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VOLUME 4

REPORT OF THE

**ROYAL
COMMISSION
AND BOARD
OF INQUIRY**

INTO THE PROTECTION
AND DETENTION OF
CHILDREN IN THE
NORTHERN TERRITORY

VOLUME 3B

35

THE CROSSOVER BETWEEN
CARE AND DETENTION

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THE CROSSOVER BETWEEN CARE AND DETENTION

INTRODUCTION

The Commission has given particular consideration to children who have been in both the youth justice and the child protection systems, those often referred to as the ‘crossover group’.¹ The Commission heard that some children in the Northern Territory experience a ‘constant roundabout’ of disengaging from school, appearing before the criminal justice system, suffering placement breakdowns and moving from one residential facility to another.²

Both the child protection and youth justice systems in the Northern Territory have failed to recognise the specific vulnerabilities and needs of the crossover group. Although many children in the youth justice system have previously been involved with child protection services, limitations in the ability to link data across Northern Territory child protection and youth justice datasets has meant that the size and nature of this group in the Northern Territory has been unknown.³

Research conducted by the Commission with the Menzies School of Health Research (the Crossover Research) sheds new light on the number of children who come into contact with both systems in the Northern Territory.⁴ The Crossover Research showed a close association between child protection and criminal offending, with the majority of children in the Northern Territory who had been found guilty of an offence having been previously reported to child protection. This suggests a trajectory where engagement with child protection services is a foreseeable pathway to later engagement with the youth justice system. The Commission has focused on understanding the pathway between the systems, their points of interaction, and the characteristics of the children who are involved in both systems.

'I think that the state and the non-government partners are culpable in the creation of criminals in our society and that the state has an obligation, as it has taken people away from their natural families on the argument that they can provide better care than those young people would receive - it's an obligation to do that'

Dr Katherine McFarlane

PAST RESEARCH

A literature review was conducted for the Commission as part of its inquiry. It explored research into the complex associations between 'child maltreatment', involvement in the child protection system and subsequent engagement with the youth justice system. The research includes cross-sectional studies, typically involving samples of incarcerated child or youth offenders, longitudinal studies that follow cohorts of children over time, and data-linkage studies that link population-level administrative data collected by child protection and youth justice agencies. It is based on data-linkage techniques that also allow for a longitudinal analysis of a cohort of children born in 1999.

Only recently has linked data been used to explore the relationship between child protection and juvenile justice involvement. An important 2016 research report from the Australian Institute of Health and Welfare used linked child protection and youth justice data, documenting a strong overlap between the two populations.⁵ It found that:

- children and young people placed on care and protection orders were 27 times more likely to be also under youth justice supervision compared to children and young people in the general population, and
- those receiving child protection services were 23 times more likely to be also under youth justice detention compared to individuals in the general population, with almost half (45%) of children and young people in youth justice detention also involved in the child protection system in the same year.⁶

In the same year, 2016, the Northern Territory Government published a report on the association between maltreatment and criminal behaviour for a cohort of children born between 1985 and 2003.⁷ It found that children subject to a child protection order were almost five times more likely to offend, at a rate of 154 per 1,000, than children who were not subject to a child protection order, at a rate of 35 per 1,000. This is the only known Australian study to extend findings into adulthood, demonstrating that maltreatment is not only related to 'youth offending' but remains a risk factor for 'adult offending'. Research in South Australia and Queensland also points to the pronounced crossover of children between the child protection and youth justice systems.⁸

With notifications for maltreatment on the rise and the inability of child protection systems to investigate all reports, some researchers have turned their attention to identifying whether the mere notification for abuse or neglect is associated with an increased risk of offending. Children who are only ever the subject of notifications are similarly at risk of engaging in youth offending compared to those who have had their maltreatment substantiated. However, it has been consistently found that those who are placed into out of home care have the greatest risk of subsequent youth offending.⁹

Estimates from other studies vary depending on the type of child protection involvement or maltreatment experienced, the type of youth justice involvement, and the research design.¹⁰ While there are limitations to the research, they provide clear evidence of an association between youth offending, youth justice involvement, child maltreatment and child protection involvement. Depending on the sample and measures used, these studies have demonstrated that up to 90% of children in detention may have experienced childhood maltreatment and that a high proportion of children in youth detention have experienced out of home care.¹¹

Another finding from past research is that the type of maltreatment can affect the child's experience.¹² Although associations have been found between all types of child maltreatment and youth offending, neglect is emerging as one of the strongest risk factors. Children who experience multiple types of maltreatment also appear to be at greater risk of offending compared to those who experience only one type. Timing is also important. Maltreatment that either starts or continues into adolescence is associated with a greater risk of offending compared to maltreatment that is limited to the childhood years.

Understanding the specific risk profiles of children in out of home care has also been a focus of research,¹³ which suggests that certain placement experiences are associated with the risk of offending, with a higher risk for those who:

- enter care due to a combination of behavioural problems and maltreatment compared to those who enter due to reasons of maltreatment only¹⁴
- are placed in foster care¹⁵ and kinship care,¹⁶ but especially for those placed in residential care, compared to those with no placement histories¹⁷
- are placed at an older age compared to those who enter out of home care in infancy and early childhood, and
- experience multiple placement changes, moves or disruptions compared to those who experience fewer placement changes.¹⁸

However, the direction of these associations between placement experiences and behaviour is unclear. Children with the most challenging behaviours are more likely to be placed into residential care or experience the greatest instability or changes in placements as a result of their difficult behaviour.¹⁹ These placement experiences might also serve to intensify behaviour problems, with the lack of security and stability potentially linked to the initiation of offending. There is evidence that being placed in residential care with older children who are already engaging in delinquent activities is a risk factor, with deviant peer associations serving to reinforce antisocial attitudes and beliefs which in turn lead to antisocial behaviour.²⁰ Placement in out of home care can be viewed as both a cause and a consequence of offending behaviour.

Longitudinal studies in Australia point to the complex nature of the associations between maltreatment, placement and offending. There are clear emerging trends, which are consistent with international findings.

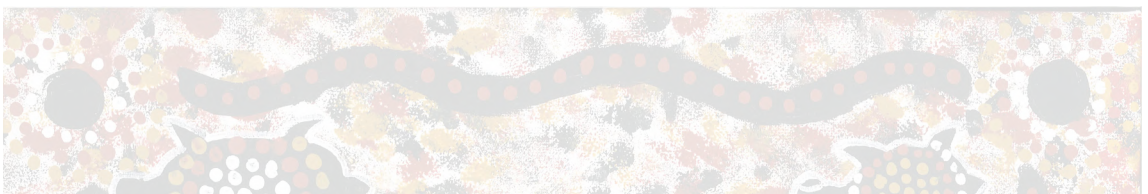
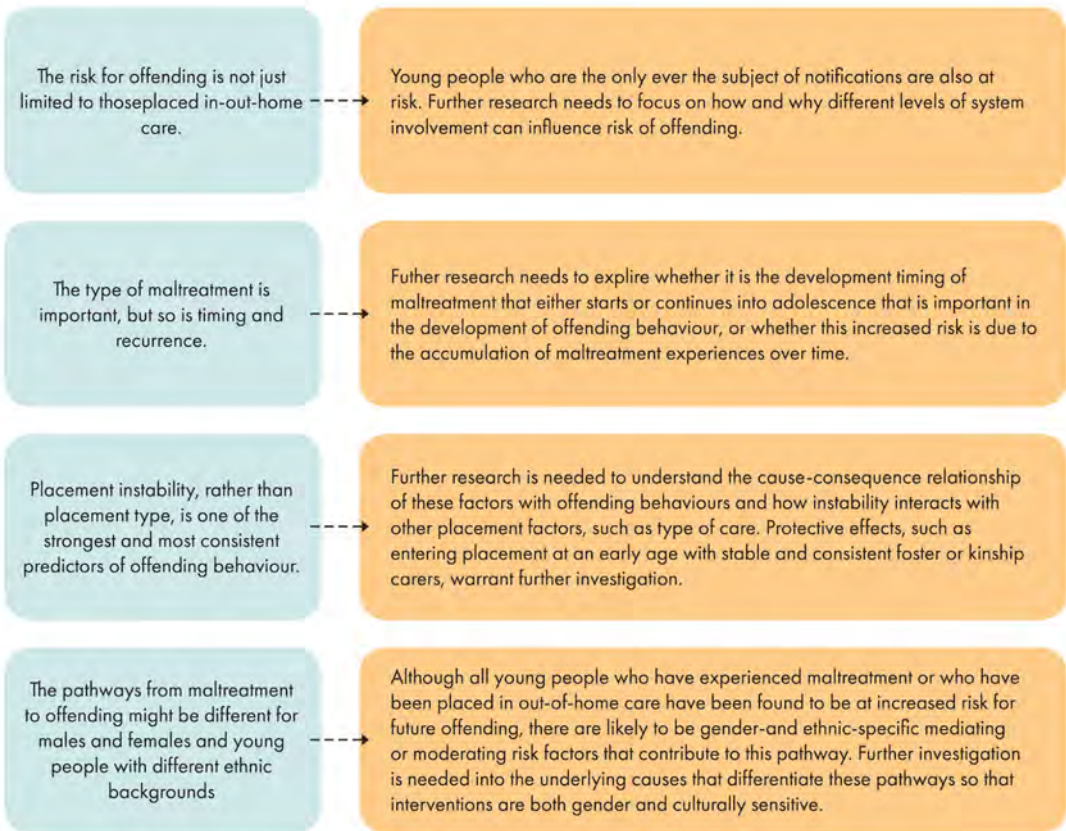


Figure 35.1: Findings from longitudinal studies in Australia



Gender differences have also been identified in the extent to which children involved in the youth justice system have also been involved in child protection system, with some estimates suggesting the rate can be as much as twice as high for girls.²¹ There may also be a relationship with the age of onset of offending, with a higher proportion of children who first appeared in juvenile courts before the age of 14 having a child protection history, compared to children or young people who had their first appearance over the age of 14.²² Children who offend and also have a history of involvement with the child protection system appear more frequently in juvenile court than children who offend and do not have a child protection history.²³



CROSSOVER RESEARCH

The Northern Territory has cultural, demographic and geographic characteristics significantly different from other jurisdictions. To date, research on the extent to which the Northern Territory's children in the youth justice system may have been the subject of child protection involvement has been limited to research on children on child protection orders. The Commission is of the view that understanding the extent of all previous child protection involvement for children in the youth justice system will provide greater insight into this association and enable intervention and prevention strategies to be targeted towards the needs of these children.

The Commission engaged the Menzies School of Health Research to construct a longitudinal dataset using linked administrative data to explore the association between child protection and youth justice involvement for the cohort of children in the Northern Territory born in 1999, who would turn 18 this year (see Crossover Technical Report at end of chapter). The research questions included the extent to which the child protection and youth justice systems overlap in the Northern Territory, the association between the level of child protection system involvement and youth offending, and the association between maltreatment type and youth offending.

Method

The project used the linked de-identified datasets assembled for the Menzies School of Health Research – Northern Territory Government Child and Youth Development Research Partnership. Although data from multiple sources were linked, the primary datasets involved child protection and youth justice. Youth justice involvement was determined by offences that were found to be 'proven guilty'.²⁴ Demographic information, including gender and Aboriginal status, was also used.²⁵

The project was based on an historical birth cohort design to enable the longitudinal analysis of data. The birth year of 1999 was chosen to maximise chances of exposure to both the child protection and youth justice systems for an equal maximum amount of time, that is, from birth up to and including the age of 16. Using data from the Perinatal Register, 2,830 individuals born in the Northern Territory from 1 January 1999 to 31 December 1999 were selected for analysis – the study population.²⁶ Of these, 1,246 were identified as Aboriginal and 1,584 as non-Aboriginal.²⁷

Results

Extent of overlap

The project demonstrated the much higher proportion of Aboriginal children in child protection or youth justice compared with non-Aboriginal children, and clearly identified that the majority of children in the Northern Territory, (75.2% of Aboriginal children and 60% of non-Aboriginal children), who had a proven guilty offence had previously been reported to child protection, see Figure 35.2 below.²⁸ The magnitude of this 'crossover' figure for Aboriginal children shows the degree of closeness of the association between youth justice and child protection in the Northern Territory.

Other key findings for the cohort were:

- 15.9% of Aboriginal and 1.2% of non-Aboriginal children with any child protection involvement were subsequently found guilty of an offence up to the age of 16
- 19.9% of Aboriginal children who had their maltreatment substantiated, and 22.8% of those placed in out of home care, were subsequently found guilty of an offence, and
- less than five non-Aboriginal young children who had their maltreatment substantiated and who were placed into out of home care were subsequently found guilty of an offence.

The analysis showed that the level of offending in the cohort increased as the level of involvement with the child protection system increased – from notification to substantiation to being placed in out of home care.

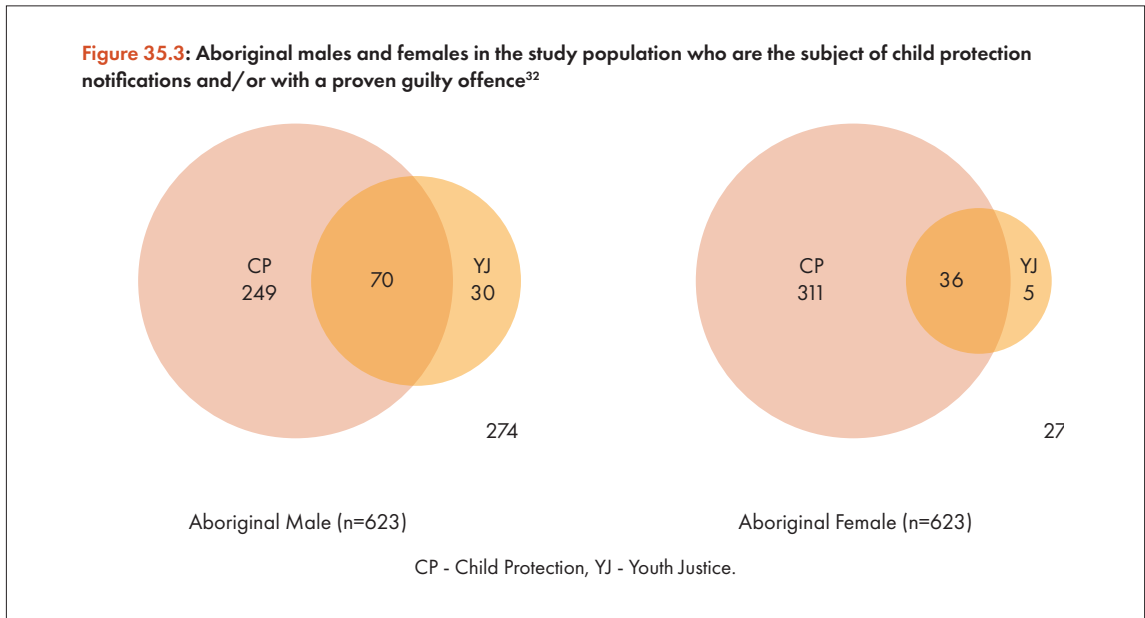
Figure 35.2: Overlap of child protection and youth justice involvement for the study population²⁹



Figure 35.2 shows children born in the Northern Territory in 1999, as were classified according to their involvement with the child protection and youth justice systems, depicted by two circles. Aboriginal and non-Aboriginal children are presented separately. The overlap of the two circles is the number of children involved in both the child protection and youth justice systems. The number outside the circles represents those children born in 1999 who were not involved in either the child protection or youth justice system.

Further analysis of the data showed that for Aboriginal children almost one quarter (23%) of the children who became known to both systems were reported to child protection before the age of three.³⁰ Of these (n = 94), 25% had later proven guilty offences. The need to provide support early in lives of children is clear.

Results show that while the above is true for both Aboriginal boys and girls, a higher proportion of girls with proven guilty offences had previously been reported to child protection, as compared to boys.³¹ Almost 90% of Aboriginal females and 70% of Aboriginal males with at least one proven guilty offence had previously been reported to the child protection system, see Figure 35.3 below.



Association between child protection system involvement and youth offending

Survival analysis was used to determine the cumulative hazard function for youth offences, that is, proven guilty at different ages, by level of involvement with the child protection system. Four groups were compared:

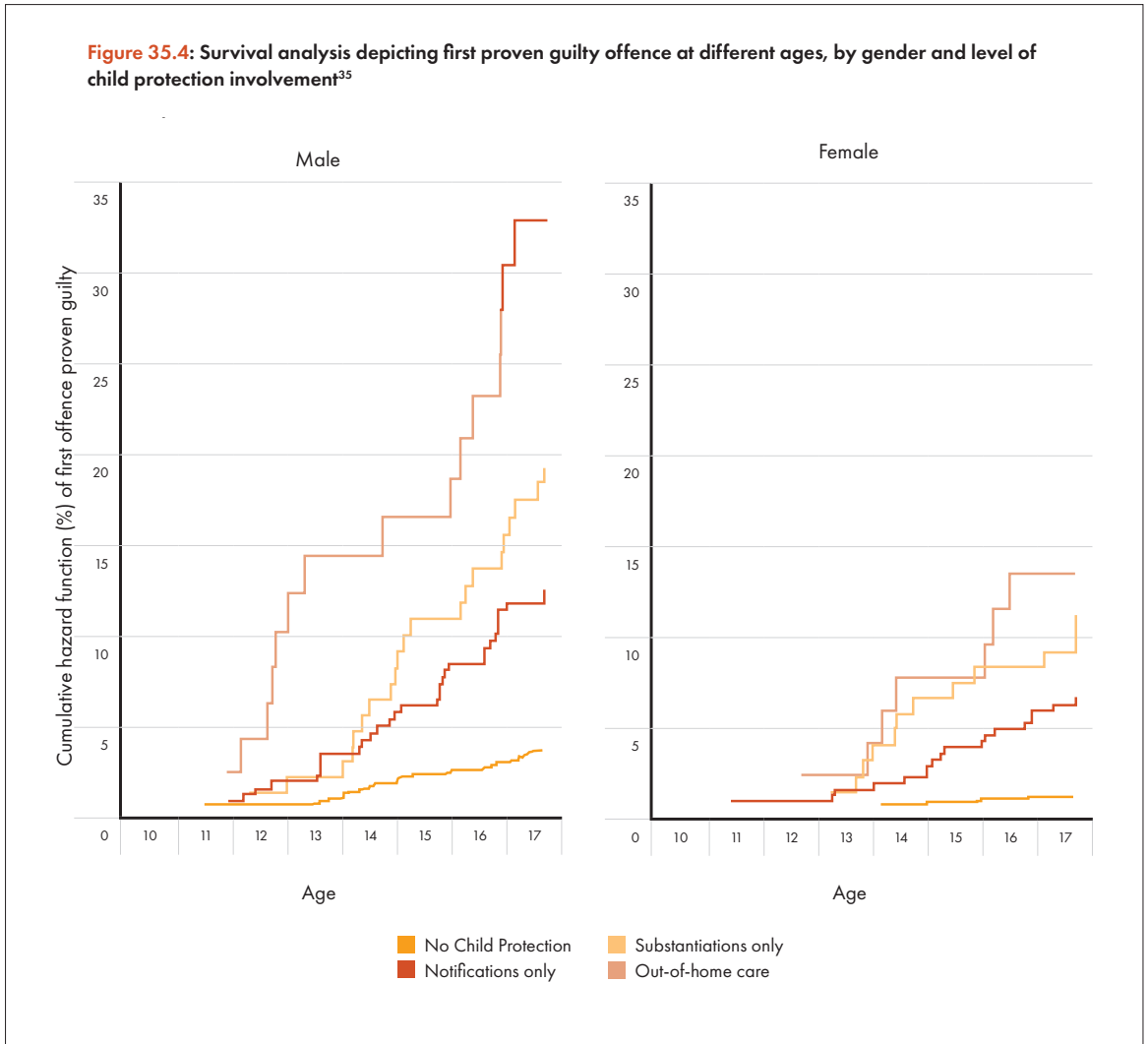
- those without any child protection records (the No Child Protection group)
- those with only notifications but no substantiations (the Notifications Only group)
- those with substantiations but no out of home care placements, (the Substantiations Only group), and
- those placed into out of home care: (the Out of Home Care group).

Due to the small number of non-Aboriginal children found in the youth justice system in this study cohort, the following analyses are broken down by gender only, see Figure 35.4.³³

For both males and females, there is an increasing gradient of risk for first proven guilty offence as level of child protection involvement increases. For males up to the age of 16, those in the No Child Protection group had the lowest cumulative hazard for a proven guilty youth offence with 3.2%

having a proven guilty offence by the age of 16; followed by those in the Notifications Only group, 11.5%; the Substantiations Only group, 18.7%; and the Out of Home Care group, 33.7%.

A similar pattern was observed for females up to the age of 16, with those in the No Child Protection group having the lowest cumulative hazard for a proven guilty youth offence, with 0.6% having a proven guilty offence by the age of 16; followed by those in the Notifications Only group, 5.9% Substantiations Only group, 8.9%; and Out of Home Care group, 13.2%. 95% Confidence intervals for each group were compared to determine any statistically significant differences, with only the difference between the No Child Protection group and the three other groups differing significantly.³⁴



Among those in the Out of Home Care group, some differences in placement experiences were found. Compared to those with a proven guilty offence, those without any proven guilty offences experienced a lower number of placements, entered care at a younger age and were in care for a shorter duration of time; see Table 35.1.

Table 35.1: Placement characteristics of males and females with and without proven guilty offences³⁶

	Male Proven guilty offence		Female Proven guilty offence	
	Yes (n = 19)	No (n = 42)	Yes (n = 9)	No (n = 57)
Number of placements*	11	3	7	3
Duration of placement (years)*	4.4	0.4	5.0	1.1
Age at first placement*	10.2	4.8	10.9	6.1

* The median of the data set has been used in each case

Association of maltreatment type and youth offending

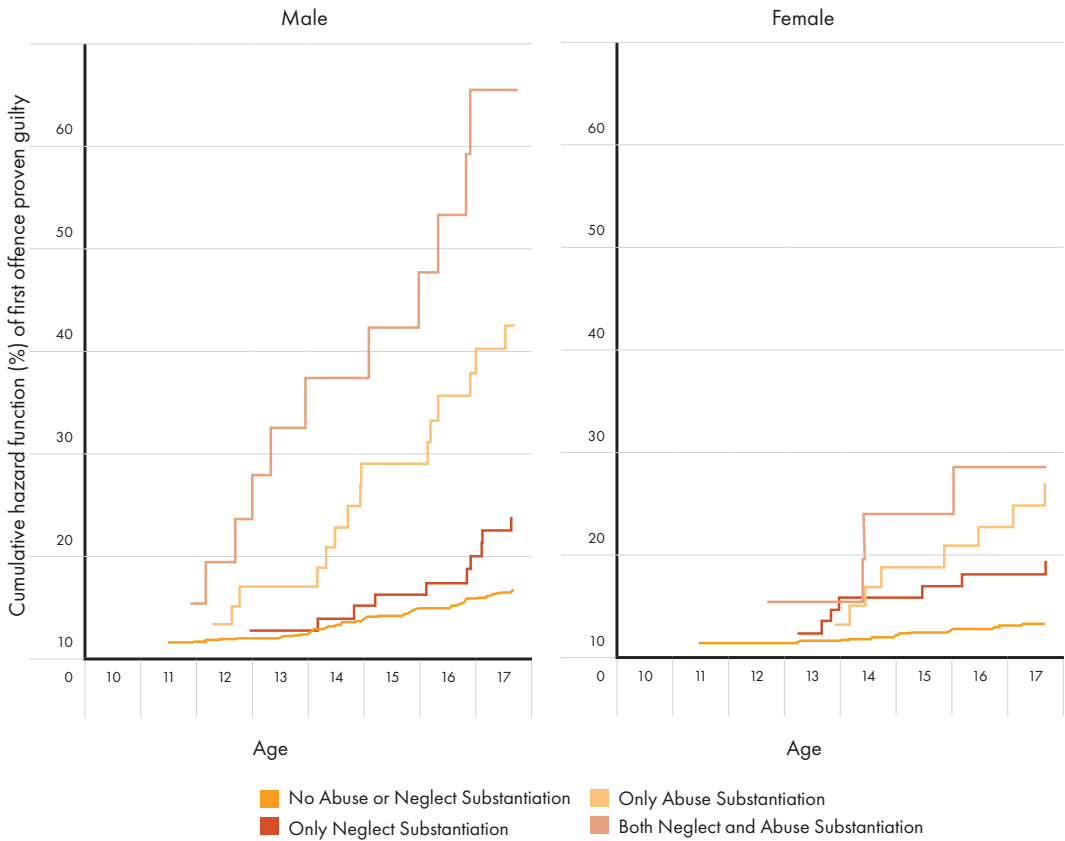
Survival analysis was used to determine the cumulative hazard function for youth offences proven guilty at different ages, by gender and substantiation type, including physical abuse, sexual abuse, emotional abuse and neglect. Four groups were compared:

- No Abuse or Neglect Substantiation group
- Only Neglect Substantiation group
- Only Abuse Substantiation group (includes physical, sexual and emotional abuse), and
- Both Neglect and Abuse Substantiation group.

A similar pattern of results was found for males and females, see Figure 35.5. For both males and females at the age of 16, those in the No Abuse or Neglect Substantiation group had the lowest cumulative hazard for a proven guilty youth offence with 4.9% and 1.8% respectively, followed by those in the Only Abuse Substantiation group with 11.0% and 6.7% respectively, the Only Neglect Substantiation group with 30.9% and 13.4% respectively, and the Both Neglect and Abuse Substantiation group with 53.6% and 17.1% respectively. 95% Confidence Intervals for each group were compared to determine any statistically significant differences, with only the difference between the No Abuse or Neglect Substantiation group and the three other groups differing significantly.³⁷



Figure 35.5: Survival analysis depicting first proven guilty offence at different ages, by gender and substantiation type³⁸



Lessons from the Crossover Research

These analyses highlight the stark overlap between the child protection and youth justice populations in the Northern Territory. An increasing gradient of risk was identified as the level of child protection involvement increased, with those without any child protection involvement having a comparatively lower risk for subsequent youth offences than those with notifications and substantiations for maltreatment. Children placed in out of home care had the highest risk for subsequent youth offences. Although part of the reason for this increased risk is likely to be a direct consequence of the maltreatment experience prior to being placed, research has also shown that certain placement factors are likely to compound initial placement difficulties. The Crossover Research highlighted that children with recorded offences entered care at an older age, experienced a greater number of placements and had stayed in care for longer periods of time.

The Commission is aware that the number of children with notifications in the Northern Territory has increased almost tenfold over the past 18 years.³⁹ If this continues unchecked, the number of children reported to the child protection and youth justice systems could only be expected to increase considerably. This means that compared to the previous generation, a child born in 2017 would be

much more likely to be notified to the child protection system and have contact with the youth justice system, and of having repeated contact with both these systems.

Although the number of children caught in the crossover is relatively small, these children are more likely to have the highest and most complex needs. The characteristics and needs of these children must be considered carefully in order to target support services and programs effectively. Research has shown that intervention programs delivered with challenging and vulnerable populations are effective if they are targeted and specifically address identified risk factors.⁴⁰ The research supports an approach which involves identifying the relevant cohort and then designing and targeting specific services for that group.

Using research to identify and understand the risk profiles of children involved in child protection who are at greater risk of engaging in offending behaviour is also important from an early intervention perspective. It is clear that treating and later trying to remedy the negative consequences of maltreatment and youth offending is both less effective and more costly than preventing this pathway from occurring in the first place. Early identification of these higher risk pathways not only has the potential to alter the trajectories of these children in a positive way, but will also help to reduce the social and economic burden faced by the government and the community.

Recommendation 35.1

Further research be undertaken in the Northern Territory to understand the characteristics and needs of children and young people who have been in both out of home care and detention, to identify the size and characteristics of the crossover issue, to measure the prevalence of trauma-related mental health issues within this group, and to identify the type of need and service requirements for this group. This research to be undertaken by the Crossover Unit mentioned below.

THE CHILD PROTECTION PATHWAY TO YOUTH JUSTICE

The Commission received more than 50 statements and submissions relating to the crossover issue. This material, together with the Crossover Research, provided compelling evidence about the particular vulnerabilities of the children who are subject to both the child protection and youth justice systems.

Other than the 2016 Northern Territory research study noted above, there has been little other research into the crossover population in the Northern Territory. In its absence, the Commission has considered the findings of research elsewhere in Australia and the implications that research may have for the Northern Territory, taking into account the demographic, geographic and jurisdictional differences. Potential lessons from research elsewhere may have value for the Northern Territory in considering options to address the crossover cohort.

Characteristics and needs

Children involved in both the child protection and youth justice systems were widely accepted as having ‘complex needs and behaviours’.⁴¹ Understanding the underlying characteristics and needs of children who offend is a necessary precondition to addressing their behaviour,⁴² especially in terms of the neurobiological consequences of maltreatment and trauma, and how they affect behaviour. Screening and assessments are believed to be critical in achieving an understanding of individual needs across both the child protection and youth justice systems.

Children in care are also more likely to receive charges for first time offences and to be placed on remand in custody instead of being granted bail.⁴³ Finally, screening and assessment of maltreatment and trauma experiences are not commonly undertaken in detention settings.⁴⁴ The consistent theme across both systems is a lack of awareness that the traumatic impact of earlier neglect and abuse on the behaviour of children can lead to the re-traumatisation of children and in detention.

Maltreatment, trauma and complex needs

Evidence to the Commission highlighted exposure to physical, sexual and emotional abuse; and identified characteristics that included a lack of engagement in education,⁴⁵ a lack of life skills, poor self-esteem and sense of purpose in life,⁴⁶ substance abuse issues,⁴⁷ disabilities,⁴⁸ and mental health problems including self-harm, suicidal ideation and suicide attempts.⁴⁹

Research from New South Wales demonstrates that children who were in out of home care who offended and were young at the time of the offence, were more likely to be charged for their first offence, had higher rates of trauma, mental illness, cognitive impairment, self-harm and suicide attempts.⁵⁰ Of these children who offended and were in out of home care 75% of the children spent time in custody on remand. Another New South Wales study found that of 361 youth detainees surveyed in 2009, 60% had a history of child abuse or trauma, 27% had been placed in out of home care and 87% were found to have at least one psychological disorder.⁵¹

A psychologist and case manager from the current Don Dale Youth Detention Centre told the Commission:

‘I would estimate that 98% of the youth we see have a trauma-related background, whether this is from repeated exposure to abuse or derogatory language, crises within the home, or mistreatment by their parents, siblings, aunts/uncles or community. Being removed from the family home is also traumatic, as is frequent incarceration. When you add to that trauma, further violence on the street or drug use, which can impact upon a person’s cognitions, a picture of the difficulty facing our case managers emerges.’⁵²

The complex needs and behaviours of children in the child protection system were identified as contributing to their contact with the youth justice system. The Commission heard evidence from the Chief Psychiatrist that child and adolescent mental health services in the Northern Territory were delivered by multiple service providers using staff with varied levels of training and therapeutic approaches. The services delivered by the Northern Territory Department of Health identified a range of gaps in service provision and assessments, particularly for children in detention and in remote areas, as well as a lack of support for carers to ensure that the needs of children in their care are met.⁵³

The services in Central Australia told the Commission that many of the children seen are not doing well in school, if they attend at all. They are likely to be significantly behind their age peers, be on partial attendance, and have experienced multiple suspensions. Very few will have been formally assessed for learning difficulties, attention, concentration and other executive functioning difficulties. Many may suffer from FASD, with its attendant learning and behavioural challenges, but again, they have usually not been formally assessed for this.⁵⁴

The inadequacy of the mental health system in dealing with the level of psychological distress, mental illness and trauma present in children has been highlighted in research emanating from other jurisdictions around Australia. Recent research in South Australia indicated that addressing the most pressing needs in children experiencing severe psychological distress requires a quadrupling of budgets and staffing of community child and adolescent mental health services.⁵⁵

Research also demonstrates that children are more likely to re-engage with services if they have started to develop a trusting relationship with workers.⁵⁶ The value of mentoring services in this area was supported by research and submissions to the Commission.⁵⁷

Neurobiological factors

Brain damage, whether caused by trauma or prenatal alcohol exposure, can negatively affect development.⁵⁸ Difficulties in attachment and forging relationships and relating to other people,⁵⁹ problems in attention, learning and educational attainment⁶⁰ and emotion regulation issues⁶¹ were identified as the main issues exacerbating the links between maltreatment, trauma and youth offending. Researchers, doctors, psychiatrists, lawyers and judges highlighted how trauma and neurodevelopmental disorders, such as FASD and Autism Spectrum Disorder (ASD), play a role in developing offending behaviour.⁶²

Early life and psychological trauma caused by childhood maltreatment can lead to disorders such as reactive attachment disorder, disinhibited social engagement disorder, post-traumatic stress disorder, acute stress disorder and adjustment disorders in later childhood, adolescence and into young adulthood.⁶³ The Commission also heard about the difficulty in diagnoses without information about an individual's trauma history, and how these trauma symptoms can often be misunderstood as symptoms of ASD, ADHD or other cognitive deficits.⁶⁴

A range of professionals and carers outlined the difficulty in arranging for assessments and obtaining up-to-date reports.⁶⁵ Evidence before the Commission indicated that assessments on a number of occasions were either not performed by Territory Families for children in care, were out of date or never provided to carers, particularly in Central Australia.⁶⁶ This is consistent with the observations of the Chief Psychiatrist that very few of the children seen by the Central Australia Child and Youth Mental Health Service have been formally assessed, given high numbers of those children are in the care of Territory Families.⁶⁷ Similar concerns were raised in the Foster Carer Community Forum and in relation to obtaining cognitive assessments within the criminal justice system.⁶⁸ The Commission heard from a senior legal practitioner in Central Australia whose experience was that the courts rarely ordered these reports due to the high associated costs.⁶⁹

Individual assessments and reports are necessary because of the way trauma responses differ among individuals.⁷⁰ In the absence of these assessments and reports, child protection workers and carers, police officers, the judiciary and youth justice officers may miss fundamental information

about how child maltreatment and neglect lead to trauma and translate into offending behaviour. In relation to court and sentencing outcomes, the culpability of children who suffer from the neurodevelopmental consequences of maltreatment and trauma might be reduced.⁷¹ It was suggested that:

*'If we know trauma impacts the ability of children to develop crucial brain functions and forge relationships and connections ... then we already know that many children who are offending are acting out and are unable to rationalise or mitigate their actions. Punishing children by placing them in detention centres, when they have already suffered disadvantage and trauma, makes no sense from an ethical, legal, economic or welfare perspective.'*⁷²

Given the clear pathway between the two systems identified by the Commission, there is an important need for the comprehensive trauma assessment of children upon entry into detention.

Social disadvantage

Children involved in the child protection and youth justice systems have often experienced entrenched social disadvantage including poverty,⁷³ parental substance use problems, mental illness, disability, low levels of education, incarceration⁷⁴ and family and community violence.⁷⁵ This disadvantage often continues across generations, leading to the disempowerment of individuals and communities.⁷⁶ The intergenerational effects of trauma were described as leading to *'an increased risk of depression and an impaired ability to manage stresses'*.⁷⁷ A solicitor at the Northern Territory Legal Aid Commission described this intergenerational cycle:

*'In one family, I represented a father facing criminal charges. He was convicted and his children were taken into care. Some years later, I represented his children, who were still subject to care and protection orders, in their own Youth Justice Court criminal matters.'*⁷⁸

There was widespread recognition in evidence before the Commission that the mental health system has a significant role to play in assisting crossover children.⁷⁹ Comprehensive mental health assessments are required in this area. The Chief Psychiatrist suggested that these assessments should not only involve the child, but also carers who can provide additional background information.⁸⁰ The need for forensic psychologists and psychiatrists to carry out these assessments, especially in court settings, and to provide appropriate youth-focused mental health services was well recognised.⁸¹

However, it was also recognised that, similar to many jurisdictions around Australia, child and adolescent mental health services struggle to meet demand, with the level of funding in the Northern Territory one of the lowest of all jurisdictions.⁸² Other issues include the limited capacity for child and adolescent mental health services to deliver treatment in youth detention centres, as well as to those living in remote areas.⁸³



Care criminalisation

'A lot of the workers were quick to call the police on me. If I got upset and threw or pushed stuff around they would say, "If you don't calm down we're calling police". Sometimes they just called the police straight away without any warning.'

Vulnerable witness, DB⁸⁴

The Commission also heard evidence that children in out of home care often receive disproportionate police attention for behaviour which would otherwise be dealt with by the family in a family home.⁸⁵ Australian research has identified that compared to parents in a normal family setting carers and residential care workers are more likely to call police to manage behaviour in out of home care settings.⁸⁶ A lawyer at the Central Australian Aboriginal Legal Aid Service (CAALAS) told the Commission:

*'In my experience, it is a common occurrence that young people under care of Territory Families are charged with offences as a result of misbehaviour in residential care placements. Often this behaviour wouldn't be criminalised if it occurred in a private home. For example, children have had outbursts, broken furniture and then have been charged with property damage.'*⁸⁷

The scale of this issue in the Northern Territory is difficult to quantify without relevant statistics.⁸⁸ There was evidence and submissions before the Commission of police being contacted for minor matters, especially those relating to property damage.⁸⁹ Examples included 'damaging a waste paper bin to the value of \$5',⁹⁰ 'kicking a door or breaking a mug',⁹¹ and 'throwing an item in the direction of a worker or breaking a kitchen utensil'.⁹² It was said that in situations such as these, workers were too quick to call for police assistance when alternatives were available.⁹³ In a statement made to the Commission, a solicitor at the Northern Territory Legal Aid Commission said 'the threat of charges and going to court [is] often used as a means to curb or modify behaviour in care'.⁹⁴

Processes by which children in out of home care come into contact with the youth justice system have been described as 'care-criminalisation'. These were:

*'... the processes by which children who are in state care in one form or another, either with foster care, with kinship care, with relatives, or institutional care such as group homes or what you know as residential care, how they end up involved in the criminal justice system.'*⁹⁵

The two primary factors contributing to care-criminalisation are the use of police to manage behaviour and the lack of care, staff training and support.



'I had a curfew from the court 7am [to] 7pm ... After 7pm I was walking out for a cigarette, I asked the carers to open the gate. They said no – if you go out there I will breach you ... I said I know the Court Order I am not dumb I can go outside the gate just not past the bridge ... They started to say okay, and then they opened the gate. Then they said we are calling the coppers. I said fine call the coppers, I know the rules I am not breaching ... So me, [redacted] and [redacted] said it's alright and we went to the bridge and started smoking a cigarette. Then the flashing lights came ... I was swearing and angry then and walked outside saying I will face up to the coppers. But I was scared and hid in the bushes. The coppers arrived ... Coppers said no we just want to talk to her and see if she is alright ... So I came out of the bushes and without even talking anything they grabbed me on my hand and wrist part and said you are under arrest ... I asked the police to stop so that I could talk – [Redacted] said you wanted to talk – I started crying now and said to them I don't want to get locked up I want to stay here and sleep at home – I didn't do anything.'

Vulnerable witness, DG⁹⁶

Dr Katherine McFarlane, who had extensive practical and policy experience in care criminalisation, told the Commission that pressing charges or prosecuting children for the types of behaviour identified above was inappropriate and overly punitive,⁹⁷ particularly for children who often have traumatic histories, and were likely to be further traumatised by these experiences. A solicitor at the Northern Territory Legal Aid Commission told the Commission:

*'While this behaviour is not ideal, it is in my opinion also not conduct that needs to come before the criminal justice system, particularly when you have regard to the circumstances of the young person who is often very troubled, comes from a difficult or traumatic background and is living in an out of home care environment.'*⁹⁸

The Commission heard that in New South Wales police were often called to find children who absconded from placements.⁹⁹ Similar evidence was heard about children who 'self-placed' with partners, friends or relatives in Katherine, where caseworkers, due to staffing limitations and legislative constraints, were forced to use the police to deal with problem behaviours.¹⁰⁰ Foster carers in Darwin expressed concerns and uncertainty as to whether it was the responsibility of Territory Families or the police to return children to their placements when they abscond.¹⁰¹

The Practice Integrity and Performance Unit within Territory Families conducted an internal review in February 2017 into the increasing number of police callouts. They analysed all reportable incidents recorded between 21 November 2016 and 27 February 2017.¹⁰² A reportable incident is any significant incident, or alleged incident, which negatively affects, or is likely to negatively affect a Territory Families client, a staff member, a contracted service provider or a member of the wider community.¹⁰³ The following key findings were produced:

- police were involved in over one third of reportable incidents (37% of cases)
- police involvement was deemed appropriate in 92% of these cases
- approximately 77% of cases involving police occurred in residential care, and
- 19 reports were assessed as inappropriate, principally either because they involved a child missing from their placement for less than 24 hours with no immediate concern for the child's

safety, or because the worker had called the police to assist in managing behaviour in circumstances where no crime was committed.¹⁰⁴

The review noted that police involvement was necessary in a number of instances but that in some cases could have been de-escalated or responded to differently.¹⁰⁵ The Commission notes that the relevant Territory Families policy¹⁰⁶ does not expressly deal with reporting incidents to police or provide practice guidance to carers and caseworkers. While it would be expected that contacting police would be the most appropriate action in some instances, the review does not appear to address the concerns raised by care-criminalisation. The Commission notes that more than a quarter of the police callouts resulted or were likely to have resulted in criminal charges against the child or young person and a further one fifth of the callouts concerned behaviour which might have resulted in criminal charges, directly raising concerns of the increased exposure of a child in care to the youth justice system.¹⁰⁷

The Commission notes that Territory Families commenced specifically recording police involvement on its reportable incident database in November 2016 and is of the view that further work is necessary to investigate the scale of this issue.¹⁰⁸

Criminalisation of behaviour and use of police related to a lack of training and support

It is important that workers delivering programs forge strong connections and relationships with children.¹⁰⁹ Children who have experienced the traumas associated with neglect and abuse are highly likely to be distrusting of adults which presents challenges to those who attempt to establish relationships with them.

A clinical psychologist who worked in the Northern Territory stated:

*'Consistency of a relationship with a professional can be more significant and effective than the type of intervention that is being delivered. It is vital to building trust with the child and their family.'*¹¹⁰

Children who have already experienced adversity and trauma are likely to exhibit challenging and aggressive behaviours, which act as a barrier to service engagement. However, the benefits of building these relationships are clear.

The Commission heard that some foster carers and staff members in non-government agencies did not receive adequate training in understanding and addressing the complex needs of children in their care.¹¹¹ Research suggests that a lack of adequate training for residential care workers is a contributor to care-criminalisation.¹¹²

The Commission noted that the evidence of the Territory Families Acting Executive Director for Out of Home Care noted a growing practice of Territory Families and non-government services engaging in therapeutic crisis training together. Further, that foster and kinship carers were required to undertake induction training that included components dealing with behaviour management and an understanding of stress and trauma.¹¹³ However, it appears there is a disjunct between the formal policies of Territory Families and their implementation.

Vulnerable witness DB told the Commission:

*'When I got upset I don't remember any workers ever asking me if I wanted to talk to some family or to a counsellor. I don't think I was ever asked if I wanted counselling at all until last year ... I knew that the workers would call the police on me for any little thing and it got to a point where I just didn't care.'*¹¹⁴

The Commission also heard evidence that legislative frameworks and funding and staffing restrictions, resulted in caseworkers having few options to address problem behaviours except by notifying the police.¹¹⁵ This suggests caseworkers may be lacking the necessary skill sets to deal with situations that are inevitable in a care environment and possibly a lack of policies and procedures to assist staff members in these situations. Although Territory Families has policies to guide the types of incidents that may require the attention of police,¹¹⁶ there does not appear to be specific guidelines or procedures for carers and workers to follow. Similarly, not all external out of home care providers have their own specific procedures about these situations.¹¹⁷

A former senior youth lawyer in the North Australian Aboriginal Justice Agency's (NAAJA) Criminal Youth Team stated:

*'It is crucial when dealing with high-needs youth, carers would have specialised training and skills. They would also have an in depth understanding of the young person's background. This should include an in-depth induction about the child and information about their unique needs, [for example], information about negative behaviour triggers and how to avoid or manage those triggers, the development and adherence to behavioural management plans, to address certain behaviours to ensure situations do not escalate. Carers should have the skills to try to manage difficult behaviours as an alternative to the child being charged.'*¹¹⁸

Research into these issues has been conducted in other Australian jurisdictions, indicating that these issues are not unique to the Northern Territory. Disproportionate police attention towards children in care has been attributed to a lack of understanding concerning the ways maltreatment and trauma can translate into aggressive and disruptive behaviour and a lack of training in de-escalating and managing these behaviours.¹¹⁹

A 2015 New South Wales study in which 160 Children's Court criminal jurisdiction case files were reviewed over an 18-month period found that almost half of these children had previously spent time in out of home care,¹²⁰ and that they were more likely to be charged for their first criminal offence, with the majority of these charges for care-related offences including property damage and assaults against staff, co-residents or carers.

The Commission acknowledges that measures have been put in place to mitigate the risk of care criminalisation of children in the Northern Territory. In Central Australia, an informal agreement has been reached between the police and CAALAS such that police will generally notify CAALAS when an Aboriginal child or young person is taken into custody.¹²¹ CAALAS, in turn will provide an after-hours, on-call service to these children prior to interviews with police.¹²² The Commission notes that no such program exists in Katherine with NAAJA,¹²³ with a former senior lawyer from NAAJA saying it was 'very rare' to get phone calls in these circumstances.¹²⁴

The Commission also learned of protocols in use in other Australian jurisdictions that are specifically aimed at reducing police contact in out of home care.¹²⁵ These would be valuable not only in

reducing police involvement, but also for maintaining and developing trusting relationships between care workers, children and young people. Reliance on the police to manage behaviour was viewed as hindering the ability to build rapport with children.¹²⁶

Finding

Territory Families, and its predecessors, failed to provide the support needed to some children in care to assist them to avoid pathways likely to lead into the youth justice system.

Recommendation 35.2

A joint protocol be developed between Territory Families, the out of home care service sector and the police to address the management and response to criminal behaviour in the out of home care environment, with an evaluation of the protocol carried out within two years.

Recommendation 35.3

The Practice Integrity and Performance Unit continue to monitor the use of police callouts by out of home care providers with respect to the behaviour of children in their care.

BIAS AND DISADVANTAGE IN THE YOUTH JUSTICE SYSTEMS

The quality and extent of police training to deal with these issues was also raised before the Commission. New South Wales research suggests that less experienced police officers may lack the skills to defuse situations where a child acts out or behaves aggressively.¹²⁷ The Commission heard of an example from an Alice Springs youth advocate where police attended following a night-time callout from a residential carer. The young person in question was alleged to have damaged a caseworker's car. By the time the police arrived, the youth's behaviour had de-escalated following intervention from the youth advocate. He was engaged in discussion with both the care worker and the youth advocate. The police insisted on arresting the youth and attempted to handcuff him despite an offer from the youth advocate to accompany the youth to the police station the following morning for the purposes of a statement. The situation escalated and the youth was then charged with resisting arrest. As he was on a good behaviour bond at the time, he was subsequently incarcerated.¹²⁸ This would now be subject to the informal agreement noted above.

The New South Wales research cited above found that police sometimes treat children who abscond from placements differently to those who run away from home.¹²⁹ Those absconding from placements were more likely to be charged or remanded in custody because they were considered to be a 'flight risk' even if committing relatively minor offences, such as shoplifting socks and deodorant or food. Territory Families policy states:

[W]hen a young person in the care of the Chief Executive Officer (CEO) appears before the Youth Justice Court, the Caseworker as the responsible adult must attend Court and remain in court to support the young person and assist the Court to understand their situation.¹³⁰

The Commission heard from the CREATE Foundation that the results of a 2016 national survey on experiences for children in care showed overall that 77% reported having some connection with the youth justice system and 34% of children and young people in care did not receive child protection support during interviews with police.¹³¹ This is consistent with evidence the Commission heard that it is not uncommon for a representative from Red Cross to be present at police interviews instead of the relevant Territory Families caseworker, or for a departmental worker with no prior relationship with the child to attend.¹³²

In addition, the Commission was told that it was a regular occurrence for Territory Families child protection caseworkers to fail to attend court. While the Commission understands that there has recently been improvement, it remains concerning that caseworkers continue to fail to attend on a regular basis.¹³³

Vulnerable witness CK told the Commission about an occasion where a child protection caseworker did not attend court and her matter was adjourned so that a departmental representative could attend. CK told the Commission that she waited in the court cells and this made her feel 'angry and upset'. When the matter resumed in the afternoon with two child protection caseworkers present, the magistrate expressed concern about the earlier absence.¹³⁴

Territory Families has a clear procedure detailing the duties of a caseworker appearing in court as either a support person or responsible adult.¹³⁵ However, evidence before the Commission indicated that practice was not always consistent with the policy and when caseworkers were involved, they often appeared to have limited understanding of their role,¹³⁶ had limited knowledge of the issues relating to the child,¹³⁷ failed to seek legal advice or representation for the child¹³⁸ or failed to engage with the child's existing legal representative.¹³⁹ The absence of a responsible adult can sometimes prolong the court process.¹⁴⁰ A former NAAJA lawyer described his interaction with a caseworker:

'I asked them to ensure the young person was aware of their right to request legal advice prior to an interview. The worker clearly was not aware that you could do this. To me, this example highlighted the failures in our system in regard to vulnerable children in police custody.'¹⁴¹

In situations where children had specific vulnerabilities or cognitive deficits, in particular mental health or FASD, that should be made known to police or the judiciary. Where a caseworker has a role as a Responsible Adult Responsible Adult but is without a complete understanding of the child's rights, such a situation is clearly detrimental to that child.¹⁴² One lawyer noted:

'Many youth clients had complex needs and issues, including mental health, untreated complex trauma, untreated substance misuse, having long disengaged from school, lack pro-social and recreational activities, influence by negative peers, low self-esteem or self-image. It was essential that we and the court were informed of their situation so that we had some chance of trying to assist where we could.'¹⁴³

The Commission was informed that a memorandum of understanding (MOU) between NAAJA and the Department for Children and Families, now Territory Families, was developed as a way to set

out the respective roles and responsibilities of the two agencies for children involved in the youth justice system.¹⁴⁴ The MOU was to assist in appropriate and timely information-sharing practices between the agencies so that children were effectively represented in court proceedings. However the Commission was also told that many caseworkers were not aware of the MOU and adherence with the MOU was inconsistent.¹⁴⁵

Issues were also raised with the Commission about the preparation of 'section 51 reports'¹⁴⁶ by Territory Families on order of the court, to determine the circumstances of children who present in court without a responsible adult. These reports often relate to children who are known to the child protection system. Some had been the subject of multiple notifications that, due to a lack of information or failure to meet thresholds, did not proceed to any investigations.¹⁴⁷ Concerns were raised by the court about the quality of these reports as not 'adequately assessing the subject children's circumstances' resulting in an internal review suggesting improvements.¹⁴⁸ The Commission heard that the timeliness of these reports was critical, with the possibility of children being remanded in custody for up to 15 days while these reports or related support plans were completed.¹⁴⁹

Problems associated with bail and diversion

The Commission heard from the Director of Community Corrections that it was widely acknowledged that there was a lack of safe, stable and supportive accommodation options for children and young people,¹⁵⁰ and heard evidence and received submissions that this was a frequent barrier to grant of bail for children in care.¹⁵¹ A specific lack of crisis accommodation in Darwin was identified.¹⁵² The Commission heard that departmental caseworkers could only request their placement team to find alternative placements after the young person was granted bail or released.¹⁵³ In the Commission's view, this would cause problems where a child's charges relate to their behaviour in the care home as the court is required to consider the previous, current or proposed living arrangements for both the child and the alleged victim under the *Bail Act (NT)*.¹⁵⁴ One legal practitioner observed that obtaining alternative placements in those circumstances was particularly difficult and finding alternative placements seemed 'complicated and arduous'.¹⁵⁵

It was suggested that caseworkers sometimes advocated for placements in detention rather than opportunities for bail and 'described Don Dale as a placement'.¹⁵⁶ A solicitor from the Northern Territory Legal Aid Commission gave the following example:

*'I recall DCF [Department of Children and Families] caseworkers attending at court, conferencing with the prosecutor and advocating that a young person in their care should not be granted bail. It was concerning that DCF seemed to take the opinion that caring for the child was too hard or that there was no other suitable placement for them.'*¹⁵⁷

The Commission also heard troubling evidence that children in care preferred being in detention to an out of home care placement.

'When CK was asked which place she thought was the best place for her to stay, CK said 'detention'.¹⁵⁸ CK explained that youth detention was her best placement when she was in care because 'no other kids were doing things like sniffing and that, and there [were] no drugs or alcohol round us, and because there was a lot of schooling and

programs and it's more safe.¹⁵⁹ CK's time in youth detention was the only placement that provided CK with an ongoing stable environment through which she could access rehabilitation services and education.'

Although described by the Children's Commissioner as an 'historical practice',¹⁶⁰ a senior manager at Territory Families said she was aware of some very extreme situations during her 13 years at Territory Families in which child protection agency representatives had taken a view that custody was better than the alternatives, or necessary to prevent continual absconsions, and this view was made known to the court.¹⁶¹ When asked about whether caseworkers could oppose bail in situations where the caseworker considered they would be better able to access the young person and to work with them, the senior manager said:

*'A case manager would never be free to make that decision themselves. There is nothing beneficial, generally, to having a young person in detention at all. That's known. There have been one or two occasions in the 14 years that I've worked with the Department, 13 years, that I am aware that a situation was so extreme and the concerns for the young person were so extreme that that was done.'*¹⁶²

Although the practical consequences of detention might enable 'a window of opportunity for their case managers to develop [a] relationship' with young people,¹⁶³ the Commission understands that it is not a 'standard position' for the Department to oppose bail or preference detention over release for these reasons. The Commission believes that careful attention should be directed towards ensuring that detention is always the last resort option for dealing with children and young people who offend.

These issues were also discussed in the 2011 review of the youth justice system:

'An additional challenge for agencies, particularly DCF [Department of Children and Families], is that there are limited options for placement, treatment and care. For example, DCF advises that there is evidence that for some young people: Involvement in both systems results in [them] being referred from one system to another, and for detention to be considered as a temporary "safe place". The issue was canvassed as a concern in the [2010 Board of inquiry].

*This is consistent with anecdotal reports received by the Review that, due to the unavailability of alternative placements, some young people who are the subject of statutory protection orders have remained in detention for longer than may otherwise be warranted.'*¹⁶⁴

Based on evidence before the Commission, it appears that there is a lack of suitable accommodation options for children in care involved in the youth justice system, raising the possibility identified by the Carney report in 2011 that on some occasions this might extend time in detention. The evidence from an Acting General Manager at Territory Families was that no such instances had come to her attention, although she could not say it had never happened.¹⁶⁵ A delayed release may also be caused by many other factors, including that workers from Territory Families fail to attend some bail applications or provide sufficient information to the court.

Research in other jurisdictions suggests that children in care who were granted bail, particularly those in residential care, could be subject to a higher level of scrutiny in complying with their bail conditions.¹⁶⁶ The Commission received submissions suggesting that Territory Families more commonly report minor breaches of parole to police, including breaking a curfew by 30 minutes.¹⁶⁷ Although children need to be held accountable for their actions, such strict and punitive responses are not necessarily consistent with good parenting practices and can lead to children spending time in custody when alternative options might be available.

The inability to provide appropriate accommodation or placements for children in these situations has been documented previously in the New South Wales context¹⁶⁸ and has been a topic of research in other Australian jurisdictions. This is also at odds with the requirements of international instruments to which Australia is a signatory and the requirements of the *Youth Justice Act (NT)*, all of which stipulate that custody for children should be a last resort option.

Lack of case coordination and planning in detention

The Commission heard evidence from senior legal and health practitioners that Territory Families often ceased providing services to children in care if they went into detention, particularly if they were to be detained for any length of time.¹⁶⁹ One practitioner was of the opinion that caseworkers from Territory Families ‘washed their hands’ of these children or failed to visit them,¹⁷⁰ while a foster carer gave evidence of her view that both the child protection and youth justice agencies were ‘handballing’ the responsibility for these children between them.¹⁷¹ This failure of ongoing responsible case management in these situations has been identified at a national level by the Chief Executive Officer of the CREATE Foundation, who said ‘there was no continuum of care established for the children by the relevant child protection agency while they were on remand or incarcerated’.¹⁷²

The evidence of Territory Families was that visits by caseworkers to children in detention usually took place weekly and there was regular information sharing with youth detention centre caseworkers. It was noted that this was dependent on individual caseworkers and how active they were as ‘existing procedures do not set out detailed requirements for how this function is to be carried out’.¹⁷³ Senior Territory Families staff recognised the need for ‘ongoing case management support’ for children in detention, but accepted this was not always achieved.¹⁷⁴ Territory Families accepted the need for improvement:¹⁷⁵

‘What tends to happen is that when children who are in care end up in Don Dale [Youth Detention Centre], or any detention centre for that matter ... because their general care needs are being met at that stage ... for case managers ... it has tended to be a time when they have got on with other work with their high caseloads, and that’s the thing that we have been trying to raise with them, the need for that continuity of the contact with the kids in care and to continue with the planning around their care planning.’¹⁷⁶

Submissions from CAALAS highlighted this failure:

‘CAALAS considers this approach to be an unacceptable abrogation of responsibility on the part of Territory Families. It is incumbent upon a government agency with parental responsibility for a child in detention to regularly monitor the circumstances of their detention and ensure their wellbeing. It is not acceptable and manifestly wrong for

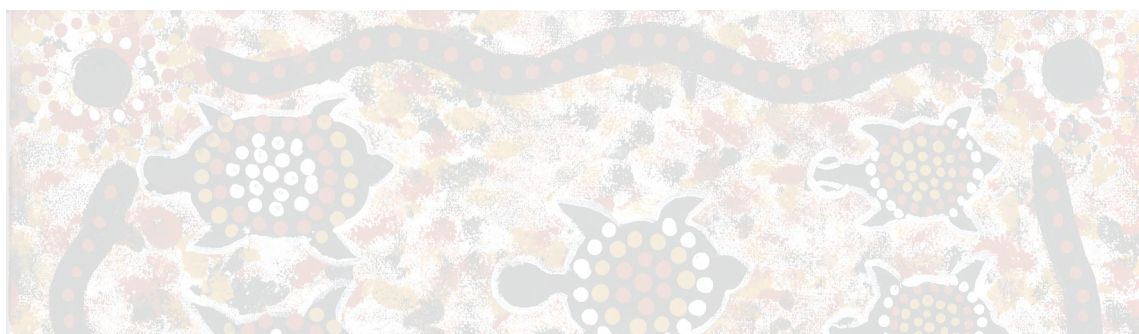
*Territory Families' workers to assume that another government department is meeting that responsibility.*¹⁷⁷

Some children leaving detention and returning to out of home care either did not have a transition or accommodation support plan, or did not have one developed in a timely manner.¹⁷⁸ In the context of bail, the inability to find a suitable placement was said to impact the length of time a child was remanded in custody.¹⁷⁹

This was said to be an additional source of stress for children in detention,¹⁸⁰ and the Commission received submissions that this was particularly so where children were not advised of their accommodation arrangements until the day of their release.¹⁸¹ For children turning 18 during their time in detention, the absence of a transition plan is especially difficult. A senior solicitor at the Northern Territory Legal Aid Commission told the Commission that some children may leave detention with minimal assistance, despite the statutory obligations owed to them under the *Care and Protection of Children Act* (NT).¹⁸² This is consistent with evidence the Commission heard in relation to deficiencies in Territory Families' processes for children leaving care.

