compared to Dec 2017, quoted in: *NT Alcohol Harm Minimisation Action Plan: February 2019 Update*. Retrieved from: https://alcoholreform.nt.gov.au/__data/assets/pdf_file/0007/658186/action-plan-alcohol-harm.pdf

services, expanding the First Response Day Patrol program, providing temporary short-term accommodation, and extending hours for youth drop in centres[4]

There are many fewer children and young people locked up in detention each day. Between 2013–14 and 2017–18, the rate of young people aged 10–17 under supervision on an average day fell in all states and territories, except the Australian Capital Territory. The rate fell most markedly in the NT, from 70 to 59 per 10,000 young people[5]. Once corrected for Aboriginality, the rates in the NT are roughly the same as other states. Similarly, data presented to the Tripartite Forum also showed Alice Springs juvenile crime stats falling sharply from a very high peak, to be much lower than normal.

However, the NT Government has so far failed to raise the minimum age of criminal responsibility above 10 which is a major policy recommendation of the NT Royal Commission. This goes against what we know about the developing brain: that parts of the brain responsible for 'higher' functions including planning, reasoning, judgement and impulse control, often do not fully develop until well into a person's twenties[6].

The failure to raise the minimum age means behavioural issues continue to be framed as a crime to be punished, rather than holding young people to account for their behaviour in a way that prevents crime and addresses its causes by providing the necessary care and support to the young person.

AMSANT have been cautiously optimistic that the NT Government has shown a desire to move away from for-profit providers and is investing more in Aboriginal organisations, who bring with them established relationships in community and greater cultural responsiveness.

Recognising that Aboriginal people comprise approximately one third of the Territory's population and also disproportionately utilises children and family services in the NT, any new funding framework must support Aboriginal organisations as preferred providers of services to Aboriginal people. This is also in accordance with the rights to self-determination of Aboriginal peoples as established the United Nations Declaration on the Rights of Indigenous Peoples (**UNDRIP**).

Advice about how to proceed and consult with the sector

AMSANT would like to see the Productivity Commission engage Aboriginal community controlled organisations to undertake consultations with communities, rather than relying on government or consultancy agencies.

We refer the Commission to *Listening and hearing are two different things*[7], a report on community and service provider workshops conducted by Danila Dilba Health Service (**DDHS**) and AMSANT in

[4] NT Budget Strategy and Outlook 2019-20, pp 15-16. Retrieved from: https://budget.nt.gov.au/__data/assets/pdf_file/0005/689522/2019-20-BP2-book.pdf
[5] AIHW (2019) *Youth Justice in Australia 2017-18*. Retrieved from: https://www.aihw.gov.au/getmedia/f80cfcb3-c058-4c1c-bda5-e37ba51fa66b/aihw-juv-129.pdf.aspx?inline=true
[6] Becroft, J.A. (2013). *From Little Things, Big Things Grow: Emerging Youth Justice Themes in the South Pacific. Australasian Youth Justice Conference: Changing trajectories of offending and reoffending*.
[7] AMSANT (2018). *Listening and Hearing are two different things.* Retrieved from: http://www.amsant.org.au/listening-and-hearing-are-two-different-things/

May-June 2018, where outcomes of the Royal Commission and expected reforms were discussed. As well as providing vital local perspectives about proposed reforms, services and community members expressed frustration about their experience with Government consultation processes and their preference for engagement through respected Aboriginal community controlled organisations.

AMSANT strongly recommends that the Commission continue to consult with NT ACCHSs over the next 9 months before handing down their final report to Government. This should include engagement with a mixture of urban and remote services, including those who have made significant service and policy development in the area of child and family services. AMSANT would be happy to advise the Commission further and help facilitate this future engagement including potential case study sites.

In-scope services and core services frameworks

Core services 0-5 years

In order for this study to effectively map services currently provided to children and families in the NT, an appropriate framework is required to map against. The NT Aboriginal Health Forum (**NTAHF**)[8] has developed an agreed framework of core services that sets out a comprehensive, public health approach for improving outcomes for Aboriginal children up to age 5.

AMSANT recommends that this document – *Progress and Possibilities: What Are the Key Core Services Needed to Improve Aboriginal Childhood Outcomes in the NT?*[9] – should provide a guide for mapping service provision for the Productivity Commission's study at least until five, with some services such as intensive and targeted family support being required up to adulthood.

