Disparity and disadvantage – the context for child protection in the Northern Territory

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Acknowledgement of the Larrakia people, Traditional Owners

Overview of presentation

1. The local context and demand drivers for child protection

2. Key Child Protection reforms arising from the Inquiry into Child Protection relating to the role of NGO's

Introduction

Since working on the Inquiry last year I have been increasingly interested in the context in which child protective services operates, especially the circumstances for children and families which act as **demand drivers** for child protection services. So before I look at some of the reforms and developments in child protection, I'd like to review some of the facts on the ground, particularly those that relate to the circumstances of Aboriginal children and families in the NT.

The arena of **policy development around Indigenous disadvantage** is a fraught one with no shortage of strongly-held opinions and beliefs – I guess 'arena' is an apt description. The pros and cons of the intervention are frequently played out in the national media, with a lot of recent comment related to the Opposition Leader's call for a new Intervention; the merits of directing infrastructure funding to the 'growth towns' are hotly disputed; there are ongoing controversies around income management; and, of course, there are ongoing battles over alcohol management policy with almost daily media comment and political posturing.

I do think that we need to be clear first about the facts of what is happening before we proffer our opinions and solutions. The late American senator and social commentator Daniel Moynihan once famously remarked when involved in some international controversy at the United Nations, "everyone is entitled to their own opinion, but not to their own facts." So I thought I'd start here with

some facts about children in the NT to consider before we move on to responding to the need as part of the child wellbeing and protection sector.

A trawl through the available research on the wellbeing of children in the NT is a truly sobering experience. I am convinced that the situation for children in the NT, and particularly Aboriginal children, is dire if not catastrophic – it's not just sexual abuse (the ostensible trigger for the Intervention) but just about every indicator of safety and wellbeing. Bits and pieces (about sexual abuse, the impact of alcohol use or violence) regularly find their way into the local and national media, but a comprehensive picture is rarely provided.

The following data are from a number of sources including NT Government and Commonwealth publications, Menzies School of Health Research, the ABS, and the NT Child Deaths Review and Prevention Committee. They highlight the absolute disadvantage experienced by Aboriginal children and families (particularly those in remote areas) as well as the disparity with respect to the non-Aboriginal children in the NT and, indeed, Aboriginal children in the rest of Australia.

Covered here are just a few of the developmental hazards that need to be survived and successfully negotiated by Aboriginal infants, especially those in remote areas. I apologise if this appears to be yet another 'misery index' (Beadman, 2011, p. 43) – but we do need to start with the facts.

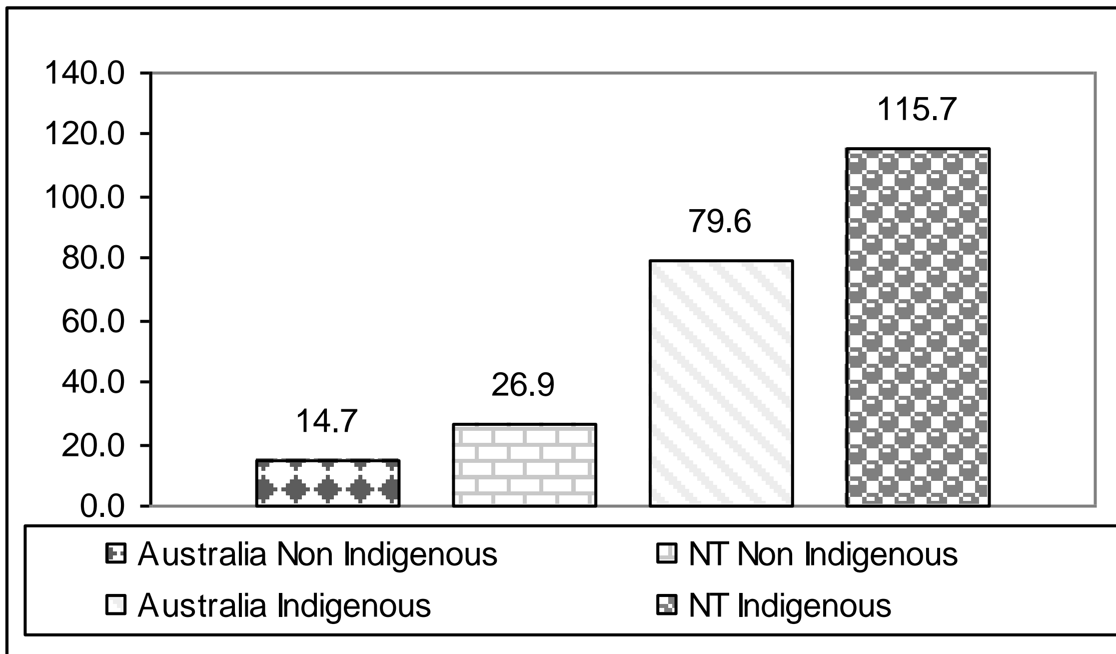
First a Caveat – the blaming of individuals, communities, or even governments.

In presenting this data I have some misgivings, being aware that this sort of information can sometimes be used to vilify and blame Aboriginal people for the predicament they find themselves in or, less subtly, to blame particular services or governments for their alleged failures. In presenting the facts I am in no sense indulging in 'victim blaming'. Indeed, I am acutely aware that the current malaise has its roots in the cultural, social and economic depredations experienced by Aboriginal Australians over the course of our nation's history. The purpose of this discussion is to stimulate discussion and solution-finding based on an honest appraisal of the facts as they pertain to vulnerable children and families across the NT.

Young mothers

If we look at prospects at the start of life, the research is clear that children born to young, especially single, mothers, are going to have a much rougher time of it. They are more likely to be poor, to experience multiple caregivers, to experience abuse and neglect, to have poor school performance and to have behavioural problems (AIHW, 2009, p. 64).

