Sunrise Health Service Aboriginal Corporation

Submission to

The Northern Territory's Child Protection System Inquiry

> Children have the right to a standard of living that is good enough to meet their physical and mental needs. Governments should help families and guardians who can not afford to provide this, particularly with regard to food, clothing and housing[1].

[1] Summary of the rights of the child under the Convention on the Rights of the Child - unicef

Acknowledgement

Sunrise Health Service Aboriginal Corporation (Sunrise) would like to acknowledge the importance of the Inquiry into the Child Protection System in the Northern Territory 2010.

Child wellbeing is a key priority area for Sunrise. Comprehensive primary health care services are accessed by up to 1,576 children aged between 0 and 19 years[2]. Sunrise delivers services across some 143 kilometres squared through health centres in the following locations - Barunga, Wugularr, Ngukurr, Manyallaluk, Jilkminggan, Minyerri, Bulman and Mataranka. Sunrise also delivers comprehensive primary health care services through outreach or other arrangements in the following additional locations Werenbun, Kewulyi, Weemol and Urapunga. Sunrise makes the following submission to the Child Protection Inquiry in good faith[3].

This submission focuses on Sunrise/Eastern Katherine Remote and Very Remote Indigenous Communities.

The submission is set out in the following way;

Introduction – The introduction provides some, general comment, commentary on the size of the task, the NTER now called NT Closing the Gap and some information about related legislation.

Section one provides responses to 6 of the 7 criteria from the terms of reference set down by the Inquiry board.

Section two contains information about data and evidence including broad policy guidelines – this section provides a context for this submission to the Child Protection Inquiry.

Section three includes general information about Sunrise.

Appendix A provides some data from the July – December 2009 period.

Methodology

This submission has been informed by

- A literature search
- Comments resulting from consultation(s) undertaken with Sunrise Board of Directors- Sunrise Women's Steering Committee, Health Centre Staff, Health Program Coordinators, the Quality and Safety Officer our Doctors, and other relevant stakeholders. The Consultation was lead by the Child Health Program Coordinator.

2 Bi-Annual Report July to December 2009 1.1 Access populace by Community, Age, Gender

3 Some sections of text in this submission are taken from the appropriate source to ensure accuracy – where this is appropriate to the topic – examples include – text from Acts of Laws, Policy Directions of COAG etc - there is no intention of plagiarism, rather this approach is for the purposes of accuracy and reference.

Introduction

Children living in some of the most remote places in the Northern Territory of Australia deserve every opportunity to build on their rich cultural inheritance and have opportunities to learn about their history within a society that is not burdened by poverty and oppression.

Each child needs a healthy home, today's children should not have to suffer the daily pressures of overcrowding and/or be held ransom to lease/financial arrangements as a trade off for healthy homes – their parents deserve the right to be economically empowered through having access to real labour force participation jobs, and to have the philosophies of self-determination supported by governments.

The circle of poverty that encompasses children's lives must be addressed as a matter of urgency to assess its impact on Child Wellbeing and Child Protection – it is acknowledged that some Aboriginal people do have incomes that exceed the poverty benchmark. It should be noted that estimates of poverty are generally estimates of relative poverty. They estimate how many families have low incomes relative to other families.

In Katherine East Communities where Sunrise delivers health services 7.7% of people had negative or nil income, 57.9% of people received between $1.00 and $249.00 per week and 12.6% receive between $250.00 and $399.00 per week.

In 2006 the mean (average) Equivalised household income for Indigenous people was $450 per week, compared with $740 for non-Indigenous people. Mean Equivalised income was lower in remote areas compared with non-remote areas for Indigenous people $539 per week in Major Cities and $329 in Very Remote areas. This pattern differed for non-Indigenous people, where mean income was higher in Major Cities ($779) and Very Remote areas ($812)[4]

It is also of interest that the national medium wage per week is $466.00 and the national medium wage per week for the Indigenous population is $278 in 2006[5].

Top down interventions and approaches will not work. Significant investment should be made in Aboriginal Community Controlled and Aboriginal community designed programs and service responses. An investment in boosting supports within Statutory Authorities, and for other administrative staff alone will also not work. Place based services that are robustly supported to meet intents are considered better practise. The Inquiry Board will also need to investigate how to achieve the right balance between a focus on co-ordination across and within Governments and investments in place based community level responses that are Aboriginal lead. Some suggestions for other models are available in section one of this submission.

Of concern is - it would appear that the spotlight has been shifted and now focuses Australian's attention on child abuse in remote communities – enormous signs are

4ABS 4713.0 Population Characteristics, Aboriginal and Torres Strait Islander Australians 2006 pp 48

5 ABS 2006 Census data Packs – Indigenous Profile Table – 104 and 125

placed in the quietest locations[6] - these signs stigmatise those who live there. It is a well known fact that child abuse and child sexual abuse occurs across the broad spectrum, no race or class of people are exempt from this. Sunrise calls upon the Inquiry board to make recommendation to the Federal Minister, Macklin to, as a matter of urgency, address this injustice. Another alternative would be that the same signs be placed across Australia in all Cities, Suburbs, and Regional Places or other locations. It is of interest to note that the Anti Discrimination Act and the principle of Equity should be applied.

Child Wellbeing and the Child Protection in the Northern Territory is a complex area for both research and analysis purposes. Sunrise asserts that we cannot look at improvements to the Northern Territory Child Protection system[7], without adopting a holistic view of all those elements that might have some influence on a child's[8] development. The Social Determinants of health must also be considered within this analysis. Some information about social determinants is available in section two of this submission.

It is important to also note that there is some uncertainty about the level of acceptance of the Growth Towns concept[9]. Concerns have been voiced about the need to invest in Outstations/Homelands – Aboriginal people living in Katherine East/Sunrise Communities have mentioned that Homelands[10] are important and that they are needed. On 10 December 2008 at the NT Outstations/Homelands Community Engagement Meeting participants from Katherine raised the following issues- Homelands are important to;

Maintain and sustain our culture and language heritage; to care for our country and protect sacred sites and site of significance; to care for the past and our ancestors – burial sites; they provide for a healthy lifestyle and Homelands are healing places. They are our spiritual places. Participants noted that Outstations should be called "homelands"[11]. Also of concern is that a service in Ngukurr alone will not work.

Issues about data collections are also related and have been raised in the Second Report of the Senate Committee on Regional and Remote Indigenous Communities. Recommendation one[12] states that government should "improve the quality of existing collections through better application of appropriate data management principals" Also of interest is that the NTER did not use ABS data sets which caused questions to be raised in the report of the NTER Review Board[13]. Data and evidence are key elements of a successful strategy and must be further considered in order to ensure information collected and progress measuring is accurate and reports are linked to the ABS.

6 Now legislated as "Prescribed Areas" under NTER/ NT Closing the Gap

7 which also includes a continuum of care that picks up and responds to child wellbeing

8 Child – the definition intended and generally used throughout this submission includes those who are less than 18 years.

9 A Territory Government Initiative – Working Future – fresh ideas/real results

10 Who changed the name from Homelands to Outstations-These are our homelands 2008 Extract from written submission #40 – Message from Mala Leaders at Galiwin'ku to the NTG

11 January 2009 NTG Outstations Policy – Community Engagement Report Socom and DodsonLane

12 page 32 – Second Report of the Senate on Regional and Remote Communities

13 2009 Second Report Senate Select Committee on Regional and Remote Indigenous Communities – p26-32

While Sunrise acknowledges the importance of Child Wellbeing and Child Protection and it committed to supporting healthy children – we do hold some concern about the background to the Little Children are Sacred Report.

It is important for the Inquiry Board to conduct further research into the platform for the Measures associated with the Northern Territory Emergency Response now called NT Closing the Gap. On the basis of the research conducted, it appears that there are key linkages to most of the activities that were undertaken as a component part of the Indigenous Community Coordination Pilots (ICCP) conducted under the Council of Australian Governments (COAG)[14]. While public claims have been made that the NTER is a direct response to the Ampe Akelyernemane Meke Mekarle "Little Children are Sacred" Report[15].

Also on 25 May 2005 - the former Australian government stated the governments challenge is how to increase the participation of Indigenous Territorians in the economy? The statement also acknowledged that a broader policy approach was needed as progress in any one area, such as increasing Indigenous employment and participation in the economy is dependant on progress in other areas, such as improving standards of education, delivering skills training, achieving better health outcomes and providing additional housing to reduce overcrowding[16]. Among the agreed priorities was a commitment to building on Indigenous wealth; employment and entreneurial culture, as these are integral to boosting economic development and reducing poverty and dependence on passive welfare[17].

Interestingly this could provide some explanation for the economic basis for the legislative framework that encompasses and governs the NTER[18].

It is noted that the Little Children are Sacred Report made up to 97 recommendations - of these the following recommendation is considered key to the success of service responses. *In the **first** recommendation, the authors have specifically referred to the critical importance of governments committing to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities, whether these are in remote, regional or urban settings*[19].

14 An example of a partnership system is the Indigenous Communities Coordination Pilot. This pilot is based on the Council of Australian Governments (COAG) agreement that all governments would work together to improve the social and economic well being of Indigenous people and communities. Governments agreed that: they must work together better at all levels and across all departments and agencies; and Indigenous communities and governments must work in partnership and share responsibility for achieving outcomes and for building the capacity of people in communities to manage their own affairs. Partners, the community, the Commonwealth and NT governments, have signed a Shared Responsibility Agreement articulating the issues identified by the community and detailing the contribution of each of the partners to meeting and sustaining the priorities and outcomes.

15 Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, Ampe Akelyernemane Meke Mekarle "Little Children are Sacred" Report. 2007.

