Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the

House of Representatives Standing Committee on Social Policy and Legal Affairs

Inquiry into Local Adoption

June 2018

Central Australian Aboriginal Congress

Central Australian Aboriginal Congress is an Aboriginal community controlled health service (ACCHS) based in Alice Springs in the Northern Territory. Since our establishment in 1973, we have developed a comprehensive model of primary health care delivering quality, evidence-based services on a foundation of cultural appropriateness. Led by our Board, we have developed extensive expertise on approaches to health service policy and delivery that take account of the social and cultural determinants of health, including poverty, housing, alcohol and other drugs and early childhood development.

The Inquiry and our response

We understand that the House of Representatives Standing Committee on Social Policy and Legal Affairs is inquiring into local adoption in Australia, with a view to establishing whether there are any unnecessary barriers to adoptions in Australia. We also understand that this is prompted by the fact that there are large numbers of children in out of home care in Australia (47,915 as at 30 June 2017[1]) there are comparatively few completed local adoptions (315 in 2016-17[2]).

The Inquiry's terms of reference relate to the potential establishment of a nationally consistent framework for local adoption in Australia, with specific reference to:

1. stability and permanency for children in out-of-home care with local adoption as a viable option; and
2. appropriate guiding principles for a national framework or code for local adoptions within Australia.

Our response to the Inquiry is based on over four decades of experience as an Aboriginal community controlled health service. While we focus on the perspective from Central Australia in the Northern Territory, we expect that many of the matters we raise will be similar to those faced by Aboriginal[3] communities elsewhere in Australia.

Congress urges the Committee to:

1. **disregard the negative and frequently ignorant public commentary around the issue of the adoption of Aboriginal children by non-Indigenous families** as this is not impeded by the Aboriginal Child Placement Principle;

2. **take account of the historical context of the forcible removal of Aboriginal children from their families (the Stolen Generations)** and the clearly established evidence of the negative health, social and wellbeing effects on those removed and their descendants;

3. **address the very high number of Aboriginal children requiring out of home care as this is the substantive issue underlying the concerns over the rates of local adoption. If there was not a need for out of home care at such high rates the adoption question would not be an issue. It is imperative that we implement** evidence-based action on the factors that drive the numbers of those children, including through action to:

    a) reduce disadvantage and inequality;

    b) address intergenerational trauma and support Aboriginal culture; and

    c) reduce alcohol availability.

4. **ensure that any national framework or code for local adoptions maintains adequate protections for Aboriginal and Torres Strait Islander children**, including the Aboriginal Child Placement Principle; and

5. **support the provision of a suite of integrated services for Aboriginal families and children to be delivered as part of comprehensive primary health care under Aboriginal community control**. This includes effective, evidenced based parenting support programs such as the Australian Nurse Family Partnership program which have been shown to prevent child neglect and dramatically reduce the need for any out of home care for Aboriginal people.

A more detailed discussion of many of the issues summarised in this document can be found in Congress' *Submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory*[4].

Contemporary situation

The Northern Territory has a very high, and rising, number of children who are in out-of-home care: from 742 in 2013 to 1059 in 2017, an increase of 30% over five years[5]. The great majority of these children are Aboriginal (85% of those admitted to out of home care in 2016-17 were Aboriginal)[6]. This is in spite of the fact that only about 15% of children with an episode of substantiated neglect are placed in out of home care – the lowest rate in Australia. The solution does not lie in more alternatives to remove children from families but better ways to prevent this situation from occurring.

However, the majority of these Aboriginal children are not placed with relatives/kin, with other Aboriginal caregivers or in Aboriginal residential care: in 2017 in the Northern Territory, less than a third (32%) were placed in such an Aboriginal context[7].

Compared to the high numbers of children in out of home care, there are very few formal local adoptions in the Northern Territory – only 9 in total in the fifteen years from 2002-03[8]. While it is not known how many of these have been Aboriginal, for Australia as a whole the number of Aboriginal and Torres Strait Islander children adopted is very small with only 125 adopted in total over the past 25 years nationally. These adoptions were

split almost exactly evenly between those going to Aboriginal and Torres Strait Islander families and those being adopted by non-Indigenous families[9].

Care and compassion for children is a central part of Aboriginal culture. Alongside the formal processes of out of home care / kinship care and adoption, Aboriginal families have their own ways of caring for children rooted in traditional kin networks but rarely recognised by non-Indigenous systems. Without the efforts of Aboriginal grandmothers and grandfathers, aunties and uncles and other kin in looking after children whose immediate families may not be able to do so, the situation for Aboriginal children in the Northern Territory would be even worse than it currently is.

