Inquiry into the Child Protection System in the Northern Territory 2010

The Aboriginal Medical Services Alliance of the Northern Territory [AMSANT] has developed the following submission into the Inquiry currently being carried out into Child Protection Services in the Northern Territory.

Aboriginal families have a historic—as well as contemporary—concern with child protection, and the ways in which it is administered. From the times of the Stolen Generations to the present, Aboriginal families have faced particular challenges in dealing with the State over the care and protection of children. These challenges have their origins in dispossession; they continue as a consequence of social determinants such as unemployment, poverty, overcrowded housing and low educational levels that all need to be addressed in order to reduce the rate of child abuse in our families and communities.

Aboriginal children are currently over represented in the child protection system, and the situation appears to be worsening—not improving. This is not in the interests of our children—or our families. It is clearly damaging to our future. It is also a burden that the entire Northern Territory community must bear—and be responsible for. What is required is a radical change in the culture of child protection in the Northern Territory, as well as other jurisdictions in the nation.

Central to our position is moving to increase the role of Aboriginal people, and Aboriginal controlled primary health care services, in the development of policy and service delivery in the area of child protection to turn the tide of this over representation in the system. Our position includes a far more activist approach to prevention through early intervention and support, as well as dealing with social and other conditions that substantially contribute to child neglect and abuse.

Rather than narrowly and reactively approaching it just as an issue of child protection, we advocate a proactively new approach: that of advancing the interests of children and families.

Together for our Health
1.0 Introduction

1.1 AMSANT represents the Aboriginal community-controlled health sector in the Northern Territory. Our emphasis is on the delivery of comprehensive primary health care to Aboriginal Territorians.

1.2 AMSANT is a member of the Northern Territory Aboriginal Health Forum [NTAHF], a tripartite body also made up of the Northern Territory and Commonwealth governments. As such, we are a major provider of policy advice on health issues to both governments, including child and family protection issues.

1.3 At the heart of our work is the development of a practice—both clinical and social—that displays our strong and central commitment to Comprehensive Primary Health Care.

1.4 This model was codified at an international level at Alma Ata in 1978, and subsequently endorsed by the World Health Organisation (WHO) and the United Nations:

*Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.*

1.5 Primary health care is socially and culturally appropriate, universally accessible, scientifically sound, first level care.

1.6 It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that:

- gives priority to those most in need and addresses health inequalities;
- maximises community and individual self-reliance, participation and control, and;
- involves collaboration and partnership with other sectors to promote public health.
1.7 Comprehensive Primary Health Care includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation services.

1.8 Comprehensive Primary Health Care prioritises dealing with health as a holistic process, which includes a strong emphasis on working with families and the communities we live in.

1.9 AMSANT has a strong commitment to an evidence-based approach to policy development. This includes matters subject of the current Inquiry into the Child Protection system in the Northern Territory.

2.0 The origins of the current Inquiry and its Terms of Reference

2.1 The issue of child protection—particularly Aboriginal child protection—has a long history since the establishment of non-Aboriginal colonial government structures across the traditional estates and domains of Aboriginal traditional owning groups in what is now known as the Northern Territory.

2.2 While that history need not be recounted in any detail here, the legacy of the Stolen Generations cannot be ignored: it is an enduring legacy that has affected our families across the Territory, and across generations. To ignore these ongoing impacts on our families is to fail to understand the origins and ongoing trauma associated with generations of dispossession, removal and poverty, all of which contribute to the over representation of our people in the child protection system.

2.3 Media reports and the 2006 inquiry that led to the production of the Little Children are sacred report led, in its turn, to the Northern Territory Emergency Response—commonly known as the Intervention—which was purportedly designed in large part to “protect the children”.

2.4 At this stage it is difficult to evaluate data on the Intervention to ascertain whether the situation for our children has improved—and in any case any apparent improvements cannot be described as dramatic. In part, this is unsurprising; any improvements can only be incremental. This has been recognised more recently with the development of Closing the Gap policies at a federal and Territory level which clearly recognise intergenerational neglect in the past, and the
intergenerational challenge of achieving equity in social outcomes for Aboriginal people in the future.

2.5 A critical gain through the Intervention has been substantial increases in comprehensive primary health care funding to the Aboriginal community-controlled sector through the Expanded Health Service Delivery Initiative (EHSDI), and the roll out of regional health boards under Pathways to Community Control which has been endorsed at Commonwealth and Territory levels. Although not an explicit, or central, aim of EHSDI, it has enhanced the capacity of the Aboriginal Comprehensive Primary Health Care sector to embrace and undertake well being programs that are of direct relevance to child and family protection.