16 2005 Indigenous Economic Development Strategy Launch – Australian Government

17 2005 Indigenous Economic Development Strategy Launch – Australian Government pp 6

18 Some information about elements of the legislative framework is included in this submission.

19 http://www.inquirysaac.nt.gov.au/pdf/report_by_sections/bipacsa_final_report-recommendations.pdf

Jones reminds us that "it has been reported that 85% of notifications for suspected child abuse occur in non Indigenous children in Australia[20]. The lessons that will be learned in trying to address the problems confronted by Indigenous abused children in the Northern Territory need to be applied to the rest of the 256 000 suspected episodes of child abuse that are notified nationally each year, and the 23 000 children who currently live in foster and out-of-home care in Australia. Certainly Indigenous children are over-represented in this group; however, it would be a great mistake to consider that the problems identified in the *Little Children are Sacred* report are specifically Indigenous, or rural - they are, sadly, a national problem that requires a sustained national response"[21].

In July 2009 Sunrise held an Aboriginal Male Health Summit– Blekbala Fathawan Helth Summit. The final summit report is available as an attachment to this submission and makes a number of key recommendations. The intent of the Sunrise Aboriginal Male Health Summit was to strengthen male's capacity to engage positively with family and community through addressing the issues of male health and the role of Indigenous males in family, community and wider society. Over 100 males created and endorsed the Banatjarl Statement this is included in this submission in section two.

Also there are a number of key pieces of legislation that currently interface with the Child Protection System. Some of these are noted briefly below; further information is available in section two of this submission for the Inquiry Board's reference.

Key Pieces of Legislation

The Northern Territory Emergency Response was announced in June 2007[22] and is governed under a legislative framework that parcels up a number of complex legislative mechanisms. As stated by Docotor Sarah Prichard in her presentation to the Human Rights and Equal Opportunity Commission - *The devil is, notoriously, in the detail*[23]. Briefly, powers under the legislative framework that impact on the health of Australian Aboriginal and Torres Strait Islander people and the wellness of Aboriginal and Torres Strait Islander children includes, but is not limited to 3 main components, these are;

The Northern Territory National Emergency Response Act 2007; The Social Security and Other legislation Amendment (Welfare Payment Reform) Act 2007, and The Families; Community Services and Indigenous Affairs and Other Legislation Amendment (Northern Territory National Emergency Response and Other Measures) Act 2007.

The legislatve framework also interacts with a number of other complex legislative measures - including the

20 Australian Institute of Health and Welfare. Child protection in Australia 2004-2005. AIHW cat no 26; Child Welfare Series no 38. Canberra, ACT: AIHW, 2006.

21 Jones PD University Department of Rural Health & Rural Clinical School Faculty of Health, University of Newcastle New South Wales, Australia 29 August 2007; Published: 5 September 2007 Child abuse and the 'Little Children are Sacred' report: a rural paediatrician's perspective Rural and Remote Health 7: 856. (Online) 2007 Available from: http://www.rrh.org.au

22 On 21 June 2007 the Northern Territory Emergency Response was announced by the former Minister for Families, Community Services and Indigenous Affairs - the Hon Mal Brough

23 2007 Dr Sarah Prichard – Notes for the Seminar NT National Emergency Response Legislation – Human Rights and Equal Opportunity Commission.

Aboriginal Land Rights (Northern Territory) Act 1976
the Racial Discrimination Act 1975
the Native Title Act 1993
the Northern Territory (Self-Government) Act 1978 and related legislation
the Social Security Act 1991 and
the Income Tax Assessment Act 1993.

On 4 March 2010 the Chairperson of the Sunrise Board of Directors stated that *the Racial Discrimination Act must be re-instated in order for people to feel well again.*

Larissa Behrendt in her Correspondence entitled, Last Drinks said - In many ways; the intervention in the Northern Territory is a text book case of why government policies continue to fail Aboriginal people. - The policy approach is paternalistic and top down – rather than collaborative and inclusive[24].

It is important to also note that Article 21 states that Indigenous peoples have the right to improved economics and social conditions. This includes in the areas of education, employment, housing, health and social security.[25]

Sunrise recently attended the NTER third tier stakeholders Re-Design Workshop held in Katherine – a formal request was made to the Hon Jenny Macklin to exempt the Katherine Region from the measures contained under the former NTER – now called NT Closing the Gap – to date there has been no response from the Hon Minister to this request. The Stakeholders who were involved in approving and putting forward the formal request to the Minister were key stakeholders in peak non government local organisations. Two emails have also been sent to the appropriate officer in the Department to follow up this request.

Mandatory Reporting – directly through the Health Centre

Anecdotal comments suggest that mandatory reporting – through Health Centres could impact on the patterns of access by young women and in particular those who are a child for the purposes of the definitions under the Act and who are pregnant or sexually active.

A further concern is how this might negatively impact on overall health; including STI's, of both young men and young women especially given the majority of the population within Aboriginal communities are the young. As at 2006 there was approximately 43% of people living in Sunrise/Eastern Katherine Communities were between the ages of 5-24 years old[26].

Sunrise has recently implemented new requirements that align with mandatory reporting – extracts from the legislation included in this submission highlight the complexities associated with reporting purposes.

24 2008 Tim Flannery; Now or Never, A Sustainable Future for Australia Quarterly Essays (31) pp 73

25 United Nations Declaration on the Rights of Indigenous Peoples

26 ABS 2006 Indigenous ERP and ABS 2006 ERP

The Care and Protection of Children Act 2007

The Care and Protection of Children Act 2007 has commenced[27] some detail on the commencement of various parts of the Act and areas of responsibility are listed below- further information is provided in section two of this submission;

The following Ministers carry responsibility under the Act

The Minister for Children and Families (except Parts 3.1, 3.3 and 5.1 and provisions relating to child protection, child care licensing and education-related children's services; The Police Civil Employment Unit is responsible for Part 3.1;

The Minister for Education and Training is responsible for provisions relating to child care licensing and education-related children's services;

The Minister for Child Protection is responsible for Parts 3.3 and 5.1; The Department of Health and Families is responsible for provisions relating to child protection). Requirements under the legislation are that (Health Services) to notify and report child at risk of harm[28] and exploitation[29] (See Part 2.1, Division 3)

Registered health practitioners in the Northern Territory (have an *additional* responsibility) to report to the Department of Health and Families or the police if they believe on reasonable grounds that:

A child aged 14 or 15 years has been or is likely to be a victim of a sexual offence and the age difference between the child and the sexual offender is greater than 2 years.

Registered Health practitioners, according to the Act include Aboriginal health workers, chiropractors, dentists; dental hygienists; dental prosthetists, dental specialists; dental therapists, medical practitioners; midwives; registered nurses authorised to practise midwifery; registered and enrolled nurses, occupational therapists; optometrists; osteopaths; pharmacists; physiotherapists, psychologists and radiographers[30].

Domestic and or Family Violence

In relation to Health Services - 124A Reporting domestic violence is a requirement. The Domestic and Family Violence Act is in force at 12 March 2009 (Department of Justice) Domestic and Family Violence is a complex area and the dynamics must be fully understood to effectively base reportable beliefs around. Concerns have been raised that to date that there have been little accessible culturally appropriate comprehensive training opportunities in Domestic and Aboriginal Family Violence conducted for health professionals.

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27 Commencement Information: Ch 1 and Pt 3.3 and Pt 5.1: 07/05/2008;

Ch 2 (exc Pt 2.1, div 6 and s 127), Ch 3 Pts 3.1 and 3.2 (exc s 187), Ch 5, Pts 5.2 to 5.6: 08/12/2008; remainder: not commenced

28 Harm includes child witnessing violence between parents; exposure of the child to physical violence- physical, psychological or emotional abuse or neglect of the child and sexual abuse or other exploitation of the child.

29 Exploitation of child includes sexual and any other forms of exploitation including involving the child as a participant or spectator in an act of a sexual nature; prostitution and or pornographic performance

30 Extract from the Act

It is also necessary to refer to the definition and object of the Domestic and Family Violence Act as in force at 12 March 2009 to fully appreciate the parameters for reporting. An area that may possibly need to be further explored by appropriately qualified data analysts is the possibility of duplication in reporting given the scope and object of this Act and what appears to be grey areas of interconnections with the Care and Protection of Children Act 2007.

Sunrise Child Health Program

As mentioned elsewhere in this submission Sunrise adopts a multidisciplinary approach to the delivery of health services. The two main components are the health services delivered through the Health Centres[31] and health promotion services.

The Sunrise Child Health Program is a part of health promotion and includes involvement with school screening programs and the promotion of immunisations. The Program helps to raise awareness of childhood infections, promotes healthy lifestyles practices, and works with women's centres and schools. The objectives of the Child Health Program include;

- Promoting culturally-appropriate screening and monitoring the growth of Children
- Early detection of growth and development issues in children
- Ensuring effective interventions for children

Sunrise currently offers Child Health Services that align with the Programs logic – these services are prevention focused and support education and awareness raising. Some of these services are;

- Education and awareness raising about the unborn child and for pregnant women to engage in healthy behaviours
- Fred Hollows – World Health Organisation; Infant and young children Complementary
- Child Health Checks and follow ups and referrals
- Monitoring the Growth Assessment and Action (GAA)
- Commencing Protective behaviours training within the School environment for children aged between
- Sexual Health Education for the Middle and High School students[32]
- Core of Life training (Program that teaches young people about the reality of Motherhood and Fatherhood)
- First Aid Training for Middle and High school students who are currently in the VET program
- Emergency First Aid for Parents – Australian Red Cross

31 Further information about services delivered through health centres is available in section three of this submission and the Healthy for Life Objectives are also available through the Australian Government Website

32 It seems that some Teachers are reluctant to deliver Sexual health education for a range of reason. Sunrise Health Service has plan to assist with delivery of the program

Sunrise utilises a multi-disciplinary approach to the delivery of services – as such a number of other health initiatives interface with the Child Health Programs. Some of these are outlined below;

Nutrition Program

The Nutrition program promotes good nutrition in the Sunrise Health Service region by liaising closely with communities to provide strategic direction and coordination in the promotion of healthy eating. The program's objectives include: Establishing nutrition programs in each community; Developing promotional materials to encourage good nutrition; Increasing opportunities for member communities to access bush tucker; and Providing nutritional advice- some further information is below.

Clinic Involvement

- Monitoring anaemia treatment in communities
- Providing nutrition education groups with (Aboriginal Health Workers) AHW for mum's and babies.
- Providing nutrition education to pregnant women especially if they have gestational diabetes.