Fig 1. Birth rates for women aged 15-19 by Australia and NT

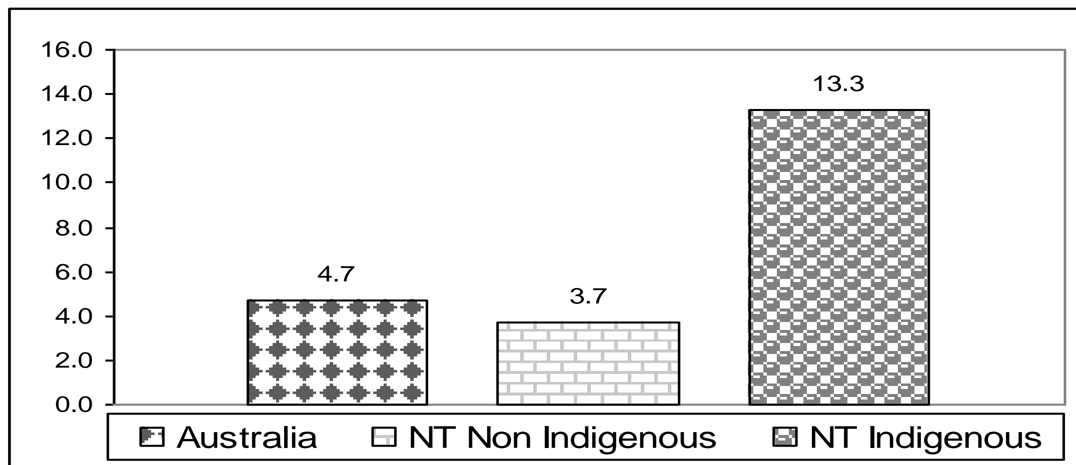


Per 1,000 females aged 15-19
Source: AIHW 2009, p. 164

Infant mortality

For many years infant mortality rates in the NT have soared above those of the rest of Australia. Whereas the rates for non-Indigenous NT babies are similar to the Australian average, the rates for Indigenous babies are approximately double the Australian average.

Fig 2. Infant mortality rates Australia, the NT, Indigenous NT



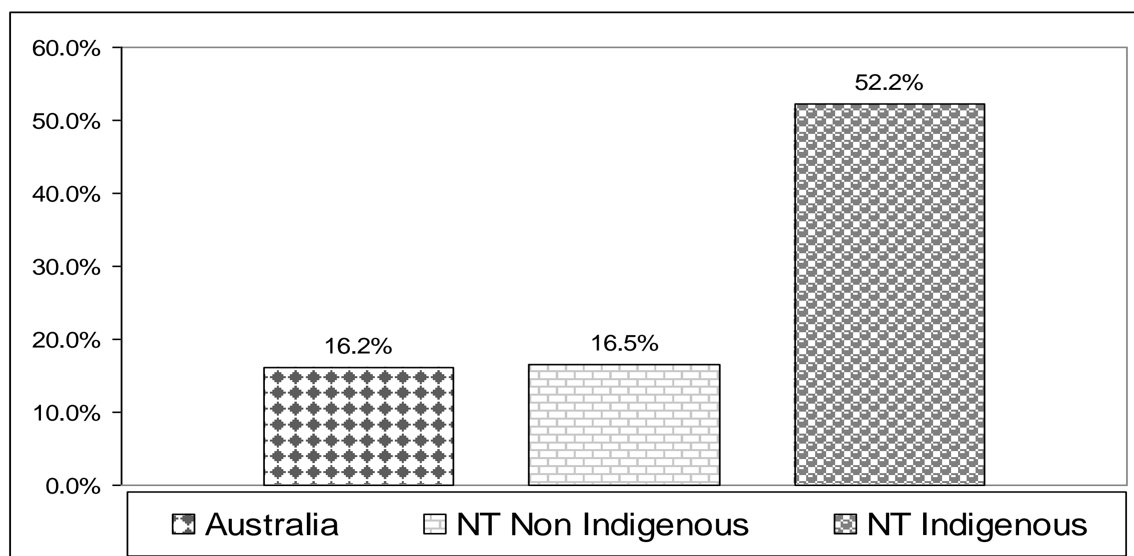
Per 1,000 live births
Source: AIHW 2009, p. 161, NT CDRPC 2010

It should be noted that death rates for Indigenous children in the NT are significantly elevated across **all child age group categories**, with deaths mainly resulting from accidents and suicide. The Annual report of the *South Australian Child Death Review Committee* just came across my desk. The child death rate in SA stands at 35.0 per 100,000. The NT CDRPC (2010) reports that ours in the NT is 82/100,000. There are indications that the suicide rate amongst young people in the NT is by far the highest in Australia and possibly one of the highest in the world.

Smoking

Smoking during pregnancy has clearly been demonstrated to be a developmental hazard and nicotine is known to be a teratogen. It has been estimated that nicotine concentrates in the foetus at 15 times the rate that it does in their mothers (Huizink & Mulder, 2006). I saw a recent estimate that smoking contributes more than three times the variance in poor health outcomes for Aboriginal people than does alcohol misuse. Smoking during pregnancy leads to infants who have a greater risk of mortality and low birth weight; children with sleep problems; and those with externalising behaviours such as irritability, drug dependence and conduct disorder (Christakis et al., 2009;Roza et al., 2009; Stone et al., 2010; Stroud et al., 2009).

Fig. 3 Smoking during pregnancy Australia, Non-Indigenous NT, Indigenous NT



Source: AIHW 2010 and supplied by NT Dept. of Health, Health Gains Planning 2011

Figures contained in the NTER Monitoring Report to December 2008 (NTER 2009, p. 9) indicate that three out of four children in remote areas and town camps are living in households with a smoker.

Alcohol

Alcohol ingestion likewise is known to have a significant impact on the developing foetus, often leading to still births, low birth weight, small head circumference and other developmental problems. In childhood and adolescence other impacts have been clearly documented including a significant association with poor cognitive functioning (e.g. learning, judgement and decision-making), social skill deficits, antisocial behaviour and criminality (Streissguth & O'Malley., 2000). Foetal Alcohol Spectrum Disorder (FASD) is considered to be the leading known cause of intellectual disability.

In 2006-07 the average Australian consumption per adult (over 15 years) was 9.88 litres of pure alcohol; in the NT it was 14.35 litres and excessive drinking is a problem for both the non-Indigenous and the Indigenous population (Stephen Skov et al., 2010.

Amongst the Indigenous population of the NT the average consumption was 16.1 litres, despite around 50% of that population group not drinking at all (ABS, 2010).

To put this another way, as 1 litre of pure alcohol equates to almost 3.8 bottles of spirits, the average adult in the NT consumes approximately 51 bottles of spirits per year or 32 cartons of full strength (5%) beer.

Focusing on Indigenous adults we know that half do not drink at all, so that that the remaining 50% of adults consume the average equivalent of over 120 bottles of spirits each year (3.8litres by 16.1 by 2) or 75 cartons of full strength beer.

According to Skov et al (2010) in the *Medical Journal of Australia*, non-Indigenous people in the NT die from alcohol-related conditions at a rate that is more than twice the national average, but the mortality rate for Indigenous Territorians is 9-10 times higher than the national average.

