Submission to the Senate Community Affairs Reference Committee Inquiry: Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation".

Aboriginal Medical Services Alliance NT (AMSANT)

October 2012

Recent health data, particularly in the Northern Territory, would suggest that Aboriginal people can be cautiously optimistic about long term trends in health outcomes. While there is a long way to go to achieve the goal of "closing the gap", the strenuous efforts of Aboriginal community controlled health services, in partnership with government, are quietly bearing fruit. This is, for once, good news for all Australians of good will who have supported our efforts in the past, and who continue to support us in this historic task.

However, there is no room for complacency. While we believe there are further resourcing issues that must be met to achieve a truly comprehensive Aboriginal Primary Health care model, we are acutely aware that we can only do so much. Unless the breadth of the social determinants of the health of our people are acknowledged and tackled, the gains we have achieved may plateau and even decline.

Such a potential crisis *can* be averted, and we welcome the work of this Senate Committee in working towards health solutions based on equity and justice for our people.

John Paterson, CEO, Aboriginal Medical Services Alliance Northern Territory

1. Introduction

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) welcomes the opportunity to respond to this important inquiry.

AMSANT is the peak body representing the Aboriginal community-controlled health sector in the Northern Territory and a peak member of the National Aboriginal Community Controlled Organisation (NACCHO).

Our emphasis is on the delivery of Comprehensive Primary Health Care to Aboriginal Territorians.

AMSANT is a member of the Northern Territory Aboriginal Health Forum (NTAHF), a tripartite health planning body also made up of the Northern Territory and Commonwealth governments. As such, we are a major provider of policy advice on health issues to both governments.

AMSANT is also a member of Aboriginal Peak Organisations NT (APO NT)[1], an alliance of NT Aboriginal peak organisations including the Northern and Central land councils, North Australian Aboriginal Justice Agency and Central Australian Aboriginal Legal Aid Service. Collectively, the alliance members address policy issues across the spectrum of the social determinants.

2. Relevance of AMSANT's work to the social determinants of health

The Aboriginal community-controlled health sector emphasises an holistic approach to health, achieved through the practice of Comprehensive Primary Health Care.

Primary health care is socially and culturally appropriate, universally accessible, scientifically sound, first level care.[2] It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that:

- gives priority to those most in need and addresses health inequalities;
- maximises community and individual self-reliance, participation and control, and;
- involves collaboration and partnership with other sectors to promote public health.

Comprehensive Primary Health Care includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation services. Importantly, Comprehensive Primary Health Care includes explicit recognition of the social determinants of health and the need for collaboration across sectors to address these determinants.

[1] www.apont.org.au

[2] See also Alma Ata Declaration, WHO, 1978.

AMSANT engages in advocacy and research on the social determinants of health with an emphasis on the particular circumstances of Aboriginal communities. A recent AMSANT monograph explores the deficiencies of Closing the Gap policies in addressing the social determinants of health affecting remote Aboriginal communities in the Northern Territory (see attached paper, *Closing the gap in cultural understanding: social determinants of health in Indigenous policy in Australia*).

AMSANT and AMSANT's member services regularly advocate to government on social determinant issues associated with health service provision to Aboriginal communities.

AMSANT's membership of the APO NT alliance provides further opportunities to advocate on the social determinants as a result of the broad responsibilities and experience of APO NT's members. APO NT has explicitly adopted the evidence base of the social determinants in guiding its policy and advocacy work (see attached document, *Guiding principles for APO NT's research, advocacy and policy work*).

2.1 Health system reform and the social determinants

Recent data on the Indigenous mortality gap in the NT provides confirmation of the success of improvements and change in the health system and health system planning in the NT, particularly in relation to primary health care. Data from a recent COAG Reform Council report shows that the NT is the only jurisdiction that is on track to close the gap in mortality by 2031, with a 26% improvement in the period 1998-2010 (COAG Reform Council 2012).

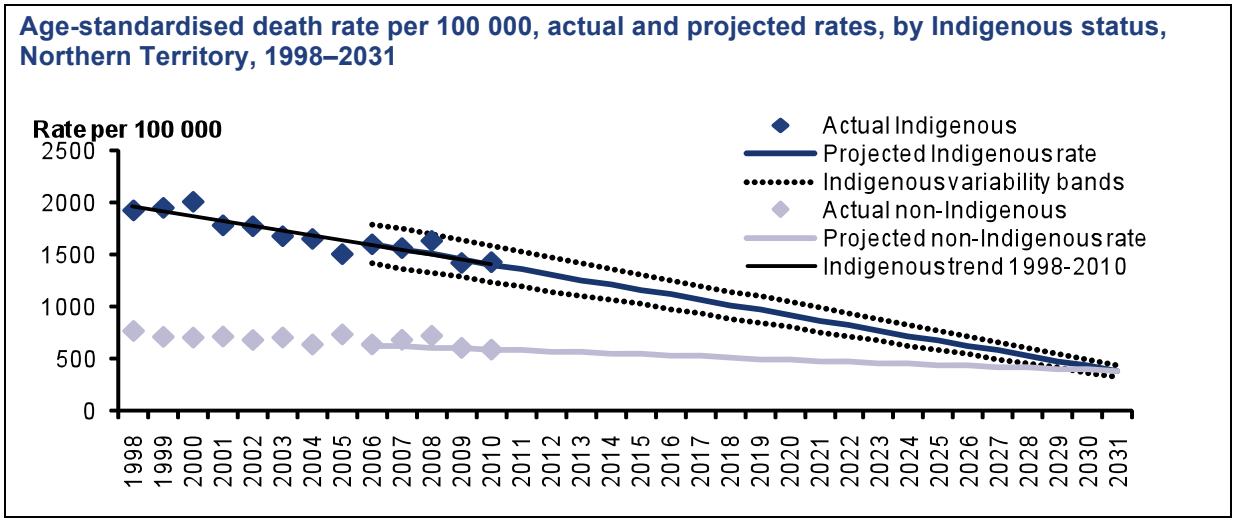

Figure 1: Actual and projected Indigenous mortality rate in the NT, 1998-2031

The turn around in these data coincided with the establishment of the Primary Health Care Access Program (PHCAP), which increased resources but, more importantly, began a process of more equitable distribution of primary health care resources. These gains were further enhanced under the Expanding Health Services

Delivery Initiative (EHSDI), which saw the average per capita primary health care investment increase from about $600 per person to $2500 per person from 2007-2011. The gains have continued under the ongoing reform process overseen by the NTAHF that has confirmed Aboriginal community control as the preferred model of primary health care for Aboriginal communities in the NT. The current Australian Government has committed to maintaining this level of funding under Stronger Futures for a further ten years.