Schools

- Bush tucker/mural painting project- education for kids about growing plants, continuing to access bush tucker and healthy eating.
- Participating in health promotion sports events

Women's Centre/ School Nutrition Program

- Providing nutrition support to staff - that make food available through the school nutrition program. This includes menu development, training and nutrition education.

Outback Stores

- Working with the nutritionist to supply clinic's with oranges to be used for health promotion with iron treatment for children.

Aural Health Program

The Aural Health Coordinator undertakes visits to the Sunrise Communities with Australian Hearing. During these trips with Australian Hearing the Aural Health Coordinator[33] conducts individual ear health education and treatment for ear health conditions. The Aural Health Coordinator also works with some of the schools to conduct Hearing Screening and treatment of ear conditions. The Aural Health Program - promotes the Breathing Blowing Coughing (BBC) program to the preschools, provides preschools with posters of the BBC program and posters of hand washing and nose blowing. Demonstrations are also carried out under the BBC program - this includes demonstrating nose blowing, hand washing, and tissue ear spear making. The Aural

33 Usually the Aural Health Coordinator will identify the ear condition and give treatment for it, as well as do some individual education with the client about ear health and medications for it. After this is done then the client will go and see the Australian Hearing Audiologist for a hearing test and/or re/fitting of hearing device/s.

Health Program also supports Sunrise Health Centres by providing information about ear treatment and medications including ear health posters, and DVD's such as the Tissue Spear DVD and Ear and Hearing Story DVD. Some training is provided to Sunrise staff whenever possible, training staff to identify ear health conditions as well as using ear health equipment and the referral process for a hearing test or ENT services.

Early Learning

The LiTTLe (Learning to Talk, Talking to Learn) Program[34] is a Health initiative concentrating on developing and improving spoken language in order to reduce the disabling effects of ear disease. The highly prevalent Middle ear disease (Otitis Media) in Australian Aboriginal children usually commences in the first year of life. The aim is to have children strong in their Home language.

The Program is now running for three of the four targeted communities - Bulman, Weemol and Wugularr. Previously, the Early Start Program operated in these communities and in Manyallaluk – however the program was limited and has now been revamped to develop and improve early language in the 0 – 5 yr age group, although the emphasis is on 0 – 3 yr olds as children older than this are now eligible to attend Pre-school and are encouraged to do so. The program activities vary from day to day and are selected from provided activity cards - Inside play, 0utside play and Communication. The activities are typical of those in a preschool setting and timetabling ensures that all areas of learning are covered with in each week.

Male Health Program

The Male Health program provides culturally appropriate initiatives and services which promote the health and well-being of the community males men within the Sunrise Health Service region. The program provides a wide range of health promotion information and educational resources to assist community leaders in formulating visions for improving their health through decision making processes. Additionally, the program strives to achieve better health outcomes for all males by combining both traditional techniques and European practices. The Male Health Program has previously undertaken the following activities

- 710 health checks - 15yrs and up, STI education at schools 15+ year olds
- Hunting / camping bush tucker trips 15+ with community male leaders
- Sometimes 1yrs + during clinical consultations after hours when relieving - general medical checks and treatment and assisting in roadshows for children - fun activities for kids

This year the Male Health Program will also

- Continue 710 health checks
- Commence father and son camps - healthy country healthy people, and
- Continue STI education at schools

34 This project is also supported by the Ian Thorpe Fountain for Youth

Section One

Criteria One

The functioning of the current child protection system including the roles and responsibilities of Northern Territory Families and Children (NTFC) and other service providers involved in child protection.

Sunrise acknowledges that the current Child Protection System in the Northern Territory is overwhelmed and under resourced and not always able to respond to reported issues of concern about a childs wellbeing in a reasonable way or within a reasonable timeframe. Coordination is a key consideration – there must be high level coordination across agencies. Relationships, roles and responsibilities need to be articulated in clearly set out and agreed Memorandums of Understanding (MOU). MOU's could also be developed for Health Service Delivery Areas.

In order for responses to be effective there must be a genuine commitment from Individual Ministers to work within a collaborative and holistic framework and regularly meet about child wellbeing and child protection issues.

It would appear that the whole Child Protection System; - which should include a continuum of care[35], that picks up child wellbeing, needs to be overhauled. A comment that highlights this is below;

> It's not working – no feedback and no one is investigating

Also support systems for FACS do not seem to be in place on the ground; there is little communication with key staff involved; very often only the clinic manager is informed of progress, and often information is not disseminated. The interaction between agencies is also poor; it is suggested that interagency meetings when appropriate need to take place in communities to support kids at risk and those trying to care for them[36].

A suggested model that aligns with this philosophy is available under criteria two.

Also there are no MOU's in place that assist to govern key interagency relationships – as such some children fall further from protection as confidentiality is prioritised rather than the child's wellbeing. One of the most frustrating parts of the current process is the lack of feedback about the child. In instances such as failure to thrive there are processes that health centre staff follow – where cases of child sexual abuse are concerned reports are usually made through the GP or DMO. A case is set out below that highlights concerns held by health centre staff that these requirements placed on health centres will cause people to avoid the clinic.

35 A continuum of care means a systematic response – there has to be appropriate service responses developed.

36 Health Centre Staff – Comments to the Child Health Program Coordinator

Young woman presented at the health centre with her mother the young woman and her mother were keen to see health centre staff about health related matters until the health centre staff member informed them about the new rules around reporting – both fled the clinic.

Sunrise is concerned as there is also some anecdotal evidence to suggest that Health Centre staff who make reports to FACS will/may face retaliation. A suggested approach that would allow for special child wellbeing workers, who may assist with this complex and sensitive area, to be attached to Sunrise Health Centers is outlined in this submission in section one.

Also the Northern Territory Government advertises that reports should be made to the 24 hour Centralised Intake Service by using the free-call phone number **1800 700 250.** It is of interest to note that in the second report of the senate committee on Regional and Remote Communities up to 70% of Indigenous people in remote areas of the Northern Territory do not have access to a telephone in their own home. While Sunrise acknowledges that the Northern Territory Government has produced a publication for Health Practitioners about reporting child sexual abuse- there is to date very little information that has been shared by the Northern Territory Government with community members. Sunrise is concerned that information must be provided at a local level in a culturally appropriate way – it is noted that on page 1 of the Northern Territory Publication it is stated - that everyone in the NT must report child sexual abuse for those under 18. It is interesting to note that in Bulman there are only four telephones available in the community and one public phone the public phone is broken. Telstra have stated that they will not be putting a mobile phone tower in Bulman.

There must also be accessible information provided at local levels to all stakeholders about how the Child Protection System actually works – flow charts and diagrams need to be developed that chart the roles and responsibilities of all stakeholders – this would assist as many people living in remote and very remote areas in the Katherine East/Sunrise communities speak English as a second or third language.

Languages spoken in all the Katherine East Region are as follows;

Alawa
Marra
Mayali
Ngalakgan
Ritharrngu
Rembarrnga
Nunggubuyu
Mangarrayi
Ngandi
Dalabon
Warndarrang
Jawoyn

Sunrise also suggests that Governments invest funds in the development of story boards – designed in consultation with and by local people and key family groups. There does need to be a concerted effort by the Northern Territory Government to train and employ local Aboriginal staff to deliver child wellbeing and child protection services in remote areas in the Northern Territory. Please see further information provided under criteria three.

Wider issues that relate to a child's well being include having access to affordable toys[37] and good quality food.

A Sunrise Health Centre manager made the following comment about the cost of toys at a remote community store-

> I could not believe the price of the small electronic cars – I mean I know these cars are expensive anywhere but the price they charge out here seems so inflated – I mean how can you get away with charging $400 - $500 for a small electronic car and you see them in less than 3 days they are broken. This puts incredible pressure on families as they are trying to make sure kids are not bored but the cost is so high. Also a Play Station Number 2 is priced at $400 out here – this is unbelievable they are not that much anywhere else not for a Play Station Number 2.

It is of concern to Sunrise that Indigenous Australians living in remote and very remote areas have among the lowest earnings in the nation, yet pay substantially higher food prices than the rest of the nation.

In one of the Sunrise/Eastern Katherine Communities a Store Manager was complaining about the Basic cards being used for Junk food; as it was to expensive to get good healthy fruit and vegetables. Last time Eva Valley store closed down was due to the Store debt associated with book up problem.

There must be appropriate supports and the necessary steps taken to drastically improve infrastructure arrangements as this will help to ensure more reasonably priced access to food supplies.

An example of a key future area for investment is the need to subsidise freight and provide greater storage and freezing facilities. The results of the Market Basket Survey conducted in May 2008 indicate that the cost of a Market Basket is $721 for Jilkminggan and that the availability was at 57% this represents $180 more than the costs of the same Market basket in Katherine town where the availability is 100%.

37 Toys are a tool to assist in the childs physical and cognitive development and their social and emotional wellbeing.

A cost comparison of nutritious food items in line with the Australian Dietary Guidelines is provides some information about one community store.

	Woolworths Nightcliff NT	Woolworths Katherine	Beswick Outback[38] Store
Powdered milk (1kg)	$ 5.99	$ 9.50	$14.95
Equal tablets (300 tablets)	$ 8.15	$ 4.99	$ 6.13
Loaf of multigrain bread	$ 2.28	$ 2.28	$ 3.00
Weetbix 1kg	$ 5.04	$ 5.04	$ 7.21
Tomatoes (1 kg bag)	$ 3.48	$ 3.48	$ 6.00
Packet frozen vegetables (1 kg)	$ 2.15	$ 3.99	$ 7.01
Apples (pack of six)	$ 2.90	$ 3.00	$ 3.37
Bananas (individually)	$ 1.03	$ 1.00	$ 0.74 cents
Vaalia double pack of yoghurt	$ 2.73	$ 2.55	$ 3.54
Tin of tuna (425g)	$ 2.07	$ 3.65	$ 6.90
12 eggs	$ 3.69	$ 3.99	$ 5.09
Lean beef (diced) rump (510g)	$ 9.50	$ 5.63	$10.84
Vita wheat savoury biscuits (250g)	$ 3.05	$ 3.05	$ 5.60
Diet coke 1.25 L	$ 2.19	$ 2.19	$ 4.00
Water 1.5 L	$ 0.96	$ 1.32	$ 4.04

Also of interest is the recent Menzies report

A Senate Inquiry has learned that the Northern Territory Intervention has had no effect on fruit and vegetables sales in ten remote indigenous stores.