The available data provided the NT Department of Health (Health Gains Planning) suggests that around **6.4% of non-Indigenous mothers** self-report using alcohol during pregnancy compared with **13% of Indigenous mothers**, In addition, patterns of dangerous binge drinking are reported to be more prevalent in the Indigenous community.

Other hazards

There are so many other hazards that confront young Indigenous infants as they set out on life. I could mention the seriously high rates of **otitis media** affecting up to 90% of children affected in some communities, leading to mild or moderate hearing loss and a subsequent impairment of behaviour and performance at school (Morris et al., 2005). Or there is the chronic and

preventable, diet-related problem of **anaemia**, with average rates of diagnosis being around 22% (Silburn 2011, p. 4) and reaching 40% in some areas. Such children are likely to have impaired cognitive abilities, school performance and motor coordination and major health repercussions later in life.

There are other pressing problems related to diet. Recent research (Malik, 2010) indicates that just one sugar drink a day (Coke, cordial or sweetened fruit juice) results in a 25% increase in the risk of diabetes – many of our children in the NT have much more than one per day. I could go on but there is a particular developmental hazard for NT infants and young children that does not get the media attention that it deserves.

Complex trauma

What would you suggest is the 'most pressing public health problem in the western world today?'

Bessel van der Kolk (2005a), one of the premier researchers into trauma and child development, has suggested that it is the **chronic exposure to violence** and the developmental sequelae. If it is such a problem in the wider society how much *more* of a concern is it in remote communities and town camps where violence is endemic – and where, to use Bruce Perry's apt phrase, so many infants and children are 'marinated in fear'?

The following is a quote from a prominent Aboriginal author and community member in the NT, Marie Munkara, from an article published in the NT News. Marie is passionate about the issue of family violence and she is happy for the piece to be used as she believes it is time to face the facts of endemic violence:

"My brother is in jail for murder, my uncle is in jail for murder, my cousin is in jail for murdering five members of our family, my promised husband is in jail for paedophilia, my cousin has served time for raping a 13 year old girl, and bashing people is a favourite pastime of my 12 year old niece…violence is spreading like a disease throughout the Indigenous population…we are infecting everyone…We live it and breathe it every day, our babies are soaking it up at their mothers' breasts, our children are practising it on each other in the playground, our teenagers are happily putting into practice what they have learned from us…Our children, our families, all deserve better than this…"

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NT News (2008, p. 29)

Neurodevelopmental research has demonstrated how exposure to chronic stressors such as direct abuse and neglect and exposure to family and community violence has devastating consequences for the developing child. Such exposure affects multiple developmental domains including *the ability to bond/attach to caregivers; the ability to trust; cognitive functions; behavioural and emotional regulation; and self-concept.* (Cook et al., 2005)

The **core outcome** for trauma-exposed children as they grow into adulthood is an **impaired ability to safely and pro-socially regulate emotions and impulses** (Schore 2003, p. 141; van der Kolk, 2005b, p. 403) – fear escalates to terror, irritation rapidly transforms into rage, sadness morphs into despair. **What do we see?** Huge numbers of people involved in reactive, impulsive violence including physical assaults, road rage, hitting and shaking infants; suicide rates that are arguably the highest in the world; and rampant substance misuse as a coping mechanism.

Compelling recent research indicates that where children have an impaired ability to regulate and maintain self-control (as happens with exposure to chronic violence) they significantly more likely to have poorer overall physical and mental health, and as they grow up, a greatly reduced capacity to learn and to hold down a job and a much higher risk of criminality (Moffitt et al., 2010).

Most of the current **Night Patrols** were funded and established by the Commonwealth government to “improve personal and community safety” (ANAO, 2011, p. 13) in Communities and town camps. The recently-released Auditor General’s review of the Northern Territory Night Patrols found that in the one year period to June 2009 the patrols assisted an astounding **75,220 people** (ANAO 2011, p. 16) – that is in a target population of around 29,000 adults in the NTER zone.

Rampant violence is seriously compromising the present security and the future prospects of numerous children across the NT. There are many causes for the high violence rates including the phenomenon of ‘lateral violence’ resulting from community dis-empowerment and the inter-generational re-enactment of trauma, but clearly the role of alcohol remains a key policy target given that around 60% of all reported violent episodes and 67% of all domestic violence are related to the misuse of alcohol (Beadman, 2011, p. 43). To the credit of the NT government, there is a strong commitment to developing practical measures to address the scourge of the “beverage of mass destruction” (Beadman, 2011, p. 42) despite the inconveniences these may pose to some in the broader NT community.

The Australian Early Development Index

We now have a new set of objective wellbeing indicators that can help us to map the developmental needs and vulnerabilities of children in various regions across Australia. They are not perfect (as they do not include very

young children or those who do not attend school) but they do give us some means for assessing the relative vulnerability of children.

The Australian Early Development Index (AEDI) provides a population-based assessment (that's much more reliable than a sampling method) of children across 5 developmental domains:

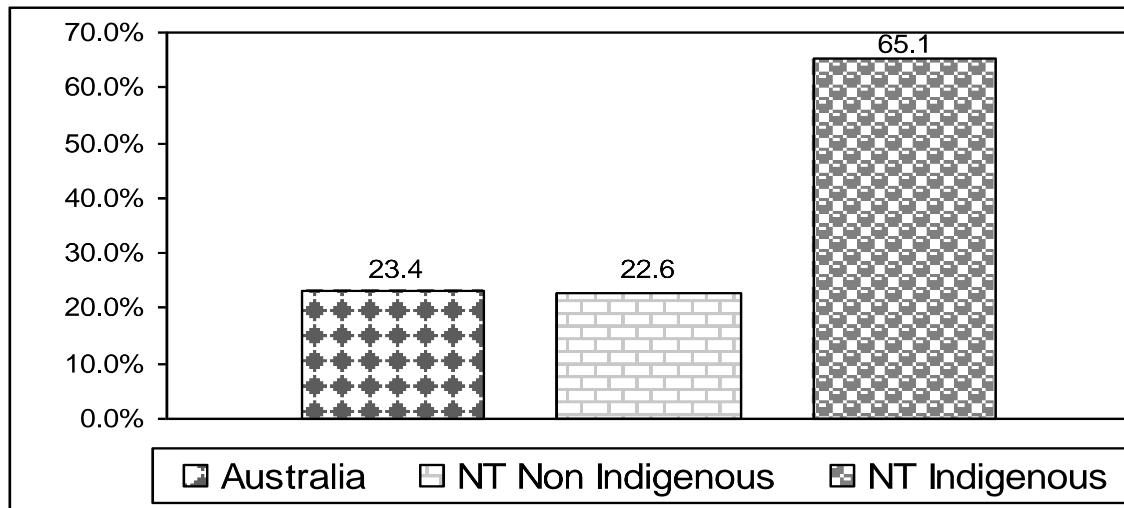
- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive skills
- general knowledge

Data are provided for each domain and for one or two or more areas of developmental vulnerability.