Progress and Possibilities sets out the core services required to improve childhood outcomes, as identified by delegates with local expertise in early childhood development at a two-day workshop in Darwin in June 2015.

The model breaks services down into three levels: universal (available and accessible to the whole population), targeted (available to 'at risk' groups or individuals), and indicated (for individuals or families with an established condition or problem). It outlines the need for an integrated system that provides trauma informed and culturally responsive services across the following key categories:

- Pre-pregnancy care
- Quality antenatal and postnatal care
- Nurse home visiting
- Clinical child health care
- Quality early learning
- Parenting programs

[8] The NTAHF comprises: Commonwealth Department of Health, Commonwealth Department of Prime Minister and Cabinet, NT Department of Health, AMSANT and the NT Primary Health Network.
[9] NTAHF (2016) *Progress and Possibilities: What Are the Key Core Services Needed to Improve Aboriginal Childhood Outcomes in the NT?*. Retrieved from: http://www.amsant.org.au/wp-content/uploads/2017/08/What-Are-the-Key-Core-Services-Needed-to-Improve-Aboriginal-Childhood-Outcomes-in-the-NT-Report-FINAL.pdf

- Nutrition
- Supporting vulnerable families
- Supporting children with physical problems and developmental delay
- Public health policy and social determinants

The health component outlined in *Progress and Possibilities* is provided in a reasonably consistent way across the sector, although a recent survey of our services found that nearly all said that they were under resourced to provide child health services, particularly to the under-five age group which is a critical period.

Services particularly noted that they were not resourced to screen for developmental delay, a practice which would allow children to be referred to NDIS services if they have significant delay. As noted below, Aboriginal children have high rates of developmental vulnerabilities on the Australian Early Development Census (**AEDC**) index.

Other components such as family support, early childhood education and support for children with disability and developmental delay are provided in a much more inconsistent and haphazard fashion, largely because they are subject to competitive tendering.

Supporting vulnerable families

Support services for vulnerable families are provided at two levels - intensive (families already in the child protection system) and targeted (families at risk). ACCCHs do provide these services in a few places, however, program funding is subject to competitive tendering, resulting in insecure and inconsistent services.

In other places, services are completely lacking or provided by mainstream NGOs with variable relationships with communities and relatively poor records of employing and supporting Aboriginal staff.

Early childhood education services

Early childhood services are also provided inconsistently throughout the NT although there has been some improvement in recent years. For example, the Abecederian enriched learning program is now provided through the Central Australian Aboriginal Congress (CAAC) as a targeted program for pre-school aged children in Alice Springs.

We also note the expansion of the Families as First Teachers (**FaFT**) program, however are concerned that this may not be provided at sufficient intensity in some communities to make an optimal difference to children.

Children with developmental delay & physical disability

Children and young people with a disability, including developmental delay, should now be eligible for services through the National Disability Insurance Scheme (**NDIS**). In theory, this should provide a significant boost to services, but the scheme has so far failed to make much impact. This is of major

concern because NT Aboriginal children have high rates of developmental vulnerability on the AEDC[10] and could greatly benefit from enhanced early intervention services, which are largely failing to be provided.

There has been an almost complete lack of planning for how market failures will be addressed or how services can be delivered in a way that is responsive to cultural and community needs. There is an urgent need to consider ways to reform NDIS so it works in remote contexts and is able to address the huge unmet need that exists is these communities.

It is AMSANT's position that this be done through a permanent planning forum which would allow for centralised funds pooling, planning and needs-based allocation of NDIS funds for Aboriginal people, and particularly Aboriginal children, with a disability.

It is a human rights issue that children and families with the greatest need for increased early intervention and disability services are finding that services are either not improving through NDIS or going backwards.

Core comprehensive primary health care services framework

Beyond the core services described above for children 0-5, the NTAHF has also developed a core PHC services framework[11] that picks up a majority of health needs for children and young people after the age of 5. In particular this framework covers SEWB services, including for mental health and alcohol and other drug (**AOD**) treatment, and has a focus on building healthy public policy, supporting health promotion and advocating for action on the social determinants of health.

This framework has supported consistent planning across Government and Community Controlled Aboriginal PHC by directing decisions about health service structures, programs and delivery.

Other specialist and youth services

Outside of the services set out in these two key frameworks, we have identified three additional areas of service delivery that should be included in the scope of this study.