From the above, it is clear that:

- despite the efforts of Aboriginal extended kin-networks in looking after children, there are a high number of Aboriginal children requiring out of home care in the Northern Territory;
- even if the rates of adoption were to increase very significantly, this would only have a small impact on the numbers of Aboriginal children in care – this means that preventing children from having to go into care in the first place is critical;
- despite the public commentary implying that the limiting factor for the adoption of Aboriginal children is the Aboriginal Child Placement Principles, nationally only half of Aboriginal and Torres Strait Islander adoptions actually conform to these principles – these principles themselves cannot therefore be a major limiting factor in the adoption of Aboriginal and Torres Strait Islander children.

Historical context

The issues facing Aboriginal children, and the background social, intergenerational and economic factors driving their overrepresentation in out of home care are not new. A quarter of a century ago, such issues were prominent in the reports of the Royal Commission Into Aboriginal Deaths In Custody, including that of the Northern Territory Aboriginal Issues Unit's *Too Much Sorry Business*[10]. Ten years ago, the report of the Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, *Little Children are Sacred,* also considered at length the issues facing Aboriginal families and children in the Northern Territory[11].

These reports made many findings about how the child protection systems were failing Aboriginal families. Unfortunately, until recently (in response to the Royal Commission into the Protection and Detention of Children in the Northern Territory) there has been no systematic attempt to implement the recommendations they made to address the issues they found.

Further, and of particular relevance to any approach to adoption, is the history of the Stolen Generations, where Aboriginal children were forcibly removed from their families from the earliest days of colonisation up to the 1970s. Stolen children were adopted by non-Aboriginal families, placed in institutions or given to non-Aboriginal households to work as servants[12]. While the children were taken ostensibly to 'protect' them, the reality was different – many suffered harsh, degrading treatment (including sexual abuse), were

indoctrinated to believe in the inferiority of Aboriginal people, and were prevented from contacting their families[13].

While the exact numbers of those removed may never be known, the estimate provided by the extensive work of the Bringing Them Home Inquiry[14] was that:

> *... between one in three and one in ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970. In certain regions and in certain periods the figure was undoubtedly much greater than one in ten. In that time not one Indigenous family has escaped the effects of forcible removal… Most families have been affected, in one or more generations, by the forcible removal of one or more children.*

Certainly, there are still many thousands of Stolen Generations survivors still alive today and still suffering the effects of forcible removal. An Australian Bureau of Statistics analysis demonstrates that:

> *Removal from natural family has been associated with higher rates of emotional distress, depression, poorer physical health and higher rates of smoking and use of illicit substances … It has also been associated with lower educational and employment outcomes. These consequences of separation not only affect those who personally experience removal, but can be trans-generational, impacting on children, families and communities[15].*

The intergenerational effects of forcible removal on the descendants of the Stolen Generations has also been demonstrated by the West Australian Aboriginal Child Health Survey (WAACHS)[16], which found that:

> *The forced removal of the parents of the current generation of Aboriginal children from their family and culture was shown in this survey to be associated with arrests, alcohol and gambling problems, poorer mental health and social skills in the parent(s), and with increased risks of emotional and behavioural difficulties in their children.*

Continuing high rates of child abuse and neglect in Aboriginal communities reflect the extreme disadvantage to which much of the Aboriginal population is exposed, such as deep poverty, insecure housing, poor nutrition, parental separation, poor mental health, drug and alcohol problems, low educational attainment, high unemployment, welfare dependency and chronic illness These vulnerabilities have their genesis in the complex trauma histories of Aboriginal people, starting with colonisation and dispossession, racism, child removal, compounded by family (and community) violence, incarceration, and premature death.

The complex nature of risk exposure in Aboriginal communities and the seriousness of consequences highlight the need for effective family support services for vulnerable families, to mitigate likely negative consequences and disrupt intergenerational pathways into profound disadvantage. The National Framework for Protecting Australia's Children 2009-2020 stresses the need of early interventions to address family issues early in a child's life and/or early in the life of the issues.

Child abuse and neglect among Aboriginal and Torres Strait Islander populations is a particular concern in Australia. Children with substantiated child neglect have much greater incidence of physical and mental illnesses in later life and a much higher premature

mortality beyond the age of 15 years. This has been recently confirmed using data linkage on longitudinal South Australian data but the magnitude of the increased mortality from age 15 in children with an episode of substantiated neglect has surprised some. The effect is even larger for children who have spent any time in OOHC.

Addressing the social determinants of health and wellbeing

The key approaches for the benefit of Aboriginal children are those that help prevent abuse and neglect and the need for children to be removed from their families in the first place. These measures include action to reduce disadvantage and inequality; to address intergenerational trauma and support culture; and to reduce the availability of alcohol.