Here are some current data on children with one (or more) developmental vulnerabilities (i.e. where they score in the lowest 10 percent nationally). The data are adapted from Silburn, McKenzie and Moss (2010) of the Menzies School of Health Research, in a publication prepared for the Northern Territory Government.

For our purposes, the AEDI could be seen as a measure of the cumulative impact of the hazards outlined above. The picture for the NT as a whole is worrying, that for regional and remote areas is positively alarming.

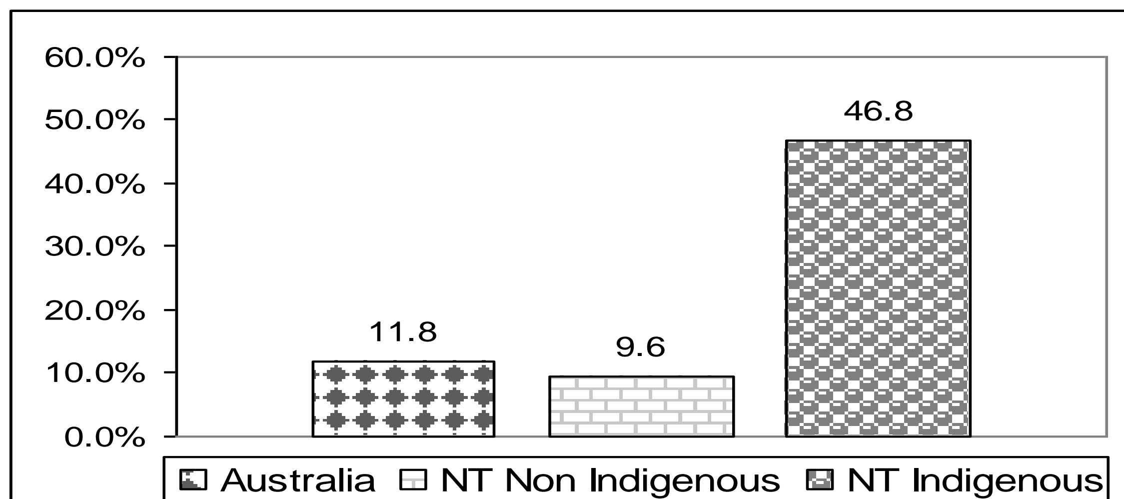
Fig 4. Percentages that are developmentally vulnerable in one or more domains



Source: Silburn et al., 2010

For Australia as a whole the percentage vulnerable in one (or more) domain is 23.4%; for NT Non Indigenous children is it 22.6%; For NT Indigenous children it is a whopping 65.1%.

Fig 5. Percentages that are developmentally vulnerable in multiple domains (2 or more) and are likely to need special assistance at school

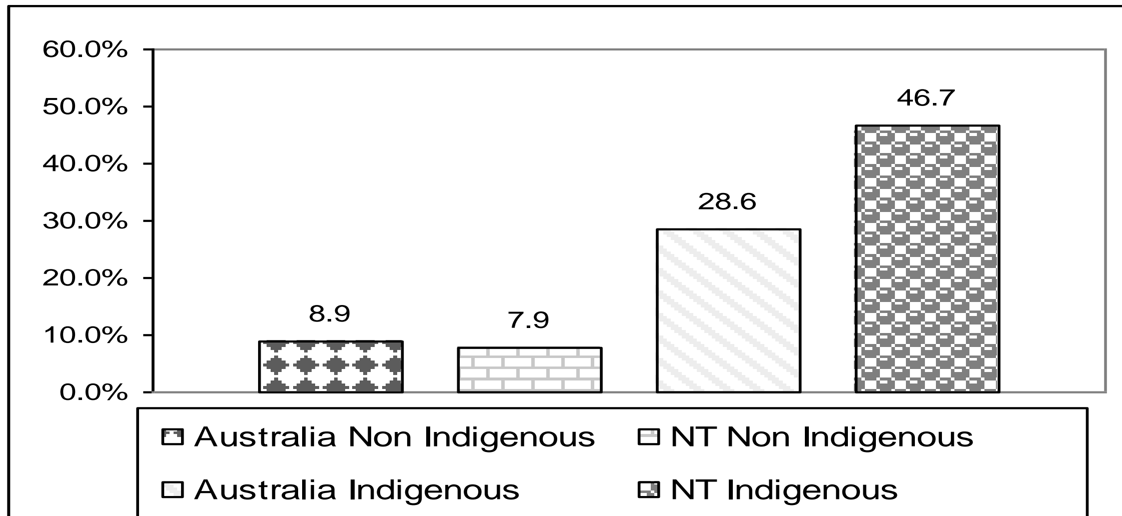


Source: Silburn et al., 2010

Again, for children who are vulnerable in *multiple* domains, the NT non-Indigenous population has slightly better results to those of Australian children as a whole (9.6% vs 11.8%) whereas in the NT Indigenous population close to half have multiple vulnerabilities.

Language and cognitive function is a developmental domain that is critical to school success.

Fig 6. Percentages who are developmentally vulnerable in the 'language and cognitive function' domain.

