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Submission to the NT Child Protection Inquiry

The key themes addressed in this submission are:

1. From crisis intervention to improved universal prevention and early intervention 'targeted' services as part of comprehensive primary health care and beyond
2. Improved response and interventions from NTFC
3. Improved recruitment and retention of staff with NTFC
4. A commitment to Continuous Quality Improvement in NTFC
5. Improved school attendance
6. Legislative reform

1. From crisis intervention to improved, universal prevention services as part of comprehensive primary health care and beyond

For many years Congress has believed that it is possible to prevent many of child protection referrals in spite of the ongoing existence of the social inequalities that are the root cause of the need for child protection services in the first place. The right range and scope of preventative services can make a big difference and this has been well described in the most recent report from Professor Michael Marmot "Fair Society Healthy Lives the Marmot review: Strategic review of health inequalities in England post 2010" (Marmot et al 2010). The main message of this report is that the early social environment makes a big difference and that children from lower socio-economic backgrounds are much more likely to grow up in families where they are more likely to be neglected and abused, not develop their potential intelligence, not attend pre-school, do poorly at primary school, drop out of secondary school, get in trouble with the law, become alcohol and other drug users etc. At a population, not an individual level, this life course progression is predictable and Marmot makes clear, partly preventable, even without major social change in terms of reduced social and economic inequalities.

It has been clearly demonstrated that in the early childhood area there are programs that work better for people who are lower down the social hierarchy and have less and less, or even no impact as you get to the top. That is, for people who are poor, socially marginalised, have little control over their lives early childhood programs such as the Old's nurse led intensive home visitation, the Perry Pre-school program and the Chicago parenting program can make a big difference whereas for parents who are well off and with good levels of control over their lives these programs hardly have any effect. They therefore help to reverse the very social gradient that is the root cause of much preventable ill health in any population. These are also the types of services

that will prevent the need for child protection services and promote healthy and safe family environments for children to grow up in. These services are very different to the vast bulk of health services which are more effective and give better outcomes to people who are already at the top of the social hierarchy. There needs to be a much greater investment in family support and early intervention services, as part of comprehensive primary health care in particular, that leaves child protection only dealing with the “pointy end” of the spectrum. What then are these services and interventions mapped out across the lifecourse?

Universal services to the whole population

1. Universal, accessible, quality antenatal care
2. Universal, nurse led home visitation either commencing antenatally or from birth until the child is aged two
3. Universal access to 3 year old pre-school, free of charge and supported by transport services, for all children from a lower socio-economic background. This could be means tested in some way but there is overwhelming evidence of the benefit of an additional year of pre-school for children from lower socio-economic backgrounds. Attendance at pre-school should also become a legal requirement for all children
4. Universal access to positive preschool and school experiences for children including a range of models to engage socially vulnerable families
5. Adult health and community services that meet the needs of parents critical to parenting

Public Health Interventions to the whole population

1. Alcohol supply reduction measures including a minimum or floor price, no take away sales one day per week linked to Centrelink payments. Prof Dorothy Scott from UNSW, one of Australia's leading academics in the Child Protection area, has repeatedly argued that alcohol supply reduction is the single most important child protection measure that needs to be put in place across the nation. This is even more true for the Northern Territory where alcohol consumption is at least 50% higher than the national average and alcohol abuse is the primary cause of child neglect and the need for child protection services

Targeted Support Services to vulnerable families and children

There needs to be an increase in the scope of targeted support services to at risk populations including vulnerable children, young people and families who are likely to be characterised by:

- multiple risk factors and long term chronic needs, meaning that children are at high risk of developmental deficits
- children, young people and families at high risk of long term involvement in specialist secondary services such as alcohol and drugs, mental health, family violence and homelessness services, and Child Protection;
- cycles of disadvantage and poverty resulting in chronic neglect and cumulative harm;

- single/definable risk factors that need an individualised, specialised response to ameliorate their circumstances
- single/definable risk factors that may need specialised one-off, short term, or episodic assistance to prevent or minimise the escalation of risk.