*'BushMob had a child bailed to their residential program from Don Dale Youth Detention [centre] who was under a long-term placement order with the Department of Children and Families. The Department of Children and Families was unable to produce a care plan and were unable to locate a suitable placement for the child when he finished the BushMob program. BushMob told the Department of Children and Families that the child did not want to go to the temporary placement that was proposed for him as he was concerned it would result in him being stressed leading to further offending. The temporary placement was nonetheless made. The child reoffended.'*¹⁸³

There are obvious and significant challenges in breaking the trajectory between out of home care and detention for the many children in care who come to the attention of police and are charged with an offence. These children face significant disadvantages at all stages of the criminal justice process, from police intervention, to court processes, bail applications, and finally, in detention. One legal practitioner was of the view that the Department had in some instances *'as the parent of these children in care, failed to fulfil their duty to ensure these children's rights and interests are protected.'*¹⁸⁴ It is clear that more needs to be done to identify the reasons for these failings and prioritise the needs of children involved with the criminal justice system when the state holds parental responsibility for them.



OTHER SYSTEMIC ISSUES

Punitive systems

The Commission heard concerns that in direct contradiction to the necessity to appreciate offending behaviour as likely to be trauma related, both the child protection and youth justice systems treat children who offend in a punitive and adversarial manner,¹⁸⁵ with the Chief Executive Officer of Danila Dilba Health Service observing:

*'The watered-down, adult appropriate competencies of these staff are inappropriate for the culturally appropriate, therapeutic, rehabilitative interventions required to work with the trauma suffered by youth in custody in Don Dale.'*¹⁸⁶

The Commission also received a submission raising concerns that staff on occasion did not understand behaviours triggered in response to previous traumatic experiences and were unable to manage such behaviours effectively.¹⁸⁷ A clinical psychologist working with children in detention said that it was typical to see children in this setting acting in a way that *'simply [expressed] the very natural distress of a child who was not able to live in the family home and felt lonely and confused'*.¹⁸⁸ Many raised concerns regarding the lack of realistic expectations placed on children, for example, even in simply being able to *'plan to be on time [or] to be self-motivated to make appointments'*.¹⁸⁹

Although many maintained the view that punitive systems do not effectively work to deter or rehabilitate children who offend, it was recognised that *'these insights are not necessarily common knowledge to all stakeholders within the criminal justice system, nor are they built comprehensively into policy'*.¹⁹⁰

Lack of collaboration and service provision

The absence of collaboration and co-ordination was also an issue. Workers in the child protection and youth justice agencies were viewed as operating separately rather than in collaboration.¹⁹¹ For example, the Commission received evidence from a non-government organisation describing how a lack of collaboration could lead to different approaches in service provision and case management.¹⁹² This included situations in which a child was permitted by Community Corrections staff to stay overnight at a family member's residence. However, Territory Families had not approved this access due to safety concerns.

The Commission notes that fortnightly communications meetings and fortnightly case conferencing have been implemented between Territory Families and the current Don Dale Youth Detention Centre since February 2016,¹⁹³ and that it is the expectation of Territory Families that the transition of youth justice to Territory Families will result in each department obtaining access to the other's databases.¹⁹⁴ The Commission views these as necessary and valuable improvements. However, the evidence continues to raise concerns about poor interdepartmental communications, such as from BushMob that:

*'There has never been a referral to BushMob showing evidence of effective joint and/or sequential case management between government agencies, nor a referral that has demonstrated the effective involvement of other service providers, families and young people themselves.'*¹⁹⁵

The July 2016 “A Safer Northern Territory through Correctional Interventions” – Report of the Review of the Northern Territory Department of Corrective Services (the Hamburger report) similarly found a lack of involvement of youth justice officers in the case management of detainees and that case management processes and outcomes within youth detention centres were not joined up with case management systems in the Department of Children and Families¹⁹⁶ Evidence before the Commission pointed to fundamental issues regarding workplace culture within Territory Families:

‘There appears to be a culture within the child protection department where there is not enough of a predisposition to work in collaboration with families and non-government organisations.’¹⁹⁷

The Commission heard evidence that following the recent transition of youth justice to Territory Families, there has been a more collaborative approach between youth detention centres and child protection caseworkers. Territory Families noted that in the past that:

‘It was not unusual for a court to order a report from Community Corrections, Territory Families and the [youth] detention centre case management and to be provided with three different reports making quite different recommendations about the young person.’¹⁹⁸

There was a view that Territory Families should take the lead role in cases where a child is involved in both the child protection and youth justice systems because of the agency’s statutory responsibility.¹⁹⁹ The evidence before the Commission was that where a young person was in detention, Territory Families maintained responsibility for matters other than those directly related to the young person’s detention, which were the responsibility of a detention case manager.²⁰⁰

Barriers to service provision within the detention setting were also identified. This included the inability of some agencies to provide services or run their programs on the outreach basis required when children are in detention.²⁰¹ Research in other jurisdictions has viewed such gaps as contributing to failures in meeting the needs of children who are in detention, especially for mental health issues.²⁰²

It is evident that adopting a predominantly punitive or adversarial approach responding to children who offend and who are suffering from the effects of past and recent trauma due to neglect or maltreatment, or who are in out of home care is neither effective for addressing challenging behaviour, nor developmentally appropriate. Responses that fail to recognise the consequences of trauma and maltreatment on brain development do nothing to meet the goal of rehabilitation and may arguably accentuate their problems. Territory Families has recognised that work needs to be done to identify the best way to case manage children involved in both systems to ensure they receive the support and services needed to address their needs and their behaviour. It has implemented changes to its practices but more work is necessary. Effective cross-agency collaboration and appropriate and timely information sharing practices are critical. Data collection in these areas must be improved so that the characteristics and needs of children involved in both systems can be identified and services can be tailored accordingly.

ADDRESSING THE PATHWAY FROM CHILD PROTECTION TO YOUTH JUSTICE

Assessing criminogenic risk in out of home care

Territory Families has identified that assessing criminogenic risk factors in children who come into the child protection system, specifically in out of home care, is a priority.²⁰³ Research suggests that these risk factors fall into two broad groups, static factors (risk factors that cannot be altered or changed) such as previous offence history or family criminality, and dynamic factors (risk factors that can be changed) such as personality attributes, attitudes, or behaviour; for example anger, aggression, substance use and antisocial beliefs.²⁰⁴

Territory Families have indicated that they are reviewing child protection system policies and procedures and are considering the introduction of a tool similar to the Youth Level of Service Case Management Index (YLS/CMI) to assess criminogenic risk in children and young people in the child protection system.²⁰⁵ This tool is currently used in the youth justice system to identify criminogenic risks and needs and to facilitate case planning.

Youth Level of Service Case Management Index (YLS/CMI)

It is unclear at what point of contact with the child protection system a tool such as the YLS/CMI might be used, other than when a *'case manager identifies that [a young person] may be at risk of entering the youth justice system, for example, where they have been exhibiting antisocial behaviour.'*²⁰⁶

The YLS/CMI was specifically designed for use with young offenders and is predominately used to assess recidivism or the risk for re-offending. If caseworkers were to use a tool of this nature to assess children and young people who are yet to engage in offending behaviour, this would run the risk of labelling children and young people before they have even started to offend. There is substantial evidence to suggest that harsh responses that fail to account for the individual needs of young offenders increases the likelihood they will offend in the future.²⁰⁷ Treating maltreated children and young people in this way could itself contribute to the risk of offending.²⁰⁸

A tool based on the YLS/CMI may be problematic. There is a substantial body of research that has tested the validity of the YLS/CMI measure in Australian jurisdictions.²⁰⁹ Studies have demonstrated weaker predictive validity, that is, the ability to discriminate between recidivists and non-recidivists for different subgroups of offenders, for example, in girls and ethnic minority groups.²¹⁰ The YLS/CMI in particular has been shown to exhibit a noticeable weakness in discriminating between high and low risk ethnic minority young offenders in Australia.²¹¹ This research suggests that due to the widespread socioeconomic disadvantage of many Aboriginal young people, scores might be inflated because of unchangeable static factors that are associated with such disadvantage.

Research has also shown that the YLS/CMI has poor predictive validity for young people who cross over between the child protection and youth justice systems.²¹² These individuals scored higher on a number of risk factors for re-offending but their risk scores did not correspond with recidivism rates. This indicated that the YLS/CMI was not a valid predictor of re-offence by risk level, and therefore might not be appropriate for the majority of children and young people in out-of-home care who are likely to have maltreatment histories.

Recommendation 35.4

The Northern Territory Government in conjunction with Menzies School of Health, investigate the development of a tool appropriate for usage in the Northern Territory, the purpose of which is to identify young people for whom intensive support and intervention would be successful in avoiding involvement in the criminal justice system.

Criminogenic risk assessments, if used in the child protection system in the Northern Territory, are to take into account:

- **the need for assessments to be properly validated in the different populations in which they are intended to be used, and**
- **cultural, gender and ethnic differences, especially given the over-representation of Aboriginal children in both systems.**

Wraparound services, advocacy programs and therapeutic models

Two Northern Territory programs which engage both youth justice and child protection staff were described to the Commission. They are the Youth Justice Advocacy Project,²¹³ which provides support and advocacy for children facing court for criminal charges, and a program run by Danila Dilba Health Service in the current Don Dale Youth Detention Centre, which focuses on therapeutic activities within the detention setting.²¹⁴

Both programs work with and engage other agencies and stakeholders, including Territory Families caseworkers, legal representatives, schools and family members, to ensure that services can be coordinated to meet the needs of their clients. Although the Commission is not aware of any evaluations into the success of these programs, they are promising because they attempt to provide wrap around services for the child rather than focusing on a single area. They also attempt to develop and strengthen relationships not only with the child, but also between all stakeholders involved in their care and rehabilitation.

Wraparound services in other jurisdictions have also been found to target the complex needs of crossover youth effectively. For example, the Children's Civil Law Service (CCLS) in New South Wales developed such a service after identifying that children with a repeat need for Legal Aid, often had involvement with both the youth justice and child protection systems. Comprising solicitors, paralegals, social workers and youth workers, the CCLS has developed a targeted service for this group that recognises their complex needs. CCLS coordinates relevant service providers across many

government and non-government areas. Success is thought to be more likely if these services are wrapped around a child, addressing the systemic issues that contribute to the crossover and tailoring services for each child. According to the senior solicitor on the team:

*'The CCLS has allowed a more nuanced approach in working together in addressing some of the issues underlying criminal charges, particularly in relation to young people in residential [out of home care].'*²¹⁵

The importance of a therapeutic relationship was also emphasised in other evidence and statements made to the Commission. Crossover youth can present more challenges to establishing relationships and it is important that workers delivering programs forge strong connections with them.²¹⁶ A clinical psychologist who worked in the Northern Territory said:

*'Consistency of a relationship with a professional can be more significant and effective than the type of intervention that is being delivered. It is vital to building trust with the child and their family.'*²¹⁷

This is often challenging for both service providers and children. As outlined throughout this chapter, children in the child protection and youth justice systems have experienced significant trauma, and these experiences shape the way they interact with others. They often exhibit challenging and aggressive behaviour, which act as a barrier to service engagement. The benefits of building these relationships are clear, with research demonstrating that children are more likely to re-engage with services if they have started to develop a trusting relationship with workers.²¹⁸ The value of mentoring services in this area is supported by research.²¹⁹

Others emphasised the importance of relationships with family members and community.²²⁰ Interventions that focus not only on the child's offending behaviour, but also on key aspects of a child's social environment, were emphasised in a statement made to the Commission:

*'Given that risk factors ... are linked to an array of environmental factors, treatments and interventions that are effective to address these issues. Interventions therefore should focus on the key aspects of a young person's social ecology, such as building more effective family functioning, disengagement youth from deviant peer networks ... as well as enhancing engagement with school and academic performance.'*²²¹

Both the Chief Psychiatrist²²² and the 2011 Carney report²²³ referred to a number of evidence-based therapeutic models operating interstate and overseas. Multisystemic therapy and functional family therapy were approaches for addressing the complex needs of young offenders.²²⁴ The acceptance of these programs is rapidly growing, with a number of evaluations conducted throughout the world.

Recommendation 35.5

Territory Families:

- **create a Crossover Unit to oversee and manage children in care who fall within the crossover group**
- **engage specialised caseworkers with training in both child protection and youth detention in the Crossover Unit to work with children who have been, or are, in care and detention, to deliver and coordinate services targeting**

- the needs of the child, to minimise the risk of offending or re-offending and work in co-ordination with any legal service representing the child, and**
- **develop, flexible, dynamic services specific to the needs of crossover youth to include:**
 - **targeted services of high intensity, designed specifically for children in the crossover group**
 - **therapeutic models that focus on meeting the needs and changing the behaviour of the child while simultaneously addressing social and environmental risk factors, and**
 - **a mentoring and/or visitor program, to provide the prospect of additional adult connections for children in the crossover group.**

Systemic changes

The Commission recognises that a whole-of-government response is required to address issues relating to the crossover between child protection and youth justice systems.²²⁵ Interagency collaboration, especially between Territory Families, police and the legal system is important.²²⁶ The development of services must take place in a multi-agency context and in collaboration with Aboriginal communities.²²⁷

There was widespread recognition across various statements made to the Commission that the mental health providers have a significant role to play in assisting crossover youth.²²⁸ Comprehensive mental health assessments of the children involved are required in this area. The Chief Psychiatrist of the Northern Territory Government suggested that these assessments should not only involve the child, but also carers who can provide additional background information and who also will be involved in care and support.

Similar to many jurisdictions in Australia, child and adolescent mental health services struggle to meet demand, with the level of funding in the Northern Territory one of the lowest of all jurisdictions.²²⁹ There is also limited capacity for child and adolescent mental health services to deliver treatment in youth detention centres, and to those living in remote areas.²³⁰ Recent research in South Australia indicated that addressing the most pressing needs in children experiencing severe psychological distress requires a quadrupling of budgets and staffing of community child and adolescent mental health services.²³¹

High importance must be placed on developing a workforce equipped to deal with the complex needs of children who crossover between the child protection and youth justice systems.²³² All stakeholders who have contact with these children require significant training to understanding the crucial stages of their development and the way maltreatment and trauma influences developmental processes. Although trauma training is likely to improve awareness and lead to 'the development of reflective practitioners',²³³ some specialist caseworkers are needed.

An experienced former NAAJA lawyer observed:

'A specialised workforce is needed to work with highly traumatised "crossover kids". This workforce needs to have small caseloads, with a trauma-informed approach that is appropriate to the developmental needs of these young people, and in relation to all

*of a child's needs, and not just in "silo". This expert workforce to work intensively with highly traumatised "crossover kids" is, in my view lacking in the Northern Territory and departmental staff are then asked to do the best they can when they simply do not have the capacity, given the rest of their workload, to support the child in the intensive way that that child needs.'*²³⁴

Managers and executives should be involved in providing regular, ongoing supervision and support for front-line workers and they, too, need to be fully conversant with the best research in this area if they are to do so effectively.

The importance of training also extends beyond those working directly with individuals in the child protection and youth justice systems. Professionals in other government and non-government agencies, including the police, legal services and the judiciary, also need to be trained in trauma-informed approaches.²³⁵

Joint planning and coordination is required, with information sharing and collaborative policies and procedures in place to ensure that the needs of crossover youth are met. This extends beyond the responsibility of Territory Families, with a whole-of-government response.

Recommendation 35.6

Child protection caseworkers:

- **have regular face-to-face contact with any child in detention who is also under care and protection orders**
- **monitor the wellbeing of children in detention and ensure that their needs are being met, and**
- **be involved in transition planning for a child in detention from the time of their entry into detention, in consultation with detention staff, key stakeholders and the child.**

Recommendation 35.7

A detailed plan for information-sharing and collaboration between workers in the child protection and youth justice sectors of Territory Families, and other relevant agencies, be developed.

Implications for further research, policy and practice

The crossover group of children presents complex management issues but they are not insuperable. The group has received limited research attention in the Northern Territory until recently, but with advances in data-linkage techniques more detailed research can guide the design and delivery of effective intervention services.

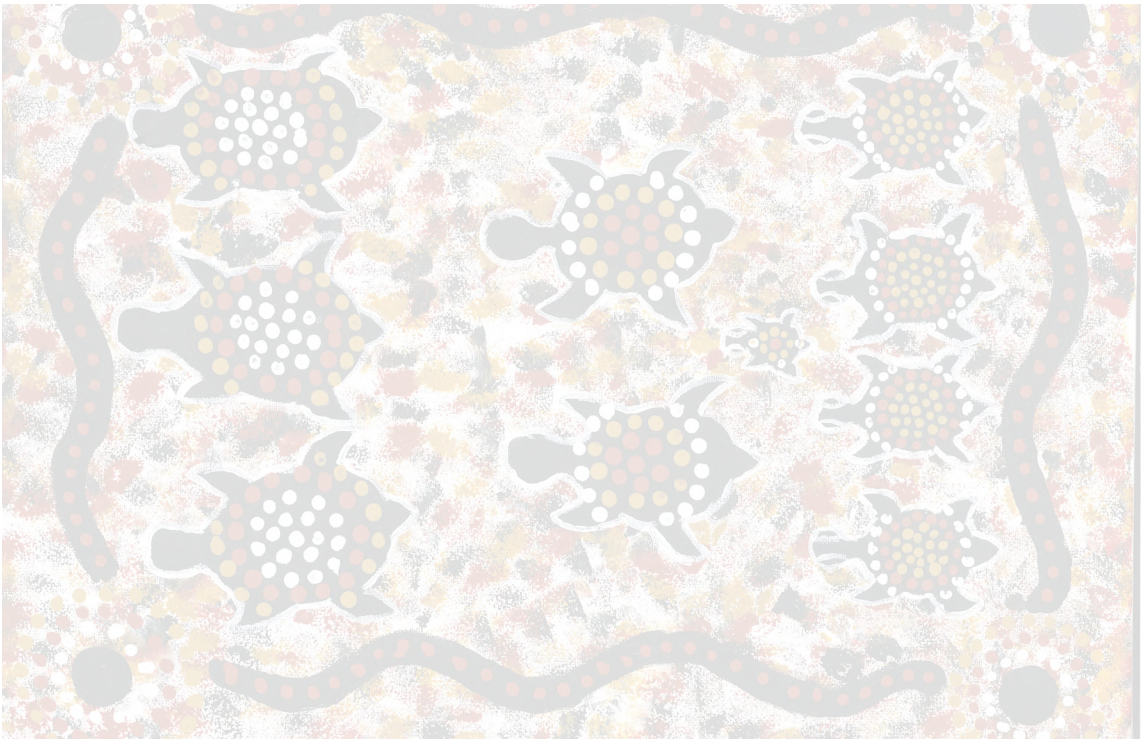
The constellation of consequences that arise from maltreatment and trauma which likely underpin antisocial behaviour can be ameliorated. For example, early attachment disorders can be rectified

through the provision of safe and stable environments with consistent and patient adults or carers.²³⁶ Self-regulation difficulties are amenable to change through early intervention.²³⁷ However, to do so requires skilled staff who understand the underlying links between trauma and behaviour. In the absence of appropriate training and support, opportunities for intervention are likely to be missed.

To this end, Territory Families has commenced a review of its policies and procedures, looking specifically at changes designed to reduce the likelihood that those involved in the child protection system will become involved in the youth justice system.²³⁸ The Acting General Manager of Youth Justice at Territory Families told the Commission that the integration of youth justice and child protection was a significant *'step forward'*, and represented a *'structural change'*.²³⁹ She noted that the review would involve changing policies to reflect Territory Families' new focus on identifying and intervening in criminogenic risk and need.²⁴⁰ The Commission was also informed that the shift in focus would involve supplementing training for case managers, both when they commence, and in an ongoing way, to equip them to recognise and act on indicators of criminogenic risk and need.²⁴¹

A deeper understanding of the systemic issues that contribute to the crossover of children between the child protection and youth justice system is also needed. This includes better training for police, lawyers and the courts.

Although the overall number of individuals who are involved with both the child protection and youth justice systems might be small, the cost of maintaining this population in these systems is often very expensive relative to the wider population. These children are more likely to give rise to longer-term social and financial costs. Interrupting this pathway, as well as preventing it from occurring in their first place, will not only result in better outcomes for the children themselves, but is beneficial for governments and society in general who ultimately bear the physical, emotional and financial costs of crime.



CROSSOVER TECHNICAL RESEARCH REPORT

Association between Child Protection and Youth Justice Involvement

Background

The Menzies School of Health Research was commissioned by the Royal Commission into the Protection and Detention of Children in the Northern Territory to undertake preliminary analyses of the association between child protection and youth justice involvement for Northern Territory (NT) children. Using linked de-identified NT government (NTG) administrative datasets, the Menzies data-linkage team have constructed a linked dataset to follow a cohort of all children, born in the NT during 1999, from birth to age 16 years.

Research Questions

The study adopted a life-course perspective to examine the following research questions:

1. What is the *cumulative hazard function*, by age of child, of the **first** episode of notification, substantiation and out-of-home care placement for NT children, by Aboriginal status and gender?
2. What is the *cumulative hazard function*, by age of child, of the **first** substantiated episode of neglect, emotional, physical and sexual abuse for NT children, by Aboriginal status and gender?
3. To what extent does contact by NT children with the child protection or youth justice system overlap?
4. What is the association between level of contact of a child with the child protection system and youth offending?
5. What is the association between the type of maltreatment of a child and youth offending?

Data sources

This project used linked de-identified datasets assembled for the Menzies-NT Government Child and Youth Development Data-linkage Research Partnership. Data linkage was facilitated by SA NT Datalink. For this project, data from the following sources were linked: *health* (perinatal and immunisation data), *education* (including school enrolment, attendance and NAPLAN data), death registration data, *child protection and youth justice* datasets.

Study design

This project used an historical birth cohort design. The birth year of 1999 was chosen to maximise the opportunity for inclusion of a child in both the child protection and youth justice data systems (that is, from birth up to and including age 16). Using Perinatal Registry data, 2,830 individuals born in the Northern Territory between 1st of January 1999 and 31st of December 1999 were selected for analysis (1,246 Aboriginal and 1,584 non-Aboriginal children). In Youth Justice data, the outcome of a young person “proven guilty” of an offence was used as the outcome measure.

Analysis methods

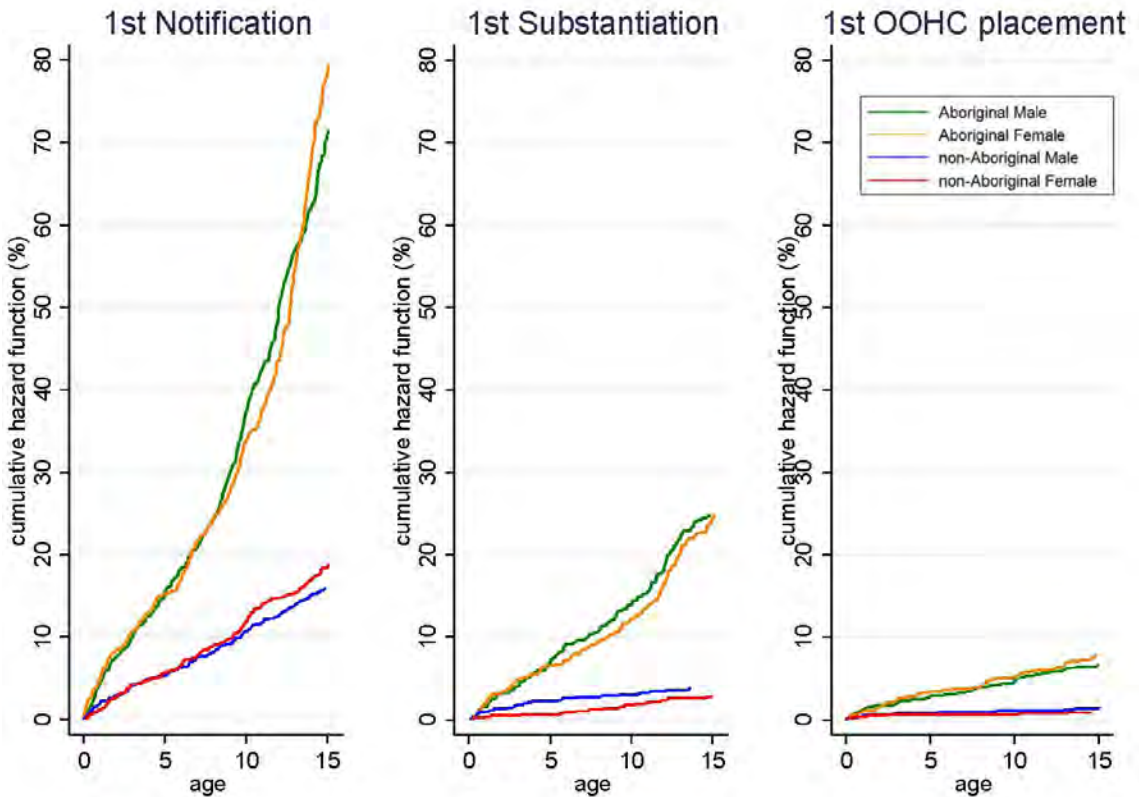
Descriptive statistics presented in Venn diagrams are used to report the overlap of children between the child protection and youth justice systems (Question 3). Survival analysis methods were used to answer the remaining four questions. These results are expressed as the *conditional probability*, by age, of a specified event, referred to statistically as the *cumulative hazard function*. For example, in Question 5, cumulative hazard functions are used to estimate the probability that a young person with different levels of exposure to the child protection system will be proven guilty of an offence *at each specific age given survival until that age*. The time-scale for the survival analysis is the time since birth, which is equal to age in years (measured as a continuous variable).

A limitation for the interpretation of the results is that they are based on a single annual birth cohort. Increases in events at different time-points may be a result of either an age effect or a period effect (for example, changes over time in policies or practices for reporting maltreatment).

Association between Child Protection and Youth Justice Involvement

Research Question 1:

What is the *cumulative hazard function*, by age of child, of the **first** episode of notification, substantiation and out-of-home care placement for NT children, by Aboriginal status and gender?



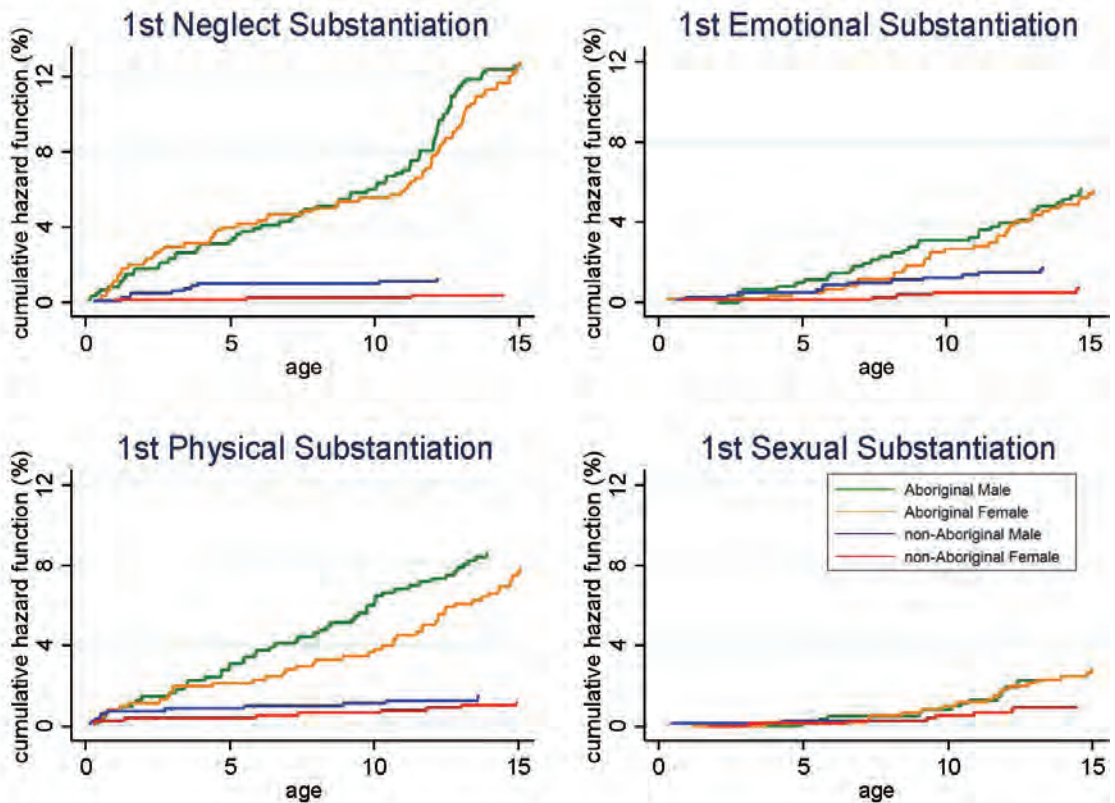
Cumulative Hazard Function (%) before age 15 for the 1999 birth cohort

Aboriginal Status	Gender	Level of Child Protection System Involvement		
		Notification	Substantiation	Out-of-home Care
Aboriginal	Male	70.9	24.9	6.7
	Female	78.4	24.2	7.8
non-Aboriginal	Male	15.9	3.9	1.4
	Female	18.5	2.9	0.9

Association between Child Protection and Youth Justice Involvement

Research Question 2:

What is the *cumulative hazard function*, by age of child, of the **first** substantiated episode of neglect, emotional, physical and sexual abuse for NT children, by Aboriginal status and gender?



Cumulative Hazard Function (%) before age 15 for the 1999 birth cohort...

Aboriginal Status	Gender	Type of Substantiations			
		Neglect	Emotional	Physical	Sexual
Aboriginal	Male	12.6	5.7	8.6	2.3
	Female	12.6	5.4	7.7	2.8
non-Aboriginal	Male	1.3	1.8	1.5	0.4
	Female	0.4	0.8	1.2	0.9

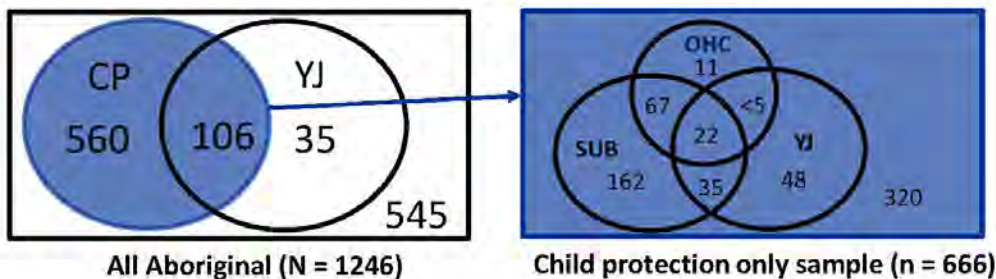
Association between Child Protection and Youth Justice Involvement

Research Question 3:

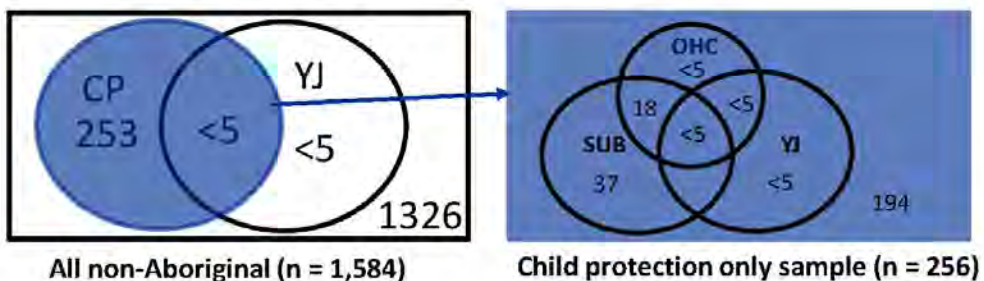
To what extent does the contact of NT children with the child protection or youth justice system overlap ^a?

Venn diagrams are used to depict the overlap of children's involvement with the child protection and youth justice systems. Amongst the child protection sample (i.e. with any notification), Venn Diagrams are used to depict the overlap of substantiations, out-of-home care and youth justice involvement.

Legend: CP = Child protection. YJ = Youth Justice. SUB = Substantiation. OHC = Out-of-home care.



- 15.9% of Aboriginal young people with any level of child protection involvement were subsequently found guilty of an offence up to age 16
- 75.2% of Aboriginal young people with at least one proven guilty offence had previous involvement with the child protection system



- 1.2% of non-Aboriginal young people ^b with any level of child protection involvement were subsequently found guilty of an offence up to age 16
- 60.0% of Aboriginal young people with at least one proven guilty offence had previous involvement with the child protection system

Notes

^a As the last available dates for data were 31st of December 2015 and 31st of December 2016, for child protection and youth justice respectively, data were unavailable for the final age groups (i.e. ages 17 and 18 years) in the study cohort. As a result, the true overlap between these two systems will be greater than that presented.

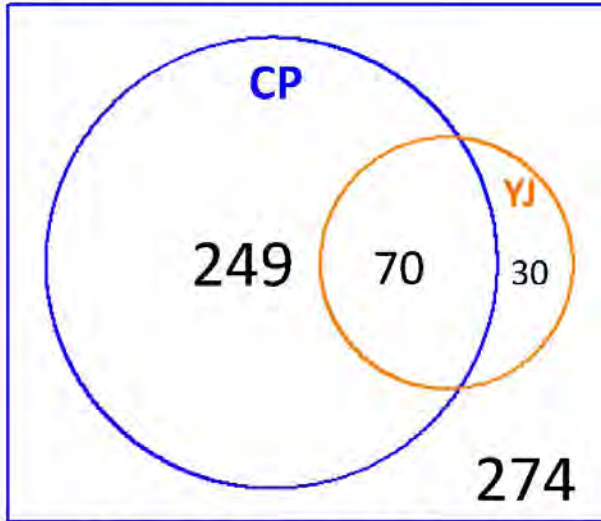
^b Due to the small number of non-Aboriginal males and females found in youth justice records for this study cohort, findings should be interpreted with caution. There is a high interstate migration in the NT non-Aboriginal population and many of those children born in the NT in 1999 will have left the NT to be replaced by other in-migrating children. As a result only small number of the non-Aboriginal birth cohort was available for analysis.

Association between Child Protection and Youth Justice Involvement

Research Question 3:

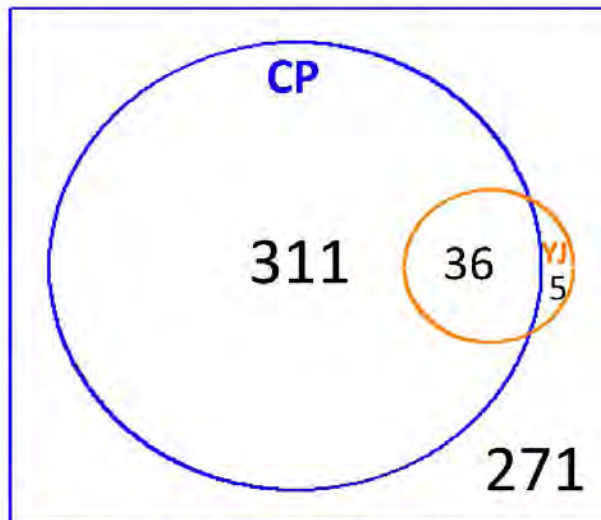
To what extent does contact by NT children with the child protection or youth justice system overlap (by gender)?

Legend: CP = child protection. YJ = Youth Justice.



Aboriginal Male (n=623)

- **21.9%** with **CP involvement** were subsequently involved in **YJ system**^{a,b,c}
- **70.0%** involved in **YJ system** had previous **CP involvement**



Aboriginal Female (n=623)

- **10.4%** with **CP involvement** were subsequently involved in **YJ system**^a
- **87.8%** involved in **YJ system** had previous **CP involvement**

Notes

^a Defined as subsequently found guilty of an offence up to age 16

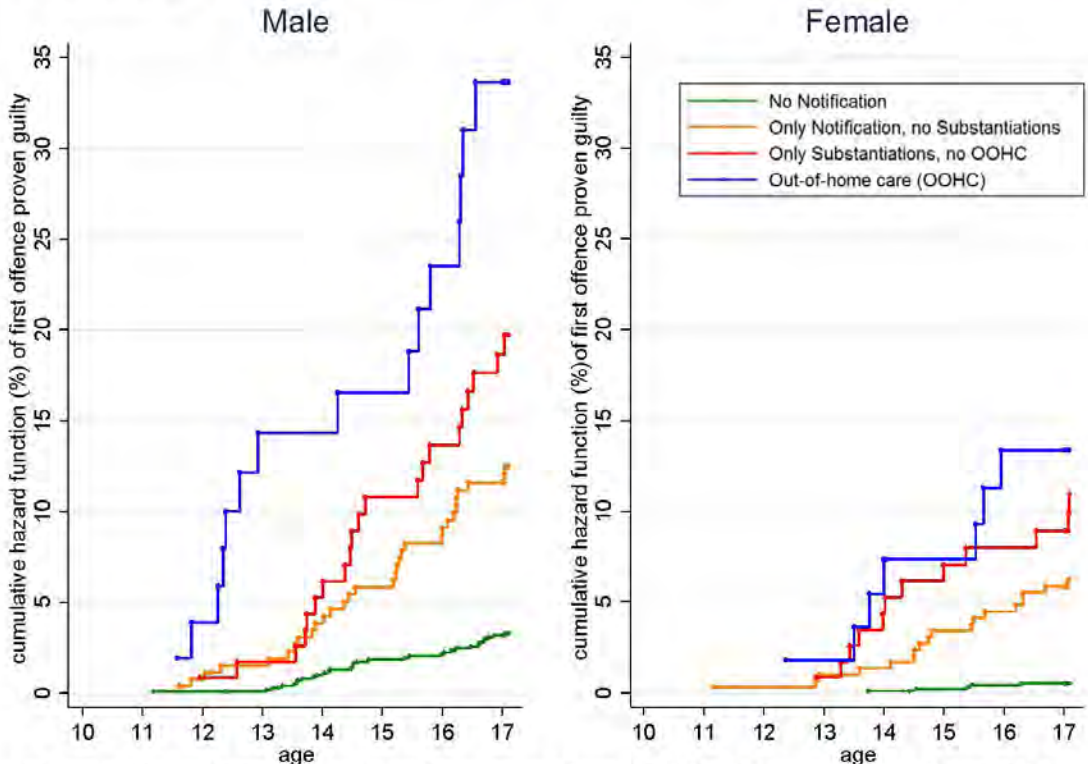
^b Due to the small number of non-Aboriginal males and females found in youth justice records for this study cohort, we did not include the Venn Diagram for the results for the non-Aboriginal, stratified by gender.

^c The proportional Venn Diagram was produced using the STATA 'pvenn2' module. (Wenfeng (Winston) Gong & Jan Osterman; Center for Health Policy and Inequity Research at Duke University, Durham, North Carolina, USA).

Association between Child Protection and Youth Justice Involvement

Research Question 4:

What is the association between level of child protection system involvement and youth offending?



For both males and females, there is an increasing gradient of risk for first proven guilty offence as the level of child protection involvement increases. For males up to age 16, those with no history of contact with the child protection system had the lowest cumulative hazard for a proven guilty youth offence (3.2% had a proven guilty offence by age 16), followed by those in the Notification Only group (11.5%), Substantiation Only group (18.7%) and OOHC group (33.7%). A similar pattern was observed for females up to age 16, with those not in contact with the child protection system having the lowest cumulative hazard for a proven guilty youth offence (0.6% had a proven guilty offence by age 16), followed by those in the Notification Only group (5.9%), Substantiation Only group (8.9%) and OOHC group (13.2%).

Among those in the OOHC group, some differences in placement experience were found. Compared to those with a proven guilty offence, those without any proven guilty offences experienced a lower number of placements, entered care at a younger age and were in care for a shorter duration of time.

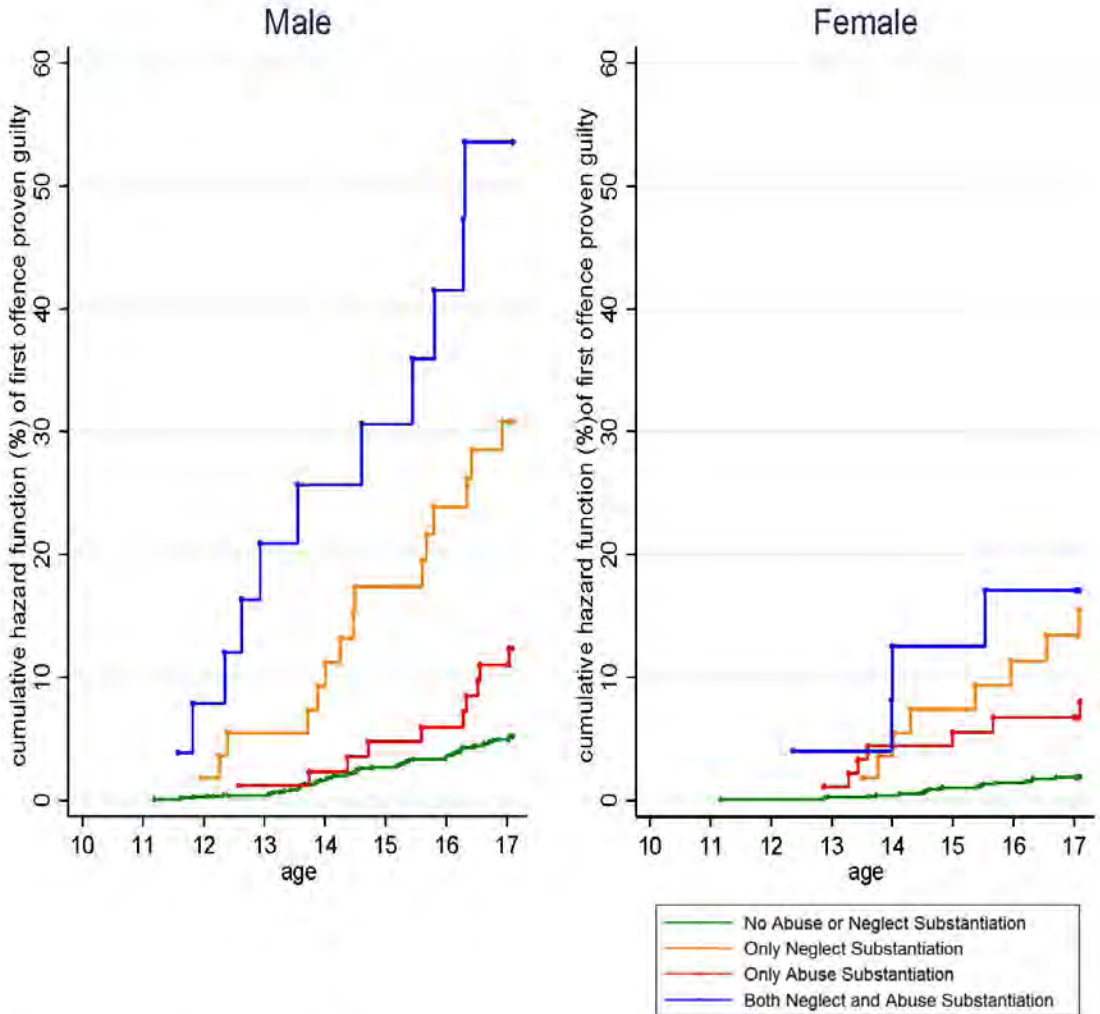
Placement characteristics of males and females with and without proven guilty offences.

	Male		Female	
	Proven guilty offence		Proven guilty offence	
	Yes (n=19)	No (n = 42)	Yes (n = 9)	No (n = 57)
Median				
Number of placements	11	3	7	3
Duration of placement (years)	4.4	0.4	5.0	1.1
Age at first placement	10.2	4.8	10.9	6.1

Association between Child Protection and Youth Justice Involvement

Research Question 5:

What is the association between the type of maltreatment of a child and youth offending?



For both males and females at age 16, those in the No Abuse or Neglect Substantiation group had the lowest cumulative hazard for a proven guilty youth offence (4.9% and 1.8%, respectively), followed by those in the Only Abuse Substantiation group (11.0% and 6.7%, respectively), the Only Neglect Substantiation group (30.9% and 13.4%, respectively) and the Both Neglect and Abuse group (53.6% and 17.1%, respectively).

95% Confidence Intervals for each group were compared to determine statistically significant differences, with only the difference between the 'No Abuse or Neglect Substantiation group' and the three other groups differing significantly (see Appendix Table for confidence intervals).

Association between Child Protection and Youth Justice Involvement

Summary of Key Findings

- These preliminary analyses highlight the stark overlap between the child protection and youth justice populations in the Northern Territory.
- The majority (75.2%) of young Aboriginal people with at least one proven guilty offence had previous involvement with the child protection system. There was only a small number of young non-Aboriginal people available for analysis but for these 5 young people, 3 (60%) had previous involvement with the child protection system. It is therefore important to recognise that young people who commit criminal acts are also likely to be victims of maltreatment and other adverse circumstances.
- An increasing gradient of risk was identified as the level of child protection involvement increased. Those without any child protection involvement had a lower risk for subsequent youth offences than those with notifications and substantiations for maltreatment. Young people placed in out-of-home care had the highest risk for subsequent youth offences.
- Those with both neglect and abuse maltreatment substantiations had the highest risk of offences, followed by those with substantiations for neglect only, those with substantiations for abuse only and those without any substantiations.
- This study found that young people with recorded offences had a history of having entered out-of-home care at an older age, experienced a greater number of placements and had stayed in care for longer durations of time. This finding requires careful analysis of the varying reasons for which children enter care.
- Overall, the findings point to an axiomatic link between maltreatment and youth offending.
- Further research that takes into account the multifactorial nature of the association between maltreatment and youth offending in the Northern Territory is needed.

Acknowledgement

We are pleased to acknowledge Catia Malvaso^{1,2,3} for her assistance in developing the research questions and analysis plan and with writing, and Joe Yick⁴ for providing invaluable input and feedback in interpretation of the datasets.

¹ Royal Commission into the Protection and Detention of Children in the Northern Territory

² University of Adelaide, Adelaide

³ University of South Australia, Adelaide

⁴ NT Department of Attorney General and Justice

Data source

The data are from the NT Child and Youth Data-linkage Project which includes administrative data supplied by the NT Government Departments of Health, Education, Attorney General and Justice, and Territory Families. For further information please contact Professor Sven Silburn Ph: +61 8 8946 8456 | email sven.silburn@menzies.edu.au

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CONFIDENCE INTERVALS

Table 1: Confidence intervals for survival analysis examining first proven guilty offence at different ages, by gender and the level of involvement with the child protection system

		No Child Protection		Notifications Only		Substantiations Only		Out of Home Care				
Male												
Age	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
11	0.1	0.0	0.7	0.8	0.2	3.0	0.9	0.1	6.1	3.9	1.0	15.5
12	0.1	0.0	0.7	1.5	0.6	4.0	1.7	0.4	6.9	14.3	6.8	30.0
13	1.0	0.5	1.9	3.8	2.1	7.2	5.2	2.4	11.7	14.3	6.8	30.0
14	1.8	1.2	2.9	5.8	3.5	9.7	10.8	6.1	19.0	16.5	8.3	33.1
15	2.2	1.4	3.3	8.7	5.7	13.2	13.7	8.2	22.7	23.5	13.0	42.5
16	3.2	2.3	4.6	11.6	8.1	16.7	18.7	12.0	28.9	33.6	20.2	55.9
Female												
Age	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
11	0.0			0.3	0.0	2.4	0.0			0.0		
12	0.0			1.0	0.3	3.1	0.9	0.1	6.1	1.8	0.3	12.7
13	0.1	0.0	0.8	1.4	0.5	3.6	4.3	1.8	10.4	7.3	2.8	19.6
14	0.2	0.1	0.9	3.4	1.8	6.4	7.1	3.5	14.1	7.3	2.8	19.6
15	0.4	0.2	1.2	4.5	2.6	7.7	8.0	4.1	15.3	13.3	6.4	28.0
16	0.6	0.2	1.3	5.9	3.7	9.5	8.9	4.8	16.5	13.3	6.4	28.0

Table 2: Confidence intervals for survival analysis examining first proven guilty offence at different ages, by gender and substantiation type

		No Abuse or Neglect Substantiation		Only Neglect Substantiation		Only Abuse Substantiation		Both Neglect and Abuse Substantiation				
Male												
Age	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
11	0.2	0.1	0.7	1.8	0.3	12.7	0.0			7.8	2.0	31.4
12	0.4	0.2	1.0	5.5	1.8	16.9	1.2	0.2	8.3	20.9	8.7	50.3
13	1.6	1.0	2.5	9.3	3.9	22.3	2.3	0.6	9.4	25.7	11.5	57.3
14	2.7	1.9	3.8	17.4	9.0	33.4	4.7	1.8	12.6	30.7	14.6	64.5
15	3.5	2.6	4.7	23.9	13.5	42.1	6.0	2.5	14.3	41.5	21.5	80.1
16	4.9	3.8	6.3	30.9	18.6	51.3	11.0	5.7	21.1	53.6	29.5	97.5
Female												
Age	%	95% CI		%	95% CI		%	95% CI		%	95% CI	
11	0.1	0.0	0.6	0.0			0.0			0.0		
12	0.2	0.1	0.8	0.0			1.1	0.2	7.7	4.0	0.6	28.4
13	0.4	0.2	1.0	3.6	0.9	14.4	4.4	1.7	11.8	12.5	4.0	38.8
14	1.0	0.6	1.8	7.4	2.8	19.7	5.6	2.3	13.4	12.5	4.0	38.8
15	1.4	0.9	2.3	11.3	5.1	25.3	6.7	3.0	14.9	17.1	6.4	45.5
16	1.8	1.2	2.8	13.4	6.4	28.1	6.7	3.0	14.9	17.1	6.4	45.5

Caveats for the Crossover Technical Research Report (a) Age 11 represent those children age 11.0000001 to 11.99999999 (Stata recorded as 12); (b) Insufficient numbers for cells with % (cumulative hazard)=0

ENDNOTES

- ¹ Exh.332.001, Statement of Jared Sharp, 21 March 2017, tendered 28 April 2017, para. 75; Exh.337.068, Judge Johnstone Juvenile Justice Summit 5 May 2017, Paper, 5 May 2017, tendered 8 May 2017, paras 86-87.
- ² Transcript, Katrina Wong, 2 June 2017, p. 4313: line 37.
- ³ The Commission initially approached the Northern Territory Government about extracting data from the respective child protection and youth justice data systems to determine the extent of the crossover of children and young persons between these systems. The Commission was advised that this would have to be done manually for each individual and that there could be inaccuracies within the datasets as children had no unique identifier across systems. In addition, the datasets would not allow comparisons between groups of children in the youth justice system with and without child protection backgrounds. As the Menzies School of Health Research held linked child protection and youth justice data from the Northern Territory, the Commission instead conducted research using those datasets. See also Exh.491.000, Statement of Karen Broadfoot, 1 June 2017, tendered 2 June 2017, paras 127-133; Transcript, Karen Broadfoot, 2 June 2017, p. 4349: lines 7-18; Exh.520.000, Statement of Colleen Gwynne, 29 May 2017, tendered 19 June 2017, paras 58-60.
- ⁴ *Crossover Research Technical Report*.
- ⁵ Australian Institute of Health and Welfare, 2016, Young people in child protection and under youth justice supervision 2013-14. Australian Institute of Health and Welfare: Canberra. Data Linkage Series No. 21. Catalogue No. CSI 22.
- ⁶ Although the accumulation of data will allow for longitudinal analyses in the future, these findings only provide a one-year cross-sectional snapshot of the crossover between these two populations in Australia.
- ⁷ Yick, J, 2016, An analysis of the association between criminal behaviour and experience of maltreatment as a child in the Northern Territory, Department of the Attorney-General and Justice, Northern Territory.
- ⁸ Stewart, A, Livingston, M, & Dennison, S, 2008, 'Transitions and turning points: Examining the links between child maltreatment and juvenile offending', *Child Abuse & Neglect*, vol. 32, pp. 51-66; Malvaso, CG, Delfabbro, P, & Day, A, 2017, 'The child protection and juvenile justice nexus in Australia: A longitudinal examination of the relationship between maltreatment and offending', *Child Abuse & Neglect*, vol. 64, pp. 32-46.
- ⁹ For a review see Malvaso, CG, Delfabbro, PH & Day, A, 2016, Risk factors that influence the maltreatment-offending association: A systematic review of prospective and longitudinal studies. *Aggression and Violent Behavior*, vol. 31, pp. 1-15.
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- ¹¹ Indig, D et al., 2011, 2009 NSW young people in custody health survey: Full report, Justice Health and Juvenile Justice, Sydney.
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- ²⁴ Proven guilty offences were chosen instead of convictions because not all youth offences that have been proven or agreed to are necessarily accompanied by formally recorded convictions. For example, under the Youth Justice Act, magistrates/magistrates (now Local Court judges) use their discretion in formally recording convictions even when charges have been legally proven.
- ²⁵ Menzies data-linkage team has established a composite measure to derive Aboriginal status for use in Northern Territory data-linkage projects of this kind. This composite measure has been developed to resolve issues of inconsistencies in identifying Aboriginal status across different datasets.

- ²⁶ Individuals were excluded if perinatal records indicated stillbirths and neonatal deaths (n = 60), children who died within 90 days of birth (n = 30), children born interstate or to immigrant mothers (n = 53), and any children who do not have records available in other Northern Territory government datasets (on the assumption that they have left the Northern Territory before the events of interest occurred; n = 606).
- ²⁷ In order to maintain the correct temporal order between associations and to avoid ambiguity that might arise when youth crime precedes maltreatment, cases in which the date of first proven guilty offence was prior to the date of first notification were excluded (n = 5). Furthermore, after the results for research question 1 were conducted, those who entered out of home care but who did not have any notifications for maltreatment were excluded from the analyses (n = 16). Some children and young people can enter out of home care for reasons not related to child maltreatment. For example, some enter care in situations where parents have suddenly died, imprisoned or were institutionalised due to mental health problems. Because we are interested in the association between maltreatment and offending, these individuals have been excluded.
- ²⁸ The analyses are based on individuals born in the Northern Territory. This is likely to be an underestimate as the last available date for data was 31 December 2015 and 31 December 2016, for child protection and youth justice respectively, therefore there is missing data for the final years of adolescent life.
- ²⁹ *Crossover Research Technical Report.*
- ³⁰ Similar analyses could not be performed for non-Aboriginal children due to small numbers.
- ³¹ Due to the small number of non-Aboriginal males and females found in youth justice records for this study cohort, findings are not presented for analysis by gender due to confidentiality.
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- ³³ A total of 620 (43.5%) males and 614 (44.2%) females were identified as Aboriginal in these analyses.
- ³⁴ *Confidence intervals for Crossover Research Technical Report, Table 1.*
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- ⁴⁰ Exh.642.000, Statement of Dr Denise Riordan, 21 June 2017, tendered 29 June 2017, para. 37.
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- ¹⁰² Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 84; Exh.875.001, Summary of Report Incidents Involving Police, March 2017, tendered 24 October 2017.
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- ¹⁰⁴ Exh.875.001, Summary of Report Incidents Involving Police, March 2017, tendered 24 October 2017, pp. 1, 2.
- ¹⁰⁵ Exh.875.001, Summary of Report Incidents Involving Police, March 2017, tendered 24 October 2017, p. 1.
- ¹⁰⁶ Exh.492.009, Annexure LW-09 to Statement of Leonie Warburton, 13 March 2017, tendered 2 June 17.
- ¹⁰⁷ 72 incidents were identified as matters where a child in care was suspected, charged or convicted of a criminal offence; a further 58 incidents concerned apparently criminal activity such property damage, serious, aggressive or threatening behaviour or assault of a carer, and consumption of alcohol or drugs or possession of drug paraphernalia at the placement Exh.875.001, Summary of Report Incidents Involving Police, March 2017, tendered 24 October 2017, p. 3.
- ¹⁰⁸ Exh.875.001, Summary of Report Incidents Involving Police, March 2017, tendered 24 October 2017, p. 1.
- ¹⁰⁹ Exh.337.068, Judge Johnstone Juvenile Justice Summit 5 May 2017, Paper, 5 May 2017, tendered 8 May 2017, para. 85.
- ¹¹⁰ Exh.683.001, Statement of Dr Ruth Rudge, 15 June 2017, tendered 30 June 2017, para. 99a.
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- ¹¹² Exh.489.000, Statement of Katherine McFarlane, 26 May 2017, tendered 2 June 2017, para. 71.
- ¹¹³ Exh.476.000, Statement of Marnie Couch, 18 May 2017, tendered 31 May 2017, paras 47, 56-57.
- ¹¹⁴ Exh.577.000, Statement of DB, 9 June 2017, tendered 26 June 2017, paras 49-51.
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- ¹³¹ Survey of 200 children and young people: ACT: 11, NSW: 33, NT: 24, Qld: 27, SA: 28, Tas: 26, Vic: 27, WA: 24 – Exh.572.000, Statement of Joseph McDowall, 25 May 2017, tendered 23 June 2017, paras 100-101.
- ¹³² Exh.355.000, Statement of Jared Sharp, 24 April 2017, tendered 9 May April 2017, paras 45-46.
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- ¹³⁷ Exh.350.001, Statement of Sandy Lau, 2 May 2017, tendered 9 May 2017, paras 48, 50.
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SEXUAL HEALTH AND HARM

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SEXUAL HEALTH AND HARM

INTRODUCTION

This chapter provides an overview of information gathered by the Commission with respect to a number of issues relating to sexual matters involving children and young people in the Northern Territory. It brings together a summary of prior investigations, the applicable legislative and policy frameworks and indicators, trends and data concerning child sexual abuse, harm or exploitation; the sexualised behaviour of children and young people; child abuse in care; and the management of young people's sexual health (including pregnancy and contraceptives).

Child sexual abuse was not included in the Commission's Terms of Reference as a specific area to examine, but the sexual abuse of children and other sexual issues involving children arise in relation to child protection. Given the time available to the Commission, it has not been possible to undertake a detailed or full investigation into all of these issues. The Commission has been able to identify and gather, where available, written material relevant to potential areas of concern. This in itself has identified possible gaps in the data and information the Northern Territory Government has in relation to some of these issues. The Commission believes that these matters continue to be significant in the context of protecting children and young people in the Northern Territory and require further examination.

The Commission has reviewed material made available to it regarding the prevalence of child sexual abuse in the Northern Territory, and the policies and procedures underpinning the approach Northern Territory agencies have taken. The Commission issued notices to agencies, asking for production of relevant material and data covering:

- the notification and substantiation of allegations involving sexual harm and exploitation of children in the Northern Territory, either leading to their removal from home, or while they were in care and in detention, and
- the management of sexual health matters in children, including data relating to the incidence of sexually transmitted infections (STIs) in children, use of contraceptives and incidence of teenage pregnancies.

Based on this information, the Commission has outlined a number of recommendations the Northern Territory Government should consider to ensure the continued protection of children and young people from sexual harm or exploitation in the Northern Territory.

The issues dealt with in this chapter have largely been the subject of earlier inquiries and investigations – they are not new problems. Child abuse and the protection of children and young people from sexual harm or exploitation is a complex and unclear area plagued by under-reporting, legislative and policy discretion, and poor data collection. The general statistics and observations relating to sexual harm and exploitation of children and young people in the Northern Territory the Commission has been able to gather are subject to significant qualification and explanation. Nevertheless, this remains an important area given the social, ethical and legal ramifications. The Commission considers that all issues addressed in this chapter continue to be of fundamental significance for children and young people in the Northern Territory.

