Central Australian Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Central Australian Aboriginal Congress' response to:

Productivity Commission discussion paper: *What is known about systems that enable the 'public health approach' to protecting children*?

March 2019

Are there any other key system characteristics a system should have to enable the public health approach to protecting children?

The Central Australian Aboriginal Congress (Congress) is a large Aboriginal community controlled health service (ACCHS) based in Alice Springs in the Northern Territory. Congress has developed a comprehensive model of primary health care delivering quality, evidence informed services on a foundation of cultural security. The ACCHS sector in the Northern Territory has a practice of Continuous Quality Improvement (CQI) built up over decades of service-delivery and collaboration with other providers and government. This makes ACCHSs, such as Congress, leading centres for evidence informed innovation and responsiveness to population and service needs, and important sites for developing the future evidence and research base.

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

- the median individual income for Aboriginal people over the age of 15 in Alice Springs is $248 per week, one third (34%) of that for non-Aboriginal people in the town;
- 86% of Aboriginal and Torres Strait Islander adults in Alice Springs did not complete schooling to Year 12; 10% did not go to school at all;
- only 37% of the Aboriginal population of Alice Springs over the age of 15 are employed (81% for non-Aboriginal residents)
- 15% of babies born to Alice Springs Aboriginal mothers are of low birth weight, with 23% of these mothers being under the age of 20, though note that on Congress' own data this has improved to 11%.
- Aboriginal children born to teenage mothers are more likely to have poorer educational outcomes. Teenage motherhood is much more common among Aboriginal girls at 21 per cent compared with 4 per cent of all births.

Nationally, in 2016–17, Aboriginal and Torres Strait Islander children were 7 times (164.3 per 1,000) as likely as non-Aboriginal children to have received child protection services (22.3 per 1,000), and 10 times (13.6 per 1,000) as likely as non-Aboriginal children to be admitted to out-of-home-care (OOHC) during (1.4 per 1,000). The rate of children in Northern Territory (NT) in out-of-home care (16.8 per 1000) is nearly twice that of the national average (8.7 per 1000) with high rates due to numbers of Aboriginal children who had been removed from their families.[2,3] Congress is aware that the rate of substantiated neglect and children in OOHC varies dramatically between Aboriginal

communities and it will be vital that this data is available to the new northern Territory Tripartite Forum to inform needs based planning for services.

Subsequently, the most important, measurable and achievable outcomes for families and children should include:

- Reducing the proportion of children with a substantiated neglect by 20 per cent/year by each community.
- Ensuring no child is removed from their family without a Family Group Conference prior to court proceedings, and with appropriate family members.
- Ensuring the majority of Aboriginal children in out-of-home care are in kinship care, with the carer identified through Family Group Conferencing.
- Reduction of the number and proportion of children developmentally vulnerable on two or more domains by at least 15% every 3 years

The major features of disadvantage that contribute to poorer outcomes for children are well known. When there is a need to prioritise it can be done based on characteristics such as:

1. parental unemployment,
2. parental educational levels,
3. parental alcohol and other drug use,
4. domestic violence and
5. parental mental illness.
6. overcrowding

Aboriginal Community Controlled Health Services (ACCHS) have access to this type of information for many families and are best placed to engage with the most disadvantaged families. However, Congress believes that all families should have access to universally available services including:

- evidence informed early childhood learning programs
- parenting and family support programs (e.g. Nurse Family Partnerships, Parents Under Pressure, and access to Targeted Family Support services for self-identified at risk families)
- two years of preschool

Families should be able to self-refer and have easy access (i.e. culturally secure, short waiting times, transport etc). Service providers and child protection may then refer families for more intense services if needed e.g. Intensive Family Support Services, individual therapies and supported accommodation without out-of-pocket expenses. This will achieve cascading interventions from primary to secondary prevention and families will not have to wait until there is a crisis to get the service they need e.g. the imminent removal of a child from his or her immediate family.