Such services will often be best located within comprehensive primary health care services and should be available to any client on referral or self presentation and include:

1. **Targeted Family Support Services** as a universal service within PHC which involves the intensive case management of high needs families either voluntarily referred from NTFC or from the community. The initial TFSS service in the Northern Territory was funded through Congress and this has demonstrated that the Aboriginal community controlled primary health care sector is better able to recruit and retain staff, better ability to find out what is really going on in families and better able to provide effective family support. This has led to improved outcomes for children and families including improved school attendance, improved child health, reduction of family violence and more informed decisions to remove children where appropriate (see attached progress report for more details on the service)
2. **Social and emotional well being services** including Parents Under Pressure, Positive Parenting and other evidence based service models. These services should also include **accessible, ambulatory alcohol rehabilitation services** based on case management, psychotherapy including CBT (and other forms of therapy, such as narrative therapy where CBT cannot be used), social and cultural support and pharmacotherapies. These services need to be available as part of all primary health care services.
3. **Residential Alcohol rehabilitation services both voluntary and mandated**
Ambulatory alcohol treatment services need to be complemented with residential treatment facilities in regional centres outside the primary health care system. In addition to this, Congress wants to be part of a dialogue to explore the possibility of giving NTFC additional powers to be able to encourage parents who are abusing alcohol and neglecting their children into treatment through the use of methods such as targeted income quarantining up to 100% and alcohol prohibition orders, as a well evaluated trial over 2 years. This may need to be done through a referral to the alcohol court which would need to be reformed to be able to deal with such non criminal matters in a way that only applies consequences outside the criminal justice system. Thus, as a first option, once referred to NTFC parents could have their welfare income quarantined up to 100% and /or have an alcohol prohibition order applied. Then parents could be advised that if they engage well with case management and alcohol treatment the income quarantining and/or a prohibition order will gradually be reduced over time thereby creating a motivation to engage well with treatment. This is likely to work in the same way as pre-sentencing diversion works and be effective. Such new approaches, if adopted, should be properly evaluated and only continued if there is evidence for their effectiveness. If parents continued to refuse to engage with treatment even using these coercive powers then there is little choice but to move to removal of children. Such an approach is worthy of more detailed consideration and

discussion between government and Aboriginal organisations, including Congress.

4. **Youth services and programs for vulnerable teenagers** need to be available to enable young people to be case managed and access a range of treatment services and programs
5. **Supported Accommodation Services** in an alcohol free environment and a controlled drinking environment. Many families are desperately trying to care for children but struggle to do so because of accommodation issues such as overcrowded housing and inability to control visitors, including drinkers. Resulting chaos includes no sleep, no food and exposure to violence, resulting in the caregiver becoming incredibly stressed and at risk of giving up. Such families, especially sole parent families and grandparents who are caring for children, want accommodation that has a capacity to gatekeep visitors and alcohol. This is reflected in the current waiting list of 20-25 families at Ayeperenye hostel for the 12 family cabins there. Ayeperenye is not flash but it does provide safe accommodation, gates are locked at night and drinkers are not allowed in. Thus, common issues impacting negatively on parenting include children exposed to an environment where there is excessive drinking, and carers who are constantly 'humbugged' for money and food by others, are mitigated. For these families, access to a secure supported accommodation setting would greatly improve their capacity to care for their children. This should include the provision of supported accommodation to families in crisis for as long as is needed depending on the parent's circumstances. In some cases this will be 12 months but in other cases this will be for a much longer time. These supported accommodation faculties could be established along the lines of the therapeutic community model with 24 hour support. With community consent, this could be done in a town camp environment with a fence around a group of houses or an entire town camp could be set up in this way. There would need to be a manager or "gate keeper" who controls entry and exit to the supported accommodation facility and is able to effectively support the residents including through the development of agreed rules about how to deal with disruptive people. The gate keeper would lock up at night and not let alcohol in. Such a facility could also be established outside of town camps. Similar models proven to be effective in this way are Aboriginal Hostels such as Ayeperenye Hostel in Alice Springs
6. **Male health interpersonal violence and empowerment services.** An expansion of male violence programs and associated wellbeing services provided by primary health care services. This type of program has been operating for four years by Congress Male Health Branch (Ingkintja) and has focussed on treating violent men in the Aboriginal community using evidence based practices. Research has shown the negative consequences that high levels of maternal stress have on the developing foetus. A violent partner is by far the most powerful factor in a stressful relationship regardless of mental health, economic, substance abuse or social factors. Early childhood exposure to violence, abuse and/or neglect is associated with the development of personality disorders, mental illness and behavioural problems that often endure throughout a person's life. The program provides specialist psychological services to treat men who are violent with a strong emphasis on the family as a whole. The programme services both male and

female offenders of all ages and provides treatment to victims of trauma. Ingkintja uses innovative approaches to engage men. The construction of a Men's shed is one such initiative.