It is important to note, as well, that this boost to primary health care funding also coincided with a near trebling of hospital funding in the Northern Territory between 2001-2010.

There are two important lessons to be drawn from the data. Firstly, it is essential to maintain the reform process of the health system, including strengthening Aboriginal community controlled health services and Comprehensive Primary Health Care, in order to continue improving access to health care—a key determinant identified in the *Closing the gap in a generation report*.

Secondly, it is essential to increase efforts and resources to tackling the other social determinants of health, which now stand as the key impediments to further improving the health and wellbeing gap and without which the current projected improvement will inevitably stall, and potentially reverse the gains made thus far.

3. What the CSDH's Final Report says about Indigenous peoples

In responding to the question of the Australian Government's response to the *Closing the gap in a generation* report it is important to first acknowledge what the report had to say specifically about the social determinants in relation to Indigenous peoples. In essence the report did not specifically address Indigenous health, focusing as it did on mainstream and national populations. Only one small but highly significant reference is made to the special circumstances of Indigenous peoples:

> *Indigenous People worldwide are in jeopardy of irrevocable loss of land, language, culture, and livelihood, without their consent or control – a permanent loss differing from immigrant populations where language and culture continue to be preserved in a country of origin. Indigenous Peoples are unique culturally, historically, ecologically, geographically, and politically by virtue of their ancestors' original and long-standing nationhood and their use of and occupancy of the land. Colonization has de-territorialized and has imposed social, political, and economic structures upon Indigenous Peoples without their consultation, consent, or choice. Indigenous Peoples' lives continue to be governed by specific and particular laws and regulations that apply to no other members of civil states. Indigenous People continue to live on bounded or segregated lands and are often at the heart of jurisdictional divides between levels of government, particularly in areas concerning access to financial allocations, programmes, and services. As such, Indigenous Peoples have distinct status and specific needs relative to others. Indigenous*

> *Peoples' unique status must therefore be considered separately from generalized or more universal social exclusion discussions.*[3]

While not detracting from the universality of the social determinants, the report thus highlights underlying or contextual issues that mediate the expression or impact of the various determinants on Indigenous Peoples and also influence the effectiveness of actions taken by governments to address the social determinants. These include:

- the importance of culture and the impacts of cultural loss, including land and language, without consent or control;
- the impact of imposed social, political and economic structures without consultation, consent or choice; and
- impacts of government policies on Indigenous lands and the daily living conditions of communities.

These must also be read in the context of the overarching priorities for action identified in the *Closing the gap in a generation* report. Under the heading "Political empowerment – inclusion and voice", the report urges the need to "empower all groups in society", including to "strengthen political and legal systems to protect human rights, assure legal identity and support the needs and claims of marginalised groups, particularly Indigenous Peoples".[4] In 2011 during a public lecture in Darwin, former CSDH Chair, Sir Michael Marmot, commented on the *Closing the gap in a generation* report recommendations:

> *Empowerment is key … we saw empowerment as having a material dimension—if you haven't the money to feed your children you can't be empowered; having a psycho-social dimension—having control over your life and not having lots of bad things happen to you; and a political dimension—having voice.*

4. Indigenous social determinants

The issues identified by the CSDH in relation to Indigenous Peoples have been the subject of a growing body of research concerning the social determinants of Indigenous health. While clearly not exclusively related to Indigenous people (i.e., acknowledging the universality of determinants), a number of determinants have particular significance and expression in relation to the situation of Indigenous Peoples generally and to Aboriginal peoples in Australia in particular. These include:

- culture, including language and land;
- control and empowerment; and
- racism, discrimination and social exclusion.

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[3] CSDH (Commission on Social Determinants of Health) (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, p36.

[4] Ibid

Culture is a universal aspect of human societies that acts to ameliorate existential anxiety through its capacity to give meaning and value to individual existence (Halloran 2004). The significance and amenity of culture is often taken for granted by dominant groups within society who face no threats or restrictions to their lifestyles or sustained societal condemnation of their culture. However, for marginalised minority cultural groups, such as Indigenous peoples in Australia, the widespread and persistent suppression of the ability to practice and maintain culture can cause severe disruption and susceptibility to trauma, collective helplessness and endemic maladaptive coping practices that can become transmitted inter-generationally (Halloran 2004).

Such outcomes have been widely documented in Australian contexts, most notably in relation to the child removal policies resulting in the Stolen Generations (Atkinson 2002), but more recently (and of relevance in relation to the current inquiry) in relation to the circumstances of high levels of social dysfunction in remote communities in central and northern Australia (Wild & Anderson 2007).

The significance of culture as a social determinant relates primarily to its psychosocial characteristics and is reflected in emerging evidence internationally and within Australia that Indigenous cultures and languages are protective factors against health and wellbeing risks (McIvor & Napoleon 2009, Chandler & Lalonde 2008, Rowley et al. 2008, O'Dea 1984, O'Dea et al. 1988, Flannery and White 1993, Burgess et al. 2009, ABS 2010, 2011). Usborne and Taylor (2010) have recently demonstrated a psychological pathway linking strong cultural identity with higher self-esteem and psychological wellbeing.

Psychosocial factors are similarly central to the determinants of control and empowerment, and racism, discrimination and social exclusion, included above. In order to be empowered and to be in control of their lives, individuals require self-esteem and a sense that they *can* be in control. This in part requires a sense that their lives and worldviews are respected and included within the broader community. Racism, discrimination and social exclusion—as products of negative societal attitudes towards Indigenous culture—work to undermine control, empowerment and self-esteem. Racism has major adverse impacts on Indigenous health and wellbeing (Awefeso et al 2011).

Structural factors are also important. Individuals require equity of access to the material resources necessary to live healthy, fulfilled lives. Discriminatory policies undermine individual access, control and choice. Inadequate and inequitably distributed services deprive individuals of the ability to achieve healthy lives.