Disadvantage and inequality

Many Aboriginal children and young people are happy, engaged with their families and culture, and prepared to make a positive contribution to their communities and to the Northern Territory as a whole. However, others come from backgrounds of profound disadvantage which are marked by intergenerational poverty, overcrowding and unemployment. Children and young people from such backgrounds are at higher risk of needing out of home care[17]. As well as absolute poverty, societies that are more unequal have been shown to be more prone to violence and to have higher rates of children in need of child protection[18].

There is widespread Aboriginal community concern that poor housing and overcrowding in particular 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[19] and needs to be addressed as a key social determinant of child protection.

Intergenerational trauma and culture

Many of the drivers of child abuse or neglect in Aboriginal communities are similar to those experienced by other populations. However, there are also factors unique to the Aboriginal experience including the history and ongoing process of colonisation such as loss of land, suppression of language and culture, forcible removal of children from families, destruction of an independent economic base, and the experience of racism. This historical and ongoing experience is recognised as resulting in 'intergenerational trauma' whereby traumatic experiences

> *… can be transferred from the first generation of survivors that have experienced (or witnessed) it directly in the past to the second and further generations of descendants of the survivors … this intergenerational trauma … is passed from adults to children in cyclic processes as 'cumulative emotional and psychological wounding' (Atkinson J 2013)*

Culture and spirituality are important in addressing intergenerational trauma through supporting resilience, positive social and emotional wellbeing, and living a life free of addiction to alcohol and drugs[20]. Aboriginal families must therefore have adequate access to services that are both trauma-informed and that validate and support Aboriginal culture and ways of being.

Alcohol

Alcohol is a major cause of child neglect both through increased exposure to domestic violence and lack of responsive care and stimulation from addicted parents. Consequences of neglect include increased risk of developmental delay (intellectual, physical and emotional), poor educational outcomes, compromised physical and mental health, drug use and incarceration and premature death[21].

Strategies to reduce the numbers of Aboriginal children needing out of home care should therefore include effective measures to reduce the availability and use of alcohol. There is incontrovertible evidence that increasing the price of alcohol, and particularly that of cheap alcohol, reduces consumption and alcohol related harm; it is also a highly cost effective intervention[22].

Addressing the needs of children and families

Aboriginal children in Out of Home Care

The number of Aboriginal children in the Northern Territory removed from their families because of abuse or neglect has been rising rapidly in recent years (see above). In those cases where Aboriginal children need to be removed from their family environment, the Northern Territory in common with all other Australian jurisdictions has adopted the Aboriginal Child Placement Principles, such that Aboriginal and Torres Strait Islander children removed from their family are placed with relatives/kin, other Aboriginal caregivers or in Aboriginal residential care wherever possible[23].

Less than a third of Aboriginal children in out of home care in the Northern Territory are placed in accordance with these Principles. This is the lowest proportion of any jurisdiction, despite the Northern Territory having the highest proportion of Aboriginal and Torres Strait Islander children in care[24].

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has recommended a five-point strategy for addressing the rising numbers of Aboriginal children being removed from their families and supporting the implementation of the Aboriginal Child Placement Principles[25]:

1. increasing community participation in decisions for the care of Aboriginal and Torres Strait Islander children, supported by community-controlled service design and delivery,
2. re-orienting service delivery to early intervention and family support,
3. ensuring that funding and policy support holistic and integrated family support and child protection services,
4. recognising the importance of supporting and maintaining cultural connection, and
5. building capacity and cultural competence for effective service delivery to Aboriginal and Torres Strait Islander children and families.

At a *Child Protection and Out of Home Care (OOHC) Workshop* hosted by the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) in April 2016, a wide range of recommendations were agreed to address the system's failings; Congress endorses

these recommendations[26]. In addition, the Aboriginal Peak Organisations – Northern Territory (APONT) developed a detailed set of recommendations to deal with out of home care of Aboriginal children in the Northern Territory; these are outlined in APONT's submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory[27].

In our view, three issues in particular need attention.

First, family group conferencing is an evidence-based approach that includes the extended family of a child in decision-making about the wellbeing of a child who is at risk of removal. This should be resourced as best practice, such that when a child may need out-of-home care, the responsible child protection agency convenes a family-group conference that includes key culturally-appropriate family members, with the aim of identifying appropriate kinship carers (who can then be subsequently supported to gain the necessary approvals if needed).

Second, Aboriginal families that take on the responsibility of kinship care should be adequately supported and reimbursed. In the Northern Territory for example, we understand that 'professional foster carers' may be paid at a much greater rate (up to $1200 per week per child) than Aboriginal kinship carers and/or general foster carers ($270 per week per child).

Third, to ensure the proper placement and support of Aboriginal children in out of home care, the responsibility for out of home care (along with all necessary resourcing) should be transitioned from government to Aboriginal community controlled organisations, which will recruit, train and support kinship and foster carers, support all placements of children, and prioritise kinship care.