PRIOR INVESTIGATIONS OF CHILD SEXUAL ABUSE IN THE NORTHERN TERRITORY

The Little Children are Sacred Inquiry (2007)

The extent of child sexual abuse in the Northern Territory was publicly highlighted with the 2007 *Ampe Akelyernemane Meke Mekarle "Little Children are Sacred": Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse* (the Little Children are Sacred report).¹ The Board of Inquiry was established following media reporting of child sexual abuse in many remote Aboriginal communities.² Its designated tasks included examining the extent, nature and factors contributing to the sexual abuse of Aboriginal children, with a particular focus on unreported incidents of that abuse.

The Board of Inquiry noted in its overview that:

*'Child sexual abuse is not a new problem... In the Northern Territory, governments, health and welfare professionals and others have been aware of sexual abuse of children for some time. The available statistics for sexually transmitted infections ... in children reflect the existence of sexual abuse, notwithstanding what is thought to be a low level of reported incidence. These figures also suggest that the STI problem and child sexual abuse is greater in Aboriginal than non-Aboriginal communities... The best it can hope to achieve is to present meaningful proposals that the government might adopt so that Aboriginal communities themselves, with support, can effectively prevent sexual abuse of their children.'*³

The Board of Inquiry made 97 recommendations encompassing issues of leadership; the need for a whole-of-government response; the role of the Northern Territory Department of Families and Child Services; crisis intervention health services; the integration of investigative and prosecution services; bail laws; sex offender rehabilitation programs; the need to address underlying risk factors; the role of primary healthcare providers; family support, education initiatives, community education and awareness; the need to facilitate dialogue with the Aboriginal community; the role of community justice groups; and cross-cultural practices.

The Little Children are Sacred report noted that sexual health practitioners in the Northern Territory had reached a view that sexual activity:

- in a child under 12 years of age is highly likely to indicate abuse
- in a child aged 12–13 years is likely to indicate abuse, and requires very close examination
- in a person aged 14 or older can often be consensual in nature but can still indicate abuse.⁴

The Commonwealth Government's *Northern Territory National Emergency Response Intervention* (the Intervention) was announced some six days after the Northern Territory Government released the report.⁵

One of the key outcomes from the Little Children are Sacred report was the creation of the Northern Territory Office of the Children's Commissioner (OCC), which would, among other functions, monitor implementation of the report's recommendations.⁶

The OCC annual reports between 2009 and 2013 did report on the implementation of those recommendations. However, the OCC noted relatively early that it had neither the staff, the resources or the powers to monitor adequately the implementation of all the recommendations.⁷ The Northern Territory Government published a response to the Little Children are Sacred report, announcing a suite of 'commitments' which would constitute its response to the report's recommendations.⁸ Ultimately, the OCC only monitored those recommendations it thought would have the most direct impact on preventing the abuse of children. By 2013, of the 55 recommendations and commitments monitored, 37 had been achieved or substantially achieved, 16 partly achieved and two not achieved. The recommendations classified as 'not achieved' were 94 and 95, which related to the implementation of a comprehensive community education strategy to highlight key messages about child protection, and child sexual abuse in particular.⁹ The OCC's annual reports note that these two recommendations were partially subsumed into the implementation of *Growing them Strong, Together*¹⁰ recommendation 146¹¹, but that there had been no specific campaign focussing on the issue of sexual abuse to let people know, particularly those in remote communities, the range of behaviours that are and are not acceptable and the impact it has on the victims, families and communities.¹²

The Commission's view is that insofar as a comprehensive community education strategy focussing on the issue of sexual abuse as identified in the OCC's annual reports has not been developed, it remains necessary. In support of that view, the Commission notes the submission from the Aboriginal Medical Services Alliance Northern Territory (AMSANT), that this education campaign is still very much needed throughout the Northern Territory.¹³

Anangu Pitjantjatjara Yankunytjatjara Lands Inquiry (2008)

The Anangu Pitjantjatjara Yankunytjatjara (APY) lands,¹⁴ which traverse South Australia, Western Australia and the Northern Territory, were the subject of a South Australian Commission of Inquiry (the APY Lands Inquiry) into the incidence of sexual abuse of persons who, at the time of the abuse, were children on APY lands.¹⁵ The APY Lands Inquiry commenced on 26 June 2007 and issued its report on 30 April 2008.

The APY Lands Inquiry conducted its investigations by visiting the main communities of the APY lands,¹⁶ holding 147 meetings with 246 people.¹⁷ It looked at several circumstantial factors to establish whether, in each particular case, it was reasonably possible that children had been sexually abused.¹⁸ These factors are similar in many respects to those considered throughout this chapter, and include:¹⁹

- underage pregnancy
- sexually transmitted infections in children and young people
- disclosures of sexual activity by children and young people
- direct evidence of young girls and boys living together
- children and young people engaging in transactional sexual conduct
- sexualised behaviour in children, and
- physical injury, particularly to the genitalia of children.

The APY Lands Inquiry Report noted some 269 allegations of child sexual abuse in the region,²⁰ and that it was difficult to gauge the extent of child sexual abuse in the APY lands because of the infrequency of disclosure.²¹ In particular, in the lands, children lived in dysfunctional communities where there was considerable violence and fear, as well as drug and alcohol abuse and a sense of hopelessness.²² The Inquiry heard evidence that girls in the APY lands were resigned to the fact that they were likely to be sexually abused in the future.²³

The APY Lands Inquiry Report observed the cumulative effect of several ongoing issues within these communities, such as the presence of drugs, alcohol, gambling and violence, and their amplifying effects on the opportunities for and impacts of child sexual abuse.²⁴

The report recommended an *'urgent need to implement strategies to prevent sexual abuse of children'*, noting that it was *'not appropriate to merely react to disclosure or detection of sexual abuse'*.²⁵ It stressed the importance of community education in preventing child sexual abuse. The APY Lands Inquiry found that resolving sexual abuse on APY lands would require *'resources and determination by the various government and non-government agencies involved in welfare and child protection, health, education and administration of justice'*.²⁶ In effect, the report considered that holistic early intervention strategies were required, echoing similar recommendations in the Little Children are Sacred report a year earlier, and reflected later in Growing them strong, together – Promoting the Safety and Wellbeing of the Northern Territory's Children – Report of the Board of Inquiry into the Child Protection System in the Northern Territory.²⁷

The APY Lands Inquiry Report contained 46 formal recommendations, including:²⁸

- placing additional social workers on the ground, including at least a proportion of female staff (Recommendation 5)
- substantially increasing services provided on APY lands, in particular mental health services for persons who were sexually abused as children (Recommendation 16)
- mandatory reporting of all positive-result STIs tests performed on children, even where the person reviewing the result had not formed a suspicion that abuse took place, as usually required for a general mandatory report under child protection legislation (Recommendation 19)
- implementing a community education program about what constitutes inappropriate sexual conduct, and its consequences (Recommendation 29), and
- accurately recording allegations of child sexual abuse, including all identifying particulars of alleged victims and perpetrators, and delivering that information to the dedicated sex crimes unit of the police. (Recommendation 38).

The Australian Crime Commission and National Indigenous Intelligence Taskforce

From 2010, the then Australian Crime Commission (ACC) conducted operations throughout various communities in the Northern Territory as part of the Intervention.²⁹ For a period these operations and investigations were carried out by the National Indigenous Intelligence Taskforce (NIITF), which was a specialised group looking into crime occurring in Aboriginal communities, including sexual abuse of children.

Northern Territory Government response to the work of the ACC

In response to a Notice to Produce, the Northern Territory Government produced to the Commission copies of a number of ACC reports and briefs, some of which reported significant dysfunction in particular communities in the Northern Territory, including in some places widespread sexual abuse of children,³⁰ as well as prevalent substance misuse.

The Commission has been informed by the Australian Criminal Intelligence Commission – the successor of the ACC – that these reports and briefs contain material obtained under processes of examination under the *Australian Crime Commission Act 2002* (Cth), which preclude their publication. The Commission sought information from the Northern Territory Government as to what actions have been taken by its various agencies in response to these ACC reports. The Commission was told by the solicitors for the Northern Territory that the extent the reports and briefs contained recommendations capable of implementation by police, that those recommendations were implemented.

The Commission was further informed by the solicitors for the Northern Territory Government that the Department of Children and Families, as it then was, ‘noted’ or ‘considered’ most of the briefs and reports, and that the Department of Attorney-General and Justice considered them as part of the Law Crime and Community Safety Council, which ‘did not have carriage of any implementation action’, and no further action considered necessary. The Commission does not have sufficient information to determine whether or not any further or other action should have been taken.

The final report of the National Indigenous Intelligence Taskforce

The NIITF published its final report in June 2014, when its funding ceased. The NIITF identified child sexual abuse to be chronically undisclosed and under reported, and said it almost certainly affected a much larger portion of the Aboriginal population that is reflected in official statistics.³¹ Although the NIITF found no evidence of organised child sexual abuse networks, the report noted that in some remote communities ‘every person [was] reportedly...affected by child sexual abuse, as a victim, a perpetrator, or a relative of either.’³² The NIITF also outlined sexualised behaviour it found in children and young people in some communities, including both problem sexual behaviour and sexually abusive behaviour, some of which was said to be ‘highly coercive’.³³

The NIITF noted that there remained a tacit acceptance of violence and child abuse in many communities.³⁴ The reasons for non-disclosure were said to be ‘complex and varied’, but the marginalised, closed and insular nature of some communities was said to allow some child sexual abuse to go unchallenged.³⁵ The NIITF expressed the view that child sexual abuse in the Northern Territory could be combatted through identifying best practice, creating safe spaces for disclosure,

and continuing to provide preventive education to both children and adults.³⁶ It canvassed possible response options focussed on expanded positive parenting programs, the provision of sexual health education, and reviewing the effectiveness of monitoring offenders in remote communities.³⁷

The NIITF Final Report also highlighted that there were issues with the scope, integrity and reliability of the data collected by the Northern Territory Government in respect of Aboriginal communities.³⁸

The NIITF Report concluded that while the NIITF was to be dismantled and defunded on 30 June 2014, this presented an important opportunity for Northern Territory Government agencies to build their capacity based on the information and research of the NIITF and continue to monitor sexual abuse in these communities.³⁹ As noted above, the Commission has not had the time or opportunity to investigate these issues further.

Royal Commission into Institutional Responses to Child Sexual Abuse

In January 2013, the Commonwealth Government announced the Royal Commission into Institutional Responses to Child Sexual Abuse (the Child Abuse Royal Commission).⁴⁰ As part of the Child Abuse Royal Commission, a case study was conducted into historical abuse which occurred at the Retta Dixon Home in Darwin, as well as into the current laws, policies and procedures governing children in out of home care in the Northern Territory (Case Study 17).⁴¹ This was published as a report, *Report of Case Study No. 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory Governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at Retta Dixon Home*, in July 2015 (the Case Study 17 report).

Dr Howard Bath, then Northern Territory Children's Commissioner, gave evidence before the Child Abuse Royal Commission as part of Case Study 17, to the effect that failure of child protection workers to meet regularly with children in care was problematic for the detection of child sexual abuse in out of home care settings.⁴² In particular, Dr Bath noted that regular face-to-face meetings were important both for building rapport so that the child would feel safe enough to disclose any sexual abuse to the case worker, and so that the case worker could pick up on indicators of child sexual abuse.⁴³ Dr Bath noted that resourcing issues and large caseloads were at least partially responsible for the failure of child protection workers to visit children in care regularly. Evidence before this Commission indicates that caseloads have not improved, and therefore might well echo Dr Bath's concerns before the Child Abuse Royal Commission.⁴⁴

The Case Study 17 report noted that Dr Bath did not believe the remoteness of Northern Territory communities to be an excuse for failing to meet with children on a regular basis.⁴⁵ It also noted that ultimately, the most successful way to reduce the sexual abuse of children in care, was to reduce the total number of children in care through practices that reduced their number.⁴⁶ The Case Study 17 report recorded Professor Muriel Bamblett's recommendation that there was a need for a body independent of the Department of Children and Families to investigate individual allegations of children in care (not merely the Department's responses to those allegations).⁴⁷

Despite more than two years since the Case Study 17 report was released, the Commission has heard evidence of continuing issues with oversight and monitoring of abuse in the out of home care system.⁴⁸

Recommendation 36.1

The Northern Territory Government consult with Aboriginal communities and the non-government sector with a view to establishing a body, such as a taskforce, to work with the Northern Territory Government to:

- review the numbers of notifications based on sexual harm or exploitation of children, and the numbers of investigations and their outcomes
- gather further information and ensure ongoing data gathering on relevant sexual issues relating to children and young people, including but not limited to the rates and incidences of contraceptive use, teenage pregnancy and incidences of STIs
- review current policies and procedures relating to sexual matters that involve children and young people, including any pregnancy or STI-related child protection reporting obligations
- engage with communities, government bodies and relevant organisations about how to address sexual issues relating to children and young people, including:
 - the incidence and reporting of child sexual abuse
 - child sexual abuse in care and in detention
 - counselling and support services available to abuse victims in care or detention
 - child and adolescent sexual health, including the rate of STIs, contraception use, pregnancy and fatherhood
 - sexual behaviour or abuse by children and young people, and education programs for offenders, and
 - the need for and implementation of a comprehensive community education strategy

The body or task force to include representatives of Aboriginal communities and service providers in remote areas, including health professionals, Territory Families and police.

LEGISLATIVE AND POLICY FRAMEWORK

Mandatory notification and reporting obligations

The *Criminal Code Act* (NT) makes certain sexual acts committed against a person under 16 years of age illegal as well as all indecent dealing with a child under 16.⁴⁹ This is referred to in the Act

as the 'age of consent', reflecting the view that a child under 16 years of age does not have the understanding, maturity or sexual literacy to make an informed decision about engaging in sexual activity. Table 36.1 sets out the triggers that initiate mandatory notification of matters which might amount to sexual harm or abuse.

Table 36.1: Triggers for Mandatory Notification

Legislative or policy requirement	Effect of obligation to notify or report
<p>Section 26 of the Care and Protection of Children Act (NT)</p>	<p>Requires all persons within the Northern Territory to report to the Territory Families Central Intake Team (CIT) or Northern Territory Police when they believe, on reasonable grounds, that:</p> <ul style="list-style-type: none"> • a person under 18 years has suffered or is likely to suffer 'harm' or 'exploitation' • there is an actual or likely sexual relationship between a person under 18 years and a person who has a relationship of 'special care' with them • any person under 14 years of age is involved in sexual activity. <p>The definitions in the Act involve concepts of sexual 'harm' or 'exploitation'. It is intended to cover:</p> <ul style="list-style-type: none"> • the sexual abuse or other exploitation of a child⁵⁰ • the sexual exploitation of a child, which includes the sexual abuse of a child or involving the child as a participant or spectator in an act of a sexual nature, prostitution or a pornographic performance.⁵¹
<p>Section 127, 128 of the Criminal Code Act (NT)</p>	<p>The Criminal Code Act makes certain sexual acts involving persons under the age of 16 years (the 'age of consent') unlawful.</p> <p>Section 127(1) states that any person who has sexual intercourse with or commits any act of gross indecency upon a child who is under the age of 16 years is guilty of a crime.</p> <p>Section 128(1) states that any adult who has sexual intercourse with or commits any act of gross indecency upon a child who is of or over the age of 16 years and under the person's 'special care' is guilty of a crime.</p> <p>A person is under a relationship of 'special care' to a person under the age of 18 years if they are:</p> <ul style="list-style-type: none"> • a step-parent, guardian or foster parent of the victim • a school teacher and the victim is a pupil • have established a personal relationship with the victim in connection with the care, instruction (for example, religious, sporting or musical instruction) or supervision (for example, supervision in the course of employment or training) of the victim • a correctional services officer at a correctional institution at which the victim is detained • a health professional or other provider of health care or treatment, and the victim is a patient or client of the offender.⁵²
<p>Section 8, 10 of the Notifiable Diseases Act (NT)</p>	<p>Registered health practitioners must report a diagnosis of a notifiable disease – such as an STI – where the person is a child who has not attained the age of 16 years. The practitioner must report the diagnosis to a designated public health officer and advise the child's parent or guardian.⁵³</p>

Legislative or policy requirement

Effect of obligation to notify or report

Guidelines on the Management of Sexual Health Issues in Children and Young People

The *Guidelines on the Management of Sexual Health Issues in Children and Young People* (the Guidelines) first released by the then Department of Health & Community Services in 2007,⁵⁴ and is now set out in a 3rd edition dated July 2011.⁵⁵ All references to the Guidelines in this chapter are to the 2011 Guidelines, which apply currently.

The Guidelines provide instruction on managing children and young people who present for care relating to sexual health issues, or who may be the victims of sexual abuse and exploitation. It is a reference for health professionals working in remote and urban clinical situations in the Northern Territory, defining the statutory requirements for primary healthcare providers in the area of sexual health.

Section 6.5 of the Guidelines states that where relevant and appropriate, the young person or family of the child should be made aware that:

- The following must be reported to the Department of Children and Families or the police:
 - sexual harm or exploitation of a person under the age of 18 years
 - a sexual relationship between a person aged under 18 years and a person who has a relationship of special care with them
 - any person under 14 who is sexually active
 - any 14- and 15-year-olds who are or are likely to be sexually involved with a person whose age differs from theirs by more than two years
- for a young woman aged under 16 years, termination of pregnancy requires a parent or guardian's consent
- if an STI is diagnosed in a person aged under 16 years, medical practitioners or delegates are legally required to notify the parents or guardian
- if an STI or pregnancy is diagnosed or suspected in a person aged 13 or younger, Department of Health policy requires the primary healthcare practitioner (PHCP) to inform the Territory Families CIT, to ensure the case receives appropriate medical and social assessment and support. This is not a formal report of harm as required under the Act.⁵⁶

There is no obligation to report 14- and 15-year-olds in sexual relationship, if the relationship between the parties meets all of the following specific criteria, namely that:⁵⁷

- the participants are peers of or over the age of 14 years
- participants are aged within two years of each other
- there is no harm or exploitation; that is:
 - participants are willing to be involved in the sexual activity
 - each person is able to say 'no' or change their mind, and that is respected
 - there is no coercion, pressure or force
 - there is equal power, control or development maturity
 - neither participant is temporarily under the influence of substances.

AGENCIES INVOLVED IN CHILD SEXUAL ISSUES

Child Protection Services

Child Protection Services of Territory Families is authorised to intervene to protect children if they are being or are at risk of being harmed within their families.

The Guidelines described the role of Child Protection Services in relation to sexual abuse issues as involving:

- responding to sexual abuse of children within the family
- ensuring children who have been reported are living in a safe environment and are being protected from sexual abuse
- investigating cases by gathering information from other government and non-government agencies or individuals – Child Protection Services does not investigate criminal matters but assists Northern Territory Police’s investigations
- developing a child protection plan and taking action to keep the young person safe
- ensuring that families have assistance in providing adequate care for their children
- providing material and other support to abused children and their families, and
- as a last option, removing children to alternative safe environments.⁵⁸

Central Intake Team

CIT receives any child protection reports – including reports that a child may have suffered or is likely to suffer sexual harm or exploitation – and identifies a response option and priority time frame. For reports based on an STI diagnosis, CIT workers are instructed to screen the notification as Priority 1, which requires a response within 24 hours.⁵⁹ An example of the procedures in place at one Aboriginal health service, applicable to reporting, and which included guidance as to the level of information to provide, was reviewed by the Commission.⁶⁰

Once a response option and priority allocation is finalised, notifications are made to the relevant work unit for investigation and assessment.

Child Abuse Taskforce

The Child Abuse Taskforce (CAT) was formed in 2006 and is a multi-agency specialised work unit comprising officers from the Australian Federal Police, Northern Territory Police and Territory Families Child Protection Practitioners.⁶¹ The purpose of the CAT is *‘to provide a more responsive and effective approach to serious and complex reports of child sexual abuse and serious reports of physical abuse and neglect of children in the Northern Territory’*.⁶² CAT takes on the more complex investigations, such as reports of serious physical and/or sexual harm/ or exploitation or sexual abuse where there are multiple abusers and/or multiple perpetrators.⁶³

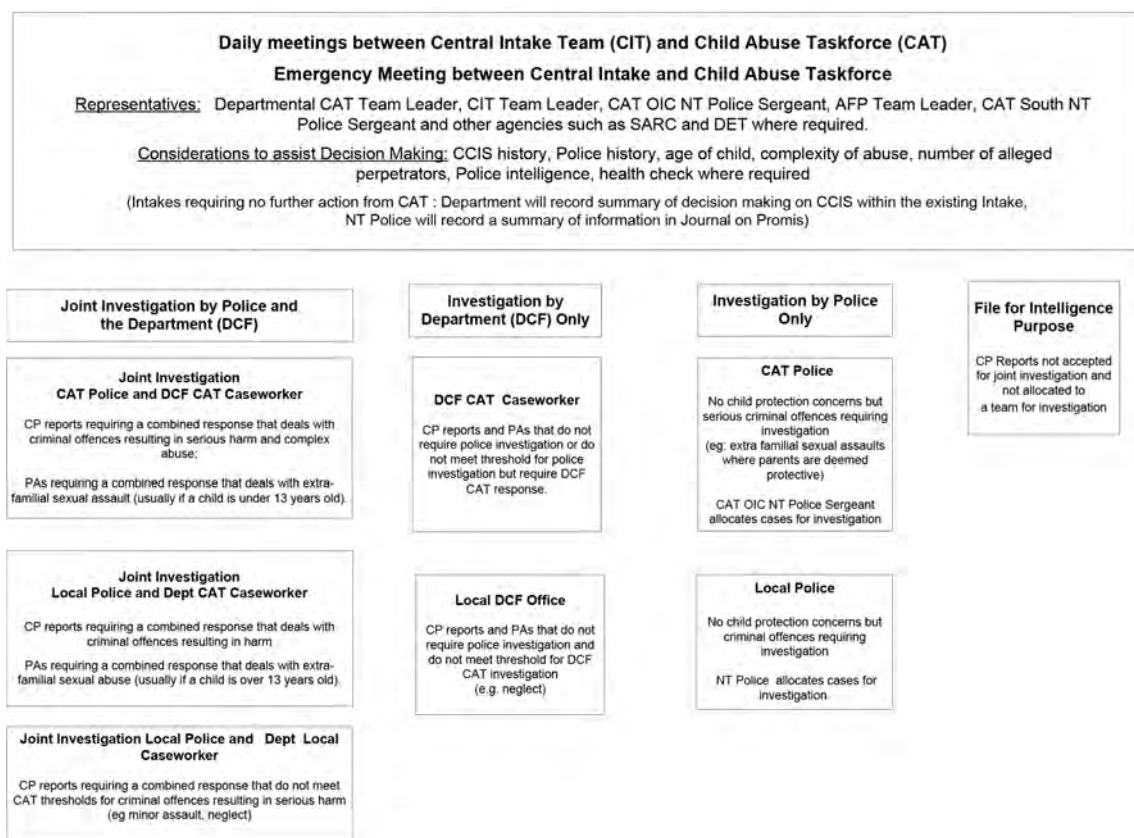
The role of CAT is to:⁶⁴

- collect evidence to prosecute the offender/s
- conduct child forensic interviews with victims
- work with the victims to increase their level of safety

- collaborate with other agencies – including Child Protection Services, the Sexual Assault Referral Centre (SARC), Royal Darwin Hospital Paediatric Department, the Mobile Outreach Service, the Department of Employment, Education and Training, and Northern Territory Police – to provide the child, family and community with support throughout the investigation and potential court case, and
- provide debriefing and education to communities where appropriate.

All reports relating to sexual harm or exploitation are directed to CAT.⁶⁵ Members of CAT meet with the CIT each weekday morning to discuss all reports involving allegations of sexual harm or exploitation.⁶⁶ A flowchart representing the decision making between the CIT and the CAT as to whether the report will be the subject of a joint investigation or an investigation by either Territory Families or the Northern Territory Police or filed for intelligence purpose is set out below.

Figure 36.1: Flowchart for Notifications in Central Intake Team and Child Abuse Taskforce⁶⁷



Thereafter, CAT’s usual activities include investigation planning, organising interviews, and discussing the possibility and nature of any potential criminal charges.⁶⁸

Interviews are usually conducted by CAT to gather relevant facts and ascertain if the harm has occurred due to a parent or caregiver’s act or omission to act. This information is obtained through a member of the Territory Families team monitoring a police-conducted Child Forensic Interview (CFI)

or conducting a joint interview with the Northern Territory Police. The objective – and one of the benefits – of a multidisciplinary approach is to minimise the impacts of investigations where different investigating teams conduct multiple interviews, which can repeat the trauma for the victim and their families.⁶⁹

CAT comprises two separate teams. The Northern Child Abuse Taskforce (CAT North) covers the Northern Territory north of Elliot and is located at Berrimah. The Southern Child Abuse Taskforce (CAT South) is located in Alice Springs.

There is some evidence to suggest that there have been undulations in the numbers of personnel in CAT over the last five years, including periods where there may have been a shortfall in the number of personnel compared to the number of funded positions in any given year and also in relative terms compared to the number of personnel five years ago.⁷⁰

Joy Simpson, Manager for CAT North, gave evidence to the Commission about challenges in filling positions in CAT quickly and with experienced staff:

*'At times Investigation and Assessment and Northern Child Abuse Taskforce face challenges to fill vacant positions quickly. When the positions are filled, most of the positions are filled with qualified but inexperienced staff. This results in the need for the implementation of intensive training, mentoring, support and supervision for these new staff members.'*⁷¹

It is of particular concern that there appear to be fewer Aboriginal Community Workers attached to CAT than desirable. CAT North has one Senior Aboriginal Community Worker even though it has funding for two.⁷² Territory Families have subsequently confirmed that any surplus funding may have been temporarily redeployed by hiring staff of different qualifications to offset any personnel shortfall. It gave, by way of example, the fact that the funding for one Senior Aboriginal Community Worker position was used to employ two Aboriginal Community Workers.⁷³

The Little Children are Sacred report identified the lack of Aboriginal Community Workers that could assist in investigating and managing sexual abuse matters. Ms Simpson reported:

*'The Greater Darwin Investigation and Assessment [unit] currently have one Australian Aboriginal Person in a Child Protection Practitioner role, and two Aboriginal Senior Community Workers working across the two teams. As a result of the limited Aboriginal workers, Northern Child Abuse Taskforce tend to request assistance when required and appropriate from Aboriginal workers from other community or regional based teams when responding to intake reports in remote communities.'*⁷⁴

In evidence before the Commission, Ms Simpson explained:

'... and that's why, as a strategy, the senior Aboriginal community workers from the Child Abuse Taskforce works across both teams, because in the Child Abuse Taskforce we're able to access other remote Aboriginal workers that can provide assistance to the Child Abuse Taskforce. So we actually have access to two senior Aboriginal community workers within investigation and assessment, plus we do have a child protection practitioner in investigation and assessment. We involve the senior

*Aboriginal community workers in matters that involve locating family, drafting up genograms, facilitating family meetings where there's a strong need, and also to liaise with Aboriginal Corporations where we believe we'll get better outcomes for children if there's an Aboriginal worker leading that engagement with that organisation. At this point in time we use that – we use those resources very wisely, and the senior Aboriginal community worker also is a consultant to me in regard to matters that are put before me that may need to go to the court, and obviously those discussions with her include, "Are there any other options? Can you identify family?" I would always welcome more senior Aboriginal community workers. We manage the best we can with the resources that we've got. To follow best practice principles, I would welcome more Aboriginal staff.'*⁷⁵

The Commission considers that ensuring there are sufficient Aboriginal staff is an urgent priority if the work of CAT is to be as effective as possible.

Sexual Assault Referral Centres

The Sexual Assault Referral Centres (SARC) are a specialist service responsible for the management of victims of sexual abuse in the Northern Territory. It provides a 24-hour, on-call crisis response service, counselling, specialist forensic and medical care, and case management services for children and adults who have been sexually assaulted, and for their families and significant others.

SARC has 4 centres: Alice Springs, Tennant Creek, Darwin and Katherine.⁷⁶

SARC is usually consulted in relation to intake reports involving sexual harm or exploitation, to ensure that children and/or families receive appropriate medical and psychological treatment and support as required.⁷⁷ SARC Darwin and Alice Springs receive all CIT notifications for children regarding sexual harm, abuse or assault.⁷⁸

The role of SARC is to:⁷⁹

- assess the urgency of the presentation and forensic specimen collection
- develop a management plan with the treating doctor and health centre staff
- conduct forensic medical examinations and coordinate these with the child forensic interviews undertaken by Northern Territory Police and CAT, as required
- provide support and information to the child and family where, with the consent of the family, there is a direct referral from the PHCP, Northern Territory Police or Territory Families, or a self-referral from the family or child
- if the forensic medical examination is not urgent, give families the choice of having a forensically trained doctor travel to their community or nearest regional centre to perform the forensic medical examination
- guide the PHCP in determining if it is reasonable to believe that sexual abuse has occurred, and whether or not to proceed with a report to CIT
- provide crisis counselling, support, follow-up and information to the child and family, and make referrals to appropriate agencies
- act as a community resource in relation to sexual assault matters for collaboration and consultation, referral and community education
- provide support to PHCP who are involved in managing cases of sexual abuse provided the family consent

- provide professional training and consultations.

The Commission has received evidence that in 2016, SARC Darwin and Alice Springs completed 114 child medical examinations, 83 of whom were children from remote communities. Between those two centres, 135 children were seen for counselling. SARC Alice Springs and Tennant Creek provide the counselling service if clients are able to travel to the centres but have no capacity to travel to remote communities due to limited staffing.⁸⁰

Mobile Outreach Service

The Mobile Outreach Service (MOS Plus) provided therapeutic community-based counselling to remote Aboriginal children and families who had experienced trauma as a result of child abuse and neglect. MOS Plus also talked with communities, schools and other workers to increase understanding of the effects of abuse, how they can support the child and how they can assist to keep other children safe.⁸¹

Submissions from AMSANT and Aboriginal Peak Organisations Northern Territory (APO NT) expressed concern that MOS Plus was defunded at the end of 2016. The Commission understands that as a result of the defunding there are now very few if any services for victims in remote communities. If sexual abuse occurs, they often need to be evacuated to regional or urban areas for treatment.⁸²

Sexual Health and Blood Borne Virus Unit

The Sexual Health and Blood Borne Virus (SHBBV) Unit is a section of the NT Centre for Disease Control. It has a broad public health role providing educational and clinical services relating to STIs, HIV, Hepatitis C and related diseases across the Northern Territory. It also provides clinical services through Clinic 34.⁸³

In particular, the SHBBV Unit receives and records all positive pathology results in accordance with the *Notifiable Diseases Act (NT)*.⁸⁴

In the event of a positive STI result in a person under 16, the Guidelines state that the SHBBV Unit will contact the medical practitioner to verify the demographic data and remind the practitioner of the mandatory reporting obligations.⁸⁵

Investigations of allegations of sexual harm or exploitation

When suspected sexual harm or exploitation is reported to the CIT, one or more of the agencies outlined above become involved. A decision is then made based on information provided in the report – and from information otherwise available to the relevant agencies – as to whether a child protection or police investigation is warranted and will commence.

The Guidelines state that not every report will be investigated and that the critical factors in deciding whether a matter will be investigated are:

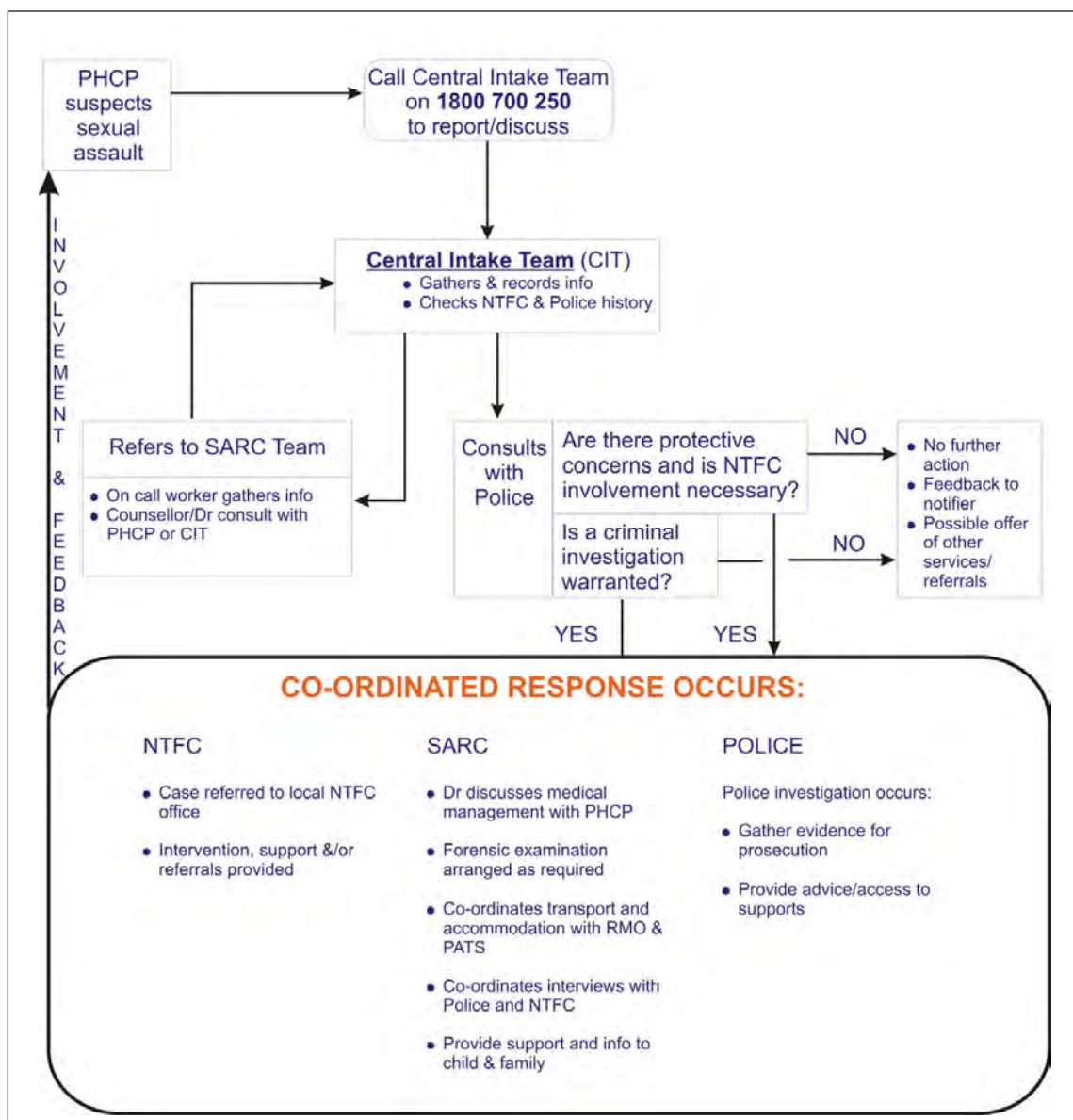
- there must be sufficient evidence for Child Protection Services and the Northern Territory Police to act
- the alleged incidents have caused serious harm to the child

- the child is likely to suffer further harm without Child Protection Services intervention, and
- there are sufficient resources available to ensure that the matter can be fully and properly investigated.⁸⁶

Child Protection Services generally only becomes involved in cases where the perpetrator is a family member (intrafamilial rather than extrafamilial cases), or where the family is not protecting the child from harm. In some cases, Northern Territory Police are involved but Child Protection Services is not.

The flowchart below, taken from the Guidelines, shows the process following a report of suspected sexual harm or exploitation.

Figure 36.2: Flowchart of Processes when a Report is made to Central Intake⁸⁷



Difficulties in identifying sexual abuse

It is well recognised that sexual abuse of children in the Northern Territory is significantly under-reported. The Little Children are Sacred report identified that ‘[s]exual abuse of Aboriginal children is common, widespread and grossly under-reported’.⁸⁸ The Guidelines note that this is particularly the case in remote Aboriginal communities, as reporting might result in possible adverse consequences that may affect the young person, family, community or reporter. It may also lead to the deterioration of family or community relations, threats to safety and the risk of retribution. In some community situations, there may be no safe place for the young person to go.⁸⁹ Sections 7 and 8 of the Guidelines deal with identifying and responding to sexual abuse, especially uncertainty as to whether sexual harm has occurred.⁹⁰

DATA INVOLVING SEXUAL HARM OR EXPLOITATION

Notification and substantiation data

There are a number of ways of looking at the available child protection data to see if it provides any insight into the prevalence or incidence of sexual harm or exploitation – insofar as that data is reported in the Northern Territory.

Each year, the OCC identifies the number of notifications with the primary harm category of sexual exploitation. It reports this in its annual reports, showing the proportion of notifications substantiated each year. As noted above, not every notification meets the threshold for investigation.

Sven Thormann from Territory Families also provided the Commission with an analysis and evidence on the numbers of notifications and substantiations.⁹¹

Table 36.2: Numbers of notifications and substantiations of notifications where primary category of harm is sexual harm or exploitation⁹²

Year	Number of Notifications	% of Total Notifications	Number of Substantiations	As a % of Notifications Substantiated	As a % of all substantiations
2008-09	1045	16.87%	101	9.47%	9.63%
2009-10	1449	21.99%	127	8.76%	9.41%
2010-11	727	11.13%	91	12.52%	4.94%
2011-12	907	11.38%	58	6.39%	3.19%
2012-13	627	6.29%	23	3.67%	1.58%
2013-14	648	5.01%	33	5.09%	1.94%
2014-15	1865	10.95%	105	5.63%	5.09%
2015-16	1784	8.72%	71	3.98%	3.72%

The number of notifications CIT received each year where the primary category is sexual harm or exploitation has varied considerably since 2008–09, albeit in part due to classification errors during the period, as discussed below.

Nevertheless, it is possible to make some general observations:

- sexual harm or exploitation is the smallest primary category of harm of the four available categories; in 2015–16 it comprised nearly 9% of all notifications. The other categories were neglect, emotional abuse and physical abuse
- similarly the percentage of notifications for sexual harm or exploitation which were investigated and substantiated was small. In 2015–16, 4% of substantiations related to the sexual harm or exploitation category of harm. By comparison, the figures were 43% for neglect, 35% for emotional abuse and 18% for physical abuse, and
- there was a steep decline in the percentage of all substantiations, from 10% in 2008–09 to 1% in 2012–13. This raised a red flag, as identified in the OCC’s 2012–13 Annual Report, which observed that *‘even though sexual abuse substantiations have always made up the smallest category of abuse and neglect, it is concerning that this category now represents only 1% of the total substantiations in the NT. There is no clear reason for the reduction.’*⁹³ The report contrasted that 1% figure against national figures, where 13% of substantiations were for sexual abuse notifications.⁹⁴

The Australian Institute of Health and Welfare compared Northern Territory data to the experience in the other Australian states, in *Child Protection Australia 2015–16*, published in March 2017 (the AIHW Child Protection Report).⁹⁵ Generally, AIHW data indicates that sexual harm or exploitation form the smallest primary type of abuse in the Northern Territory,⁹⁶ and that girls were more likely to be the subjects of substantiated sexual abuse than boys.⁹⁷

Reviews of notification and substantiation rates (2013)

In 2013, in response to the concern identified in the OCC’s 2012–13 Annual Report, the Quality Analysis & Practice Integrity branch of the Professional Practice Division of the Department of Children and Families undertook an analysis to develop an understanding of the reasons for the declining trend in notifications of sexual exploitation progressing to investigation, and the drop in substantiations following an investigation (the QAPI Review). The report which followed, entitled *‘Analysis of Child Protection Cases with a Primary Reported Harm Type of Sexual Exploitation’*, was produced in February 2014.⁹⁸

The QAPI Review’s findings included the following:

- With the exception of sexual exploitation, there has been growth in the other primary reported harm types over the period from 2008–09 to 2012–13. Other than a spike in the number of notifications in 2008–09 and 2009–10, during the same period, there was a 40% decline in sexual exploitation as the primary reported harm type.
- The reason for the steady decline in the number of notifications with sexual harm or exploitation as a primary category of harm was due, in part, to a *‘classification error’*, where some of the notifications for this type of abuse were classified under the *‘neglect’* category.⁹⁹ Other factors proposed in the QAPI Review included the decline in numbers being linked to the changing nature of reporting and the Department of Children and Families (DCF) threshold through the introduction of the Structured Decision Making Tool into the intake procedures in June 2010; fewer awareness raising campaigns since the Intervention; and incidents of sexual abuse and exploitation were continuing to occur but were going unreported.

- In 2012–13, 67% of notifications with the primary reported harm type of sexual exploitation did not proceed to investigation. While the QAPI Review noted that this was a high number which may need a more in-depth review to ascertain integrity of the data, quality of practice and potential risks to services users and DCF, one of the reasons offered for the decrease in notifications that did not proceed to an investigation was that some notifications were being ‘screened out’ due to not having sufficient information to inform quality decision-making, rather than being ‘screened in’ so sufficient information could be obtained and a quality decision could be made.¹⁰⁰
- Based on a review of the sample of files, there were deficiencies in various key decision-making points, which ultimately influenced the quality of the investigation itself. The review identified that:
 - in cases with an outcome of ‘No Abuse or Neglect’ found, children and young people subject to allegations were often only seen or spoken with in meaningful face-to-face contact once and/or in the presence of the parent(s) or the alleged offender
 - investigation practice in some cases lacked joint planning with Northern Territory Police, and risk assessments were often not robust and did not include risk analysis for the child
 - the practice of diagnosing children with STIs and response to diagnosis was varied, as was the practice of investigating and assessing the potential risk of children alleged to have sexually harmed other children
 - in some investigations where more than one harm type was reported, more emphasis was placed on substantiating one harm type over the other, resulting in potential sexual harm or exploitation not being addressed.¹⁰¹

The QAPI Review concluded that:

‘The analysis identified some of the dynamics involved in assessing indicators and investigating allegations and disclosures of sexual abuse and sexual exploitation and how quality of practice, decision making and recording practice impact quality of DCF service provision, data and reporting. The analysis identified that data regarding the sexual abuse category should be interpreted with caution due to the methodological limitations and integrity of the data ... making the actual notification is not within DCF’s control. DCF has more control over the assessment of concerns rose and decision making at point of Intake (e.g. the number of [Child Protection] reports that proceed to investigation). This is an area of practice where some issues have been identified. [Child Protection] investigations recorded with an outcome ‘Not Substantiated’ is another area of practice that may need further review due to the high number and issues identified.

Assessment and investigation of sexual abuse and sexual exploitation is complex and from a child protection practice perspective challenging. It is imperative that DCF provide a quality service to children and young people who have or may have suffered sexual abuse or sexual exploitation and provide them with a safe environment to help them tell their story.’¹⁰²

While a number of recommendations were made in the report, the primary recommendation was that the findings of the analysis should be forwarded to the Executive Director Professional Practice division and the Executive Leadership Group of the Department of Children and Families, to enable

any current practice issues to be identified at a strategic level.¹⁰³

In September 2014, a letter was sent to Dr Howard Bath, then Children’s Commissioner, confirming that some sexual exploitation matters had been incorrectly recorded as neglect matters, and that steps had been taken – through training, engagement with the providers of the Structured Decision-Making tool, and a new policy direction issued by the Executive Director to the CIT in May 2014 – to rectify the recording errors.¹⁰⁴ The letter foreshadowed that while the figures for 2013–14 would probably again show an overall low proportion of sexual exploitation notifications and substantiations, the figures for 2014–15 would show a significant rise in rates based on the changes made. The figures outlined in Table 36.2 above confirm that this was eventuated.

Although it is unclear what exact practice issues were identified and changed following the report, the OCC’s 2014–15 Annual Report noted that following changes in the way notifications were categorised, the number of sexual abuse or exploitation notifications substantiated had increased and was ‘returning to levels experienced in [2009-10]’.¹⁰⁵ However, there is little information as to what lessons and practical changes have been considered and effected at the practice level to remedy the deficiencies identified in the QAPI Review.

Subject to the limitations identified above, the Commission’s observations are that the data suggests:

- the number of notifications where the primary category of harm is sexual harm or exploitation has generally increased in the last 10 years. This may reflect greater awareness of child sexual harm or exploitation, or greater understanding of the need to report suspicions that a child may be at risk of sexual harm or exploitation. If that is the case, the increased number of notifications may not necessarily suggest a greater prevalence of child sexual harm or exploitation, but simply a correction of historic under-reporting. It is also entirely possible that the increased figures do reflect increasing incidences of child sexual harm or exploitation. The material available to the Commission does not enable it to make a finding either way, and
- the proportion of substantiated notifications has decreased significantly compared to 10 years ago. The Commission’s concern about this trend, supported by an internal review of substantiation rates in 2013, is that it reflects resourcing constraints and is low because cases are not being identified as warranting an investigation, or because investigations are being conducted inappropriately.

STI rates in children and young people in the Northern Territory

The Guidelines state that the majority of victims of sexual assault or abuse – whether they are adults or children – do not have or present with STIs. Although an STI may be a ‘marker of abuse’, STIs in young people often occur as a result of consensual sexual activity.¹⁰⁶

The Guidelines describe a ‘grey zone’ of age, within which it may be very difficult to determine whether sexual activity might be consensual or abusive.¹⁰⁷ For that reason and for reporting purposes, the Guidelines state that the threshold for considering STIs or pregnancy in children to be the result of sexual abuse until proven otherwise is set at under 14 years.

Accordingly:

- any diagnosis of a STI or pregnancy in a child under 14 years old is considered to be the result of sexual abuse until proven otherwise, and must be reported to CIT for appropriate social and medical assessment, and
- for young people 14 years and older diagnosed with an STI or pregnancy, a more 'discriminating' approach must be taken, and action should be determined in the context of available clinical and social information.¹⁰⁸

The Department of Health provided the Commission with data in relation to STIs in children and young people for the period from 2006 to 2016 (STI Data).¹⁰⁹ The Department made a number of caveats in producing the STI Data, including that:

- notified cases represent only a proportion of the true number of cases, and the proportion of cases notified is in itself variable and unpredictable, which may lead to misleading assumptions about trends if the STI data was relied on
- rates of illness and trends of STIs are very much subject to variations in testing; increasing rates may be due to an increase in screening and monitoring, which has an effect on comparisons between rates of STIs in Aboriginal and non-Aboriginal populations, and
- laboratory notifications do not distinguish between sexually and non-sexually acquired infections; the Northern Territory Department of Health states that in children up to four years of age it is known that an STI, even of the genital area, may have been acquired from the mother at the time of delivery or via inadvertent nonsexual spread.

The Commission's comments below on the trends, based on its review of the STI Data, should be considered in light of the above caveats.



Figure 36.3: Number of Notified Cases of Chlamydia in Children under 16 by Aboriginal Status¹¹⁰

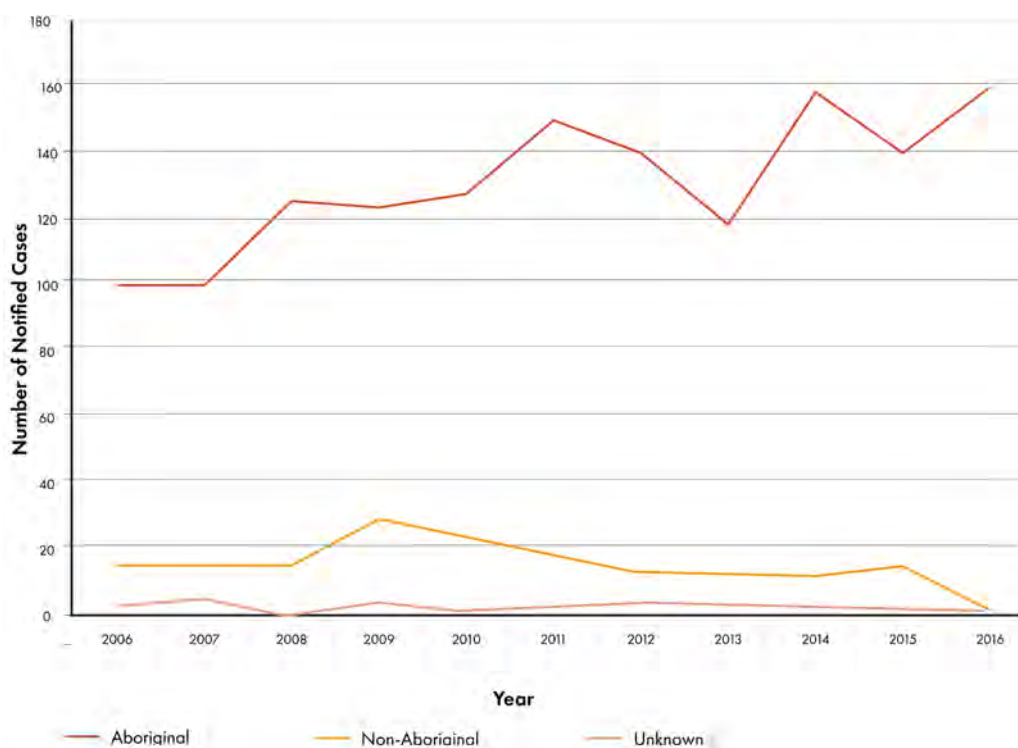


Table 36.3: Number of Notified Cases of Chlamydia in Children under 16 by Aboriginal Status¹¹¹

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Aboriginal	100	101	126	124	128	150	141	118	159	140	161
Non-Aboriginal	15	15	15	29	25	19	13	13	12	15	3
Unknown	3	5	0	4	1	3	4	3	3	2	2

Figure 36.4: Number of Notified Cases of Gonorrhoea in Children under 16 by Aboriginal Status¹¹²

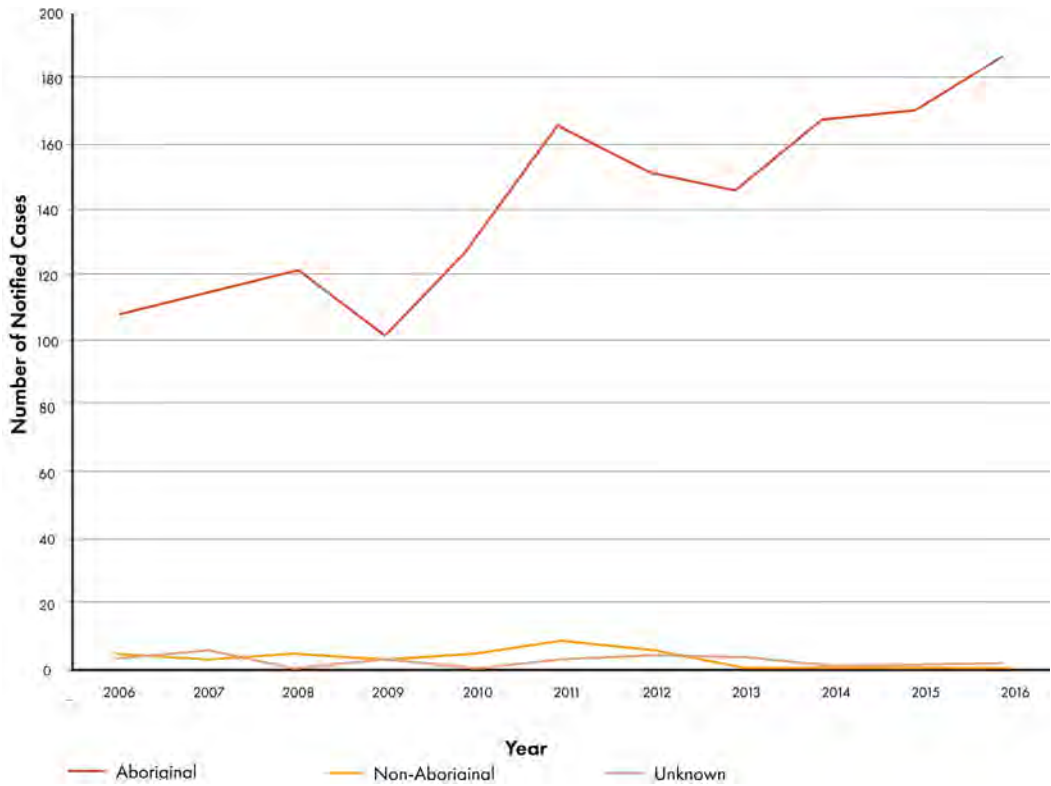


Table 36.4: Number of Notified Cases of Gonorrhoea in Children under 16 by Aboriginal Status¹¹³

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Aboriginal	109	115	121	102	129	165	151	146	167	170	186
Non-Aboriginal	4	3	4	3	5	8	5	0	0	1	1
Unknown	3	5	0	2	1	3	4	3	0	1	1

Figure 36.5: Number of Notified Cases of Syphilis in Children under 16 by Aboriginal Status¹¹⁴

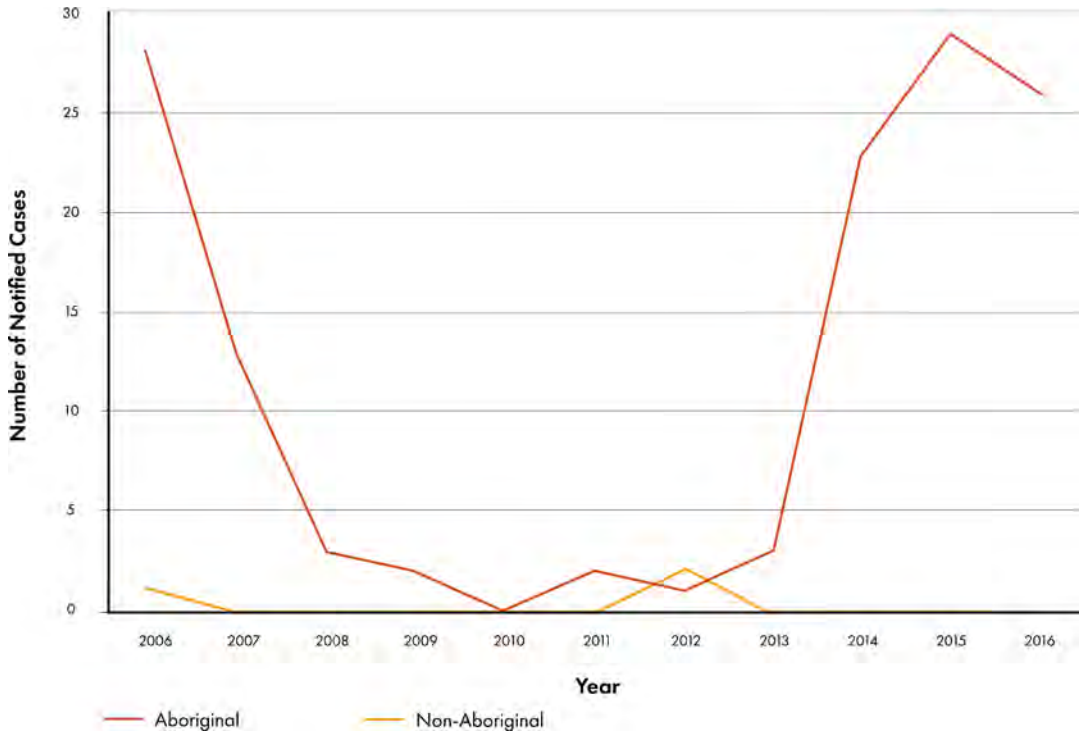


Table 36.5: Number of Notified Cases of Syphilis in Children under 16 by Aboriginal Status

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Aboriginal	28	13	3	2	0	2	1	3	23	29	26
Non-Aboriginal	1	0	0	0	0	0	2	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0

Figure 36.6: Number of Notified Cases of Trichomoniasis in Children under 16 by Aboriginal Status¹¹⁵

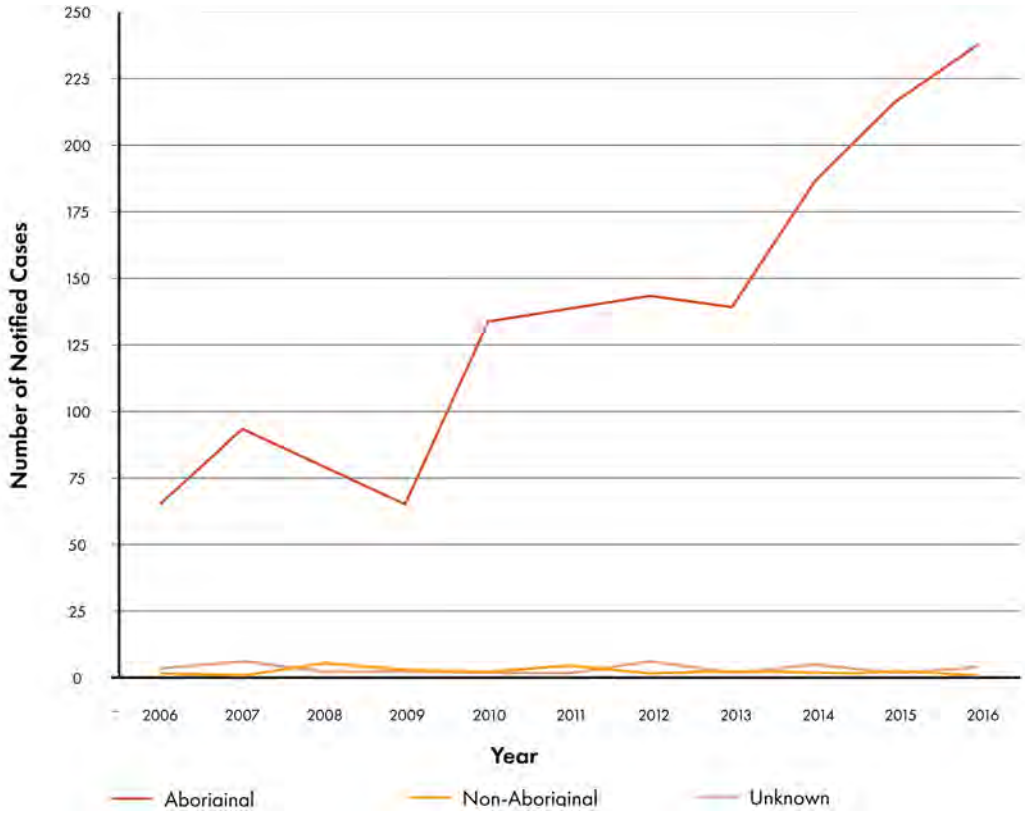


Table 36.6: Number of Notified Cases of Trichomoniasis in Children under 16 by Aboriginal Status¹¹⁶

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Aboriginal	66	94	80	65	134	139	144	140	187	218	240
Non-Aboriginal	2	0	5	1	0	4	1	0	0	2	0
Unknown	3	5	2	2	1	2	5	1	4	2	4

By way of general observation, there was an increase in the number of notifications for all four types of STIs in 2016 compared to 2006. Over that 10-year period:

- there were 180% more notifications for trichomoniasis
- there were 60% more notifications for gonorrhoea
- there were 30% more notifications for chlamydia, and
- there were 0.09% more notifications for syphilis.

The available STI data also confirms that STI rates in Aboriginal males and females are significantly higher than for their non-Aboriginal counterparts, including for females under 12.