Child and adolescent mental health services

There are currently very limited specialist child or adolescent psychiatry services available in remote areas of the NT. The NT Government's Child and Adolescent Mental Health Services (**CAMHS**) have highly restrictive referral criteria for many conditions, and rarely provide outreach services.

This has not always been the case, with outreach services provided regularly to some areas through CAMHS up to 2016. While many ACCHSs reported a lack of cultural responsiveness within this outreach program, we are concerned that these services have not been replaced, and local PHC providers have not been funded to provide these services within existing SEWB teams.

[10] AEDC Data Explorer. Retrieved from: https://www.aedc.gov.au/data/data-explorer?id=-1&term=northern%20territory%20aboriginal%20children

[11] Tilton, E., and Thomas, D. (2011) *Core functions of primary health care: a framework for the Northern Territory.* Northern Territory Aboriginal Health Forum. Retrieved from: http://www.amsant.org.au/wp-content/uploads/2014/10/111001-NTAHF-ET-External-Core_PHC_Functions_Framework_FINAL.pdf

It is AMSANT's position that culturally responsive child and adolescent mental health services should be funded for remote areas, as in-reach within existing SEWB teams wherever possible.

Sexual assault services and community education

There is also a significant lack of counselling services for children who have been a victim of sexual abuse, particularly in remote communities, although even services in regional towns and centres are limited. Children can be evacuated from remote communities for initial medical treatment and assessment at the Sexual Assault Referral Centre (**SARC**) in Darwin, Katherine, Tennant Creek or Alice Springs.

However, while SARC is able to provide ongoing counselling services in these towns, they are not funded to provide ongoing services to children who return to remote communities. This means that children are sent back to their communities without ongoing follow up. This kind of outreach was available as a program called Mobile Outreach Service Plus (**MOS Plus**), between 2008 and 2016.

Funding for this program was cut by a joint decision from the Commonwealth and NT governments with no consultation with communities or service providers. Instead, services were asked to refer children to CAMHS which had also recently ceased to provide outreach to some remote communities whilst other communities never had any services in the first place.

MOS Plus had some major flaws – it was a vertical government provided program which expanded too quickly due to pressure in the NT Emergency Response context, resulting in services lacking in cultural safety and effectiveness as a result of a flawed model. Regardless, the lack of consultation with service providers and communities about ceasing this sensitive and important program with no effective alternatives is symptomatic of how governments at times fail to respond to the needs of vulnerable children and families and communities.

Services available to young people in the juvenile justice system are improving slowly but there are still key gaps, noting in particular the lack of rehabilitation and therapeutic programs for young people who have committed sexual offences.

Similarly, there is a lack of preventative and community education programs about child sexual abuse and inappropriate sexual behaviour. Prevention strategies should be funded both at individual child and community levels to address this, including education on appropriate sexual behaviour for young people and community as well as tertiary services for children and young people with significantly aberrant behaviour.

Youth services, including diversion, treatment and rehabilitation

Finally, we seek for the Commission to include youth services, diversion, and treatment and rehabilitation programs as services reviewed by this study. There is a particular need to focus on universally available youth services as prevention, and not just services funded for young people who may be at risk already. These universal approaches are non-stigmatising and develop connections and support between young people who are more vulnerable and others.

AMSANT refers the Commission to CAYLUS' submission for a more detailed discussion of youth services. In particular, we would like to highlight the results of a social return on investment study of

three programs run by CAYLUS that demonstrated that for every dollar invested in the programs analysed, between $3.48 and $4.56 of value was created[12].

Response to Terms of Reference

I. The extent of duplication and lack of coordination across Australian and Northern Territory Government funding arrangements, individual programs and service providers

The NT Royal Commission recommended the establishment of a Tripartite Forum *"to ensure coordinated cross-government and interdepartmental cooperation in overseeing the delivery of the reform agenda and services for children and young people"*[13]. This Forum has been established and in operation for one year now with 3 APO NT representatives, 1 from NAAJA and 3 from NTCOSS, and two representatives from each of the Commonwealth and NT governments.

It is important that the status of this Forum, as the primary advisory body on child and family services in the NT, is recognised by all agencies and levels of government. Our experience from participating in the NTAHF demonstrates that positive outcomes in equitable needs-based service planning and system reforms result when members are able to engage in robust discussion and decision-making supported by appropriate evidence, rather than just sharing information. We would also note our experience that having the Secretariat support for NTAHF sit outside of government has been beneficial for facilitating a more productive dynamic.