Congress aims to prevent child neglect and out-of-home care by working with highly vulnerable families through well established, evidenced informed programs focused on primary and secondary prevention. For example, Targeted Family Support Services (TFSS) and Intensive Family Support Program (IFSS) support parents and caregivers of children who may be referred or self-refer (primarily TFSS), or where neglect has either been substantiated by child protection or where child protection service are of the belief that there is a high risk of neglect occurring (primarily IFFS). Since Congress' IFFS program began in October 2014, children from 56 families were prevented from going into out-of-home care out of the 62 at risk families seen in total. Both services have been evaluated and are making an impact in a highly complex service delivery area.

To improve outcomes for families, Congress uses a bicultural worker model e.g. Caseworkers (e.g. social workers or psychologists) and Aboriginal Family Support Workers (AFSWs) working in pairs across all aspects of their work with families.

Working in bi-cultural 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 AFSWs bring extensive knowledge and skills in negotiating and 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 programs.

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 the family's problems. 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.

A recent independent evaluation of the Congress' Nurse Family Partnership Program (nurse home visiting from maternal to two years postnatal) by UniSA from 2009 to 2015 showed a major impact on the primary prevention of child neglect and out-of-home-care. Compared to matched controls over the same period, the children of families on the program were 62% less likely to have any episode of substantiated neglect and the children of first time mothers were 94% less likely to spend any annualised days in out-of-home-care. If this program was available across all NT Aboriginal communities we could expect to see a significant reduction in child neglect and out-of-home-care. Given the impact that child neglect has in later adolescence on imprisonment rates and premature mortality from alcohol and drug related deaths, prevention has to be the main focus.

A key complementary approach to parenting support in improving outcomes for children and ensuring that children are strong, resilient and ready to learn is universal access to play based early learning centres with wrap around support services. Such centres should be accessed by children from disadvantaged families before they go to pre-school from the age of 6 months to 3-3 ½ years of age. Such centres need to be bilingual and bicultural and ensure that reading and other activities are provided in both first language and English. Play based learning can include use of the ABC/Care learning games. Based on current evidence children need to attend for about 20 hours per week. An independent evaluation of Congress' early learning services for non-working families is currently being finalised.

In addition to this, parental alcohol dependence and violence is probably the major cause of child neglect and the need for out-of-home care. Although there are significant social determinants of alcohol dependence a large, immediate impact on the primary prevention of neglect can be achieved by effective alcohol supply reduction measures. The NT is implementing the most effective package of measures anywhere in Australia and will have an important impact.

Congress also works in partnership with other organisations e.g. Central Australian Women's Legal Services, Alice Springs Hospital, NT Police, residential drug and alcohol services and education services.

What are the main barriers and enablers to implementing the public health approach in a system to protect children in Australia (with a focus on working across the entire system)?

The main barrier to a public health approach to child protection is competitive tendering. It is the most difficult and inefficient funding process as funding is not directed to where it is most needed. For almost a decade, there has been an increased emphasis on competitive tendering in the allocation of funds in Aboriginal health, leading to a more fragmented and unstable service delivery environment.

Competitive tendering process favoured larger mainstream organisations over smaller Aboriginal organisations with fewer resources to make complex applications within short time frames, and that the tendering processes did not recognise the enhanced service delivery outcomes deliverable by Aboriginal organisations.

Competitive funding processes has led to a reduction in Congress' Targeted Family Support Services (TFSS). TFSS is a voluntary early intervention service that receives self-referrals and referrals from the community (i.e. before involvement of child protection services), as well as referrals from child protection for high needs families that do not require a statutory response and promotes the safety, stability, development and well-being of vulnerable children and their families.

In 2016, as a result of a poorly run tender process, the NT Government stopped funding Congress' TFSS program. The NT Government did not disclose the maximum efficient funding allocation for the grant applications which had been determined by a private consultancy which has never been made public. Congress' estimated costs were well over the undisclosed maximum allocation per family and the application was immediately culled and not reviewed. There was no opportunity to argue that a service model without qualified social workers working in partnership with Aboriginal Family Support Workers would not achieve significant outcomes even though a service model with only certificate 4 level workers is much cheaper.

A collaborative, needs based planning process (see below) would have been transparent and allowed this important discussion to occur prior to effective services being defunded. The capacity of the service has since been reduced to only 10 families at a time, which cannot meet current demand meaning families risk reaching a crisis point such as a notification to child protection services before they receive the support they need. Consequently, in the last 12 months two families who have been on the Congress TFSS waiting list had their children removed, identifying a need to further expand family support services to meet demand and prevent children from being admitted into out of home care.