Integrated family and children's services from primary health care

Congress has developed an integrated model for child and family services to support Aboriginal families raise their children to be happy, healthy and ready to be strong and productive members of the Aboriginal community.

This model, delivered as part of our comprehensive model of primary health care is founded on a long-term, population health approach that can be expected to deliver results in health and wellbeing across the life course, and to prevent the need for Aboriginal children and families to be involved in child protection services.

Key to the achievement of this potentially transformative change is integration. The advantages of Congress' integrated approach are that:

- it is built on existing, positive relationships that Congress has with Aboriginal families in Alice Springs through the delivery of supportive, culturally appropriate primary health care
- it allows an evidence-based approach, with common goals, which can be modified to meet the particular cultural and social needs of our clients
- it supports a consistent approach to screening, allowing children and families to be referred to programs that best meet their needs
- it encourages purposeful partnerships with researchers to evaluate progress and with other service providers for follow-up of clients

- it allows internal efficiencies between programs to enhance services without the need for additional resources
- there can be secondary gains for other not specifically child-related programs (for example, working with client families on healthy lifestyles or addiction issues).

In terms of the capacity to prevent child neglect, child protection referrals and days in out of home care the as yet unpublished results from an independent evaluation of the modified Nurse Family Partnership model, delivered by Congress is very important. This program is an effective strategy for reducing child protection system involvement in a highly vulnerable Aboriginal population. It is also leading to improvements in other key outcomes such as pregnancy spacing and hospitalisation for injuries.

Children in Families with first time mothers on the program were 50% less likely to be reported to child protection and those that were reported were 62% less likely to have a substantiation. These same children spent many less days on average in OOHC with a 94% reduction on mean days per year in OOHC for children on the program to first time mothers.

It is vital that we are able to deliver programs that prevent child neglect by providing effective parental and family support. It is very costly to intervene once child neglect has occurred and even the very best OOHC systems cannot care for children as well as family with appropriate support when needed. The enhanced mortality rates for children who have had substantiated neglect or days in OOHC requires a much greater focus on prevention. There is no evidence that these outcomes are any better when children are adopted.

The Nurse Family Partnership (NFP) at Congress through effective parental support is achieving the primary prevention of key adverse events in early childhood that are known to lead to premature death and physical and mental ill health in later life.

See attachment for a detailed description of the integrated child and family services model, including the NFP which we believe forms a good basis for the development of similar approaches in other comprehensive primary health care services under Aboriginal control.

Attachment: Central Australian Aboriginal Congress: Comprehensive services for children and families

Summary

Congress's comprehensive primary health care includes clinical care as well as our Child & Family Service section which supports Aboriginal families to help their children to learn well and grow strong. Our multi-disciplinary team approach ensures all children have access to best practice comprehensive primary health care including:

- Routine and systematic child health checks and developmental screening through all of our clinics (using the ASQ-TRAK assessment tool) for children 0-5 years old, with support provided to parents and carers to attend appointments. This includes following up recalls when appointments are due to ensure children are able to attend.
- Further developmental assessments for delay and disability are provided through our Child and Youth Assessment service of allied health professions in collaboration with Alice Springs paediatricians and community health services. This includes the capacity to diagnose FASD along with other neurodevelopmental conditions in collaboration with paediatricians from Alice Springs hospital and supported by PATCHES Paediatrics and the Telethon Institute in Western Australia.
- We provide evidenced-based early childhood learning programs within our child and family services. This approach is based on play based learning using learning games, conversational reading, language priority and enriched care giving. We use a strategic population health approach and specific one on one interventions to improve the health and developmental trajectory for developmentally vulnerable children. Congress operates:
    - Two early learning centres for children from both working families and non-working families (this includes support and engagement of parents and carers to participate in the Centre).
    - A Preschool Readiness Program.
    - We also work closely with education providers to support children to be healthy and developmentally ready for preschool and school, and to gain any additional supports needed for preschool and school.
- Our Intensive Family Support programs support vulnerable families to keep children safe at home and for families involved with the child protection system, in addition to providing support for parents more broadly through the Parenting Under Pressure Program.
- Routine child health checks and immunisations are provided by child health nurses who refer children on to GPs as needed. Child health nurses are also trained to use tympanograms to identify issues with ear health, and children have access to an in-house audiologist. Referrals are made for specialist appointments with support provided by an Aboriginal Liaison Officer(ALO)for these appointments.

- We provide a holistic young person's healthy lifestyle education program in schools targeting children at age 12 years known as the Community Health Education Program or CHEP.
- Congress also promotes healthy lifestyle through, for example, smoking programs, alcohol reduction and advocacy for access to healthy foods.