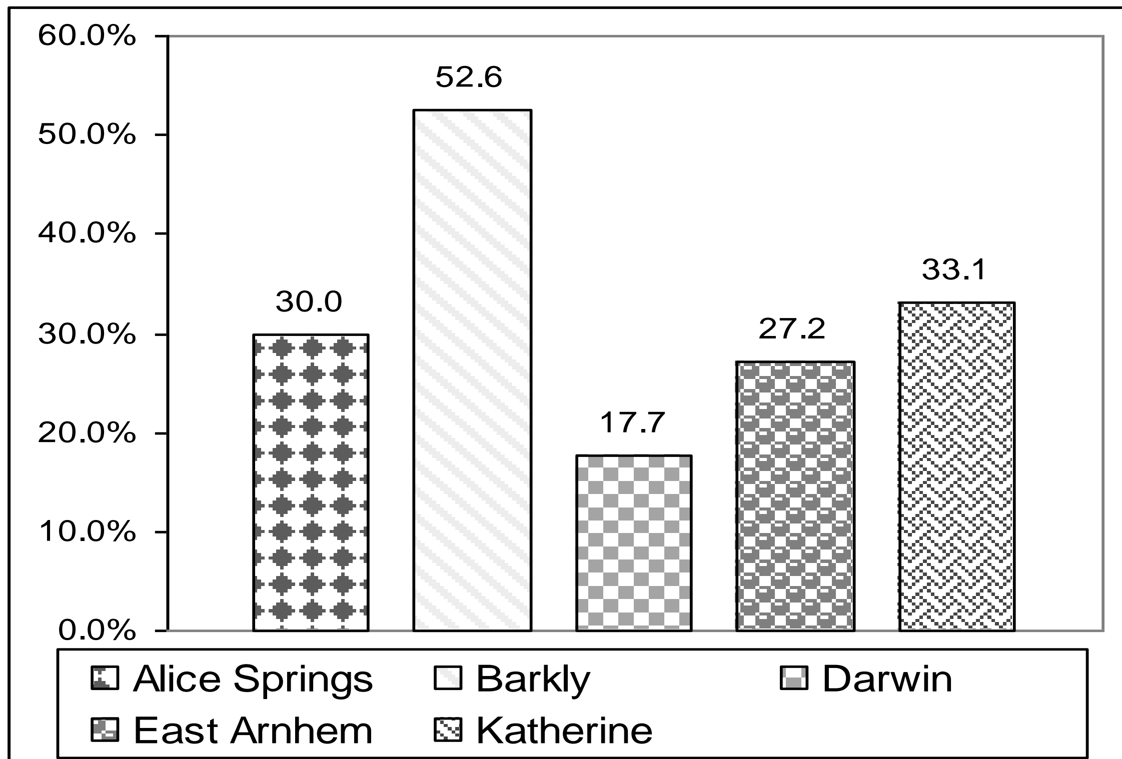


Source: Silburn et al., 2010

It can be seen that close to half (46.7%) of the Indigenous children in the NT are vulnerable on this critical domain, a much higher percentage than their Indigenous counterparts in the rest of Australia (28.6%).

There is an uneven distribution of vulnerability across the NT as seen in the following figure. These numbers are a little hard to interpret as there are mixed populations in all areas.

Fig 7 Percentages that are DV in multiple (2 or more) domains by NT region



Source: Silburn et al., 2010

It needs to be pointed out that the results for remote Indigenous children are really **much worse than are presented here**. The ratings are done by teachers who have a good, recent knowledge of the students. Thus, the large cohort of unenrolled children are not represented at all, nor are those with very poor attendance.

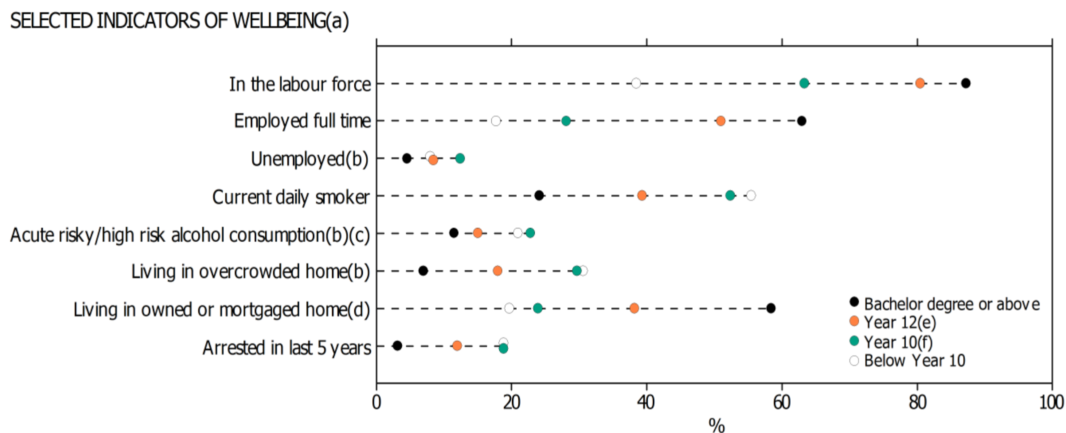
The role of formal education

I have reviewed just a few of the facts about children and families in the NT. We all know there are no simple solutions but there are some clear directions for the way ahead. Education (both formal and informal) has to be at the forefront. Education must include broad community-based education campaigns as well as programs aimed at educating and training parents, but I want to focus for a moment on formal schooling.

Recent research has clearly demonstrated an almost linear relationship between level of education and outcomes on many indicators of wellbeing – and this is particularly true for the Indigenous population.

The following graph is adapted from a recent ABS publication on Australian Social Trends (ABS, 2011):