Table 36.7: Cases of STIs diagnosed in female under the age of 12 years over the period 2006 to 2016¹¹⁷

Type of STI	Aboriginal female diagnoses	Non-Aboriginal / unknown female diagnoses
Chlamydia	95	0
Gonorrhoea	30	0
Syphilis	2	0
Trichomoniasis	32	0

Similar observations can be made as to the differences between Aboriginal and non-Aboriginal rates across the older age groups.

Table 36.8: Increased Likelihood of Aboriginal children being diagnosed with various STIs over the period 2006 to 2016, as compared with their non-Aboriginal counterparts¹¹⁸

Type of STI	Aboriginal female	Aboriginal male
Chlamydia	3.5 times	5.4 times
Gonorrhoea	25.3 times	21 times
Syphilis	58.3 times	23.4 times
Trichomoniasis	31.9 times	26.7 times

Northern Territory Police data regarding child sexual assault offences

In response to a Notice to Produce issued by the Commission, Northern Territory Police produced documents summarising:

- the number of child sexual assault offences and number of people Northern Territory Police charged with child sexual assault offences between 2006–07 and 2016–17, and
- the court outcome of the child sexual assault charges from 2006–07 to 2016–17.

A summary of the numbers of people charged with Child Sexual Assault Offences (based on offences with a description indicating the sexual assault victim is under 16 years old age and those with case notes stating the victim is under 16 years old) is set out below.¹¹⁹

Table 36.9: Numbers of persons charged with Child Sexual Assault Offences by Aboriginal Status and Gender 2006 - 2017¹²⁰

Year	No of Aboriginal Persons Charged (M)	No of Aboriginal Persons Charged (F)	No of Non-Aboriginal Persons Charged (M)	No of Non-Aboriginal Persons Charged (F)	Total Number of Persons Charged
2006-07	47	0	34	4	85
2007-08	34	0	33	1	68
2008-09	46	0	34	0	80
2009-10	48	0	37	0	85
2010-11	38	0	38	0	76
2011-12	37	2	27	3	69
2012-13	45	2	30	2	79
2013-14	56	1	29	2	88
2014-15	59	1	32	0	92
2015-16	57	0	19	0	76
2016-17	48	1	23	0	72

As the table shows, the vast majority of offenders are male. These numbers have remained relatively steady over the last 10 years, with only a variance of 24 between the low of 68 total persons charged in 2007–08 to the high of 92 persons charged in 2014–15.

A second table produced by Northern Territory Police showed the final court outcome for child sexual assault offenders on finalisation occasions. It identifies the year of the court outcome, and the court outcome: imprisonment, partially suspended imprisonment, fully suspended imprisonment, community work order, monetary penalty, other orders, or withdrawn or acquitted.

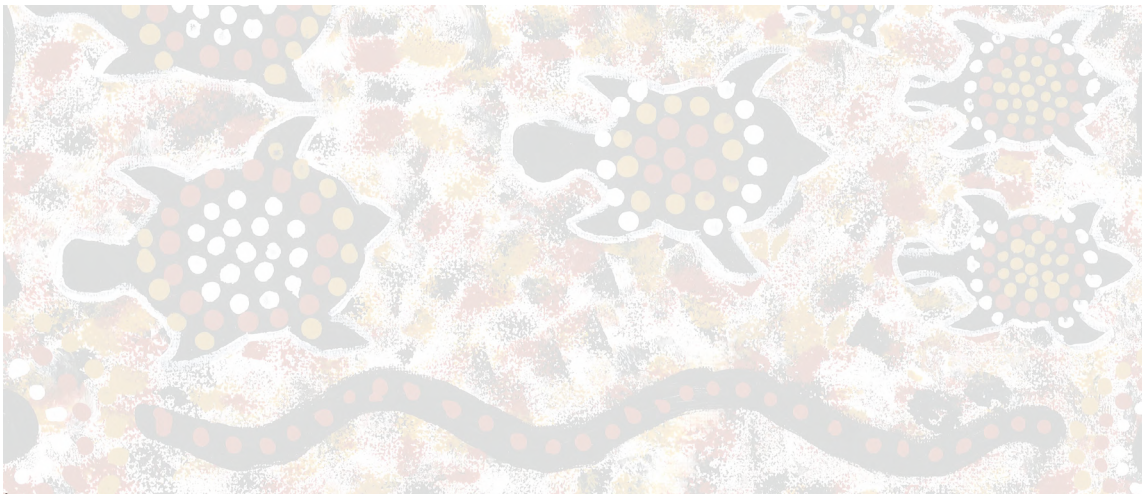


Table 36.10: Final Court Outcome for Child Sexual Assault Offenders on Finalisation Occasions¹²¹

Year	Imprisonment	Partially suspended imprisonment	Fully suspended imprisonment	Community Work Order	Monetary Penalty	Other Orders	Withdrawn / Acquitted	Total
2006-07 ¹²²	30	29	4	0	0	1	55	119
2007-08	19	22	11	0	1	3	59	115
2008-09	29	23	7	0	1	3	69	132
2009-10	28	27	6	0	6	2	68	137
2010-11	22	23	5	0	4	6	72	132
2011-12	30	31	0	0	2	5	58	126
2012-13	25	21	2	0	5	3	75	131
2013-14	27	29	8	1	5	5	82	157
2014-15	36	28	6	1	3	1	75	151
2015-16	28	33	7	0	7	4	61	141
2016-17	33	26	10	0	3	5	74	151

A number of observations can be made in relation to this data:

- The present number of cases resulting in a court outcome is, overall, only slightly higher than in 2006–07. The number of court outcomes in the last two years are the top three highest numbers of case outcomes involving child sexual assault offenders. Whether or not this might suggest a more improved rate of police action is difficult to determine.
- Between 38% and 62% of cases result in the charge being withdrawn or the person charged being acquitted.

Abuse as a factor in the removal of children

The process by which suspected sexual harm or exploitation is investigated and by which agency is covered earlier in this chapter. Chapter 32 (Entry into the child protection system) also sets out the process and considerations that must be applied in deciding to remove a child from their home and place them into some form of care.

None of the data sources considered in this chapter include information as to outcomes following substantiation of sexual harm or exploitation. Up until 2012–13, the OCC’s annual reports did not include data on the number of cases where substantiated sexual abuse or exploitation was the reason for a child or young person being made subject to a temporary placement arrangement or any other type of order.

After 2012–13, the OCC annual reports began identifying the numbers of cases where substantiated sexual abuse or exploitation was the reason why a child was made subject to a temporary placement arrangement. Importantly, the numbers of cases do not account for the numbers of children entering the care of the Chief Executive Officer through other types of orders, such as a provisional protection order, a temporary protection order or a protection order.

What data is available suggests that it is relatively uncommon for a temporary placement arrangement to be made even following substantiation of sexual abuse or exploitation.

Table 36.11: Cases where substantiated sexual abuse or exploitation was the reason for a Temporary Placement¹²³

Year	Number of Cases
2012-13	1
2013-14	4
2014-15	0
2015-16	0

This is supported by the evidence given by the Manager of the Investigations and Assessment division of Territory Families:

‘In reference to the Child Abuse Taskforce, it is very, very infrequent that we remove children from their families. Very, very infrequent. Noting that the Child Abuse Taskforce works with the most complex sexual and physical abuse in the Northern Territory ... we encourage parents to identify family where they would like their child to be cared for by, whilst they’re addressing some of the issues that are presented before Territory families ... It could be other significant extended family – to identify a suitable family member or members that can take care of the child. It’s a last resort to bring a child from – for the Child Abuse Taskforce out of the family based in a remote location. And in the whole time I’ve been in the – in that role, managing the Child Abuse Taskforce, I can recall – I think we’ve done it on two occasions since I’ve been managing that work – that work unit.’¹²⁴

What is unclear based on the evidence available to the Commission is the degree to which victims of substantiated sexual harm or exploitation remain in their current care arrangements. The evidence given by a Territory Families’ CAT Officer was to the effect that if a standard decision-making assessment had been applied to a case, the outcome suggests that the children are at ‘low or moderate risk’¹²⁵ of experiencing harm in the next 18 months and legal intervention is not initiated, the case is referred to the Territories Families Family Support Panel, seeking recommendations for holistic support or intervention for the family and their children.

Taking the anecdotal evidence given, as repeated above, that it is ‘very, very infrequent that [CAT] remove children from their families’, and given the considerations that must be given to the safety of the child and exposure to further abuse as outlined in the Guidelines, the assumption is that the decision to leave children in their current care arrangements is based on a finding that the sexual harm or exploitation was not the result of parental neglect or a failure to supervise, and the child is not at risk of further sexual harm or exploitation if there is no change to their circumstances. However, the Commission accepts this is speculative only and this would have to be tested by reviewing cases in which there were repeated incidents of sexual harm or exploitation, to determine if the appropriate decision had in fact been made at the relevant time.

Reporting allegations of harm while in care

An investigation involving allegations that a child has suffered or is likely to suffer harm while in the care of the Territory Families Chief Executive Officer is referred to as a 'section 84A case'.¹²⁶ Under section 84C of the *Care and Protection of Children Act*, the Chief Executive Officer is required to notify the Children's Commissioner of each case where a child protection investigation has resulted in substantiated allegations of harm or exploitation while the child was in the Chief Executive Officer's care. Section 10(1)(f) of the *Children's Commissioner Act 2013* (NT) specifies that the Commissioner must monitor the way the Chief Executive Officer deals with suspected or potential matters involving abuse in care.

Between 1 July 2015 and 30 June 2016, the Chief Executive Officer of Territory Families notified the Commissioner of 81 cases of harm and exploitation involving 70 children in out of home care.

- Five of those cases involved 'sexual harm and exploitation'
- Four of the five cases involved Aboriginal children, and
- Of the four categories of abuse, cases of sexual harm or exploitation comprise the lowest percentage of cases (6%). Physical abuse comprised 34% of cases, emotional abuse 30% and neglect 30%.¹²⁷

The relatively low percentage of cases involving sexual harm or exploitation is consistent with the low percentage of overall notifications involving allegations of sexual harm or exploitation. One conclusion might be that the risk of sexual abuse occurring in the out of home care system is no greater than the risk of sexual abuse occurring while the child or young person is outside the care system.

From 2015, the Children's Commissioner began to report a breakdown the substantiations in relation to children in out of home care. The OCC annual report for 2014-2015 reports 11 substantiations for sexual harm or exploitation for children in the care of the Chief Executive Officer, and the 2015-2016 annual report records five such substantiations.¹²⁸

The Commission received evidence about the process by which these cases are assessed. One Territory Families CAT officer, said she was currently investigating two such cases (in May 2017). One alleged sexual harm was perpetrated by a male carer at a residential care home; the other was perpetrated by a male neighbour against a young person in care.¹²⁹

Although Chapter 33 (Children in out of home care) provides more detail about the processes implemented when identifying appropriate out of home carers, the current carer screening processes require a Working with Children Clearance, criminal history checks, and child protection history checks for all persons residing in the household who are aged 15 or above.

There is little evidence before the Commission as to what steps are taken in relation to out of home care providers subject to an allegation of sexual harm or exploitation, which has not been substantiated or who has who has not been convicted of an offence.

In the event of a substantiation of abuse or harm against a service provider or a staff member as a result of an assessment, evidence before the Commission is that a formal meeting is convened with the service provider. The other attendees of the meeting include the Executive of the Territory Families' Out of Home Care and Procurement Branch (if the placement is part of the funded service). The purpose of these meetings is stated as being to review the substantiation to consider if amendments to the service are required, if further training is necessary for staff or if the relevant child or young person requires additional support. The Commission is also informed that if required, a formal plan is developed with the service to resolve the matter with scheduled reviews to ensure resolution.¹³⁰

While the processes in place would suggest that any individual or provider who does not satisfy the current carer screening processes would not be cleared to continue providing out of home care services¹³¹, there is a need for clear guidelines and provisions around the risk assessment which will be implemented to ensure this is the case.

Data on institutional responses to child sexual abuse

By way of comparison, a notice was issued for the Department of Children and Families (DCF) to provide the Child Abuse Royal Commission with child protection data. In response to the notice, DCF produced a document outlining 48 allegations of sexual exploitation and harm in care over the five-year period between 2008–2009 and 2011–2012.¹³²

An analysis of the data suggests:

- 36 of the 48 (75%) alleged cases involved an Aboriginal child
- 16 of the 48 alleged cases involved a male child and 32 involved a female child
- in terms of the relationship of the person believed to be responsible for perpetrating the sexual exploitation:
 - 10 were foster carers
 - eight were another child in care
 - five were kinship carers
 - five were residential care workers
 - four were the foster carer's son or partner
 - two were referred to as the 'boyfriend'
 - the other 12 were unknown
- in terms of the reported outcome:
 - nine allegations were classified as not meeting the threshold to investigate, so there was no child protection investigation and the child remained in the same care arrangements
 - six allegations were identified as not constituting maltreatment, so no child protection investigation occurred or there was no other action possible
 - six allegations were classified as having insufficient information, so no child protection investigation took place or the outcome was recorded as *no abuse or neglect found*
 - 26 allegations proceeded to an investigation, and of these:
 - > four were substantiated
 - > 14 did not find abuse or neglect, and
 - > eight were classified as 'No Action Possible – Other' (for example if the child had left the Northern Territory or was in other care arrangements).

Complaints of sexual or indecent assault in Northern Territory youth detention centres

The Commission received evidence that there were 138 complaints of assault, indecent assault and sexual assault made by children and young people in Northern Territory youth detention centres between March 2007 to June 2016.¹³³ As recorded in the data produced to the Commission, 25 of the 138 complaints raised by detainees were complaints relating to incidents of sexual assault (actual or threatened), indecent assault or indecent dealings occurring at a youth detention centre, reported to the Northern Territory Police. Of these:

- 22 occurred at the Don Dale Youth Detention Centre
- one occurred at the Alice Spring Youth Detention Centre
- one occurred at the Darwin Correctional Precinct, and
- one occurred while a detainee was in a court cell.

Three of the incidents involved allegations of youth justice officers assaulting, threatening to assault or improperly dealing with a detainee, and 22 of the incidents involved other detainees.

This list does not capture other incidents involving sexual acts, such as the disturbance at the former Don Dale Youth Detention Centre in December 2011. Among other events, the incident involved two male and three female detainees jumping into the pool together and engaging in suspected sexual activity. The ‘morning after’ pill was prescribed the following day.¹³⁴ A mandatory report was made to the police about the suspected sexual activity.¹³⁵

Directives

During this period the reporting procedure for an incident of sexual assault, indecent assault or indecent dealing was outlined in a series of Northern Territory Correctional Services (NTCS) directives concerning incident reporting and recording. The first, dated 31 March 2008,¹³⁶ was replaced in July 2015 by the *NTCS Directive – Incident Reporting and Recording Youth Justice*.¹³⁷ which remains in force.¹³⁸

The 31 March 2008 directive was not specific to youth justice. It classified ‘serious sexual assault’ as a Level 1 Incident. This was the case regardless of whether or not the parties to the assault were detainees or prisoners.¹³⁹ The directive¹⁴⁰ defined ‘serious sexual assault’ and the internal reporting procedure for responding to a serious sexual assault. Additionally, the directive stated that ‘[f]or Level 1 incidents the Superintendent may notify the NT Police where deemed required’.¹⁴¹ No other provision of the directive required a police report.

The 31 March 2008 directive was replaced on 14 July 2015 by a new directive specific to youth justice. The July 2015 Directive covers a matrix of incidents, including a category called ‘assault serious (sexual)’. This occurs where ‘[a] victim reports that any person in any manner has sexually assaulted him/her’.¹⁴²

The directive provides that *'all sexual assaults and alleged sexual assaults must be reported to the Northern Territory Police'*.¹⁴³ It further states that officers are expected to treat allegations of sexual assault sensitively, regardless of perceptions of seriousness at the time of the incident. The section also states that in the event of a physical sexual assault, the detainee *'must be immediately referred to the Primary Health Care Provider'*.¹⁴⁴

In addition to reporting the incident to the Northern Territory Police, the directive requires the Superintendent to prepare a *'flash brief'* of the incident for the Minister for Correctional Services, within three hours of the incident occurring.¹⁴⁵ The flash brief must contain all of the details of the incident, and will be sent to the Executive Director of Youth Justice for endorsement, who forwards it to the Commissioner for approval.

The July 2015 directive also provides that suspected or actual misconduct by staff – including sexual and indecent assault – must be reported to Northern Territory Police.¹⁴⁶

Responses to incidents

Flash briefs issued by Territory Families show the steps which might be taken after an incident is reported. In 2014 a detainee advised a youth justice officer that he had been groped and propositioned for sex by one of his cellmates. A document from this date states that the detainees *'were immediately separated into separate rooms and are currently being kept apart. The matter was reported to the Police'*.¹⁴⁷

In 2017, a detainee reported that he had been sexually assaulted by a detainee at a youth detention centre.¹⁴⁸ A review of the IOMS system confirmed the detainees were accommodated together in a room on the night in question. Northern Territory Police were notified and immediate steps were taken to rehouse the alleged perpetrator into a single room with a note that he should not be left unsupervised with any other detainee. The alleged perpetrator was in remand for the offence of sexual intercourse without consent, so a serious question arises as to why, in those circumstances, he had been placed unsupervised into a shared room with another younger detainee. The report noted that a review would be instigated regarding the management and accommodation decisions affecting young people who have a history of sexual assault.

There are other instances where reporting has been delayed or steps not taken to minimise the likelihood of a further incident. In 2015, a detainee reported that a cellmate attempted to assault him sexually. He alleged the other detainee pulled down his pants and made verbal threats of rape. Although youth justice officers intervened, there were concerns that the incident was not immediately reported in accordance with mandatory reporting requirements.¹⁴⁹ Shortly after the incident, the complainant was released from the current Don Dale Youth Detention Centre. Days later he was again remanded at the current Don Dale Youth Detention Centre. While his admission was being processed, a further allegation was made that the same offender had made verbal threats of rape.¹⁵⁰

Counselling for detainees involved in sexually inappropriate behaviour

The information before the Commission suggests that the majority of incidents in detention involving some element of sexual assault relate to interactions between detainees, and would not amount to sexual harm or exploitation abuse as defined in sections 15 and 16 of the *Care and Protection of Children Act*.

While there are allegations involving sexual assault or indecent assault or dealings perpetrated by staff against detainees, the reports the Commission has reviewed suggest that those allegations were investigated in an appropriate manner.

However, there is little information about what support services are provided to victims following the incident. They may be interviewed by the police or caseworkers, but there is little evidence as to whether counselling or any other form of therapeutic service is offered to or provided to victims following each incident.¹⁵¹

There are few, if any, therapeutic services for young people under the age of 18 who exhibit sexual predator-type behaviours, and for any perpetrator of sexual abuse which would be an opportunity for intervention and rehabilitation.¹⁵² This is a specialist area and the Griffith University Adolescent Sex Offender treatment program within the Griffith Adolescent Forensic Assessment and Treatment Centre which has operated for over 10 years has had evaluated success in rehabilitating these young offenders.¹⁵³

Responding to sexual behaviours in children and young people

The Commission has also received a number of department alerts and updates highlighting the difficulties that arise for staff members when responding to sexual behaviours exhibited by children and young people in the care of the Chief Executive Officer.

This difficulty manifests itself in a number of cases involving children sexually abusing other children, particularly cases involving young children who sexually abuse other children significantly younger than they are.

One of the recommendations of the Little Children are Sacred report was the need for education and counselling not only for victims of sexual abuse but also for perpetrators who are children or young people.¹⁵⁴ Attention needs to be given to all parties involved in such 'child-on-child' instances of abuse. It is well known that many perpetrators of child sexual abuse have themselves been abused.

In 2012, DCF developed and approved a proposal for actions that would establish systemic responses to children and young people exhibiting problem sexual behaviours or sexually abusive behaviours, or committing sexual offences.¹⁵⁵

DCF appears to have determined that additional training was required to enhance the capacity of operational staff, including caseworkers, foster carers, residential care workers and family support workers. This training would help them better understand, identify and effectively respond to sexual behaviours in children and young people, and implement child sexual abuse prevention strategies. It would also reduce situational opportunities for child sexual abuse by raising awareness of contexts where child sexual abuse – including child-to-child sexually abusive behaviour – is perpetrated. In 2016, a Training Curriculum Brief and Business Case were prepared, for a project that would address the training requirements, review existing policy and conclude with a project evaluation.¹⁵⁶ It is not clear to the Commission whether this project has been approved or implemented, although this question was not specifically asked.

The Commission has reviewed a number of documents referencing child-to-child sexual assault in care, and sexualised behaviour by children and young people in care and in detention.

In one case in 2016, two young people aged 13 and 15 were charged with indecently dealing with a child aged 13 at a rehabilitation centre for young people. A news report noted that:¹⁵⁷

'The incident has further heightened concerns about the sexualisation of children and young people in underprivileged Northern Territory communities, partly driven by technology and mobile phones enabling greater access to pornography...'

The Northern Territory Children's Commissioner said sexualised behaviour was; 'It's common knowledge that there's concern regarding the sexualised behaviour of young children, and that there has been for some time' she said.

In 2014, an urgent brief was circulated within DCF regarding the sexual abuse of a child by another child in the care of the Chief Executive Officer.¹⁵⁸ In this case, the children were in the care of the Chief Executive Officer and in the same placement. A child protection investigation identified that one of the children had sexually assaulted another child. The investigation revealed that two years prior, the same older child had sexually interfered with a younger child. The older child also indicated that when he was younger, he had sexually assaulted three other boys and had 'same age' sex with another boy. The report noted:

*'[C]ase management file has not consistently recorded ... sexualised behaviour, nor has case work comprehensively case planned therapeutic support to address the same behaviours. Critical documents including Case Plans, Placement Referrals, Transfer Document and Essential Information Forms have not recorded ... sexual history.'*¹⁵⁹

The case file identifies seriously inadequate record-keeping in so far as this young person in care is concerned. It had the consequence that there was a failure of a quite fundamental kind to protect the victims in care.

Renae Moore, Acting Executive Director Allied Health for Top End Health Services, gave evidence to the Commission about the problem of sexualised behaviours:

'The ability to provide ongoing counselling and therapeutic intervention with children 10 years and under who show problem sexualised behaviours (PSBs) is another gap in the SARC service. Based on anecdotal evidence acquired through the number of intakes and enquiries made to SARC, it appears that the level of PSBs in the community among this cohort of children is high. However without systematic research into the current levels of PSBs, it is unclear as to whether these behaviours are being under or over represented.'

While SARC sees children up to ten years or younger displaying problem sexualised behaviour or harmful sexualised behaviour, they are not currently seeing children over ten years of age who engage in PSB. Once children over ten years of age engage in PSB, they enter the criminal age and the concern exists that rather than receiving intensive therapeutic support they might be dealt with via a criminal justice response. SARC collaborates with police for the management of these children. Evidence shows that a child-centred, coordinated response between services produces the best outcome. In order for this to be accomplished, intensive support needs to be

available to children and families coupled with access to ongoing SARC counselling and child protection case management.¹⁶⁰

Recommendation 36.2

Territory Families implement:

- **sexual health education programs for children and young people, directed at responding to sexualised behaviours**
- **counselling programs and other forms of therapeutic services for victims following an incident of sexual abuse or assault, and**
- **specialised expert programs for children and young people who perpetrate sexual abuse or assault on other children or young people.**

Recommendation 36.3

Territory Families review departmental policies and processes, identifying improvements to ensure that:

- **any history of allegations involving sexualised behaviour or sexually abusive behaviour by children and young people is taken into account in the level of supervision and support afforded to the child or young person, and**
- **any history of allegations involving sexual assault or indecent assault is taken into account when placing detainees in shared facilities.**

MANAGING THE SEXUAL HEALTH OF CHILDREN AND YOUNG PEOPLE

The Commission has sought to review information relating to teen pregnancy and the use of contraceptives by children and young people.

Policies in relation to sexual and reproductive health

There is no specific stand-alone policy addressing the provision or use of contraceptives for children and young people in care in the Northern Territory, although some broader policies relating to the management of sexual health in children and young people refer to the use of contraceptives.

Table 36.12: Policies in relation to sexual health and activity of children in care

Policy	Key Points
<p>Policy: Sexual and Reproductive Health (the Policy)¹⁶¹</p>	<p>Policy purpose:</p> <p>Healthy sexual development is critical to the overall development of young people and should be considered when planning to meet the health needs of young people in care.</p> <p>The policy statement includes the following points.</p> <ul style="list-style-type: none"> • Decision-making processes should always include the young person. • Aboriginal Cultural Practice Advisors should be consulted when planning for the personal and sexual education of Aboriginal young people in care, or young people in care who are from a culturally diverse background. • All young people in care must have access to personal development, personal safety education, and sexual and reproductive health information that is appropriate for their age and development, and culturally secure. If the young person is sexually active access to contraception will be provided by their caseworker. • Young people in care who are engaging in high-risk sexual behaviour should undergo a risk assessment and, where necessary, must have a comprehensive intervention strategy as part of their case plan.
<p>Procedures: Sexual and Reproductive Health¹⁶²</p>	<p>The Procedures identify factors caseworkers should consider when a child under the Chief Executive Officer’s care is engaging in sexual activities, and how discussions with the child should be approached – including if caseworkers must explain to the child any responsibility to advise the police if there is a reasonable belief that a criminal act has occurred. They also identify considerations regarding female genital mutilation, addressing high-risk sexual behaviour and cultural considerations.</p> <p>The types of high-risk sexual behaviour referred to include:</p> <ul style="list-style-type: none"> • having regular unprotected sex • having unprotected sex with a partner who has a STI, or a partner who is an intravenous drug user • having unprotected intercourse with multiple partners, or with one partner who has multiple partners • having a sexual relationship with an older adult, and • engaging in transactional sex and/or prostitution. <p>The procedure requires intervention by, among other things, working with the young person to identify any high-risk situations; develop specific safety plans to be implemented when those situations arise; and ensure the young person has planned and regular access to sexual health services, with regular clinical reviews including STI health checks and safe sex education.</p>
<p>STI’s in Children and Young People (see section 11 of the Guidelines)¹⁶³</p>	<p>The Guidelines provide that healthcare professionals should actively screen young people for STIs whenever possible, even in consensual and apparently monogamous situations. The Guidelines record that health care professionals should only use a speculum for examination and collection of samples for laboratory tests as a last resort and only after discussion with SARC. In that scenario, the Guidelines identify recommended laboratory tests for pre-pubertal children and non-sexually active young people, and treatment protocols for children under the age of 12 years.</p> <p>The Guidelines state that a positive STI laboratory result in a child or young person may be the consequence of sexual abuse and may be the first indication that abuse has occurred, but may also have been acquired as the result of peer sexual activity; inadvertent non-sexual spread such as autoinoculation; or non-sexual contact with another person or as a result of vertical spread from the mother (in children three and under) or a false positive laboratory result.</p>

Policy	Key Points
Contraceptives for Children and Young People	<p>There is no specific policy addressing the provision of or use of contraceptives for children and young people in the Northern Territory.</p> <p>Section 4.8 of the Guidelines addresses ‘safe sexual practices’ and provides that where a young person presents with a sexual health concern, the opportunity should be taken to provide health information on safe sexual practices, including condom use and the importance of early self-presentation.</p> <p>The Guidelines recommend that an appointment be scheduled to cover:</p> <ul style="list-style-type: none"> • STIs and their transmission • contraceptives protect against pregnancy, however they are generally not protective for STIs • only condoms will protect against the majority of STIs • the importance of sexual health checks following unsafe safe practices • the importance of early presentation if STI symptoms are present • safe and unsafe sexual practices • how and where to obtain condoms and use them correctly • contraceptive options • negotiation techniques and the right way to say no to unwanted and unprotected sex, and • consent. <p>The Policy Statement in Policy: Sexual and Reproductive Health provides that all young people in care must have access to personal development; personal safety education; and sexual and reproductive health information that is appropriate for their age and development, and culturally secure. If the young person is sexually active, their caseworker will provide access to contraception.</p> <p>Young people in care who are engaging in high-risk sexual behaviour should undergo a risk assessment and, where necessary, have a comprehensive intervention strategy as part of their case plan.</p>

Contraceptive use by children and young people in care

In the Northern Territory there is no statutory age of consent to medical treatment. Instead, the common law principles around consent apply – both in the Northern Territory and in other Australian jurisdictions that have not legislated on the matter.

The common law recognises that a child or a young person may have the capacity to consent to medical treatment on their own behalf and without their parent’s knowledge. The landmark United Kingdom judgement of *Gillick v West Norfolk and Wisbech AHA*¹⁶⁴ addressed the issue of whether a minor under the age of 16 years could give consent to contraceptive treatment without the parents’ knowledge or consent. *Gillick* was followed by the High Court of Australia in *Secretary, Department of Health and Community Services (NT) v JWB and SMB*¹⁶⁵ (*Marion’s case*) which affirmed the capacity of ‘mature minors’ to make decisions about medical treatment without parental involvement, and reflect the concept of evolving capacities.¹⁶⁶ As a result, consent is a matter of judgment for the treating practitioner, who must document how they determined that the child had the capacity to provide consent.

Some other states do have statutory provisions dealing with consent for medical treatment by or on behalf of a child or young person. In New South Wales the *Minors (Property and Contracts) Act 1970* (NSW) provides that where medical treatment is carried out on a minor aged 14 years and above with their prior consent, then that consent has the effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment¹⁶⁷ and in

South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* confirms persons aged 16 and above may make decisions about their own medical treatment as validly and effectively as an adult.¹⁶⁸ Additionally, in South Australia a child under the age of 16 years can consent to medical procedures if:

- the medical practitioner who is to administer the treatment is of the opinion that the patient is capable of understanding the nature, consequences and risks of the treatment and the treatment is in the best interests of the health and wellbeing of the child, and
- that opinion is corroborated in writing by at least one other medical practitioner who has personally examined the child before the treatment was commenced.¹⁶⁹

The *Remote Health Atlas – Clinical Protocols: Under Age Sexual Activity* notes that the Fraser Guidelines require the health professional to be satisfied that:

- the young person will understand the professional’s advice
- the young person cannot be persuaded to inform their parents
- the young person is likely to begin or to continue having sexual intercourse with or without contraceptive treatment
- unless the young person receives contraceptive treatment, their physical or mental health, or both, is likely to suffer, and
- the young person’s best interests require them to receive ‘*contraceptive advice treatment*’ with or without parental consent.¹⁷⁰

The DCF document *Policy: Sexual and Reproductive Health* provides that:

*If the young person is sexually active access to contraception will be provided by their Caseworker. Young people in care who are engaging in high risk sexual behaviour should undergo a risk assessment and where necessary will have a comprehensive intervention strategy as part of their case plan.*¹⁷¹

The DCF document *Procedures: Sexual and Reproductive Health* identifies factors that caseworkers should consider when a child under the care of the Chief Executive Officer is engaging in sexual activities, and how discussions with the child should be approached, including if caseworkers must explain to the child if they have any responsibility to advise the police of a reasonable belief that a criminal act has occurred. It also sets out considerations regarding female genital mutilation, high-risk sexual behaviour and cultural considerations.¹⁷²

The details of section 4.8 of the Department of Health Guidelines on Sexual and Reproductive Health for children and young persons is discussed in Table 36.12 above.

Issues in relation to contraception

The use of contraceptive implants, in particular Implanon, in girls as young as 11 was raised with the Commission as an issue directly by some foster carers and residential care workers. The Commission understands Implanon¹⁷³ to be a 4-centimetre-long plastic rod inserted under local anaesthetic into a girl’s upper arm, which releases a small amount of hormone to prevent pregnancy for three years.

To inform itself further of the matter, the Commission issued a notice to Territory Families requesting, among other material:¹⁷⁴

- all current and former policies relating to the use of contraceptive implants or devices in girls who are in the care of the Chief Executive Officer
- all documents comprising or concerning the processes and procedures which apply in respect of girls who are in the care of the Chief Executive Officer being given contraceptive implants or devices, including the information provided to the girls and the procedures for obtaining informed consent during the relevant period
- a document which shows the total number, ages and locations of girls in the care of the Chief Executive Officer who have been given contraceptive implants or devices in the last 12 months or during the relevant period, and
- any document identifying the youngest age at which Territory Families have approved the use of contraceptive implants or devices in girls in the care of the Chief Executive Officer.

In relation to the first two categories of documents identified above, the policies, processes and procedures governing the use of contraceptive implants or devices in girls under the care of the Chief Executive Officer are summarised above.

In relation to the third category of documents, Territory Families was not able to produce a summary or report reflecting the data requested and in the form sought by the Commission within the time available. Territory Families did however refer to a *'reportable incident set'*, but qualified that the dataset neither had the capacity to show reliably the use of Implanon in girls aged 16–17, nor contained more than minimal information on whether other forms of contraception such as the oral contraceptive pill have been used.

In relation to the fourth category of documents, seeking documents identifying the youngest age at which Territory Families have approved the use of contraceptive implants, Territory Families informed the Commission that records were not kept in a way that would enable the Territory Families to produce a document responding to the request in the time available.

Consequently, the Commission conducted its own electronic search term searches for references to 'Implanon' across documents that had been produced to it under Notices to produce.¹⁷⁵ The Commission reviewed the material returned by these searches, which included documents comprising a variety of administrative notes, medical records and contact summary lists on case files. Although the search results may not constitute a complete or exhaustive set of relevant files and documents, the Commission nevertheless identified from among them 26 individuals about whom there were references to the use of Implanon. On the face of the documents, the documents say that for the 26 individuals at the time when Implanon was inserted:

- six of the individuals were aged 12
- four of the individuals were aged 13
- four of the individuals were aged 14
- three of the individuals were aged 15
- three of the individuals were aged 16, and
- four of the individuals were aged 17 (although in two of those cases, the documents related to re-insertion, indicating initial insertion at a younger age).

In the remaining two cases, there was insufficient information on the face of the documents as to the age of the individuals at the time Implanon was said to be inserted.

Although the Commission acknowledges the limitations of its review and the data available to it in relation to the number of children and young people in the Northern Territory who have had Implanon inserted, including those in care of the Chief Executive Officer, it is of concern that of the 26 cases identified from the documents available to the Commission, a very high proportion were under 16, and almost half were under 14.

Further, the Commission received material that noted Implanon could be seen or felt in the arm.¹⁷⁶ A letter from a psychologist to the Children's Commissioner in April 2016 stated that:

*'Our young women are often getting Implanon and their first STI by the ages of 12 or 13 or pregnant by 14 or 15. They are nearly always reticent to discuss who they acquired the STI from, or who the father of the baby is and there is little by way of investigation. When they have Implanon inserted, the bandage covering the Implanon in their upper arm stands out to the men in the community as a neon sign for sexual availability, regardless of consent or legal ages for consent.'*¹⁷⁷

Although the Commission is not proposing to make any findings, given the limited information it has on the issue, the Commission does consider that at a minimum, the use of contraceptive implants or devices in girls under 16, and as young as 11, is an issue requiring further examination and consideration.

The Commission is also aware that this is a health issue and that there are medical considerations, including side effects,¹⁷⁸ involved in the decision to insert contraceptive implants such as Implanon. Given the confidential nature of the doctor-patient interaction, visibility of the actual practices of health practitioners in clinical settings may be limited.

The Commission is aware that the Central Australian Aboriginal Congress health clinic in Alice Springs has introduced an audit protocol and associated audit tool to review decisions made by clinicians, in cases where children under 16 who could be at risk of sexual harm present to the health service with issues that may be related to sexual activity (STIs, contraception, pregnancy).¹⁷⁹ The audit tool is designed to capture the situation of the child, and the decisions made concerning them in 'real time',¹⁸⁰ so that any potential risk of harm can be reported without delay. The audit is conducted by a separate health practitioner within the clinic and considers the treatment decisions made, and any areas for improvement, as well as whether a report to Territory Families should be made in relation to the case (if not already made). The Commission understands that the audit tool has led to an increase in reports to Territory Families.

The Commission is aware that at least one health clinic in the Northern Territory now has a policy of not inserting contraceptive devices such as Implanon in girls under 16. The Commission understands that the issue has been discussed by government and health professionals, and recommends that Territory Families develop appropriate policies in conjunction with the Department of Health, health professionals and community organisations, surrounding usage of these devices and implants.

The issue of contraception use among young girls in care has a second dimension: high teenage pregnancy rates in the Northern Territory, which validate concerns about the risk of girls in care

becoming pregnant in their mid-teens or even earlier. Having children too early heightens the risk that a young mother in care will be unable to care properly for the child, who will in turn be taken into care, continuing a cycle within the family of children needing care and protection and parents losing their children through an inability to care for them. The Little Children are Sacred report commented that:

*'[of] particular concern to community members and professionals was the young age at which Aboriginal women (girls) were falling pregnant and the lack of skills these youngwomen had about caring for their child. The development of life skills and healthy relationships courses for adolescents has been widely adopted in Australia ... Many of these courses incorporate components where young people are taught parenting and childrearing skills. The intention is to teach the next generation of parents the skills they need before they are parents and, thus, to break what can be inter-generational cycles of poor parenting and maltreatment.'*¹⁸¹

The Commission shares these concerns and asked for data from Territory Families which would show the level of teenage pregnancy among girls in care, so it could better understand the concerns the Department has to balance. The Commission asked Territory Families to produce:¹⁸²

- its policies relating to teenage pregnancy and motherhood among girls – and fatherhood among boys – who are in the care of the Chief Executive Officer
- information as to the total number, ages and locations of girls who are in the care of the Chief Executive Officer and have become pregnant or given birth, and of boys who are in the care of the Chief Executive Officer and have either fathered a child or caused a girl to become pregnant:
 - in the last 12 months
 - over the relevant 10-year period.
- If no such document exists, the Commission requested documents that together show the relevant numbers of girls, and their ages and locations. Names were not required.

The policies produced to the Commission relating to teenage pregnancies, motherhood or fatherhood are discussed below.

The information provided included:

- a list of department reports that 'A child in care has become pregnant or will become a father', which includes reports in the years 2012 to 2017.¹⁸³ The list contains 14 reports of a child in care becoming pregnant
- a document indicating that a child in care is to become a father (the child was 16 years of age),¹⁸⁴ and
- a number of 'flash briefs' relating to a pregnant girls in care and the handling of their situations.

Of the 14 references to a child in care becoming pregnant, the breakdown of the ages of the child or young person is as follows:

Table 36.13: Ages of girls in care when pregnancy reported 2012 - 2017¹⁸⁵

Age of child	Number of reports
12	1
13	2
14	3
15	2
16	2
17	4

In relation to information about the number of pregnancies among girls in care, Territory Families informed the Commission that the reporting incident data set provided showed only pregnancies since 2012, as prior to that time, records were not kept in a way that would be able to be aggregated.

Although the Northern Territory Government has confirmed the completeness of the data it provided dating back to 2012, that data:

- relies on a report being made for each event
- cannot reliably show where pregnancies may have ended in miscarriage before Territory Families was made aware of the pregnancy
- cannot reliably show the use of Implanon on girls aged 16–17
- contains minimal information on boys responsible for a pregnancy, and
- contains minimal information on the use of contraception other than Implanon.

The Northern Territory Government has also confirmed that to provide any further information, Territory Families would have to review thoroughly thousands of individual case files to identify documents containing relevant material. In addition, Territory Families did not have any other documents or records which would provide the type of aggregated data the Commission wanted.

In seeking to identify other potentially relevant information, the Commission reviewed other available data regarding pregnancy in the Northern Territory. This data confirms that the rate of teenage pregnancy among Aboriginal girls and young women is significantly higher than the national average.

Table 36.14 shows the number of Aboriginal girls and women aged 15–19 in the Northern Territory who gave birth between 2004 and 2015. This group makes up a disproportionately large percentage of mothers in the Northern Territory – four to eight times the national average.

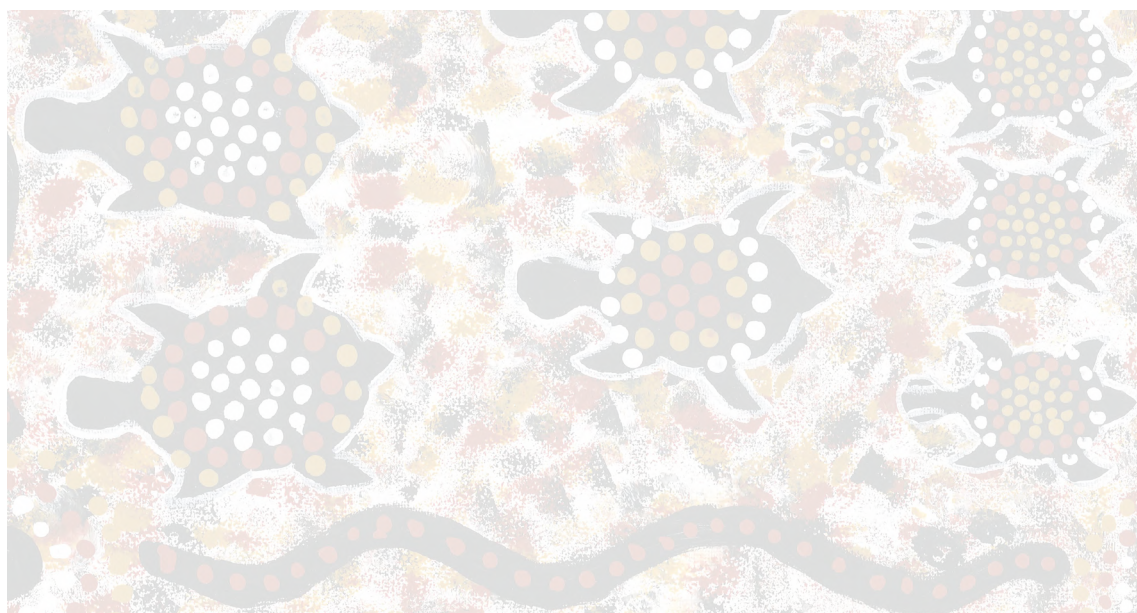
Table 36.14: Aboriginal Girls and Women in the Northern Territory aged 15 to 19 who gave birth in the years 2004 to 2015¹⁸⁶

Year	No. of births to Aboriginal mothers in the Northern Territory (aged 15-19)	% of total births to Aboriginal mothers in the Northern Territory	% of total national births to mothers aged 15 - 19
2004	338	23.9%	4.3%
2005	342	25.0%	4.2%
2006	373	25.6%	4.1%
2007	364	24.2%	4.1%
2008	308	21.5%	4.3%
2009	306	22.0%	4.2%
2010	318	22.1%	3.9%
2011	280	19.7%	3.8%
2012	309	21.4%	3.7%
2013	248	19.1%	3.4%
2014	279	20.9%	3.1%
2015	223	17.9%	2.8%

Policies, procedures and guidelines relating to pregnancy in care

Territory Families provided the Commission with the following Guidelines on pregnancy in children and young People.¹⁸⁷

Table 36.15: Guidelines relating to Pregnancy in the Northern Territory



Document	Provisions about Pregnancy
<p>Guidelines on the Management of Sexual Health Issues in Children and Young People</p>	<p>Section 9 of the Guidelines provide that:</p> <ul style="list-style-type: none"> • presentation of a pregnancy in a young woman under the age of 18 years is not uncommon but must be assessed to exclude the possibility of sexual abuse and to consider whether she is mature enough to consent to medical care, and • presentation of a pregnancy in a young woman under the age of 13 years or under must be reported to the Central Intake Team. <p>However, the Pregnancy Guidelines note that this is not the same obligation to report suspected sexual harm or exploitation under the Act.</p> <p>The Guidelines outline a suggested management plan, liaison and reporting to the Central Intake Team and ongoing management of the pregnancy.</p>
<p>20.20 Pregnancy Support for Young People in Care</p>	<p>The draft Pregnancy Support procedures provide that:</p> <ul style="list-style-type: none"> • where termination of pregnancy (within 14 weeks) is considered the young person must be given early access to, and be encouraged to receive, psychological counselling • the young person must also have access to her legal representative before the decision to terminate the pregnancy • the young person's parent(s) must be involved in the decision making where the young person is 15 years or younger and the parent(s) have retained parental responsibility as only they may sign the consent form for a medical procedure to terminate the pregnancy, and • the caseworker should ensure that the medical practitioner is informed of the wishes of the child, the view of the counsellor, the view of the legal representative and the view of the person with parental responsibility (caseworker or parent) so as to assist the medical practitioner's decision on whether to carry out the procedure. <p>As far as the Commission has been able to determine, this draft policy has not been adopted in final form as part of the Policy and Procedures Manual or as a standalone policy.</p>

As discussed above, in the Northern Territory there is no statutory age of consent to medical procedures to allow a child to consent which may override a parent or guardian's right. Section 11(5) of the *Medical Services Act* (NT) until 1 July 2017 stated that a young woman under the age of 16 could not consent to a termination of pregnancy. In this case, the consent of each person who had legal responsibility for her (in most cases, both parents or official guardians) was required for this procedure.¹⁸⁸ The *Termination of Pregnancy Law Reform Act* (NT), which commenced on 1 July 2017, repealed section 11 of the *Medical Services Act*.¹⁸⁹

Territory Families provided documents to the Commission showing examples of the process by which a termination of pregnancy is approved if it involves a child in the care of the Chief Executive Officer. Those cases broadly reflect and follow the guidelines and procedures outlined above in relation to managing pregnancy in children and young people in care. The documents relate to four particular cases in which a request for termination of pregnancy was raised for consideration by the Chief Executive Officer. Those cases involved four 15-year-old girls.

Notably, in most of the cases provided to the Commission:

- an assessment was made at the outset as to whether other agencies – such as the Child Abuse Taskforce or Northern Territory Police – should be notified if the child or young person is under the age of consent. In most cases reviewed, no action is taken or deemed necessary because there

was evidence that the sex was consensual and the person who fathered the baby is either the same age or close in age

- the caseworker or youth worker supported the child or young person by accompanying them to appointments with medical practitioners, family planning clinics and hospitals,
- where a termination of pregnancy is undertaken, in all cases this reflects a decision recorded as having been made by the child or young person. If the child is in the care of the Chief Executive Officer, in all cases a psychologist must provide a report to confirm that the child or young person is capable of making an informed decision. In one case, a 15-year-old girl had originally indicated she wished to continue the pregnancy, during the initial meeting with her boyfriend, his grandmother and a psychologist.¹⁹⁰ Some eight days later, the case manager was advised that the young person had requested to terminate the pregnancy. What followed was a case management plan involving a follow-up medical consultation and a psychologist consultation, as well as follow-up discussions to identify any other support required by the young person.

Given the reliance placed on guidelines and procedures in managing pregnancy in children and young people, the Commission is concerned about the lack of data Territory Families keeps relating to the level of teenage pregnancy among girls in care. Territory Families should be collecting and analysing this data to ensure that the guidelines and procedures remain relevant in addressing the issues associated with teenage pregnancy.

Recommendation 36.4

The proposed task force or body review current policies, processes or protocols regarding the health management of girls in care and who are under 16 with respect to:

- **contraception, including contraceptive implants**
- **pregnancy, and**
- **termination**

for issues including informed consent, capacity, and age.

Recommendation 36.5

The proposed task force or body develop policies and protocols regarding data collection, reporting and the introduction and use of audit processes for health professional decision making. Such policy and protocol development include the undertaking or commissioning of studies as appropriate.

ENDNOTES

- ¹ Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016.
- ² Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016, p. 41. Page 41 of the report refers, in particular, to an 'ABC Lateline program on 15 May 2006 in which NT prosecutor, Dr Nanette Rogers, highlighted the extent of violence and child abuse in Aboriginal communities in Central Australia. This story attracted national interest and considerable media coverage. The Lateline program subsequently aired a story on a suspected paedophile trading petrol for sex with young girls in the Central Australian community of Mutual. Following this, on 22 June 2006, the Chief Minister announced the government would establish an inquiry into child sexual abuse in Northern Territory communities ...'
- ³ Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016, p. 14.
- ⁴ Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016, p. 107.
- ⁵ Australian Government, 20 June 2008, Northern Territory Emergency Response: One Year On, Australian Government: Canberra, p. 3.
- ⁶ Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016, p. 22: Recommendations 9 and 10.
- ⁷ Exh.469.010, Children's Commissioner Annual Report 2009-2010, 31 October 2010, tendered 31 May 2017, p. 19.
- ⁸ Exh.469.010, Children's Commissioner Annual Report 2009-2010, 31 October 2010, tendered 31 May 2017, p. 21.
- ⁹ Exh.469.136, Office of the Children's Commissioner Annual Report 2011-12, 31 October 2012, tendered 31 May 2017, pp. 87-90, listing the only two recommendations not achieved; Exh.469.178, Office of the Children's Commissioner Annual Report 2012-13, 31 October 2013, tendered 31 May 2017, p. 32, indicating that only two recommendations have not been achieved but not naming them.
- ¹⁰ Exh.013.001 Board of Inquiry Report – Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory's Children' - Summary Report, 18 October 2010, tendered 12 October 2016, p. 88 - Rec 146: 'That the Northern Territory Government develops and implements a comprehensive community education strategy to highlight key messages about child protection and child wellbeing and to accompany the service delivery enhancements contained in this Report.'
- ¹¹ Exh.469.136, Children's Commissioner Annual Report 2011-2012, 31 October 2012, tendered 31 May 2017, pp. 87 – 90.
- ¹² Exh.469.136, Children's Commissioner Annual Report 2011-12, 31 October 2012, tendered 31 May 2017, pp. 87-90; Exh.469.178, Children's Commissioner Annual Report 2012-13, 31 October 2013, tendered 31 May 2017, p. 36.
- ¹³ Submission, Aboriginal Medical Services Alliance Northern Territory, 15 June 2017, p. 1.
- ¹⁴ The APY Lands is a region of central Australia, predominantly forming part of South Australia. However, many members of communities in the APY Lands often travel to Alice Springs as it is the nearest large town, the Commission believes that concerns about this region ought to be considered as context of the Commission's inquiry.
- ¹⁵ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands: Commission of Inquiry - A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, pp. ix, xi.
- ¹⁶ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, p. xii.
- ¹⁷ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, pp. xii-xiii.
- ¹⁸ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, pp. xii-xiii.
- ¹⁹ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, p. xiii.
- ²⁰ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, pp. xii-xiii.
- ²¹ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, p. xiv
- ²² Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, p. xiii.
- ²³ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, p. xiii.
- ²⁴ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, p. xiv.
- ²⁵ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, p. xiv.
- ²⁶ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, pp. xvi – xvi
- ²⁷ Exh.018.001, Annexure 1 to statement of Patricia Anderson AO, 30 April 2007, tendered 12 October 2016; Exh.014.001, Board of Inquiry Report – Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory's Children' - Volume 1, 18 October 2010, tendered 12 October 2016.

- ²⁸ Exh.024.014, Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A Report into Sexual Abuse, 30 April 2008, tendered 13 October 2016, pp. xix – xxix.
- ²⁹ Department of Social Services, 2006, Closing the Gap for Indigenous Australians – Northern Territory – National Indigenous Violence and Child Abuse Intelligence Taskforce, Commonwealth Department of Social Services website, viewed 29 October 2017 <<https://www.dss.gov.au/about-the-department/publications-articles/corporate-publications/budget-and-additional-estimates-statements/indigenous-budget-fact-sheets/closing-the-gap-for-indigenous-australians-northern-territory-national-indigenous-violence-and-child-abuse>>.
- ³⁰ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 8.
- ³¹ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 8.
- ³² Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 8.
- ³³ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 9. Problem Sexual Behaviour is considered to be ‘sexual behaviour that is outside normal developmental activity and has a detrimental effect on a child or young person’s engagement in everyday tasks’: Family and Community Services, August 2016, Review of approaches to prevent and respond to problem sexual behaviour of children and young people in out of home care, New South Wales Government Department of Family and Community Services: Sydney, p. 2. Sexually Abusive Behaviour usually refers to sexualised behaviour of children or adolescents which is directed towards others and in situations where the child is over the age of criminal responsibility: Australian and New Zealand Association for the Treatment of Sexual Abuse, March 2016, Standards of Practice for problem sexual behaviour and sexually abusive behaviour treatment programs, p. 6. For an indicative list of the sorts of behaviours associated with these terms, see Department of Human Services, May 2012, Problem sexual behaviour or sexually abusive behaviour, Victorian Government: Melbourne.
- ³⁴ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 12.
- ³⁵ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 12.
- ³⁶ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 13.
- ³⁷ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 9.
- ³⁸ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, p. 15; see further Chapter 41 (Data and information sharing).
- ³⁹ Exh.1145.001, Final Report of the National Indigenous Intelligence Taskforce 2006 – 2014, 2014, tendered 3 November, pp. 2-3.
- ⁴⁰ Royal Commission into Institutional Responses to Child Sexual Abuse, July 2015, Report of Case Study No. 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory Governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at Retta Dixon Home, Commonwealth Government: Sydney, Appendix A.
- ⁴¹ Royal Commission into Institutional Responses to Child Sexual Abuse, July 2015, Report of Case Study No. 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory Governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at Retta Dixon Home, Commonwealth Government: Sydney, p. 3.
- ⁴² Royal Commission into Institutional Responses to Child Sexual Abuse, Transcript, 30 September 2014, C-5523-5.
- ⁴³ Royal Commission into Institutional Responses to Child Sexual Abuse, Transcript, 30 September 2014, C-5524: lines 6-45
- ⁴⁴ See further Chapter 32 (Entering the Child Protection System)
- ⁴⁵ Royal Commission into Institutional Responses to Child Sexual Abuse, July 2015, Report of Case Study No. 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory Governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at Retta Dixon Home, p. 58.
- ⁴⁶ Royal Commission into Institutional Responses to Child Sexual Abuse, July 2015, Report of Case Study No. 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory Governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at Retta Dixon Home, p. 59.
- ⁴⁷ Royal Commission into Institutional Responses to Child Sexual Abuse, July 2015, Report of Case Study No. 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory Governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at Retta Dixon Home, p. 60.
- ⁴⁸ See further Chapter 33 (Children in out of home care)
- ⁴⁹ *Criminal Code Act (NT)* ss. 127, 132.
- ⁵⁰ See definition of ‘harm’ pursuant to section 15 of the *Care and Protection of Children Act (NT)*.
- ⁵¹ See definition of ‘exploitation’ pursuant to section 16 of the Act.
- ⁵² See section 128(3) of the Northern Territory Criminal Code Act 2017.
- ⁵³ *Notifiable Diseases Act section 8 and 10 and Public and Environmental Health Act section 76.*
- ⁵⁴ Exh.831.001, 031908 FINAL Mandatory reporting for pregnant children 03MAR08, 3 March 2008, tendered 24 October 2017.
- ⁵⁵ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017.
- ⁵⁶ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, pp. 34-35.
- ⁵⁷ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 19.
- ⁵⁸ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 22.
- ⁵⁹ For further information on the Central Intake Team, see Chapter 32 (Entry into the child protection system)
- ⁶⁰ Exh.1235.001, Central Australian Aboriginal Congress – Corporate Procedures: Child Protection, 30 July 2017, tendered 6 November

- 2017,, pp. 4-5.
- ⁶¹ The Commission understands that the Australian Federal Police intend to withdraw from the Child Abuse Taskforce in 2018.
- ⁶² Child Abuse Taskforce, 2013, Presentation on the Child Abuse Taskforce, Australian Institute of Criminology Taskforce website, viewed 8 October 2017 <http://www.aic.gov.au/media_library/conferences/2013-accan/presentations/Eyden.pdf>.
- ⁶³ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 23.
- ⁶⁴ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 23.
- ⁶⁵ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 23.
- ⁶⁶ Exh.513.000, Statement of Joy Simpson, 25 May 2017, tendered 19 June 2017, para 13.
- ⁶⁷ Exh.1148.001, Department of Children and Families: Flowchart for decision making between Central Intake Team and Child Abuse Taskforce, 12 March 2015, tendered 3 November 2017.
- ⁶⁸ Exh.519.00, Statement of Sarah Huddleston, 7 May 2017, tendered 19 June 2017, para 19.1; Exh.513.000, Statement of Joy Simpson, 25 May 2017, tendered 19 June 2017, para 14.
- ⁶⁹ Exh.519.000, Statement of Sarah Huddleston, 7 May 2017, tendered 19 June 2017, para 19.3.
- ⁷⁰ Exh.513.000, Statement of Joy Simpson, 25 May 2017, tendered 19 June 2017, para 8.
- ⁷¹ Exh.869.000, Supplementary Statement of Joy Simpson, 18 June 2017, 24 October 2017, para 28.
- ⁷² Transcript, Sarah Huddleston, 19 June 2017, p. 4460: lines 20-21.
- ⁷³ Exh.869.000, Supplementary Statement of Joy Simpson, 18 June 2017, 24 October 2017, para 29.
- ⁷⁴ Exh.869.000, Supplementary Statement of Joy Simpson, 18 June 2017, 24 October 2017, para 29.
- ⁷⁵ Transcript, Joy Simpson, 19 June 2017, p. 4434: lines 2-18.
- ⁷⁶ Exh.663.001, Statement of Renae Moore, 15 May 2017, tendered 30 June 3017, para. 71.
- ⁷⁷ Exh.513.000, Statement of Joy Simpson, 25 May 2017, tendered 19 June 2017, para 14.
- ⁷⁸ Exh.663.001, Statement of Renae Moore, 15 May 2017, 30 June 3017, para. 73.
- ⁷⁹ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, pp. 23-24.
- ⁸⁰ Exh.663.001, Statement of Renae Moore, 15 May 2017, 30 June 3017, para. 74.
- ⁸¹ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 24.
- ⁸² Submission, AMSANT, 15 June 2017, p. 1; Submission, APONT, 31 July 2017, p. 72.
- ⁸³ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 24.
- ⁸⁴ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 25.
- ⁸⁵ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 25.
- ⁸⁶ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 39.
- ⁸⁷ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 41.
- ⁸⁸ Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016, pp. 16-17.
- ⁸⁹ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 19.
- ⁹⁰ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, pp. 36-48.
- ⁹¹ Exh.680.002, Annexure 1 to Statement of Sven Thormann,, 4 January 2017, tendered 30 June 2017.
- ⁹² Exh.680.002, Annexure ST-1 to Statement of Sven Thormann, 4 January 2017, tendered 30 June 2017.
- ⁹³ Exh.469.178, The Children's Commissioner Annual Report 2012 - 2013, 31 October 2013, tendered 31 May 2017, p. 53.
- ⁹⁴ Exh.469.178, The Children's Commissioner Annual Report 2012 - 2013, 31 October 2013, tendered 31 May 2017, p. 53.
- ⁹⁵ Australian Institute of Health and Welfare, 2016, Child Protection Australia 2015-16, Australian Institute of Health and Welfare.
- ⁹⁶ Australian Institute of Health and Welfare, 2016, Child Protection Australia 2015-16, Australian Institute of Health and Welfare, Figure 3.3.
- ⁹⁷ Australian Institute of Health and Welfare, 2016, Child Protection Australia 2015-16, Australian Institute of Health and Welfare, p. 25.
- ⁹⁸ Exh.879.001, Overview Report - Analysis of Child Protection Cases with a Primary Reported Harm Type of Sexual Exploitation, February 2014, tendered 24 October 2017.
- ⁹⁹ Exh.879.001, Overview Report - Analysis of Child Protection Cases with a Primary Reported Harm Type of Sexual Exploitation, February 2014, tendered 24 October 2017, p. 4.
- ¹⁰⁰ Exh.879.001, Overview Report - Analysis of Child Protection Cases with a Primary Reported Harm Type of Sexual Exploitation, February 2014, tendered 24 October 2017, p. 5.
- ¹⁰¹ Exh.879.001, Overview Report - Analysis of Child Protection Cases with a Primary Reported Harm Type of Sexual Exploitation, February 2014, tendered 24 October 2017, p. 6.
- ¹⁰² Exh.879.001, Overview Report - Analysis of Child Protection Cases with a Primary Reported Harm Type of Sexual Exploitation, February 2014, tendered 24 October 2017, p. 18.
- ¹⁰³ Exh.879.001, Overview Report - Analysis of Child Protection Cases with a Primary Reported Harm Type of Sexual Exploitation, February 2014, tendered 24 October 2017, p. 19.
- ¹⁰⁴ Exh.836.001, Letter from Luke Twyford, Acting Executive Director, Professional Practice Division, Department of Children and Families to Dr Howard Bath, Children's Commissioner, Office of the Children's Commissioner, 17 September 2014, tendered 24 October 2017, p. 1.
- ¹⁰⁵ Exh.493.000, Children's Commissioner Northern Territory Annual Report 2014-2015, October 2015, tendered 2 June 2017, p. 29.
- ¹⁰⁶ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 38.
- ¹⁰⁷ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 38.
- ¹⁰⁸ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, p. 38.
- ¹⁰⁹ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.