Underpinning this integrated and holistic service is the principle of Aboriginal Community Control, where services are culturally safe for those who use them, provided by a large Aboriginal workforce, and governed by an Aboriginal Board and membership. All programs are evidenced-based, measured and evaluated, with improvements driven by data and Continuous Quality Improvement. Children and families are actively followed up and supported to attend appointments by our ALOs. We also have strong partnerships with specialist and education services, and other government and non-government services, so that services are coordinated, easily navigated by families, and that children do not fall through the cracks.

Services related to young people, children, and young people as parents.

As an ACCHS, Congress provides a suite of holistic and integrated services to support general, mental, sexual and reproductive health, as well as providing pregnancy and maternal health services, parenting and children's services. This is through health promotion activities, primary and secondary prevention and clinical services. Services work closely with other providers including education services and accommodation providers.

These services support young people, young people as parents, and their children with the aim to protect and improve health and wellbeing outcomes, break the cycle of disadvantage experienced in many Aboriginal communities, setting a foundation for improved educational and employment outcomes.

Services are delivered through a number of settings including:

- Clinics providing services including treatments, health checks (adult and child) and immunisations
- Social and emotional well-being services
- Alice Springs *headspace* which offers services to young people 12-25 years old including mental health counselling, social support and physical and sexual health testing.
- Alukura Women's Health Service - an Aboriginal women-only service for Aboriginal women and babies and includes the provision of contraception education and advice; care for mums and their babies during and after pregnancy; and Sexually Transmitted Infections (STI) checks and treatment.
- Ingkintja - an Aboriginal male-only place providing care for male health and wellbeing including health checks and STI checks. The service is provided in a culturally safe place for clients with only male workers to support men on male health issues.

Health promotion, sexual health services, counselling and referrals

Congress Community Health Education Program (CCHEP)

Since 1998 the Congress Community Health Education Program (CCHEP) has delivered the Young Males Community Health Education Program (YMCHEP) and the Young Woman's Community Health Education Program (YWCHEP) to youth aged 10 - 20 years of age, in schools and community services/organisations.

Both programs deliver similar units covering basic holistic health. The units covered in the female package include: puberty, sex, well women's checks, safe sex, STIs, contraception, pregnancy, relationships and body care. The male package includes; puberty, sex, well male's checks, safe sex, STIs, fatherhood, relationships and body care.

CCHEP’s goal is to help young people gain the knowledge, skill and positive attitudes to grow as strong, aware and confident people who can make healthy choices about their relationships and sexuality. This is achieved in a fun, interactive and culturally appropriate way, so that the learning experience is memorable. Education is through series of learning activities which are designed to encourage youth to actively participate and share their views.

Sexual health services

Young people attend Congress services for sexual health, pregnancy testing and care, sometimes coming in alone, sometimes with a carer or older relative. Referrals are also received from other services. Regardless of the reason for presenting, young people are opportunistically offered sexual health checks and given education around safer sex, contraception and importance of regular check-ups.

Services are very flexible and accommodating, and manage drop in clients while aiming for continuity of practitioner. When appointments are made, they aim to suit the client e.g. after school. Transport is also available which can be essential for young clients.

Congress clinicians facilitate access to contraception for young people. For example, clinicians are trained in inserting the contraception implant (Implanon) and often provide this on the same day visit.

Access to free condoms is provided at all Congress clinics, with dispensers in the client toilets and clinic rooms, as well as the provision of condoms in Alice Springs public toilets.

Pregnancy

Pregnancy counselling services for unplanned pregnancies are available through Congress’ services, in particular Alukura Women’s Health Service and Social and Emotional Wellbeing. Depending on the patients’ decision, referrals are made for: more counselling; termination of pregnancy; or early antenatal care.

If the decision is made to continue the pregnancy, antenatal care and postnatal care is provided with birthing through Alice Springs Hospital. There are strong links and referrals to other services as needed. For example, referrals to dieticians are frequent as iron deficiency and poor access to healthy foods is common in Central Australia.

Congress services such as Alukura will also facilitate accommodation and seek to ensure the safety of young women as needed. Congress refers young women to services such as Ampe Akweke, part of Alice Springs Youth Accommodation and Support Services which

provides accommodation and support services for women aged 14-23 years who are pregnant or have a young child. Some pregnant women and young mothers have also attended Alice Outcomes - an alternative education program offering opportunities for young people who have become disengaged from mainstream schooling.

Parenting and children: Child and Family Services

The key role for primary health care services in improving self-control, educational attainment and then employment is in the area of early childhood, especially in the years from pre-birth to 4 years when it is only health services that regularly provide care and support to young parents and their children. These are the critical years for determining a person's whole life story including their life long health and well-being.