2.5 Concomitant with developments that followed Little children are sacred, the Northern Territory Government instituted new legislation, the Care and Protection of Children Act, which replaced the quarter century old Social Welfare Act. The new Act followed a period of 18 months of public and stakeholder consultation, and bipartisan support in the parliament.

2.6 Consequent to the passing of the legislation, a number of criticisms of the Act arose, particular with regard to mandatory reporting of—in particular—sexually active 14-15 year olds by health professionals. After substantial lobbying by the Really Caring for Kids Coalition, sponsored in significant part by AMSANT, amendments were made to the Act which went a large way towards clarifying the obligations of health professionals around reporting. These amendments received substantial bipartisan support, and a further review of the Act was promised for early 2010. Although not explicitly stated by the Government, this review appears to have been suspended in favour of waiting for the final report of the current Inquiry.

2.7 As an ancillary to increased resources into child detection and reporting through agencies such as the Sexual Assault Referral Centre [SARC], the Intervention also granted additional and specific powers to the Australian Crime Commission [ACC] to undertake investigations into child sexual abuse. This led to litigation in the Federal Court by two (unnamed) Aboriginal health services who raised substantial concerns that ACC access to patient files may lead to distrust of health services amongst vulnerable young patients—particularly in remote areas where there is no choice in seeking medical advice.
2.8 On an appeal which ultimately allowed access to files, the Court was nevertheless critical of the ACC’s “laconic formulate and often unhelpful” approach to going about explaining how they took children’s interests into account:

... in our view, the clear implication... is that the interests of Indigenous children is a matter required to be taken into account by the Examiner when deciding to issue the Notice [of seeking access to files]. In circumstances where the concern of NTD8 that the eight female Aboriginal children and, indeed, other children might be deterred from availing themselves of the services of NTD8 was before the Examiner, he was required to take that concern and the likely effect on the children into account.

2.9 Following a series of coronial hearings over the year 2009 that highlighted episodic—perhaps entrenched—difficulties within the child protection system in the Northern Territory, the Government announced the current Inquiry into the system. The key Terms of Reference to that Inquiry state:

Specifically, the inquiry is to report and make recommendations on:

• the functioning of the current child protection system including the roles and responsibilities of Northern Territory Families and Children and other service providers involved in child protection;

• specific approaches to address the needs of Territory children in the child protection system, including the delivery of child protection services in regional and remote areas as part of the development of A Working Future;

• support systems and operational procedures for all workers engaged in child protection, in particular staff retention and training;

• quality, sustainability and strategic directions of out of home care programs including support systems for foster parents, carers and families;

• the interaction between government departments and agencies involved in child protection, care and safety and non-Government organisations and other groups involved in the protection, care and safety of children.

The inquiry will consider and where appropriate incorporate:

• findings and recommendations arising from recent coronials and other recent investigations, reviews and inquiries into the functioning of the
child protection system; and

- child protection issues and developments at the local, national and international level and its implications for the Northern Territory.

2.10 In this response to the Terms of Reference, AMSANT does not seek to rake over the coals of the past in a detailed way, but looks to provide a series of principles and recommendations that we hope will guide the future direction of child protection in the Northern Territory. In this, we undertake the major themes of:

- changing the culture of child protection from one of reactive and ineffective forensic detection and uncoordinated management, to one of proactive advancement of the interests of children and families;
- prevention, and action to remove the proximate and general causes of child neglect and abuse; and
- management through Comprehensive Primary Health Care through Aboriginal community-controlled health services resourced to provide universal family support services as a primary prevention strategy for child abuse and targeted services as a primary and secondary prevention strategy.

2.11 Throughout this submission we also address the issue of re-structuring the current Northern Territory Families and Children agency and the Office of the Children’s Commissioner, with the provision also of independent policy and advice from a statutory Aboriginal Children and Families Advancement Agency Northern Territory.

2.12 A final point. When we speak of this as an issue that affects all Territorians, we point out that a failure to act will cost us all in terms of children abandoned in early life who—in later life—will then be represented in the courts and justice system; the mental health system; the health system generally; and early graves for themselves and their families. This is not just an inquiry into the “child protection system”, but an inquiry into how dealing justly with the vulnerable means justice for all of us.

3.0 Changing the culture of child protection in the Northern Territory

3.1 No one can pretend that administering and delivering services to children at risk, or subject of actual neglect or abuse, is an easy task—nor that it is problematic solely in the Northern Territory. While it may suit the desire of headline writers
and hunters to suggest otherwise, child abuse and neglect is endemic throughout Australia as well as internationally. If there were easy, straight-forward solutions, they would have been universally adopted by governments a very long time ago.

3.2 This is not to suggest the gravity of the problems identified in *Little children are sacred* was understated, nor that the problems have been substantially, or even partially, ameliorated since the publication of that report three years ago. Child abuse and neglect is an ongoing crisis in much of the Northern Territory, and Aboriginal families are over represented in the child protection system. The need for urgency in tackling the problems has not diminished.