Rick Hind reports that two researchers at the Darwin based Menzies School of Health have written a letter revealing their initial findings after studying the 18 months before and the 18 months after income management was introduced. The letter says restricting half of welfare payments to essentials, caused a reduction in soft drink sales for the first six months but after that soft drink and confectionary sales climbed to rates higher than before the intervention started. Income management appears not to have reduced tobacco or cigarette sales either.

The researchers aren't talking until after their research is peer reviewed and printed in a medical journal. Health researchers have informed a Senate Inquiry into welfare reform that income management has failed to reduce tobacco sales at stores in ten remote Indigenous communities.

[38] It is of importance to note that the Bulman Store has higher prices than the Beswick Store.

Rick Hind also reports that;

Income management or welfare quarantining was a central plank of the Northern Territory intervention in 2007 and the Indigenous Affairs Minister plans to expand it nationwide. But two researchers from the Menzies School of Health Research have written a letter to the inquiry looking into the changes. Their initial findings based on sales figures for ten remote stores show quarantining half of welfare payments has had little effect in reducing tobacco and cigarette sales. Their letter says once the federal stimulus payment is taken out of calculations, sales of food and drink and fruit and vegetables have also been unchanged. Soft drink sales dropped for the first six months but are now higher than when the intervention started. The researchers are presenting their study for peer review and publication in a medical journal.

> As we all know, 'decent' food is expensive, difficult to come by in the "off truck weeks" and during the wet. It is often of poor quality either by accident (delayed transport) or design. Many of our clients do not have the means and money to shop in Katherine as we do and as such, are stuck with what they can obtain within the constraints of the money available. Often this means a pie and a can of coke is cheaper and easier than buying the ingredients for a healthy meal[39]

Also Sunrise is aware that Outback Stores also report increased fruit and vegetables but this is represented as a portion of sales and they decline to mention how much the sale of coke and pies has gone up alongside all of this.

> When money is limited it is well documented that people will purchase foods that will fill them and their families' stomachs for the lowest cost. The nutritional value of the food is a lower priority. Bread, damper, soft drink, pies and other convenience food are therefore most frequently on the menu. Also people do not have the facilities for storage and cooking, and overcrowding impacts on the ability to purchase and prepare foods that need storage and require cooking[40]

39 Primary Health Care Coordinator

40 Public Health Nutritionist

Criteria Two

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 the Working Future initiative.

It is critical that approaches to address Indigenous disadvantage and the underlying causes of abuse and neglect are holistic and culturally sensitive, and empower families and communities to develop and (deliver) community-identified solutions[41] Aboriginal and Torres Strait Islander children are significantly over-represented in all parts of the child protection system. Addressing Indigenous disadvantage is critical to addressing the factors that put Aboriginal and Torres Strait Islander children at-risk of abuse and neglect. Child abuse and neglect can be prevented by addressing disadvantage (for example, overcrowded and inadequate housing); recognising and promoting family, community and cultural strengths that protect children; and developing community-wide strategies to address specific risk factors where they occur in high concentration, such as alcohol misuse.

Maintaining connection to family, community and culture is essential within a framework that respects the physical, mental and emotional security of the child. This is particularly important in light of the historical experiences that Aboriginal families have had with child protection agencies. There are special provisions in the law for Aboriginal children. The Aboriginal Child Placement Principal recognises the importance of keeping Aboriginal children with their family and for Aboriginal children to grow up safe - knowing their culture. A local placed based approach to the delivery of prevention and early intervention programs will assist with implementing the Principal.

There are ongoing issues with all associated service providers sharing and updating information – the FACS system is a Maze you don't know who you are talking to until the child is assigned a case. This is often to do with key staff being on leave and follow up taking too long.

The following information highlights this issue.

> The delivery of service (once again) takes too long; I have reported 2 cases through the intake team- 1 was considered not worth following up
> - relates to neglect and emotional abuse by a step parent.
>
> The second is an open case where FACS visited the community the day before looking for a child. To report that I had seen this child, I was asked to go through the intake team again.
>
> The next day I was contacted by Katherine FACS; the case worker was going on leave and asked that any further issues be forwarded through the intake team. Nothing further has happened[42]

41 (Aboriginal Child Sexual Assault Taskforce 2006; Anderson & Wild 2007; Atkinson 2002; Gordon, Hallahan & Henry 2002; Robertson 2000; Silburn, et al. 2006).

42 A period of two weeks has passed and there is till no response as at 19 February 2010

Suggested Models

The following models/ideas for service delivery are suggested and should be further investigated and or funded.

An Aboriginal Child Care Agency needs to be established as a matter of importance and urgency. Staff ideally would need to be Aboriginal People.

Supports provided indirectly through the Health Centre

This suggested approach would involve a male and a female worker who are local Aboriginal people and who are trained to work closely with the Health Centre Manager to provide the following;

- Help for families and children
- Raise awareness about new laws
- Manage on a Case by Case basis,
- Coordinate where needed other relevant people (possibly through the interagency framework mentioned also in this section) or through individual face to face means.

Suggested Criteria for the positions would be

- Good literacy and numeracy
- Child Protection Check
- National Police Check for Working with Children
- Willingness to undertake child wellbeing and protection training

These must be real workforce-labour force positions

Kids Safety Houses

For Children who are neglected the Kid's Safety House is a good model. This would need to be supported by accommodation and be staffed by local Aboriginal People.

Attributes for staff criteria is as above.

These must be real workforce-labour force positions

Family Group Homes

Family Group Homes need to be funded and established at local levels – this would greatly assist in reducing pressures and overcrowding and providing the right support in the right way to all family members.

Resource Booklets for Staff

Resource booklets for staff would greatly assist - these booklets need to contain up to date information including contact numbers.

Integrated Interagency Arrangements

An integrated, interagency group framework could be applied to community safety strategies at a local level. Weekly meetings could be held involving Roper Gulf Shire, Police, Health Centres, Child Protection, School, Health Workers and other interested community representatives with confidentiality agreements in place.

The purpose of the meeting would be for the community, to assist in problem solving with some of the issues on the ground; more often that not, it revolved around children. Much can be achieved. These types of arrangements have resulted in the following benefits;

- Communication flowed.
- Kid's needs were met.
- Protection was introduced sensitively.
- Community had control over decision making and found their own solutions that were culturally appropriate and saved heaps of shame and embarrassment.
- We all supported each other.

And they also solved a lot of the substance abuse and boredom issues, and created an environment of trust where people came to this group.

Sunrise Aboriginal Male Health Summit 2009

The following information is taken from the final report of the Summit and is relevant to the Inquiry. Resources are needed[43] to nurture, coordinate and deliver programs, such as, but not limited to:

- male support groups;
- places of healing for Aboriginal males, including men's shelters/sheds;
- short term 'drying out' places for men, and more resources for long-term rehabilitation of Aboriginal males with alcohol and other drug problems and
- 'half-way' houses to give 'time out' to move slowly back into work/family/training, to be run by Aboriginal males[44].

The Summit recommends[45] the Federal and Northern Territory Government seriously consider housing shortages in major regional centres in their implementation of recent policy changes.

43 Please see a copy of the Final Report which includes all recommendations and full recommendations

44 Recommendation 2 – Develop specific Male health resources

45 Recommendation 14: Address housing shortages in community and towns

Comment: “I tried for 20 years to get a home in my community, but when the GBM moved into my community he had a house and satellite television installed in two weeks.”

Change the mindset[46]: we require a change in mindset of government from an approach which manages dysfunction to one that supports functional communities. Current approaches pay for the consequences of dysfunction, rather than taking positive steps to overcome it. We need a proactive system of service delivery to Indigenous communities focused on building functional, healthy communities

Re-assert our cultural norms and regain respect in our communities**:** Family violence and abuse is about lack of respect for Indigenous culture. We need to fight it as Indigenous peoples, and rebuild our proud traditions and community structures so that there is not place for fear and intimidation[47]

Banatjarl Family Resource and Healing Centre

The Banatjarl Women’s Council is committed to the establishment of a Healing Centre at Banatjarl it has been proposed that the Healing Centre will provide a safe place for

Women and Children – survivors of violence to recuperate

Training and programs and support to break the cycle of violence and dependence (family violence and alcohol)

- Pass on and strengthen culture
- Old people to have a break
- Establishment of a “mothers” Women’s Resource Centre
- Offenders Programs
- Youth Programs
- Conferences and meetings

The program priories in establishing the Healing Centre must focus on family wellbeing. The concept of healing and promotion of the concept – providing information about the impacts on families, barriers to wellbeing and strategies for solutions is critical to the long-term success of the Healing Centre. Engaging and stimulating discourse within communities about acceptable standards of family wellbeing will re-engage and strengthen cultural values and practices[48].

46 Recommendation 15: Five year community Planning and funding

47 Recommendation 19: Reassert our Culture norms

48 2009 Katona Jacqui, The Fred Hollows Foundation Banatjarl Women’s Council – Banatjarl Family Resource and Healing Centre

Criteria Three

Support systems and operational procedures for all workers engaged in child protection, in particular staff retention and training.

At the local Health Centre level concerns have been raised as Health professionals are unaware of the arrangements for any children being cared for in out of home situations in the local communities. The following reflects a general and often asked question- How would I find this out?

Also there are informal arrangements that some people are aware of, that FACS may not actually recognise.

Support systems must be in place – in relation to training and staff retention. Sunrise would suggest that Government makes every effort to employ and train local Aboriginal people to deliver child well being and child protection services.

The following model to support a locally based approach to the provision of services is suggested and is considered worthy of investment.