The NT Royal Commission also recommended the development of a joint Commonwealth/NT Coordinated Funding Framework, and it is our position that this framework should be managed by the Tripartite Forum. In relation to this funding framework, AMSANT supports a process of nominal funds pooling, meaning that the two levels of government commit to funding arrangements and amounts but don't have to set up a formal mechanism to hold and administer funding.

It is also necessary to recognise the role of the PHC system, in particular services delivered by the ACCHSs sector, as an integral part of child and family services. These include annual child health checks and developmental screening; evidence-informed early childhood learning programs; and parenting and family support programs.

The Aboriginal PHC sector already has a mature, collaborative needs-based planning structure in the NTAHF that provided a model for the development of the Tripartite Forum. It is vital that these two forums now work in collaboration in ensuring coordination in the planning and provision of services for children and families, as was also noted in the NT Royal Commission's final report[14].

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[12] Nous Group (n.d.). *Investing in the Future*. CAYLUS. Retrieved from: https://static1.squarespace.com/static/50061cbb84ae216bb5cb9339/t/59d30529e5dd5b2e94a7c302/1507001676651/The%2Bimpact%2Bof%2Byouth%2Bprograms%2Bin%2Bremote%2Bcentral%2BAustralia-%2Ba%2BSocial%2BReturn%2Bon%2BInvestment%2B%28SROI%29%2Banalysis-1.pdf

[13] Final Report of the Royal Commission into the Protection and Detention of Children in the Northern Territory. Volume 4, pp 80.

[14] Final Report of the Royal Commission into the Protection and Detention of Children in the Northern Territory. Volume 4, pp 79.

It is worth noting that the success of the NTAHF is based on the agreed commitment of both the NT and Commonwealth governments to the ACCHSs model of PHC supported through a pooled funding approach. The NT ACCHSs sector advocated since the 1990s for a funding model for delivery of primary health care based on both pooled grant funding as well as access to Medicare and the PBS.

The need for this reform was made evident by lower rates of access to Medicare and the PBS and the reality that funding levels were not being allocated based on need, with little or no coordination between levels of governments, leading to large inequality between regions of the NT in access to health services.

A planned, collaborative approach to allocating funding, overseen by the NTAHF, has delivered significant improvements in health outcomes for Aboriginal people over the last twenty years with reductions in inequitable funding along with an overall increase in funding. This in turn has contributed to substantial gains in life expectancy for Aboriginal people in the NT.

A COAG report from 2013 demonstrates that while educational attainment, average income, employment and overcrowding did not change in the NT, we were still the only jurisdiction on track to meet its 'Close the Gap' life expectancy targets by 2031[15]. Given no other changes in these key determinant, we suggest that these gains can be attributed to health system improvements.

Unfortunately these gains have stalled since this time, coinciding with a shift towards competitive tendering that occurred from 2009 onwards (refer to section III below for further discussion), a growing chronic disease burden and ongoing failure to address key social determinants of health.

II. Whether the approach to program design aligns with policy objectives

Public health approach

Improving outcomes for vulnerable and disadvantaged children and families requires a comprehensive response that addresses underlying causes. There is no single cause of child abuse and neglect. The harms that children incur result from a mixture of complex dynamics that exist at and between the level of the individual, family, community and society.

In the context of Aboriginal children and families, some of the most complex health, mental health, substance use, justice and child protection issues can best be understood in the context of historical and transgenerational trauma.

Colonisation, dispossession and displacement from traditional lands, loss of culture, the separation of families through past government policies, high levels of incarceration, and ongoing discrimination and racism have all contributed to continuing disadvantage, poor health and poor social outcomes for many Aboriginal people.

> *"The problems prevalent in Aboriginal and Torres Strait Islander communities today – alcohol abuse, mental illness and family violence… have their roots in the failure of*

[15] COAG Reform Council, *Indigenous Reform 2011-12: Comparing performance across Australia*. 2013, COAG Reform Council: Sydney

Australian governments and society to acknowledge and address the legacy of unresolved trauma still inherent in Aboriginal and Torres Strait Islander communities"[16]

These root causes, also referred to as social and cultural determinants (see section V. below for more discussion about these determinants) are considered to account for some 39% of the gap in health status between Indigenous and non-Indigenous Australians[17]. Addressing these determinants is therefore essential to improving outcomes for Indigenous children, and will require collaboration across agencies and organisations in different areas of service delivery.