3.3 A strong focus of critiques of the child protection system in the Northern Territory has been directed at the culture and processes within the Families and Children agency within the Department of Health and Families. Such critiques are not new: most recently the audit carried out by the current Children’s Commissioner before he took up the position indicated a range of suboptimal practices within what was then Family and Children’s Services. Coronial recommendations in recent times have also raised criticisms of processes—if not culture—within the agency.

3.4 In addition, there has been concerted political and media pressure on the agency. The Northern Territory is hardly unique in this respect: state and territory-based child protection agencies have been fair game throughout Australia amidst an atmosphere often verging on moral panic rather than dispassionate discourse.

3.5 Understandably—in many ways—this has led to a bunker-like mentality from child protection agencies, not least in the Northern Territory. Often citing privacy issues—which of course are important—agencies such as Families and Children have retreated from an important debate. This has included withdrawing from constructive engagement with the very media and political forces it seeks to avoid.

3.6 This is in many ways quite understandable. Quite apart from the day-to-day operational pressures and challenges that staff of Families and Children experience, these external pressures have contributed to widespread disillusionment and poor morale within the agency, with consequent high staff turnover and difficulty in filling vacancies within the agency. AMSANT understands that, for example, child protection vacancies within the agency are currently in excess of 50 positions. This poor morale has, arguably, spread to
foster carers within the system, and consequent difficulties in recruitment and retention.

3.7 Notwithstanding all of this, AMSANT believes that—with a change of approach and culture surrounding child protection—a small jurisdiction like the Northern Territory can make a difference in conjunction with the Comprehensive Primary Health Care sector.

3.8 Fundamental to this change of culture must be a readiness of NT Families and Children as an agency to abandon its siege mentality and be prepared to work in partnership with the primary health care sector, as well as other non-government stakeholders. In addition, the agency must be more open in its dealings with the general public and the media so as to increase public knowledge and understanding of this urgent issue.

3.9 A corollary of this is that government, in support of its agency in particular, as well as child protection in general, must be more open to working in partnership with its political opponents such that the issue of child and family protection becomes a bipartisan rather than politically contested issue in which political point scoring predominates over the interests of children and families. To be frank, mutually shared information and discussions across party lines can make a huge difference to de-politicising the issue of children’s and family protection.

Recommendation:

That the Legislative Assembly establish a Standing Committee on Child and Family Protection, with the willingness and capacity to work in partnership with each other and relevant stakeholders to develop a bipartisan approach to this issue.

3.10 AMSANT’s membership wishes to strongly put to the Inquiry the issue of maximizing Aboriginal employment and/or engagement in the child and family support, including the work of the Families and Children agency. There are two aspects to this issue: correct use of Aboriginal staff, knowledge and cultural protocols, and training and employment of Aboriginal staff within the sector.

3.11 Many of our services have experienced the Families and Children agency allocating inexperienced and inappropriate staff into the field—and this is a
consequence of structural problems with the workforce (see 5 below): we too often end up with employees of the Agency who simply do not have the skills or cross cultural understandings necessary to their jobs well.

3.12 Ongoing cross cultural training for all Agency staff must be part of Continuous Quality Improvement, and must preference delivery of such programs by Aboriginal groups that are supported by the Aboriginal Comprehensive Primary health Care sector.

3.13 There is a strong preference amongst our membership to build the capacity of the Aboriginal community to deal with family dysfunction ourselves—and that means skilling and employing our people to work in the field of personal and community well being programs, as well as child protection.

4.0 The place of Families and Children within executive government: more than mere Administrative Orders

4.1 AMSANT is of the view that there would be advantages in Families and Children becoming an agency independent of its current “parent” department, Health and Families. We believe that it would allow a greater administrative focus on its core responsibilities, without being subsumed within the broader culture of a large department which—inevitably—has priorities such as hospitals and acute care. We believe that there would be a better chance of developing an esprit de corps in a re-focused agency, and therefore a greater chance of cultural change.

4.2 We recognise, however, that administrative arrangements can be essentially arbitrary. A division of the health department in this case could lead to silo-ing, and a lack of networking and cooperation with other sectors of the health system—not least the vital primary health care sector. As we will discuss below under Prevention, sectors such as mental health and Alcohol and Other Drugs [AOD] must be integral to our collective efforts in child and family protection. This might be difficult in a “divided” department.

4.3 For that matter, child and family protection should not—and must not—be quarantined as a solely “health department” concern. Early childhood interventions that will be discussed below clearly have linkages with the Education Department; the Department of Justice has obvious concerns, as have the Public Service
Commissioner; Training and Employment sectors; Housing; Police; Treasury and so on.