That the Inquiry Board further consult with the Ngukurr Community with a view to determine the feasibility of establishing a Training Authority (hub based service) in Ngukurr to support and provide training that is registered and accessible. This would provide an ideal and realistic support to ensure every opportunity is offered to Aboriginal people to take up real labour force participation waged jobs and thereby also assist in closing the gap. A comment from the health centres is that there are not enough job opportunities on communities.

The comment below was provided on 4 March 2010 as a component part of the consultation conducted to inform this report.

> Local people need to be the foster carers – it won't work otherwise.

Also current procedures do need to be reviewed particularly in the case of children who are removed from the care of parents, families and or community - too often Sunrise hears

> No one explains that people's kids have been taken away – no one gives us any feedback.

In instances where there are no Aboriginal people who can be trained and employed then Sunrise suggests that these workers need to be trained in cross cultural awareness and how to engage with Aboriginal people in remote areas – this training must be undertaken by workers as a minimum criteria.

Criteria Four

Quality, sustainability and strategic directions of out-of-home care programs including support systems for foster parents, carers and families.

Recent research has shown that a good deal of children who have been in and out of home care have significant mental health, developmental and learning difficulties[49].

It is imperative that assessments be conducted on placements – children who are removed from home – those at the end of the continuum must have their safety plans developed and there must be a full assessment conducted on the adults in the home where the child might be placed.

About Governments obligations to provide foster care this requirement is impacted by the fact that Housing is in a poor state of repair and there is significant overcrowding. Other alternatives are that the Inquiry Board and or governments might consider is housing that is better designed for example some housing designs that consider the extended family concept have a breeze way and are more suited for extended families. If these issues are not dealt with it is impossible to provide healthy homes for out of home care or foster care. There is a majority of Indigenous Communities and urban households with the problem of over crowding. In most cases up to four generations of the same family have been living together. This is due to the lack of foresight of population increase and access to better health delivery services. For years the lack of concern for Housing needs for the remote Indigenous populace has created this chaos of bad health standards. As health improves for Indigenous people the need for improved and additional infrastructure is needed badly[50].

Comment from health centre staff is below;

A male who is living and working in the Katherine area,

recently asked the Health Centre Manager the following question?

> Why are they taking money from me? Is it because I am a black fella? There are many people who are feeling disempowered and that the Australian Government is not being fair and providing a rule for all to follow – rather they are supporting one rule for Aboriginal people and another for other Australians.

49 Tarren-Sweeney M, Hazell P. Mental health of children in foster and kinship care in New South Wales, Australia. - Journal of Paediatrics and Child Health 2006; 42: 89-97. and Jones PD, Psychiatric diagnoses in children in foster care in rural NSW. Journal of Paediatrics and Child Health 2005; 41: S9-10.

50 Environmental Health Program Coordinator.

It is interesting to note that in the National Indigenous Housing Guide the former Minister stated - improving the health of Indigenous Australians is a priority for the Commonwealth Government. The poor standard of housing for Indigenous peoples is a known contributor to their health problems, particularly the high rate of infectious diseases among children. Lack of attention to detail in house design, careless or sub standard construction and no cyclical maintenance make houses unsafe, affect health and waste valuable resources[51].

Also a recent public case[52] highlights the need to ensure appropriate assessments are conducted – the child must be seen not just the carer.

Aboriginal Placement Principal

The Aboriginal Child Placement Principle (ACPP) is documented in the *Care and Protection of Children Act 2007*, which legally requires NT Families and Children (NTFC) to place Aboriginal children in the care of Aboriginal people wherever possible. Equally as important, it upholds the rights of the child's family and community to have some control and influence in decisions being made about their children[53].

While Sunrise acknowledges the importance of the fact that Government has attempted to recognise the rights of Indigenous Children by trying to redress the issues that compounded the stolen generations – it is impetrative for Governments to ensure that housing and other social determinants are addressed. Overcrowding is a significant problem in some remote communities in the Katherine East Region. Anecdotal evidence and verbal advice suggests that FACS will not place children in overcrowded houses – this is consistent with FACS guidelines.

There is also a lack of supportive infrastructure – i.e. interagency meeting are not held at a community level, comprehensive training is not offered and the support provided to carers is not sufficient.

It appears that FACS guidelines are not always adhered to when Aboriginal children are placed in out of home care. This has also been highlighted in some recent public information[54], while the Aboriginal Child Placement Principle is an important principle there must be a case by case analysis applied to the placement of children in out of home care arrangements. Blanket approaches will not work in this very complex and sensitive area. Sunrise suggests that the Northern Territory Government adopt a more comprehensive approach to the design and delivery of service responses - the following process is considered to be appropriate

Firstly develop a true picture of the services needed in each community

Developing a service response in Ngukurr alone will not work – Sunrise suggests that a mapping of all services be conducted and that this be benchmarked against community needs location by location – this will inform a current gap analysis

51 2003 National Indigenous Housing Guide

52 Deborah Melville Case

53 http://www.nt.gov.au/health/docs/fostercare_factsheet_11_aboriginalplacementprinciple.pdf

54 No safety net for children at risk in the NT

Secondly provide a culturally sensitive service that reflects community's needs

A culturally sensitive service response must be developed in consultation with those people in the individual communities – every community is not the same.

Thirdly develop a community response that promotes safety including the safety of children and young people

A community response must be comprehensive and tailored to the needs of each community. This community response needs to be supported and informed by local people and senior people – this needs to be done in collaboration with the ICC, Health Centres, Police, Roper Gulf Shire, Schools and other relevant stakeholders.

A model for consideration is one that endorses a Government Champion approach Individual Communities can be supported by Senior Government Champions this can assist coordination and advocacy.

Fourthly support local people to build on and develop the necessary skills to take up full wage labour positions. As mentioned elsewhere in this submission local Aboriginal people should be employed and trained to deliver services. Sunrise has recently commissioned a consultant to document the Sunrise Way – The 'Sunrise Way' document expresses a vision of how Sunrise Health Service wants to work in harmony with the culture of its communities, to address health disadvantage. According to Sunrise Way communication within Sunrise and its communities will respect core Aboriginal values, and recognise the importance of different types of relationships – relationships which are the underpinning of contemporary, as well as traditional Aboriginal society. Sunrise Way is a concept of defining how SHS conducts its health business within the context of its Community Controlled governance and structure. It is a departure from conventional health service practice. Sunrise Way is based on a set of principles (the Cultural Framework) and all activities are harmonized with that.

Sunrise Way recognises that remote is different, that Indigenous health needs different approaches, and that remote Indigenous health has shown no appreciable improvement over the past 30 years. It represents a paradigm shift in the provision of remote Indigenous health. The Sunrise Way also represents an approach to service provision in Sunrise' group of communities, which is in keeping with the culture of these communities, and the aspirations of the people. It builds on past experience, but is not tied to it. It seeks to reclaim the good health and associated practices of the past.

The vision contained in Sunrise Way is of a health service in tune with its communities culturally, building and using new knowledge which comes from traditional practice and conventional health practice while maintaining the highest quality of health care, using a mainly Aboriginal workforce, particularly at the professional levels, and in control in its dealings with external agencies including funders, health institutions, and service providers.

As mentioned previously there must also be accessible information provided at local levels to all stakeholders about how the Child Protection System actually works – flow charts and diagrams need to be developed that chart the roles and responsibilities of all

stakeholders – this would assist as many people living in remote and very remote areas in the Katherine East/Sunrise communities speak English as a second or third language.

Sunrise also suggests that Governments invest funds in the development of story boards – designed and developed in consultation with and by local people and key family groups. Top down interventions will not work and certainly don't in a predominate Aboriginal or Indigenous setting – approaches that support a fly in fly out type of service model will also not be successful – Governments must ensure that programs and services are delivered in genuine partnership with Aboriginal people. Parenting and other support programs also need to be designed and delivered by Aboriginal people in order for them to be effective.

Criteria Five

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.

Culturally appropriate responses need to be based on partnership arrangements between Indigenous families and communities, and between Indigenous agencies, mainstream service providers and governments. Strategies should build on existing strengths, match expectations with appropriate supports, and recognise the importance of Indigenous-led and managed solutions [55]

Higgins reminds us one of the things I think we should have learned by now is that you can't solve these things by centralised bureaucratic direction. You can only educate children in a school at the place where they live. You can only give people jobs or get people into employment person by person. And I think my own view now is that the lesson we've learned is that you need locally based action, local resourcing, local control to really make changes. But I think governments persist in thinking you can direct from Canberra, you can direct from Perth or Sydney or Melbourne, that you can have programs that run out into communities that aren't owned by those communities, that aren't locally controlled and managed, and I think surely that is a thing we should know doesn't work. So I am very much in favour of a model which I suppose builds local control in communities. Not central bureaucracies trying to run things in Aboriginal communities. That doesn't work. - They're locked into systems which require central accounting, which require centralised rules and regulations. They're not locally tailored[56].

55 (Higgins 2005).

56 http://www.inquirysaac.nt.gov.au/pdf/report_by_sections/bipacsa_final_report-recommendations.pdf

Criteria Six

Child protection issues and developments at the local, national and international level and their implications for the Northern Territory.

Please also see section two of this submission which provides some information on stakeholder policy areas and the current environment. Place based responses can not be limited to an investment in Ngukurr alone- there must be a systematic response that provides resources for Preventions, Early Intervention. Identification of the location for responses should also be Aboriginal lead.

Over Crowding

Sunrise agrees with the statement made by COAG – "Housing is an essential building block in closing the gap on Indigenous disadvantage. Sub-standard and overcrowded housing has detrimental impacts on the health of tenants as well as their ability to participate in education and employment"[57].

Overcrowded environments and low incomes work against supporting healthy childhood development. It is recommended that the Australian Government review its stringent requirements for people to sign leases by way of a trade off for housing and housing repairs. Health Homes is a key target of the COAG. Children will not fair well being raised in unhealthy housing environments. Overcrowding will also impact school attendance and school participation. Health Centre staff has confirmed that overcrowding is definitely a problem to be further investigated and resolved.