- ¹¹⁰ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.
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- ¹¹³ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.
- ¹¹⁴ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.
- ¹¹⁵ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.
- ¹¹⁶ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.
- ¹¹⁷ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.
- ¹¹⁸ Exh.847.001, Summary data of sexually-transmitted infections in those aged under 18 in the NT: 2006-2016, 12 September 2017, tendered 24 October 2017.
- ¹¹⁹ The data also included the number of Child Sexual Assault Offences Charged by Indigenous Status and Sex of the Offender.
- ¹²⁰ Exh.855.001, NTG Tables in response to N543 enclosed in letter to the Royal Commission, 12 September 2017, tendered 24 October 2017, tables 1, 1b.
- ¹²¹ Exh.855.001, NTG Tables in response to N543, 12 September 2017, tendered 24 October 2017, table 2.
- ¹²² In producing this table, the Northern Territory Government noted that apprehensions prior to 1 July 2006 had been excluded from the dataset and that this would have the effect of the numbers for the first year being less than in the subsequent years, as apprehensions from the previous years would result in cases being finalised in 2006-2007.
- ¹²³ This table is compiled from the available information from the annual reports of the Office of the Children's Commissioner of the Northern Territory (Exh.469.009, The Children's Commissioner Annual Report 2008-2009, 30 October 2009, tendered 31 May 2017; 469.010, The Children's Commissioner Annual Report 2009-2010, 29 October 2010, tendered 31 May 2017; Exh.469.136, The Children's Commissioner Annual Report 2011 - 2012, 31 October 2012, tendered 31 May 2017; Exh.469.178 The Children's Commissioner Annual Report 2012 - 2013, 31 October 2013, tendered 31 May 2017).
- ¹²⁴ Transcript, Joy Simpson, 19 June 2017, p. 4452: lines 2-5, 9-12, 29-34.
- ¹²⁵ Exh.519.000, Statement of Sarah Huddleston, 7 May 2017, tendered 19 June 2017, para 19.5; Transcript, Sarah Huddleston, 19 June 2017, p. 4457: line 3. The original paragraph read 'high or very high risk'. This was corrected in evidence as should have been 'low or moderate risk'.
- ¹²⁶ Exh.519.000, Statement of Sarah Huddleston, 7 May 2017, tendered 19 June 2017, para 16.
- ¹²⁷ Exh.495.000, Children's Commissioner Northern Territory Annual Report 2015 - 2016, 31 October 2016, tendered 2 June 2017, p. 64.
- ¹²⁸ Exh.493.000, Children's Commissioner Northern Territory Annual Report 2014 - 2015, 31 October 2015, tendered 2 June 2017, p. 63; Exh.495.000, Children's Commissioner Northern Territory Annual Report 2015 - 2016, 31 October 2016, tendered 2 June 2017, p. 66.
- ¹²⁹ Exh.519.000, Statement of Sarah Huddleston, 7 May 2017, tendered 19 June 2017, para 16.
- ¹³⁰ Exh.476.000, Statement of Marnie Couch, 18 May 2017, tendered 31 May 2017, para 78.
- ¹³¹ Section 189 of the Care and Protection of Children Act (NT) provides that a person convicted of an offence or has a criminal history prescribed by regulation must not be issued with a WWCC.
- ¹³² Exh.830.001, Copy of DCFD2013-4351 ATT A_NTP 92_Abuse in care_2007-2012, 23 June 2017, tendered 24 October 2017.
- ¹³³ Exh.895.001, Complaints by Youth, undated, tendered 24 October 2017.
- ¹³⁴ Exh.311.002C, Flash Brief - Incident at Don Dale Juvenile Detention Centre - Fire Alarms Activated, 28 December 2012, tendered 28 April 2017, p. 1.
- ¹³⁵ Exh.311.002C, Flash Brief - Incident at Don Dale Juvenile Detention Centre - Fire Alarms Activated, 28 December 2012, tendered 28 April 2017, p. 2.
- ¹³⁶ Exh.741.080, Annexure MP-80 to Statement of Mark Payne, 31 March 2008, tendered 25 July 2017.
- ¹³⁷ Exh.741.082, Annexure MP-82 to Statement of Mark Payne, 14 July 2015, tendered 25 July 2017.
- ¹³⁸ Exh.741.000, Statement of Mark Payne, 23 February 2017, tendered 25 July 2017, para 62.
- ¹³⁹ Exh.741.080, Annexure MP-80 to Statement of Mark Payne, 31 March 2008, tendered 25 July 2017, Appendix B.
- ¹⁴⁰ Exh.741.080, Annexure MP-80 to Statement of Mark Payne, 31 March 2008, tendered 25 July 2017, Appendix B.
- ¹⁴¹ Exh.741.080, Annexure MP-80 to Statement of Mark Payne, 31 March 2008, tendered 25 July 2017, p. 5.
- ¹⁴² Exh.741.082, Annexure MP-82 to Statement of Mark Payne, 14 July 2015, tendered 25 July 2017, Appendix A.
- ¹⁴³ Exh.741.082, Annexure MP-82 to Statement of Mark Payne, 14 July 2015, tendered 25 July 2017, p. 6.
- ¹⁴⁴ Exh.741.082, Annexure MP-82 to Statement of Mark Payne, 14 July 2015, tendered 25 July 2017, p. 7.
- ¹⁴⁵ Exh.741.082, Annexure MP-82 to Statement of Mark Payne, 14 July 2015, tendered 25 July 2017, p. 6.
- ¹⁴⁶ Exh.741.082, Annexure MP-82 to Statement of Mark Payne, 14 July 2015, tendered 25 July 2017, p. 8.
- ¹⁴⁷ Exh.884.001, Re: Don Dale Detainee Sexual Allegations, tendered 24 October 2017.
- ¹⁴⁸ Exh.896.001, DCFD2017-[redacted] - Flashbrief - Third Party Alleged Sexual Assault, tendered 24 October 2017.
- ¹⁴⁹ Exh.882.001, File Note of Incident regarding [redacted], Undated, tendered 24 October 2017.

- ¹⁵⁰ Exh.882.001, File Note of Incident regarding [redacted], Undated, tendered 24 October 2017.
- ¹⁵¹ Exh.895.001, Complaints by Youth, undated, tendered 24 October 2017.
- ¹⁵² Exh.519.000, Statement of Sarah Huddlestone, 7 May 2017, tendered 19 June 2017, para 26.2.
- ¹⁵³ See further, Griffith University, undated, Adolescent sex offender treatment program, Griffith University website, viewed 29 October 2017 <<https://experts.griffith.edu.au/project/ne60df7f1a5d73586eb73ed8a5588aaa>>.
- ¹⁵⁴ Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016, Recommendation 37.
- ¹⁵⁵ Exh.838.001, DCFD2012-1161 SIGNED MEMO Proposal address children & young people exhibiting problem sexual behaviour, 26 March 2012, tendered 24 October 2017.
- ¹⁵⁶ Exh.1187.001, Training Curriculum Brief, 26 August 2016, tendered TBC; Exh.1186.001, Business Case: Develop and deliver specialised training on sexual behaviours of children and young people [Draft], Undated, tendered 4 November 2017.
- ¹⁵⁷ Aikman, A, 4 February 2016, Northern Territory boy, 13, victim of sexual assault at rehab centre, The Australian.
- ¹⁵⁸ Exh.894.001, DCFD2014-2951 MEMO Sexual abuse by a child in care of the CEO, [Redacted] against [Redacted], tendered 24 October 2017.
- ¹⁵⁹ Exh.894.001, DCFD2014-2951 MEMO Sexual abuse by a child in care of the CEO, [Redacted] against [Redacted], tendered 24 October 2017.
- ¹⁶⁰ Exh.663.001, Statement of Renae Moore, 15 May 2017, tendered 30 June 2017, para. 81-82.
- ¹⁶¹ Exh.832.001, Sexual and Reproductive Health Policy, 27 April 2016, tendered 24 October 2017.
- ¹⁶² Exh.833.001, Sexual and Reproductive Health Procedures, 27 April 2016, tendered 24 October 2017.
- ¹⁶³ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017, Section 11.
- ¹⁶⁴ [1986] AC 112.
- ¹⁶⁵ (1992) 175 CLR 218.
- ¹⁶⁶ Secretary, Department of Health and Community Services (Northern Territory) v JWB and SMB (1992) 175 CLR 218, 237-238.
- ¹⁶⁷ Minors (Property and Contracts) Act 1970 (NSW) s 49(2).
- ¹⁶⁸ Consent to Medical Treatment and Palliative Care Act 1995 (SA), s 6.
- ¹⁶⁹ Consent to Medical Treatment and Palliative Care Act 1995 (SA), s 12.
- ¹⁷⁰ Exh.092.100, Annexure CC.3.6 to Statement of Dr Christine Connors, 20 February 2017, tendered 16 March 2017, p. 6.
- ¹⁷¹ Exh.832.001, Sexual and Reproductive Health Policy, 27 April 2016, tendered 24 October 2017, p. 1.
- ¹⁷² Exh.833.001, Sexual and Reproductive Health Procedures, 27 April 2016, tendered 24 October 2017, pp. 1-2.
- ¹⁷³ Implanon, here, refers to both the brand name drug from Merck Pharmaceutical, and its bioequivalent, Implanon NXT (World Health Organisation Expert Committee, 2015, The Selection and Use of Essential Medicines, WHO Technical Report Series No. 994, World Health Organisation: Geneva, p. 332).
- ¹⁷⁴ Notice to Produce No 528/17 issued to Territory Families on 23 June 2017.
- ¹⁷⁵ Exh.1190.001, Confidential Exhibit, tendered 5 November 2017; Exh.1200.001, Confidential Exhibit, tendered 5 November 2017, pp. 0938; EXH.1220.001, Confidential Exhibit, tendered 5 November 2017; Exh.1221.001, Confidential Exhibit, tendered 5 November 2017; Exh.1199.001, Confidential Exhibit, tendered 5 November 2017; Exh.1192.001, Confidential Exhibit, tendered 4 November 2017; EXH.1204.001, Confidential Exhibit, tendered 4 November 2017; Exh.1222.001, Confidential Exhibit, tendered 6 November 2017; Exh.1223.001, Confidential Exhibit, tendered 5 November 2017; Exh. EXH.1202.001, Confidential Exhibit, tendered 4 November 2017, p. 3; Exh.1193.001, Confidential Exhibit, tendered 4 November 2017, pp. 1-2; Exh.1195.001, Confidential Exhibit, tendered 4 November 2017, p. 2; Exh.1191.001, Confidential Exhibit, tendered 4 November 2017; Exh.1203.001, Confidential Exhibit, tendered 4 November 2017, p. 2; Exh.1194.001, Confidential Exhibit, tendered 4 November 2017, p. 2; Exh.1189.001, Confidential Exhibit, tendered 4 November 2017; Exh.1224.001, Confidential Exhibit, tendered 6 November 2017; Exh.1225.001, Confidential Exhibit, tendered 6 November 2017; Exh.1226.001, Confidential Exhibit, tendered 6 November 2017; Exh.1227.001, Confidential Exhibit, tendered 6 November 2017; Exh.1228.001, Confidential Exhibit, tendered 6 November 2017; Exh.1229.001, Confidential Exhibit, tendered 6 November 2017; Exh.1230.001, Confidential Exhibit, tendered 6 November 2017, p. 2; Exh.1196.001, Confidential Exhibit, tendered 5 November 2017; Exh.1107.000, DB Case Study Tender Bundle, Tab 86, pp. 0176, 0239, 3071; Exh.1231.001, Confidential Exhibit, tendered 6 November 2017; Exh.1232.001, Confidential Exhibit, tendered 6 November 2017; Exh.1233.001, Confidential Exhibit, tendered 6 November 2017; Exh.1201.001, Confidential Exhibit, tendered 5 November 2017.
- ¹⁷⁶ Exh.1123.001, Notes from a workshop 'You Talk, We Listen', 20 May 2017, tendered 2 November 2017, p. 5.
- ¹⁷⁷ Exh.1142.001, CCM.5003.0001.0029 - Letter from [Redacted] B Psych to Ms C Gwynne, 11 April 2016, tendered 3 November 2017.
- ¹⁷⁸ Inoue, K., Kelly, M., Barratt, A., Bateson, D., Rutherford, A., Black, K. I., Stewart, M. & Richters, J., 2016, Australian women's experiences of the subdermal contraceptive implant: A qualitative perspective. *Australian Family Physician*, vol. 45(10), pp. 734-739, pp. 734, 735; Roke, C., Roberts, H., & Whitehead, A., 2016, New Zealand women's experience during their first year of Jadelle contraceptive implant, *Journal of Primary Health care*, vol. 8(1), pp. 13-19, p. 16; Therapeutic Goods Administration, 24 November 2016, Implanon NXT Product Information, Therapeutic Goods Administration: Canberra, pp 5-6.
- ¹⁷⁹ Exh.1179.001, Mandatory Reporting of Child Sexual Harm – Audit Tool, August 2017, tendered 6 November 2017; Exh.1234.001, Mandatory Reporting of Child Sexual Harm – Audit Protocol, August 2017, tendered 6 November 2017.
- ¹⁸⁰ Exh.1234.001, Mandatory Reporting of Child Sexual Harm – Audit Protocol, August 2017, tendered 6 November 2017, pp. 3, 9. In the context of the tool, 'real time' is understood to mean within one month of seeing the client.
- ¹⁸¹ Exh.018.001, Annexure 1 to Statement of Patricia Anderson AO, "Little Children are Sacred" Report, 30 April 2007, tendered 12 October 2016, pp. 158 – 159, citing Tomison, A M & Poole, L., 2000, Preventing Child Abuse and Neglect: Findings from an Australian Audit of Prevention Programs, Australian Institute of Family Studies: Melbourne.

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- ¹⁸² Exh.1146.001, Notice to Produce No 528/17 issued to Territory Families on 23 June 2017, tendered 3 November 2017.
- ¹⁸³ Exh.834.001, Girls pregnant in care, 27 June 2017, tendered 24 October 2017.
- ¹⁸⁴ Exh.835.001, Territory Families - Boys fathering babies, 27 June 2017, tendered 24 October 2017.
- ¹⁸⁵ Exh.834.001, Girls pregnant in care, 27 June 2017, tendered 24 October 2017.
- ¹⁸⁶ Australian Bureau of Statistics, 2016, Births, Australia 2015 (Cat. No. 3301.0), ABS.Stat Datasets – Aboriginal and Torres Strait Islander Fertility, by age by state; and Births by Age.
- ¹⁸⁷ Exh.876.001, NTFCRM2012 Sexual Health Guidelines, July 2011, tendered 24 October 2017; Exh.1144.001, DRAFT 20.20 Pregnancy Support for Young People In Care, 24 August 2011, tendered 3 November 2017.
- ¹⁸⁸ Medical Services Act s 11(5). The Criminal Code previously permitted a termination of pregnancy when the young person had applied to the court and the court has considered the case and determined the outcome. Since 2017 the Termination of Pregnancy Law Reform Act now enable lawful termination of a pregnancy to be performed (or directed to be performed) by a 'suitably qualified medical practitioner'.
- ¹⁸⁹ Termination of Pregnancy Law Reform Act (NT) s 22.
- ¹⁹⁰ Exh.935.001 - Flash brief – young person in the care of the CEO is pregnant and requesting a termination, 28 April 2017, tendered 25 October 2017.

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CHILD PROTECTION
OVERSIGHT

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CHILD PROTECTION OVERSIGHT

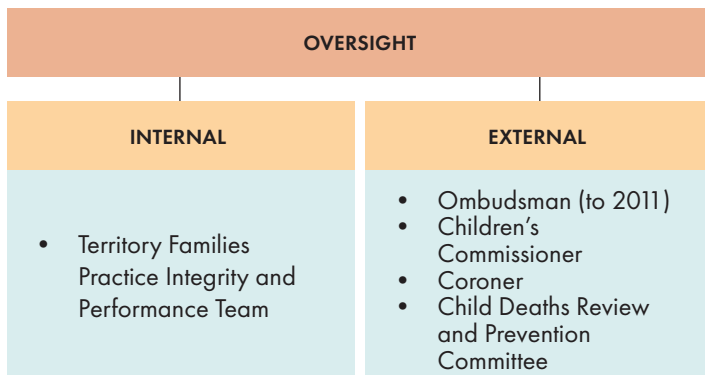
INTRODUCTION

The impact of child protection decisions and actions taken by any government in relation to children and families cannot be underestimated. The gravity of the potential consequences for children who are the subject of those decisions and actions lends force to the need for them to be consistent with appropriate standards of fairness, objectivity and rigour. To maintain the public's confidence in the proper exercise of these powers, it is essential to have appropriate checks and balances, and effective oversight mechanisms.

It is particularly important to ensure oversight of decisions involving children, as their voices often go unheard when decisions are made about their lives and families, notwithstanding the legislative requirement that the child should be given adequate information and an opportunity to express their wishes and views and have them taken into account.¹

This chapter focuses on the legal and policy framework of current oversight mechanisms relevant to child protection in the Northern Territory. These mechanisms include internal oversight, which refers to the systems Territory Families has established to monitor its own performance, and external oversight, which encompasses the work of independent statutory bodies that routinely inspect and monitor the performance of Territory Families. The most important of these bodies is the Northern Territory Children's Commissioner, but the Coroner and the Child Deaths Review and Prevention Committee also have specific monitoring roles. The chapter also reviews the complaint-handling functions of both Territory Families and the Children's Commissioner, which offer oversight in their investigatory roles.

Figure 37.1: Child protection oversight



HUMAN RIGHTS STANDARDS FOR EFFECTIVE OVERSIGHT

The *United Nations Guidelines for the Alternative Care of Children* (the Guidelines) provide an internationally recognised standard for the protection and wellbeing of children who are deprived of parental care or who are at risk of being so.² The Guidelines were endorsed by the United Nations General Assembly on the 20 November 2009 as part of the 20th anniversary of the *United Nations Convention on the Rights of the Child* (CRC), to supplement the implementation of the convention as well as all other human rights instruments. The Guidelines state that:

'Agencies, facilities and professionals involved in care provision should be accountable to a specific public authority, which should ensure, inter alia, frequent inspections comprising both scheduled and unannounced visits, involving discussion with and observation of the staff and the children.

To the extent possible and appropriate, inspection functions should include a component of training and capacity building for care providers.

States should be encouraged to ensure that an independent monitoring mechanism is in place, with due consideration for the principles relating to the status of national institutions for the promotion and protection of human rights (the Paris Principles).

The monitoring mechanism should be easily accessible to children, parents and those responsible for children without parental care. The functions of the monitoring mechanism should include:

- a. *Consulting in conditions of privacy with children in all forms of alternative care, visiting the care settings in which they live and undertaking investigations into any alleged situation of violation of children's rights in those settings, on complaint or on its own initiative;*

- b. *Recommending relevant policies to appropriate authorities with the aim of improving the treatment of children deprived of parental care and ensuring that it is in keeping with the preponderance of research findings on child protection, health, development and care;*
- c. *Submitting proposals and observations concerning draft legislation;*
- d. *Contributing independently to the reporting process under the Convention on the Rights of the Child, including to periodic State party reports to the Committee on the Rights of the Child with regard to the implementation of the present Guidelines.*³

In its working paper on accountability for children's rights in 2015, the United Nations Children's Fund (UNICEF) emphasised that:

*'A cornerstone of human rights law is accountability, or in its simplest terms, the ability to make certain that those charged with protecting and fulfilling child rights actually do what they are supposed to do.'*⁴

Functioning accountability processes are needed to plug the gap between laws and policies for children, and the outcomes children experience.⁵

INTERNAL OVERSIGHT BY TERRITORY FAMILIES

Territory Families uses several internal oversight processes to monitor the quality of its service delivery and performance. The Commission has been reliant upon the advice of senior management of Territory Families who have outlined written policies and procedures. The Commission has been unable to undertake a detailed audit which includes discussions with a sufficient number of frontline officers to draw any definite conclusions about how this translates into robust and effective oversight.⁶

Work unit summary reports and monthly performance reports

The Business Intelligence Team, which is located within Territory Families' Corporate Services Division, produces regular reports based on data extracted from Territory Families' information systems, including a work unit summary report and monthly performance report.⁷

The work unit summary report provides details of cases that do not meet performance benchmarks specified in legislation and policy.⁸ This includes, for example where a child protection investigation has been open for more than 28 days and should be finalised.⁹ The work unit summary report is provided to front-line office managers and other people in leadership positions, and is used to identify cases that require attention.¹⁰

The monthly performance report contains data on a broad range of indicators relating to Territory Families' services, such as the number of calls to Central Intake, the percentage of investigations commenced within particular timeframes and the percentage of children without a current care plan.¹¹ It is an important tool in assessing performance.¹² The report is provided to Territory Families' Executive and divisional line management.¹³ The Practice Integrity and Performance Team reviews and analyses the monthly performance report¹⁴ and also prepares an accompanying narrative that explains, where possible, the drivers in data trends.¹⁵ The reports can

identify trends in the number of children in out of home care, their age, complexity level, authority type and placement type.¹⁶ The analysis and narrative is provided to the Executive and discussed at Executive Leadership Group meetings.¹⁷ The reports are said to inform Territory Families' strategic planning and decision-making but it is not clear how this is systematically achieved, recorded or followed up.¹⁸

The role of the Practice Integrity and Performance Team

The Practice Integrity and Performance Team is responsible for the internal review and oversight of Territory Families' practice and client outcomes including:¹⁹

- internal practice reviews
- case reviews
- higher level monitoring of trends in respect of section 83B of the *Care and Protection of Children Act* (NT) inquiries concerning the well-being of a child in the Chief Executive Officer's care²⁰
- higher level monitoring of trends in respect of section 84A of the *Care and Protection of Children Act* inspections of places where a child in the Chief Executive Officer's care resides²¹
- reviews and reports on 'reportable incidents',²² and
- maintaining a database on the abuse of children in out of home care and reportable incidents under section 26 of the *Care and Protection of Children Act*.²³

Each of these responsibilities is discussed below.

Internal practice reviews

Internal practice reviews examine identified trends and practice issues.²⁴ The Acting Executive Director of the Governance Division at Territory Families told the Commission:

*'Internal practice reviews are a valuable tool for gaining an understanding of things like the difficulties which case managers face, the impact (or otherwise) of policy and procedures on the delivery of services at the front line, and evolving practice trends which may need to be addressed by changes to systems and processes.'*²⁵

The trends and practice issues that lead to internal practice reviews are identified in various ways, including through the monthly performance report and work unit summary report, an increase in complaints in a particular area, feedback from stakeholders and quality checking.²⁶ The Acting Executive Director of the Governance Division at Territory Families indicated that:

*'In reality, most practice reviews examine practice issues which are already the subject of some interest based on anecdotal reports. They often add weight or legitimacy to these issues and help to define them more clearly for the purposes of planning and decision-making.'*²⁷

The Practice Integrity and Performance Team has two staff members who are dedicated to conducting these internal reviews.²⁸ A review usually involves selecting a sample set of cases to examine. Depending on the nature of the review, this may be a random sample of between 25 and

80 cases that represent all local offices. However, where the issue being examined involves a small set of cases, such as a review of adoption cases, all relevant cases may be included in the review.²⁹ A good example of an internal practice review is discussed in Chapter 32 (Entry into the Child Protection System). The Practice Integrity and Performance Unit completed a review focused on whether child protection practitioners were appropriately considering cumulative harm in their decision making, as well as how the current procedures and tools influence the assessment of cumulative harm.³⁰ The overall finding was that the accurate use of the Structured Decision Making Risk Assessment tool should be a key area for improvement in the Northern Territory.³¹ Other internal practice reviews have examined aspects of the Family Support, Child Protection, Out of Home Care and Adoptions portfolio areas.³²

The Commission was told that ongoing practice reviews were part of operations, with individual teams in regional offices conducting their own regular practice reviews to assess the quality of services staff members delivered to clients in their geographical area.³³ Examples of this included team leaders or managers reviewing child protection investigations and care plans.³⁴ Front-line staff members – including case managers, team leaders and office managers – have access to a range of reports in the Community Care Information System (CCIS), which helps them to identify cases in their work units that require attention.³⁵

Internal case reviews

Internal case reviews focus on the in-depth analysis of specific cases.³⁶ These reviews usually occur in complex cases. These include where there is a significant complaint, where a case is of particular interest, where a regional office requests it or where a child has died.³⁷

Recommendations Register

The Practice Integrity and Performance Team maintains a Recommendations Register. The register includes recommendations from the internal practice and case reviews, as well as those from the Children’s Commissioner and the Coroner.³⁸ There is no formal reporting system through which the progress of individual recommendations can be monitored.³⁹ The Practice Integrity and Performance Team currently contacts divisions or reviews records to determine whether a recommendation has been implemented.⁴⁰ The Commission was told:

‘... it can be difficult to pinpoint the point at which a specific recommendation has been fully implemented, and the register may not always be updated straight away. It is important to recognise that an omission to record a recommendation as ‘completed’ in the register does not mean that the recommendation has not been implemented, nor that its progress is not being monitored.’⁴¹

Under a proposed organisational restructure, monitoring of the Recommendations Register would be moved to an implementation team in the Operational Support Division, under the same line of authority as training, education and operational policy, to be overseen by the same Deputy Chief Executive Officer.⁴² Territory Families believes this approach is advantageous because most recommendations that make up the register relate to training and policy. Currently, monitoring under the Practice Integrity and Performance Team involves coordinating responses and liaising with other

divisions to document progress.⁴³

The Commission has reservations about this proposal, as the division historically subject to the most recommendations would then be responsible for monitoring its own implementation of them. A better approach is to have functional independence between those implementing and those in an oversight role. The proposed change by Territory Families does not, on its face, increase the transparency of implementation. Territory Families need to ensure that it is meeting best practice standards in its approach to monitoring compliance with its legislation in all areas, and should review its current processes and systems to determine if it meets appropriate standards.

The Recommendation Register is not released publicly, and only recommendations made by the Coroner were mentioned in Territory Families' 2015–16 Annual Report.⁴⁴

Sections 83B and 84A monitoring of the Care and Protection of Children Act

The Practice Integrity and Performance Team monitors any issues and themes arising from notifications to Territory Families under sections 83B and 84A of the *Care and Protection of Children Act*.⁴⁵ These notifications relate to concerns for the safety and wellbeing of children in out of home care. Part of the team's role is to bring staff members within Territory Families together for a case coordination meeting, to ensure a coordinated response to issues raised as a result of inquiries or inspections.⁴⁶ A database is maintained on these cases, from which the Practice Integrity and Performance Team extracts information to identify themes and issues and prepares analysis reports provided to the Executive Leadership Group.⁴⁷

The July–December 2016 analysis report noted a significant increase in section 83B inquiry cases.⁴⁸ The report also noted that where a person other than a parent or carer causes harm to a child, the outcome may be recorded as 'no abuse or neglect'. This means that the data does not provide an accurate reflection of harm experienced by children in the care of the Chief Executive Officer.⁴⁹ Territory Families has prioritised reviewing the policy and procedures for responding to allegations of harm in care in 2017, and has indicated that where a person other than a parent or carer causes the harm it will examine how substantiation can be recorded.⁵⁰ This is essential if an accurate picture of the extent of harm to a particular child is to be understood and a more general understanding of the nature and extent of harm to children is to be achieved.

Recommendation 37.1

The internal oversight processes in Territory Families be responsive, transparent and timely and be staffed with highly skilled people who have the capacity to undertake investigative work of a high quality.

Reportable incidents

The Practice Integrity and Performance Team reviews all reportable incidents. Territory Families defines a reportable incident as:

*'Any significant incident, or alleged incident that negatively affects, or is likely to negatively affect a Territory Families client and in turn affect a staff member, contracted service provider or members of the wider community, which cause the person to suffer harm.'*⁵¹

All reportable incidents are recorded in a database, which the Practice Integrity and Performance Team uses to identify issues. It prepares analysis reports that are provided to the Executive Leadership Group.⁵² The Acting Executive Director of the Governance Division at Territory Families informed the Commission that:

*'Although the information recorded in the reportable incidents database ought to be correct in the context of individual records, the information is recorded for the primary purpose of managing responses to incidents, and is not recorded with the same rigid parameters and definitions as would be required for a system designed to produce statistics for external use.'*⁵³

This is unsatisfactory given that the Executive Leadership Group is using the analysis of this data as a basis for identifying further issues to review and ultimately inform its policy decision-making on the wellbeing of children. Although a more detailed investigation may subsequently be undertaken once an issue is identified by the Executive Leadership Group, it is preferable in the interests of accuracy and efficiency that the correct data be available in the first instance.

Out of home care monitoring

In a statement to the Commission, the Acting Executive Director for Out of Home Care at Territory Families indicated that, as part of the audit process for residential care providers, the Out of Home Care Division and Procurement Branch make scheduled and unannounced site visits to residential care facilities.⁵⁴ They use an audit tool to assess items according to service agreements, as well as the completion of a checklist based on the National Standards for Out of Home Care.⁵⁵ Where areas for improvement are identified, feedback is given to service providers and a written report, which includes follow-up actions for Territory Families or the service provider, is produced.⁵⁶ The Acting Executive Director indicated that in the second half of 2017, rolling audits would extend into purchased home-based care placements.⁵⁷ Monitoring of purchased home-based care is discussed further in Chapter 33 (Children in Out of Home Care).

Recommendation 37.2

The Chief Executive Officer of Territory Families give effect to the provisions of sections 294-298 of the *Care and Protection of Children Act (NT)* by establishing a review team or teams to oversee the departmental operations of Chapter 2 and monitor the quality of the services.

Other oversight in the *Care and Protection of Children Act*

Part 5.2 of the *Care and Protection of Children Act* envisages the establishment of review teams on an ad hoc basis to ensure that the operation of Chapter 2 of the *Care and Protection of Children Act* is consistent with the objects and underlying principles of the Act and that the services delivered under the auspices of Chapter 2 are “of a high standard”.⁵⁸ Chapter 2 sets out the way in which the Northern Territory Government protects children who are in need of protection, promotes the wellbeing of children who have left the Chief Executive Officer’s care and mandates reporting children who are at risk of harm or exploitation.

The objects of the *Care and Protection of Children Act* are:

- to promote the well-being of children including:
 - protecting them from harm and exploitation
 - maximising the opportunity to realise their full potential
- to assist families to achieve these things, and
- to ensure any person having responsibilities for children has regard to these objects in fulfilling those responsibilities.

The underlying principles are set out in sections 7 to 12 of the *Care and Protection of Children Act* and cover the central role of the family in the upbringing of a child and treating children with respect, including what regard should be had when making a decision in the best interests of the child, the obligation to include the child in any decision made about them and provisions concerning Aboriginal children. For example, ‘kinship groups, representative organisations and communities of Aboriginal people have a major role, through self-determination, in promoting the wellbeing of Aboriginal children’.⁵⁹

The Chief Executive Officer may appoint a team (by *Gazette Notice*) to:

- conduct a review and make recommendations about:
 - the operation of specific provisions: Chapter 2
 - the provision of specific services in relation to that service
- conduct a review of the implementation of the recommendations, and
- perform any other specified function in relation to a Chapter 2 matter.⁶⁰

The team must have at least three members. A team member must represent at least one of the following:

- the Police Force
- an Agency having responsibility relating to health, education, housing, family or children
- an organisation promoting any one of:
 - the well-being of children
 - the interests of people with disabilities
 - the interests of Aboriginal people, and
 - multiculturalism.

The legislation plainly envisaged that there would be more than one review team and that the teams would be active, with section 297 requiring a team after each of its meetings to provide the Chief Executive Officer a report of its current operations, and to the Children’s Commissioner. At the end of the financial year the Chief Executive Officer is required to give the Minister an Annual Report ‘about the operation of all the teams during that year’ and to provide a copy to the Children’s Commissioner.⁶¹

It was contemplated that regulations would be made governing the nomination of candidates to be members of a team, operational guidelines, the functions of a team and its meetings.⁶²

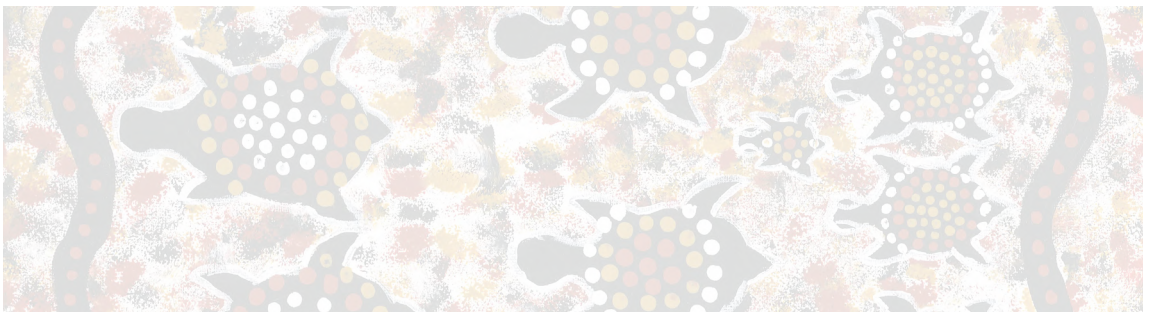
This oversight of the performance of the department is not internal nor can it be characterised as fully external as the members are appointed by the Chief Executive Officer and undertake the reviews as the Chief Executive Officer directs. The Acting Executive of Director Governance Division of Territory Families advised she was not aware of any review team being established.⁶³

The Acting Executive Director of the Governance Division at Territory Families’ explanation of the failure of the department and its successive Chief Executive Officers to give effect to this important legislative provision for performance oversight was:

‘I do not know why the review teams were never formed ... I am not able to say whether the formation of a review team as contemplated by Part 5.2 would have been of assistance to the delivery of services by the Department, because the scope of the teams set out in the Act is so broad. It appears to me that Part 5.2 of the Act provides a very broad power to create teams which include a very wide variety of potential members, and which undertake one or more of a very large range of potential functions. Accordingly, it is difficult to speculate on what any team created under Part 5.2 might have done, or to comment meaningfully on whether that team might have been of assistance.

If the review teams were formed to undertake the same function as the child protection teams which operated under the Community Welfare Act, they would be conducting a similar function to other existing mechanisms which provide oversight of child protection investigations, such as operational-level practice review, internal practice reviews and the Office of the Children’s Commissioner.’⁶⁴

As discussed below, the Children’s Commissioner was given broad investigative powers with respect to the administration of the *Care and Protection of Children Act*.



Recommendation 37.3

Territory Families:

- makes the complaints process more prominent on its website, providing a link on its home page to the complaints policy and a child-friendly version of this policy
- include in its Complaints Management Policy, practical guidance for its staff to inform clients about their rights to raise concerns and complaints
- record information in its complaints database about complaints made by children, with Territory Families reporting on these complaints in its Annual Report
- includes detailed information in its Annual Report about complaints it has received, including the types of issues, classes of complainant, outcomes and complainants' level of satisfaction with the process, and
- regularly survey complainants about their satisfaction with the complaints process and reports on the results of its surveys in its Annual Reports.

Internal complaints and complaints handling by Territory Families

The Growing Them Strong, Together - Promoting the Safety and Wellbeing of the Northern Territory's Children - Report of the Board of Inquiry into the Child Protection System in the Northern Territory (the BOI report) recognised the importance of the then Department of Children and Families developing an effective complaints management system. It recommended that:

*'Northern Territory Families and Children develops an effective complaints management process for clients of the service (and others affected by decisions) that provides for the speedy resolution of complaints. The procedural guidelines for the process should be made available on the Northern Territory Families and Children website.'*⁶⁵

Territory Families provided the Commission with its *Complaints Management Policy* dated 24 February 2017, which sets out how it receives and resolves complaints.⁶⁶

Clients of Territory Families and members of the public can make complaints about its policies, procedures and services, including those services it funds.⁶⁷ The policy does not limit the kind of complaints that can be made or the categories of people who can make complaints.

A foster carer, for example, could make a complaint where a service expected from Territory Families has not been provided to a child in his or her care. A child in out of home care could use the process to complain about their caseworker. A family whose child has been removed and who is unhappy with contact visit arrangements or a lack of communication by Territory Families could also use this process.

*'I didn't know I could make a complaint about OCF [Office of Children and Families]. I thought they were the boss. I thought if I complained they would come and take the rest of my kids. I am still scared that they will come and do that because I am making this statement and being a part of the Royal Commission.'*⁶⁸

Vulnerable Witness, CM

The complaints process also needs to be seen within the broader context of the right to lodge a complaint with the Children's Commissioner, as well as review and appeal rights in the courts, where they are available.

Territory Families has a Complaints Unit which can be contacted via email, post or a 1800 phone number. Complaints can also be made by phone to the team leader or manager of any regional or local office.⁶⁹ The Complaints Unit maintains a central database of all complaints, and the *Complaints Management Policy* states that it is 'mandatory that all complaints details are recorded and provided to the Complaints Unit'.⁷⁰ The policy describes what complainants can expect when lodging a complaint,⁷¹ and provides guidance about how staff members should handle complaints.⁷² It also assures complainants that they will be dealt with 'courteously and professionally, without bias or prejudice'.⁷³

Territory Families tries, in the first instance, to resolve complaints at the regional office level.⁷⁴ Regional offices report any complaints received, and the progress of complaints, to the Complaints Unit.⁷⁵ Complaints that remain at the regional office level are classified as Level Two complaints, which include matters such as specialist appointments for children not going ahead, or birth parents believing they are not being given adequate access to their child.⁷⁶ Most complaints are resolved at the regional office level.⁷⁷ Level One complaints require more intensive management and are generally more complex. They may include complaints about issues such as parents not being kept up to date with their child's progress, the time Territory Families takes to conduct an assessment or the way a child protection investigation has been conducted.⁷⁸ The central Complaints Unit at Territory Families manages these complaints.

In its 2015–16 Annual Report, Territory Families states:

*Complaints are a valued component of the Department's continuous improvement processes and allow staff to understand client and stakeholder views. Responding to, and resolving, complaints demonstrates that the Department is accountable to service users, partners and the community.*⁷⁹

The *Complaints Management Policy* expresses the philosophy and potential value of a complaints system. It refers to the use of feedback in improving and refining service delivery⁸⁰ and states that Territory Families is committed to managing complaints in 'an accountable, transparent, timely and meaningful way'.⁸¹

The policy also highlights the importance of letting people know that they can make complaints, stating that 'all Territory Families staff are expected to inform clients about their right to raise concerns

and make complaints about their experiences in dealing with Territory Families.⁸² While the policy recognises the importance of this, it does not provide guidance in terms of how it should happen.

Approach to complaints

The Acting Executive Director of the Governance Division at Territory Families described the Department's approach to complaints handling as:

*'[C]onsultation with a complainant aimed at negotiating an outcome with which all parties can be satisfied ... The aim in complaint resolution is to achieve a good client outcome and also a good corporate outcome. It is not always possible to give clients the outcome they would prefer, but a good client outcome is one where all issues have been addressed and the client feels listened to and feels that the complaint has been dealt with fairly and objectively. A good corporate outcome is one which promotes Territory Families' objectives, such as foster carers feel valued and appreciated.'*⁸³

When asked about the safeguards Territory Families had in place to ensure complaints were dealt with professionally and objectively, the Acting Executive Director's response was:

*'I think the way I'd like to frame the answer to that is that the safeguard is that there's multiple eyes – as humble as it is, there are multiple eyes on a complaint. The person who may prepare a response to a complaint – it gets assessed by a secondary officer ... we will uphold the values that the agency operates under to be honest and transparent and treat everything with respect, and the objectivity will come in from multiple professionals assessing a matter before it is concluded.'*⁸⁴

The Chief Executive Officer of the Foster Carers Association NT provided the Commission with a different view about Territory Families' approachability and response to complaints. She indicated that feedback from some foster carers suggested they were fearful of the Association raising complaints with Territory Families on their behalf because of potential negative consequences.⁸⁵ The Chief Executive Officer said that a common fear of foster carers in this context was that the children in their care would be removed.⁸⁶ Such a perception, even if unjustified, will constrain the use of the complaint mechanism and impede information sharing between foster carers and Territory Families.⁸⁷ She also expressed concern that there appeared to be no avenue for responding to or reviewing decisions made by Territory Families.⁸⁸ She stated that when carers did make complaints, the complaint would sometimes be referred to the Territory Families officer who originally investigated it, not to an independent officer to review.⁸⁹

The information given to people about their right to make a complaint and the *Complaints Management Policy* need to confirm and reassure potential complainants that no adverse action will be taken against them for making a complaint. Practice Standard 2.11, which is cited in the *Complaints Management Policy*, explicitly states that Territory Families should respond to client complaints in a way that does not prejudice future or current services.⁹⁰ Explicit reference should be made to the precautions Territory Families takes to protect complainants against victimisation.

The process needs to be supported by policy and practice that promotes the independence of the

process and allows complainants to understand the steps Territory Families intends to take to ensure that complaints are dealt with professionally and objectively. It is not enough to say that there are ‘multiple eyes’ on a complaint.⁹¹ Procedures that embody fairness, accessibility, responsiveness and efficiency must be evident.

Complaints data

The complaints Territory Families has received and resolved over the past three years are provided in the table below.

Table 37.1: Number and resolution time of complaints to Territory Families over the past three years⁹²

	2013–14	2014–15	2015–16
Number of complaints received	145	203	256
Number of complaints resolved	141	192	252
Average number of days taken to resolve complaint	21	13	28
Number of complaints that are ongoing	4	11	4

The number of complaints received is increasing, as is the number of days taken to resolve complaints. The increase in complaints received may not necessarily be indicative of a worsening service or situation, but could be the result of people becoming more confident in making a complaint, or an increase in public awareness of the complaints mechanism. The *Complaints Management Policy* commits to ensuring that all complaints are assessed ‘as quickly as possible’, but does not provide benchmarks or timeframes.⁹³ Recommendation 142 of the BOI report required that Northern Territory Families and Children develop an effective complaints management process for clients of the service (and others affected by decisions) that provides for the speedy resolution of complaints.⁹⁴ The Commission is aware that Territory Families monitors the average number of days taken to resolve complaints and reports on it in its Annual Report.⁹⁵ Conveying expected timeliness standards for handling a complaint is an important part of an effective and transparent complaint system and should be included in the policy.⁹⁶

Although it might be assumed that complaints are made by parents, foster carers and kinship carers, the Annual Report provides little detail about the nature of the complaints, who made them, the regions they came from, trends or the outcomes of complaints. Reporting such information publicly would provide more transparency and accountability.⁹⁷

The Complaints Unit’s quarterly report for 1 October 2016 to 31 December 2016 gave more detailed information about the types of complaints received.⁹⁸ The highest number of complaints – 22% of 79 complaints – related to planning and the provision of services for children in out of home care.⁹⁹ Other concerns included placements for children, access to children and the registration of carers.¹⁰⁰ Two complaints in this period were received from children in out of home care.¹⁰¹

Territory Families advised that its Complaints Unit ‘ascertains the complainant’s degree of satisfaction with the complaint outcome’.¹⁰² No information was provided as to how this information is collected or used, and whether it is disclosed.

The *Complaints Management Policy* outlines that clients and members of the public can expect to receive assistance when making a complaint,¹⁰³ but it is not clear how this works in practice and how the right to complain is promoted.

Sources of complaints

Children

Article 12 of the CRC provides that a child should have 'the right to express his/her views in all matters affecting him/her and to have her/his views considered in accordance with... age and maturity'.¹⁰⁴ Section 11 of the *Care and Protection of Children Act* (NT) requires that, as far as practicable, children should be given the opportunity to respond to proposed decisions involving them and express their wishes and views freely. It also provides that they should be given assistance in expressing their wishes and views, taking into account their maturity and understanding. Given the power imbalance and disadvantage experienced by children in the child protection system, it is not enough to simply 'make a complaints system available'. This is clearly recognised in the *Care and Protection of Children Act*.

The Acting Executive Director of the Governance Division at Territory Families said that:

*'Most complaints are received from parents, families and carers. Very few complaints are received from children and young people. I hope to address this in the near future by directly promoting information about making complaints to children and young people who are involved with Territory Families, although no concrete plans have been laid as yet.'*¹⁰⁵

The Executive Director of the Strategy and Policy Division at Territory Families informed the Commission that Territory Families is currently preparing for the second National Survey of Children in Out of Home Care using the Viewpoint software system.¹⁰⁶ As a part of this preparation, Territory Families is exploring how the survey tool can be implemented as part of regular casework practice, as is done in Western Australia.¹⁰⁷ If progressed, it will provide the ability to survey children in out of home care about their views on their current safety and stability, their level of contact with family, their understanding of their culture, their level of engagement with friends and social activities, and their level of satisfaction with the services they require.¹⁰⁸ The Executive Director indicated that this could provide 'an opportunity to improve individual outcomes for children, as well as build a performance monitoring tool for ongoing system improvement and evaluation'.¹⁰⁹

The BOI report recommended developing a 'Charter of Rights' for children in out of home care in the Northern Territory.¹¹⁰ In 2014, this became a legislative requirement.¹¹¹ A Charter of Rights for children and young people in out of home care in the Northern Territory was published by Territory Families in March 2015 and is available on Territory Families' website.¹¹²

Figure 37.2: Extract from Charter of Rights for children and young people in out of home care in the Northern Territory



Section 68A of the *Care and Protection of Children Act* stipulates that Territory Families must provide all children with a copy of the Charter of Rights as soon as practicable after they come into out of home care, unless it considers that it is not appropriate to do so ‘*having regard to the child’s maturity and understanding*’.¹¹³

It is the case manager’s responsibility, as a delegate of the Chief Executive Officer, to provide children with a copy of the Charter of Rights, explain it to them in age-appropriate language, and ensure that the child understands the complaint process and how to access it.¹¹⁴ If the case manager determines that the child is too young or lacks the maturity to understand the Charter, they should provide a copy to the child’s carer.¹¹⁵

Section 68A(2) of the *Care and Protection of Children Act* requires the Chief Executive Officer of Territory Families to promote compliance with the Charter of Rights.¹¹⁶

The Charter of Rights booklet and poster is visually bright and attractive. Territory Families makes a commitment in its Practice Framework to ensure children, young people and families ‘*fully understand*’ what is being communicated. This includes people whose first language is not English.¹¹⁷

Figure 27.3: Extract from the Charter of Rights for children and young people in out of home care in the Northern Territory



The New South Wales Department of Family and Community Services makes its charter of rights available in video, booklet and poster formats.¹¹⁸ Similarly, the Australian Charter of Healthcare Rights is an excellent example of how it is possible to translate a charter into other community languages. The charter is available in 17 community languages, as well as available as an audio resource and in braille.¹¹⁹ The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council has produced a number of resources in Ngaanyatjarra and Pitjantjatjara languages including DVDs books and posters. These resources focus on parenting skills, children’s development, mental health, fetal alcohol spectrum disorder, domestic violence and nutrition. These examples show how the

Charter of Rights for children in out of home care in the Northern Territory could be made available in Aboriginal languages.

The CREATE Foundation's *2013 Report Card* described the experiences of children in out of home care in Australian jurisdictions other than Western Australia.¹²⁰ It reported concerns about children who wanted to complain about an issue, but refrained from doing so because they feared negative outcomes.¹²¹ Of those children who volunteered their thoughts as to why they did not make a complaint, 28.7% (56 out of 195) felt scared or were concerned about the possible consequences. Around 10.3% (20 out of 195) were advised not to complain by another person, and 9.7% (19 out of 195) were worried about the effect the complaint might have on others and how they would feel. Approximately 5.1% (10 out of 195) of respondents felt that there was no use in doing anything; 10.8% (21 out of 195) did not know what to do; and 35.4% (69 out of 195) indicated that the situation had improved such that the issues were no longer worth worrying about.¹²² Respondents in the Northern Territory complained at a rate well above the national average of 19.1%, and considered complaining more frequently than the overall rate of 23.9%.¹²³ However, as noted in the report *'these NT results were influenced to some extent by the composition of that territory's sample, which had a high Residential component'*.¹²⁴ There were 67 participants from the Northern Territory.¹²⁵

BushMob, who have had long experience managing children in care who have left detention, said in its submission:

*'Complaints by young people to DCF [the Department of Children and Families] are rare because they do not feel empowered to do so.'*¹²⁶

The Executive Director of Research at the CREATE Foundation told the Commission that across all jurisdictions in Australia, existing complaints mechanisms place too much emphasis on the child initiating a complaint, rather than on the authorities creating opportunities for children to speak up about their experiences. He said:

'... I think we place too much onus on the young people to be able to advance these issues and introduce them into the system when they're making complaints. We know from our work that about half the young people have a rough idea what to do to make a complaint, but a lot of them are then concerned if they do make a complaint. What's the consequences? Am I going to get into trouble? Will I get somebody else into trouble?

*So these are real worries that the young people have. And I think we need a mechanism that doesn't place the onus on them to make the decision to complain and have to do something special: find a particular service or find a Commissioner or find an Ombudsman to raise the issue. We need mechanisms that are much more user-friendly, proactive, that will allow the young people to have a voice.'*¹²⁷

Another important part of making complaints systems accessible to children is to ensure that people acting on their behalf are properly recognised. As the Queensland Child Protection Commission of Inquiry pointed out:

*'Individual advocacy incorporates the proposition that children are best supported by those with whom they have a relationship and in whom they trust, and they relate better with a person they know is on their side rather than someone they feel is a mere representative of the system.'*¹²⁸

The Commonwealth Ombudsman recommends that agencies be flexible when dealing with complaints, and show a readiness to deal with guardians, friends, advocates or other people acting on behalf of a complainant.¹²⁹

The Charter of Rights booklet advises children that they can first talk to their carer or caseworker (Step 1) or someone else in Territory Families (Step 2) before contacting the Children's Commissioner to make a complaint.¹³⁰ The booklet states: 'If you want to make a complaint and you have already tried Steps 1 and 2 you can call the Children's Commissioner'.¹³¹ This is not correct. Children do not have to go through Steps 1 and 2 before approaching the Children's Commissioner directly. They have the right to make a complaint without going to Territory Families first.

When the Acting Executive Director of the Governance Division at Territory Families was asked about the challenges faced by children who needed or wanted to make a complaint, she told the Commission:

*'Look, I absolutely commend the young people that are using the advocacy sources to lodge their complaints. Certainly, we have experienced where they are utilising the Children's Commissioner, we've seen experiences that they're utilising NAAJA [North Australian Aboriginal Justice Agency] – credit to them. But certainly, what we would like to see happen in the future, that young people feel more confident to raise their voice perhaps more in situ in the offices or the points of contact that they have in the system. So it could be something like – and Ms Couch [Acting Executive Director for Out-of-Home Care, Territory Families] might be able to answer this – it could be in a residential care facility that there's an internal complaints mechanism ... or a feedback mechanism. It doesn't always have to be negative, just offering the young people a voice to go, "All right, is this about the services I'm receiving", or, "I don't like this about the services", but the challenge is to – we have some very confident people out there, but making more young people confident. If they raised a complaint, there's not going to be negative ramifications from it.'*¹³²

When it comes to listening to the concerns children have about their lives in out of home care, there should be no gap between policy and practice. The Commission believes that it is imperative for children to have ready access to an independent agency, such as the Children's Commissioner, to raise any concerns in a safe and secure environment.

The Executive Director of the Strategy and Policy Division at Territory Families told the Commission that the department was currently considering legislative amendments that would reflect

contemporary reforms in other jurisdictions. He made particular reference to the package of amendments underway in South Australia as a result of the Nyland report. He specifically stated that Territory Families would consider South Australia's *Children and Young People (Oversight and Advocacy Bodies) Act 2016 (SA)*,¹³³ which provides for a Commissioner for Children and Young People, a Guardian for Children and Young People, a Child Death and Serious Injury Review Committee and a Child Development Council. He also suggested that as part of the review and amendment of the legislation Territory Families may consider introducing independent oversight or community visitor powers.¹³⁴

The Commission encourages Territory Families to ensure that children have full freedom to be represented in the complaints process by advocates, guardians or friends, without prejudice or bias.

Recommendation 37.4

The Commission for Children and Young People monitor and report on how the Charter of Rights for children and young people is being implemented in the Northern Territory, pursuant to section 68A of the Care and Protection of Children Act (NT).

Territory Families work with the Commission for Children and Young People to provide child-friendly complaints processes, including:

- reviewing the level of knowledge and understanding of the complaints process and the Charter of Rights among children in out of home care and ensuring that information is provided in easy-to-understand language, including for children whose first language is not English, and
- providing the Charter of Rights as an audio and video resource, in different languages, to cater for Aboriginal language speakers and those from culturally and linguistically diverse backgrounds.

Foster and kinship carers

Territory Families' preference is for carers to attempt to resolve their concerns through the Child Protection Offices and Carer Assessment and Support teams. Carers can contact the Territory Families Complaints Unit if they feel the matter has not been resolved.¹³⁵

The Chief Executive Officer of Foster Carers Association NT told the Commission that the Association advocates on behalf of carers to have their concerns heard and considered by Territory Families.¹³⁶ The Chief Executive Officer indicated that often where a caseworker has made a decision that the carer disagrees with, there is no avenue for a response and no review process.¹³⁷ The Chief Executive Officer indicated that sometimes it was necessary for the Association to escalate the issue within Territory Families.¹³⁸

The Association strongly advocated for the implementation of a formal and impartial complaints mechanism, including an independent body.¹³⁹ The body would be separate from Territory Families and responsible for reviewing decisions made about children in foster care.¹⁴⁰

The Foster and Kinship Carers Charter of Rights was launched on 26 May 2017. It emphasises that carers have the right to feel supported, the right to feel safe, the right to feel valued and the right to be part of the child's care planning.¹⁴¹ Under the right to be treated fairly, the Charter of Rights includes a provision that foster and kinship carers have the right 'to appeal or raise complaints in line with procedural fairness'.¹⁴² The Chief Executive Officer of Foster Carers Association NT said that this was an important step forward for foster and kinship carers because it will embody their rights and expectations, something that has not previously been available in the Northern Territory.¹⁴³ This development is consistent with the BOI report recommendation:

*'That Northern Territory Families and Children facilitates the development of a 'charter' for all carers which sets out expectations, rights and responsibilities. A charter will confirm the important role all those involved in out of home care play in the child's life. It can also be used to determine policy, standards and procedures and for training of carers and staff.'*¹⁴⁴

Recommendation 37.5

The Northern Territory Government consult with foster and kinship carers and the Foster Carers Association NT to develop complaints mechanisms for foster and kinship carers, as well as individuals who have applied for these roles.

Complaints handling by contracted service providers

As discussed in Chapter 33 (Children in Out of Home Care), some children in out of home care reside in purchased home-based care, a fee for service arrangement where care is provided by family day carers who are subject to the standards and requirements governing the business of a long day child care provider.¹⁴⁵

It is essential that children in the care of contracted service providers enjoy the same access to complaints mechanisms as others in the Northern Territory out of home care system.

Territory Families mandates that contracted service providers must have complaints processes in place.¹⁴⁶ The Commission received information that some providers already have their own processes for internal resolution. For example, Anglicare NT manages 'minor complaints or feedback' from children in out of home care at the residential unit level.¹⁴⁷

However, such internal processes for managing minor complaints or concerns raised by children in purchased home-based care were not evident in all cases. For example, such processes do not appear to be included in the out of home care policies and procedures of one provider that delivers a large proportion of purchased home-based care in the Northern Territory.¹⁴⁸

If children in purchased home-based care are to have the same rights as other children in out of home care, there must be a robust and independent complaints mechanism to ensure that their complaints are heard and dealt with effectively.

Territory Families must ensure that purchased home-based care providers and other providers of residential care for children have a complaints policy in their own processes that is in addition to, and not a substitution for, the Territory Families' complaints process.

The Chief Executive Officer must ensure that every child in purchased home-based care receives the Charter of Rights, as well as information about their right to complain to both Territory Families and the Children's Commissioner.

Training

Training staff members in complaints handling is also important. In its consultation paper on best practice principles in responding to complaints of child sexual abuse in institutional contexts, the Royal Commission into Institutional Responses to Child Sexual Abuse states that complaints handling policies should set out the training to be provided to staff members.¹⁴⁹ While acknowledging that some in the Northern Territory have the opportunity to participate in training modules about standards of care and the Charter of Rights,¹⁵⁰ training in complaints handling should be given a higher priority.

Recommendation 37.6

Territory Families standardise complaints handling processes, including training for carers and residential workers about how to respond to complaints made by children.

Policy review

Territory Families told the Commission that it intends to review its complaints management policy and processes in 2017, with a view to centralising complaints across all portfolios as part of the organisational functional review:

*'[T]here is a need for Territory Families to introduce standard policies covering centralised functions such as complaints management, reportable incidents, critical case reviews and other corporate issues (i.e. travel, and work health and safety), so that there is one common understanding of the principles, approach and procedure.'*¹⁵¹

The Commission was told this would also be considered as part of the review of the Care and Protection of Children Act in 2017–18. Territory Families Executive Director Strategy and Policy Division indicated that efforts are being made to 'bring together the practice integrity and professional standard responses to allegations and wellbeing concerns for children who are in care and are in detention' where there will be one practice integrity and complaints management unit responsible for all Territory Families business, including youth justice and child protection.¹⁵²

EXTERNAL OVERSIGHT

A number of independent external statutory bodies in the Northern Territory have important child protection oversight responsibilities. Before 1 July 2011, the Ombudsman had an oversight role; however, the Children's Commissioner has since assumed these responsibilities.

The role of the Ombudsman

Before 1 July 2011, the Ombudsman provided independent external oversight over Family and Children's Services, which was part of the Department of Health and Families.¹⁵³ In November 2009, the Ombudsman commenced an own motion investigation into Family and Children's Services. This investigation related to the Central Intake Service and the process of making and investigating notifications¹⁵⁴ of alleged harm to children after concerns had been raised by health workers.¹⁵⁵ At the time, there was not only a backlog of cases, but also a backlog of reports about children who were believed to have been harmed, or who were likely to be harmed, while awaiting a 'danger' assessment.¹⁵⁶

The BOI report recommended that the Ombudsman's power to investigate complaints about 'vulnerable children' be transferred to the Children's Commissioner.¹⁵⁷ Recommendation 136 of the Board of Inquiry stated:

*'That the Northern Territory Government reviews the roles and functions of the Children's Commissioner in the light of this Inquiry with a view to amending the Act to address the needs for: an 'own motion' investigation capacity; the extension of his/her advocacy and complaint management responsibilities to other identified groups of vulnerable children in Northern Territory Government-funded care; specific powers for the Children's Commissioner to obtain documents, examine persons, or carry out any type of investigations as part of his/her monitoring functions; a broader role in monitoring the implementation of Northern Territory Government decisions arising from any inquiries in relation to the child protection system or the wellbeing of children under the Inquiries Act.'*¹⁵⁸

In response the government transferred this investigation power to the Children's Commissioner.¹⁵⁹ The operative provisions of the *Care and Protection of Children (Children's Commissioner) Amendment Act 2011* commenced on 1 July 2011.