For communities to be in control of their community circumstances and destinies governments must devolve governance and service delivery responsibility to communities while at the same time removing structural barriers in the institutions of society preventing equitable access to mainstream services and resources and participation in broader political and governance processes.

Ultimately, for Aboriginal communities in the NT all these issues are filtered though the lens of culture, most significantly the attitudes and policies of governments towards Aboriginal culture and its place within the broader community. This in turn determines the capacity and quality of government processes in terms of the potential for inclusion and participation of Aboriginal people, cultural awareness and competency, and the ability to meet the cultural needs of Aboriginal communities.

In the Australian context there is a pressing need to address and redress historic and ongoing discrimination and its impacts on Aboriginal people. This includes the need for significant additional investment to redress decades of under-investment in the housing, infrastructure and services of Aboriginal communities and the entrenched income inequality of Aboriginal people.

More intangible is the need to address the deeply entrenched social exclusion that continues to position Aboriginal people and their cultures on one side of a nation divided and with growing inequality. Such exclusion is reflected in continuing deficits such as the abandoned national reconciliation process and the ongoing failure to genuinely confront racism. In the fading afterglow of the 2008 Apology, the main substantive legacy was the Closing the Gap agenda—essentially government finally taking responsibility to provide long denied basic citizenship entitlements. Many Aboriginal people in the NT would argue that the blame and opprobrium heaped on Aboriginal communities and their cultures as a result of the NT Intervention (later incorporated into Closing the Gap) has increased their social exclusion.

4.1 Priorities for government

The above provides a critical background and context for improving outcomes in Aboriginal health and wellbeing. Evidence suggests that important areas for investment and action in most effectively driving such improvement are:

- early childhood;
- education;
- alcohol and other drug use;
- housing and overcrowding;
- employment and welfare; and
- access to health care.

However, for such action to be successful, the evidence strongly suggests—and AMSANT strongly advocates—that governments must also ensure that complementary and crosscutting action is taken to:

- increase Aboriginal control, particularly in governance and service delivery;
- provide equitable resourcing, including redressing historic under-investment;
- base resource allocation on evidence and need;
- avoid fragmented and uncoordinated program and service delivery; and
- genuinely address past and ongoing racism and discrimination and its impacts.

The *Closing the gap in a generation* report provides three overarching priorities that should structure government action:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money and resources
3. Measure and understand the problem and assess the impact of action.

Of particular note here is the need to focus on inequality, expressed as a social gradient within countries. Evidence strongly shows that health and social problems are worse within unequal countries with impacts felt disproportionately by those at the bottom (Wilson & Pickett 2009). Australia is one of the most unequal countries in the OECD and inequality here is growing (OECD 2011).

Taken together, the actions outlined above—focusing investment on key determinants based on evidence, including action specifically addressing Indigenous determinants, and according to overarching concern for daily living conditions, inequality and measurement of action—provide strong direction for government in closing the gap.

Yet the reality of government action to close the gap in Australia is far from this ideal. Section 5 addresses the problems with the Australian Government's current approach to Closing the Gap. Section 6 then addresses ways in which governments and the Australian Government in particular, can significantly improve the impact of closing the gap through appropriate action in key priority areas.

5. Australia's "Closing the Gap" – a flawed approach

The Commonwealth's primary policies addressing Indigenous health and disadvantage sit within the Closing the Gap framework. Closing the Gap adopts a generational approach, however, its development was only indirectly in repose to the CSDH *Closing the gap in a generation* report. Rather, Closing the Gap was primarily a response to domestic political circumstances and the timely emergence of an NGO-driven 'Close The Gap' campaign (Cooper 2011). It was developed through the mechanism of the Council of Australian Governments (COAG), a formal inter-governmental structure that excludes non-government input and participation.

In November 2008, a large funding package of $4.6 billion was committed to Closing the Gap targets in health, housing, early childhood, economic participation, and remote service delivery. Implementation is via a series of intergovernmental agreements termed National Partnership Agreements (NPAs) between the Commonwealth and state and territory governments, under an overarching National Indigenous Reform Agreement (NIRA). Additional funding commitments tied to NPAs have been made over time.

Although bringing significant new investment, Closing the Gap is a flawed approach to addressing the social determinants of health that fails to follow the blueprint of priority actions set out in the CSDH *Closing the gap in a generation* report. There are a number of key failings.

1. Representation and participation of Indigenous people was not provided in developing Closing the Gap policies.
2. Rather than seeking to increase Indigenous control and empowerment, implementation of Closing the Gap policies has offered reduced opportunity for Indigenous participation in decision-making and service delivery.
3. Closing the Gap policies have been developed with only cursory and selective reference to the evidence base of the social determinants and are neither comprehensive nor needs based.
4. There has been a lack of coherence and coordination across the different levels and agencies of government involved in delivering Closing the Gap programs.
5. There was a lack of adequate baseline data and analysis in determining the basis of need and action, and ongoing deficiencies in the collection and reporting of data necessary to measure the impact of Closing the Gap policies.

In addition to failing to follow the *Closing the gap in a generation* blueprint, the Australian Government's actions also contravene international protocols, most significantly the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) that offers clear guidelines for government in developing policy related to the health, wellbeing and development of Aboriginal communities.

The adverse consequences of these deficiencies have been highlighted in the recent report of the NT Coordinator General for Remote Services. The report notes that five years into the Closing the Gap program progress in the NT has been patchy and poor overall, in large part because governments have failed to deliver properly targeted, coordinated or sufficient services to achieve Closing the Gap targets (Havnen 2012).

In relation to Aboriginal participation, the Coordinator General found a central concern has been the marginalisation of Aboriginal people in decision making and resource allocation, remarking that "there is now a dearth of formal indigenous representation in any of the key governance roles that lead decision making and priority setting in Indigenous communities".

The Coordinator General also noted that "Government agency reporting is based largely on inputs and outputs rather than outcomes, and the absence of reliable and transparent data and reportage make it difficult ... to determine whether the myriad programs are meeting their objectives ... much of the expenditure appears to be taken up by the bureaucracy".

