Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Response to the
Department of Social Services Consultation Paper:
Implementing the successor plan to the National Framework for Protecting Australia's Children 2009-2020
August 2021

Executive Summary

Aboriginal families have been profoundly impacted by the processes of colonisation, including the dispossession and impoverishment of communities, the forcible removal of children and families (and its intergenerational effects), the suppression of culture and language and the ongoing experience of racism and discrimination. In this context, many Aboriginal families experience vulnerabilities that impact on the health and developmental outcomes of their children.

Central Australian Aboriginal Congress – in recognition of the need for supports that strengthen families' capacity to care for children and reduce families' involvement with the child protection system – has focused our efforts on creating an innovative model for delivering child and family services to improve outcomes of Aboriginal children and families.

Supporting our model of evidence-based child and family services is our advocacy to improve the social determinants of health.

Recommendations

Recommendation 1: The successor plan should commit to action that addresses poverty and inequality as fundamental to improving outcomes in children and families and preventing involvement in the child protection system.

Recommendation 2: The successor plan should recognise the importance of all families having access to universally available services including:

- Evidence informed early childhood programs including Child Health and Development Centres for non-working families
- Parenting and family support programs (e.g. Nurse Family Partnership, Parents Under Pressure, and access to Targeted Family Support Servicers for self-identified at-risk families)
- Two years of preschool from the age of three.

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Recommendation 3: The successor plan should recognise the value of investment in models that privilege Aboriginal culture and ways of being in strengthening workforce capability, particularly in programs/services that work with Aboriginal children and families.

Recommendation 4: The successor plan should recognise the importance of investing in and implementing evidence-informed, data driven services that can be systematically evaluated.

Recommendation 5: The successor plan should acknowledge the benefits of integrated models of child and family services that are embedded within comprehensive Aboriginal community controlled primary health care services in strengthening families and improving outcomes for children.

Recommendation 6: The successor plan should recognise Aboriginal community-controlled organisations as preferred providers of child and family services to the Aboriginal community, as such organisations have structural advantages in delivering services and improved outcomes compared to non-Indigenous services.

Background

Central Australian Aboriginal Congress

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

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

2. Congress delivers services to more than 17,000 Aboriginal people living in Alice Springs and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

3. Over the last 20 years, the community-elected Congress Board of Directors has focused on improving the developmental outcomes of Aboriginal children. This has led to the creation of an innovative model for the delivery of child and family services, based on the belief that the best way to 'close the gap' is to make sure it is not created in the first place. Embedded in Congress' way of working is a strong focus on prevention.

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

Congress' response to this Consultation Paper

4. Congress welcomes the reorientation of the successor plan to place greater focus on the importance of the early years of a child's life, the intergenerational impacts of trauma (including the impacts of trauma on health outcomes), and the protective nature of culture and community for Aboriginal children and families. Likewise, it is pleasing to see the guiding principles as set out in the Discussion Paper that have been informed by the Closing the Gap reform priority areas along with the *Family Matters* work.

5. This submission will first of all provide an overview of the context within which Congress works, before describing Congress' integrated model of working with children and families. Following this is a response to a selection of Strategic Priorities as set out in the Consultation paper:
   - Addressing the over-representation of Indigenous children in child protection systems
   - Improved information sharing, data development and analysis
   - Strengthening child and family sector workforce capability
   - Priority groups:
     - Aboriginal and Torres Strait Islander Children and Families
     - Supporting families with multiple and complex needs
   - Role of the non-government sector

Impact of colonisation on children and families today

6. The nurture and care of children is at the heart of Aboriginal culture. For tens of thousands of years, our diverse peoples raised healthy, resilient and creative children. Today, many of our families still do.

7. However, contemporary Aboriginal families have been profoundly affected by the processes of colonisation including the dispossession and impoverishment of our communities, the forcible removal of children from their families and its intergenerational effects; the suppression of culture and language; and the ongoing experience of racism and discrimination.