Fig 8. Indigenous educational attainment by selected indicators of wellbeing

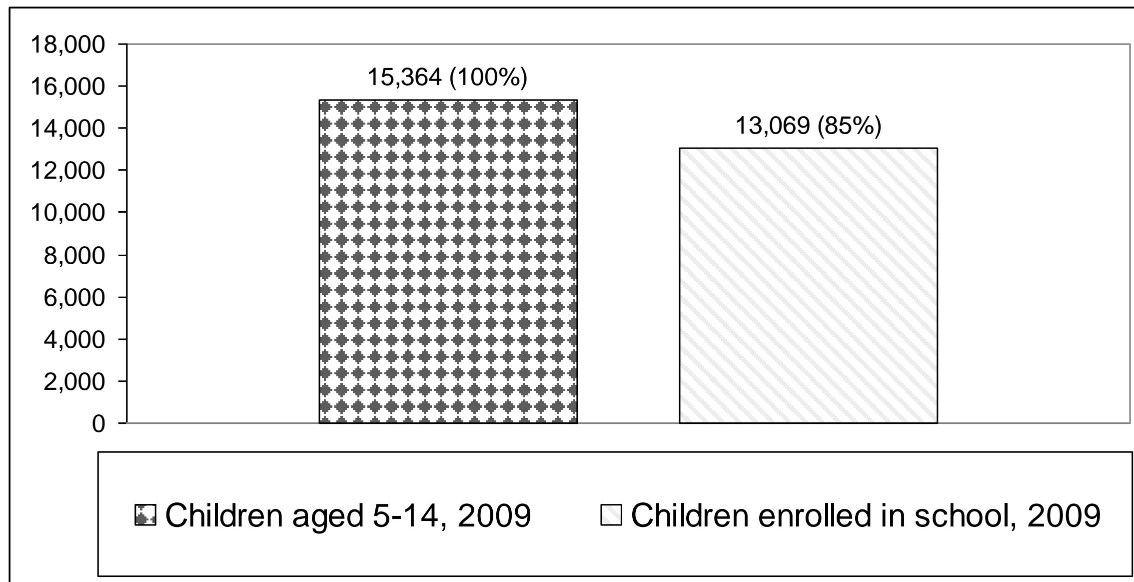


Source: ABS 2011

Here we can see that there is a very strong, even linear, relationship between educational attainment and wellbeing, and this graph is specific to Indigenous people across Australia. I am aware that remote communities in the NT present unique challenges with respect to wellbeing indicators, for example, even with a good education it is hard to rent or buy a house and access to work is limited. However, the existing data present a very **powerful case for prioritising education** in any gap-closing initiatives – that is, we need a focus on improving the quality and relevance of the education provided, the upgrading of physical plant, recruitment and retention of teachers, broader community education about the importance of education and laws requiring attendance, the development of local, place-based attendance measures (e.g. ‘no school, no shop’), and truancy initiatives in addition to Territory and Commonwealth incentives and disincentives.

So what do the NT attendance figures reveal? Please bear with me as I review few more confronting statistics.

Fig 9. School enrolments for Indigenous children aged 5-14 years in the NT



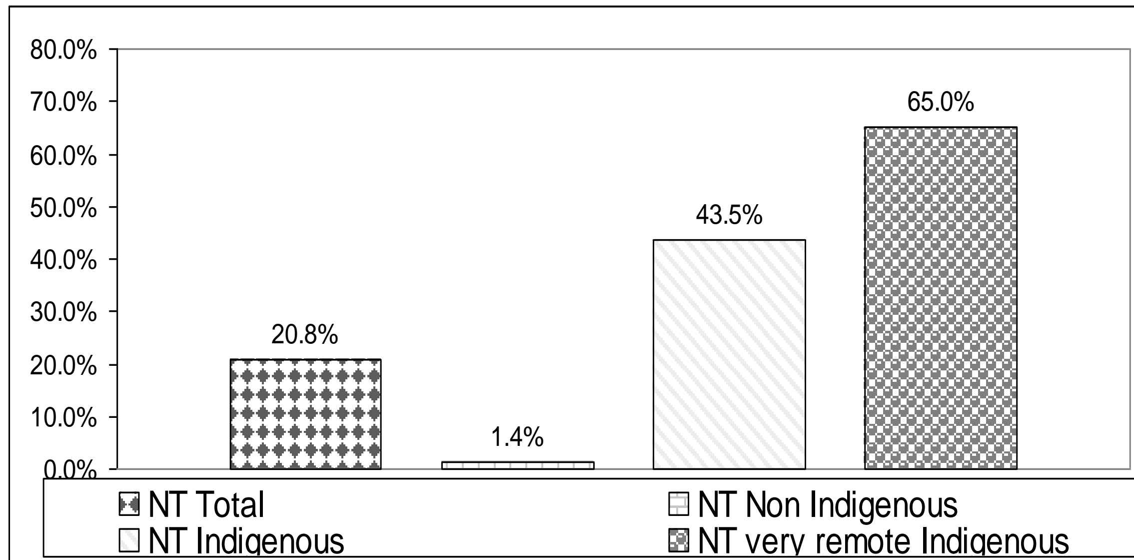
Source: NT Department of Education and Training 2011
Note: Although every attempt has been made by DET to ensure the accuracy of these data, they should be considered estimates.

The first challenging statistic, as mentioned above, is that around 2,000 or 15% of all school-aged Indigenous children in the NT do not appear to even be enrolled in school at all. **How can this be acceptable to anyone who cares about the safety and wellbeing of children?** I notice that the Coordinator General has expressed his disbelief that under the SEAM (School Enrolment and Attendance Measure) enrolment measure there have only been two suspensions of income support to date so that the 'stick' piece of the 'carrot and stick' measures is meaningless (Beadman, 2011, p. 9).

The following graphs illustrate the current attendance patterns for Indigenous children who are enrolled in the NT, with data adapted from DET and ABS tables. Again, to me they are another aspect of the developing catastrophe. Formal education is the most obvious path out of disadvantage, a fact that is apparent right around the world across cultures, ethnicities, and nations. The clearest pathway to redressing disadvantage is blocked for a significant proportion of Indigenous children.

It is unlikely that a child who attends school less than 60% of the time is going to make any significant progress. Here are some NT data on enrolled children who attend school less than 60% of the time.

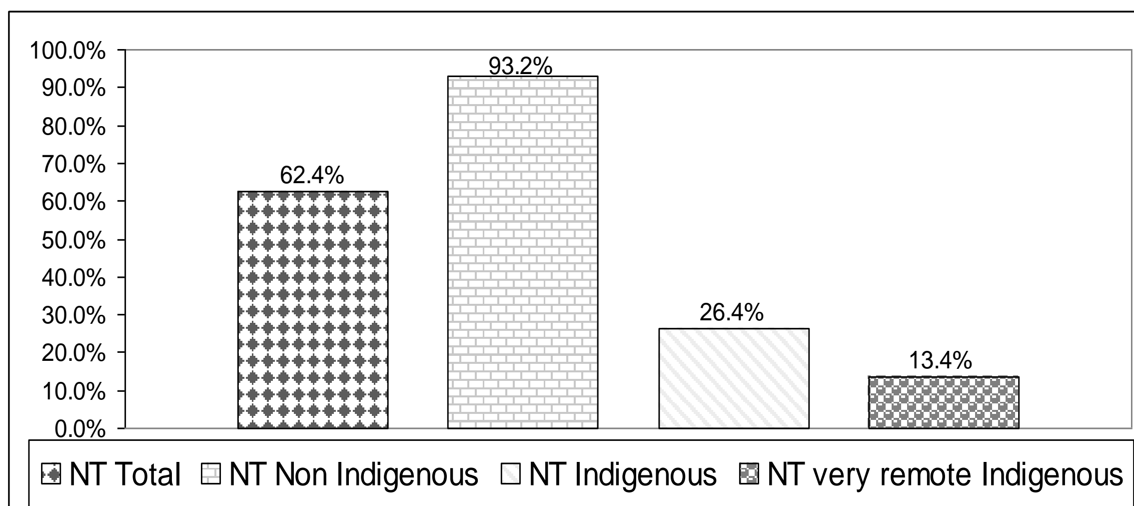
Fig. 10. Percentage of NT enrolled children attending school less than 60% of the time, NT 2010



Source: NT Department of Education and Training 2011
Note: Although every attempt has been made by DET to ensure the accuracy of these data, they should be considered estimates.