Given the central role of the Australian Government in funding and overseeing the Closing the Gap framework it is essential that it take measures to reform the process and to ensure the compliance of state and territory governments.

5.1 NTER and Stronger Futures

The Northern Territory Emergency Response (NTER or NT Intervention), launched in 2007, comprised an extensive and controversial package of measures targeting disadvantage in NT Aboriginal communities. Initially a response to concerns over the abuse and welfare of children in Aboriginal communities, the NT Intervention measures became incorporated into the Closing the Gap framework as a specific NPA—the Closing the Gap in the Northern Territory National Partnership Agreement.

Many of the NT Intervention measures lacked an evidence base and were broadly opposed by Aboriginal communities. These included imposed bureaucratic oversight (Government Business Managers), Commonwealth-controlled leases over Aboriginal communities, the removal of traditional owners' powers to restrict access to communities on Aboriginal land, prohibition on customary law being taken into account in sentencing and bail, compulsory income management and blanket bans on alcohol and pornography in communities—the latter in particular because of prominent public signs announcing the restrictions, which were seen as stigmatising communities.

Some measures, such as income management, were supported and regarded as useful by some people subject to them, while others, such as blanket alcohol bans, duplicated bans already voluntarily set by communities themselves. Overall, the strongest community opposition was to the blatantly racially discriminatory nature of the measures and their protection from legal challenge through the suspension of the *Racial Discrimination Act*.

Other measures, particularly in relation to the expansion of primary health care funding through the Expanding Health Service Delivery Initiative (EHSDI), have brought positive outcomes. This has been described by AMSANT Chairperson Paula Arnol:

> *From the moment the Northern Territory Emergency Response—the Intervention—was announced on 21 June 2007, the challenge for the Aboriginal Community Controlled comprehensive primary health care sector was clear: we would either unilaterally oppose the huge raft of changes the Intervention would bring, or we would critically engage in the process.*
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> *In the event, and not without considerable internal debate, we chose the latter course of action. While there were many aspects of the Intervention we condemned, we also took the opportunity to take the then Federal government at its word in pushing for significant investments into Aboriginal comprehensive primary health care in the Northern Territory, which we argued was critical to any success in Closing the Gap of Aboriginal health outcomes.*[5]

[5] AMSANT Annual Report 2011-2012, in production.

The NT Intervention and its associated NPA ended in August 2012, replaced by Stronger Futures, a package continuing a number of the NT Intervention measures, implemented through a new NPA, Stronger Futures in the Northern Territory.

Some aspects of Stronger Futures represent an improvement on the government's policy approach, indicating a willingness to learn from the mistakes of the NT Intervention. This includes:

- a ten year commitment to Stronger Futures funding, including in relation to Aboriginal primary health care funding, which will enable long-term planning and development and improved workforce stability for Aboriginal organisations;
- a commitment of support for homelands communities; and
- improved consultation over the implementation of Stronger Futures.

In other respects, Stronger Futures is disappointing, particularly in continuing measures that are managerial, coercive, discriminatory and not evidence-based. These include:

- an inadequate and flawed consultation process in developing the Stronger Futures policy;
- continuation of compulsory aspects of income management that indirectly but broadly target Aboriginal people in the NT;
- expansion of the coercive School Enrolment and Attendance Measure (SEAM);
- continuation of the inappropriate use of the Australian Crime Commission, including 'star chamber' powers, in relation to the investigation of child abuse in Aboriginal communities in the NT; and
- the continued prevention of customary law and cultural practice being taken into account in relation to sentencing and bail applications.

5.2 National Aboriginal and Torres Strait Islander Health Plan

A potentially positive development in the Australian Government's Closing the Gap approach is the commitment to develop a new National Aboriginal and Torres Strait Islander Health Plan through the National Aboriginal & Torres Strait Islander Health Equity Council (NATSIHEC).

The Council includes Aboriginal and Torres Strait Islander representatives, including from the National Aboriginal Community Controlled Health Organisation (NACCHO) and the National Congress of Australia's First Peoples.

Agreed key principles in developing the plan include: a holistic definition of health, a social determinants approach, recognition of comprehensive primary health care and support for community control.

A challenge for the new health plan, as with previous plans, is the degree to which it will be implemented by government. In particular, how it will be incorporated within and result in the amendment of the current suite of NPAs under the COAG that collectively constitute the Closing the Gap policy framework.

APO NT has called for the NPAs and other COAG agreements associated with Closing the Gap to be re-visited to include effective Aboriginal participation, input and consent. The new health plan provides a compelling reason to ensure that this occurs.

6. Recommendations for improving the Commonwealth's impact on "Closing the Gap"

This section provides discussion and recommendations on selected key priority areas for government action and investment that can significantly improve progress on closing the gap. It draws on evidence from the social determinants of health and the particular circumstances of Aboriginal communities in the NT.

The areas for *evidence-based* action covered below are:

- increase Aboriginal control and empowerment;
- avoid fragmented and uncoordinated program and service delivery;
- strategically target early childhood priorities;
- improve educational attainment;
- action on alcohol and other drugs;
- needs-based housing provision;
- flexible employment provision; and
- comprehensive approach to trauma and social and emotional wellbeing.

6.1 Increase Aboriginal control and empowerment

The evidence of the importance to health and wellbeing of individuals and communities having control over their lives and circumstances is well established. As Michael Marmot noted, "empowerment is key".

It is also clear that government policies have resulted in an alarming disempowerment and disengagement of individuals and communities and the marginalisation of Aboriginal people in governance and decision-making. The NT Coordinator General noted:

> *Changes to governance and administrative structures, representative bodies, agencies, policies and programs over the past eight years—including the axing of ATSIC and community government councils, the introduction of large 'super' shires, changes to CDEP and the rapid introduction of NTER measures in 2007—has seen increasing disengagement, powerlessness and marginalisation of Aboriginal Territorians, especially those living in areas prescribed under the NTER.* (Havnen 2012).

Government engagement, where it has occurred at all, has been through a proliferation of consultative boards, committees and reference groups that provide no formal decision-making role for community members and constitute a significant burden and source of frustration.

These initiatives have been accompanied—and in significant measure implemented through—the increasing mainstream delivery and tendering out of service provision to non-Indigenous NGOs at the expense of Aboriginal controlled organisations and service providers.