On 1 June 2011, the Ombudsman released a partial report of her investigation into the notification and assessment procedures of the Child Protection Authority, *A Life Long Shadow: Report of a partial investigation of the Child Protection Authority*.¹⁶⁰ The report found, among other things, that there was a practice in the Central Intake Service of recording notifications as 'abuse/neglect not substantiated' when they had not been investigated at all.¹⁶¹ The Ombudsman made six recommendations to the Department of Health and Families. These included:

6. *That another phone be established seven days per week 24 hours a day that is dedicated to, and only given to professional notifiers and which receives priority in being answered. That phone number should also be available to NT Police and the Principal and Deputy Principal of schools*

7. That the facility for professional notifiers to email or facsimile notifications be restored to the NT public hospitals
8. That if the practice of intake workers going off line from the telephone to complete entry of a notification into CCIS is to continue that the number of intake workers answering the phones be increased
13. That a review of the adequacy of orientation training is pursued by the CPA [Child Protection Authority] to identify training needs for intake workers so that they have the capability to use CCIS effectively.
15. That the position of an intake worker stationed at RDH [Royal Darwin Hospital] become a permanent arrangement even if only half time at RDH with that worker being able to accept notifications directly from RDH personnel.
16. That the CPA examine the files of the children identified in this report whose circumstance should have been investigated under the third report rule but weren't to determine how best to configure the case management system CCIS to automatically highlight that a notification is a third one within 12 months for children in the same household.¹⁶²

In terms of implementing the recommendations, the then Ombudsman told the Commission that:

*'Six of them [recommendations] related to the Department. The Department disagreed with each of those recommendations. The CPA [Child Protection Authority] agreed with some, but not all of my recommendations. I am not aware of how many of those recommendations were subsequently implemented.'*¹⁶³

The importance of independent oversight is illustrated in *A Life Long Shadow: report of a partial investigation of the Child Protection Authority* revealing as it did a practice that left at risk children about whom a notification had been received.

The Children's Commissioner

The Office of the Children's Commissioner has a vital role to play in the child protection system in the Northern Territory. It provides the only external oversight of the statutory child protection process as well as decisions made under the Act about the care and protection of children. It is essential that the Office is resourced and equipped to cover the wide area of responsibility and oversight it has under the *Children's Commissioner Act* (NT), given the many children and families affected. The background and development of the Office of the Children's Commissioner is highlighted in Chapter 30 (The Child Protection Landscape).

Under section 50 of the *Children's Commissioner Act* (NT), the Children's Commissioner must review the 'operation and effectiveness' of the *Care and Protection of Children Act* as it relates to vulnerable children at least once every three years and report the findings to the Minister. The Children's Commissioner said:

*'This provision commenced operation with effect from 1 January 2014. The first review is due under this provision on 1 January 2017. We have commenced work on this review and have completed the stakeholder engagement phase of it. This included discussions with the Department of Children and Families ('DCF', but now called Territory Families) about the scope of our review.'*¹⁶⁴

In a later statement to the Commission, the Children’s Commissioner noted that:

*In my first statement I referred to a report being prepared on the operation and effectiveness of the Care and Protection of Children Act, which at the time I expected would be complete by January 2017. This review was postponed given the likelihood that there would be amendments to that Act made by the government either on its own initiative or as a result of this Royal Commission’s recommendations.*¹⁶⁵

The Children’s Commissioner has a number of other oversight functions in relation to the child protection system, including:

- undertaking inquiries relating to the care and protection of vulnerable children
- monitoring the implementation of government decisions relating to any inquiries into the care and protection of vulnerable children
- monitoring the administration of the *Care and Protection of Children Act* (NT), where relevant to vulnerable children
- monitoring how the child protection department deals with abuse in care allegations, and
- reporting to the Minister on matters relating to the Commissioner’s functions.

Section 30 of the *Children’s Commissioner Act* empowers the Children’s Commissioner to undertake an inquiry related to the care and protection of children in the Northern Territory, either on his or her own initiative, or if directed to do so by the Minister. This power has not been used,¹⁶⁶ despite a range of matters that might have been usefully examined.

Although the Children’s Commissioner has broad oversight and monitoring responsibilities relating to vulnerable children in the Northern Territory, the statutory responsibilities of the position cannot be met by the resourcing capacity provided to the Office. The Children’s Commissioner told the Commission that she did not have the budget, staff or resources to carry out her statutory functions adequately.¹⁶⁷ She suggested that in order to be able to provide independent oversight of the child protection and youth justice system across the Northern Territory she would need at a minimum, four extra staff members with appropriate expertise.¹⁶⁸ She also indicated that there are both complaint and own initiative investigations that she would like to commence but cannot.¹⁶⁹ The Children’s Commissioner’s 2015–16 Annual Report shows that none of the 90 complaints received that year proceeded to an investigation, and only five investigations were finalised.¹⁷⁰

The current organisational chart lends weight to the view that she has a ‘very limited’ ability to look at systemic issues.¹⁷¹

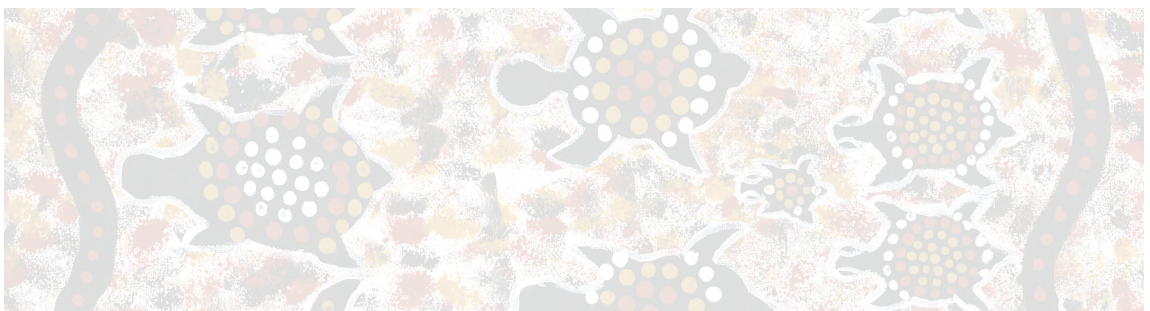
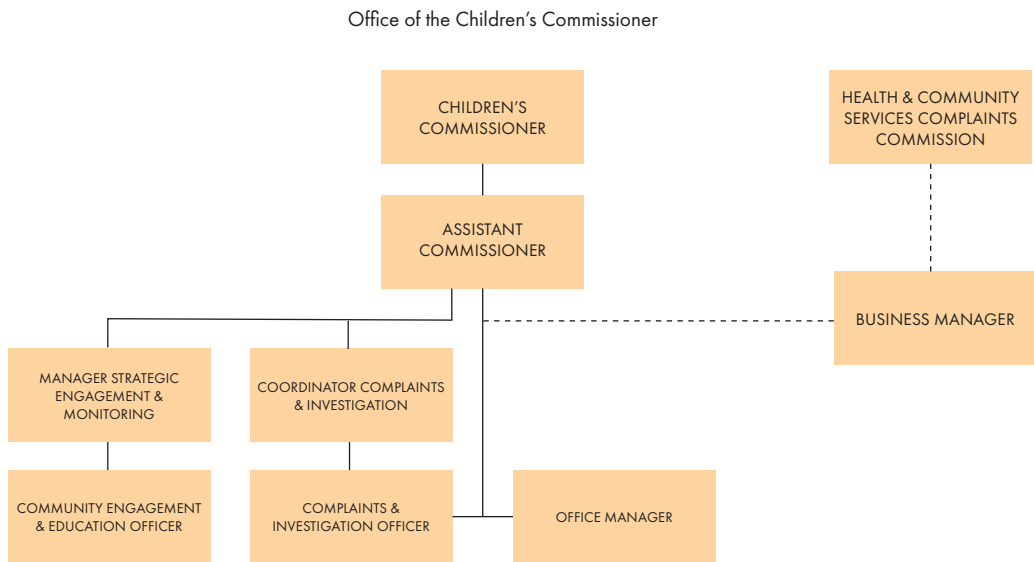


Figure 37.4: Organisational Chart of the Office of the Children’s Commissioner



Source: Office of the Children’s Commissioner Northern Territory¹⁷²

The Children’s Commissioner’s current approach to staffing and resources has been to restructure the organisation to reduce the number of staff members who focus on investigations and complaints management, and to increase the focus on education and communications.¹⁷³ It is concerning that investigative resources are as a consequence being reduced. Recommendation 137 of the BOI report stipulated that the Northern Territory Government ensure the Children’s Commissioner be adequately funded to carry out any additional functions.¹⁷⁴

Finding

The office of the Children’s Commissioner is under-resourced to perform its full range of statutory functions in relation to the care and protection of vulnerable children in the Northern Territory.

Monitoring the administration of the Care and Protection of Children Act

The Children’s Commissioner produces a comprehensive Annual Report that provides extensive information about the child protection system in the Northern Territory. The Annual Report sets out the approach of the Children’s Commissioner to monitoring the administration of the *Care and Protection of Children Act* and focuses on Chapter 2 of the Act, which concentrates on safeguarding the wellbeing of children. As the Children’s Commissioner points out, Chapter 2 of the Act contains most of the child protection provisions, including the administrative powers of the Chief Executive Officer of Territory Families and the various legal orders that can be put in place to protect children.¹⁷⁵ The Annual Report reviews historical and operational data to determine trends and overall changes in the system.¹⁷⁶ Data includes notifications, investigations, substantiations, case closures, the rate of children in out of home care, regional differences and the rate of over-representation of Aboriginal children in the child protection system.¹⁷⁷

The Children’s Commissioner also reviews case files. These reviews focus on statutory and policy compliance – for example examining whether children have care plans or leaving care plans, the contact they have with their caseworkers and the use of temporary placement arrangements.¹⁷⁸ The Children’s Commissioner told the Commission that she had concerns about some of the data she received from Territory Families. For example:

‘We have experienced issues with the reliability of DCF [Department of Community and Families] data – this includes lack of/insufficient CCIS progress notes, lack of contemporaneous notes, and the inability of CCIS to facilitate the scanning of signed/authorised documents and notes from interviews/meetings.’¹⁷⁹

She pointed out that the BOI report also raised problems in record keeping as a serious concern¹⁸⁰ and said that it remained a fundamental problem. She suggested front-line staff members be provided with laptops and tablets which would allow them to enter data directly into the systems.¹⁸¹

The quality of data the Children’s Commissioner receives invariably affects the extent to which she can effectively execute her monitoring functions.¹⁸² Any lack of thorough record keeping also affects the quality of information available to those children who choose to access their records later in their lives. This has the potential to deny them the opportunity to find an accurate record of their time in out of home care.

As discussed elsewhere in this report, Territory Families is due to overhaul its child protection case management system CCIS.¹⁸³ As it develops the new case management system it will be important to address these issues.

The Children’s Commissioner’s case file reviews currently have a narrow scope and do not look more broadly at the kinds of risk factors which also affect the wellbeing of children in out of home care. Examples of issues that may warrant review include education and school attendance, health issues, stability in out of home care and the information given to children. The Commission strongly supports the Children’s Commissioner extending her role in this way.

The Commission noted that the Children’s Commissioner receives little input from children in carrying out her role. The legislation has no clear provisions for engagement and consultation with children, and there is no express requirement to consult with them.¹⁸⁴ It can be contrasted with the National Children’s Commissioner, who has extensive engagement with children.¹⁸⁵ In her 2015–16 Annual Report, the Children’s Commissioner acknowledged that:

‘The OCC [Office of the Children’s Commissioner] currently has limited capacity to facilitate this engagement [with children] at desired levels.’¹⁸⁶

The Children’s Commissioner told the Commission:

‘We need to get out and talk to people to understand, not just relying on what we see through complaints and our investigations to understand where the problems lie in terms of vulnerable children.’¹⁸⁷

The Children’s Commissioner also told the Commission that more engagement with children could help in identifying gaps in service delivery:

‘... we want to be not in the chaos like the system is, but more in a – in the early intervention proactive space where we understand where the gaps of service delivery are by analysing the data, monitoring what’s going on, coupled with talking to the children who are subject to the services, and working across the sector to understand what their issues are so we can provide government the best advice which is evidence-based.’¹⁸⁸

While recognising that resourcing is limited, it is insufficient to use desktop research as the principal means of gathering the views of vulnerable children in the Northern Territory or monitoring their wellbeing. Monitoring should include seeking as well as listening to the views of children their parents and their caregivers.

Abuse in care

One of the most important functions of the Children’s Commissioner is to play a role in monitoring the handling of reportable incidents and allegations of abuse in out of home care.

Sections 83A–84D of the *Care and Protection of Children Act* give authorised officers of Territory Families and police officers¹⁸⁹ the power to inquire into and/or investigate allegations of harm or exploitation of children in out of home care. Section 83A of the Act provides for inquiries to be made while section 84A provides for investigations.

Section 10(1)(f) of the *Children’s Commissioner Act* requires the Children’s Commissioner to monitor how the Chief Executive Officer of Territory Families deals with suspected or potential harm to or exploitation of children in the Chief Executive Officer’s care. Under section 84C of the *Care and Protection of Children Act* the Chief Executive Officer must as soon as practicable notify the Children’s Commissioner of any cases where a child protection investigation has substantiated allegations of harm or exploitation of a child in out of home care.

In its 2015–16 Annual Report, Territory Families reported that:

‘Whenever the Department receives information that a child in care may not be safe, an immediate response to address the concerns occurs. Through this process the Department’s Practice Integrity Unit coordinates a Departmental response to any concerns about the safety or wellbeing of a child in care. Overall in 2015-16 the Department investigated 496 concerns about the wellbeing and safety of children in care and in 86 cases found that the child had been or was at risk of harm. This compares to 123 substantiations that occurred in 2014-15.’¹⁹⁰

For the past two years, the Children’s Commissioner has reviewed substantiated cases of harm or exploitation of children in out of home care. The Children’s Commissioner reported that in 2015–16, Territory Families notified the Commissioner of 81 substantiated cases of harm or exploitation involving 70 children in out of home care.¹⁹¹

Of the 81 cases, 90% involved Aboriginal children with 34% of cases involving physical abuse, 30% emotional abuse and 30% neglect.¹⁹² About 6% were cases of sexual harm or exploitation.¹⁹³ Children were removed from the placement in 5% of these cases, with 48% remaining in the placement.¹⁹⁴

Self-placements

Self-placement refers to a child who leaves their out of home care placement on their own initiative and resides elsewhere, often returning to family or becoming homeless. Self-placements accounted for 38% of substantiated cases, while 22% occurred in foster care, 19% in kinship care, 11% in home-based care and 10% in residential care.¹⁹⁵ The Children's Commissioner noted the increase in the number of substantiated harm and exploitation cases among children in self-placements in the Northern Territory.¹⁹⁶ In 2014–15, only 5% of cases (six out of 110) involved children who were in self-placements but in 2015–16, this increased to 38% (31 out of 81).¹⁹⁷

The Children's Commissioner advised the Commission of concerns about how Territory Families was conducting section 83B inquiries and section 84A investigations, saying:

'I believe this rate [22 per cent of substantiated cases of abuse in care occurring in foster care] under-reports the scale of the problem. Territory Families are required to report all matters of substantiated harm to a child in care to the Northern Territory Children's Commissioner, despite whether it is conducted in accordance with 83A or 83B of the Care and Protection of Children Act.

Territory Families policy 'concerns about the safety of children in care' is clear that all concerns that suggest that a child in the care of the [Chief Executive Officer] 'has suffered, is suffering or likely to suffer harm or exploitation' will be assessed under the investigation powers of section 84A of the Care and Protection of Children Act. However, it has come to the attention of my Office that there are concerns that meet this criteria that are being dealt with as a section 83B inquiry and not as a section 84A investigation.

Furthermore, I am concerned that those dealt with as an 83B inquiry have less stringent response times and investigative procedures.¹⁹⁸

The Children's Commissioner said:

'My view is that we probably should get all cases, whether they're substantiated or not, just by virtue of the fact that any abuse in care, I think, needs to be looked at independently.'¹⁹⁹

In her 2015–16 Annual Report, the Children's Commissioner observed:

'We owe it to those children who are, for whatever reason, placed in OoHC (out-of-home care) to ensure they receive a high standard of care.'²⁰⁰

Complaints to the Children’s Commissioner

If a child, young person, family member, carer or interested adult is dissatisfied with the manner in which Territory Families delivers its services to children they can complain to the Northern Territory Children’s Commissioner. Receiving these complaints is a core function of the Children’s Commissioner, as set out in section 10(a) of the *Children’s Commissioner Act*.²⁰¹

A complaint to the Children’s Commissioner must be made within 12 months of the matter occurring unless the Commissioner considers it appropriate to accept a complaint in the public interest or because of special circumstances.²⁰² Complaints to the Children’s Commissioner can be lodged by a vulnerable child or an adult acting on behalf of a vulnerable child.

The Children’s Commissioner has the power to examine the ‘quality or absence of reasonably expected services’ provided by Territory Families and can investigate the circumstances surrounding a decision ‘including whether legislative, policy and practice standards were complied with in making the decision’.²⁰³ Under section 5(1)(a) of the *Children’s Commissioner Act*, the Commissioner must consider whether the outcome of the decision was in the best interests of the child.

Section 10 of the *Children’s Commissioner Act* also permits the Children’s Commissioner to investigate on the Commissioner’s own initiative, matters that may form the grounds for making a complaint.

The *Children’s Commissioner Act* prescribes the process by which the Children’s Commissioner must manage complaints.²⁰⁴ Section 23 of the Act sets out the options available to the Commissioner on receipt of a complaint including the grounds on which a complaint may be investigated, resolved, declined or referred.²⁰⁵

Once a complaint has been received, the Children’s Commissioner must, within 28 days, decide whether to investigate the complaint, refer it to another person for investigation or resolve it without investigation.²⁰⁶ The identity of the ‘other person’ is not specified.

The Children’s Commissioner monitors how complaints referred to other bodies are managed by them. According to the Children’s Commissioner’s Annual Report in 2015–16, ‘there were a number of issues relating to the adequacy of the investigations conducted by some of these complaint bodies’ although the report provides no further detail.²⁰⁷

Number of complaints and issue types

In 2015–16, the Children’s Commissioner received 231 ‘approaches’ of which 90 were treated as ‘complaints’.²⁰⁸ The complaints involved 108 vulnerable children of whom 88% were Aboriginal.²⁰⁹ Of the complaints received 62 related to out of home care, 13 to youth justice and eight to residential care.²¹⁰ This compares with 210 vulnerable children in 2014–15²¹¹ of whom 77% were Aboriginal²¹² and 142 vulnerable children in 2013–14,²¹³ of whom 78% were Aboriginal.²¹⁴ No explanation was ascertainable for the fluctuations in overall figures.

In 2015-16, the Children’s Commissioner referred 41 complaints to Territory Families for investigation and resolution. At 30 June 2016, 40 of these had been resolved and one was in the process of being resolved.²¹⁵ The Children’s Commissioner also commenced and completed five investigations of complaints relating to services provided by Territory Families.²¹⁶ These investigations centred on issues related to inadequate safety assessments, child protection investigations, case management and placement arrangements.²¹⁷

In a statement to the Commission the Children’s Commissioner indicated that the most prevalent types of complaints her office received in relation to child protection matters included:

- a lack of appropriate therapeutic out of home care placement options for children with significant and complex needs
- a lack of appropriate planning and action taken to address the safety and wellbeing of children in out of home care who were ‘self-placing’
- inadequate access arrangements between children in care and their family or significant others or previous long-term carers
- inadequate and/or inappropriate kinship care placements in out of home care for children in remote areas and departmental monitoring of these placements
- inadequate child protection investigations, poor responses to the concerns raised by professionals and insufficient inquiries to establish the correct level of risk associated with a child’s circumstances.²¹⁸

The Children’s Commissioner often requires information from Territory Families in order to deal with complaints and to complete investigations. Section 35 of the *Children’s Commissioner Act* empowers the Children’s Commissioner to issue notices requiring the provision of specified information within a certain timeframe. Except in certain circumstances, the failure to comply with such a notice is an offence.

The Children’s Commissioner told the Commission that these notices are not always complied with within the specified timeframe and that sometimes the information requested is provided after months of delay.²¹⁹

Recommendation 37.7

The Commissioner for Children and Young People publish in its Annual Report the number of compulsory notices it issued under section 35 of the Children’s Commissioner Act (NT) in that year and whether they were complied with, including any delays in compliance.

The Children’s Commissioner told the Commission about positive steps taken towards reducing red tape and speeding up the resolution of complaints concerning Territory Families. This included the introduction of a ‘minor complaints resolution process’.²²⁰ As part of this process, the Children’s Commissioner and Territory Families meet each week to discuss complaints that may be able to be resolved close to the source of the complaint.²²¹ The Children’s Commissioner told the Commission that:

'what we're able to achieve now is some really timely resolution of matters that would historically take sometimes months and years to resolve. Now, the focus of both our office and Territory Families is the child at the centre of those decisions.

*... what we've been able to achieve is the department self-managing those complaints in consultation with my office and getting better and quicker resolutions ...'*²²²

When asked if referring complaints to the body that is the subject of those complaints means that the Children's Commissioner has 'necessary confidence' in Territory Families' internal review mechanisms, the Commissioner stated:

*'It doesn't take my responsibility away from the oversight. The intent was – number one intent was to bring back the child as the centrepiece of any discussion, as opposed to it being caught up in the administration between my office and Territory Families, which often happened, and it was – a lot of it was done through formal correspondence, and it would take time. And my concern was while we were pushing letters back and forward, disputing parts of responses or the obligations of the department, it was the child that was being let down in this process. So my view was if we start to try and work with the department much earlier on, the outcomes for the child would be much better.'*²²³

*... So my responsibility is to also ensure that the department has a complaints and investigation area that is able to administer the complaints which it receives.'*²²⁴

*... And I think it's working and I think it's certainly changed some of the relationships and it's changed our ability to resolve matters to the satisfaction of the complainants and better outcomes for young people. It's not perfect, but we're in a much better place now than what we were six months ago.'*²²⁵

When asked whether in some circumstances it was better for individual complaints to be dealt with by her office rather than being referred to Territory Families in the first instance, the Children's Commissioner said:

*'Absolutely. And I think that will probably never go away. I think that's just the nature of the work. So there's two investigations I see that we would be undertaking. One would be in relation to a matter where it is so significant it requires an independent investigation, findings and recommendations to deal with it. The other is where we have those systemic issues that keep coming up, as I've just mentioned to the Commissioner. If it keeps raising through complaints or through our discussions that we're now having during our engagement sessions, we will then undertake an investigation.'*²²⁶

Despite recognising the value of having the Children's Commissioner review matters of concern Territory Families indicated that there are sometimes challenges in providing a complaint response that 'satisfies' the Commissioner that the complaint has been fully resolved.²²⁷

It is good administrative practice to seek first to remove complaints by the process initiated between the Children’s Commissioner and the department. It will be more effective if the representatives of Territory Families are knowledgeable and skilled across the whole department and authorised to make decisions.

The Coroner

Investigative function of the Coroner

The Northern Territory Coroner is responsible for investigating any death that is ‘reportable’, and reporting its findings to the National Coronial Information System (NCIS).²²⁸ The death of a child is reportable if the child was in out of home care or in custody at the time of death.²²⁹

Under section 12 of the *Coroners Act* (NT), Territory Families must report the death of any person under the care of the Chief Executive Officer to the Coroner. Section 15(1)(a) of the *Coroners Act* 1993 requires the Coroner to conduct an inquest into the death and publish the findings.

The Commission sought information from the Northern Territory Coroner’s Office as to the number of deaths in care which were investigated. The Deputy Coroner told the Commission that between August 2006 and October 2016 there were 11 deaths of children in out of home care reported to the Coroner’s Office with a further two under ongoing investigation.²³⁰ The Commission understands that both of those investigations have now concluded. There have been two further investigations concluded where the death was of a child known to the child protection system or where that death was attributed to neglect.²³¹ Territory Families is required to respond to any recommendations made under section 46B of the *Coroner’s Act*. The Minister for Territory Families advises the Attorney-General of the department’s position on each recommendation before a report setting out the findings and responses is tabled in the Legislative Assembly.

Coroner’s reports and recommendations

The Coroner’s publicly available reports confirm the scope of its investigations which includes the capacity to make findings and recommendations with respect to individuals, institutions and governmental bodies based on the forensic review of individual child deaths. This process has been recognised in other jurisdictions as playing an important role in identifying concerns with the child protection framework.²³²

Where a child known to Territory Families dies, an individual forensic review is also undertaken internally. The Practice Integrity and Performance Team conducts these reviews and focuses on in-depth analysis of cases to identify key practice issues that may have contributed to the death.²³³

Territory Families has a *Death of a Child in Care Policy* and an accompanying procedures document. These resources focus on the ‘statutory obligations’ of Territory Families in the immediate aftermath of the death, and on immediate responses and arrangements, including notifying the Coroner.²³⁴

In some instances the Coroner will adopt recommendations arising from internal reviews by departments or institutions.²³⁵ In other instances the Coroner makes his or her own

recommendations.²³⁶ While the recommendations may arise from a particular death they are often directed towards broader problems that might occur in other situations. For example in one inquest into the death of a child the Coroner recommended legislative reform to the *Care and Protection of Children Act (NT)*.²³⁷

A number of the care and protection issues identified by this Commission have also been identified by the Coroner, including:

- the breakdown in the transfer of information between child protection caseworkers²³⁸
- the inadequacy of departmental support for foster carers especially in respect of paediatric information²³⁹
- the failure to regularly review care plans of children in the care of Territory Families²⁴⁰
- the inadequacy of resources provided to child protection services in Alice Springs in particular to deal with staffing and training issues.²⁴¹

Territory Families said it accepts the majority of recommendations the Coroner makes²⁴² which are also entered into the Recommendations Register. The lack of ongoing reporting on the implementation of recommendations in the register has been noted above and is equally applicable here. The extent to which Territory Families effectively and purposefully implements some recommendations is questionable.

The case of Baby C is one example.²⁴³ In this case, the Coroner recommended that the Department of Health and the then Department of Children and Families work together with foster care agencies to achieve a workable protocol and practice to ensure foster carers have access to nurses with experience in paediatric issues when children in out of home care require health services.²⁴⁴ The department noted in its register that this was to be explored. It then actioned the recommendation as completed but the Acting Executive Director of the Governance Division at Territory Families told the Commission that it did so on the basis that the two departments had concluded that services meeting the substance of the Coroner's recommendation were already in place.²⁴⁵

In some instances, the same recommendation has been made in more than one of the Coroner's reports. In 2010 the Coroner recommended in relation to the death of a young person that the then Department of Family and Community Services develop a written handover system to use when one caseworker takes over another's case, including a short succinct summary identifying any risk factors or areas of concern pertaining to the child in out of home care. The department indicated that the recommendation was completed through amending the policy and procedures manual to ensure that guidelines were in place for all situations where caseworkers take on a new case.²⁴⁶

In 2016, following the death of another young person the Coroner recommended that the then Minister for Children and Families direct all case managers to provide formal written confirmation of all information exchanged between case managers when a case involving a child in the care of the Chief Executive Officer pursuant to any order under the *Care and Protection of Children Act (NT)* is handed over. This recommendation is still open in the Recommendations Register; scoping for a practice review is underway, and the review has been added to the review schedule.²⁴⁷ The Executive Director of the Strategy and Policy Division at Territory Families told this Commission that:

In specific response to the Coroner's recommendation on 16 November 2016, the Minister for Territory Families directed the [Chief Executive Officer] of Territory Families to direct all case managers to provide formal written confirmation of relevant information exchanged between case managers at the time of handover of any case relating to a child in the care of the [Chief Executive Officer] pursuant to any order under the Care and Protection of Children Act. Prior to doing this, the Minister for Territory Families confirmed this action to the Attorney-General on 13 November 2016. Since the Minister's direction, Territory Families has reviewed the Case Transfer Report template to improve the capture of immediate-, short- and long-term case management actions for a case to ensure the child's immediate needs are met.²⁴⁸

The Coroner's process remains an important independent component of the matrix of oversight and monitoring bodies involved in child protection. Table 37.3 includes a selection of Coroner's reports into children known to child protection services at the time of their death.

Despite the obvious need for the Coroner's recommendations to be implemented the Coroner has no powers to monitor and ensure the implementation of any recommendations made in relation to an investigation into a particular death. Territory Families does report on coronial inquests into the deaths of children in out of home care including whether recommendations were made in its Annual Report; however there appears to be no separate report on the implementation of recommendations made by the Coroner.²⁴⁹

The Commission is of the view that Territory Families' implementation of the Coroner's recommendations needs to be externally monitored. This role would be suited to the Children's Commissioner in conjunction with the Child Death Review and Prevention Committee and could be reported on in the Children's Commissioner's Annual Report.²⁵⁰

Recommendation 37.8

Amend Part 3.3 of the Care and Protection of Children Act (NT) to require the Commission for Children and Young People in conjunction with the Child Death Review and Prevention Committee to monitor Territory Families' implementation of coronial recommendations relating to children who died while in out of home care.

The Child Death Review and Prevention Committee

The Northern Territory has a Child Death Review and Prevention Committee (CDRPC), a statutory body under the *Care and Protection of Children Act* which reviews the deaths of children for the purpose of examining the broader circumstances surrounding their death. These reviews provide 'social autopsies' allowing the CDRPC to identify trends and patterns in child deaths.²⁵¹

The CDRPC was created in response to the *Little Children are Sacred* report,²⁵² which recommended establishing such a committee and providing it with the power to undertake case-specific reviews of

serious child abuse cases where the child has survived.²⁵³

The CDRPC's role is to help prevent child deaths through:²⁵⁴

- maintaining a database on child deaths (the Child Deaths Register)
- conducting research into child deaths as well as diseases and accidents involving children
- raising public awareness about the causes and nature of child deaths and their prevention or reduction
- making recommendations arising from its research and monitoring their implementation, and
- developing appropriate policies to deal with such deaths diseases and accidents.

The Children's Commissioner acts as the Convenor of the CDRPC having been appointed by the then Minister for Child Protection in 2008.²⁵⁵ The CDRPC itself has no independent staff members²⁵⁶ and the Office of the Children's Commissioner acts as the CDRPC secretariat.²⁵⁷ The current committee includes doctors, public health experts, police officers, lawyers and government agency representatives.²⁵⁸ One member of the CDRPC must be a Deputy Coroner and at least two members should be Aboriginal people. The CDRPC releases an Annual Report outlining its activities including any recommendations made and their implementation.

Statutory review of the CDRPC

The legislation establishing the CDRPC required that a review be completed after three years to determine if the operation of the provisions met the objective of the legislation.²⁵⁹ The Attorney-General conducted this review in 2012²⁶⁰ identifying a number of challenges and issues faced by the CDRPC. Among them was that while the CDRPC had developed internal policies for the holding of data on child deaths it had not developed specific policies for the prevention of child deaths.²⁶¹

The recommendations of the Attorney-General's review included:

*'Recommendation 1: That section 207 of the Care and Protection of Children Act be amended to clarify that an object of Part 3.3 is for the Committee to provide recommendations for the development of appropriate policy to deal with child deaths, diseases and accidents.'*²⁶²

*Recommendation 4: That there is no extension of the Committee's power to conduct individual reviews of child deaths. [On accounting for the already established jurisdiction of the NT Coroner and the [Chief Executive Officer] of the agency administering the Act].'*²⁶³

Section 207 of the *Care and Protection of Children Act* has been amended as proposed.

Work of the CDRPC

One of the CDRPC's key functions is maintaining a Child Deaths Register²⁶⁴ – a database that records the number of child deaths as well as causes patterns and trends relating to those deaths.²⁶⁵

Table 37.2: The number of child deaths in the Northern Territory since the inception of the CDRPC²⁶⁶

Year	Number of still-births	Number of post-natal deaths						Total
		Under 1 month	1–12 months	1–4 years	5–9 years	10–14 years	15–17 years	
2015	35	15	8	3	1	6	5	73
2014	29	16	2	7	3	8	8	73
2013	44	20	8	7	1	6	10	96
2012	26	11	12	6	4	5	8	72
2011	28	24	14	8	4	5	8	91
2010	33	17	7	5	4	5	5	76
2009	43	17	9	7	4	6	3	89
2008	25	17	11	6	3	6	11	79
2007	30	21	10	4	3	6	9	83
2006	44	19	11	3	4	6	6	93

The CDRPC has made a number of findings in relation to child deaths, not including stillbirths, in the five-year period from 2011 to 2015:²⁶⁷

- Of the 242 child deaths the CDRPC recorded, nearly three-quarters (74.4%) were Aboriginal children despite only making up 41% of children in the Northern Territory.
- More than two-thirds (70.7%) of child deaths involved children residing outside the Greater Darwin area (classed as 'Rest of the NT') despite the fact that the population is similar in both areas.
- More than half (53.3%) of the child deaths occurred within the first 12 months of life. More than two-thirds of those (67%) were neonatal deaths (occurring within a month of birth). Of these neonatal deaths, nearly three-quarters (72.7%) were Aboriginal children. This is substantially higher than for the non-Aboriginal children in that age group (approximately 40%) in the Northern Territory.²⁶⁸
- The distribution of child deaths across other age categories was as follows: 1–4 years (12.8%), 5–9 years (5.4%), 10–14 years (12.4%) and 15–17 years (16.1%).
- There were 162 stillbirths registered in the Northern Territory. Of these, 50% were Aboriginal children and 50% were non-Aboriginal children.
- Nearly a third of child deaths (31.7%; 27 out of 78) were considered preventable.²⁶⁹
- More than a quarter (26%) of reported child deaths involved children who were 'known' to the Department of Children and Families within the three-year period before their death.²⁷⁰

CDRPC research work

One of the CDRPC's key functions is to conduct or sponsor research into child deaths diseases and accidents involving children, and other related matters such as childhood morbidity and mortality.²⁷¹ The CDRPC has, based on a review of its Annual Reports, sponsored three significant research or literature review projects since its inception in 2007. The most important for the purposes of this Commission is *Suicide of Children and Youth in the NT, 2006–2010: Public Release Report for the Child Deaths Review and Prevention Committee* (the 'Menzies Suicide Report').

In May 2011 the CDRPC commissioned the Menzies School of Health Research to conduct research into recent trends in child and youth suicide in the Northern Territory – including the relative influence of factors elevating the risk of suicide and the data linkages that would be necessary to improve the monitoring and evaluation of suicide deaths in the Northern Territory.²⁷² The resulting report was released in late 2011.²⁷³ Youth suicide is also discussed in Chapter 3 (Context and Challenges) of this report.

The Menzies Suicide Report concluded that over four years there had been a sustained increase in the suicide rates for children and young people in the Northern Territory. It also found that although there had been a slight decrease in the very high number of young people aged over 18 who had committed suicide, there had been an increase in suicide deaths for young people under the age of 18. Between 2006 and 2010 there were 18 suicide deaths of people aged under 18 with all but one of these involving Aboriginal children.²⁷⁴

The Menzies Suicide Report also found that:

- the majority of suicide deaths occurred in or near the deceased person's home²⁷⁵
- a significant number of suicide deaths occurred shortly after violence or other conflict with family members or partners.²⁷⁶

The Menzies Suicide Report included 15 recommendations aimed at preventing and reducing the number of suicide deaths.²⁷⁷ At the time of its 2013–14 Annual Report the CDRPC had not received advice from the government as to whether it accepted its recommendations.²⁷⁸

In its 2013–14 Annual Report the CDRPC noted that there had been a further 17 intentional self-harm deaths involving children between 2011 and 2013, almost equal to the number in the preceding four-year period that led to the Menzies Suicide Report. Of the 17 deaths 14 of them involved Aboriginal children, all but two of whom resided outside the Greater Darwin area.²⁷⁹ The CDRPC concluded that child deaths in the Northern Territory as a result of intentional self-harm continued to occur at the high rates identified in the 2011 study, but did not make any recommendations in relation to those observations.²⁸⁰ On the basis of the information before the Commission the current status of the Menzies Suicide Report recommendations remains unclear. Amongst the Menzies Suicide Report recommendations was strengthening injury prevention counselling and education in primary health care, and using targeted education among high-risk groups relating to specific risks to reduce the incidence of childhood injury.

Ongoing and future research

One of the statutory functions of the CDRPC is to monitor the implementation of recommendations arising from its research.²⁸¹

The process for publicly reporting on implementation requires improvement. The CDRPS's Annual Report for 2015–16 makes no reference to previous recommendations, nor does the 2014–15 report. The 2013–14 Annual Report mentions only that there were recommendations arising from the 2012 Menzies Suicide Report and that the government had not notified the CDRPC whether it intended to accept its recommendations. In its 2011–12 Annual Report the CDRPC noted that:

*'The Committee will continue to monitor the implementation of its recommendations to address potentially preventable deaths. In particular, it is seeking a formal response from the new NT Government to the Committee recommendations on preventing child and youth suicide.'*²⁸²

In its 2012–13 report the CDRPC indicated that it would 'continue to monitor the incidence of child suicide in the NT and monitor the response of Government to the Committee's recent recommendations'.²⁸³ The 2010–11 and 2011–12 Annual Reports do not make any references to previous recommendations.

By way of comparison the Commission notes that the NSW Child Death Review Team's Annual Report:

- identifies the NSW Child Death Review Team's observations and any recommendations further to the findings made in reports or research studies, and
- outlines in a separate chapter the results of the NSW Child Death Review Team's monitoring of recommendations made in previous reports and the extent to which those recommendations have been implemented.²⁸⁴

In New South Wales for example, a Child Death Review Team with similar responsibilities to that of the CDRPC is located in the NSW Ombudsman's office.²⁸⁵ The team maintains a register of child deaths, undertakes research and makes recommendations about legislation, policies, practices and services.

One important difference is that the NSW Ombudsman has the power to conduct individual reviews into certain categories of child deaths which includes children in out of home care. One of the recommendations made in the Little Children are Sacred Report was that the CDRPC's terms of reference be expanded to enable 'case specific reviews of serious child abuse cases where the child has survived'.²⁸⁶ Recommendation 4 of the Attorney-General's review of the CDRPC in 2012 however, advised against expanding the power of the CDRPC to include individual reviews.

Recommendation 37.9

The functions of the Child Death Review and Prevention Committee be expanded to include the power to conduct case-specific reviews of serious cases of child abuse in out of home care where the child has survived.

Location of the CDRPC

The evidence before the Commission highlights areas in which improvements can be made to the CDRPC's operations some of which have been previously identified. The Commission considers that by comparison with the equivalent bodies in other states and territories there are shortcomings in the CDRPC's model and operations, including its funding and support, the failure to provide specifically for the review of deaths of children known to the child protection system and its monitoring of recommendations.

The Commission understands that a decision has been made to transfer the administration of the CDRPC to the Coroner's Office, which is scheduled for late 2017.²⁸⁷ The Commission is not confident that transferring the CDRPC to the Coroner's Office is the best option in light of earlier recommendations in this chapter to strengthen and enhance the role of the Office of the Children's Commissioner.

The Commission's view is that any transfer of the CDRPC responsibilities to the Coroner's Office should be delayed pending a decision in relation to the future of the Office of the Children's Commissioner following the report of this Commission. There is a strong case for strengthening the CDRPC and including it more directly within the role of the Children's Commissioner.

Recommendation 37.10

In light of recommendations the Commission has made in relation to the Office of the Children's Commissioner, the Children's Commissioner Act (NT) be amended to provide that the Children's Commissioner is the Convenor of the Child Death Review and Prevention Committee with statutory responsibility for its operations, with the Child Death Review and Prevention Committee adopting a more comprehensive and regular process for reporting on its monitoring of the implementation of recommendations.

CONCLUSION

As this chapter has discussed the Northern Territory consistently with all other Australian jurisdictions, has a number of independent external statutory bodies charged with the oversight of legislation policy and decisions made under policy that affect the health and wellbeing of children. They generally carry out their oversight functions faithful to their respective charters but are hampered in being fully effective by under-resourcing and in some cases, by jurisdictional limitations.

The Commission has made recommendations to address these matters.

Other individuals and groups who are concerned to advocate for children and those on the front line such as foster and kinship carers who act as agents of the state in its protective role, must be given the opportunity to be heard respectfully on administrative decisions without frustrating barriers and delays.

The Commission recognises that Territory Families is also working on developing more practical and streamlined processes that strengthen the mechanisms for internal oversight. It has a responsibility to actively monitor its own compliance with legislation and policy and identify ways for continuous improvement of its own performance. It should not be dependent on external bodies to point out any failings. The ultimate effectiveness will depend on the officers of Territory Families embracing thoughtful criticism and seeing it as a means to improve the delivery of services to the children in their charge. The review teams envisaged in Chapter 5 of the *Care and Protection of Children Act* if established would operate as a beneficial means of drawing together other agencies with an active interest in the wellbeing of children who come into the care of the department.

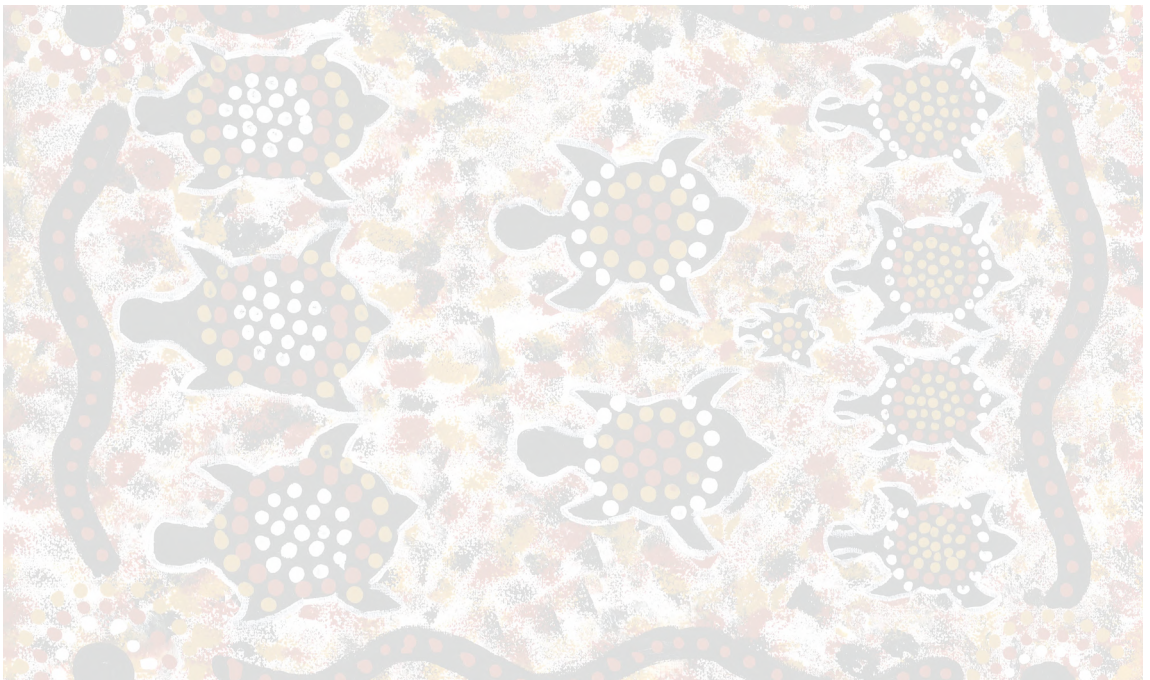


Table 37.3 –Selected Coroner’s inquests into children in care or detention at the time of their death

NAME OF DECEASED	SUMMARY	RECOMMENDATIONS
<p>Madeline Jocelyn Rose Downman (6 June 2014)</p>	<p>In 2014, Maddy, a 17-year-old Aboriginal girl, was found dead at the residential care facility where she lived. The Coroner found that Maddy had committed suicide and that she had a history of mental health issues following her removal from her mother at the age of nine. While she was in care, she had 26 different placements the longest of which lasted just six months. Despite the mental health issues Maddy faced there were significant periods of time where Maddy was not attending counselling appointments. The Coroner found that the Department of Children and Families (DCF) did not take proactive steps to prevent placement breakdown and instability for Maddy and that it failed to properly share or record her history of self-harm.</p>	<p>The Coroner reviewed and referred to DCF’s own review and its failings in the following key areas:</p> <ul style="list-style-type: none"> • protection investigation • delivery of out of home care services • assessment and management of high-risk behaviour • collaboration with other agencies. <p>Ultimately the Coroner made a number of findings regarding DCF’s significant failings which negatively affected the care that should have been provided to Maddy, although he made clear that those failures and errors did not necessarily lead to or contribute to her death.</p> <p>The Coroner recommended that then Minister for Children and Families direct all case managers to provide formal written confirmation of all information exchanged between case managers when a case involving a child in care is handed over. The Coroner also recommended that the recommendations made following the internal reviews be approved and implemented as soon as possible. The Coroner also ‘strongly encouraged’ the Minister for Health to ensure that the department was sufficiently resourced to implement its recommendations.</p>
<p>Baby C (9 January 2013)</p>	<p>Baby C was a six month old Aboriginal baby girl when she died. Before her death Baby C had been placed in foster care following an incident in which she had been left unattended and subsequently shaken by her mother. The Coroner found evidence that Baby C was not well while she was in foster care. The Coroner also found that Baby C had been born prematurely at 32 weeks and had been small from the time she was born.</p>	<p>The Coroner determined that he could not come to a view based on the evidence as to the cause of the death of Baby C but chronic malnutrition was ruled out.</p> <p>The Coroner made no findings or criticisms in relation to the role of the Department of Health, the Department of Children and Families (DCF), the parents or the carer. The carer was 81 years old when she was selected to be Baby C’s carer. However, the Coroner recommended that the Department of Health and DCF work together with foster care agencies to achieve a system where experienced paediatric nurses would be available (by phone or in person) to assist with any health enquiries that a foster carer looking after young babies might have.</p>

NAME OF DECEASED	SUMMARY	RECOMMENDATIONS
<p>Johnno Johnson Wurrarrarba (10 February 2000)</p>	<p>Johnno, an Aboriginal boy from Groote Eylandt was found dead at Don Dale Youth Detention Centre on 10 February 2000. The Coroner found that Johnno had been involved in some crimes during his youth and that the Northern Territory's mandatory sentencing regime had resulted in his incarceration at Done Dale.</p> <p>The Coroner ruled Johnno's death to have been a suicide and noted failures in the centre's management. The Coroner found that Johnno had become disturbed by his time at Don Dale and had indicated that he was hearing voices and that he intended to kill himself. After a minor altercation Johnno had been sent to his room and locked inside. It was there that he committed suicide. The Coroner found that there had been a disorganised response in administering sufficient and appropriate first aid after Johnno was discovered.</p>	<p>The Coroner made wide and sweeping recommendations, including:</p> <ul style="list-style-type: none"> • improving bush courts • improving resources for Aboriginal Legal Aid organisations. <p>The Coroner also made recommendations specific to the detention centre including:</p> <ul style="list-style-type: none"> • providing all staff members at Don Dale with formal training in recognising the risk factors and behaviours of young people that may increase the likelihood of harm • providing formal training to staff members on mental illness • improving staff training on emergency procedures and equipment • improving staff first aid training • providing all staff members with training on the incident protocol • providing all staff members with training on any new system such as emergency telephones • improving room placements at Don Dale • leaving the door open or constantly observing detainees during placement periods • improving record keeping • updating the Don Dale procedure manual to reflect these changes.
<p>Deborah Leanne Melville-Lothian (12 July 2007)</p>	<p>Deborah a 13-year-old Aboriginal girl, died at Royal Darwin Hospital on 12 July 2007. Deborah had been in the care of Family and Community Services (FACS) since 2000 following significant abuse and neglect issues in her immediate family. The Minister for Family and Community Services had authorised her great aunt to be her foster carer. FACS was unaware at the time, but one of her great aunt's own children had previously died while under her care.</p> <p>In the three weeks before her death, Deborah complained of an injury to her leg following a sports day. Despite this injury she was never taken to a doctor or hospital to receive treatment (a matter the Coroner described as 'deplorable neglect'). As a result an infection in her upper thigh led to septicaemia and pyaemia which caused all of her major organs to shut down. The Coroner ruled this to be the cause of death. The Coroner also found serious deficiencies and systemic and individual failures by FACS in the monitoring and review Deborah's placement, which contributed to her death.</p>	<p>The Coroner made recommendations concerning amendments to the <i>Care and Protection of Children Act</i> and accompanying regulations to establish:</p> <ul style="list-style-type: none"> • regular visits by a person authorised by the Chief Executive Officer the basic standards of care to be provided to a child at a placement arrangement • regular reviews of the care plan to assess whether those basic standards are being met • regular court review of protection orders • additional training for FACS staff members on identifying and dealing with issues of cumulative harm • a written handover system between caseworkers that identifies risk factors and areas of concern • an enhanced computerised information system to identify 'red flag' issues • protocols with the police regarding children under placement arrangements, changes to carer application forms to include a full history of children in the applicant's care and provision of sufficient administrative support to enable caseworkers to focus on their core responsibilities of protecting children in care.

NAME OF DECEASED	SUMMARY	RECOMMENDATIONS
Kunmanara Forbes (15 December 2006)	<p>Kunmanara a 15-year-old Aboriginal girl, was found dead in bushland following an argument with her mother. The Coroner ruled the death to be a suicide. The Coroner found that in the six months before her death Kunmanara had been the subject of attention and interest by both Northern Territory Police and FACS. Two of the reasons for this were her 'petrol-sniffing' and the possibility that she was the victim of sexual abuse by adult men. The Coroner found evidence of another suicide attempt four months earlier and evidence that Kunmanara had tested positive to two sexually transmitted infections at the age of 13.</p>	<p>The Coroner made a number of recommendations including that the:</p> <ul style="list-style-type: none"> • Police Commissioner ensure the Coronial Investigation Unit in Alice Springs is appropriately staffed and resourced • Police Commissioner put specific strategies in place to ensure that reportable deaths are investigated in a timely way • Director-General for the Department of Health introduce an Adolescent Health Service within the Northern Territory Department of Health.
(Baby) Kalib (1 June 2005)	<p>Baby Kalib a seven-week-old Caucasian baby boy, was found dead on 1 June 2005. Baby Kalib's mother and siblings were known to FACS from previous notifications and child protection orders. The Coroner found that the mother of baby Kalib had an ongoing history of drug use as well as physical abuse and neglect towards her children as far back as 2000. Baby Kalib's siblings had been in and out of care during this period. The Coroner ruled the primary cause of death to have been 'failure to thrive due to insufficient caloric intake'. The Coroner further found that baby Kalib's death would have been preventable if FACS had acted as they should have. Baby Kalib's mother pleaded guilty to the manslaughter of her child and was sentenced accordingly.</p>	<p>The Coroner noted that FACS and Northern Territory Police had conducted a joint critical incident review into the circumstances concerning baby Kalib's death. Eight recommendations had been made which the Coroner commended.</p> <p>The Coroner noted the establishment of the Child Abuse Task Force in November 2006 and FACS's centralised intake service which had been made operational for 24 hours seven days a week.</p> <p>The Coroner also recommended that adequate resources be provided to fix the problems in FACS's operations in Alice Springs including in relation to systems, staff recruitment, training and support and that the memorandum of understanding between FACS and Northern Territory Police be formally signed off.</p>

ENDNOTES

- ¹ Transcript, Joseph McDowall, 23 June 2017, p. 4938: lines 19-47, Care and Protection of Children Act 2007 (NT) Section 11.
- ² UN General Assembly, Guidelines for the Alternative Care of Children: resolution / adopted by the General Assembly, 24 February 2010, A/RES/64/142, p. 2.
- ³ UN General Assembly, Guidelines for the Alternative Care of Children: resolution / adopted by the General Assembly, 24 February 2010, A/RES/64/142, pp. 18-19, <https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf>.
- ⁴ United Nations Children's Fund, Accountability For Children's Rights: With special attention to social accountability and its potential to achieve results and equity for children, 2015, p. 4.
- ⁵ United Nations Children's Fund, Accountability For Children's Rights: With special attention to social accountability and its potential to achieve results and equity for children, 2015, p. 14.
- ⁶ Submission. Aboriginal Peak Organisations Northern Territory, 31 July 2017, p.117, Submission on Child Protection. Central Australian Aboriginal Legal Aid Service Ltd, July 2017, p.40. In its submission to the Commission, the Aboriginal Peak Organisations Northern Territory (APO NT) argued that Territory Families was under resourced and lacking in internal mechanisms to ensure consistency, transparency and accountability' This was reinforced in the submission made by Central Australian Aboriginal Legal Aid Service (CAALAS). Both also called for greater external oversight in child protection matters.
- ⁷ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, paras 29-30.
- ⁸ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 35.
- ⁹ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 36.
- ¹⁰ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 36.
- ¹¹ Exh.492.002, Annexure LW-2 to statement of Leonie Warburton, 12 May 2017, Monthly Performance Report Template, undated, tendered 2 June 2017.
- ¹² Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 31.
- ¹³ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 31.
- ¹⁴ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 33.
- ¹⁵ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 33.
- ¹⁶ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 34.
- ¹⁷ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 33.
- ¹⁸ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 34.
- ¹⁹ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 12.
- ²⁰ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 67.
- ²¹ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 70.
- ²² Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 12.
- ²³ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 70.
- ²⁴ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 42.
- ²⁵ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 55.
- ²⁶ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 45.
- ²⁷ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 58.
- ²⁸ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 54.
- ²⁹ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 53.
- ³⁰ Exh.553.029, Annexure BT-029 to Statement of Bronwyn Thompson, 9 June 2017, tendered 22 June 2017, p. 1.
- ³¹ Exh.553.029, Annexure BT-029 to Statement of Bronwyn Thompson, 9 June 2017, tendered 22 June 2017, p.1.
- ³² Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 47.
- ³³ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 15.
- ³⁴ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 15.
- ³⁵ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 16.
- ³⁶ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 60.
- ³⁷ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, paras 60-63.
- ³⁸ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 93.
- ³⁹ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 97.
- ⁴⁰ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 97.
- ⁴¹ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, paras 100-101.
- ⁴² Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 184.
- ⁴³ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, paras 183-186.
- ⁴⁴ Exh.618.000, Territory Families, Annual Report 2015-16, tendered 28 June 2017, p. 40.
- ⁴⁵ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 67.
- ⁴⁶ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 69.
- ⁴⁷ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, paras 70-71.
- ⁴⁸ Exh.492.000, Annexure LW-7 to Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, pp. 1-2.
- ⁴⁹ Exh.492.000, Annexure LW-7 to Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, pp. 1-2.
- ⁵⁰ Exh.492.000, Annexure LW-7 to Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, pp. 1-2.
- ⁵¹ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 75.
- ⁵² Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, paras 82-85.

- ⁵³ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 86.
- ⁵⁴ Exh.476.000, Statement of Marnie Couch, 18 May 2017, tendered 31 May 2017, paras 70-73.
- ⁵⁵ Exh.476.000, Statement of Marnie Couch, 18 May 2017, tendered 31 May 2017, para. 73.
- ⁵⁶ Exh.476.000, Statement of Marnie Couch, 18 May 2017, tendered 31 May 2017, para. 73.
- ⁵⁷ Exh.476.000, Statement of Marnie Couch, 18 May 2017, tendered 31 May 2017, para. 74.
- ⁵⁸ Care and Protection of Children Act NT 2007, s.294(b).
- ⁵⁹ Care and Protection of Children Act NT 2007, s.12(1).
- ⁶⁰ Care and Protection of Children Act NT 2007, s.296.
- ⁶¹ Care and Protection of Children Act NT 2007, s.297.
- ⁶² Care and Protection of Children Act NT 2007, s.298.
- ⁶³ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para 19.
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- ⁸⁰ Exh.492.013, Annexure LW-13 to Statement of Leonie Warburton, Policy: Complaints Management, 24 February 2017, tendered 2 June 2017, p. 1.
- ⁸¹ Exh.492.013, Annexure LW-13 to Statement of Leonie Warburton, Policy: Complaints Management, 24 February 2017, tendered 2 June 2017, p. 1.
- ⁸² Exh.492.013, Annexure LW-13 to Statement of Leonie Warburton, Policy: Complaints Management, 24 February 2017, tendered 2 June 2017, p. 1.
- ⁸³ Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, paras 103-104.
- ⁸⁴ Transcript, Leonie Warburton, 22 June 2017, p. 4807: line 46 – p. 4808: line 8.
- ⁸⁵ Transcript, Ann Owen, 23 June 2017, p. 4940: lines 40-47.
- ⁸⁶ Transcript, Ann Owen, 23 June 2017, p. 4940: lines 40-47.
- ⁸⁷ Exh.571.000, Statement of Ann Owen, 23 May 2017, tendered 23 June 2017, paras 32, 74.
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- ¹⁶³ Exh.010.001, Statement of Carolyn Richards, 7 October 2016, tendered 11 October 2016, para. 29.
- ¹⁶⁴ Exh.016.001, Statement of Colleen Gwynne, 7 October 2016, tendered 12 October 2017, para. 13.
- ¹⁶⁵ Exh.520.000, Statement of Colleen Gwynne, 29 May 2017, tendered 19 June 2017, para. 77.
- ¹⁶⁶ Exh.016.001, Statement of Colleen Gwynne, 7 October 2016, tendered on 12 October 2017, para. 39.
- ¹⁶⁷ Transcript, Colleen Gwynne, 19 June 2017, p. 4486: lines 39-44; p. 4487: line 40-43.
- ¹⁶⁸ Transcript, Colleen Gwynne, 19 June 2017, p. 4487: lines 15-25.
- ¹⁶⁹ Transcript, Colleen Gwynne, 19 June 2017, p. 4491: lines 27-29.
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The Commission has been informed that from 25 July 2017, the Assistant Children's Commissioner has delegated authority under s. 51(1) of the Children's Commissioner Act 2013 (NT), which allows the Children's Commissioner to delegate to a person any of the Commissioner's powers or functions under the Act. The delegated sections include ss. 23, 25, 28(1)-(3), 34 and 35. The Children's Commissioner also delegated authority to the Coordinator of Complaints and Investigation (ss. 23(2), 25, 28(1)-(3), 34 and 35) and the Complaints and Investigation Officer (ss. 23(2), 25, 28(2)-(3), 34 and 35); Exh.814.001, Delegation, 25 July 2017, tendered 25 October 2017.
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- 229 Cf. A child who is no longer in the care of the child protection services, but who was previously known to child protection (see, for example, Commission for Children and Young People Act 2012 (Vic), s. 34)
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- 244 Inquest into the death of Baby C [2014] NTMC 017, para 78.
- 245 Exh.492.000, Statement of Leonie Warburton, 12 May 2017, tendered 2 June 2017, para. 174.
- 246 Exh.492.019, Annexure LW-19 to Statement of Leonie Warburton, undated, tendered 2 June 2017, p. 2.
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- ²⁶⁸ Exh.522.000, Office of the Children's Commissioner Northern Territory, 2016, Northern Territory Child Deaths Review and Prevention Committee Annual Report 2015-16, Northern Territory Government, Darwin, tendered 19 June 2017, p. 18.
- ²⁶⁹ Preventable deaths included those caused by car accidents as an occupant; accidents as a pedal cyclist or pedestrian; accidental poisoning to gas and other vapours; assault by hanging, strangulation, suffocation, knife or a sharp object by a parent; accidental hanging, strangling, drowning and submersion; exposure to uncontrolled fire; inhalation and ingestion of food or other objects; and intentional self-harm by hanging.
- ²⁷⁰ A child is considered to be 'known' to the child protection system if an 'action' has been taken under Chapter 2 of the Care and Protection of Children Act 2007 (NT) to safeguard the wellbeing of the child. An action can involve receiving or assessing a child abuse notification; child protection investigations; the undertaking of protective assessments; the provision of family support services; the taking out of statutory child protection orders; or the placement of a child into care.
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EARLY SUPPORT

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EARLY SUPPORT

INTRODUCTION

The Commission is aware that there are many children in the Northern Territory whose life opportunities are compromised by a complex layering of pervasive disadvantage, poverty and overcrowding, poor parental mental health, substance misuse and family or community violence.¹ For Aboriginal children, this adversity is compounded by intergenerational trauma, erosion of culture and a lack of access to early childhood, education and family supports that children and their families in other parts of Australia take for granted.