4.4 Therefore, while the issue of Families and Children as a separate administrative agency might be arguable one way or another, it is imperative that Child and Family Protection become a cornerstone issue across government at the highest levels.

Recommendation:

That Child and Family Protection issues form part of the permanent “check list” of impacts and implications across all Cabinet Submissions and Decisions.

That a permanent Child and Family Protection Interdepartmental Committee be established of departmental heads across relevant government administrative units, to advise and coordinate whole of government efforts in child and family protection.

That the Office of the Children’s Commissioner; his/her proposed co-Commissioner, and the proposed Aboriginal Children and Families Advancement Agency Northern Territory, while not having formal membership of this Interdepartmental Committee, shall have ex officio access to the Committee.¹

4.5 The role of the Commonwealth under these arrangements should not be ignored. Especially since the Intervention, the Australian Government has increased its involvement in funding investigative, intervention and service delivery in the area of Child and Family Protection. This has primarily been through the departments of Health and Ageing [DoHA] and Families Housing Community Services Housing and Indigenous Affairs [FaHCSIA], as well as Attorney General.

4.6 While AMSANT welcomes these additional resources, we are concerned that their distribution is sometimes not evidence-based; is uncoordinated; is silo-ed and not necessarily allocated on a population base and according to need; and is often

¹ As independent statutory entities, it is preferable for these to remain independent of administrative and policy decisions of the proposed Interdepartmental Committee.
distributed to NGOs that do not have experience of, or strong links to, the Comprehensive Primary Health Care sector. There is a low level of uniform and transparent data collection and evaluation of these resourcing streams.

4.7 It is AMSANT’s view that these Commonwealth resources should be subject to a regime of partnership with the Northern Territory Aboriginal Health Forum, and the potential evaluative processes of the Northern Territory Aboriginal Health Key Performance Indicators [NTAHKPIs].

Recommendation:

That the Australian Government be encouraged to coordinate its resourcing of Child and Family Protection programs with the Northern Territory Aboriginal Health Forum.

5.0 Staffing the front line of Child and Family Protection: looking after the troops

5.1 Anyone with a modicum of experience of Child and Family Protection is aware of the pressures on front line staff, whether working in government or non-government sectors. It is well known that staff turnover and burn out is extremely high—and the Inquiry would do well to consider statistics on this matter. Low morale—and some of its causes—have been discussed above.

5.2 AMSANT is of the view that the structure of staffing within NT Families and Children is fundamentally wrong-headed—though it should be noted that other jurisdictions in Australia suffer from similar dysfunctional approaches in child protection.

5.3 For example, physicians and surgeons—and lawyers and politicians for that matter—with increased skills and experience are rewarded with higher remuneration. This achieved by remaining at the top of their game, as practitioners in their field. At present, a large—if not overwhelming—proportion of front line child protection staff are relatively inexperienced, both academically and in the field. Experienced staff—if they survive—are promoted out of the field into management or policy, and consequent better pay structures. It is a staffing/experience structure that is fundamentally flawed, and for very good reasons is not replicated in other professional fields.
5.4 The direct effect of this is perverse: removing experience and mentorship where it is most needed in the front line of child protection, in favour of populating the workforce with the least experienced practitioners. Inexperienced, front line staff, working in a high pressure environment, are thus left in a vulnerable, unsupported position. Little wonder that turnover and burn out is substantial; vacancies are rife; and the costs of recruitment are so high.

5.5 Further, there are no rewards in the sector for dedication or longevity in the field, or for working in rural-remote areas. Unlike, for example, the generous relocation and retention payments made to general practitioners working in rural and remote areas\(^2\), child protection workers are ill rewarded despite the difficulties of their job.

Recommendations:

That the pay and conditions structures for child protection workers be entirely recast such that front line practitioners be promoted and rewarded in the field rather than being promoted out of the field into policy and management.

That, in consultation with relevant representative groups, the remuneration structures include relocation and retention incentives.

5.6 A second major element of burn out and staff turnover lies with the culture of blame that prevails within the child protection environment. Unlike other areas of health, where there is an increasing trend to adopt no-fault regimes where mistakes are acknowledged and used as a basis for continuous quality improvement, child protection uniquely seeks to attribute fault and blame. Again, for reasons outlined above, this culture of blame very often targets relatively inexperienced and unsupported field staff.

Recommendation:

That the culture of blame within the Families and Children agency be replaced by a culture of continuous quality improvement.

\(^2\) From 1 July 2010, doctors relocating from a capital city to rural and remote areas of Australia will be eligible for a relocation grant of between $15,000 and $120,000 and, for the first time, more than 2400 rural practitioners will become eligible for retention payments of between $12,000 to $47,000 per annum after five years.