The attrition and loss of capacity of Aboriginal organisations over time has been significant and alarming, resulting in a dearth of Aboriginal organisations remaining with the capacity to deliver services independently or in partnership. The implications of this trend in terms of the loss of Aboriginal governance, leadership and organisational capacity, as well as employment opportunities in Aboriginal communities, is deeply worrying.

This situation has to be reversed. There are three essential actions or principles that should guide government policy and service delivery:

- government investment must be aligned to contribute to the capacity development of communities and Aboriginal organisations and to the (re)building of Aboriginal organisations in areas where they currently do not exist;
- governments must ensure that where not-for-profit NGOs are required to deliver services that they are mandated to partner with a relevant local Aboriginal organisation where existing, and to have a capacity development plan that will result in sustainable benefits for partner organisations and the broader community; and
- government must ensure that where community-level decisions are made (eg Local Implementation Plans, housing, service delivery) that communities are provided with formal decision-making roles through appropriate Aboriginal controlled structures rather than consultative roles determined and controlled by bureaucrats.

The success of the Aboriginal community controlled health sector in the NT provides an example of the positive outcomes that can be achieved.

6.2 Avoid fragmented and uncoordinated program and service delivery

The NT Coordinator General's recent report outlined key deficiencies in government program and service delivery in the NT. These include:

- the failure of whole-of-government approaches due to entrenched 'silos' and an inability to effectively communicate and coordinate between different agencies;
- the counter-productive fragmentation of program and service delivery through the increasing trend to tender out government services to non-Indigenous NGOs and the patchwork duplication of service provision by different agencies; and
- inadequate resourcing and inequitable distribution of services.

Examples of these deficiencies are particularly manifest in early childhood services, youth services and AOD and social and emotional wellbeing (SEWB) services. For

example, in one small central Australian community there are currently 15 separate agencies delivering a range of uncoordinated social and emotional wellbeing programs to the community.

It is clear that current approaches are resulting in a significant waste of government investment, poor outcomes for communities and significant opportunity costs. Foremost amongst these costs is the undermining of the capacity and potential for local Aboriginal controlled organisations to deliver services and to contribute to sustainable local capacity development and employment.

The three principles for government policy and service delivery outlined above provide an important part of a reformed government approach.

However, governments must also genuinely confront the reality of their own failure to break down the entrenched 'silo' mentality within government and consequent inability to effectively coordinate and communicate.

6.4 Strategically target early childhood priorities

Early childhood development, including physical, social/emotional and language/ cognitive development, lays the foundations for future health, wellbeing and life opportunities. Investment in early childhood development provides the best returns that can be made in improving health and social outcomes and reducing health disparities.

The Australian Early Development Index (AEDI) measured that in the NT, 46.8% of Aboriginal children are vulnerable in two or more domains compared with 9.6% of non-Indigenous children and 29.5% of Indigenous children nationally.

There is a complex web of causative factors underlying these high rates of developmental vulnerability in Aboriginal children in the NT. These factors include anemia, malnutrition, frequent infections, poor parenting skills and lack of access to quality childcare, and the impacts of alcohol and other drug use by mothers, including during pregnancy but also whilst parenting (leading to child neglect) as well as others within the family. NT Aboriginal children have unacceptably high rates of low birth weight babies, children with "failure-to-thrive" up to the age of five and children with fetal alcohol spectrum disorder (FASD).

The NT Coordinator General found that early childhood services in remote and very remote locations are poorly developed, with inadequate infrastructure and resources, poor program and service quality and lack of access to culturally relevant parenting programs.

> *The levels of enrolment and attendance in preschool education by Aboriginal children across the NT is deeply concerning given the importance of early childhood education and care.*

(T)he vast majority of highly vulnerable children in remote communities do not have access to high quality early childhood education, child care and/or preschool.

The Australian Government has already by a long way missed its 2008 COAG Closing the Gap headline target to ensure that all Indigenous four year olds in remote communities have access to early childhood education within five years.

The Coordinator General found a central problem to be the proliferation of small scale, short-term programs and multiple providers that has characterised the current system and recommended substantial reform of the system and service delivery model. This will also require significant additional investment.

Parenting and parent child programs and early learning programs are particularly important in reducing the causative factors for developmental vulnerability.

For example, the Olds Nurse Led Home Visitation program provides structured support for women in pregnancy until the child is aged two. The program has very strong evidence of improving outcomes for both mother and child in a range of areas including educational attainment for children, reduced rates of child neglect and abuse, reduced rates of juvenile offending for children and reduced alcohol and other drug use in the mother and child. The program is being successfully trialled by AMSANT's member service, the Central Australian Aboriginal Congress, and *AMSANT recommends that the program be expanded to all Aboriginal communities in the NT.*

The following evidence-based measures for improving early childhood outcomes are recommended:

- universal access to evidence based early childhood development and early education programs according to need;
- parenting support based on a long-term relationship in the most critical period—such as the Olds Nurse Home Visitation Program;
- educational Day care from 6 months to 5 years;
- 2 years of pre-school for at least 28 hours per week—currently there is only a mere 15 hours for 1 year – the worst in the OECD;
- intensive Family Support programs for families of children that have fallen behind, especially children 7 years and younger;
- reduce the factors that negatively impact on early development especially parental addictions and family violence through both evidence based public policy and treatment programs (with treatment available as part of comprehensive PHC) and reducing overcrowding for households with school aged children; and
- adult literacy programs targeting parents as this will assist them to educate their children.

6.5 Improve educational attainment

Evidence shows a strong link between educational attainment and life long health and wellbeing. Improving educational attainment to year 12 level or above leads to improved outcomes in reducing chronic disease as well as secure employment and increased capacity to control their own lives and destiny.

The Closing the Gap Clearinghouse report, *What works to overcome Indigenous disadvantage* summarised key evidence from Australian and international research. Key evidence from schooling and education research shows:

- successful programs or strategies were supported by the local community, delivered by highly skilled and committed teachers and recognise Indigenous culture;
- projects characterised by a high degree of Indigenous involvement and control produced significant benefits for participants; and
- engaging parents in children's learning was of critical importance.