8. Numerous inquiries are reports have noted the profound challenges our communities and families face in caring for their children. Such issues were prominent in the reports of the Royal Commission into Aboriginal Deaths in Custody in 1991,[1] and the report of the Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, *Little Children are Sacred* in 2007.[2]

9. In 2015 Aboriginal children were twice as likely as non-Aboriginal children to be developmentally vulnerable on one or more domains (42% compared to 21%) and two-and-a-half times as likely as non-Aboriginal children to be developmentally vulnerable on two or more domains two or more domains (26% compared to 10%). This is the first gap that needs to be closed at age 5 if the Life Expectancy gap across the life course is to be closed.

10. The inequity is much greater in remote areas and in Alice Springs, in 2009, 43% of Aboriginal children were developmentally vulnerable on two or more domains compared with 7% of non-Aboriginal children and in some remote parts of Central Australia it is up to 80%. This data has not been available since then and although there have been improvements the gap will still be unacceptable.

11. Social and environmental influences in early childhood shape health and wellbeing outcomes across the life course. Adverse childhood experiences are highly correlated to a wide range of physical health problems, as well as to increased levels of depression, suicide attempts, sexually transmitted infections, smoking, and alcoholism.[3] A recent Australian study has shown the devastating impact that an adverse early childhood has on premature mortality.[4]

12. It is too late to wait until a child is ready for school at around age five to address vulnerabilities in development, as by this point many critical developmental periods or gateways have been passed, and a child's developmental trajectory already set. After this point, interventions require increasing amounts of resources and produce diminishing returns as the child gets older.[5]

13. Congress orients its services to strengthening and supporting families in the early stages of their child’s life, in recognition that this period of time is crucial for shaping the trajectory of a child’s lifecourse.

Congress’ integrated model supporting early childhood development

14. Congress has developed a culturally safe, integrated approach to child physical and social and emotional wellbeing, operating a range of programs within a framework for early childhood development and family support that make up an integrated and comprehensive, preventative approach. These are both primary and secondary prevention programs delivered either in the home or in a dedicated centre. The holistic group of services is outlined in the following table:

	Primary Prevention		**Secondary Prevention**	
	Child Focus	**Carer Focus**	**Child Focus**	**Carer Focus**
Centre Based Most work is done at a centre where child or families come in to access service	• Child Health and Development Centre • Immunisations • Child health checks • Developmental screening	• Health advice to parents in clinic (e.g. nutrition, brushing teeth, toilet training)	• Child-centred play therapy • Therapeutic day care • Preschool Readiness Program • Antibiotics	• Filial therapy • Circle of security • Parenting advice/programs • Parent support groups
Home visitation Most work is done in the homes of families where staff outreach to children and families	• Mobile play groups	• Nurse home visitation • Families as first teachers (home visiting learning activities)	• Child Health Outreach Program • Ear mopping	• Targeted Family support • Intensive Family Support • Case management models for children at risk • Parents Under Pressure (PUP)

15. Congress maintains that early childhood programs for Aboriginal children should be delivered through Aboriginal community-controlled health services, inclusive of supportive services including family/parent engagement and support, transport and the provision of nutritious food. This recognises and integrates the multiple factors needed for healthy childhood development (e.g. stimulation and nutrition), as well as the social determinants of health (e.g. social support for low income families, transport).

Addressing the Strategic Priorities

Strategic Priority: Addressing the over-representation of Indigenous children in child protection system

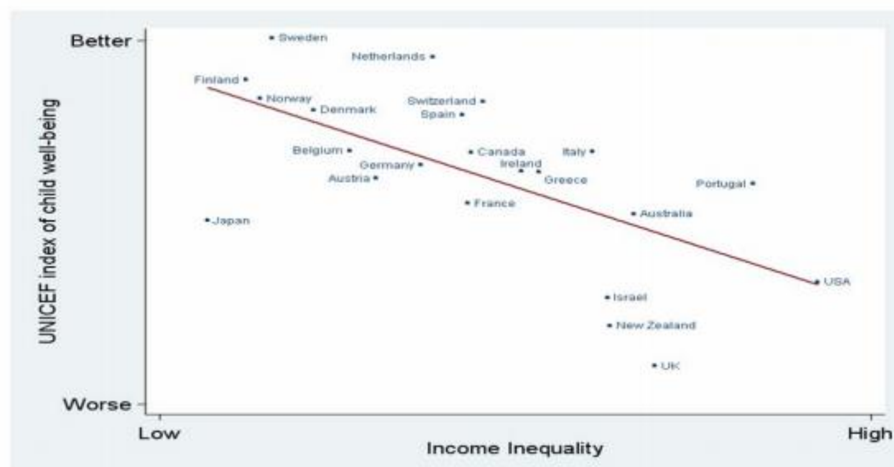
Addressing poverty and inequality first and foremost