Congress' core services and programs make up an integrated and comprehensive approach to child and family services. These are both primary and secondary prevention programs and are delivered either in the home or in a dedicated centre. A holistic group of services is outlined in the following table:

	Primary Prevention Targets children with no current problems but who are at risk of developing problems – identified risk usually based on low SES or maternal education level		**Secondary Prevention** Targets children with current problems identified early in life when most likely to respond to intervention and before gets worse – determined by screening or referral to services	
	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	• Early Childhood Learning 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 (PUPS)

Focusing on the Parent and Carer

Nurse Family Partnership[28]

The Nurse Family Partnership (NFP) program is a cost effective program that promotes healthy development in early childhood. The focus of this program is on the primary carer of the child, usually the mother. NFP aims to:

- Improve pregnancy outcomes
- Improve child health and development
- Improve parents' economic self-sufficiency

These aims are achieved through a home visitation program and the mother is visited by the same Nurse Home Visitor and Aboriginal community worker throughout the program in order to be able to build a strong relationship. The frequency of visits is between weekly and bi-weekly from no later than 28 weeks gestation until the child is 2 years of age.

Parenting Under Pressure[29]

The Parenting Under Pressure (PUP) program combines all areas of life and how they influence a person's development, both parent and child, from the broadest influences (e.g. community, housing, income) to the more individual factors (nature of person, health, social connections). This includes parenting values and expectations, complemented by the parents developing an understanding of child development e.g. physical, behavioural, social, emotional, and cognitive development.

All interventions are based on Cognitive Behavioural Therapy and Motivational Interviewing with some mindfulness and acceptance, and interpersonal therapy. All therapies are recognised by Medicare as evidence-based psychological treatments and PUP provides these as a package.

The program can be implemented at any stage with any client/family of any age and is flexible to the families' needs. Interventions include parents:

- understanding themselves as parents (own attachment style and upbringing),
- managing own emotions (mindfulness)
- connecting with children (attachment)
- understanding child development and needs
- understanding how to manage their children.

The program also looks at the parent needs including:

- managing Alcohol and Other Drug issues,
- extending their own networks e.g. engaging in playgroups
- life skills e.g. finances, routines at home
- personal and intimate relationships including domestic violence.

Targeted Family Support Service (TFSS) & Intensive Family Support Service (IFFS)[30]

The Targeted Family Support Services (TFSS) is a voluntary early intervention service (i.e. pre-child protection involvement) that aims to promote the safety, stability, development and well-being of vulnerable children and their families. TFSS provides a range of services including: information, active engagement, assessment, case management, counselling and in-home support. TFSS receives self -referrals and referrals from the community.

The Intensive Family Support Program (IFSS) aims to improve the safety and wellbeing of children within the family and their community. Referrals to this program are aimed at parents and caregivers of children where neglect has either been substantiated by child protection or where child protection are of the belief that there is a high risk of neglect occurring.

Both the TFSS and IFSS programs work with high needs, vulnerable families, in partnership with other key service providers with the aim of supporting and empowering parents and caregivers to make sustainable changes in their lives to improve the health and wellbeing outcomes for their children.

Focusing on the child

It is now well established that in the first few critical years, children need stimulation and positive relationships with care givers to develop neural systems crucial for adult functioning and positive mental health. Longitudinal studies show that parenting support

programs and targeted early childhood educational programs reduce the risk factors for children that may lead to poor mental and physical health in adulthood.

Such evidence-based programs have, for example, reduced rates of alcohol and other substance use by young adults, improved educational and employment outcomes, reduced the proportion of teen pregnancies, and are associated with more active lifestyles and reduced incarceration rates.

Early Childhood Learning[31]

Congress operates two early childhood centres. *Ampe Kenhe Apmere* Congress Childcare is for working families and also provides early childhood education. Many of the children enrolled in the Centre are in out-of-home care.

Arrwekele akaltye-irretyeke apmere is an early childhood learning centre for Aboriginal children from non-working families living in Alice Springs, aged 6 months to 3.5 years old.

Both Centres use an international evidence-based program modified for the Australian context and adapted in language for Aboriginal communities. This approach is based on play based learning using learning games as well as conversational reading, language priority and enriched care giving. It has shown a major impact on the developmental, educational and health outcomes across the lifespan for children from at-risk and vulnerable families in many studies. This program is integral to *Arrwekele akaltye-irretyeke apmere* due to the known impact on children of disadvantaged, non-working families. The aim of the Centre is to achieve the above health outcomes and break the cycle of disadvantage.

This program will be rigorously monitored and evaluated to determine achievement of the outcomes and to add to the body of evidence on early learning.