It is essential for governments to commit to the provision of sufficient high quality teachers and adequately resourced schools. It is also vital that schools positively engage families and communities to provide a high degree of Indigenous involvement and control, and to recognise Indigenous culture.

Contrary to such a blueprint, evidence suggests systemic, racially discriminatory under-resourcing of Aboriginal education in the NT. Research in the community of Wadeye found that Wadeye children received less than half the average per capita funding for children attending school in the Territory. In a case to the Human Rights and Equal Opportunity Commission (HREOC) this was found to be racially discriminatory. Recent claims suggest such under-resourcing—achieved by funding Aboriginal remote schools based on an expected participation rate of about 35% compared with 97% for non-Aboriginal children—is endemic. In addition to this, some small schools in remote communities are not recognised by the NT Government as schools but are classified as Homeland Learning Centres and do not receive the infrastructure and funding of normal schools.

A recent COAG Reform Council report documents some concerning outcomes in education in the NT over the period 2007 to 2010. Despite concerted action by the Commonwealth and NT governments associated with the NT Intervention, particularly in relation to school attendance, Year 10 attendance rates plummeted by eight points to just 61 per cent. Only 29.8 per cent of Indigenous students in the Territory completed Year 12 in 2010, down from 45.9 per cent in 2007.

The current approach of both the NT Government (with primary responsibility for education) and Australian Government (via the NT Intervention/Stronger Futures) is called into question by the evidence of a worsening of school attendance figures in many schools, despite an increased focus on the issue by both governments.

Governments' focus on coercive measures (such as the SEAM trial and recent NT legislative changes that provide for fines and other parental sanctions) and apparent lack of support for the inclusion of cultural aspects into schooling (including support for bilingual education and other language and culture programs) is not supported by evidence. Moreover, such approaches fail to positively engage Aboriginal parents in encouraging school attainment to their children.

In contrast, the recent report of a federal parliamentary inquiry into Indigenous languages, *'Our Land Our Language'*, recommended (amongst a raft of recommendations) proper resourcing for bilingual school education programs (Recommendation 18) and that 'the Commonwealth Government include in the Closing the Gap framework acknowledgement of the fundamental role and importance of Indigenous languages in preserving heritage and improving outcomes for Indigenous peoples' (Recommendation 1) (Commonwealth of Australia 2012).

The evidence suggests that improving education outcomes for Aboriginal children in the NT requires more effective government action, particularly in relation to:

- ending the inequitable and discriminatory under-resourcing of Aboriginal schools in the NT; and
- adopting education policies based on evidence, such as that provided by the *What works to overcome Indigenous disadvantage* report.

6.6 Evidence-based action on alcohol and other drugs

The reported incidence of alcohol-related trauma among Aboriginal and Torres Strait Islander people in the Northern Territory is the highest in the world (Jayaraj et al. 2012). Alarming as this is, it is but one of a multitude of statistics that catalogue the devastating impacts of alcohol and other drugs on Aboriginal lives and communities in the NT.

The impacts of alcohol are indeed devastating: unacceptable rates of death and trauma, assault, including family violence, neglect of children, chronic disease, and fetal alcohol spectrum disorder (FASD)—the list is long.

Reports have repeatedly highlighted these problems, however, the responses of the Australian and NT governments have been dismally deficient: an array of sporadic, uncoordinated, mostly non-evidence-based alcohol policy measures that have always appeared to have been developed more with an eye to their appeal to the broader community.

Examples include the NT Intervention alcohol measures, which included non-evidence-based blanket alcohol bans over communities and Aboriginal land that over-rode NT alcohol legislation, functioning alcohol management plans and resident initiated 'dry' community declarations that were already in place.

A deeply concerning current example is the intention of the newly-elected CLP Government in the NT to criminalise drunkenness through the creation of

compulsory alcohol rehabilitation centres targeting heavily dependent drinkers who are repeatedly picked up by police for intoxication. The policy is at least in part to remove them from the streets (Finnane 2012) and blatantly and disproportionately targets Aboriginal people.

Government policy responses are all the more distressing in that the evidence is very clear about what works. Aboriginal organisations such as AMSANT, APO NT as well as community groups such as the Peoples Alcohol Action Coalition (PAAC) have long advocated for such evidence-based solutions. AMSANT has an alcohol control policy that outlines key evidence-based measures needed in the NT.[6]

Price is strongly linked with consumption levels and effective measures include the removal of low-cost high alcohol products favoured by heavily dependent drinkers, such a 4-litre cask wine and 2-litre port.

Evidence indisputably shows that the most effective overall measure is a floor price or volumetric tax on alcohol that would ensure a minimum price per standard drink. The Australian Government has, thus far, refused to support legislation to implement such a measure.

Restrictions on availability have also been shown to be effective, including restrictions on trading hours especially for take away alcohol, and regulating outlet density.

Properly developed alcohol management plans (AMPs) supported by the community have proven to be effective, particularly in remote communities and regional centres.

Measures to reduce levels of alcohol consumption must also be accompanied by action to address the harm and impacts of alcohol.

This includes access to sufficient, culturally appropriate alcohol and other drugs treatment within primary health care supported by specialist services including rehabilitation services. Currently, there is a lack of such services in the NT, particularly in remote areas.

Criminal justice system approaches are also important given the very high level of alcohol-related crimes involving Aboriginal people in the NT. The Alcohol and Other Drugs Tribunal in the NT, due to be disbanded, was a significant measure for diverting those with alcohol and other drugs problems who come before the courts.

The high co-morbidity of AOD and mental health problems supports the need for coordinated mental health and social and emotional wellbeing services. AMSANT advocates the need for the incorporation of such services within primary health care

[6] AMSANT 2008, Options for Alcohol Control in the Northern Territory. At http://www.amsant.org.au/documents/article/178/080101-Policy-DC-External-Alcohol Control Policy.PDF

service delivery and has developed a model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory.[7]

Ongoing support and development of services in line with this model represents a culturally appropriate, evidence based and cost effective approach to addressing the many health and social consequences of alcohol and other drug misuse, including FASD. There is no other realistic way to provide culturally appropriate screening, early intervention and ongoing therapy for people living in remote communities. The model also includes a community based prevention component.