16. Any efforts to reduce the over-representation of Aboriginal children in the child protection system must be underpinned by a commitment from Government to reducing poverty and inequality. Income and wealth in Australia are not distributed equally and Aboriginal and Torres Strait Islander people receive, on average, a personal income that is only two-thirds of that of non-Indigenous Australians.[6] Nationally, in very remote areas – including most of Central Australia – Aboriginal and Torres Strait Islander incomes are falling in real terms, and the income gap is widening.[7]

17. Further, addressing inequality is crucial. Bywaters et al[8] provide the following insight which translates well to the Australian context:

    …an inequalities perspective necessarily requires paying attention to comparisons across populations, rather than treating individuals as a series of cases, it opens up questions of causation in child maltreatment. It draws attention to factors beyond the immediate behavioural or individual context, highlighting the role of societal patterns and the structures that underpin them. It extends the consideration of family economic circumstances from a focus on poverty alone, taking into account relative social position.

18. This is consistent with the social determinants approach which has the broader aim of improving the circumstances in which people live and work.[9]



19. There is also widespread community concern that poor housing and overcrowding is having a major negative impact on the ability of parents to care for and protect children, as well as their ability to ensure children get sufficient sleep to attend school

the next day. This is clearly supported by evidence[10] and needs to be addressed as a key social determinant of child protection.

Addressing the social determinants of child neglect

20. In this context, it is also important to consider the range of social determinants of child neglect, which include parental alcohol and other drug (AOD) use, domestic and family violence, parental mental health, family resources including parental educational attainment, and social and community networks. These are included within the Parental Strengths and Needs Assessment tool structured decision-making tool, which is used by Congress' Children and Family Intensive Support (CaFIS) service (described below).

21. Harmful alcohol use by parents and carers is a key risk factor for child neglect[11] and is known to be associated with a lack of responsive care and stimulation in early childhood. Whilst there are significant social determinants of alcohol dependence, a substantial, immediate impact on the primary prevention of neglect can be achieved by effective alcohol supply reduction measures. The Northern Territory has been implementing an effective package of evidence-based measures to address harms associated with alcohol consumption.[12] Early indications (report not yet unpublished) suggest these combined measures are beginning to show large declines in child neglect.

22. Parental – and particularly maternal – educational attainment and literacy is an important protective factor for strengthening families and improving outcomes for children. Infant mortality and chances of survival are shown to be closely linked to the mother's education, with greater survival disadvantage experienced by children born to women with lower levels of education.[13]