Under a public health approach, as outlined on page 5 of the issues paper, the weight of investment should shift from the high cost statutory end of the system to the preventative measures of primary and secondary interventions leading to ongoing cost reductions at the statutory end over time.

While the public health approach is, in theory, the dominant framework for child wellbeing in Australia, and has been endorsed by the NT Government, it is our experience that it is still considered the ideal rather than the reality, with significantly greater investment being targeted at the tertiary end of the system rather than being refocussed in early intervention and prevention.

However, we acknowledge that whilst this transition is occurring, there is likely to be a need to spend more for some time as the preventative policies will take time to have a full effect. Some may have an impact quickly, while others will have generational effects as children with good support and early childhood programs are better able to parent themselves. Investment in tertiary and crisis services will continue to be required, however, the amount of investment required will decrease as prevention policies start working.

Placed-based decision making

ACCHSs are a long-standing model for placed-based decision making in the health sector. The NT and Commonwealth governments have committed to transfer PHC to Aboriginal controlled services through the Pathways to Community Control policy and there are three areas in active transition. However, overall progress has been slow with inconsistent support from the Commonwealth Government and considerable risk aversion by the NT Government.

The Aboriginal community controlled model of delivering comprehensive PHC provides a number of significant additional benefits that are not provided through government, not-for-profit and private sector providers. These benefits considerably add to the cost-effectiveness of investment in ACCHSs, both in terms of the quality of service provision as well as in relation to broader health and health-related outcomes. These benefits include:

- The ACCHSs model engages the community in governance structures and contributes to community and individual self-reliance, participation and control. These factors are known to have positive health and community wellbeing outcomes.

[16] Aboriginal and Torres Strait Islander Healing Foundation Development Team (2009).
[17] AHMAC 2017, Health Performance Framework

- ACCHSs contribute to improved performance of the broader health system in meeting the needs of Aboriginal people, through partnerships with other health professionals, organisations and government, and advocating on behalf of Aboriginal communities to inform health policies.
- The ACCHS sector is the largest employer of Aboriginal people in Australia, and provides training pathways in a range of management, administrative and health careers[18]
- ACCHSs increase Aboriginal peoples' access to primary health care, including among hard-to-reach populations such as those with mental illness. Multiple studies describe a preference among Aboriginal peoples for ACCHS-delivered care, suggesting this is because it is flexible and responsive, culturally appropriate and delivered by trusted staff in a safe setting[19].
- The ACCHSs model of comprehensive PHC facilitates an integrated and comprehensive approach to service delivery.
- Research from Canada has also demonstrated that greater community control of services can lead to lower suicide rates[20].

The NT Government's Local Decision Making (**LDM**) policy is an encouraging initiative which is seeing promising results in some communities. The aim is to allow communities to have more control over their own affairs so that policies and programs better reflect their needs and aspirations. This can include transitioning services to community control. The policy has a ten year time frame. However, the positive outcomes that we have seen are largely occurring in communities where strong Aboriginal controlled service organisations or representative bodies already exist.

There is concern about limited investment in capacity building for smaller organisations, without which LDM's success risks being limited to communities and organisations with existing capacity and strength, meaning that smaller, less 'recognised' and potentially most in need communities and organisations will not receive the benefits of the policy.

Related to this is concern that LDM is not sufficiently focused on building Aboriginal controlled service delivery or linked to regional and jurisdictional level needs based service planning that incorporates strong Aboriginal governance, and that LDM is inconsistently supported at the Departmental level. This risks an outcome of inequitable and uneven provision of services and programs and a continuation of existing ways of working with communities with only minor changes in service delivery.

[18] NACCHO, *Aboriginal Community Controlled Health Services are more than just another health service*. Retrieved from: https://www.naccho.org.au/wp-content/uploads/Key-facts-1-why-ACCHS-are-needed-FINAL.pdf

[19] Vos T et al (2010). *Assessing cost-effectiveness in Prevention (ACE-Prevention): Final Report*, ACE Prevention Team: University of Queensland, Brisbane and Deakin University, Melbourne

[20] Chandler M. and LaLonde C. (1998). *Cultural Continuity as a Hedge Against Suicide in Canada's First Nations. University of British Columbia, Vancouver*.