6.7 Needs-based housing provision

Lack of adequate housing has serious impacts on health and wellbeing. Overcrowding is an important determinant of poor health outcomes and has also been associated with increased risk of neglect and abuse, family and community violence and poor employment and educational outcomes.

The Northern Territory has the highest rate of homelessness in Australia with a rate of 792 per 10,000 people compared to the national rate of 45 per 10,000. The Australian Bureau of Statistics' (ABS) new methodology for counting homelessness has been applied to 2006 Census data, more than tripling the previous count for the NT to 792 out of every 10,000 people.

The new methodology applies a stricter definition of homelessness to previous Census data. The new methodology counts severe overcrowding as homelessness (with definitions of overcrowding and severe overcrowding) and discounts those who have alternative accommodation options, such as 'grey nomads' and 'owner/builder' residing on building sites.

The links between poor housing—and overcrowded housing—and poor health is confronted day-to-day by AMSANT member services. They, in turn, have little control over this major social determinant of health. The fact that the ABS now classes "severe overcrowding" as a form of homelessness emphasises the daily calamity our services face.

To take one condition, for example, trachoma. Trachoma is a disease that can very easily lead to blindness. It is famously almost a Northern Territory disease, because we seem to have it in greater quantities than most of the rest of the world—including most Third World nations. Although there are multiple causes for trachoma, the World Health Organization's guidelines on avoiding trachoma include: "avoid overcrowding".

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[7] AMSANT 2011, *A model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory.* http://www.amsant.org.au/documents/article/178/110308-Review-LM-External-Model for Integrating Alcohol and Other Drugs.pdf

For thousands of Territory Aboriginal people, there is little choice—and little chance—in "avoiding overcrowding". In this case overcrowding is a direct cause of debilitating illness which can lead to permanent disabilities such as blindness.

Article 11 of the *International Covenant on Economic, Social and Cultural Rights*, to which Australia is a party, recognises the right of all people to **adequate** housing, and commits state parties to take appropriate steps to ensure the realisation of that right. Article 11 recognises, "... the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing..." and that "States Parties will take appropriate steps to ensure the realisation of this right". Severely overcrowded housing is not "adequate"—and is in fact the direct cause of illness. Overcrowding does not meet the international human rights law definition of "adequate": indeed such housing in the Northern Territory can make you blind.

Currently there are about 5000 remote public housing dwellings in the NT with a population in excess of 40,000 and an occupancy rate that continues to be more than 8 people per dwelling, with many houses recoded as having far higher occupancy levels.

Given the high levels of overcrowding and homelessness in the NT, action on providing adequate housing is a major priority for government. Housing has been identified as a priority under the COAG Closing the Gap, however there are concerns about the effectiveness of current policy settings, particularly in the NT.

In the NT, COAG Indigenous housing funding is being rolled out under the National Partnership Agreement on Remote Indigenous Housing (NPARIH). A revised plan for the NPARIH estimates 934 houses and 415 rebuilds will be delivered by 2013 and after 2013 there will be an additional 1,400 new houses built in smaller communities.

However evidence suggests this level of investment will fail to adequately or even significantly reduce the level of overcrowding and housing need in the NT due to:

- the level of the historic backlog in housing that far exceeds the number of new houses to be provided;
- the replacement of existing houses required over the period due to normal rates of deterioration;
- the projected increase in population in Aboriginal communities.

In addition to the inadequacy of current government policies in housing provision have been the negative impacts of Australian Government reform of Aboriginal public housing. The reforms have involved the abolishing of Aboriginal community housing organisations and the transfer of Aboriginal housing and housing management to a government agency, Territory Housing, through compulsory 40 year housing leases.

This represents a significant loss of Aboriginal controlled organisations and Aboriginal control over the ownership and management of public housing, as well as

the associated benefits of secure employment and training opportunities for local Aboriginal people.

Thus far, Territory Housing has proved incapable of coping with the extra demands placed on it as a result of the demise of Aboriginal community housing organisations. For example, its database of housing and the tenants who live in them is for all practical purposes non-existent. It cannot, for example, determine how much rent is being paid by whom for what premises. This has led to substantial over payment of rents by people on very low incomes.

In other words, housing 'reform' has seen Aboriginal control replaced by government control with arguably worse outcomes. Under Territory Housing:

- tenancy management is grossly inadequate;
- there are not enough functional houses;
- there is continuing overcrowding;
- repairs and maintenance can be slow;
- many houses ("legacy dwellings") are not protected by the Residential Tenancy Act; and
- communication with remote tenants is poor and lacks cultural understanding.

The example of Aboriginal housing provides a case study of the failure of the Australian Government to follow the blueprint for action outlined in this submission.

6.8 Flexible employment provision

Employment is a key element in improving socioeconomic status, self-esteem and empowerment and is strongly linked with health and wellbeing.

Aboriginal employment levels in the NT are low with limited prospects for full-time employment in remote areas due to the limited scale of local economies.

It is of significant concern therefore that recent Australian Government reform of remote employment services has and is resulting in a significant reduction in employment and income levels in remote communities. The new Remote Jobs and Communities Program (RJCP) completes a reform process that is removing the jobs component of the Community Development Employment Projects (CDEP) scheme and transferring all employment services clients to welfare.

The CDEP waged employment program has benefitted remote Aboriginal communities and economies and has provided an incentive-based job environment that is preferable to a welfare participation model.

The removal of the CDEP waged employment component in remote communities represents the loss of 8,000 jobs over time. Those employed under the scheme earn on average $100 more per week than those on welfare payments, representing a significant reduction of income given that average income for Aboriginal people in

the NT is amongst the lowest in the country at just $311 per week. This also represents the loss of over $30 million per year to remote communities.

The removal of CDEP jobs significantly reduces access to meaningful employment opportunities and increases numbers on welfare and income support, denying the opportunity for work relationships that contribute to family and child welfare and equip children for future economic participation.

A key problem with a welfare/mutual obligation approach is its focus on compliance and sanctions rather than reward/motivation. Evidence shows that 'negative reinforcement' (punitive measures) is highly ineffective in changing behaviour and can result in 'learned helplessness' and other adverse consequences.

AMSANT has advocated for the retaining of a waged employment scheme in remote communities.