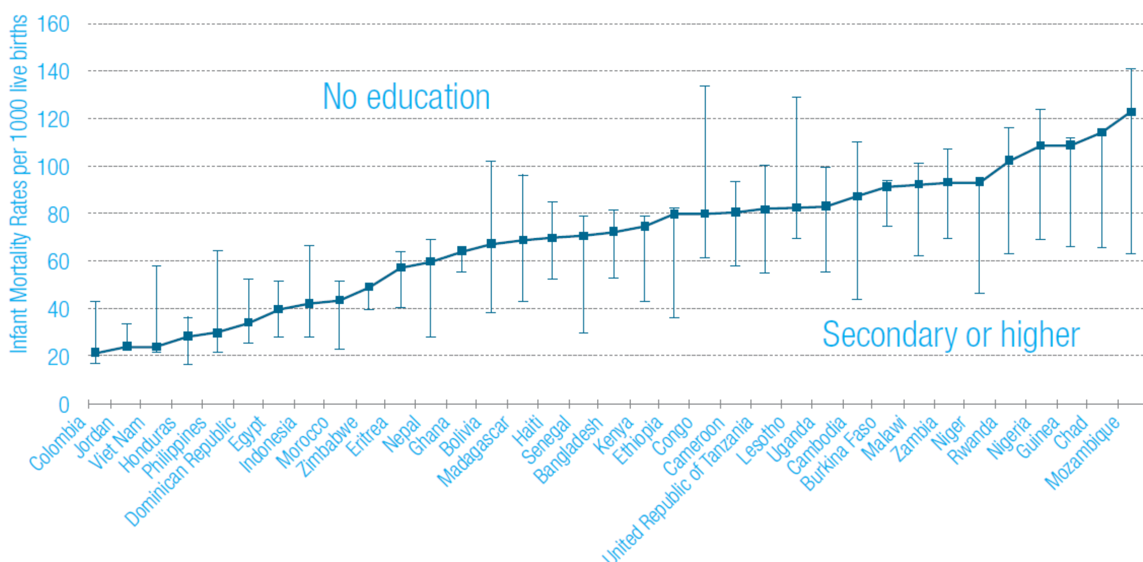


Figure 2.1: Inequity in infant mortality rates between countries and within countries by mother's education.

Source: CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization.

23. Literacy levels among Aboriginal adults in Australia are significantly lower than those in the non-Aboriginal population. Evidence from various sources suggests that at least

35% of the Aboriginal and Torres Strait Islander adult population have minimal English literacy.[14] The figure is much higher in the Northern Territory, where it is estimated that 80% to 90% of Aboriginal people do not have a level of English literacy sufficient to operate independently on literacy and numeracy tasks in education and the workforce.[15] Thus improving adult literacy in English is critical to empowering people to take control of their lives and addressing unemployment, inequality and poverty, which in turn strengthen families' capacity to protect against child neglect.

Prevention, front and centre

24. Congress's primary work with children and families aims to **prevent** Aboriginal children and families from becoming involved in the child protection and of-of-home care system from the outset.

25. We do this by working with highly vulnerable families through well established, evidence informed programs focused on primary and secondary prevention. Quality childhood development programs are a key, cost-effective intervention to address and offset the effects of adverse early childhood development. Such programs are proven to support cognitive, social, communicative, physical and emotional development and thereby improve long-term health, education and employment outcomes for young children from disadvantaged families.[16] [17] [18] [19]

26. Congress' key child and family-focused programs and services are outlined below:

The **Australian Nurse Family Partnership Program (ANFPP)** is a sustained home visitation program that promotes healthy development in pregnancy and early childhood. The focus of the ANFPP program is on the primary carer of the child, usually the mother. The ANFPP aims to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency. The mother is visited, from no later than 28 weeks' gestation until the child is two years of age, by the same Nurse Home Visitor ad Aboriginal Community Worker throughout the program, in order to build and maintain strong, trusting relationships. An independent evaluation of this service at Congress from 2009 to 2015 has shown that this service has had a major impact on reducing child protection involvement and days in out-of-home care, increasing birth spacing, reducing nutritional disorders such as childhood anaemia, and reducing hospitalisations for injury.[20] These benefits are reported in the long term studies of the nurse home visitation model that was developed by Professor David Olds in the USA over the last 30 years.[21]

A **Child Health and Development Centre**, *Arrwekele akaltye-irretyeke ampere*. The centre accepts children from disadvantaged, non-working families from the age of six months until the child enters preschool. The centre has developed a culturally adapted version of the Abecedarian approach, using evidence-based strategies for teaching and learning with a strong focus on Aboriginal language and culture, along with family engagement. The effectiveness of the centre is shown in two recent, independent evaluations (currently pending publication).[22]

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

A **Preschool Readiness Program**, which provides targeted interventions to up to 10 children between the ages of 3.5 to five years old who have been identified as

having developmental delays, or who come from families experiencing vulnerabilities or disadvantage. The program helps children and families to prepare for preschool, whilst providing intensive support across developmental domains such as fine motor development, gross motor development, speech, receptive language and expressive language. An independent evaluation found that responsive supports provided by this program was able to reduce barriers to participation for Aboriginal children.[23]