The disparity between non-Indigenous and Indigenous children is stark. **Is it really possible that 65% of very remote Indigenous attend school less than 60% of the time?** By the way, nearly 6,000 (5,970) or 60% of NT Aboriginal children are classified as living in very remote locations.

Fig. 11. Percentage of NT enrolled children attending school more than 80% of the time, NT 2010

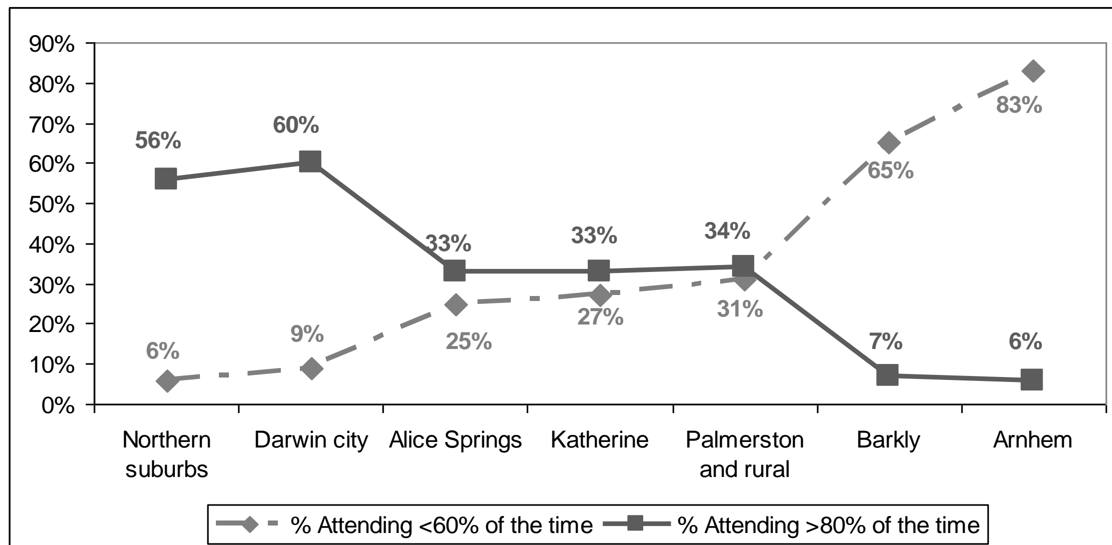


Source: NT Department of Education and Training 2011
Note: Although every attempt has been made by DET to ensure the accuracy of these data, they should be considered estimates.

Again, the differences between non-Indigenous and Indigenous children are stark with a 67 percentage point difference. Only 13% of Indigenous children (one in seven) in very remote areas have anything like a reasonable attendance (between 80 and 100%).

Figure 12 illustrates attendance patterns for Indigenous children by region. It can be seen that there is a great deal of regional variation.

Fig. 12. School attendance of enrolled NT Indigenous children by region, 2010

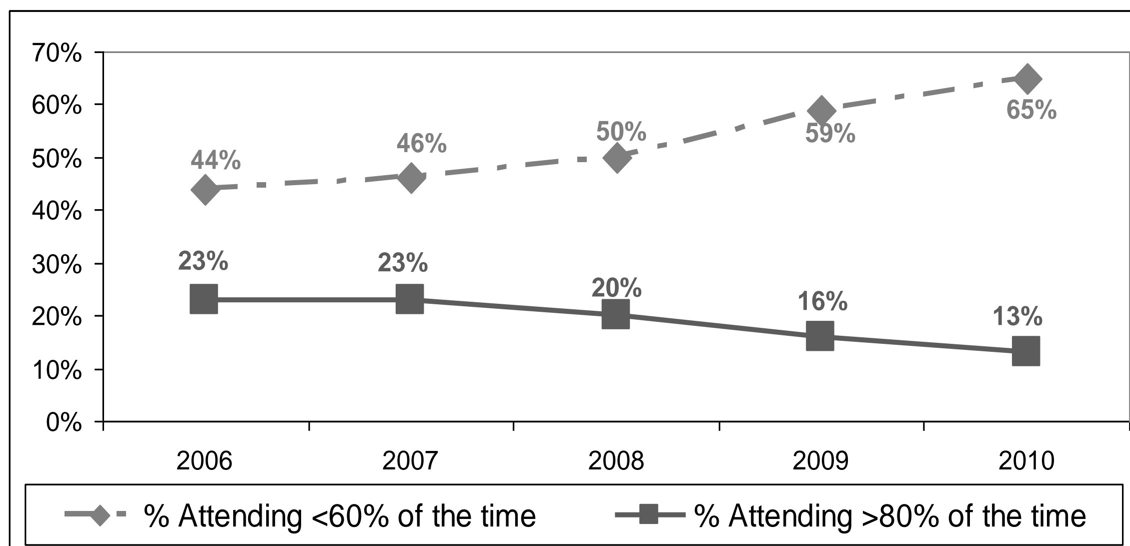


Source: NT Department of Education and Training 2011
Note: Although every attempt has been made by DET to ensure the accuracy of these data, they should be considered estimates.

None of the regions is particularly impressive but **what can I say about the numbers from Arnhem and Barkly?** - these children are getting negligible schooling.

Placing the current attendance rates in the context of data from the last five years gives us a clear sense of the direction in which engagement with formal education is heading.

Fig. 13 School attendance of very remote Indigenous children in the NT by year



Source: NT Department of Education and Training 2011
Note: Although every attempt has been made by DET to ensure the accuracy of these data, they should be considered estimates.

The attendance trajectories for very remote Indigenous children carry a clear and unambiguous message – formal education, one of the few protective factors available to very remote children, is rapidly becoming an irrelevance.

Conclusion

So what do all these facts and figures tell us? As I said earlier, in my view they are all symptoms of a catastrophe. Last year's BOI referred to a 'tsunami of need' that is overwhelming the Indigenous population - that is not exaggerating the situation.

How can the gap be closed when we have a generation of children (now 43% of the NT population) with such devastatingly poor prospects for health, safety, and education, and that's before we even consider systemic issues such as the lack of housing, welfare dependence and negligible opportunities for employment?