Together for our Health
6.0 Restructuring the way the agency does its business

6.1 There are two major areas in which the Families and Children agency operates: confusion between the investigative/forensic roles of the department and the child protection/case management, functions; and poor communications with outside agencies, especially the Primary Health Care sector.

6.2 Forensic investigation and child protection case management need to be distinct and separate functions. The main objective of forensic investigations is to assess whether criminal investigations are required, and to provide forensic evidence for those investigations. The main objective of case management is to take actions that will lead to the best outcome for the child in an ongoing, supportive framework. Even where a criminal investigation is to be undertaken, the child still requires assessment and case management by a skilled social worker.

6.3 AMSANT understands that police independently assess all cases of suspected child sexual abuse reported to Families and Children. AMSANT believes that the agency should work collaboratively with the police on these investigations, but that the agency should take the lead given that they have the professional expertise required to investigate and manage these cases so that the child’s needs are central.

6.4 An example of where children are denied case management is in cases of suspected child abuse where the perpetrator is outside the family. AMSANT understands that the agency is not routinely involved in these cases while it is involved if the perpetrator is within the family. AMSANT believes that trained child protection professionals should be involved in all cases of child abuse investigations irrespective of whether police are involved or not.

6.5 It is common that there is little communication back to Primary Health Care clinicians when they notify a case to the agency. The lack of communication between Primary Health Care practitioners and child protection authorities has been found to be associated with a reluctance to notify (Flaherty et al, 2005, Flaherty 2000). Given that Primary Health Care teams have much more frequent contact with high need families than Families and Children (especially in remote areas where the agency can only visit episodically).

6.6 This reluctance to communicate and collaborate leads to suboptimal outcomes for the child. AMSANT understands that there are sometimes confidentiality issues,
but we believe that this does not exempt the agency from the responsibility to communicate in the best interest of the child.

6.7 AMSANT is of the view that the agency must develop a completely different approach to the Primary Health Care sector. While our particular concerns involve the Aboriginal controlled sector, especially as Pathways to community control is rolled out, our comments here apply equally to primary health practitioners in the government and private sectors.

6.8 Families and Children should move from an approach of secrecy to one of collaboration and cooperation with the Primary Health Care sector. It should be noted in this context that while there has been a substantial widening of statutory obligations on Primary Health Care practitioners, there has been no complementary move to broaden collaboration such that these practitioners can be part of the solution in cases of child neglect and abuse.

6.9 The AMSANT board has suggested that the agency develops an MoU with Aboriginal Community Controlled Health Services and AMSANT which sets out the expectations of Primary Health Care services and Families and Children in regard to communication and collaboration.

6.10 The Little children are sacred report identified lack of knowledge and skill in primary health care professionals as being a factor in lack of detection of sexual abuse. The Care and Protection of Children Act make it a legal responsibility for primary health care services to inform all practitioners of their legal responsibilities under this Act. Formal education on child abuse has been found to markedly increase the likelihood that PHC practitioners will report appropriately (Flaherty et al., 2000; Badger 1989).

6.11 The Office of Aboriginal and Torres Strait Islander Health [OATSIH] has funded a series of workshops on the detection and management of child abuse targeted to clinicians working in Aboriginal primary health care. These have been well received. Education in this area needs to be provided regularly given rapid staff turnover and a high proportion of locum/inexperienced staff due to workforce shortages. Aboriginal Community Controlled Health Services (and other services) need to be assisted to orientate their staff in this area. Queensland Health has developed a self-capability assessment which is followed by an education program if required (Queensland Health).
6.12 Given the remote, dispersed nature of the Aboriginal Primary Health Care workforce in the NT, self assessment and education could be developed as an online orientation module backed up by ongoing workshops on child abuse. Families and Children should undertake this work in partnership with primary health care.

6.13 The trend to increasing notifications is occurring Australia wide and worldwide (AIHW 2008). Victoria has adopted a system of referring children to NGOs/family support agencies for intensive case management when the child is not in urgent danger (Department of Human Services, Children, Youth and Families). This has proven successful in reducing the pressure on the child protection workers and allowing them to concentrate on their statutory role whilst NGOs are in a better position to form collaborative relationships with families, given that are not the decision makers in case investigation and potential child removal.

6.14 For Aboriginal people, Aboriginal Community Controlled Health Services in the Primary Health Care sector are ideally placed to provide culturally appropriate case management and intensive support to Indigenous children in this category. Referrals would come from Families and Children but could also come from other agencies including schools and primary health care services. Including, indeed, from the community itself.