A **Child and Youth Assessment and Treatment Service (CYATS)** was established by Congress in 2018 in response to the prevalence of developmentally vulnerable Aboriginal children in the communities we serve. CYATS provides a best-practice service for the early detection of neurodevelopmental conditions such as FASD, ADHD and Autism Spectrum Disorder (ASD), providing a multidisciplinary approach to diagnostic assessment, early intervention, and support for families to access the NDIS. This service, the first of its kind in the Northern Territory, is founded on a strong partnership with Alice Springs Hospital paediatrics and other health and education agencies, and is integrated with other child, youth and parenting programs within Congress. An important part of CYATS is the level of engagement by the team with the families.

The **Congress Children and Family Intensive Support Service**, which provides services that build on the strengths of families and communities to care for children within their culture while supporting families to navigate through the formal (western) world; supporting families to keep children safe at home and for families at risk of involvement with the child protection system; in addition to providing support for parents more broadly through the model of the Parenting Under Pressure (PUP) program.

Recommendation 1: The successor plan should commit to action that addresses poverty and inequality as fundamental to improving outcomes in children and families and preventing involvement in the child protection system.

Recommendation 2: The successor plan should recognise the importance of all families having access to universally available services including:

- **Evidence informed early childhood programs** including Child Health and Development Centres for non-working families
- **Parenting and family support programs** (e.g. Nurse Family Partnership, Parents Under Pressure, and access to Targeted Family Support Services for self-identified at-risk families)
- **Two years of preschool from the age of three.**

Strategic Priority: Improved information sharing, data development and analysis

27. The health sector has a longstanding tradition of using evidence to inform practice and collecting data that enables improvements to be measured. Aboriginal community

controlled health services such as Congress use a Continuous Quality Improvement (CQI) approach which uses clinical data to monitor outcomes and continuously improve services. The child and family services operated by Congress collect data and use it to inform service improvements in the same way.

28. A key development that has enabled much stronger evaluation of early childhood programs is the use of data linkage through the SA/NT data link project. This process enable all programs to be evaluated against a matched, control group giving a quasi-experimental design. This is much stronger than other methods except for Randomised Controlled Trials which are often unethical due to the strong evidence base for services already being trialled. Congress use data linkage to great effect in the evaluation of the ANFPP and is planning to use this in the next evaluation of our Child Health and Development Centre. This is the way of the future for the evaluation of early childhood programs.

29. Interagency data sharing can be beneficial to support work with children and families when parameters are clearly identified and agreed by all parties. For example, Congress has a formal memorandum of understanding with the NT Department of Education that allows for certain data (e.g. immunisation records, ASQ-TRAK, preschool enrolment and participation) to be shared to allow effective follow up for children attending preschool. Likewise, Congress' CaFIS team and Territory Families share data and information under an agreed framework as relates to families involved with both services.

30. Benefits of sharing information and data must be balanced by the risks, particularly as they relate to personal and sensitive information and the jurisdiction that governs health organisations such as Congress in the way we can and cannot use and disclose personal and/or sensitive information.

31. The successor plan should seek to align with the National Agreement on Closing the Gap – *Priority Reform Four, Shared access to data and information at a regional level*, particularly when developing and implementing strategies that are targeted to Aboriginal children and families and the associated data.

Strategic Priority: Strengthening child and family sector workforce capability

Congress' bicultural way of working

32. Across our teams working with children and families, Congress has embedded a bicultural, or two-way, approach. This is best demonstrated by our Children and Family Intensive Support Service (CaFIS), in which highly skilled Aboriginal Family Support Workers who have strong connections to community are paired with Caseworkers (social workers, counsellors or psychologists, for example), who work together across all aspects of their interactions with families.