Income Management

Sunrise also suggests that Managed Income be applied on a case by case basis rather than as a blanket approach. Managed Income strategies currently being delivered by Centrelink are disempowering to Aboriginal and Torres Strait Islander people living in Sunrise/Eastern Katherine Region and do not support important self determination principals. Furthermore parents and others have no way of knowing their balances and often shop without knowing how much they have to spend or how much they have left. Please also see our submission made to the Senate Select Committee on Regional and Remote Communities.

SEAM –Schools Enrolment and Attendance Measure

While Sunrise congratulates the Australian government on their intent to assist Indigenous children to attend school we are deeply concerned about the powers over peoples' income that the School Enrolment and Attendance Measure provide for.

An MOU has been signed between NT DET, DEEWR and Centrelink to assist in governing the SEAM. It is a pilot that will be rolled out for a period of one year and then evaluated.

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6 National Health and Medical Research Council. 2000. Nutrition Aboriginal and Torres Straight Islander People-an information paper. National Health and Medical Research Council: Canberra

57 Council of Australian Government National Partnership Agreement on Remote Indigenous Housing

The following comment reflects concerns about this initiative

> But what am I going to do – I have that red mark on my Centrelink and I told the school that my daughter was sick that day but I still got a red mark and they are going to take away my money for 8 weeks, - they can – how am I going to feed the kids - I have 6 children.

SEAM appears to contradict statements made in the Ministers (Rudd) speech on 1 April 2008 the Prime Minister said "that Income Management provides better financial management for some mothers, grandmothers and other community members to feed and raise their children".

SEAM does not fit well with Healthy for Life Initiatives - and as Professor Larissa Behrendt and Ruth McCausland have pointed out, there is scant evidence that linking income management to school attendance and educational outcomes.

In fact, in the areas where such approaches have been trialled in the East Kimberley, there was *no evidence* that it boosted school attendance. Yet families will face the possibility of having their income suspended for up to 13 weeks if their kids are not enrolled or attending school.

This is a very concerning measure as we are not sure how people will fair especially those in vulnerable groups such as anaemic children, pregnant mums and the elderly.

Suspension means a person (the parent or the person who a child would normally reside with) can be suspended from their Income Support Payment from Centrelink. NT DEEWR confirmed that this means the parent would not receive any of their Income Support Payment including their basic card. Income Support Payments can be suspended for up to 13 weeks. (This does not include peoples Health Care Card and FTB). School attendance will be monitored by NT Department of Education. Centrelink will check about/verify enrolments and or attendance with NT DET. At this stage[58] they have only allowed for one verification process of the child's enrolment and or attendance at school. – Sunrise is not sure what will happen for parents who move from one community to another. Some further information about SEAM is available in section two of this submission.

[58] Workshop conducted in Katherine on 28 January 20009

Section Two

Policy Environment - Data and Evidence

Coordination is a key consideration –given the dearth of information, numbers of departments and other agencies involved, relevant emerging information and new directions under the COAG. Coordination activities also need to include monitoring and accountabilities – these may be best provided for through formal Memorandums of Understanding and Working Protocols between partner agencies that govern and guide relationships. Roles need to be clearly articulated for each agency and or department within a Whole- of Government(s) Framework.

Also given that there is a National Child Protection Framework – there must also be a set of guidelines to accompany this framework that ensure Aboriginal Children who are in need of supports are appropriately responded to.

Policy Environment

– Whole of Government Headline Targets and Related National Partnership Agreements are relevant to Child Wellbeing and Child Protection – some of these are listed below for the Inquiry Boards reference.

There is an Integrated Strategy for Closing the Gap to be incorporated into the National Indigenous Reform Agreement[59]. There are seven platforms upon which COAG intends the reform agenda to be based. These are proposed to be:

- Early Childhood
- Schooling
- Health
- Economic Participation
- Healthy Homes
- Safe Communities
- Governance and Leadership

COAG has also agreed to a number of National Partnership Agreements which are new forms of payments to fund specific projects and to facilitate and reward states and territories that deliver on agreed reforms.

The National Partnership Agreements related to Indigenous service delivery include:

- Remote Indigenous Service Delivery;
- Indigenous Economic Participation;
- Indigenous Early Childhood Development;
- Indigenous Health; and
- Remote Indigenous Housing[60].

Information on some of these initiatives' is set our below and provides a context for the current environment in Australia.

59 Council of Australian Governments, National Indigenous Reform Agreement, November 2008, p.3,

http://www.coag.gov.au/intergov_agreements/federal_financial_relations/index.cfm

60 2009 Second Report Senate Select Committee on Regional and Remote Indigenous Communities, p. 9

Remote Indigenous Service Delivery

Through this Agreement, the Commonwealth, the states and Northern Territory governments have agreed to improve access to government services including early childhood, health, housing and welfare services all through a single government interface[61].

This Agreement intends to provide $291.2 million over six years with the Commonwealth government agreeing to provide $187.7 million with the aim of improving access to services for Indigenous people living in 26 remote communities. The Commonwealth government has stated that it intends to create a new service delivery model in these communities to clearly identify service standards, roles and responsibilities that people living in these communities will be able to rely upon[62].

National Partnerships on Indigenous Early Childhood Development

The National Partnerships on Indigenous Early Childhood Development commenced on 1 January 2009 with joint funding of $564 M over six years to 2014, the Commonwealths' contribution is some $489.6 M[63].

The partnerships is stated to be based on evidence that improvements in Indigenous child mortality require better access to antenatal care, teenage reproductive and sexual health services, child and maternal health services and integrated child and family services.

Children and Family Centres are due to commence operations from June 2010.

National Framework for Protecting Australia's Children 2009 -2020

Protecting children is everyone's responsibility. Parents, communities, governments and business all have a role to play.

Australia needs a shared agenda for change, with national leadership and a common goal. All Australian governments have endorsed the first *National Framework for Protecting Australia's Children 2009-2020* and are committed to implementing the initial actions it contains. It is a long-term, national approach to help protect all Australian children.

The National Framework represents an unprecedented level of collaboration between Australian, State and Territory governments and non-government organisations to protect children. Placing children's interests firmly at the centre of everything we do. Reducing child abuse and neglect is not an easy task and it will take time.

The National Framework provides the foundation for national reform[64].

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61 Council of Australian Governments, National Partnership Agreement on Remote Service Delivery, November 2008,http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/national_partnership_on_remote_service_delivery_with_amended_schedule.pdf

62 The Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs, Budget Statement – Appendix B, 12 May 2009,

www.fahcsia.gov.au/about/publicationsarticles/corp/budgetpaes/budget09_10/indigenous/documents/closingthegap/appendix_b.htm

63 2009 Second Report Senate Select Committee on Regional and Remote Indigenous Communities, p 11

64 Endorsed at the Council of Australian Governments meeting on 30 April 2009

Children have a right to be safe, valued and cared for. As a signatory to the United Nations Convention on the Rights of the Child, Australia has a responsibility to protect children, provide the services necessary for them to develop and achieve positive outcomes, and enable them to participate in the wider community.

In line with Australia's obligations as a signatory to the UN Convention, the National Framework is underpinned by the following principles:

- All children have a right to grow up in an environment free from neglect and abuse. Their best interests are paramount in all decisions affecting them.
- Children and their families have a right to participate in decisions affecting them.
- Improving the safety and wellbeing of children is a national priority.
- The safety and wellbeing of children is primarily the responsibility of their families, who should be supported by their communities and governments.
- Australian society values, supports and works in partnership with parents, families and others in fulfilling their caring responsibilities for children.
- Children's rights are upheld by systems and institutions.
- Policies and interventions are evidence based.

The National Framework also recognises the importance of promoting the wellbeing of Aboriginal and Torres Strait Islander children, young people and families across all outcome areas. Under the *National Framework for Protecting Australia's Children*, protecting children is everyone's responsibility. Some of the key groups and their involvement in the National Framework are described below.

Parents and families care for and protect their children and engage in decision making that has an impact on them and their children.

Children and young people participate in decisions affecting them.

Communities support and protect all their members, and support families to raise their children, particularly vulnerable families.

Non-government organisations deliver services (including on behalf of governments), contribute to the development of policy, programs and the evidence base and actively promote child safety, protection, rights and wellbeing.

The **business and corporate sector** supports parents to raise their children through family friendly policies. They may also support programs and initiatives to directly assist children and families, including direct financial assistance, pro bono activities of their staff and professional support to community organisations.

Local governments deliver a range of services to vulnerable families, including youth and family centres and local infrastructure, and play a pivotal role in engaging vulnerable children and their families in those services.

State and Territory governments deliver a range of universal services and early intervention initiatives to prevent child abuse and neglect, and fund and coordinate many services by the non-government sector.

The **Australian Government** delivers universal support and services to help families raise their children, along with a range of targeted early intervention services to families and children.

The foundation of the Australian Government's support is the provision of income and family support payments to provide both a broad social safety net and specifically support families in their parenting role.

This includes pensions, family payments, childcare benefit and tax rebates. Please see the response found in Section One – under Criteria 6 – Income Management.

SEAM

NT Trials to boost school attendance a new initiative called School Enrolment and Attendance Measure (SEAM) An MOU has been signed between NT DET, DEEWR and Centrelink to assist in governing the SEAM. It is a pilot that will be rolled out for a period of one year and then evaluated. Funds of 17.6M has been provided to establish the trials – the total amount of which has been spent on building the capacity of Centrelink includes designing the system and includes IT supports.

A concern is that SEAM appears to contradict statements made in the Ministers (Rudd) speech on 1 April 2008 the Prime Minister said "that Income Management provides better financial management for some mothers, grandmothers and other community members to feed and raise their children". SEAM does not fit well with Healthy for Life Initiatives - the well being of vulnerable groups such as children, pregnant women and the elderly is under question when SEAM gives the power to the Australian Government to withhold all of an individual's entitlement under income and family support payments.

What does suspension mean?

Suspension means a person (the parent or the person who a child would normally reside with) can be suspended from their Income Support Payment from Centrelink.

NT DEEWR confirmed that this means the parent would not receive any of their Income Support Payment including their basic card.

They did mention that suspension of Centrelink Income Support would be a last measure.

What are the Penalties?