III. The approach to engaging service providers and allocating funds

Increased overall funding

Expenditure on child protection and out of home care (**OOHC**) services for Aboriginal children in the NT has increased at a much lower rate than demand between 2008 and 2016[21]. Similarly, there have also been declines in Aboriginal per capita expenditure in the NT for many service sectors that affect child health and wellbeing[22].

We therefore urge the Commission to recommend an overall increase in funding across child and family services in the NT as a foundation for a successful new coordinated funding framework, having already noted that we are likely to need a period of substantially increased funding before the need for crisis services substantially decreases.

Workforce development

Investing in Aboriginal workforce development is critical to providing effective and culturally safe service delivery, particularly in the sensitive areas of working with vulnerable families where there is a well justified mistrust of "welfare" workers as a result of past policies such as the Stolen Generation.

To do this work well, it is critical that families and young people trust the workers and also that non Aboriginal staff are working in partnership with Aboriginal staff. Current short term competitive funding grants do not support organisational and workforce development. This leaves Aboriginal workers often at the lower levels of the organisation with little capacity to advance to more senior levels through funded TAFE/tertiary courses and mentorship.

We thus recommend that funding mechanisms include generous allocations for training and support of Aboriginal staff across child and family services and youth justice. There also needs to be greater investment in scholarships and mentoring schemes in key tertiary courses such as social work and psychology.

Competitive tendering

It is AMSANT's experience that many aspects of Aboriginal health and the wider human service delivery sector are largely not suited to the introduction of greater competition through competitive tendering processes. This is due to a number of inter-related factors that underpin the need to recognise Aboriginal community controlled service organisations as preferred providers of services to Aboriginal people:

- the benefits and better outcomes demonstrated by Aboriginal community controlled services (as outlined on pp 10-11 above);
- the preference of Aboriginal people and communities for Aboriginal service providers;
- the holistic nature of Aboriginal service models;

[21] Based on a comparison of Northern Territory Office of the Children's Commissioner Annual Reports (https://occ.nt.gov.au/publications) and the Productivity Commission's 2017 Indigenous Expenditure Report (https://www.pc.gov.au/research/ongoing/indigenous-expenditure-report/2017).

[22] Productivity Commission (2017) *Indigenous Expenditure Report*. Retrieved from: https://www.pc.gov.au/research/ongoing/indigenous-expenditure-report/2017

- the existing system of comprehensive PHC provided by ACCHSs and supported through a collaborative, needs-based planning system that includes government (the NTAHF); and
- the concentration of Aboriginal population in remote and regional areas where there is a lack of market capacity and limited service providers.

We have found that the reintroduction of open competitive tendering processes from around 2009 has contributed to a more fragmented and ineffective service system that lacks Aboriginal input and leadership.

We suggest that the NT and Commonwealth governments' inability to track and report the child and family services that they fund for the purposes of the NT Royal Commission is reflective of a lack of coordination, and demonstrates that competitive tendering is not working.

The current approach has facilitated the entry of numerous non-Aboriginal NGOs that do not have strong links with communities or other local service providers, have little history of successful service delivery in the challenging cross-cultural and infrastructure-poor environments of the NT, and do not have the long-term commitment required for sustainable and effective service provision.

In response to this this reality, the Aboriginal Peak Organisations of the NT (**APO NT**) developed a set of principles (APO NT Partnership Principles[23]) to guide non-Aboriginal organisations in the development of a partnership approach to service delivery, with the essential goal of strengthening and rebuilding an Aboriginal controlled development and service sector in the NT.

Contracting and procurement

AMSANT also recommends that the Commission consider the current development of an Aboriginal Contracting Framework for the NT, led by the Department of Trade Business and Innovation (**DTBI**). Stakeholders are currently waiting to see a draft of this framework.