Estimating costs to run a service must reflect the challenges of delivering services to highly complex and vulnerable families whose lives are often chaotic and require significant time to engage and gain trust. Costs should also reflect a highly skilled and committed workforce, inclusive of language speakers, within a culturally secure environment, recognising the challenges of delivery of services in remote areas. Aiming for a cheaper service that does not include these qualities will jeopardise family engagement and not deliver the expected outcomes.

The decision to stop funding Congress' TFSS service is also contrary to evidenced-informed policy making as the Charles Darwin University evaluation of TFSS in the NT (which included the Alice Springs model operated by Congress) concluded that while there are challenges associated with delivering the TFSS program, there was broad agreement that the service is meeting a need and is having an impact.[4]

A key enabler of a public health approach is collaborative needs based planning to advise on the allocation of funding is the most effective funding process. In the NT this has been achieved through

the Northern Territory Aboriginal Health Forum (NTAHF). Collaborative needs based funding in health care is supported by a set of agreed core primary health care functions including a range of clinical services, support services, social and preventative programs and policy and advocacy functions.

Through the NTAHF, which includes high-level representation from all significant service delivery and funding bodies in the Northern Territory (including the Territory and Commonwealth Governments, the NT PHN and the Aboriginal Medical Services Alliance Northern Territory), funds have been allocated effectively and equitably based on an assessment of need in different areas of the jurisdiction.

Along with the development of core, evidence informed primary health care services, describing what is being funded, there has been the corresponding development of key performance indicators that enable service agencies to monitor and improve their services, and maintain accountability through reporting to their communities and to funding bodies.

While not without its challenges, this planned, collaborative approach to the application of funding resources to support sustainable services has delivered significant improvements in health outcomes for Aboriginal people in the Northern Territory.

Between the late 1990s and around 2011 there was a more than 30% decline in all-cause mortality for Aboriginal people, and that alone of all the jurisdictions, the Northern Territory was at that stage on track to meet its 'Close the Gap' Life Expectancy targets by 2031.

Note that during this period, other key drivers of health outcomes such as educational attainment, average income, employment and overcrowding did not change in the Northern Territory[5] and therefore the positive changes can be attributed to health system improvements including better access to primary health care supported by a planning process that was able to allocate new resources to where they were needed most. This resulted in the average per capita funding for primary health care increased from $700 per person in 1999 to more than $3000 per person in 2013. While the absolute increase in funding was important the priority allocation of new funds to the least funded communities and the enhancement of Aboriginal community control both made the health system more efficient.

A process similar to this for Family Support Services would be first getting agreement about an evidence informed, community supported service model, including the workforce needed to deliver it. Then, there would need to be an agreed set of KPIs to assess both its implementation and outcomes. We could then map out the need for this across the NT and resource it according to need beginning with the areas that have the highest rate of child neglect and other child health indicators.

Additionally, universal funding should support all Aboriginal families to be able to access early learning programs free of charge. Equivalent mainstream services should also be universally accessible.

The evidence that all children should access 2 years of pre-school at a minimum of 20 hours per week is also very clear yet this is not available in the NT. This is especially important for children from disadvantaged families as it works against the social gradient in educational outcomes. The need for such a universal approach will not be addressed with only a place based approach. Prof Michael Marmot uses the term “proportionate universalism” which is also important as this enables a universal approach that targets the most disadvantaged. An example of this would be the need to

offer access to early childhood learning centres to all children from disadvantaged families across the NT from 6 months to age 3 leading into 2 years of Preschool.

Congress' secondary prevention services including TFSS and IFSS are available to our clients as required. High demand means they are not always easily accessed in a timely way. Funding splits should recognise this and achieve sufficient balance between primary (universally accessible) and secondary (targeted) prevention. See attached Congress' Child and Family Services framework and related services, including supportive evidence.

In order to protect the necessary investment in universal, population wide primary prevention services and programs it is vital that this funding stream is separated from secondary prevention services. For example at present both the Commonwealth and NT governments fund Family Support Services for children in child protection and for very high needs families but neither government has quarantined a funding stream for the development of primary prevention, universal services. If this is not done all available resources will continue to be utilised for children already in child protection and we will not break the cycle. It would be a great step forward to have clear funding delineation for universal and targeted services.