Income Support Payments can be suspended for up to 13 weeks. (Does not include their Health Care Card and FTB)

If the parent complies within this period their Income Support Payment will be reinstated and they will receive back pay.

If the parent does not comply within this 13 weeks period they could then be placed on an extended suspension period and also lose their Health Care Card and FTB.

13 weeks does not have to be 13 consecutive weeks it could be that John is suspended from his Income Support Payment for say 4 weeks and then his child is

attending school so his money is reinstated – he may then receive a further suspension if his child is not attending school on so on.

How long will people be suspended for?

- Parents can be suspended for as long as they do not comply
- Parents must take reasonable steps to get their child to attend school
- Parents have to actively work with the school to get their children to attend.

Verification of child/children's attendance?

School attendance will be monitored by NT Department of Education. Centrelink will check about/verify enrolments and or attendance with NT DET.

At this stage[65] they have only allowed for one verification process of the child's enrolment and or attendance at school. – Sunrise is not sure what will happen for parents who move from one community to another.

NT DET mentioned they still have to work out the detail about a number of elements of the SEAM. Including defining what is a reasonable excuse? How the verification process will actually work with schools and others and defining attendance.

Local Centrelink Officer confirmed;

- CDEP recipients will not be affected
- The appeals process will/will not apply – waiting for confirmation.
- The SEAM will only be rolled out in Katherine and Katherine Town Camps – not all areas of Katherine.

Northern Territory - Care and Protection of Children Act 2007

Sunrise has recently implemented - Requirements (Health Services) to notify and report child at risk of harm and exploitation and Requirements for employees working with Children

A person is guilty of an offence if the person; - believes on reasonable grounds that a child;- has been or is likely to be a victim of a sexual offence or otherwise has suffered or is likely to suffer harm or exploitation

Requirements for employees working with Children (See Chapter 3 Part 3.1) have also been implemented. Child related work involves health services in which children are ordinarily patients[66] and services for the care of a child if the child is less than 13 years old[67]; - A national Police Check for working with Children – means a national criminal history check undertaken by relevant State Police where the check is undertaken specifically in relation to working with children.

65 Workshop conducted in Katherine on 28 January 20009

66 pp 90 of the Act

67 the care is provided at a place other than the childs usual place of residence – the services are provided by a person who has been given the responsibility for the care of the child by someone having daily care and control

Northern Territory - Domestic and or Family Violence

Domestic and Family Violence Act as in force at 12 March 2009 (Department of Justice). In relation to Health services 124A Reporting domestic violence is a requirement – this is also quite a complex piece of legislation in that there are a number of definitions that must be understood.

These can be quite technical for example, Physical harm is the type of harm that needs to be reported and serious harm is the severity or threshold it needs to fit within for mandatory reporting obligations to apply.

To decide if you must make a report, consider: Is the TYPE of harm physical? (per section 1A of the Criminal Code)

"Physical harm includes unconsciousness, pain, and disfigurement, infection with a disease and any physical contact with a person that a person might reasonably object to in circumstances, whether or not that person was aware of it at the time".

Is the harm **serious harm**? (per section 1 of the Criminal Code)

Serious harm means any harm (including the cumulative effect of more than one harm):

(a) that endangers, or is likely to endanger, a person's life; or
(b) that is or is likely to be significant and longstanding.

Concerns have been raised that to date that there has been very little accessible culturally appropriate training opportunities conducted for health professionals. Domestic and Family violence is a complex area and the dynamics must be fully understood to effectively base reportable beliefs around.

It is also necessary to refer to the definition and object of the Domestic and Family Violence Act as in force at 12 March 2009 to fully appreciate the parameters for reporting. An area that may possibly need to be further explored by appropriately qualified data analysts is the possibility of duplication in reporting given the scope and object of this Act and what appears to be grey areas of interconnections with the Care and Protection of Children Act 2007.

Data and Evidence about Some Social Determinants

Katherine town is home to an estimated 9,031people, 4.4% of the Northern Territory population (203,404), while the region is home to 17,920 people. (*ABS Cat 3218.0 – June 2006)*. The population of the Katherine region is expected to rise to about 22,460 people by 2021, based on medium growth projections by the ABS. *(ABS Cat 1362.7 Dec 2006)*

Almost one third of the preliminary estimated resident population reside in Major Cities (32%); 21 % lived in Inner Regional areas; 22% in Outer Regional areas; 10% in Remote areas and 16% in Very Remote areas.

For the non-Indigenous population, there was a much higher concentration in Major cities (69%) and less than 2% in Remote and Very Remote Australia. Of the states and territories, Northern Territory had the largest proportion (45%) of its population living in

Remote and Very Remote areas, with four-fifths (79%) of its Indigenous Population living in these areas[68].

While it is acknowledged that Katherine is a vibrant town there are areas of disadvantage, particularly for Indigenous people living in Remote and Very Remote areas[69] Based on a Northern Territory Government analysis of 2006 ABS Census data, there were about 41,130 people living in the NTER[70] communities. (including town camps and significant numbers of outstations). Of these people 35,929 or 87% were Indigenous population.

According to the ABS the most disadvantaged areas of Australia are located in Remote areas of Northern Territory[71]

Indigeneity is highly correlated with relative socio-economic disadvantage at an area level. It has been shown that on average, Indigenous Australians have significantly lower levels of income, employment and education than the rest of the population[72]

Growth Predictions

In the 2006 Census 24.7% of the population usually resident in Northern Territory were children aged between 0-14 years, and 13.6% were persons aged 55 years and over. The median age of persons in Northern Territory was 31 years, compared with 37 years for persons in Australia.

Labour Force Participation and Income

Katherine town had an estimated 5,083 people in the labour force at December 2006 and a 2.9% unemployment rate, just above Northern Territory average of 2.5%. The unemployment rate for the Katherine region was estimated at 4.9%. *(DEWR Small Area Labour Markets -December Quarter 2006, unsmoothed series* Of Indigenous CDEP participants counted in the 2006 Census:

The majority were in Very Remote areas (76%) and a further 14 % were in Remote areas. The largest proportion were in the Northern Territory (37%) Three-quarters (75%) worked part time. Two in five (40%) worked between 16 and 24 hours per week in the week prior to the Census[73].

An important unit for assessing income, especially in the context of assessing links to financial status, is the family and/or household level. In 2006 the mean (average) Equivalised household income for Indigenous people was $450 per week, compared with $740 for non-Indigenous people.

Mean Equivalised income was lower in remote areas compared with non-remote areas for Indigenous people $539 per week in Major Cities and **$329** in Very Remote areas.

68 ABS 4713.0 Population Characteristics, Aboriginal and Torres Strait Islander Australians 2006 pp13

69 The Northern Territory National Emergency Response was initiated in 2007 & in the 2009 Budget was termed NT Closing the Gap; there is significant evidence to support the need for coordination and prevention activities that promote social inclusion.

70 Northern Territory Emergency Response (NTER) – governed under a number of pieces of legislation and amendments.

71 Socio-Economic Indexes for Areas (SEIFA) – media release March 2008

72 ABS Socio-Economic Indexes

73ABS 4713.0 Population Characteristics, Aboriginal and Torres Strait Islander Australians 2006 pp 39

This pattern differed for non-Indigenous people, where mean income was higher in Major Cities ($779) and Very Remote areas ($812)[74]

Other Indicators

The quality of life of Aboriginal and Torres Strait Islander people is a matter of national urgency that all Australians want addressed and remedied. The Ministerial Council for Aboriginal and Torres Strait Islander Affairs (MCATSIA) is charged by the Council of Australian Governments with ensuring that all levels of government, that is national, state and territory and local, work together to improve the life and well-being of Australia's Indigenous people[75].

COAG agreed to the operating arrangements for the Coordinator-General for Remote Indigenous Services (the Coordinator General). The Coordinator-General will work with coordinators identified by Commonwealth agencies and State and Northern Territory coordinators-general to coordinate planning for, and monitor the delivery of, programs and services in the 26 locations selected under the Remote Service Delivery National Partnership (NP) agreed by COAG at its November 2008 meeting.[76]

The 2009 *Overcoming Indigenous Disadvantage Report*

The three priority outcomes that sit at the top of the report's framework reflect COAG's vision for Indigenous Australians to have the same life opportunities as other Australians. The priority outcomes are interlinked — no single aspect of the priority outcomes can be achieved in isolation. 'Positive child development and prevention of violence, crime and self-harm' are key determinants in the achievement of 'safe, healthy and supportive family environments with strong communities and cultural identity'.

Crime Indicators

Addressing the Security Council in 2004, the United Nations Secretary General observed that '[i]n matters of justice and the rule of law, an ounce of prevention is worth significantly more than a pound of cure…prevention is the first imperative of justice' (United Nations 2004: 1). The average rate of detention of young people aged 10–17 years per 100 000 in the population aged 10–17 years increased from 26.8 per 100 000 in 2003-04 to 35.9 per 100 000 in 2007-08, with rates varying across jurisdictions.

Social inclusion - Although interpretations vary, definitions of social inclusion (or conversely, social exclusion) commonly concern access to opportunities such as education and employment and the capacity required to capitalise on those opportunities. Specific dimensions used to measure social inclusion or exclusion often includes the presence or absence of: geographic disadvantage (for example, having limited or no access to public transport and other community and neighbourhood resources), joblessness, intergenerational disadvantage, child poverty, chronic ill-health and homelessness[77].

[74] ABS 4713.0 Population Characteristics, Aboriginal and Torres Strait Islander Australians 2006 pp 48
[75] http://www.mcatsia.gov.au/
[76] Council of Australian Governments' Meeting 30 April 2009 - http://www.coag.gov.au/coag_meeting_outcomes/2009-04-30/index.cfm#children
[77] *Source*: ABS (2004b); Australian Government (2008b; 2009); Hunter (2009); Productivity Commission (2003); Scutella, Wilkins and Horn (2009).

Living Arrangements

Among Indigenous households, multi-family[78] households were the most common in Very Remote areas where 20% were multi-family. In comparison, multi-family other households were most common in Major Cities, However this accounted for only 1% of all household types. The condition of houses in Indigenous Remote communities is deteriorating. Between 2001 and 2006, the percentage of houses requiring major repairs in remote communities increased from 19% to 23%. One in four houses needing major repairs is currently inhabitable[79].