7. **Sex offender rehabilitation programs** to ensure there is a reduction of sexual abuse in the community. Similar to the above programme but with specialised approaches for this type of offender. This issue needs to be addressed primarily with a public health approach and delivered in the prison system and the wider community.
8. **Support for women who drink dangerously during pregnancy**
For women who drink at harmful levels in pregnancy they would also be referred to ambulatory (non residential) alcohol treatment services. This referral should be done in a way that advises the woman that a referral is being made because the health service has a duty of care to the unborn child who is being put at risk due to heavy alcohol use. This is a different approach to the normal process of seeking consent to a referral where the client is asked whether they would like to be referred or not.

If a pregnant woman who is clearly drinking in a harmful way refuses to be referred or fails to engage in treatment then this woman should be referred into the child protection system. At this point, a thorough review of the individual's circumstances should be completed and a comprehensive case plan formulated to ensure the best possible support has been offered. Once it is clear that the best possible services have been offered and the pregnant woman is refusing those services then Congress wants to be part of a dialogue that would consider giving NTFC the power to apply 100% income quarantining and an alcohol prohibition order in a manner which advises the woman that should she now change her mind and agree to participate in case management and alcohol treatment then these measures will be removed over time according to progress. This is the same approach that could apply to all parents neglecting their children as outlined earlier. If the coercive powers of the NTFC were agreed to as a trial and could be shown to work and the woman then accepts alcohol treatment as a result, the treatment could occur in a non secure residential treatment facility or even a supported accommodation house with an ambulatory treatment program. If however, in spite of applying up to 100% quarantining and a prohibition order the pregnant woman does not then agree to accept treatment the woman should be mandated into a secure residential treatment facility until the birth of the baby. This would be an absolute last resort and should not be needed very often if this sequence is followed. This is similar to the Canadian approach and it seems to be working. If the full range of service outlined here are in place, including the supported accommodation option below this should dramatically reduce the incidence of foetal alcohol spectrum disorder.

2. Improved intervention from NTFC

At present it appears that NTFC is not able to deal effectively with even high risk cases of child abuse and this is being left to the community sector. However, if the community sector is appropriately resourced, including the existence of effective supported accommodation options, it will be better able to respond effectively to the needs of families before the risks to children escalate to a point where statutory

intervention is required. This should enable NTFC to provide a more effective response to those families that clearly require a statutory response.

Once it is necessary to remove children then there needs to be better options than is currently available to NTFC. The single most significant service gap in this area is the need for the re-introduction of the Family Group Home model. For Alice Springs this is a case of “back to the future” as this type of service used to exist at St Mary’s. There is an urgent need for a Family group home model with house parents with carers who are skilled, well supervised and paid and have good professional development opportunities. There should be no more than 6 children per house. There would also need to be adequately funded respite carers for carers who had annual leave, sick days, days off for PD, etc. This complex might also include housing for families who need safe accommodation so that they can adequately care for their children themselves. And safe accommodation for older people who do not need nursing home care and want to be living with their families.

In addition to the Family group home model there also needs to be the option of extended day care services where children at high risk can be placed and where it has not been possible to support parents to care for their children’s education and development needs in particular in a satisfactory way. Such services would provide the children with their 3 daily meals and be open from 7am until about 9pm. Children would sleep at home and parents can be engaged in a way that maximises their involvement but in many cases they would not be able to become regularly involved due to alcohol abuse or other problems. In all cases parents should be free to come and go as they please but the goal is to ensure that children are well cared for during the day and have a positive social environment. This approach has been shown to be effective and such services are currently being run by the Victorian Child Protection Society in poorer suburbs of Melbourne.

It is also important to recognise that the current NTFC approach is taking children into and out of care is compromising children’s developmental outcomes because children are changing carers at critical attachment periods early in life. This is a very unsatisfactory situation and needs to stop.

3. Staff turnover and unfilled positions within NTFC

It appears that there have been major problems with NTFC with unfilled positions and staff turnover. Congress believes that the level of remuneration being offered to staff may still be inadequate in some cases and this is part of the problem. This seems to be especially the case for the front line staff who seem to be paid significantly less than those in managerial and administrative positions. However, other more significant issues that need to be addressed include:

1. A clear and manageable case load limit for staff
2. More flexible hours
3. Taking on call role off front line service staff
4. Rotating staff through different areas so they are not always on child protection
5. Better supervision and support
6. Better orientation to address the lack of corporate memory
7. Better professional development opportunities

4. Quality Improvement

It seems that there has been no consistent, regular, transparent quality improvement process within NTFC. Congress believes that there needs to be regular auditing of complex cases open to all service providers to participate in. In addition, NTFC needs to ensure all cases are reviewed every 3 months and these reviews could also include appropriate NGO's when they are involved in the care being provided. Care plans should be updated through these reviews and every child in care needs to have such a care plan which should be circulated to all the providers involved in the care. Such a process would identify the issues raised by Congress in the attached letter of complaint to NTFC around four specific cases (names have been removed).