Provide examples of approaches to address system design and implementation challenges and their applicability to, or success in, the Australian context (including across different cultural groups and locations)

To allow greater access to vulnerable Aboriginal families, services should be provided through Aboriginal Community Controlled Health Services (ACCHS). Aboriginal people consistently prefer to use ACCHSs over mainstream services giving them a strong advantage in addressing access issues. A high Aboriginal workforce supports this.

Although they have a more complex and high needs population ACCHSs achieve health outcomes that are comparable or better than mainstream services.[6,7,8] Evidence points to improved health outcomes in mortality, sexual health, smoking cessation and cardiovascular programs, as well as maternal and child health outcomes, including birth weights, anaemia and immunisations.[9,10]

ACCHS are also cost effective. An economic evaluation of Danila Dilba Health Service in the Darwin region showed that in 2015-16 services were estimated to contribute $5.60 million in incremental benefits based on improved health outcomes for its clients in three areas, type 2 diabetes, chronic kidney disease and maternal and child health.[11] This is comprised of $0.43 million in avoided health and other financial costs, and $5.17 million in improved value of life.

A recent publication, The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples[12] summarised the evidence for greatly improved services where services were moved to Aboriginal community control, including:

- increased access to and improved quality of primary health services;
- improved delivery of culturally secure care;
- increased employment of local community members including Aboriginal Health Practitioners;
- a greater focus on public health, health promotion and prevention (including in relation to mental health and chronic disease); and

- improved community participation.

Understanding the evidence base around the differential effectiveness of Aboriginal organisations compared to mainstream organisations including non-Aboriginal NGOs is critical in designing effective and efficient funding processes. Congress is willing to provide a more detailed, referenced analysis if required.

We are seeking your view on public health approaches used in other social service areas and the lessons they provide for designing a system to protect children?

Broader public health measures that protect children include controlling alcohol supply to reduce the impact of alcohol-related harms, including family violence. For instance, since the Northern Territory government introduced a suite of measures to limit alcohol supply, in particular the introduction of a floor price on alcohol, point of sale interventions and a Banned Drinkers Register, alcohol related assaults and alcohol related domestic violence assaults have each been reduced by nearly half.

Alice Springs: Alcohol – related assaults

- Oct. 2017 – Dec. 2017 quarter: 382
- Oct. 2018 – Dec. 2018 quarter: 192

  Difference: 190 (-49.7%)

Alice Springs: Alcohol – related DV assaults

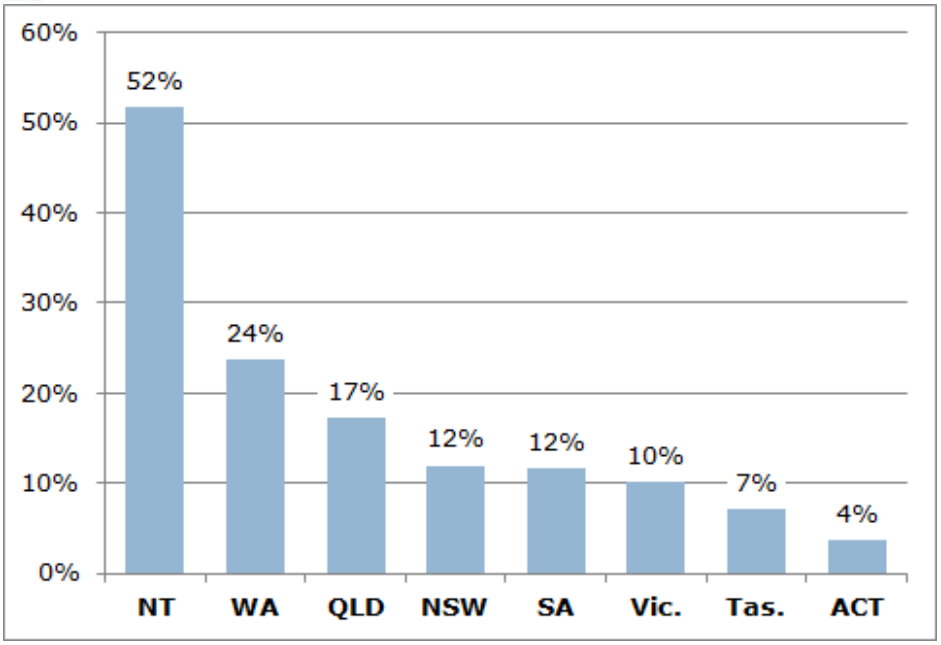
- Oct. 2017 – Dec. 2017 quarter: 244
- Oct. 2018 – Dec. 2018 quarter: 128