A number of general recommendations have been workshopped by APO NT as part of ongoing reform of contracting and procurement processes here in the NT. These include:

- Aboriginal organisations should be considered 'preferred providers' in the delivery of services where the identified beneficiaries are Aboriginals people and/or communities.
- Tender assessment panels should be reformed to include Aboriginal members and people with local knowledge
- Assessment criteria should be amended to enable assessment of demonstrated capacity or ability to support:
    - Aboriginal participation in decision-making, governance
    - Aboriginal employment, training and career pathways
    - Organisational cultural competence
- Contracts to incorporate requirements for non-Aboriginal enterprises in local employment and upskilling plans, local capacity-building, demonstrate cultural competence, establish governance arrangements to enable shared decision-making

[23] APO NT Partnership Principles, retrieved from: http://www.amsant.org.au/apont/our-work/non-government-organisations/apo-nt-ngo-principles/

- Procurement rules and programs should support joint ventures between Aboriginal and non-Aboriginal enterprises and sub-contracting Aboriginal enterprises, in line with the APO NT Principles.
- Introduce Aboriginal procurement targets and mandatory reporting for all Departments and agencies against those key measures.

IV. Accountability, reporting and monitoring requirements for service providers and governments

Within the ACCHSs sector, members often inform AMSANT that reporting requirements are onerous, do not effectively facilitate capacity building, and often may not produce useful data for Clinical Quality Improvement (**CQI**) processes.

It has also been our experience that there is a general lack of government accountability relating to issues such as late release of funding, funding of programs that are not evidence based, and reliance on a system of competitive tendering that does not have a good evidence base.

Similarly, it is common for service providers to report a lack of co-design in the development of program evaluations, as well as a lack of feedback following the completion of evaluations. In this regard, we refer the Commission to a recent Lowitja report that sets out a coherent framework to inform the content and conduct of evaluations of programs with the aim of improving Aboriginal and Torres Strait Islander wellbeing[24].

In addition we would like to flag the following reform/policy development processes that relate to accountability and evaluation for further investigation by the Commission as part of this study:

- A suite of reforms to the NT Office of the Children Commissioner were made as part of the NT Royal Commission's final report[25]. AMSANT recommends the Commission further investigate the implementation of these recommendations as part of determining what accountability mechanisms are in place for oversighting child and family services in the NT.
- The Productivity Commission has recently announced a project to develop a whole-of-government Indigenous Evaluation Strategy, to be used by all Australian Government agencies, for policies and programs affecting Aboriginal and Torres Strait Islander people.

AMSANT members have also raised concerns about the level of administration expenses in service delivery. It is false economy to release grants with unrealistically low levels of administration allowed. This will deter Aboriginal organisations from applying because they understand how expensive it is to provide services in the NT.

By contrast, large mainstream organisations may apply as they have economies of scale but they are also then likely not to invest time and resources in working with communities to plan programs and may have minimal budgets for staff training and support.

[24] M. Kelaher, J. Luke, A. Ferdinand, D. Chamravi, S. Ewen & Y. Paradies (2018). *An Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health*, the Lowitja Institute, Melbourne

[25] Refer to Volume 4, Chapter 40 of the Final Report of the Royal Commission into the Protection and Detention of Children in the Northern Territory.

V. Levels of access to services and approaches to service delivery

In regard to levels of access to services, we refer to comments made in the above section titled *In-scope services and core services.*

Approaches to service delivery must be evidence based and build on the public health and place-based approaches outlined above. Equally, there must be recognition of the impact of broader social and cultural determinants in preventing harm to children. Services and programs for children and families will remain limited in their impact as long as these determinants remain unaddressed.

Trauma, disconnection and culture

The historical and ongoing experience of colonisation for Aboriginal people is now recognised as resulting in 'intergenerational trauma' whereby traumatic experiences are transferred through generations. Such trauma is described as being "…passed from adults to children in cyclic processes as 'cumulative emotional and psychological wounding'"[26].

Systems of care, justice, health and child protection that have been developed for Aboriginal people, but not by Aboriginal people, have a long history of perpetuating and exacerbating traumatic experiences. These systems have, therefore, further contributed to the very issues that they have been funded to prevent or manage.

Systems must be reformed so that they are trauma informed, culturally informed and effectively working toward recovery and healing. AMSANT has developed a model of culturally responsive trauma-informed care[27] which we have begun to provide as training to ACCHSs and other service providers in the NT.

It is important to note that this training and support comes at a cost as organisational change is a long term complex process. Some organisations are spending fairly minimal amounts providing basic on line education about trauma but this is not sufficient – the whole organisation needs to undergo transformative change. Funding must be allocated long term towards supporting trauma informed care in children and family services.