Do such circumstances constitute the grounds for a new or renewed Intervention such as Tony Abbot has called for? Words such as 'emergency' and 'intervention' have now become so politically charged that it is hazardous to use them but I cannot see that the circumstances on the ground amount to anything less than an ongoing crisis that calls for an extraordinary response.

I accept that a lot of positive work is being done at the community, Territory and Commonwealth levels, the Coordinator General's reports on Remote

Service Delivery attests to that, but, in my view, the pervasive nature of the problem, particularly in town camps and remote areas of the NT, calls for more than a limited ‘emergency response’ – it requires a multi-year, multi-government development program based on a considered, rather than a news-bite-filtered, appraisal of the needs; that addresses a range of economic, social, safety and wellbeing needs; that is based on genuine consultations with Aboriginal communities; and that harnesses the skills and perspectives of both NGO and government service providers as well as academic and research institutions. I note that the Indigenous Policy Minister, The Honourable Malarndirri McCarthy, recently called for a new “grass roots” intervention.

Child protection services in this context

I have reviewed these depressing statistics because they help to define the context in which child protection services operate. If the primary efforts of government are not directed at addressing these hazards, formal child protection services will never be able to keep up. Although it is sometimes a public expectation, Child Protection Services cannot be expected to address the broader circumstances of disadvantage.

I would like to briefly highlight just **three major Child Protection reform areas** arising from the Report that encompass several specific recommendations. Each has special relevance to the NGO sector represented here today.

1. The development of new services

The recent BOI highlighted the need for a range of services at the primary, secondary and tertiary levels. There was a lot of discussion about the need for the development of primary and universal services - It is heartening to see that there is a lot of movement in this space, a lot of it funded by the Commonwealth and delivered either through the local NT Health and Education Departments or by NGO’s under contract.

Of the 147 recommendations of the recent BOI, The one for me that stands out as the most critical one is 6.3. It reads, in part:

> *That the Northern Territory Government makes a very significant and sustained new investment in the development (and expansion) of a suite of secondary prevention, tertiary prevention, therapeutic and reunification services for vulnerable and at-risk children, families and communities…*

Someone asked why we did not make more specific recommendations regarding new universal or primary services. There were reasons for that, and one is that the traditional primary-secondary-tertiary dimension is not as relevant in remote communities as it may be elsewhere. As the data indicate,

virtually all children in some remote areas are at risk so we cannot be too precious about demarcations between the service levels. Secondary prevention simply means a service designed for a population deemed to be at risk, for example, families afflicted with the array of challenges outlined earlier.

The recommendation went on:

The majority of these services should be provided by the non-government sector…

And should include:

Intensive maternal and child support, therapeutic services for children, youth and families, substance abuse treatment, parenting skills development, intensive family preservation, targeted family support, and community development and healing (around issues such as sexual abuse, alcohol abuse, neglect, domestic violence and gambling).

This, the most detailed recommendation, went on to specify that the planning for these services needs to be based on a set of principles that included intensive consultation with all stakeholders, the active involvement of the community recipients of the services, a focus on capacity-building within communities, and longer-term funding cycles.

I was recently asked what I thought was the most critical recommendation of the BOI. Well, in my view, if in three years time we do not have a significant new array of support and therapeutic services for vulnerable families and children, especially those living in remote areas and town camps, then the reforms will have been a failure.

2. New ways of doing business

The second key area of reform relates to **new ways of doing business**. If there is a significant boost in family support and therapeutic services over the next few years this should enable the **development of a dual pathway** referral and support system).

Dual pathway referral and support pathways
Community Child Safety and Wellbeing Teams
Hospital Child Safety and Wellbeing Teams

Currently where a family or child is in need, anyone can refer that child to the Central Intake service of DCF. In three years time I would hope that an **alternative referral pathway** for families can be established so that they can receive services outside of the statutory system where a child is not at significant, immediate risk.

I expect that vulnerable NT families and children will be assessed and supported by many of the agencies represented here today as an alternative to statutory involvement. This may involve the commissioning of an NGO to establish a service 'gateway' as is the case in Victoria, NSW and Tasmania.

Perhaps the most radical change with respect to child protection is the establishment of **Child Safety and Wellbeing Teams** in the growth towns and major urban hospitals. In the communities, these teams will be interdisciplinary ad inter-Agency in nature and involve Health, Education and other workers as well as qualified community members. They will have a sound local knowledge and will be able to work closely with DCF where are child is deemed to be at significant risk.

In the **hospitals** it is hoped that the CSWT teams will provide an inter-agency, inter-disciplinary intake and referral function especially around complex cases and by so doing will help to minimise the chronic inter-agency demarcation professional response disputes that we have seen in recent years.

These teams will represent a formalising of the notion that protecting children is 'everyone's business' – and not just the domain of DCF.

3. The complaint and 'own motion' functions of the Children's Commissioner

Given the recent publicity over changes to the *Care and Protection of Children Act* I thought I'd conclude this morning by summarising the key recent changes to the functions of the CC - these relate, in part, to services provided by NGO's.

You may be aware that the CC can currently receive and process complaints about services to 'protected' children. From 1 July (or when the amendments are formally commenced), the CC will be able to receive complaints about services to 'vulnerable children'.

For the purposes of this *Act*, a 'vulnerable' child is:

A 'vulnerable' child is a child who:

- is a 'protected' child (known to DCF)
- has been arrested, is on bail, or has a YJ order
- is on an order under the VSA Prevention Act
- is suffering a mental illness or mental disturbance or who has a disability
- is seeking 'child-related' services – to protect, care or support the child
- has left the CEO's care.

The CC can investigate complaints relating to the services provided or that might reasonably be expected to be provided, for such children.

The services investigated can be provided by "a public authority, or another person or body acting for or under an arrangement with a public authority…"

The next major change is that the CC now has **'own motion' powers** that cover similar matters to those that can form the basis of a formal complaint. If a matter comes to the attention of the CC that could form the basis of a complaint, he is empowered to investigate it whether or not a complaint is received.

Lastly, the CC is *not* responsible for monitoring the government response to the BOI recommendations – that is being undertaken by an expert Committee headed by Professor Graham Vimpani. However, the CC *is* able to receive and 'deal with' what are termed **"submissions" relating to the recommendations of the recent Inquiry into child protection**. This covers many of the 147 recommendations and is a function that is hard to explain in a public forum like this. However, it provides stakeholders such as yourselves with an avenue for raising concerns about the implementation process.

Thank you for your time this morning. I look forward to working with you and wish you the best in your work with vulnerable children and families across the Northern Territory.

HB

12.4.11

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