  Difference: 116 (-47.54%)

This reduced exposure to alcohol and alcohol related violence in the family home is expected to have a significant impact on vulnerable children including reductions in Adverse Childhood Experiences and out-of-home care. Additionally, reducing alcohol supply and consumption at a public health level is considered one of the most effective ways of reducing the risk of Foetal Alcohol Spectrum Disorder, particularly as alcohol can have a harmful effect before a woman knows she is pregnant.[13]

Access to quality housing is another public health measures that critically impacts on children and their ability to go to school. The housing situation for Aboriginal communities remains very poor, particularly in remote areas and in the Northern Territory. In 2008, nearly three in every five (57%) Aboriginal Territorians were living in overcrowded houses1; this has improved but still over half (52%) were in overcrowded houses in 2014[14] (Figure 1). Aside from the numerous issues associated with overcrowding (see below) it is shown to be the greatest predictor for school non-attendance in a major data linkage study (attached).[15]

Figure 1: Proportion of Aboriginal and Torres Strait Islander people living in overcrowded houses, by State / Territory (2014-15)



Additionally, communities report that repairs and maintenance of public housing is so inadequate that many houses fail to support healthy living i.e. working facilities for washing people, for washing clothes/bedding, for storing/preparing food, and sewerage ('health hardware').[16] This has a direct impact on their capacity to protect themselves from key communicable diseases such as trachoma.

There is a huge amount of literature on the link between health and housing. The key relationships which are commonly observed at the community level in Central Australia, and supported by the evidence, are outlined below:

- **Early childhood development.** A child's experience in the first few years of life is known to set the foundations for physical health and social and emotional wellbeing across the lifespan. Poor living conditions contributes to the poorer physical and socio-emotional outcomes of Aboriginal children, while improvements in housing can be expected to translate into gains in child development outcomes.[17]This is consistent with an association between lower housing standards and decreased school attendance observed in Northern Territory remote Aboriginal communities.
- **Physical health.** A range of communicable diseases are associated with poorly maintained housing, particularly washing facilities, and overcrowding including: trachoma, bacterial ear infections and scabies, Rheumatic Heart Disease, and bronchiectasis. Recurrent infections can undermine healthy childhood development and educational outcomes and contribute to the development of chronic disease in later life. [18] Access to effective equipment to wash people and clothes can reduce communicable diseases e.g. water supply, pumps, tanks, pipes, valves, taps, hot water system, tub and drainage pipes.
- **Mental health and social and emotional wellbeing**. Insecure, poor facilities and/or overcrowded housing is associated with a range of mental health issues such as depression, anxiety and suicide. [19] The social stress associated with over-crowding may also be a contributor to family and sexual violence[20, 21]. In 2012-13, across Australia one in ten Aboriginal and Torres Strait Islander adults reported overcrowded housing as a stressor in their lives.

- **Exposure to tobacco smoke.** Poorly designed, overcrowded houses increase the exposure of the family to tobacco smoke, with increased risk of respiratory disease and (for children and babies), heightened risk of Sudden Infant Death Syndrome, asthma, and ear infections. [22] 12% of the burden of disease that the Australian Aboriginal and Torres Strait Islander population experienced in 2011 is caused by tobacco use. [23]

Despite the evidence on the relationship between remote Aboriginal housing and: health, wellbeing & education, there remains an impasse between the Australian Government and the Northern Territory Governments, and a huge underspend on committed funds. Aboriginal community controlled health services and other public health organisations are calling for the standoff to cease and a level of investment to meet the needs for new housing and maintenance. See https://www.caac.org.au/news-events/news/2019/3/close-the-gap-for-vision-by-2020-alice-springs-declaration-2019

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