33. Working in bicultural pairs combines the skills and knowledge of both workers to build an understanding of family functioning in both the formal world and informal world. Caseworkers bring particular skills in negotiating and understanding the formal world of the family, while Aboriginal Family Support Workers bring extensive knowledge and skills in understanding the informal world of the family and a particular understanding

of the cultural context. Moreover, Aboriginal staff with language skills are integral to family engagement and success of this service, as with other Congress programs.

34. The combined knowledge and skills of both workers together, ensure a comprehensive understanding of the family and results in a more finely tuned and meaningful response to challenges the family may be experiencing. This approach is effective in improving engagement with children and families, improving outcomes for families and contributes to a high level of worker satisfaction and increased staff retention. This is critical in the child protection context, where – particularly in the Northern Territory – turnover of staff working in child protection has been alarmingly high (up to 80% in some parts of the NT only a decade ago)[24]; in contrast, within the Congress Intensive Family Support Team, the shortest tenure is currently 2.5 years with most other team members having spent five or more years as part of the team. This is almost unheard of and is reflective of the particular strengths of the bicultural worker model. This also has contributed to significant outcome from this service in terms of being able to prevent the removal of children from high needs, complex families referred by Child Protection.

Recommendation 3: The successor plan should recognise the value of investment in models that privilege Aboriginal culture and ways of being in strengthening workforce capability, particularly in programs/services that work with Aboriginal children and families.

Priority Group: Aboriginal and Torres Strait Islander children and families

Recognising and supporting families' rights to be self-determining

35. Congress recognises that families will do the work when they are ready. Our programs and services are responsive to families' rights to self-determination and agency, in recognition that the right to be 'self-determining' is central to the thriving of Aboriginal people.[25] As our services and programs are voluntary, we must accept that sometimes families are not yet ready.

36. As discussed earlier in this submission, intergenerational trauma is ongoing for many families seeking family support in Alice Springs. For some families, there are generational histories of child protection involvement.

Bicultural support for families to navigate systems

37. Navigating systems is one of the biggest challenges for the Aboriginal families Congress works to support. The bicultural approach to working with Aboriginal families, as described above, is grounded in an understanding of the unique and often challenging social and cultural context of everyday life for families in Alice Springs.

38. Congress model pairing caseworkers and Aboriginal workers provides support to families to strengthen the relationship between caregivers and their children. They do this using culturally appropriate ways of working, including a Yarning Mat and 'being time'. The model focuses on building the parent or caregiver's view of self as a parent/caregiver, helping them to understand and manage their own and their children's emotions, thus supporting and enabling them to live and negotiate between the informal (Aboriginal) and formal (Western) worlds.

39. Other practices supporting this model include:

- the Parents Under Pressure model
- trauma-informed service delivery
- holistic, strengths-based, family-led, child-focussed approach
- collaboration with other services
- referrals to specialist services
- case management
- advocacy
- Cultural brokerage.

Investing in Congress' model is worthwhile

40. The strength of Congress Children and Family Intensive Support Service is evident in its outcomes. Over the past six years, the service has provided intensive family support to close to 100 families. The majority of families who have self-referred to the service have very complex needs which may include domestic violence, homelessness, and/or substance abuse, which has impacted on their parenting capacity.

41. Of those families that Congress has provided support to over this time period, ***only seven*** children have been removed from their parents through a child protection intervention. This is remarkable when considering the high level of vulnerabilities experienced by the families we work to support, and the comparatively high rates of child removal in the Northern Territory.

42. The CaFIS service has sustained high caseloads throughout the time is has been operating. Despite increased funding three years ago to increase the caseload capacity of the service (16-18 families at any one time; approximately 40 families per year), the service is operating at capacity with a waitlist of families.

43. Evaluations on the CaFIS service over the last decade have shown the value of the service for vulnerable families, who reported that they feel heard and supported, and the value of strong collaborative ways of working with key stakeholders. Whilst the model is more costly than others (e.g. models that use lower qualified staff working as individuals, which will always be 'cheaper' than a model that embeds bicultural pairs).

Recommendation 4: The successor plan should recognise the importance of investing in and implementing evidence-informed, data driven services that can be systematically evaluated.