6.15 Central Australian Aboriginal Congress is now successfully providing this service to children in Alice Springs using social workers and Aboriginal family support workers. Wurlu Wurlinjang in Katherine is commencing on a similar path. This should be extended to other Primary Health Care services that have the capacity to provide this service, and who judge it culturally appropriate given local circumstances. There is currently a reform process underway in the NT—Pathways to community control—which will result in Aboriginal Primary Health Care being provided by large regional Aboriginal Controlled Health Services. The capacity of this sector to provide specialised support programs across the NT will thus increase, allowing Aboriginal Controlled Health Services to provide specialised services such as intensive case management of families at risk as they see locally appropriate.

6.16 However, it should be accepted that different Aboriginal Community-Controlled Health Services will have approaches that are suited to local conditions—and these are highly relevant. For example, health services in remote areas are often the only service bodies that are accessible—and trusted—within the region. For this reason,
locally designed child and family advancement programs will be developed, and
should be supported (rather than controlled by) government agencies.

6.16 Children who are in the care of the Department often have complex physical and
psychosocial health needs. Routine health care is often not up to date. However,
children often present to primary health care clinics with carers or department staff
as a new patient and there is no relevant health information provided to the
primary health care clinician. Furthermore, carers may not know vital health
information such as medications, allergies or how to treat an asthma exacerbation.
This results in poor care for these vulnerable children, and will lead to important
health issues being neglected. It also has the potential to lead to a serious adverse
event if a child is treated incorrectly because of lack of information.

6.17 Families and Children must take responsibility for ensuring that the health care of
children is coordinated as they move between home care and out of home care or
between different care placements. The Department also has a responsibility to
ensure that children in care receive comprehensive health assessments and that the
health problems identified are managed in a coordinated way. This may require a
health professionals located within the agency to coordinate the care of children as
they move through the system. Carers must also be provided with relevant health
information.

6.18 AMSANT has concluded that building strong communications and collaboration
with the Primary Health Care sector is critical to changing the culture of child
protection in the Territory, and the way Families and Children does its business.

6.19 This may well lead to a reduction in the workforce within the agency, and the
transfer of resources to the Primary Health Care sector. This should not be seen as
an attack on the agency, but as a way of promoting the kinds of child protection
team approach as exemplified by Congress programs emphasising family case
management.

Recommendations:

That the investigative/forensic functions of Families and Children be separated
from its child protection/case management functions.
That Families and Children radically change its approach to dealing with the Primary Health Care sector, seeking cooperation and collaboration as the prime benchmark for that relationship.

That regional Aboriginal Controlled Health Services be resourced to undertake intensive family case management programs where such programs are culturally appropriate.

7.0 Prevention: discussion and recommendations

7.1 The NT (like other jurisdictions) must address the causative factors that are driving the rising rates of child notifications to Families and Children in order to make a sustained impact on the damage to children caused by child abuse and neglect. The child protection system will continue to be under severe strain until these underlying factors are addressed.

7.2 Social determinants such as unemployment, poverty, overcrowded housing and low educational levels all need to be addressed in order to reduce the rate of child abuse. There is nothing new in this analysis, and has formed the basis of broad ranging inquiries at least as far back as the Royal Commission into Deaths in Custody two decades ago, through to key recommendations of the Little children are sacred report.

7.3 However, proximate factors that can be addressed in the health, social services and education sector to reduce causative factors and make an impact in a relatively short time frame include:

- High rates of alcohol misuse
- Mental health problems and the lack of community based care for people with mental illness
- Lack of child care particularly for families where there is significant dysfunction
- Teenage pregnancies and access to youth friendly health services
- Lack of services for perpetrators of sexual abuse
- Lack of a comprehensive system for family support and early intervention.

7.4 Alcohol excess is a major causative factor in high rates of child notifications with around 50 per cent of cases in Australia being associated with parental alcohol use (Scott, 2008). The NT has one of the highest consumptions of alcohol in the world.
Alcohol is associated with 70-90 per cent of episodes of family violence in the NT (Health Management Advisors 2005).

7.5 Alcohol control measures are the most effective measure to reduce alcohol consumption - including in people who have serious alcohol problems (Preventative Health Taskforce; Doran 2008). AMSANT has an endorsed policy on alcohol control in the NT which includes the following evidence based supply measures:

- Reduce liquor outlets to a level commensurate with national average
- Reduce trading hours, particularly for sales of take away alcohol.
- Introduce a minimum floor price for alcohol
- Support communities to design and implement alcohol management plans that are accepted by the community (requiring consultation) but also evidence based.

7.6 Demand measures include:

- Improved treatment for AOD and including treatment in primary health care
- Aligning Centrelink payment days to days in which take away alcohol sales are banned
- Banning promotion of alcohol

7.7 There has been some progress on alcohol supply measures particularly in Alice Springs and the Gove Peninsula and Groote Eylandt, but the effort across the Territory is patchy, and meets considerable opposition from the liquor industry and members of the general public. Although it has been advocated for by the Peoples Alcohol Action Coalition in Alice Springs, NTCOSS and AMSANT, there is no move to set a minimum floor price across the NT.