Indigenous households tended to be larger than other households (average of 3.3 persons per household, compared with 2.5 respectively). One of the major factors contributing to this difference is the higher number of dependent children in Indigenous households- for all Indigenous family types the average number of dependent children was 1.1 compared with 0.5 for other households[80].

For Indigenous households, household size tended to rise with increasing remoteness, from an average of 3.1 persons per household in Major Cities to 4.9 in very remote areas[81].

The average occupancy per dwelling in remote areas is estimated to be 8.8 persons per dwelling, while the average National occupancy rate is almost 2.6 persons[82]. Local observations and anecdotal evidence suggests that the average occupancy per dwelling in remote areas is estimated to be up to 17 people per household.

Birthweight of Babies

The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2006, 91.8 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Hilder 2008). The average birthweight for all live births was 3370 grams. In 2006, the average birthweight of liveborn babies of Indigenous mothers was 3169 grams (tables EA.22 and EA.23). This was 209 grams lighter than the average of 3378 grams for liveborn babies of non-Indigenous mothers (Laws and Hilder 2008).

Among live babies born to Indigenous mothers in 2006, the proportions with low birthweight (12.4 per cent) and very low birthweight (2.3 per cent) were around twice the proportions born to all Australian mothers.

Principal Causes of Death[83]

The most common causes of death among Australians in 2007 were: diseases of the circulatory system (including heart disease, heart attack and stroke), cancers, and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.5 and EA.17). In 2007, malignant neoplasm's (cancers) were the main underlying cause of death of 30 per cent of all registered deaths and ischemic heart disease was the primary cause of a further 16 per cent of deaths (ABS 2009a).

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[78] two or more families pp 21 ABS 4713.0
[79] Council of Australian Governments National Partnership Agreement on Remote Indigenous Housing
[80] ABS 4713.0 Population Characteristics, Aboriginal and Torres Strait Islander Australians 2006 pp 21
[81] ABS 4713.0 Population Characteristics, Aboriginal and Torres Strait Islander Australians 2006 pp 21
[82] ABS Community Housing and Infrastructure Needs Survey 2006
[83] 2010 Report on Government Services Volume 2

Selected Indicators of Health Outcomes

It is difficult to isolate the effect of health care services on the general health of the population. Socioeconomic factors (such as residential location, income levels and employment rates) and the provision of non-health care government services (such as clean water, sewerage, nutrition, education and public housing) each contribute to overall health outcomes. The outcomes and effectiveness of health services are also influenced by population factors external to governments' control, including geographic dispersion, age and ethnicity profiles, and socioeconomic status[84].

Diet and Exercise[85]

Diet and exercise are also important behaviours that can reduce health risks and improve health outcomes. The NHMRC Australian dietary guidelines recommend a minimum of two serves of fruit per day for adults and five serves of vegetables (NHMRC 2003). A serve of fruit is approximately 150 grams of fresh fruit or 50 grams of dried fruit while a serve of vegetables is approximately 75 grams. Around half of Australians surveyed in the National Health Survey were consuming the recommended two or more serves of fruit per day in 2007-08 and only 8.8 per cent were consuming the recommended five or more serves of vegetables per day (table EA.13). Over a third of all Australians surveyed in the National Health Survey were sedentary in the two weeks prior to interview in 2007-08 with a further 36.9 per cent undertaking a low level of exercise, 21.6 per cent undertook a moderate level of exercise and 6.2 per cent a high level of exercise (table EA.13).

[84] Report on Government Service 2010 volume 2
[85] Report on Government Service 2010 volume 2

Sunrise Aboriginal Male Health Summit – Banatjarl Statement[86]

Banatjarl Statement
"Prevention not intervention!"

We the Aboriginal males from Katherine East Region gathered at Banatjarl on July 2 2009, make the following statement:

We are proud Aboriginal men, proud of our culture and to achieve our vision we call on the Australian Government and the Northern Territory Government to reform the intervention, reinstate the Racial Discrimination Act and reduce the barrage of complex and contradictory changes that are disempowering Aboriginal males, resulting in "widening the gap" in Aboriginal male health and severely impacting on the lives of our children, families and the communities in which we live.

We resent that the Government has allowed the media to portray all Aboriginal men as paedophiles, and subjected us to unwarranted suspicion -we love our children and our families – we are human. We call on the Australian and Northern Territory Government to join us in the outright rejection of this practice

We feel fearful that we are misunderstood in our natural loving actions, and this stops us fulfilling our roles as fathers, uncles, brothers, grandfathers and carers.

We have developed strategies, networks and recommendations to ensure our future roles as men in caring for children in a safe family environment that will lead to a happier, longer and healthier life that reflects opportunities experienced by the wider community.

86 The highlighted background is part of the design of this Statement and is not intended to highlight this statement over any other made in this submission.

Section Three

Sunrise Health Service Aboriginal Corporation - Description of Organisation

Sunrise Health Service Aboriginal Corporation's main purpose is to improve the health and wellbeing of the people in the region east of Katherine in the Northern Territory. This is done using a holistic approach that includes providing a high standard of medical care, the promotion of social justice and the overcoming of the sickness that affects so many people in the region.

Sunrise Health Service Aboriginal Corporation became a fully-fledged service in mid-2005 after successfully completing a Coordinated Care Trial, and the community-controlled organisation now successfully provides quality Primary Health Care services from nine health centres located in Barunga, Wugularr, Manyallaluk, Bulman, Mataranka, Jilkminggan, Minyerri, Ngukurr and Urapunga. The outstations associated with these communities also have access to the services.

Health education and promotional programs are also undertaken in communities in the areas of Nutrition, Women's and Maternal Health, Men's Health, Child Health, Aged Care, Physical Activity and Aural Health.

Sunrise Health Service Aboriginal Corporation incorporates both new and ancient methods to help move away from the past and work towards closing the gaps in health between Indigenous and non-Indigenous Australians. This is done through health clinics and health education, mixing together traditional Indigenous culture and the best of mainstream medicine.

Sunrise Health Service Aboriginal Corporation currently employs more than 150 staff across its eight health centres and head office in Katherine. The name 'Sunrise' refers to a custom around Katherine in the Northern Territory to for those living east of the Stuart Highway to describe themselves as the 'Sunrise' or 'Sun-come-up' mob. It is a term that is culturally inclusive, as well as expressive of the hopes that are held for Sunrise Health Service.

Sunrise covers 143,000 sq km with an Indigenous population of 3,700 – that's 3 people in every 100 km^2. According to the ASGC Remoteness Category, 94% is rated 'very remote'

Purpose of the Organisation

Sunrise Health Service Aboriginal Corporation is an Aboriginal community-controlled health service that advocates for, and works in partnership with other organisations and the community to provide and enhance equitable access to culturally-appropriate primary health care services for people in its region.

The service is responsible for the management of holistic health programs that address physical, social, emotional and cultural well-being that are delivered in a culturally respectful manner using an approach that contributes to building capacity in the community to promote self-determination and empowerment.

Sunrise Health Service also plays an important role in advocating for the rights of Indigenous people in Australia.

Board Member/Governance Details

Integral to the success of Sunrise Health Service Aboriginal Corporation has been the sense of ownership developed in the community of the service. From the beginning, the need for an independent community-controlled health service was expressed by the regional community.

Self governance ensures that communities are well informed about the health issues in their communities and can become involved in their management.
The premise is that if Aboriginal people can own and control the services provided to Aboriginal people, then self-determination can occur and empowerment result. When populations are empowered they have a voice and political standing.

Sunrise Health Service takes direction from the Board, which is made up of representative from all Sunrise communities. All Board members undergo training to ensure they have the right skills and knowledge to govern. The establishment of the Community Health Committees (CHCs) ensured local autonomy within the broader regional approach of the service and real involvement in planning at a community level. CHCs operate in all communities, and are comprised of local people, traditional or culturally significant persons and elected representatives from other community groups. Ultimately, CHCs ensure that programs delivered by Sunrise Health Service are culturally appropriate and encourage local ownership.

Mission Statement

Sunrise Health Service is a community controlled organisation that strives to provide equitable and culturally appropriate Primary Health Care outcomes for Aboriginal People living in the Sunrise region. Sunrise should always provide good governance at all levels to ensure our work lasts forever.

Vision Statement

The vision for health in the Sunrise region is that there will continue to be a community-controlled organisation that is committed to and values its people, which seeks to improve their health, well being and life span, and enables access to opportunities in all aspects of life that are available to the wider community.

Core Values

Sunrise Health Service believes that healthy communities result when Aboriginal people own and control their health services. The core values that guide health service planning, delivery and evaluation for Sunrise Health Service are as follows:

- We believe Aboriginal community control is essential for health;
- We want health programs to be holistic and culturally appropriate, incorporating traditional healing and the use of bush medicines;
- We encourage two-way learning blending cultural way “mununga” way to grow and maintain a strong health service;
- We promote mutual respect between the staff and community;
- We believe in a fair go for everyone and to be open and transparent in all our business;
- We are committed to regular communication with individuals, communities and to the wider Australian community to promote health;

- We respect client confidentiality and the individual's rights to make their own decisions about health;
- We actively seek and promote opportunities for Aboriginal people to develop careers in health and training for board members to advocate for health;
- We are committed to developing the skills and knowledge of all staff through professional development opportunities; and
- We believe people are the most important asset to ensure a high quality of service provision.

Terms of Reference

The Northern Territory Chief Minister and Minister for Children and Families have commissioned a Board of Inquiry to conduct a broad-ranging public inquiry under the *Inquiries Act* into the Northern Territory's child protection system.

The purpose of the Inquiry is to review the child protection system and to make recommendations to strengthen and improve the system to enable it to meet the needs of the Northern Territory's children.

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 (NTFC) 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 the Working Future initiative.
- 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:

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

Timeframe

The Board of Inquiry must provide their report to the Chief Minister by 25 April 2010.

Submissions are due to be lodged before 12 March 2010