The 'epidemic' of child abuse and neglect in the Northern Territory urgently demands a public health response,² of which prevention and early support are fundamental components. Expert witnesses, Aboriginal controlled organisations, government officials and community members endorsed a public health approach as the way forward in preventing child abuse and neglect in the Northern Territory.³ As the Northern Territory Children's Commissioner told the Commission:

*'Traditionally, our response to child abuse and neglect has been really around systems and we've based it on systems for many years and then we keep refining systems and it doesn't really get us anywhere. My view is that unless we take an approach akin to a public health approach... if we think about child abuse and neglect, the same as we think about public health, like cancer and the range of public health issues, and apply the same rigor and regard to child abuse and neglect, then it's going to lead us to a different response.'*⁴

Early support and prevention measures have gained increasing currency in the area of child protection, providing a conceptual framework for creating more preventive and collaborative systems for protecting all children.⁵ This approach recognises that there is a complex interplay of problems that lead to the abuse and neglect of children.

A public health approach was proposed and outlined in detail by the 2010 Board of Inquiry.⁶ The Commission heard evidence that the Northern Territory Government was initially committed

to implementing the Board of Inquiry recommendations. However, by 2012 it is clear there was a decision by the incoming government to not proceed with this approach due to fiscal considerations.⁷

Today, the statutory child protection system continues to be overburdened. While the 2010 Board of Inquiry's public health approach remains fundamentally sound, the Commission was told it needs to be revisited with an updated understanding of the characteristics and extent of child abuse and neglect.⁸ Early support and prevention cannot be the sole responsibility of the statutory child protection agency. The responsibility for early support service provision is a whole of government responsibility involving programs and services across multiple government departments such as the Department of Housing and Community Development, the Department of Health and the Department of Education.

EARLY SUPPORT AND PREVENTION

The primary goal for an effective child protection system is that it is pre-emptive rather than reactive, attempting to prevent harm and the risk of harm rather than reacting once risk factors present. It should be an evidence based system that is tailored to local needs.⁹ In the Northern Territory prevention efforts must be coordinated across government agencies, the Aboriginal controlled health sector, the non-government sector and local communities.

In this context, early support can be defined as *'strategies or programmes that avert or delay the onset or severity of health, mental health or social problems'*. A comprehensive early support and prevention model requires three levels of intervention: primary, secondary and tertiary.¹⁰ The first two levels are categories of support available universally or selectively applied to target groups with elevated risk.¹¹ The three tiers of intervention involve:

Primary Prevention: a range of services and programs available to all children, young people, families and communities. They are also known as *'universal'* or *'core'* interventions. Broadly, these interventions focus on policy and legal reforms that alleviate social inequalities.¹² At a service delivery level, they may include early childhood services to promote healthy child development, home visiting programs to support all new parents, parenting programs for all new parents, or community education to raise awareness about nutrition and hygiene.

Secondary Prevention: a range of strategies services and programs targeted to vulnerable or *'at risk'* children, families or communities to identify and target the complex and often inter-related risk factors that underlie child abuse and neglect. They are also known as *'targeted'* or *'early'* interventions or supports. These programs and services are available to children, young people and their families, before the point of notification to the statutory child protection agency.¹³ They should be non-stigmatising and have *'soft'* entry points. This means services such as health, education and police can refer directly into them or families can refer themselves. Example of such service might be:

- prenatal home visiting services to support and educate young mothers
- therapeutic health services for parents experiencing substance misuse
- therapeutic group work programs for preschool and primary school children exhibiting behavioural difficulties
- youth outreach, and
- family support programs.

Tertiary intervention: a range of strategies, programs and services intensively targeted to children and their families, once abuse and neglect has occurred to prevent reoccurrence and minimise

harm. This level includes services provided as part of the statutory process, including intensive family support services and the removal of a child.

It is the view of the Commission that effective early support and prevention in the Northern Territory should be the highest priority of programs targeting children and families. This requires a system that:

- identifies vulnerable children and families before any risk of harm escalates to the level of a notification
- assesses, on an early and ongoing basis, the type and degree of risk factors present in the life of a child with effective mechanisms for sharing relevant information and program and agency co-ordination to accurately match the child's needs with the appropriate intervention and
- has the relevant support and services readily accessible and available for a sustained response.

An effective early support and prevention system must have capacity to identify and support families who have low to moderate risk factors present, at the earliest possible opportunity. It is important that a notification or subsequent investigation by the statutory agency is not the sole trigger for a service or support response and that agencies work in collaboration to provide early support and preventive services to families who require them.

A part of achieving this is implementing a 'no wrong door' framework for service provision. The methods of assessment and referral pathways within the system should be sufficiently sophisticated so that irrespective of how a relevant risk to a child is identified or the nature of that risk, the system is able effectively to match the risk factor to the most appropriate support. For the system to be effective there must also be adequate geographic coverage to ensure all communities in the Territory have access to preventive services commensurate to their needs. This is particularly important in the Northern Territory, given the distances and remoteness of many communities.

The Commission proposes a model of a place-based approach that uses soft entry points to services, as opposed to a notification in the statutory system, to ensure a community level nexus between the assessment of risk or need and appropriate service provision. For example, the community relationships parents might have with a local doctor, nurse, teacher, social worker or sporting coach could be utilised as networks through which to encourage families to engage in relevant services or be referred to the most appropriate providers. This relies on these professionals having the training and skills to identify when a referral might be needed, the knowledge of where to make a referral and for some of them, the capacity to provide follow up.¹⁴

None of this can be fully achieved without an effective information sharing network, the establishment of which is an essential precondition to implementing an early support and prevention system.

National Framework for Protecting Australia's Children 2009-2020

At a national level, the importance of early support has been acknowledged in the *National Framework for Protecting Australia's Children 2009-2020*, which has a particular focus on the first 1000 days for a child.¹⁵ Action areas under Strategy 1 include:

- increasing awareness of the importance of child development and parenting and normalising families asking for help
- improving access to evidence based family support services for expectant, new and vulnerable parents where substance misuse, mental health and domestic and family violence co-occur and

-
- implementing joined up responses for families with young children across agencies and sectors.¹⁶ The Commonwealth reports that it is working collaboratively with Aboriginal and Torres Strait Islander organisations and communities through SNAICC – National Voice for Our Children (Secretariat of National Aboriginal and Islander Child Care).¹⁷

The Commission was told that Community Services Ministers have announced a reform agenda with respect to early support and Aboriginal and Torres Strait Islander families and children.¹⁸ This is reflected in the Community Services Ministers consideration of a set of Early Intervention Principles that will underpin tangible actions for all jurisdictions.¹⁹

System Reorientation – Other Jurisdictions

Recent inquiries within Australia strongly advocate for system reorientation that places greater emphasis on early support and prevention services for families, delivered outside of the statutory system. Those inquiries included *Always was, always will be Koori children: Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria* (2016),²⁰ the *Child Protection Systems Royal Commission, South Australia* (2016)²¹ and *Queensland Child Protection Commission of Inquiry* (2013).²² A system reorientation requires growing the evidence base about the services that families need, where they need them, and which services are most likely to work. This data can then be used to systematically plan services state-wide.

Internationally, New Zealand has introduced fundamental reforms to better support vulnerable families. These reforms attempt to reorientate the system to have a stronger focus on children and strengthening culture.

The Systemic Inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria, *Always was, always will be Koori children* (2016) identified that rigorous data analysis can inform service system planning and reform. The inquiry drew largely on Taskforce 1000, an action research project, which reviewed the cases and life stories of 980 Aboriginal children in out-of-home care. It found overwhelmingly that Aboriginal children are entering care as a result of family violence and parental substance abuse,²³ requiring targeted responses to address those concerns and the associated issues of parental functioning, child abuse and neglect. It concluded the Aboriginal community controlled sector lacked sufficient resourcing for early years programs to provide this support and reduce the growing number of Aboriginal children entering the out-of-home care systems.

Andrew Jackomos, Victorian Aboriginal Commissioner for Children and Young People gave evidence to the Commission of the importance of early support and prevention services provided by Aboriginal community controlled organisations. Wrap-around early support services in the local community were seen to reduce the likelihood of Aboriginal children being removed in the first place. Commissioner Jackomos highlighted that access to Aboriginal health services is not just about supporting the literal health of the children. They also form important cultural hubs where Aboriginal children can go and play safely with each other.²⁴

'We have an excellent model run by Mallee District Aboriginal Services... that have developed a model of wrap around services so a young mum, expecting mum, she walks through that one door and in that corridor there are dental hygiene, there's family violence, there's perpetrator programs, there's accommodation, there's family services, and by wrapping around those services... has significantly reduced children being removed. It's fundamental. It's where people can trust the – going there and that's why

I believe that children transitioned back to our Aboriginal community organisations that have those wrap around services will not only prevent children being removed, because the work that they do in growing strong families will also return children home quicker by working with the families.²⁵

In response to recommendations made in the Royal Commission Report *The life they deserve*, the South Australian Government has invested \$12 million to create the Early Intervention Research Directorate (EIRD). Based within the Department of the Premier and Cabinet, the EIRD will lead the development of data, monitoring and evaluation systems to better understand where and what services are needed to support vulnerable families to prevent children entering the child protection system.²⁶

The Directorate has a specific focus on Aboriginal children and families. This work will aim to reduce the over-representation of Aboriginal children in South Australia's child protection system through enhanced understanding and culturally suitable approaches to early support and prevention. The Directorate's work will inform future funding decisions through its collaborative research and evaluation program. It will develop and manage an ongoing evaluation framework, using existing data and new analytic tools to measure programs and services against desired outcomes. This approach will not only deliver strong outcomes for the child development system, but will also improve the use of new data systems.

Recently, the Queensland Government in partnership with Family Matters and community organisations released *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families* and *Changing Tracks: An action plan for Aboriginal and Torres Strait Islander children and families*. Guided by Aboriginal and Torres Strait Islander perspectives, *Our Way* outlines an approach, across twenty years, to work differently together to improve life opportunities for vulnerable Aboriginal and Torres Strait Islander children and families.

RISK AND PROTECTIVE FACTORS FOR CHILD ABUSE AND NEGLECT

A number of high profile public inquiries have put the spotlight on the abuse and neglect of children in the Northern Territory.²⁷ These inquiries have made comprehensive recommendations to address the failings of the Northern Territory child protection system through investment in prevention and early support to address identified risk factors. The *Growing them strong, together – Promoting the Safety and Wellbeing of the Northern Territory's Children – Report of the Board of Inquiry into the Child Protection System in the Northern Territory* (BOI report) provided a comprehensive analysis of the risk factors for abuse and neglect,²⁸ categorised in Table 38.1.



Table 38.1: Risk factors identified by the Board of Inquiry for child abuse and neglect²⁹

Category	Risk factors
Economic factors	Poverty, unemployment, overcrowded or unstable housing
Social factors	Racism, discrimination, social isolation and exclusion
Community factors	Dangerous, disadvantaged or socially excluded communities, communities who have lost many community members
Parental factors	Mental health, substance abuse, family/domestic violence, learning difficulties, parental anger, strong beliefs in corporal punishment, transgenerational trauma and its impact on parenting, lower levels of empathy
Child characteristics	Low birth weight, special needs, difficult temperament, behavioural problems
Family characteristics	Poor relationships, large number of children, single or early parenthood
Ecological factors, environmental toxins	Violence, gambling, pervasiveness of unresolved grief, loss and trauma, previous experiences of abuse or neglect – for parents or children
Abuse or neglect	Previous experiences of abuse or neglect

The 2010 Board of Inquiry recommended developing an integrated framework for promoting the safety and wellbeing of children in the Northern Territory. However, that framework was not realised and many of the recommendations required to create it were not implemented: see Chapter 30 (The child protection landscape).

Some of the recommendations that were not fully implemented were:

- Recommendation 9: Northern Territory Government to explore “on-community” therapeutic options for families
- Recommendation 10: Significant investment in therapeutic and preventative services for at risk children and communities
- Recommendation 11: Strategic review with Commonwealth on Child and Family Wellbeing services
- Recommendation 117: Delivery of a dual pathways approach, development and extension of Community Child Safety Wellbeing Teams and new CCSW Centres.

These recommendations were attempts at providing support to families before the necessity of statutory intervention arose. Measures such as a strategic review with the Commonwealth government around service planning to overcome any fragmentation and duplication of service delivery and the creation of child wellbeing centres around the Northern Territory were vital then, and remain necessary now, in order to meaningfully assist children and families before they enter the statutory child protection system.

The categories of harm identified by the Board of Inquiry and the evidence before the Commission about the relevant risk factors in the Northern Territory underlines the complexity and diversity of issues required to be addressed by the early support and prevention framework.³⁰ Exposure to risk factors is cumulative - the more risk factors in a child's life, the greater the chance that they will experience maltreatment.³¹

The Commission understands, however, that the presence of risk factors does not, of itself, mean that the child has been or will be exposed to abuse or neglect.³² Every family situation will vary and there may be protective factors present that strengthen the resilience of families and their capacity to support the healthy development of children. They can serve as safeguards that help parents find resources or supports and encourage coping strategies that allow them to parent effectively, even under difficult circumstances.³³ These include connection to culture, country and kinship networks. Just as risk factors do not cause abuse and neglect, the presence of protective factors does not guarantee that a child will be kept safe.

The most common reason Aboriginal children are removed from their families is neglect and the child protection system needs to prioritise that concern. Professor Leah Bromfield told the Commission:

*'The very nature of neglect is not that a child has not had their lunch once, it's that a child is persistently hungry; that their ear infections are persistently untreated, causing hearing loss. It's that they have persistently not had an adult interact with them and so they have poor speech development, they have poor attachment... But none of those things are likely to trigger a system to say we must get out there within four hours, because there's an imminent risk. But it doesn't change the fact that that child, if they are experiencing chronic neglect, is at great risk of harm...And we have a system that is not designed to respond early to prevent child neglect and those cumulative impacts.'*³⁴

Professor Frank Oberklaid clarified that any effort to identify definitive causes of child abuse and neglect is complicated by the interrelatedness of factors:

*'We see services for family violence, for depression, for alcohol abuse; we see services to improve children's behaviour, to improve language. They're fine, but the problem is if you've got one problem or risk factor, you've often got others as well.'*³⁵

Risk factors when considered in isolation may not indicate that a child is at 'at risk', but when examined in combination may indicate cumulative harm. The ability to identify cumulative risks early and meet those risks with appropriate supports effectively is essential in avoiding a child protection system that inevitably defaults to crisis responses.

*'The Australian child protection model is 'protection' oriented with a focus on crisis or tertiary intervention. Because of this it can be experienced as an adversarial and punitive process for children and families.'*³⁶

One example that emphasises the necessity of effective prevention and early support is the emerging identification and treatment of fetal alcohol spectrum disorders (FASD). FASD is an umbrella term to describe a spectrum of conditions caused by fetal alcohol exposure during pregnancy³⁷ and is recognised as the most common cause of intellectual disability in the Western world.³⁸

*'...FASD and early life psychological trauma truly are a sleeping giant within the child protection and justice systems in the Northern Territory and in other places, and they are a potent driver of engagement of young people in these systems.'*³⁹

The Commission notes in this respect that the provision of high quality prenatal care for mothers and infants will set a foundation for a child which can last a lifetime.⁴⁰ Professor Oberklaid told the Commission:

*'I think we have to start from the time of conception, even before the child is born. There's pretty good evidence now of a link between what happens in utero to the foetus and later development. And I think the very best example of that is foetal alcohol syndrome. If a pregnant woman drinks during pregnancy, that can have a very deleterious effect – the newborn baby and then, indeed, right through life. That has been very well established. But even more subtle things, like smoking during pregnancy or not getting good medical care, they can affect your own foetus as well.'*⁴¹

The Australian Early Development Index Census National Report 2015 highlighted that nearly a quarter of children aged between 5 – 6 years old in the Northern Territory were developmentally vulnerable in two or more domains of early childhood development,⁴² compared to 11% nationally.⁴³

Dr Howard Bath, Chair of the 2010 Board of Inquiry, cautioned that there is a need to have a preventive mindset if the numbers of children entering the child protection system are to be reduced.⁴⁴

Understanding the causes and effects of risk and protective factors enables the development of both universal and targeted approaches to reducing the incidence of child abuse and neglect.⁴⁵ The wide range of socio-economic issues to be addressed must be filtered to avoid assumptions that all communities will have similar problems, when in reality the relevant issues may well differ. Chapter 3 (Context and challenges) provides a more detailed discussion of the challenges facing children and families in the Northern Territory.

ADDRESSING THE RISK FACTORS

The Commission, like the Board of Inquiry, is of the view that a public health approach will be the best means of averting or mitigating at an early stage the relevant risks posed to children, and remains the preferable model of service delivery. A public health approach to child protection shifts the focus to a service system that provides early support to children and families to prevent entry into the statutory child protection system. This support includes core, universal services to all families and targeted support to vulnerable families. Additionally, such an approach must not only address the spectrum of supports and services needed to promote the safety and wellbeing of children, but also the differing levels of willingness and capacity of individuals to access and receive those supports and services.

Public health efforts systematically examine causes and consequences of problems, based on a clear understanding of prevalence, to design a system of strategies, programs and services, commonly known as 'interventions'. Central to a public health approach is its emphasis on prevention, early support and the importance of collective action.⁴⁶

Public health approaches have been successfully applied to addressing complex health issues that require sustained, multi-prong strategies that can adapt to changes over time. These approaches have shown that co-operative efforts from diverse sectors such as health, education, social services, justice and policy are necessary to solve what are usually assumed to be purely 'medical' problems.⁴⁷



Population: 606

Aboriginal Population: 545 (90%)

Children and young people 0 - 19 years: 284(47%)

Services listed in the Government Services Lists as being available in Lajamanu at some point between 2014 to 2017:

- Families as First Teachers

Picture sourced from the Northern Territory Land Information Systems (NTLIS). List based on information provided by the Commonwealth and Northern Territory Governments, noting the limitations provided by both the Commonwealth and Northern Territory that it may not be complete or current. Population statistics taken from ABS: 2016 (SA1). The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

In applying a public health approach in the Northern Territory careful consideration is necessary to ensure early support and prevention services are provided to the people who require these services and that the services can actually reach the people who need them. Fly in, fly out services have been identified as a particular barrier for effective service provision in Aboriginal remote communities.⁴⁸ Issues associated with fly in, fly out services include that those services may not be available when needed and that access can be infrequent, sporadic and impersonal.⁴⁹ To address the shortcomings of fly in fly out services, there needs to be greater focus on developing the local service sector capacity through place based approaches.⁵⁰

A key rationale for prevention strategies is the long term cost benefit of addressing the causes, rather than just the effects, of child harm. Although increased initial investment may be required, there are a range of direct and indirect positive social effects and economic savings that flow on from adopting protective over merely curative measures. Professor Oberklaid told the Commission:

'Increasingly we're seeing an economic focus on early childhood and on prevention.... If you just care about the economics, it just makes...so much more sense economically

to prevent and intervene early. And increasingly we're seeing interest by economists, World Bank, WHO [World Health Organisation], all around the world arguing for prevention – increased attention to early intervention."⁵¹

The National Framework for Protecting Australia's Children states:

*'Just as a health system is more than hospitals so a system for the protection of children is more than a statutory child protection service.'*⁵²

EARLY SUPPORT - THE CURRENT POSITION

Various early support and prevention services which do not form part of the statutory child protection system, are currently delivered separately by a number of government departments, both Commonwealth and Northern Territory, non-government organisations and Aboriginal controlled health and community organisations.

The obvious risk which arises from so many disparate entities providing assorted services is that the result can be uncoordinated and inefficient. It will fail to maximise the outcomes of the resources expended and fail to maximise service reach, population coverage, or discrete service areas. The evidence before the Commission suggests that much energy and resources have been expended in the past ten years in attempting to provide early support services of various kinds, in various ways, across the Northern Territory. But the focus on the means of service delivery must not obscure the end result required, which is to ensure a cohesive and comprehensive framework that delivers the specific services needed to the children and families who need them. That end cannot be achieved without central co-ordination, and accurate and current information as to the particular needs of the local communities and what supports are currently in place.

The Commission sought to examine these issues in the first place by establishing what services were being delivered in the Northern Territory, where, and to whom. The Board of Inquiry in 2010 tried to conduct the same exercise in the absence of any composite information about services and their availability. The Board of Inquiry set out its findings in Appendix 6.1. Examples of services they found to be provided then included:

- at Kintore, a Volatile Substance Abuse Worker
- at Lajamanu, Families as First Teachers, a Women's Safe Place, a crèche, Communities for Children and an Indigenous Parenting Support Service, and
- at Maningrida, Integrated Child and Family Centre, Families as First Teachers, Maningrida Child Safety Service, Remote Community Education & Alcohol Management Planning (RAMP), Women's Safe Place, Men's Cooling off Place, Remote Area Health Services, a crèche, and Indigenous Parenting Support Service.⁵³

In order to assess the reach and delivery of early support and prevention services the Commission asked both the Northern Territory Government and the Commonwealth Government to provide an updated version of the Board of Inquiry table identifying services. The Commission asked the governments to list services which they provided or funded at the listed locations throughout the Northern Territory, in relation to families and children.

Both the Commonwealth and Northern Territory Governments took steps to compile information for the Commission, to the extent that they could, and each provided a list of services to the Commission in the form of a spreadsheet or table (the Government Services Lists).

Each qualified the information provided, cautioning that it may have inaccuracies or be incomplete, given the time available for the task.⁵⁴ The Commonwealth Government advised it did not maintain a comprehensive list of service relating to children and families.⁵⁵

Government Services Lists

The Commission reviewed the Service Lists which included many programs and activities listed by each of the Commonwealth and Northern Territory Governments. In particular, it sought to identify the range of programs and services that related to early support for children and families, and where those programs and services were available in the Northern Territory.

In assessing whether a program related to early support for vulnerable children and families, the Commission sought to identify programs and services that directly or indirectly targeted one or more of the risk or protective factors associated with child abuse and neglect, as discussed above. Those risk and protective factors were: parental mental illness, parental substance misuse, family violence, housing programs for vulnerable families, parenting skills, early childhood support, school attendance support, and maternal and infant health. Primary health and housing programs were excluded unless they focused specifically on vulnerable families.

However, the programs and services in the Commonwealth and Northern Territory Services Lists could not always be readily compartmentalised. Programs and services may indirectly target multiple risk and protective factors for vulnerable children, young people and families. For example, some homelessness services may also address mental health and substance misuse issues or early childhood services also provide parenting support. This highlights the interrelatedness of risk factors that underpin child abuse and neglect and the necessity for careful record-keeping and data collection to account for precisely what funding has been allocated to address which risks and needs.

In the process of identifying early support programs and services from the Commonwealth Services List, the Commission only included direct expenditure from the Commonwealth and excluded any funding provided by the Commonwealth to the Northern Territory Government for services to be delivered by the Northern Territory Government. Examples of exclusions are funding provided under National Partnership Agreements, including Stronger Futures in the Northern Territory and Northern Territory Remote Aboriginal Investment.

After identifying the early support programs and services from both Services Lists, the Commission also sought to identify which of the services and programs were delivered by an Aboriginal Community Controlled organisation or a mainstream organisation, and whether delivery was targeted at Aboriginal people or communities with majority Aboriginal populations.

Both Services Lists included the location of programs and services where that information was available from departmental systems or where larger numbers of communities received the service. In order to enable a potential geographic analysis the Commission undertook additional research to identify the location of various programs and services.

The Commission does consider that a directory bringing together information about available services would be desirable to enable each government to effectively plan, assess and audit the outcomes of program and service delivery funded by Commonwealth and Territory agencies. The absence of any central directory would also make it difficult for organisations outside government to know the service framework in which they were operating.

Commonwealth Government Services Information

The Commonwealth Services List illustrated the striking complexity in the funding and service delivery arrangements surrounding child protection and youth justice programs in the Northern Territory. The Commonwealth Services List identified approximately 2,000 separate activities delivered by at least 20 separate Northern Territory Government departments and agencies and more than 450 non-government organisations; administered by 13 separate Commonwealth agencies and organised into at least 200 separate programs.⁵⁶ The Commonwealth provides extensive programs in a number of different areas, including drug and alcohol services, family and parenting programs, school nutrition programs, nurse family partnership programs and early childhood services.

The activities were administered by a number of Commonwealth departments, which included:

- the Department of Prime Minister and Cabinet
- the Attorney-General's Department
- the Department of Social Services
- the Department of Health
- the Department of Education
- the Department of Infrastructure and Regional Development
- the Department of Industry, Innovation and Science
- the Department of Environment and Energy, and
- the Department of Communications and the Arts.

The Commission has selected some examples of the various programs and services provided by various Commonwealth Departments and the location of those programs along with amount of funding allocated to them, which are set out in Table 31.3.

An important limitation on the information is that while locations have been identified as being covered by a program, it is not clear how those programs are provided within communities, i.e. by those who reside within the community, by regular regional visits or on a fly in fly out basis (see below the section on the need for place based programs). For example, while the North Australian Aboriginal Justice Agency is listed in the table as being a program that is delivered in Maningrida this program is delivered as an outreach service and does not have a permanent presence in Maningrida.⁵⁷

Northern Territory Government Services Information

The Northern Territory Government provided the Commission with an updated version of Table 6.1 from the Board of Inquiry (**the NTG Services List**). The NTG Services List detailed programs and services delivered by various Northern Territory Government Departments, including:

- Territory Families
- the Department of Housing and Community Development
- the Department of the Attorney-General and Justice
- the Department of Education
- the Department of Health
- the Department of Trade, Business and Innovation
- the Department of Tourism and Culture
- the Police, and
- the City of Darwin.

The NTG Services List outlined the early support programs that were, or had been, available in communities across the Northern Territory at some point during 2014 to 2017 and included for each location:

- the programs available
- the target age group for the service
- the service provider
- the agency that funded the service
- funding information, where possible, and
- whether the program was universal, secondary or tertiary.

The NTG Services List included information about various Commonwealth programs, and included information about programs provided by non-government organisations.

There were 1,031 activities identified in the NTG Services List. However, some programs did not include information about whether they were currently funded or if funding had ceased and as a result it was not possible for the Commission to identify the activities currently funded.⁵⁸ It appeared from the information provided to the Commission, in terms of the overall number of programs and services funded, that early childhood, family violence and maternal and infant health programs were the dominant programs.⁵⁹ Other programs and services funded relate to addressing housing/homelessness, youth services, parenting services, alcohol and other drugs, and mental health and social emotional wellbeing.⁶⁰

The Commission has selected some examples of the various programs and services listed by the Northern Territory Government and the location of those programs along with amount of funding allocated to them, which are set out in Table 38.4.⁶¹ The Commission accepts there are significant limitations in the information, given the time available to compile the data.

Lack of co-ordination of services

Despite the extensive number of services being funded and delivered by or for the Commonwealth or Northern Territory Governments, often in the same location, the Commission is not aware of any overall framework for co-ordination between the Northern Territory and the Commonwealth with respect to service selection, design or planning. Lack of co-ordination of services for early support and prevention services in the Northern Territory has been a consistent theme that has emerged in a number of reports.⁶²

The 2010 *Board of Inquiry* also reported a difficulty in identifying what services the Commonwealth funded, what the Northern Territory funded and what the funding arrangements were between the two.⁶³ It observed that different agencies were being funded to provide similar services in the same location rather than providing complementary services along a continuum of care to meet the needs of families and communities.⁶⁴

The Board of Inquiry recommended that the Northern Territory Government, in cooperation with the Commonwealth, undertake a strategic review of child and family wellbeing services in the Northern Territory and develop and implement a joint strategic plan around service planning and funding.⁶⁵ This recommendation was not implemented.

In 2012, the lack of a shared strategy, coordination and resulting inconsistency of service delivery was again identified by the Northern Territory Coordinator-General for Remote Services.⁶⁶

The Coordinator-General noted that funding was *'highly fragmented, complex and administratively burdensome'* and that a major issue was the *'level and proportion of investment in crisis/tertiary programs rather than prevention and early intervention.'*⁶⁷ It was concluded that there was *'little, if any, evidence that existing small-scale, fragmented early childhood initiatives will produce any improvements in the development and wellbeing of children'*.⁶⁸

The concerns about a lack of co-ordination between the Commonwealth and Northern Territory Governments in the provision of services also emerged from consultations with a wide range of stakeholders involved in the early support and prevention services sector, carried out as a part of a project Deloitte has recently undertaken for Territory Families, examining the move to a Dual Pathways Model.⁶⁹ During 2017 Deloitte engaged in extensive consultation and held eight design labs across five locations (Nhulunbuy, Darwin, Katherine, Tennant Creek and Alice Springs) with 118 participants from non-government organisations, Aboriginal controlled organisations, Northern Territory Government staff (from Territory Families, Police, Health and Education) and Commonwealth Government staff.⁷⁰ Deloitte also engaged in individual consultations with relevant stakeholders of the sector.⁷¹

A key theme which emerged was that co-ordination between services and service providers needed to be improved across the sector. The report of the consultations (the Dual Pathways report) said *'Workshop and survey participants described many situations where families were visited by multiple organisations at the same time, each with no knowledge of the other.'*⁷²

The Dual Pathways report also said:

'A lack of service co-ordination and case management across the sector is giving communities a disjointed service response that hinders the services provided and the willingness of families to participate.

*Currently there are multiple, unrelated points of entry and contact for Family and Parenting support. This means that families are accessing services from a host of organisations in a variety of ways with no coordination of service delivery.'*⁷³

The Dual Pathways report acknowledged the number of programs and services provided by various Departments - including Territory Families, the Department of Housing and Community Development, the Department of Health, the Department of Education and Federal Government Departments. It was noted however that the services are often delivered independently of each other, despite having similar objectives and reporting requirements, resulting in a *'disjointed pursuit of parallel outcomes'*.⁷⁴ The Commission was told of this same phenomenon during its community visits in 2016.

The Commission was told that the fragmentation in service delivery can also result in children, young people or families not receiving the services that they require and that a more cohesive and co-ordinated approach would be beneficial in enabling people to reach the service they need.⁷⁵ Professor Oberklaid told the Commission:

'...traditionally – if you go into any community and you map all of the programs going to that community, including disadvantaged communities, there are scores – and sometimes even hundreds – of little individual programs, all of which have been developed in good faith, often with good – always with good intentions, of course, but focusing on one narrow risk factor, or one single problem... We see services for family violence, for depression, for alcohol abuse; we see services to improve children's behaviour, to improve language. They're fine, but the problem is if you've got one

*problem or risk factor, you've often got others as well. So, anecdotally, we see that children and families still fall between the cracks of those sorts of services, because they're not well coordinated, and we hear again that there's wrong doors. Families get turned away from particular services because, "They've got problems that my program hasn't been established to address."*⁷⁶

The Chief Executive Officer of Territory Families told the Commission that the Northern Territory Government is:

*'engaging with the Commonwealth to align family support efforts. Currently there is little coordination between the funding and services invested in the Northern Territory child protection and youth justice systems by the Commonwealth Government and those delivered by the Northern Territory Government. An emphasis on alignment of services is directed at reducing overlap.'*⁷⁷

Territory Families told the Commission that improving co-ordination between the Commonwealth and Northern Territory Governments is a priority, but the Commission is not aware of any particular co-ordinating approach or structure which has been adopted at this stage.⁷⁸

Lack of a Service Directory

The recent Dual Pathways report prepared by Deloitte identified a further problem with respect to the difficulty of compiling information about the many and various services which were available in different locations. That project appeared to encounter similar difficulties to the Commission when attempting to scope and list the services provided within the early support and prevention sector in the Northern Territory in the absence of comprehensive service directory.

The Dual Pathways report said that the starting point to implement a dual pathways approach to early support and prevention was to identify *'what services are being provided and agreeing on how to classify these services across the sector'*.⁷⁹ Deloitte attempted to comprehensively map the services provided across the Northern Territory by asking the family support sector and levels of government about the family support services they provided, specifically:

- the service type delivered
- the target group of the service
- the locations where the service is delivered
- funding body
- current referral pathways
- average number of clients
- direct client support hours
- average number of clients unable to access the service (due to waiting lists, etc), and
- the cost of delivery.⁸⁰

Deloitte reported that while the Northern Territory Government provided them with a large list of the services delivered across the Territory, it was unable to provide many of details about the services. They were advised to refer to the service providers for further details.⁸¹

Deloitte reported that neither the Northern Territory government nor other stakeholders in the sector were able to provide the information required to undertake a comprehensive service mapping of the early support and prevention sector. A matrix detailing the service hours, number of clients and cost of delivery, as it appears Deloitte originally intended, was not able to be developed.⁸²

This information gap echoes the Commission’s experience. It is clear that much is being done by way of service delivery by various entities, but on the information available, the Commission was not able to establish a precise picture of the service landscape, particularly as to service availability in different locations. Without a clear or definitive list of services, overlaps and gaps in the service framework could not be identified. Deloitte similarly found that *'manual service mapping that relies on piecemeal information from the sector or various Government Departments is never going to provide comprehensive and accurate service mapping.'*¹⁸³

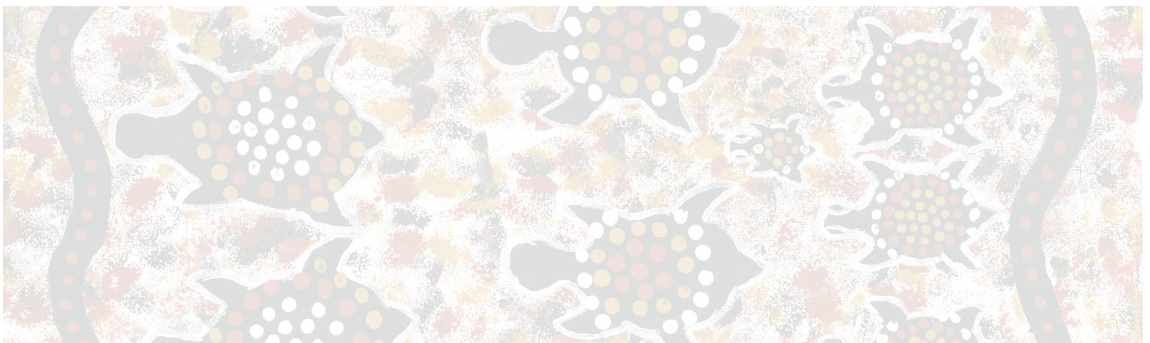
The shortfalls in information must also impede the development of any effective overall strategy by governments and non-government organisations to ensure comprehensive coverage of the shifting needs of communities through aligned funding schemes. For these reasons, the Commission will be recommending that a service mapping exercise be conducted as a high priority so that both governments have an accurate and comprehensive understanding as to the overall service situation as it exists today.

Place-based services and differing needs

The Commission believes that the most effective way to provide early support and services to families is to provide those services in the local area where families live. In the Commission’s view, place-based services are an important part of ensuring that programs and services reach families that need them and this can only be assessed by looking at service availability place by place. The provision of place-based services are likely to be more effective because services can be provided by organisations who know the families and understand their problems, will be familiar with what supports are available and can ensure the accessibility and availability of those supports and services.

The Dual Pathway report highlighted that stakeholders across the early support industry indicated that different areas throughout the Northern Territory required different types of services. While universal community services and practical family support were services stakeholders indicated were necessary, there were variances in the importance placed on and anticipated need for different services within the rural and urban communities.

The draft report indicated that the surveyed stakeholders within the urban centres (Darwin and Alice Springs) highlighted the need for Universal Community Services, whereas the more rural areas (Tennant Creek, Katherine and Arnhem) focused more on services for children and youth.



Urban

Alice Springs:

- In-home support programs
- Life skills programs
- Gambling cessation support programs
- Strengthening community programs
- Reunification Support
- Community reintegration support
- Youth support programs

Darwin:

- Community Employment Programs
- Safe Houses
- Neighbourhood watch
- Community safety programs
- Perpetrator support
- Home security services
- Youth diversion programs

Rural

Katherine

- In-Home Support program
- Life skills program
- Gambling cessation support programs
- Trainee and apprenticeship programs
- School re-engagement programs
- Community employment programs
- Trauma programs

Arnhem

- In-home support programs
- Childhood development education
- Life skills program
- Gambling cessation support programs
- Parent support programs
- Community centres
- Safe houses

Tennant Creek

- In-home support programs
- Childhood development education
- Life skills program
- Gambling cessation support programs
- Parent support programs
- Community centres
- Safe houses

Remote Areas

The Commission is also acutely aware of the problems with providing place-based services to remote communities or communities which have small populations, and acknowledges the considerable difficulties in ensuring that early support services are adequately provided to the people of the Northern Territory. The small population at approximately 228,833,⁸⁴ is geographically spread over a large area.

An examination of the 2016 census figures demonstrates that while there are many communities with a relatively small population, there still may be high populations of children and young people between 0 to 19 years old in them.

Currently it appears that the commissioning of services in the Northern Territory for particular locations is determined without an overall strategic plan, in addition to the coordination issues noted above.

Population Examples (See Table 38.2) *

- Darwin has the largest population in the Northern Territory at 78,804, 18,724 of whom are children and young people. Darwin has the second highest Indigenous population at 5,828,
- Palmerston has the second largest population in the Northern Territory at 33,786 of which 10,759 are children and young people aged between 0 to 19 years old. The Indigenous population is 3,809,
- Alice Springs has the third largest population at 24,753. Alice Springs has an

- Indigenous population of 4,361 people. Alice Springs has a high population of children and young people with 6,614 people aged between 0 to 19 years old,
- Maningrida is the ninth largest centre with a population of 2,380. The Indigenous population is 2,064 and the number of children and young people between 0 to 19 years old is 800,
 - Yirrakala has the twenty-first largest population with 809 people, 676 of which are Indigenous people and 312 are children and young people who are 0 to 19 years old,
 - Lajamanu has the twenty-fifth largest with a population of 606, an Indigenous population of 545 and 284 children and young people aged between 0 to 19 years old,
 - Hermannsberg has the twenty-sixth largest total population with 605 people. Hermannsberg has an Indigenous population of 537 and 195 children and young people, and
 - Kintore has the twenty-ninth largest population with 410 people, an Indigenous population of 376 and 144 children and young people between 0 to 19 years old.

* The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

Table 38.1 lists the 30 places with highest populations in the Northern Territory, by total population. Table 38.2 lists the 20 places with the highest populations type by Indigenous population. These measures are based on 2016 census data used to determine the communities with the largest populations in the Northern Territory. The Commission recognises that there may be issues with the collection of data in remote areas and in some cases, a fluid population.

Nevertheless data collection is an important tool to ensure that early support services are reaching the children, young people and families who require assistance, adequately addressing their needs and that government funds are being spent effectively on programs that address the issues within each community. An examination of the 2016 census demonstrates that while there are many communities with a relatively small population, there still may be high populations of children and young people who are between 0 to 19 years old in those communities. Poor population information can lead to gaps in service delivery and a lack of knowledge about whether the current level and type of service provision meets the needs of children and families.

Detailed mapping is needed to determine the geographic coverage of particular services provided, who provides those services and how those services can be accessed. Not being able to identify this information means that while a large number of communities might be said to have access to services, it is not possible to determine what level of access is actually being provided, or whether those services correlate to the specific needs of the community.

The Commission was told that in some remote communities access to early support service may not be readily available prior to entering the statutory child protection system.⁸⁵

In the Northern Territory context, knowing how far people have to travel to access services and the means they have to get there is critical to determining the reality of whether services are meeting the needs of the population. As a result, the geographic coverage initially indicated by the number of locations identified as receiving some kind of service must be considered with a high degree of caution.



Population: 605

Aboriginal Population: 537 (89%)

Children and Young People: 195 (32%)

Services listed in the Government Services Tables as being available in Hermansburg at some point between 2014 to 2017:

- Families as First Teachers
- Remote Aboriginal Community and Family Worker
- Women's Safe Place
- Remote Area Health Services including: Healthy Under 5s Check, school Screening, STI Screening, Antenatal Programs, Anti-suicide programs, Supporting grandparents to support young children, young adult health checks
- Bushmob Project
- Computer room support

Picture sourced from the Northern Territory Land Information Systems (NTLIS). List based on information provided by the Commonwealth and Northern Territory Governments, noting the limitations provided by both the Commonwealth and Northern Territory that it may not be complete or current. Population statistics taken from ABS: 2016 (SA1). The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

Much more detailed mapping is needed to determine geographic coverage with any confidence, and to get the balance right between providing services on the ground and determining how to get services to people in the communities that are remote or small in size. Each community needs to have a comprehensive needs-based assessment, which takes the size and remoteness of the community into account.

This should be done in a coherent services framework, so that a co-ordinated, strategic approach is employed by the Commonwealth and Northern Territory Governments to deliver services and programs within the Northern Territory. Examples of place-based early support and prevention services currently in operation in the Northern Territory are set out below.

Continuity and Sustainability of Services

Analysis of the Commonwealth and Northern Territory Services Tables also shows that early support and prevention service provision funding is often provided on a short term basis. This may lead to organisations obtaining smaller amounts of funding across multiple strategy funding streams.⁸⁶ As a result, it is difficult to determine exactly how much funding individual organisations receive and from whom. Funding from multiple streams may result in organisations having multiple and overlapping reporting mechanisms, placing a further burden on resources.⁸⁷

The Commission’s analysis of the data provided by the Commonwealth Government demonstrated that:⁸⁸

- over the last three years, the Commonwealth funded over 450 different organisations to deliver approximately 2,000 different activities across the Northern Territory⁸⁹
- across the 2014-15 and 2015-16 financial years, the majority of funding payments for these specific activities fell between \$100,000 and \$500,000 (approximately 65% in 2014-15 and 56% in 2015-16).⁹⁰

However, what is unclear from the data is the period of delivery to which the payment relates, making meaningful analysis difficult. There is the possibility that allocations of funding are actually smaller than they appear once they are spread longer than a 12-month period.

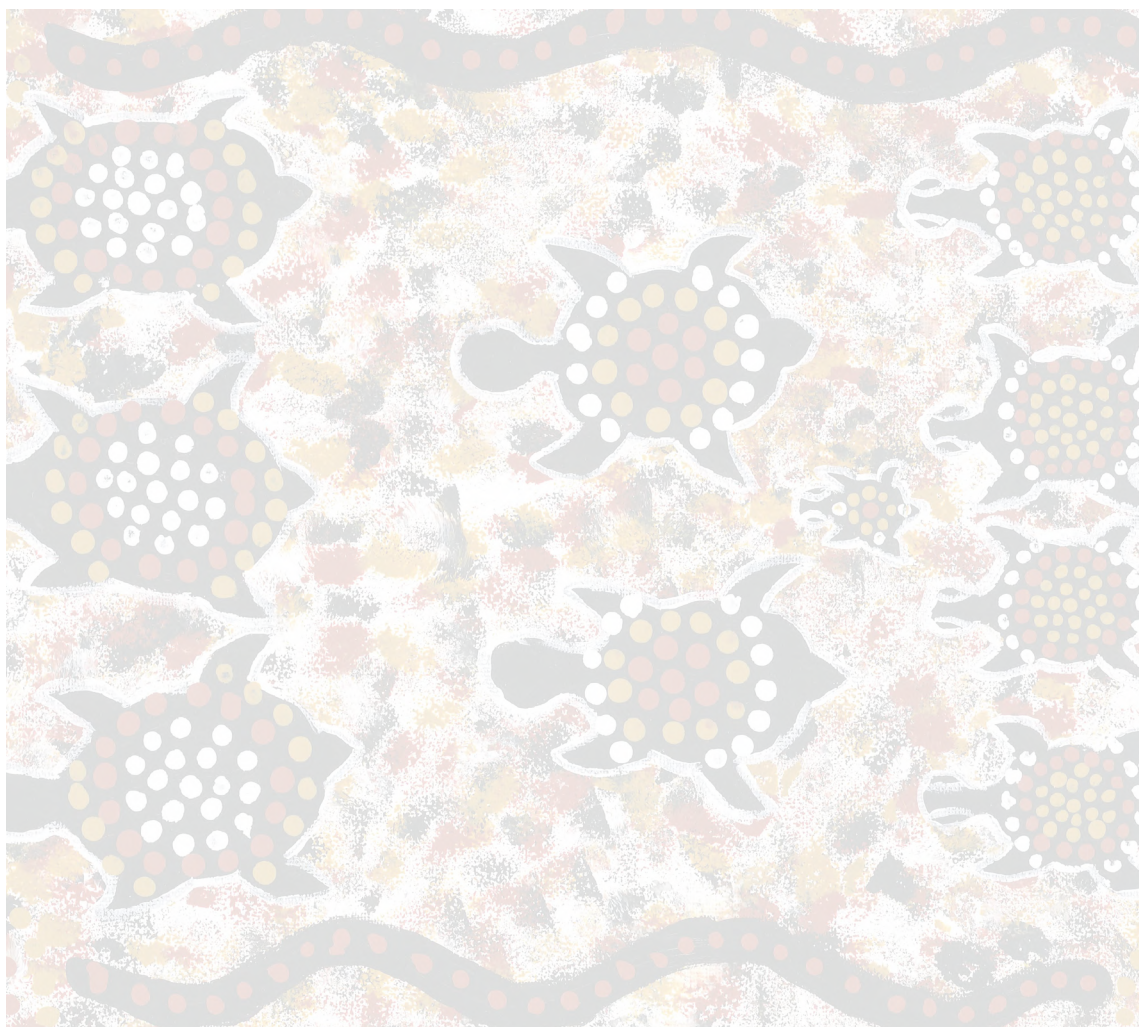
Communities for Children Program

Since 2004-05, the Commonwealth Government has funded the Communities for Children Program. A whole-of-community, place-based approach to support the health and wellbeing of children from birth to 12 years with a focus on:

- Healthy young families – supporting parents to care for their children before and after birth and in the early years
- Supporting parents and families – support to parents to provide children with secure attachment, consistent discipline and safe, secure environments
- Early learning – provide access to high quality learning opportunities in the years before school, provide early identification and support for children at risk of developmental and behavioural problems

- School transition and engagement – support children and families to make a smooth transition to school and work with schools to assist with children and families in their ongoing engagement in school.
- This program is a placed-based, integrated suite of services for local communities across Australia. A Facilitating Partner in each site maintains a committee of community representatives that helps the Facilitating Partner to decide which services to fund based on community need. Facilitating Partners then subcontract Community Partners to deliver services including parenting support; group peer support for children, families or carers; case management; home visiting services; and other supports to prevent child abuse and neglect.

The model has a strong emphasis on better coordination of local services. In 2016/17, Communities for Children in the Northern Territory was funded \$4.022 million, delivered in the regions of Palmerston, Tiwi Islands, Alice Springs, East Arnhem and Katherine.⁹¹





Population: 410

Aboriginal Population: 376 (92%)

Children and Young People: 284 (69%)

Services listed in the Government Services Tables as being available in Kintore at some point between 2014 to 2017:

- Youth Diversion Worker
- Women's Safe Place
- Crèche
- Communities for Children
- Indigenous Parenting Support Service

Picture sourced from the Northern Territory Land Information Systems (NTLIS). List based on information provided by the Commonwealth and Northern Territory Governments, noting the limitations provided by both the Commonwealth and Northern Territory that it may not be complete or current. Population statistics taken from ABS: 2016 (SA1). The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

Analysis of the duration of Commonwealth funding agreements identifies several trends:⁹²

- The majority of funding agreements over the last three financial years had a duration of either 6 - 12 months or 2-3 years⁹³

- Aboriginal organisations were over-represented in funding agreements of these two categories, comprising approximately 77% of organisations who received those funding periods⁹⁴
- Mainstream organisations, only began to overtake Aboriginal organisations, as the majority of recipients once funding duration reached between three and five years,⁹⁵ and
- Only 1% of funding agreements had a duration of more than five years and the recipients of these are all mainstream organisations.⁹⁶ This follows the national trend of Aboriginal organisations being more likely to receive shorter funding agreements for lower amounts, and non-Aboriginal services being more likely to receive longer term contracts for larger amounts.⁹⁷

From the information provided by the Northern Territory Government it was not possible to complete a similar analysis of funding arrangements as many of the funded programs and services listed did not include information on funding or on the number of years for which funding was provided.⁹⁸

Stronger Communities for Children (SCfC)

The Commonwealth Government funds Stronger Communities for Children (SCfC), which is an adaptation of the Communities for Children model, specifically supporting local Aboriginal people as drivers of change in their communities. SCfC operates through a local Community Board, comprising local Aboriginal community members whose role is to advise on culturally appropriate ways of doing business; identify priority needs and people's ideas on local solutions; ensure the needs of all clans and groups (such as families, young people, men and women) are understood and represented; help select and guide the contracted SCfC Facilitating Partner (co-ordinating NGO) to work in a locally relevant way; work collaboratively with the SCfC Facilitating Partner in each site on how funding is used within scope of the initiative; encourage local people to run their own services and take up local community service jobs; and help define what success or achievement is from the community's perspective.⁹⁹

The 10 locations of the SCfC project in the Northern Territory are Galiwin'ku, Ngukurr, Ltyentye (Santa Teresa), Ntaria (Hermannsburg), Wadeye, Gunbalanya, Maningrida, Lajamanu, Utopia Homelands, and Atitjere/Engawala/Bonya.¹⁰⁰

A SCfC Quality Service Support Panel comprising of Ninti One and Menzies School of Health Research works alongside Community Boards and Facilitating Partners to identify services and activities to meet their needs. The Support Panel provides information and resources around data collection, impact assessment, community engagement and service delivery.¹⁰¹ The implementation of SCfC Facilitating Partner services will be monitored on an ongoing basis by the Local Community Board and reported against at the monthly Local Community Board meeting.¹⁰²

Examples of the programs SCfC is supporting include bush medicine healing to improve mental health and wellbeing, bush tucker nutrition workshops to increase usage of local bush foods in everyday meals, youth leadership training to support young adults to fill leadership roles, early years parenting programs and cyberbullying education in schools as a rising concern in many remote areas.¹⁰³ Funded under the Indigenous Advancement Strategy's Children and Schooling Programme, the Commonwealth Government has committed \$25.45 million to SCfC through to 30 June 2018.¹⁰⁴

The Commission was told that short term funding can create difficulties in realising early support strategies, which require continuity and long term provision of services.¹⁰⁵ The Menzies School of Health Research told the Commission that:

*'...you need at least 10 years to – to ... build a capacity to deliver services properly, but also to evaluate the impact. The first three years are going to be just setting things up, then getting into service delivery and then looking at what are the ongoing supports and maintenance you need to – for it to function effectively. I think there's a realisation in governments around the world that you do need these longer time frames to look at developmental outcomes.'*¹⁰⁶

A lack of long-term strategic planning and the prevalence of short-term funding agreements are also likely to impact negatively on the ability of service providers to build an evidence base, plan for the future, strengthen workforce capacity and build confidence and trust with the community, all of which are critical to the success of an early support strategy.¹⁰⁷ The Commonwealth Government supports the principle that, where possible and appropriate, longer-term contractual periods for grants can contribute to improved stability for provider organisations.¹⁰⁸ The average term of grant in the Northern Territory is higher (27 months) than the national average (23 months).¹⁰⁹

The Dual Pathways report found that the current funding for the early support and prevention system was characterised by 'short-term grant agreements with restrictive conditions', with the effect of 'creating siloed practices... hindering the long-term impacts NGOs can make with parents and families.'¹¹⁰

Deloitte recommended that the Northern Territory Government attempt to overcome some of the difficulties with continuity and sustainability of services by investing in extended funding terms and longer-term contracts, but requiring continuous assessments and longer term evolution of services to be drafted into the contracts. The Commission agrees that investing in longer term funding agreements is important to developing a more sophisticated approach to early support and prevention.





Population: 809

Aboriginal Population: 676 (84%)

Children and Young people: 312 (39%)

Services listed in the government Services Tables as being available in Yirrkala at some point between 2014 to 2017:⁵

- Families as First Teachers
- Remote Primary Care Health Care
- Safety and Wellbeing (Raypirri Rom)
- Remote Area Health Services, including:
 - Healthy Under 5’s Check
 - School Screening
 - STI Screening
 - Antenatal Programs
 - Anti-suicide programs
 - Supporting grandparents to support young children
 - Young adult health checks
- Community Play Group
- Communities for Children
- Indigenous Parenting Support
- Service
- Long day care and nutrition program
- After School Care
- Computer room support

Picture sourced from the Northern Territory Land Information Systems (NTLIS). List based on information provided by the Commonwealth and Northern Territory Governments, noting the limitations provided by both the Commonwealth and Northern Territory that it may not be complete or current. Population statistics taken from ABS: 2016 (SA1). The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

The Commission understands that the Northern Territory Government is considering expanding funding arrangements to provide for five year funding periods.¹¹¹ The Commission supports this development, but is of the view that it is important that any increased funding arrangements are tied more closely with efficient reporting and effective evaluations of the services and programs to ensure that they are meeting, and continue to meet, the needs of the communities and families to whom they provide services.

Evaluations of Programs

It is important to monitor the outcomes of delivery of services and programs to ensure that they adequately and effectively meet the specific needs of families and communities.

The Commission reviewed evaluations of seven programs funded by the Commonwealth Government.¹¹² These evaluations related to the Communities for Children Program, the Remote School Attendance Strategy, Targeted Community Care Mental Health Initiatives, the Safer Futures in the Northern Territory Act, the Home Interaction Program for Parents and Youngsters, the Intensive Family Support Service Program and the Let's Start program.¹¹³

From the evaluation reports the following issues were identified:

- evaluations may be completed within a short period time after the introduction of the program so medium and/or long-term impact cannot be identified
- outcomes may be statistically insignificant, meaning that it cannot be ruled out that outcomes are due to chance
- outcomes may not be connected directly to the relevant service delivery
- cultural competence and overall service quality may not be measured
- evaluations may not include:
 - rural and/or remote sites
 - communities that have high populations of Aboriginal people, or
 - data collected from those accessing/receiving the service.

Aside from program evaluation, the main method used by the Commonwealth for measuring performance is reporting by funding recipients, normally on a 6 or 12-month basis. Funding recipients are required to report on a number of key performance indicators set by the Commonwealth outlined in individual funding agreements.¹¹⁴

Criticisms have previously been made of the reporting requirements in relation to programs and services funded under the Indigenous Advancement Strategy (the Strategy). A review of the Indigenous Advancement Strategy by the Australian National Audit Office published in 2017 found that:

- The performance framework and measures established for the Strategy do not provide sufficient information to make assessments about program performance and progress towards achievement of the program outcomes.¹¹⁵
- The performance indicators at the Strategy level for 2014–2015 and 2015–16 were primarily quantitative, output-focused and did not provide targets or benchmarks by which to measure progress in achieving program objectives.¹¹⁶
- The performance indicators against which funding recipients report cannot be easily linked to the achievement of results and intended outcomes across the Strategy. More than half of the indicators are deliverables and do not measure outcomes.¹¹⁷

The Department of Prime Minister and Cabinet developed a system by which entities could provide performance reporting information electronically. However, the process to aggregate and use this information was not sufficiently developed to allow the Department to report progress against outcomes at a program level, benchmark similarly funded projects, or undertake other analysis of program results.¹¹⁸

In response to the concerning findings regarding the Indigenous Advancement Strategy, the Department of the Prime Minister and Cabinet provided additional information to the Commission as to future investment in, and the direction of, evaluation efforts under the Indigenous Advancement Strategy:

*'The evaluation strategy for the IAS, called the Evidence, Evaluation and Performance Improvement Strategy (EEPIS), is currently being revised. A new Evaluation Framework will guide future evaluation. \$40 million has been committed over the next four years to strengthen IAS evaluation.'*¹¹⁹

\$10 million has been committed over the next three years from 2017-18 to establish an Indigenous Research Fund that will add to the Indigenous policy evidence base, and a further \$2.9 million over four years from 2017-18 has been allocated for the Productivity Commission to enhance its role in Indigenous policy evaluation.¹²⁰

While the inability to measure outcomes is a significant barrier to designing and implementing an early support strategy, the Commission cautions there is also a risk in being too prescriptive when it comes to requirements that programs are evidence based. The Commonwealth acknowledges that there is a need to ensure that community driven initiatives or programs tailored to meet specific community needs are not excluded.

Evaluating services also provides organisations and the government with the ability to determine the needs of the community and whether they are being met, or whether funding should be reallocated. The 'Dual Pathways' report highlighted that currently some of the stakeholders who were consulted were unable to specify the population or demographics of the client base that they were meant to service. Further observations in the Report indicate that there is currently a limited understanding in relation to the extent of need for early support and prevention services throughout the Northern Territory and that the capability and capacity of the non-government sector throughout the regions was also unknown.¹²¹

The process of building an evidence base around what support services work for whom and in what locations in the Northern Territory also needs to be culturally competent and compatible with local community contexts.

Ensuring high quality data collection and evaluation will require careful consideration of what tools and methods will be most effective. For example, common data collection methods used elsewhere in Australia, such as postal, telephone and online surveys or interviews, are likely not going to be as effective in remote Aboriginal communities and new tools may need to be developed.