Housing

In 2014, over half (52%) of Aboriginal Territorians were living in overcrowded houses, substantially more than in any other jurisdiction[28]. Overcrowding and poor living conditions contribute to poorer physical and socio-emotional outcomes for children as well as to the mental and physical health of parents and families[29].

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[26] Atkinson, J. (2013). *Trauma-informed services and trauma-specific care for Indigenous Australian children*. Australian Institute of Health and Welfare & Australian Institute of Family Studies: Canberra / Melbourne.

[27] Dyall, D., Haythornthwaite, S., and Torcetti, S. (2018). *Culturally responsive trauma-informed care within primary health care*. AMSANT

[28] Australian Bureau of Statistics (ABS) (2016). *4714.0 - National Aboriginal and Torres Strait Islander Social Survey, 2014-15*. Retrieved from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02014-15?OpenDocument#Publications.

[29] Dockery, A.M., et al. (2013), *Housing and children's development and wellbeing: evidence from Australian data*. Australian Housing and Urban Research Institute Melbourne

A sophisticated data linkage study recently found that overcrowded housing accounted for 35 absent days from school per year which was over three times as many absent days of school as the next most important risk factor (English as a second language)[30]. This is likely to have further flow on effects for other important social outcomes, with strong evidence that children who are absent frequently from school are much more likely to do poorly on other measures of wellbeing.

Welfare

The Community Development Program (**CDP**), is exacerbating poverty and disadvantage in the NT. CDP is a remote-area Work for the Dole scheme with around 35,000 participants, of whom 84% are Aboriginal or Torres Strait Islander people[31]. The CDP requires participants to work up to 20 hours a week (formerly 25 hours until March 2019) at pay rates half the current minimum award.

The CDP has imposed increasingly onerous conditions and intensive surveillance on participants relative to past employment programs. These burdensome requirements are resulting in alarming rates of breaching penalties on remote CDP participants and there are serious concerns that this program is exacerbating poverty and food insecurity in many communities, and resulting in increased disengagement with the program.

Participants who have been breached or disengaged entirely must then rely on family and other community members for food and support. The pressure that this places on families is a major factor impacting on the wellbeing of children throughout the NT.

Alcohol

Parental alcohol dependence is a major cause of child neglect and the removal of children from their families, with some research suggesting it is associated with approximately 70% of children entering out-of-home care[32]. In addition, FASD is estimated to be between three and seven times as common in the Aboriginal population as it is in the non-Aboriginal population[33] 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[34].

A large and immediate impact on the primary prevention of neglect can be achieved by effective alcohol supply reduction measures. The NT is currently implementing an evidence-informed package

[30] Silburn, S., Guthridge, S., McKenzie, J., Su, J.Y., He, V., Haste, S. (2018) Early Pathways to School Learning: Lessons from the NT data linkage study. Darwin: Menzies School of Health Research, pp. 93.
[31] Department of Prime Minister and Cabinet (2017) Community Development Program Regions. Retrieved from: https://www.pmc.gov.au/resource-centre/indigenousaffairs/community-development-program-regions
[32] Scott, D. (2015), Children in Australia: Harms and Hopes. Family Matters No. 96. Retrieved from: https://aifs.gov.au/publications/family-matters/issue-96/children-australia
[33] Gray, D., et al. (2008), Substance misuse, in Aboriginal Primary Health Care: An Evidence Based Approach S. Couzos and R. Murray, Editors. Oxford University Press: Melbourne.
[34] O'Leary C, et al. (2013), Intellectual disability: population-based estimates of the proportion attributable to maternal alcohol use disorder during pregnancy. Dev Med Child Neurol. 55(3), pp. 271-7.

of measures, stemming from the Riley Review[35], which is already corresponding with reduced alcohol related assaults and presentations to ED[36]. This can be expected to have both short and long-term benefits for child safety and wellbeing.

[35] NT Review of Alcohol Policy and Legislation: Final Report (2017), Retrieved from: https://alcoholreform.nt.gov.au/__data/assets/pdf_file/0005/453497/Alcohol-Policies-and-Legislation-Review-Final-Report.pdf

[36] NT Alcohol Harm Minimisation Action Plan: February 2019 Update. Retrieved from: https://alcoholreform.nt.gov.au/__data/assets/pdf_file/0007/658186/action-plan-alcohol-harm.pdf