7.8 Untreated/poorly treated mental health problems or dual diagnosis (co existing mental health and AOD problems) are other important causative factors in child neglect and abuse (Scott, 2008).

7.9 Aboriginal people in the NT have a high burden of disease due to mental health problems (Measy, 2005: NT government 2001). The lack of community care is a factor in high rates of admission and re-admissions for psychiatric problems (NT Government, 20007: Nagel 2006). Dorothy Scott recommends family centred
practice in AOD and mental health services as part of a broader public health approach to child protection (Scott 2006).

7.10 Aboriginal Community Controlled Health Services are ideally placed to provide family-centred care for patients with AOD and mental health problems as part of Comprehensive Primary Health Care. This service would provide screening and early intervention as part of adult health checks, as well as prevention and community development activities, thus contributing to primary prevention of child abuse and neglect.

7.11 Specific parenting programs provided within Aboriginal Controlled Health Services should be developed. However, it should be noted that remote area services will need greater resources for such programs to be established and achieve success. Again, local solutions are important and, while they should be evidence-based, will adopt different structures and patterns. There is evidence from elsewhere about what works to reduce abuse, but these evidence-based models will need to be adapted to the Indigenous context (McMillan 2009). Men’s services within Aboriginal Controlled Health Services have done promising work on building self-esteem of men, and thus help them be better fathers.

7.12 However, currently only some regional Aboriginal Controlled Health Services provide social and emotional well-being services and even these services are not well resourced enough to meet demand. AMSANT urges that all Aboriginal Controlled Health Services in the NT be resourced to provide AOD and mental health services as a core part of Comprehensive Primary Health Care.

7.13 AMSANT also supports the expansion of residential rehabilitation services which can cater and provide support to the whole family.

7.14 NT teenage pregnancy rates are significantly higher than the national average in both Aboriginal and non-Aboriginal young people (ABS Births Australia 2007). Teenage pregnancies (particularly in younger teenagers) are high risk for poorer outcomes and children of teenage mothers are more likely to be notified to child protection authorities (World Health Organization, 2007; Scott D, 2008). Access to reliable contraception through confidential and adolescent friendly health services has been shown to be a major factor in reducing teenage pregnancy rates (Santelli, 2007 AIHW, 2003). Youth workers as part of Primary Health Care teams...
can actively support young people to access contraception and other Primary Health Care services.

7.15 Trained youth workers and social workers are also be able to assist Primary Health Care practitioners to assess sexually active young people (particularly those under 16) to assess whether they are at risk of significant harm or are being abused. Large regional Aboriginal Controlled Health Services sometimes have youth teams but remote services generally do not: AMSANT recommends that Aboriginal Controlled Health Services be resourced to employ youth teams (including Aboriginal youth workers) as part of Comprehensive Primary Health Care.

7.16 A neglected secondary prevention strategy of sexual abuse is to treat perpetrators of sexual abuse as well as those who have been identified as having deviant sexual behavior. Young Aboriginal people provided support in this way often recover well (personal communication Malcolm Frost Central Australian Aboriginal Congress). However, this treatment is not readily accessible to most who need it. A specialist service to perpetrators should be provided in regional centres and as an outreach service to remote communities.

7.17 Provision of free high quality child care to families in high risk environments or where there is significant family dysfunction will mitigate effects of neglect on brain development and behavior (Shonkoff and Phillips 2000). Free child care should be provided in regional centres to families identified as requiring support by family support services. Child care and kindergarten services in remote communities should also be provided throughout the NT.

7.18 Aboriginal Controlled Health Services should be resourced to provide universal family support services as a primary prevention strategy for child abuse and targeted services as a primary and secondary prevention strategy.

7.19 High quality antenatal care provided within Primary Health Care is essential and will enable risk factors such as alcohol consumption, family violence and mental health issues to be addressed during the pregnancy. Child surveillance as part of child and maternal health programs enables children at risk to be detected early. Childhood surveillance will contribute to preventing abuse only if Aboriginal Controlled Health Services are resourced to provide effective and assertive case management to children detected as being at risk.

Together for our Health
7.20 These services, if provided to all mothers of young children in a structured way (e.g., as per the Olds method) have been proven to have long-term benefits for the child including reduced rates of child abuse (Olds D et al, 1998; Mcmillan 2009). In the NT, two regional Aboriginal Controlled Health Services are providing home visitation services using the Olds Model with some modifications to make these services culturally appropriate. Service models that can work in remote areas need to be developed.