Based on longitudinal studies of the approach, expected long term benefits are:

- improved education and employment outcomes
- increased health and wellbeing as young adults, including reduced smoking and drug use, reduced proportion of teen pregnancies, more active lifestyles
- reduced risk of chronic disease in later adulthood (lower prevalence of risk factors for cardiovascular and metabolic diseases)

Preschool Readiness Program[32]

As part of the Preschool Readiness Program, Congress has been using the same approach of learning games, conversational reading, language priority and enriched care giving in an intensive eight week program for children aged between 3 and 5 years of age. The children undergo a holistic assessment, carried out by nurses, an occupational therapist and psychologist. The assessment covers all school readiness domains, including: fine and gross motor development; expressive and receptive language; cognitive screening and testing; social skills; and emotional health.

This is achieved by utilising a comprehensive range of tests which include the ASQ-Trak, Peabody Picture Vocabulary Test (PPVT), Bracken Concept Development Program and followed up with more diagnostic tools such as the Bayley Scales of Infant and Toddler Development, Achenbach scales, Conners Comprehensive Behaviour Rating Scales and

the Child Behaviour Checklist (or ASEBA). Nurses undertake health checks and immunisations.

Following the assessment, programs for children are individually planned and achievements are measured with post-testing. Children have shown significant improvements across all school readiness domains and have successfully integrated into pre-schools.

Partnering with the Northern Territory Department of Education

Congress has partnered with the NT Department of Education (NTDE) to integrate early childhood health and education services for children under 5 years of age in Alice Springs. Funded through the Australian Government "Connected Beginnings" program, both sectors will be increasing identification of children who will require additional services to become preschool and school ready, and coordinating health, social and education services. The most critical part of this partnership is the need for the NTDE to ensure that all disadvantaged children can access 2 years of pre-school for a minimum of twenty hours per week.

A strong evidence base: Research, data collection & Continuous Quality Improvement

ACCHSs such as Congress are leading centres for evidence-based innovation and responsiveness to population and service needs, and important sites for developing the future evidence and research base. Congress' services and programs are underpinned by a robust Continuous Quality Improvement program which includes the collection of key output and outcome data. Our research division builds on the existing evidence by facilitating evaluations and research in partnership with universities and other research institutes.

Economic and cultural security: Education, training & strong Aboriginal workforce

The Aboriginal community controlled health sector has a role in the training and employment of Aboriginal people in clinical, administrative, research and support services. The reasons for this are twofold:

- A high quality Aboriginal workforce is better able to ensure culturally appropriate care in the services they deliver, to improve access and to meet the health needs of Aboriginal communities.
- An Aboriginal workforce is also another way to address the social determinants of health through increased training and employment.

Congress has promoted and supported local Aboriginal women to undertake midwifery training. Two local women have recently successfully completed their Bachelor of Midwifery which has includes support and mentorship at Congress while studying at the Australian Catholic University. Both are now developing exciting professional careers.

Engaging fathers[33]

By providing these services it is clear that there is a need for a special focus on fathers as engaging them in parenting will lead to even better outcomes. Parenting interventions are inclusive of both parents and the involvement of fathers is often critical. Unless fathers in their role of caregivers are fully engaged, parenting activities and programs are likely to be less successful. Even if fathers are not present, they have a significant impact on children, mothers, and the functioning of the family. Congress is increasing efforts to

involve fathers, and is making inroads into engaging dads within the Nurse Family Partnerships and at *Arrwekele akaltye-irretyeke apmere*.

Notes

[1] Australian Institute of Health and Welfare 2018. Child protection Australia 2016–17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW

[2] Australian Institute of Health and Welfare 2017. Adoptions Australia 2016–17. Child welfare series no. 67. Cat. no. CWS 61. Canberra: AIHW

[3] Central Australian Aboriginal Congress uses the term 'Aboriginal' to refer to all Aboriginal and Torres Strait Islander peoples as this is the preferred term in Central Australia.

[4] Central Australian Aboriginal Congress 2018, *Submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory.* Available: https://www.caac.org.au/uploads/pdfs/Congress-Submission-to-NT-Royal-Commission-FINAL-as-submitted-1-November-2016.pdf

[5] AIHW 2018 table S55

[6] AIHW 2018 table S51

[7] AIHW 2018 table S45

[8] AIHW 2017 table S13

[9] AIHW 2017 report, pages vi and 35

[10] Royal Commission Into Aboriginal Deaths In Custody (RCIADIC) (1991). National Report: Volume 1 by Commissioner Elliott Johnston, QC. Adelaide

[11] Wild R and Anderson P (2007). Little Children are Sacred: Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse. Darwin, Northern Territory Government

[12] Ministerial Council of Aboriginal and Torres Strait Islander Affairs (2003). Evaluation of Responses to Bringing Them Home Report: Final Report, Success Works

[13] Healing Foundation (2015). Healing for our Stolen Generations: sharing our stories. Canberra, Aboriginal and Torres Strait Islander Healing Foundation