Currently, intake assessment is a one way street with no feedback or inadequate feedback to referring organisations.

Another major problem that Congress has identified is that children in the care of NTFC do not get adequate medical follow up arranged for them. These concerns can be identified and addressed through a regular file audit process that is inclusive of key service providers such as Congress.

5. School attendance

Regular and consistent attendance at school is a major strategy to better protect children including the ability to identify problems early. Probably, the major reason why some Aboriginal children become non attenders is that they are not able to achieve at the same level as the other children due to reduced brain development as a result of their early childhood experiences. In the very recent study referred to earlier Marmot (2010) has identified that the IQ of children develops dramatically from birth and is very dependent on certain key interventions in the early social environment. This includes:

1. Being read to every day prior to pre-school
2. Going to bed at the same time every night and ensuring adequate sleep
3. Good socialisation with other children of the same age
4. Regular physical activity
5. Attendance at pre-school

These are basic good parenting skills that unfortunately some Aboriginal and non Aboriginal children miss out on. Marmot shows that missing out on these things affects brain development and leads to children being unable to effectively learn in primary school for a range of reasons including lower IQ, the development of behavioural problems and social and emotional problems. These children are then the

ones who drop out of school because that are at the bottom of the education hierarchy. School makes them feel inadequate compared to others and they can be ridiculed as a result. They then take to the streets and get into alcohol and other drugs and other risk behaviours. They are the kids who also get into trouble with the law. This is a predictable consequence of the poor early social environment that these children have grown up in and is amenable to many of the interventions already described in this submission. However, in addition to home visitation, parenting programs and other services consideration should be given to making pre-school attendance compulsory at 3 years on for children from low socio-economic backgrounds and 4 years on for all children.

There also needs to be an adequate response from NTFC when children who are not attending school are reported, especially in the pre-school and primary years. At present, Congress is aware that many school principals have stopped reporting to NTFC because they say that NTFC cannot do anything. In this regard Congress wants to be part of a dialogue about the need to give NTFC the power, as a last resort, to apply non criminal consequences to parents who do not send their children to school where it is clear that quality schools are available with adequate teacher numbers and class sizes for their children to attend. Such powers would only be used after the whole range of targeted family support and alcohol treatment services where needed, have been tried and failed due to lack of engagement. Once it is clear that parents are either not willing or not able to engage in these types of service due to reduced cognitive ability then Congress wants to be part of a dialogue to further consider whether NTFC should be able to quarantine the income of such parents up to 100%. They could also be able to apply alcohol prohibition orders if necessary as well. Again, this should be done in a manner that rewards improved school attendance with a reduction in these measures over time. As before, this should be introduced as a well evaluated trial over 2 years and only kept in place if there is evidence for its effectiveness.

In addition to this, Congress believes that we need to build on the apparent success of the Bradshaw Primary School Irrkelantye model which has dramatically improved regular school attendance for Aboriginal children and has a waiting list of over 30 children. There needs to be a similar Aboriginal unit in every pre-school and primary school with parents and grandparents able to attend and adequate Aboriginal staff employed. This is an essential part of making quality schools available for all children.

6. Legislative reform

Finally, as mentioned earlier there needs to be legislative change to enable child protection to be applied to parents who are neglecting either the unborn child or their children. Congress understands that this legislative reform has already occurred in Victoria to enable the child protection provisions to apply to the unborn child.

Congress has many services now in place but still some pregnant women continue to drink heavily even when they have already had several low birth weight, brain damaged babies. There are parents who are also neglecting their children and refusing to engage in appropriate services and case management. We cannot just sit back and watch this occur. In a similar way there are pregnant women who refuse treatment for

a diagnosed STI placing them at serious risk of premature labour, a low birth weight baby and stillbirth. These need to be considered child protection issues.

In these cases NTFC and the child protection system needs to be able to intervene and provide consequences for this behaviour that is outside the criminal justice system but could lead to improved behaviour. Congress is still not certain what types of consequences are the most appropriate and wants to be part of a further dialogue with government about this. The consequences outlined in this submission are for further consideration and would only be applied as a last resort and as part of case management and effective service provision. If it was agreed that this was a useful and potentially effective way to go then in order to give the necessary powers to NTFC there would need to be legislative reform and there may be a need to refer some parents to the alcohol court for this to occur. In the latter case the alcohol court would need to be reformed to be able to deal with non criminal matters and apply non criminal sanctions but a better approach would probably be to establish a process completely outside the court system for this function. This perhaps could be a Family Responsibility Commission type structure.