7.22 This service is a core PHC service as set out in the Northern Territory Aboriginal Health Forum document, *Access to Indigenous core primary health services*. The expansion of Aboriginal primary health care services currently underway in the NT is being guided by the set of services set out in this document at the first base line funding level of level of $3,00 per person. Children can be vulnerable because of health/developmental issues with the child, parental and family problems as well as environmental and community factors. It was notable that prior to the EHSIDI investment in primary health care, many Aboriginal Controlled Health Services reported that services to these families was lacking because of lack of funding.

7.23 Aboriginal Controlled Health Services require sustained investment to provide more intensive support and monitoring to families of vulnerable children. Primary Health Care staff that would provide such support include Aboriginal Health Workers, child health nurses and Aboriginal family support workers, social workers and visiting specialist staff such as paediatricians and allied health professionals.

8.0 Broader reforms and recommendations for the future of the Child Protection system in the Northern Territory.

8.1 Central to our position is moving to increase the role of Aboriginal people, and Aboriginal controlled primary health care services, in the development of policy and service delivery in the area of child protection to turn the tide of the over representation of Aboriginal children in the child protection system. Our position includes a far more activist approach to prevention through early intervention and support, as well as dealing with social and other conditions that substantially contribute to child neglect and abuse.
8.2 A key to moving towards solutions lies with greater direct involvement of the Comprehensive Primary Health Care sector in preventing child neglect and abuse through team-driven processes directed at families at risk (rather than just children at risk).

8.2 Rather than narrowly and reactively approaching it just as an issue of child protection, we advocate a proactively new approach: that of advancing the interests of children and families.

8.3 The 2007 Care and Protection of Children Act, for the first time in the Northern Territory, established the Children’s Commissioner as statutory office to monitor the child protection system, as well as overseeing recommendations of the Little children are sacred report. The Children’s Commissioner reports directly to Parliament.

8.4 Given the over representation of Aboriginal children in the protection system, AMSANT proposes the establishment of an Aboriginal Co-Commissioner to this statutory office to work with the current Commissioner. The Aboriginal Children’s Commissioner would have specific carriage of issues directly affecting Aboriginal children and families. There is a precedent for such a position within the federal Human Rights and Equal Opportunities Commission, which houses commissioners specialising in particular areas, such as the Social justice Commissioner.

8.5 Since the demise of Karu, the Northern Territory has not had a resourced Aboriginal child care/protection agency. This has been a significant gap in the child protection landscape, and one which the Aboriginal Community Controlled Health Service sector has not been able to adequately fill.

8.6 Interstate experience in both Queensland and Victoria indicates there is a strong role to be played around policy and service delivery in the field of child protection through Aboriginal Child Care agencies.

8.7 This submission endorses the statutory establishment of an Aboriginal Children and Families Advancement Agency. The mandate of such an agency, focusing on Aboriginal children and families, would involve:
• Policy and advocacy around Aboriginal child and family protection and 
advancement issues
• Collaboration with government agencies, NGOs and Aboriginal Community 
Controlled Health Services about improved policy and practice in Aboriginal 
child protection
• Support the development of quality culturally appropriate out of home care for 
Aboriginal children
• Support Aboriginal Community Controlled Health Services in working with 
families who are high risk for abuse or in the child protection system
• Provide an Indigenous perspective in individual child protection cases, such as 
is the case in Victoria.

8.9 AMSANT recognises the general reluctance of government to establish a plethora 
of statutory bodies. However, the converse is true: the establishment of statutory 
bodies demonstrates a strong legislative commitment to tackling major social 
issues such as child abuse and neglect.

8.10 Prior to statutory establishment of the Aboriginal Children and Families 
Advancement Agency, AMSANT would consider discussing auspicing such a 
body until it becomes independent agency.

8.11 Public education about the child and family protection system in the Northern 
Territory is negligible and little, if any, attempts have been made to explain and 
describe the system through the media. For such a vital and at times fraught issue 
that consumes significant amounts of taxpayer funds, this is unacceptable. It is a 
symptom of the bunker mentality of the agency noted above.

8.12 Within obvious privacy restrictions relating to particular cases, AMSANT is of the 
view that public support for a revitalized child and family protection system can 
only come about through greater access to information, and a greater 
understanding of the enormous challenges facing the system. This would involve, 
among other things, far greater transparency to the media.

Recommendations:

Together for our Health
That the government establishes an Aboriginal Children’s Co-Commissioner to the current Children’s Commissioner under the Care and Protection of Children Act.

That the Government establishes a statutory Aboriginal Children and Families Advancement Agency.

That the Inquiry supports greater public and media access to the policy and service delivery workings of the child protection system in the Northern Territory.
References


Northern Territory Government. Submission to Senate Inquiry into Mental health Attachment 24

Northern Territory Aboriginal Health Forum” Indigenous access to core primary health services in the NT.