[14] Human Rights and Equal Opportunity Commission (HREOC) (1997). Bringing them Home. Sydney, Spinney

[15] Australian Bureau of Statistics (ABS). (2011). "4704.0 - The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010." Retrieved 25 August 2016, from http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter470Oct+2010

[16] Blair E M, Zubrick S R and Cox A H (2005). "The Western Australian Aboriginal Child Health Survey: findings to date on adolescents." Med J Aust **183**(8): 433-435

[17] Senate Select Committee on Regional and Remote Indigenous Communities (2010). Indigenous Australians, Incarceration and the Criminal Justice System: Discussion paper prepared by the committee secretariat. Canberra, Parliament of Australia; Jesuit Social Services (2013). Thinking Outside: Alternatives to remand for children. Richmond, Jesuit Social Services

[18] Wilkinson R and Pickett K (2009). Violence: Gaining Respect. The Spirit Level: Why More Equal Societies Almost Always Do Better. London, Allen Lane

[19] Silburn S, McKenzie J, Guthridge S and Li L (2014). Unpacking Educational Inequality in the Northern Territory. Research Conference 2014: Qulaity and Equity

[20] Dudgeon P, Walker R, Scrine C, Shepherd CCJ, Calma T and Ring I (2014). Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Canberra / Melbourne, Produced for the Closing the Gap Clearinghouse. Australian Institute of Health and Welfare / Australian Institute of Family Studies. **Issues paper no. 12**

[21] ACE Study. The Adverse Childhood Experiences Study. -; Available from: http://www.acestudy.org/index.html; Brown D W, et al., Adverse childhood experiences and the risk of premature mortality. Am J Prev Med, 2009. 37(5): p. 389-96

[22] Babor T and Caetano R (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press

[23] AIHW 2018, page 47

[24] AIHW 2018, page 23

[25] Secretariat of National Aboriginal and Islander Child Care (SNAICC) (2014). Submission to the Senate Inquiry into Out of Home Care. Melbourne, SNAICC

[26] AMSANT (Aboriginal Medical Services Alliance Northern Territory) (2016). Child Protection and Out of Home Care (OOHC) Workshop. Darwin, Aboriginal Medical Services Alliance Northern Territory

[27] See http://www.amsant.org.au/apont/wp-content/uploads/2017/01/20170731-RC-APO-NT-Submission-FINAL.pdf

[28] *For further information, see* Olds D L, Eckenrode J, et al. (1997). "Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial." JAMA 278 (8): 637-643

[29] *For further information, see* Bronfenbrenner, U. (2009) Bronfenbrenner's Ecological Theory. The ecology of human development. Harvard University Press; Parents Under Pressure (PuP) program website: http://www.pupprogram.net.au/

[30] *For further information, see:* Arnott, A., Guenther, J. and Cummings, E. Evaluation of the Northern Territory Targeted Family Support Service Interim evaluation report. Prepared by the Charles Darwin University Social Partnerships in Learning (SPiL) Consortium, 28 December 2010 (Updated 25 March 2011); Segal, L., Nguyen, H. (2014) Evaluation of the Intensive Family Support Services (IFSS) implemented by Central Australian Aboriginal Congress Aboriginal Cooperation, Health Economics & Social Policy Group, University of South Australia.

[31] *For further information see:* Shonkoff J P and Phillips D A, From Neurons to Neighborhoods: The Science of Early Childhood Development, Committee on Integrating the Science of Early Childhood Development, Editor. 2000, National Academies Press: Washington, DC.; Tayler C, Cloney D S, and Niklas F, A bird in the hand: Understanding the trajectories of development of young children and the need for action to improve outcomes. Australasian journal of early childhood 0 2015. 40(3): p. 51-60.; Ramey C T and Ramey S L, Early learning and school readiness: Can early intervention make a difference? Merrill-Palmer Quarterly, 2004. 50(4): p. 471-491.

[32] *For further information see:* Moss, B., Harper, H., Silburn, S. (2015) Strengthening Aboriginal child development in Central Australia through a universal preschool readiness program. Australasian Journal of Early Childhood—Volume 40 No 4 December.; McTurk, N., Nutton, G., Lea, T., Robinson, G., Carapetis, J. 2008 The School Readiness of Australian Indigenous Children: A Review of the Literature. Available: http://library.bsl.org.au/jspui/bitstream/1/3734/1/The_school_readiness_of_Australian_Indigenous_children_reviewofliterature_aracy2008.pdf.

[33] *For further information see:* Panter-Brick, P. Burgess, A, Eggerman, M., McAllister, F., Pruett, K., and Leckman, J. Practitioner Review. Engaging Fathers- recommendations for a game change in parenting interventions based on a systematic review of the global evidence. Journal of child Psychology and Psychiatry 55:11 (2014) 1187-1212.