AMSANT also believes that it is essential that the significant Australian Government investment in remote welfare and employment services is harnessed towards developing local community economies through local Aboriginal owned and controlled enterprise development, and providing diverse pathways for engagement in available employment and relevant skills development. Government procurement policies should also place priority on Aboriginal employment and use of Aboriginal business and organisations.

Employment prospects can also be significantly enhanced by developing the number and capacity of Aboriginal controlled organisations providing services in remote communities. AMSANT points to the significant local employment opportunities provided by investment in the health workforce, particularly in Aboriginal community controlled services.[8]

Comprehensively address social and emotional wellbeing (SEWB) and trauma

Alcohol and other drug misuse are often focused on as the major issue affecting safety and wellbeing in Aboriginal communities. However, this focus obscures pervasive and complex issues surrounding the impacts of trauma and other threats to social and emotional wellbeing (SEWB), which often underlie the more visible and politically arresting issues of alcohol and drug use. Alcohol and other drug issues are closely associated with trauma and social and emotional wellbeing both as symptoms and as causal factors, however, the dimensions and impacts of the latter within Aboriginal communities are arguably more extensive and pervasive.

Worryingly, the indicators are not improving. For example, the NT Coordinator General noted:

[8] APO NT has a well developed response to this issue (see http://www.amsant.org.au/documents/article/154/120503%20-%20APO%20NT%20-%20Response%20to%20Remote%20Jobs%20and%20Communities%20Program.pdf)

> *The level of suicide and self-harm among people in Aboriginal communities affected by the NTER is extremely alarming. It has risen 360% in the five years since the intervention, from 57 to 261, and is now equal to the number of people involved in aggravated assault.* (Havnen 2012:103)

Suicide among Aboriginal communities is now three to four times the rate of non-Aboriginal communities and similar trends have been experienced in Indigenous populations in other countries. Violence is also prevalent with assault being the main cause of hospitalisation for both Aboriginal men and women (at 8 and 69 times the rate for non-Indigenous males and females respectively).[9]

A common thread to the issues experienced by Aboriginal communities since colonisation, whether it be experiences of violence, removal from land, removal from family, discrimination, or the disruption or devastation of cultural practices and cultural identity, is the trauma that is a consequence of these experiences.

Pervasive, transgenerational trauma is understood to underlie the various degrees of social and emotional difficulties being experienced in communities. Atkinson (2002) has described the mechanism of trauma transmission across generations—the following in relation to exposure to violence:

> *Childhood experiences of violence are, in many cases, traumatising experiences that may have serious impacts on child development … their adult behaviour resembling an enactment of the suppressed feelings of the original trauma … that is then transmitted across generations.*

Such experiences of early life trauma (ELT), which includes adverse social, nutritional and emotional experiences, are common amongst Aboriginal children in the NT, and along with FASD, result in impaired brain development, ongoing learning difficulties and impaired social functioning abilities. Trauma experience by children has been associated with significant health impacts, including increased risk for circulatory, endocrine and musculoskeletal conditions (Ko et al. 2008).

Intergenerational transmission also occurs with historical trauma, whereby the subjective experiencing and remembering of events is passed from adults to children. As with cultural trauma, described earlier, such trauma can result in collective endemic maladaptive and dysfunctional behaviours, including substance misuse and family and community violence. In its most extreme manifestations, community deterioration results in escalating violence over generations that is termed 'dysfunctional community syndrome' (Atkinson et al. 2010).

If we consider the additional factors of exposure to continuing high levels of stress and trauma including multiple bereavements and other losses, it can be glimpsed how social and emotional wellbeing difficulties, including significant mental health issues, substance misuse, violence, self-harm and suicide, as well as associated poor

[9] Figures are for July 2006 to June 2008, AIHW 2011.

health outcomes, reflect an extensive and pervasive impact of trauma on Aboriginal communities.

The Framework outlining core functions of Primary Health Care throughout the NT, developed in 2011 for the NT Aboriginal Health Forum, identifies the delivery of SEWB and AOD services as an important component of comprehensive primary health care. AMSANT views AOD and SEWB services as an integral part of service delivery because not only are they significant issues for our communities in their own right, but these issues also weigh heavily upon many of the other health issues being faced in our communities. AMSANT is advocating a model for integrating AOD and mental health services within primary health care.[10]

Addressing AOD issues can benefit many aspects of health care and is therefore an important component of holistic health care. Addressing SEWB issues within PHC allows our services to provide a fully coordinated service that addresses the physical and mental health needs of the person in the context of their family and community. This provides an accessible, culturally appropriate, integrated approach that can link to specialist services where required.

However, although clinical services are clearly important, they are not sufficient given the high levels of complex trauma at both the individual and community level in Aboriginal communities. AMSANT believes that a broad based prevention and community development strategy is also needed. This should be informed by the substantial literature and experience with community development and trauma informed approaches both in Aboriginal communities but also other vulnerable traumatised populations (eg, Kaplan and Victorian Foundation for Survivors of Torture 1998). However, it is important to facilitate community development and prevention without being prescriptive.

There are a number of existing examples of programs that have addressed trauma and related violence and substance use, with whole of community, community-driven and owned approaches. The most successful approaches are informed by cultural knowledge and culturally informed healing—with the aim to strengthen cultural identity as a component of healing from trauma and dealing with consequent issues and poor health outcomes. Successful examples include:

- The Family Wellbeing Program (McCalman et al 2010);
- Fitzroy Valley - From Community Crisis to Community Control. A Recovery Plan (Calma 2010);
- We-Al-Li (Atkinson 2002); and
- The Marumali Program: An Aboriginal Model of Healing (Purdie et al. 2010).

[10] AMSANT 2011, *A model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory.* http://www.amsant.org.au/documents/article/178/110308-Review-LM-External-Model for Integrating Alcohol and Other Drugs.pdf

Some AMSANT member services have been successful in developing community-centred programs addressing social and emotional wellbeing, substance misuse and associated issues. For example, the Strongbala Men's Health Program.[11]

It is also essential that trauma informed approaches are applied to many aspects of program design and service delivery. Importantly, the significance and importance of cultural identity as a source of strength and resilience (and healing from trauma) must be supported in ongoing approaches to health and SEWB and not ignored or undermined in the design and implementation of various policies and programs.

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