Priority Group: Supporting families with multiple and complex needs

Congress' integrated model

44. Close collaboration between health, education and other social service providers is imperative, particularly for children from disadvantaged families with complex needs.

45. Congress' public health approach to integrated children's and family services is best described in the MJA article *Towards an integrated model for child and family services in Central Australia*:[26]

The Congress model is founded on a long term population approach to deliver results in health and wellbeing across the life course. Integration of services under a single provider is the key to achieving this potentially transformative change, enabling children and families to be referred seamlessly to the services that best meet their needs. Such integration is now recognised as a crucial reform needed to increase the cost-effectiveness of services and improve access and outcomes for children and their families.

46. In a practical sense, families may initially access Congress services through a Congress health clinic, or by self-referral. Children and families may then be referred between Congress programs and services, e.g. from the Australian Nurse Partnership Program to the Child Health and Development Centre, to the Preschool Readiness Program.

47. Congress scaffolds the support provided to children and families with wrap-around services that can provide a package of screening, diagnosis, intervention and treatment. Through the use of one client record system, each program or service a family is involved with is able to see what other programs or services are also providing support to a family, making it as seamless as possible for the families involved.

Working with children exposed to trauma

48. Through Congress' work with families who are involved in our programs – whether the Australian Nurse Family Partnership Program, the Child Health and Development Program, Preschool Readiness or Children and Family Intensive Support Service – there is a focus on helping families to understand how the brain develops throughout their child's early years. Having Aboriginal staff who can explain in language about brain development and the importance of good food, good rest time and sleep, and nurturing stimulation through play and enriched caregiving is vital to working with families with vulnerabilities and complex needs.

Recommendation 5: The successor plan should acknowledge the benefits of integrated models of child and family services that are embedded within comprehensive Aboriginal community controlled primary health care services in strengthening families and improving outcomes for children.

Role of the non-government sector

The importance and benefits of Aboriginal community control

49. Congress fundamentally believes that services targeted to Aboriginal children and families should be delivered by Aboriginal community-controlled organisations.

50. Aboriginal community control is at the foundation of all Congress' work, reflected by our strategic priority *Aboriginal health in Aboriginal hands*.[27] Similarly, the new National Agreement on Closing the Gap[28] includes *Building the community-controlled sector* as its second priority reform area.

51. Aboriginal organisations have a range of inter-linked structural advantages in delivering services and hence improved outcomes compared to non-Indigenous services, whether government or private. These advantages, which are generalizable to all Aboriginal community-controlled organisations (not just health services), include:

- a holistic approach to service delivery, including through addressing the social determinants of child and family wellbeing, based on a lived understanding of the Aboriginal conception of health;
- culturally secure services: Aboriginal community-controlled organisations are able to provide their care within a culturally secure setting, based on local knowledge, an Aboriginal governance structure and workforce, and strong relationships with the communities that they serve;
- better access, based on community engagement and trust: a strong practice of community engagement founded on strong relationships with the community, in turn based on a sense of ownership and history. Aboriginal people consistently prefer to use Aboriginal organisations such as ACCHSs over mainstream services giving them a strong advantage in addressing access issues;
- Aboriginal governance: individuals and communities are encouraged and enabled to participate in decisions on service delivery, including though formal governing Boards;
- an Aboriginal workforce: community-controlled services are significantly better at attracting, training and retaining Aboriginal staff leading to greater cultural appropriateness of services as well as benefits through providing employment and capacity building in the Aboriginal community;
- high levels of accountability: Aboriginal community-controlled services are highly accountable to their funders through robust data collection and a reporting regime which is above the requirements of mainstream health and wellbeing services.

Recommendation 6: The successor plan should recognise Aboriginal community-controlled organisations as preferred providers of child and family services to the Aboriginal community, as such organisations have structural advantages in delivering services and improved outcomes compared to non-Indigenous services.

NOTES

[1] Langton M, et al., *Too Much Sorry Business: The Report of the Aboriginal Issues Unit of the Northern Territory*, in Royal Commission Into Aboriginal Deaths in Custody 1991: Adelaide.
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