Example of Evidence Based Program: Let's Start Parent-Child Program

The Let's Start Parent-Child Program was an evidence-based therapeutic parenting program that supported the social and emotional needs of children as they transition to school.¹²² Developed and delivered by Menzies School of Health Research, it had an integrated focus on child development, early learning and parenting and maternal and child wellbeing.¹²³

Established by the Tiwi Island Health Board as an early intervention program to respond to a cluster of suicides on the island,¹²⁴ it evolved over 10 years of working with children and families in remote and urban settings in the Northern Territory. It was respectful of kinship, culture, and Aboriginal family values, and adapted to meet local needs.¹²⁵ As an action research project, it improved children's early education and behaviour outcomes.¹²⁶ The BOI report indicated that parent skills training, and particularly programs that have a parent-child interaction component have better outcomes than parent education alone.¹²⁷

Let's Start worked with parents to develop their strengths and capacities through engagement with their children in collaborative play and learning. It was designed to identify children who were at risk of later problems or had already experienced difficulties and to reduce these risks by supporting parents and children.¹²⁸ Professor Sven Silburn, from Menzies School of Health Research told the Commission:

*'They take on children aged four and five, particularly in the years before they're going to school. They get a lot of referrals of children who have child abuse concerns, and they involve the parents learning different ways of managing difficult behaviour, avoiding difficult behaviours emerging, and it also involves a group work activity for the children on their own, which they enjoy. They come with their parents. They have a time together. It involves a lot of traditional stuff. There's a lot of singing and activities that parents enjoy. A number of parents have come back voluntarily to do the program a second or a third time because they found it beneficial or they have come back when they have another child that's in that age range, and we see that as a good thing.'*¹²⁹

The program trained local community members to deliver the program.¹³⁰ It also worked with local organisations like schools, preschools, health care centres, childcare centres and child protection services to ensure that parents were supported in their local communities. The Commission heard that Commonwealth funding for Let's Start ceased in 2017 and the implementation team has moved its resources to work in other jurisdictions.¹³¹

Core Services Required

The Commission heard evidence about the core prevention and early support programs and services that may be needed to build an integrated public health approach for preventing child abuse and neglect. These services would be delivered outside the statutory child protection system and, with the Northern Territory having a relatively small population, may often work with the same children, young people and families as child protection services. For example, Central Australian Aboriginal

Congress (Congress) reports that is already delivering an integrated suite of services for children, young people families and their communities. As a comprehensive primary health care service it provides services ranging from pre-birth through to aged care. With respect to child protection, Congress is also funded to deliver the intensive family support service, youth outreach, and Headspace, an adolescent mental health service.¹³²

In 2015, the Northern Territory Aboriginal Forum's Primary Health Care working group convened a two day workshop, sponsored by Northern Territory Department of Children and Families. Representatives from non-government and government agencies within the health, education, welfare and academic sectors attended. The outcome of this forum was a core set of early childhood services needed to improve Aboriginal childhood outcomes in the Northern Territory.¹³³

The Forum concluded a universal platform of services should be adopted across the following areas:

- Quality antenatal and postnatal care within Aboriginal primary care
- Clinical and public health services for children and families including ear and dental programs
- A nurse home visiting program offered universally or to all first time mothers
- Parenting programs after the completion of the nurse home visiting program who are assessed as requiring support
- Intensive evidence, quality child development programs that improve educational outcomes;
- Two years of preschool from age three to five, with increased hours for those targeted groups at higher risk of poor educational outcomes
- Indicated services for vulnerable children and families including targeted or intensive family support, and
- Supportive policies in the areas of social determinants.¹³⁴

This process built upon an existing primary health care framework and involved a collective review of universal, secondary and tertiary core services and whether and how they affect a child's physical, cognitive and social emotional wellbeing domains. The list of services is set out at Table 38.4.

The lack of an integrated public health framework for developing, implementing and evaluating a system for protecting Northern Territory children has meant the burden of responsibility for supporting vulnerable children defaults to Territory Families and the Commonwealth Government. The seemingly narrow conceptualisation of early support as preventing children entering out-of-home care, as opposed to preventing child abuse and neglect, overlooks the opportunity for other statutory agencies and non-government organisations to share the responsibility for child wellbeing and safety. As Professor Silburn told the Commission:

*'I think the department struggled to get the level of commitment from health and education and other departments in addressing some of those primary health care needs. I think the department was very much on its own in trying to deal with all aspects of the implementation of the report [Board of Inquiry].'*¹³⁵

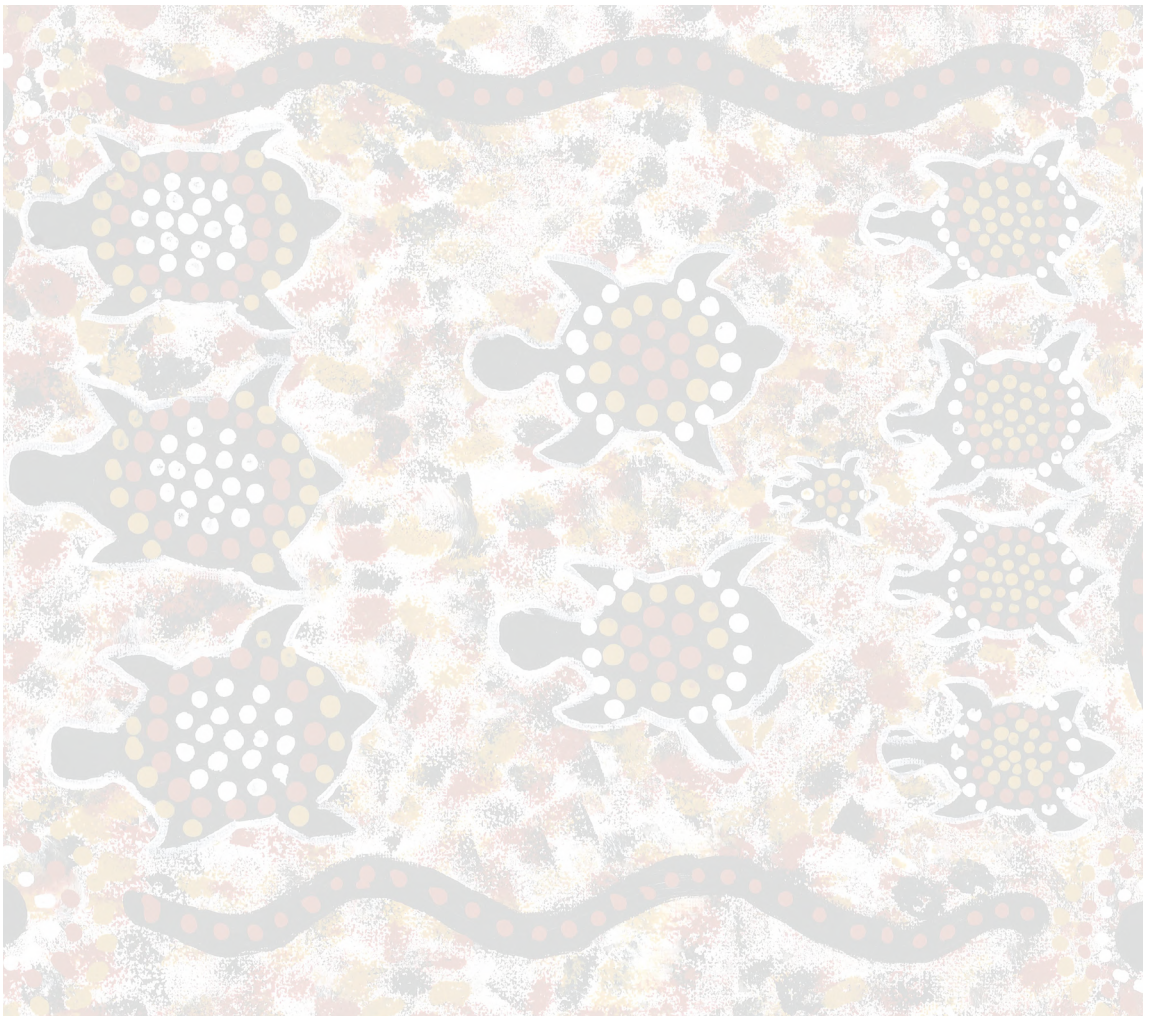
The Commission notes there have been clear efforts to conceptualise and design a public health approach to support the healthy development of children in the Northern Territory, notably in the areas of Primary Health Care and Early Childhood.

Aboriginal Service Providers

The Commission also sought to analyse the information provided in the Government Service Tables to determine the percentage of early support activities targeted at Aboriginal people and communities. While acknowledging the limitations of the information provided within the timeframe and the qualifications expressed, it appears that over 80% of early support activities being delivered in the Northern Territory are targeted at Aboriginal people and communities.¹³⁶

The Commonwealth Government has informed the Commission that 64% of current funding to the Northern Territory under the Indigenous Advancement Strategy goes to 157 Indigenous organisations.¹³⁷ It appears from the Northern Territory Government Services Table that approximately 70% of the activities funded were delivered by mainstream service providers, including Northern Territory Government departments and mainstream non-government organisations.¹³⁸

The success of large mainstream organisations in winning tenders has been attributed, in part, to the reduced capacity of Aboriginal community-controlled organisations, who do have strong relationships with communities, to respond to tenders within short timeframes.¹³⁹





Population: 2,308

Aboriginal Population: 2,064 (76%)

Children and Young People: 800 (35%)

Services listed in the Government Services Tables as being available in Maningrida at some point between 2014 to 2017:

- Integrated Child and Family Centre
- Families as First Teachers
- Maningrida Child Safety Service
- Remote Community Education & Alcohol Management Planning (RAMP)
- Women's Safe Place
- Men's Cooling Off Place
- Remote Area Health Services including:
 - Healthy Under 5s Check
 - school Screening
 - STI Screening
 - Antenatal Programs
 - Anti-suicide programs
 - Supporting grandparents to support young children, young adult health checks
- Crèche
- Indigenous Parenting Support Service

Picture sourced from the Northern Territory Land Information Systems (NTLIS). List based on information provided by the Commonwealth and Northern Territory Governments, noting the limitations provided by both the Commonwealth and Northern Territory that it may not be complete or current. The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

Place-based service: Aboriginal community controlled health and community services

Aboriginal controlled community health services (ACCHS) provide a range of programs targeting the health and wellbeing of children and families, including early childhood, early intervention and support services in relation to alcohol and other drugs (AOD), family violence and social and emotional wellbeing support for young people.¹⁴⁰ These include Anyinginyi Health Aboriginal Corporation in Tennant Creek,¹⁴¹ Danila Dilba Health Service in Darwin, Miwatj Health Aboriginal Corporation in North East Arnhem, Wurli Wurlijang Health Service in Katherine and Central Australian Aboriginal Congress in Alice Springs. The Commission also acknowledges the important role of Aboriginal community controlled organisations and councils such as NPY Women's Council and Tangentyere Council.

ACCHS are often aware of children and families in vulnerable circumstances in communities and in remote settings they may be the only local providers of support and referral services.¹⁴² The Commission heard that there is a significant degree of untapped potential for the delivery of early support services via existing Aboriginal community organisations.¹⁴³

Aboriginal community controlled health services have an established presence in all Northern Territory regional and many remote communities and are highly regarded and trusted by Aboriginal people.¹⁴⁴

'I think there's enormous opportunity for Aboriginal organisations and even regional organisations to claim this space. It's a question of doing some mapping. I mean, if you look at the way in which the Aboriginal community controlled health sector has sort of evolved over the last 20 years, we've got quite sophisticated organisations providing very complex services in geographically remote and isolated communities. I think that's a really good model for governments to have a look at'.¹⁴⁵

There is potential for ACCHS to support a reformed service system through utilising existing services and with additional resources.

A NEW PUBLIC HEALTH APPROACH

Obvious concerns arise from the difficulties encountered by the Commission and the Commonwealth and Northern Territory Governments in ascertaining:

- what services are currently being funded in the Northern Territory
- where and how those services are being delivered
- who accesses these services, and
- how effective these services are in addressing the issues faced by families, children and young people.

The lack of a comprehensive compilation repository of such information has been raised by other inquiries and the Commission reiterates that this is an essential task on which the Northern Territory Government and Commonwealth Government need to collaborate. Now is the opportunity for them to utilise the existing service infrastructure to implement a public health approach. The Commission was told that:

*'System reform is not simply a matter of starting with a blank slate - an effective, systemic response to the welfare of children and families must integrate existing capacity and services that have been proven to work into a multidisciplinary, whole of government framework.'*¹⁴⁶

To adopt a public health approach there needs to be a fundamental shift away from a service-driven system where a patchwork of services are funded to address an issue in isolation and towards a child-centred system where the unique needs of the families and communities within which they grow up are understood and matched to an effective response. A public health approach will provide the data and evidence to inform, and the strategic structure to integrate and co-ordinate individual services and programs so they work in collaboration and complement each other with a focus on outcomes for children and families. The Commission's recommendations to achieve this are set out in Chapter 39 (Changing the Approach to Child Protection).

The Commission endorses the view that the primary goal for child protection must be prevention over reaction and that this requires coordination and collaboration between various different government agencies, at a Commonwealth and Territory level, non-government organisations and local communities.

A public health approach does not pit early support against statutory child protection: *'it is not an either/or equation'*.¹⁴⁷ Both should sit by side and interact effectively in ways to create multiple pathways for families.

Championing a public health approach does not mean transferring responsibility from one government agency to another. A successful public health approach to preventing child abuse and neglect would create a structure to coordinate programs and policies to engage a range of partners from other service systems, including early education, schools, police, health care, parent education and family support. It activates existing community infrastructure such as community centres, sporting facilities and social institutions and educates the public through media and other outreach efforts.¹⁴⁸

Applying a public health approach requires planning, needs analysis and data to inform the design of a child-centred system. It requires the development of a co-ordinated, integrated service system where all children and families across all geographic locations have access to core, universal services as well as targeted services when needing extra support. Identified and developed in consultation with the communities with which they are engaged, these place-based services should be culturally safe, child and family-centred, have 'no wrong door' and have strong accountability and continuous quality assurance mechanisms.

The Commission recognises that this change in approach, and any significant increase in investment in early support and prevention programs, will have budgetary implications. However ultimately this approach should prove more cost-effective over the longer term, if it decreases reliance on the statutory system and leads to a reduction of costs in that area.

EXAMPLES FROM INTERNATIONAL JURISDICTIONS

International

The Commission has examined recent child protection reforms in other countries, particularly New Zealand and Canada which have aimed to achieve transformative system-level change. These system changes reflect the application of a public health approach to improve outcomes

for vulnerable children and families.¹⁴⁹ The Commission notes that like the Northern Territory, these jurisdictions all faced entrenched systemic problems including high caseloads, a lack of positive outcomes for children,¹⁵⁰ a fragmented service system lacking strategic direction and clear accountability, a workforce lacking the capabilities and capacity to meet the increasingly complex needs of children and families, and a loss of public confidence in child protection and welfare services.¹⁵¹ The Commission identified several common themes amongst these reforms.

Scale and Implementation of Reforms

The level of fundamental system reform undertaken in these countries has involved major cultural changes across the whole of government to re-calibrate aspects of the system so as to centre on the needs and outcomes of individual children and families.¹⁵²

New Zealand

The current New Zealand Children's Commissioner, Judge Becroft, told the Commission that the care and protection system prior to the reforms saw complex issues being '*dumped at the feet of the Child, Youth and Family government service, with little involvement from education and mental health services*'.¹⁵³ The *Vulnerable Children Act 2014* outlines a whole of government strategy achieving outcomes for vulnerable children by actively reducing child abuse and neglect.¹⁵⁴

Underpinning the *Vulnerable Children Act* is the belief that no single agency alone can protect vulnerable children, with provisions for joint responsibility across government and non-government agencies and communities to promote their wellbeing and safety.¹⁵⁵ Judge Becroft told the Commission:

*'It's not rocket science but it's great to have it reflected in legislation and impose burdens on government agencies to work together.'*¹⁵⁶

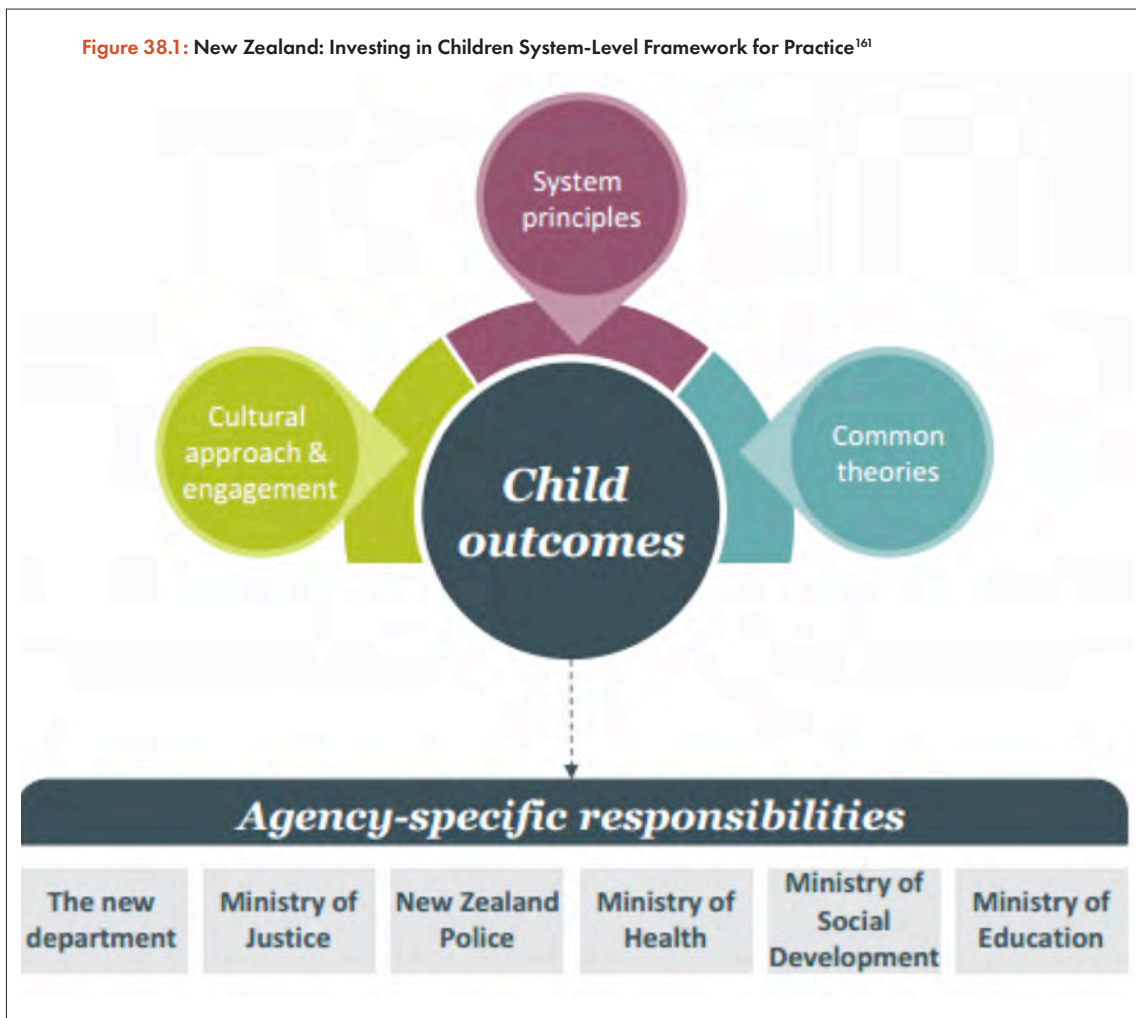
As part of an urgent overhaul of the system by the New Zealand Government the *Investing in Children Programme* was established,¹⁵⁷ tasked with delivering a new child-centred operating model for vulnerable children and young people.¹⁵⁸ The new model is based on five core service areas: prevention, intensive support, care support, youth justice and transition support. While the *Investing in Children Programme* strengthens central accountability for vulnerable children, the place-based Children's Teams are developed to strengthen delegated decision rights and local ownership. In practice, both central and local elements are needed.¹⁵⁹

The *Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 1989* (NZ) took effect on 13 July 2017. Under the new Act, the purposes have been broadened to clearly capture the child-centred intent of the legislation and to reflect the expanded scope of the new operating model. The new purposes of the Act specifically promote the well-being of children and their family groups through:

- updated general duties of the chief executive to promote the establishment of services designed to improve the wellbeing and long term outcomes of children and young persons, in support of a social investment approach
- measures to empower the Ministry for Vulnerable Children, Oranga Tamariki to respond more flexibly to reports of concern
- revised principles to support early intervention response and help ensure safe, stable and loving care for children and young persons

- a tailored information sharing framework within the Act
- accountability arrangements to ensure the co-ordination of prevention activity across government and to address the needs of children and young persons in need of care or protection (but not in care), in the youth justice system and in care.¹⁶⁰

Figure 38.1: New Zealand: Investing in Children System-Level Framework for Practice¹⁶¹



The *Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act* places greater emphasis on improving outcomes for Māori children. It includes a number of elements to recognise the specific cultural values and concerns of Māori and the role of whānau, hapū and iwi in the lives of children and young people. It places a duty on the chief executive to provide practical commitment to the principles of the Treaty of Waitangi.

The new model also complements the work of the Social Investment Agency, which works with social work agencies, non-government organisations and government to drive their investment decisions in order to improve the way funds reach the public. It encourages greater use of data and a focus on measuring outcomes to enable social sector agencies to make informed decisions about what sort of support to provide.¹⁶²

Canada

The Northern Territory and Canada share similar characteristics of having a high proportion of First Nation people in remote communities. In Canada, the Kuuwanimano Child and Family Services is an agency operating from a foundation of recognising, claiming, honouring and promoting the strength and dignity of First Nations people and culture.¹⁶³ Kuuwanimano provides prevention and family services to eleven First Nations communities. Services include counselling, referrals, family support, prevention services, advocacy and customary/foster care.¹⁶⁴

The agency's primary objective is to create a culturally appropriate approach for the delivery of child welfare and prevention services. Kuuwanimano's practice philosophy aims to understand clients in terms of their strengths, with Aboriginal culture itself considered a source of strength and an effective tool in the healing process.¹⁶⁵ Aboriginal cultural practices, traditions, customs, values and knowledge are all core components of Kuuwanimano's direct practice with clients, emphasising the need to reconstruct a positive concept of self and community. A strong indicator of the success of Kuuwanimano can be seen through the consistent rise in the agency's voluntary client caseload.¹⁶⁶

Implementation Period

Transformative system reforms like these are significant and take some time to implement successfully. Scotland phased in its current reforms over a 10 year period and Ireland is implementing its reforms through a series of three year strategic plans. The New Zealand Government designed an implementation plan, broken down into several tranches, over a four to five year timeframe giving it time to develop what it saw as key elements to success. These elements were strong leadership to facilitate the significant cultural change needed across organisations; more sophisticated funding and program management processes; comprehensive engagement and communication; and cross-sectoral capacity building.¹⁶⁷

Data

Reflecting a public health approach, decisions about the target groups, types and locations of support services are informed by a greater use of data.¹⁶⁸ New Zealand and Ireland are investing in improved data collection to map the number of children who may require support now and into the future.¹⁶⁹ Data, developed over time, will provide greater detail of the characteristics and interdependencies across the target population to help inform operational investment decisions about which children and families require additional support. That information, in combination with evidence about what works for whom, means that the makeup and scale of services can be further tailored towards those children and young people who would benefit from them the most.¹⁷⁰

Integrated Place Based Support

The reforms in Ireland, New Zealand and Scotland all centre on re-designing systems to deliver support that is more integrated, better coordinated and tailored at the local level. On 1 April 2017, the New Zealand Government established a new stand-alone Ministry for Vulnerable Children, *Oranga Tamariki*.¹⁷¹ This Ministry represents a single point of accountability for vulnerable children.

In Ireland in 2014, the Child and Family Agency, known as Tusla, was established as an independent legal entity responsible for improving outcomes for Irish children, bringing together all child welfare and protection services previously delivered across several government agencies and departments.¹⁷²

In Scotland, the implementation of *Getting It Right For Every Child* (GIRFEC) is facilitated by 31 Child Protection Committees (CPCs). CPCs are locally based, inter-agency strategic partnerships responsible for the design, implementation and evaluation of child protection policy and practice across the public, private and wider third sectors in their area.¹⁷³ Scotland also provides a 'Named Person', for every child from birth to 18 years old who is an identified point of contact available to children and families to help them access the information, advice or support they need if and when they need it.¹⁷⁴ Where support from more than one service is needed, GIRFEC provides a consistent approach to planning support through a single planning framework, called a Child's Plan, coordinated by a single 'Lead Professional'.¹⁷⁵

In Ireland, Tusla established Child and Family Support Networks (one per 30,000–50,000 inhabitants) with either virtual or physical hubs at their core.¹⁷⁶ Partnership-based networks aim to harness the power of existing services, through better coordination and integration. These networks are open to any service that engages with families' lives.¹⁷⁷ Tusla's goal is to work with families to ensure that there is 'No Wrong Door' and that support services are available as locally as possible.¹⁷⁸

In New Zealand, local multi-disciplinary Children's Teams similarly support a collaborative approach by bringing together professionals from health, justice, education and social services to create a single plan to help and support children who are at risk of abuse or neglect.¹⁷⁹

Child and Family Centred Programs

In all of these countries, the reform agenda has placed children and outcomes, rather than agencies and processes, at the centre of the system. Rather than children and families having to navigate a fragmented system, the service who first comes into contact with the child and their family acts as a lead facilitator to engage local networks and form a team around the child to deliver the necessary support. In Ireland and Scotland, any professional coming into contact with children and families will be trained in a common practice model to assess the needs of children and families.¹⁸⁰ In New Zealand, reforms ensure that funding will follow the child, rather than being 'siloed' in individual agency processes or thresholds.

A current example of this conception of service delivery can be found in the Aboriginal Children and Families Centres, originally funded by the Commonwealth to provide integrated family support, child care, education and health services. Thirty-eight Children and Family Centres in total were planned nationally, with twenty-three Centres in regional or remote areas and fifteen centres in urban areas.¹⁸¹ The program commenced roll-out in 2011 but the program was terminated in July 2014.¹⁸² State and Territory governments had the option of continuing to fund the centres.

The Commonwealth Government previously contributed \$292.62 million to establish the Children and Family Centres in urban, regional and remote areas with high Indigenous populations and high disadvantage.¹⁸³

SNAICC outlined their concerns about the funding of the Aboriginal Children and Family Centres, stating they were poorly implemented in the Northern Territory and constitute a significant missed opportunity:¹⁸⁴

'The Federal Government took a position that they had only committed to fund the children in family centres through their establishment phase. The State and Territory Governments in general took a position that they had never undertaken to fund the

*children and family centres, and so it became very much a debate between the different levels of government, and that has resulted in very different processes of implementation and support across the country for those centres.*¹⁸⁵

The ACFCs in the Northern Territory, now referred to as 'Child and Family Centres' are managed by the Northern Territory Department of Education. There are currently six Child and Family Centres located on school sites in Yuendumu, Maningrida, Gunbalanya, Ngukurr, Palmerston (non-school site), and Larapinta.¹⁸⁶ SNAICC reported it had recently conducted a telephone survey to ascertain the current status of development of ACFCs in the Northern Territory and had identified:

- a centre with a predominantly non-Indigenous client group
- centres where contrary to their intended design, decision-making authority remains primarily with government rather than community
- a centre where services have been pared back due to funding cuts, and
- a centre that has been operational for less than a year despite the process for its development beginning approximately 6 years ago.¹⁸⁷

The Commission understands that a review of the effectiveness of the Children and Family Centres will take place in 2018.¹⁸⁸ The Aboriginal Children and Families Centres are an example of integrated service hubs within local communities, which provide a significant opportunity to develop and deliver holistic, place-based early childhood and family support services, supported by infrastructure. The model for these ACFCs is similar to that described in the *Little Children are Sacred* Report. The vision behind the Centres was for a community run, integrated services hub where families obtaining child support could also obtain other, related supports. The intention was to take an early support approach with capacity building for families and early identification of problems.

In effect, establishing a network of centres along these lines is the approach which the Commission is recommending, as set out in more detail in Chapter 39 (Changing the Approach to Child Protection). This Commission's proposals in turn reflect the recommendations of the BOI report to establish a network of centres. The Commission urges the Commonwealth Government to participate in the funding of the centres proposed by this Commission, as a part of its commitment to improving conditions for Aboriginal children and families.

EARLY CHILDHOOD DEVELOPMENT PLAN

On 6 October 2017 the Northern Territory Government released a draft plan for early childhood development, *Starting Early for a Better Future: Early Childhood Development in the Northern Territory 2018-28*.¹⁸⁹ Further consultation will underpin the final plan.¹⁹⁰

The draft plan outlines the Northern Territory Government's 10 year strategy to build an equitable, high quality and culturally responsive early childhood development system.¹⁹¹ It includes a phased approach to implementation.¹⁹² The Northern Territory Government states that there will be an increase in the number of programs and investment in integrated services to better support families and ensure greater access to, and easier transitions between, services.¹⁹³

The focus of the draft plan is to expand a range of core services delivered to families including:

- Antenatal and postnatal care within Aboriginal and other Territory primary health services
- Clinical and public health services for children and families (including childhood surveillance, ear and dental programs, and case management for children with significant physical conditions)

- Facilitation of access to a home visiting program offered at least to all first-time mothers
- Universal access to parenting programs for families requiring support
- Increase support for child care services
- Establishing four new early childhood learning and development centres, and
- Expanded access to two years of preschool from age three, with increased support for those at higher risk of poor educational outcomes.

For most actions proposed, the draft plan does not yet specify the areas or locations which will receive service enhancements.

The draft plan was developed with a Panel of Experts, and in partnership with academics, Aboriginal controlled organisations and the non-government sector, and confirms a shift in Northern Territory Government thinking from early childhood being seen as a 'cost' to government to an 'investment'. The Commission is of the view that the plan is an important step in developing an integrated early support and prevention service system for all children and families.

The plan addresses a number of the concerns raised in relation to current service planning and delivery. It sets out proposed actions and investments, as well as specific targets which can be used to measure outcomes. It includes a proposal to develop a consistent approach to measure performance across the system. It highlights improving co-ordinated direction between government agencies and NGOs, through the NT Ministerial Advisory Committee providing expert advice across both the government and NGO sector.

All of these components reflect a more comprehensive approach, of the kind the Commission considers is required. The draft plan, when finalised, will be a valuable input to the broader generational plan, covering all children and young people, which the Commission is recommending be developed.

The Commission agrees that the range of early development services covered in the draft plan are essential components in a more comprehensive plan, which should address the placement of services and reflect community needs.

The Commission also notes that in May 2016 the previous Northern Territory Government released a Strategic Plan covering early childhood, *Great Start Great Future – Northern Territory Early Years Strategic Plan, 2016-2020*.¹⁹⁴

Great Start Great Future identified resilient families as a key building block to achieve the best possible outcomes for Northern Territory children aged from birth to eight years old. That Plan sought to engage parents and the community in quality universal, targeted and intensive programs and increase the capacity of services to identify and respond to children and families affected by trauma and family violence.¹⁹⁵ Progress was to be measured by a reduction in the number of young children who are the subject of successive substantiations of abuse or neglect, increased participation of vulnerable children in preschool and other early childhood programs and improved educational outcomes for children in out-of-home care.

Both the 2016 *Strategic Plan* and the 2017 *Starting Early for a Better Future Plan* address a number of the key areas where improvements in service planning and delivery need to occur, including having a whole of government/cross-agency approach, a broader focus on prevention and early support services, a focus on the life outcomes of children, an integrated service system, and providing universal, targeted and intensive services. The value of any plan is inevitably in its implementation, but no plan can succeed unless there is a commitment to maintain a plan for the period the plan covers, which for a ten year plan will often outlast any one government.

A comprehensive systemic approach to preventing child abuse and neglect must include but go beyond early childhood, and take into account the full range of risk and protective factors for child abuse and neglect. It must integrate with other strategies and engage service providers targeting issues such as family violence, alcohol and other drugs, mental health, and gambling. The Commission welcomes the *Starting Early for a Better Future: Early Childhood Development in the Northern Territory 2018-28*, and considers that the components of this plan can and should be developed further, including as a part of a broader framework and plan covering all children in the Northern Territory.

NORTHERN TERRITORY GOVERNMENT PROPOSALS

The Commission is aware of a number of steps taken by the Northern Territory Government to address the issues which have been raised. The Northern Territory Government's phased implementation of a dual pathways model and a Referral Gateway to connect families to services is a positive step,¹⁹⁶ aimed at providing additional support to families and reducing the number of families entering the statutory system.¹⁹⁷

However the 'Dual Pathways' report observed that the current early support system in the Northern Territory required holistic change:

*'The level of change that is required in the Northern Territory system goes beyond the implementation of a call centre or a data tracking solution. The current system is fragmented and poorly coordinated. It focuses on attempting to solve individual presenting issues through specifically targeted programs. It also predominately responds in crisis situations or when a family is reported and comes in contact with the child protection system.'*¹⁹⁸

The Commission notes that in this regard the Northern Territory Government has taken steps to plan and implement reforms to shift the focus of service delivery to early support and prevention, part of which involved the Deloitte project and extensive consultation. The Commission understands that the Northern Territory Government is proposing significant changes in addition to the introduction of a dual pathways model, including the mapping of Family and Parenting Support Services and the development of a service directory, and investment in programs to connect families prior to involvement with the statutory child protection system.¹⁹⁹

The Commission understands that a Children and Families Wellbeing and Safety Strategy for the Northern Territory is also proposed, to be developed in collaboration with the non-government sector, to include an outcomes evaluation methodology to ensure that future funding is appropriately invested.²⁰⁰ The Commission supports and itself proposes such a strategy, but its development should follow studies which identify the information needed to optimise such a strategy, including assessing how to best provide services to reach people who need them.

The Northern Territory Government has also indicated its intention to improve coordination between government and non-government organisations in early support and prevention services. The proposed model is 'anticipated to address system fragmentation through improved referral and service collaboration'.²⁰¹

These proposed changes recognise that significant change is required. The overwhelming message reported from the stakeholder consultations was that fundamental reform of the whole system is needed, and not just a change in programs or investment priorities.²⁰²

Stakeholders voiced strong concern that the design and implementation of an enhanced family and parenting support system should not be rushed and that any new system needed to be evidence-based and incorporate the findings of the Commission and other government initiatives.²⁰³ They were reported as calling for a new system with a whole of government approach, improved service coordination and contract management, community-led interventions and one that re-builds trust in the community.²⁰⁴ In order for these important initiatives to be successful in addressing the identified issues with the current Northern Territory system the government must ensure there is adequate funding to make these changes sustainable. Underfunding these initiatives will jeopardise any prospects of their success.

CONCLUSION

The expressed need for a shift towards a greater emphasis on early support for families is not new, but responding to that need requires a clear change in the approach to child protection in the Northern Territory. The information the Commission obtained from the Northern Territory and Commonwealth Governments with respect to the services available to families and children in the Northern Territory showed that while many different services are being provided, in many different locations, there is no co-ordinated, evaluated and sustainable framework that accurately matches services to needs.

There is currently very significant investment by both the Commonwealth and the Northern Territory in early support programs and services, but without further information it is not possible to know whether the allocation of expenditure to the various programs and services currently available and the placement of the services is achieving the best possible outcomes for children. Gathering the information to determine this should be a high priority, to maximise the benefits of the resources expended.

The Commission welcomes the steps taken by the Northern Territory Government to consult with stakeholders about what is needed, and to look at the development of additional avenues by which families can be connected to services they need. The adoption of a public health model would provide such a framework and a basis on which to plan and if necessary re-configure services. Placing these changes in a public health framework will ensure that the approach taken is planned, comprehensive, and needs based.

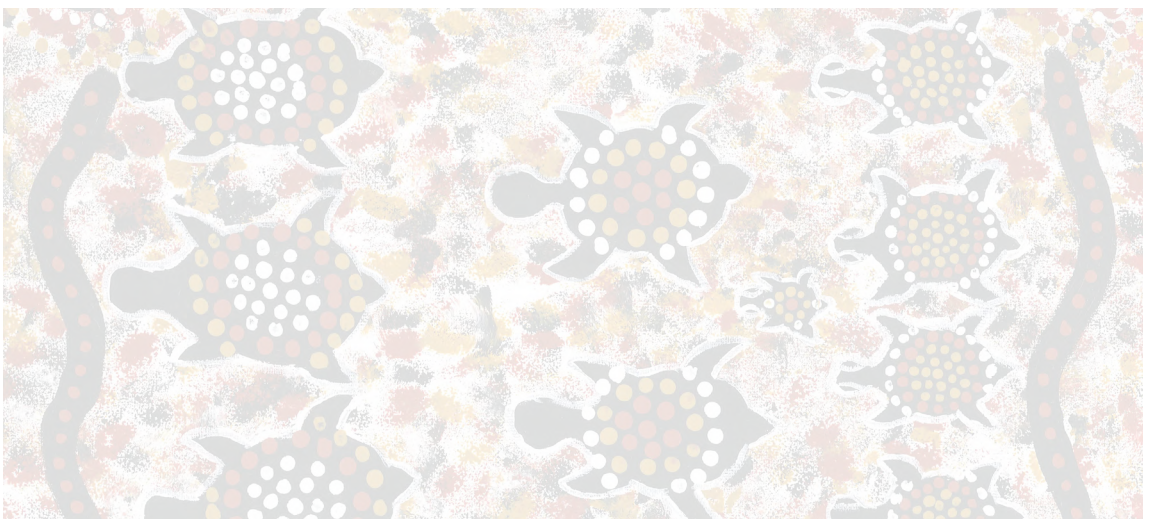


Table 38.1: Rank of 30 communities with highest population

Rank	Area	Population ²⁰⁵	Aboriginal Population	Rank (Aboriginal Population)
1.	Darwin	78,804 ²⁰⁶	5,828	2
2.	Palmerston/East Arm	33,786	3,809	4
3.	Alice Springs	24,753 ²⁰⁷	4,361	3
4.	Katherine	9,717 ²⁰⁸	2,145	5
5.	Nhulunbuy	9,529	6,308	1
6.	Howard Springs	5,132	211	26
7.	Humpty Doo	4,380	303	23
8.	Tennant Creek	2,991	1,536	9
9.	Maningrida	2,308 ²⁰⁹	2,064	7
10.	Wadeye/Victoria-Daly	2,280 ²¹⁰	2,043	8
11.	Galiwinku	2,206 ²¹¹	2,067	6
12.	Wurrumiyanga (Nguiv)	1,563 ²¹²	1,411	10
13.	Milingimbi	1,225 ²¹³	1,157	11
14.	Ngukurr	1,149 ²¹⁴	1,079	12
15.	Yulara	1,099	156	28
16.	Jabiru	1,081	263	25
17.	Gapuwiyak	923	868	13
18.	Alyangula	873 ²¹⁵	73	29
19.	Borroloola	871 ²¹⁶	669	17
20.	Angurungu	855 ²¹⁷	828	14
21.	Yirrkala	809	676	16
22.	McMinns Lagoon	796	53	30
23.	Yuendumu	759 ²¹⁸	652	18
24.	Numbulwar	723 ²¹⁹	678	15
25.	Lajamanu	606 ²²⁰	545	19
26.	Hermannsburg (also known as Ntaria)	605	537	20
27.	Batchelor	507	187	27
28.	Alpurrulam	420	387	21
29.	Kintore	410	376	22
30.	Kalkarindji	392 ²²¹	285	24

Note: General populations were taken from Australian Bureau of Statistics, Statistical Area 1 (SA1), unless otherwise indicated in the table. The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

Table 38.2: Rank of 20 communities with highest Aboriginal population

Rank in order of Aboriginal Population	Area	Aboriginal Population	Population	Breakdown of ages (total population)
1.	Nhulunbuy	6,308	9,529	0-4: 831 5-14: 1,932 15-19: 246
2.	Darwin	5,828	78,804 ²²²	0-4: 5,345 5-14: 9,202 15-19: 4,177
3.	Alice Springs	4,361	24,753 ²²³	0 – 4: 1,808 5 - 14: 3,383 15 – 19: 1,423
4.	Palmerston/East Arm	3,809	33,786	0 – 4: 3,485 5 - 14: 5,230 15 – 19: 2,044
5.	Katherine	2,145	9,717 ²²⁴	0 – 4: 800 5 - 14: 1,392 15 – 19: 572
6.	Galiwinku	2,067	2,206 ²²⁵	0 – 4: 201 5 - 14: 496 15 – 19: 233
7.	Maningrida	2,064	2,308 ²²⁶	0 – 4: 209 5 - 14: 409 15 – 19: 182
8.	Wadeye/Victoria-Daly	2,043	2,280	0 – 4: 238 5 - 14: 488 15 – 19: 192
9.	Tennant Creek	1,536	2,991	0 – 4: 246 5 - 14: 400 15 – 19: 180
10.	Wurrumiyanga (Nguiu)	1411	1,536 ²²⁷	0 – 4: 99 5 - 14: 285 15 – 19: 125
11.	Milingimbi	1157	1,225 ²²⁸	0 – 4: 93 5 - 14: 246 15 – 19: 136
12.	Ngukurr	1079	1,149	0 – 4: 122 5 - 14: 254 15 – 19: 142

Rank in order of Aboriginal Population	Area	Aboriginal Population	Population	Breakdown of ages (total population)
13.	Gapuwiyak	868	923	0 – 4: 94 5 - 14: 174 15 – 19: 101
14.	Angurugu	828	855	0 – 4: 55 5 - 14: 158 15 – 19: 131
15.	Numbulwar	678	723	0 – 4: 62 5 - 14: 123 15 – 19: 79
16.	Yirrkala	676	809	0 – 4: 82 5 - 14: 153 15 – 19: 77
17.	Borroloola	669	871	0 – 4: 99 5 - 14: 156 15 – 19: 79
18.	Yuendumu	652	759	0 – 4: 66 5 - 14: 152 15 – 19: 45
19.	Lajamanu	545	606	0 – 4: 49 5 - 14: 175 15 – 19: 60
20.	Hermannsburg (Ntaria)	537	605	0 – 4: 54 5 - 14: 89 15 – 19: 52

Note: General populations were taken from Australian Bureau of Statistics, Statistical Area 1 (SA1), unless otherwise indicated in the table. The Commission notes that these population figures do not factor in the Indigenous net undercount rate in Australia, set by the ABS, being an adjustment (up) 17.5% in 2016.

Table 38.3: Examples of Commonwealth funded programs and services delivered in the Northern Territory²²⁹ [not an exhaustive list]

Examples of Commonwealth Funded Programs and Services	Example Locations	Funding Expended During 2014/15 – 2016/17 financial period Total funding
Prime Minister and Cabinet		
<p>School nutrition programs to provide meals for students attending school in communities across the NT to support school attendance and education outcomes</p>	<p>This program is delivered in communities across the NT, including: Belyuen, Minyerri, Pine Creek, Barunga, Pirlingimpi, Ngukurr, Numbulwar, Borroloola, Kintore, Canteen Creek, Ampilatwatja, Alekarenge, Epenarra, Murray Downs, Wugularr (Beswick), Robinson River, Alpurrurulam, Areyonga / Utju Community, Finke River, Imanpa, Ikuntji Community, Titjikala Community, Atitjere, Umbakumba, Milyakburra, Angurugu, Engawala Community, Laramba Community, Nyirripi Community, Yuelamu, Wilora, Ltyentye, Bulman, Manyallaluk, Gunbalanya, Kalkaringi, Ramingining, Milingimbi, Mt Liebig, Yarralin, Peppimenarti, Gapuwiyak, Palumpa, Galiwinku, Yirrkala, Warruwi, Ti-Tree, Jilkminggan, Sadadeen, Mt Liebig Community, Ali Curung Community, Wutunugurra Community, Elliott Community, Ampilatwatja (Aherrenge) Community, Imangara Community, Tara Community, Gapuwiyak, Yuelamu Community, Nyirripi Community, Willowra Community, Wilora Community, Laramba Community, Engawala Community, Lajamanu, Kalkarindji, Areyonga Community, Finke (Apatula) Community, Haasts Bluff (Ikuntji) Community, Imanpa Community, Titjikala (Maryvale) Community, Nganmarriyanga, Nitjpurru, Maningrida, Yirrkala, Kybrook Farm, Tennant Creek Township;Ti Tree Community, Ramingining, Santa Teresa, Wadeye, Wurrumiynaga, Daly River, Bulman, Manyallaluk, Yuendumu Community, Jilkminggan, Angurugu, Umbakumba, Milyakburra, Galiwinku, Milingimbi, Ngukurr, Papunya (Warumpi) Community, Numbulwar, Canteen Creek (Owaitilla) Community, Warruwi, Barunga, Milikapiti, Gunyangara/Birritjimi/Galupa</p>	<p>\$18,700,384</p>
<p>Remote School Attendance Strategy Projects - to lift school attendance levels in specific remote communities by employing local teams to support parents, guardians, carers, community members and students to help get children to school.</p>	<p>Delivered in communities across the NT including: Maningrida, Alice Springs, APY Lands, Darwin, Finke, Jabiru, Katherine, Ltyentye Apurte (Santa Teresa), Nauiyu (Daly River), Palmerston, Tennant Creek, Barkly Region, Titjikala, Tiwi, Wadeye, Groote Eylandt, Bickerton Island, Yirrkala, Elcho Island, Gunyangara, Nhulunbuy, Gapuwiyak, Papunya, Borroloola, Ngukurr, Numbulwar, Arnhem Land, Tiwi Islands, Hermannsburg, Kalkarindji/Daguragu Nauiyu/Daly River, Pine Creek, Timber Creek, Yarralin, Yuendumu</p>	<p>\$30,767,097</p>

<p>Family Violence Prevention Legal Services - assist Aboriginal adults and children who are victims-survivors of family violence. Central Australian Aboriginal Family Legal Unit Aboriginal Corporation; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation; North Australian Aboriginal Family Legal Service</p>	<p>Three Indigenous organisations funded to deliver the program in locations across the NT (suggest including only some of the below): Alice Springs, Ntaria, Papunya, Yuendumu, Tennant Creek, Barkly, Hermannsburg, Yuendumu, Elliot, Katherine, Pine Creek, Beswick, Barunga, Ngaanyatjarra Pitjantjatjara Yankunytjatjara lands, Amoonguna, Wallace Rockhole, Santa Teresa, Utju (Areyonga), Mutitjulu, Darwin, Adelaide River, Alyangula, Angurugu, Batchelor, Belyuen, Borroloola, Daly River, Galiwinku, Gapuwiyak, Jabiru, Maningrida, Milikapiti, Milingimbi, Milyakburra (Bickerton Island), Minjilang, Nauiyu, Nganmariyanga (Palumpa), Nhulunbuy, Numbulwar, Oenpelli (Gunbalanya), Peppimenarti, Pirlangimpi, Ramingining, Robinson River, Ski Beach (Gunyangara), Umbakumba, Wadeye (Port Keats), Warruwi, Wurrumiyanga, Yirkala, Amanbidj, Bulman, Daguragu, Eva Valley, Jilkminggan (Duck Creek), Kalkarindji, Lajamanu, Mataranka, Minyerri (Hodgson Downs), Ngukurr, Timber Creek, Urapunga (Rittarangu), Yarralin</p> <p>PMC note: Funding to NPY Women's Council for FVPLS includes activities in the NPY region across SA, WA and the NT.</p>	<p>\$ 14,218,864</p>
<p>Stronger Communities for Children - provides a suite of holistic integrated services for children 0-12 years, young people and families in their local community including some activities that focus on targeted early intervention approaches to bring about positive family functioning, safety, child development and engagement in education outcomes for children and their families, and parents.</p>	<p>Delivered in communities across the NT, including: Elcho Island, Galiwin'ku, Alice Springs, Karnte Town Camp, Yuendumu, Darwin, Tiwi Islands, Nauiyu Nambiyu, Nganmariyanga, Nganambala, Peppimenarti, Ngukurr, Numbulwar, Milingimbi, Ngukurr, Daly River, Santa Teresa Community, Lajamanu.Santa Teresa (Ltyentye Apurte), Ngukurr, Galiwin'ku, Ntaria, Utopia, Gunbalunya, Wadeye, Maningrida</p>	<p>\$ 18,696,721</p>
<p>Relationships Australia - the Healing our Children (HOC) Project targets pregnant women and those with children under three years who may in the future be at risk of exposure to family violence and women with older children who are currently or have previously experienced family violence to build the capacity of Aboriginal women in communities for early response and prevention strategies and prevent the long term effects of intergenerational trauma in Aboriginal children suffered as a result of exposure to family violence.</p>	<p>Tiwi Islands, Palmerston, Katherine</p>	<p>\$280,000</p>

<p>Sunrise Health Service Aboriginal Corporation and Council for Aboriginal Alcohol Program Services Incorporated- funded for programs to better promote and support drug and alcohol treatment services and to effectively identify and treat substance misuse for young people and adults. (Further funds of approximately \$36 million are provided to other organisations for such programs)</p>	<p>Delivered from Katherine, Manyallaluk, Barunga, Beswick, Bulman Weemol, Jilkminggan, Minyerra, Ngukurr, Numulwar, Mataranka and Darwin</p>	<p>\$5,977,789</p>
Attorney-General Department		
<p>Domestic Violence Unit and Health Justice Partnership - delivers wrap-around services to women experiencing or at risk of domestic violence within the Alice Springs region.</p>	<p>Alice Springs</p>	<p>\$450,000</p>
<p>Legal assistance services funded under the National Partnership Agreement on Legal Assistance Services 2015-20, the Indigenous Legal Assistance Programme, Expensive Commonwealth Criminal Cases Fund and the Community Legal Services Programme. Service providers deliver legal information, assistance and representation.</p>	<p>Alice Springs, Darwin, Katherine, Top End, Tennant Creek, Hermannsburg, Kintore, Mutitjulu, Papunya, Ti Tree, Yuendumu, Santa Teresa, Haasts Bluff, Harts Range, Docker River, Lake Nash, Ampilatwatja, Finke, Hermannsburg, Kintore, Mutijulu, Ali Curung, Elliott, Yuelemu Darwin, Katherine, Borroloola, Maningrida, Ramingining, Oenpelli, Jabiru, Wurrumiyanga, Milikapiti, Daly River, Wadeye, Alyangula, Nhulunbuy, Numbulwar, Galiwin'ku, Gapuwiyak, Alyangula, Groote Eylandt, Barunga, Ngukurr, Timber Creek, Yarralin, Kalkarindji, Lajamanu</p>	<p>\$36,907,318.00</p>
Social Services		
<p>Communities for Children delivered by Anglicare NT, The Smith Family, Australian Red Cross Society - facilitates a whole of community approach to support early childhood development and wellbeing for children from birth to 12 years. The Department funds a Facilitating Partner in each site who then funds other organisations to provide services they assess as being needed in their local communities.</p>	<p>Katherine, Palmerston, Tiwi Islands, Alice Springs, East Arnhem</p>	<p>2014-15 \$51.165M (Nationally) \$4.198M (NT)</p> <p>2015-16 \$52.255M (Nationally) \$4.295M (NT)</p>

<p>Personal Helpers and Mentors Program delivered by CatholicCare NT, Mission Australia, Sunrise Health Service Aboriginal Corporation, Top End Association for Mental Health Inc., Walpiri Youth Development Aboriginal Corporation - to improve the independence and participation of people aged 16 years and over, severely affected by mental illness.</p>	<p>Highest-need locations across the Northern Territory</p>	<p>2014-15 \$121.166M (Nationally) \$4.999M (NT)</p> <p>2015-16 \$123.834M (Nationally) \$5.154M (NT)</p>
<p>Intensive Family Support Services</p>	<p>Wadeye, Darwin, Gurdorrka, Katherine, Mataranka, Beswick, Barunga, Palmerston, Imanpa, Mutitjulu, Apatula (Finke), Kaltukatjara (Docker River), Amata, Pukatja (Ernabella), Indulkana, Mimili, Alice Springs, Tennant Creek, Ali Curung, Wutunugurra (Epenarra), Elliott, Santa Teresa, Ntaria, Ngukurr</p>	<p>2014-15 \$8.405M (SA & NT)</p> <p>2015-16 \$8.871M (SA & NT)</p>
<p>The Home Interaction Program for Parents and Youngsters delivered by the Brotherhood of St Laurence – parenting support and early learning for families with 4 to 5 year olds.</p> <p>The Commonwealth provides funding to the Brotherhood of St Laurence who holds the sole licence from HIPPY International to deliver HIPPY in Australia. BSL has sub-license arrangements with over 60 community organisations to deliver the program in 100 sites across Australia, including 50 Indigenous focussed communities.</p>	<p>Alice Springs, Katherine, Palmerston, Darwin, Millingimbi Island, Tennant Creek</p>	<p>2014-15 \$8,914,714 (Nationally)</p> <p>2015-16 \$23,013,976 (Nationally)</p>
<p>Reconnect is a community-based early intervention and prevention program for young people aged 12 to 18 years (or 12 to 21 for newly arrived youth) who are homeless or at risk of homelessness and their families. Reconnect aims to break the cycle of homelessness by providing counselling, group work, mediation, specialised mental health assistance and practical support to the whole family.</p>	<p>Greater Darwin (including Palmerston), East Arnhem Land, Alice Springs</p>	<p>\$2,977M²³⁰</p>

Health

<p>The Australian Nurse Family Partnership Program is a nurse home visiting program that supports mothers and babies from 16 weeks pregnancy until the child is two years old. The program aims to improve pregnancy outcomes by helping women engage in preventive health practices; support parents to improve their child's health and development; and help parents continue their education and find work.²³¹</p>	<p>Alice Springs Town Camps, Alice Springs, Amoonguna, Ntaria (Hermannsburg), Wallace Rockhole, – Santa Teresa, Utju (Areyonga), Mutitjulu – Titjikala, Hermannsburg</p>	<p>\$3,947,097.00 (to non NTG orgs) \$863,689.50 (to NTG)</p>
<p>The Commission has requested funding information for the 2014-15 and 2015-16 financial years; however, in 2016-17 the Department contracted an additional two ANFPP sites in the Northern Territory; Danila Dilba Health Services (Palmerston/Darwin) and Wurli Wurlijang Aboriginal Corporation (Katherine).</p>	<p>Wadeye, Maningrida, Gunbalanya and Wurrumiyanga</p>	<p>Total \$ 4,810,786.50</p>
<p>New Directions Mothers and Babies Services - provide Aboriginal families access to antenatal care, advice and assistance with baby care, nutrition and parenting; monitor developmental milestones and provide health checks for children before starting school.²³²</p>	<p>Ampilatwatja and Outstations, Alice Springs Town Camps, Mutitjulu - Uluru – Imanpa, Darwin - Inner Suburbs, Lajamanu, Victoria River, Daguragu - Kalkarindji and Outstations, Walangeri, Yirrkala, Laynhapuy - Gumatj Homelands, Marthakal Homelands – Galiwinku, Nhulunbuy – Gnyangara, Yirrkala, Douglas-Daly, Thamarrurr inc. Wadeye, Walungurru and Outstations, Elsey – Roper, Gulf Ngukurr, Hermannsburg, West MacDonnell Ranges, Yuendumu and Outstations, Katherine Town, Papunya and Outstations, Urapuntja</p>	<p>\$5,059,766.84 (to non NTG orgs) \$1,916,085.00 (to NTG) Total \$6,975,851.84* *The total figure does not include 2015-16 funding for original New Directions sites as this funding was consolidated into Primary Health Care Funding agreements and actual figures cannot be determined.</p>
<p>The Access to Allied Psychological Services (ATAPS) Program - provides short-term evidence based mental health services.²³³</p>	<p>NT Wide</p>	<p>\$4,616,808.12²³⁴</p>

Locally based suicide prevention activities for at-risk groups such as men, Aboriginal people and people in rural and remote areas. ²³⁵	Alice Springs, APY Lands, Darwin, Finke, Jabiru, Katherine, Ltyentye Apurte (Santa Teresa), Nauiyu (Daly River), Palmerston, Tennant Creek, Tiitjikala, Tiwi, Wadeye" Arnhem Land, Barkly Region, Central Australia, Greater Darwin region, NT wide	\$3,645,470.46 ²³⁶
CatholicCare NT - Drug and Alcohol Intensive Support for Youth (DAISY) Project provides drug and alcohol intensive support for youth and families. The program provides counselling, case work, group work and community education. ²³⁷	Darwin, Palmerston, Batchelor	2014-15: \$321,294 2015-16: \$321,294
Education and Training		
Early Childhood Services, crèches, playgroups, and outside school hours care	Minyerri, Alawa, Nyirripi, Mutitjulu, Ali Curung, Ampilatwatja, Elliot, Urapuntja, Barunga, Batchelor, Alice Springs, Laramba, Yuelamu, Darwin, Wadeye, Elcho Island, Gapuwiyak, Groote Eylandt, Yirrkala, Angurugu, Milingimbi Katherine, Minijilang, Borroloola, Aputula Finke, Ikuntji, Ntaria, Kintore, Mount Liebig Watiyawanu, Santa Teresa, Tiitjikala, Areyonga, Papunya, Mataranka, Manyallaluk, Wugularr, Ngukurr, Bathurst Island, Pirlangimpi, Melville Island, Daly River, Pine Creek, Yuendumu, Goulburn Island, Emu Point, Tennant Creek, Docker River (Kaltukatjara), Milyakburra, Palmerston	\$25,250,278.60
Infrastructure and Regional Development		
Culturally Appropriate Counselling and Activity Space "Bough Shed" - provide a culturally sustainable space for women and children to gather together and undertake traditional and non - traditional activities.	Barkly	\$60,000
Industry, Innovation and Science		
Cooperative Research Centre for Remote Economic Participation - delivers solutions to address the social and economic disadvantage in remote areas.	Alice Springs	\$9,000,000

Source: Exh.580.000A, Commonwealth Services Spreadsheet, tendered 5 November 2017.

Table 38.4: Examples of Northern Territory Government funded programs and services during the relevant period [not an exhaustive list]

Examples of Northern Territory Government Funded Programs and Services	Locations	Funding Period and funding amount
Territory Families		
Tennant Creek Women’s Refuge Inc –culturally appropriate counselling and community education for women and children affected by and/or at risk of family violence.	Tennant Creek	2017/18 - \$726,419
Ali Curung Safe House - 24 hour 7 day a week access to a safe and secure crisis accommodation and culturally appropriate support, assistance, advocacy and referral for women and children who are affected by and/or at risk of family violence.	Ali Curung	2017/18 - \$160,271
Catholic Care NT - Milikapiti Family Safe House provide 24 hours, 7 days a week, 365 days a year access to safe secure crisis (0-3 nights) and short term (up to 13 weeks) accommodation.	Milikapiti	2017/18 - \$227,650
Therapeutic Intervention Services for Children provided by Relationships Australia - provide therapeutic support to children at risk of entering the child protection system by working in a holistic, case management care team approach with children and their families.	Darwin Palmerston Tiwi Katherine	2017/18 - \$390,000
Tangentyere Council Aboriginal Corporation – Tangentyere Women’s Family Safety Group	Tangentyere	2017/18 - \$321,925
CatholicCare NT - Intensive Family Preservation Services	No further information was provided by the Northern Territory Government	No further information was provided by the Northern Territory Government
Nhulunbuy Toy Library - Promotion of the learning, development and wellbeing of children and to enhance positive parenting practices.	Nhulunbuy	2017/18 - \$17,640
Housing and Community Development		
Aboriginal Hostels Limited - short-term, transitional accommodation and support for families who are homeless/at risk of homelessness.	South Terrace Managed Accommodation (Akangkentye Hostel) – Alice Springs	2016/17 - \$1,996,811
	Alyerre Hostel Service – Alice Springs	2017/18 – 2019/20 - \$1,386,000

<p>Anglicare – Youth Accommodation and Support Service</p> <p>Short-medium term supported accommodation for young people aged 15-19 years (singles, couples, those with children) who are homeless/ at risk of homelessness. Case management and outreach services are focussed on building capacity for independent living to reduce the risk of clients (and their dependants) entering a chronic cycle of homelessness.</p>	<p>Katherine (Katherine Youth Accommodation and Support Service).</p> <p>Darwin (Youth Accommodation and Support Service Darwin).</p> <p>Palmerston and Rural (locations for rural unspecified)</p>	<p>2016/17 - \$1,257,564</p>
<p>Tangentyere Council Aboriginal Corporation, Anglicare NT, CatholicCare NT - tenancy support programs for public housing waitlist applicants or tenants who are at risk of sustaining a public housing tenancy and case management services to support clients to avert the risk of homelessness.</p>	<p>Central Australia (Alice Springs and urban areas), Town Camps Alice Springs, Borroloola Darwin, Katherine, Nhulunbuy Tenancy Support Program Tennant Creek</p>	<p>2016/17 - \$5,186,603</p>
<p>Mental Health Association of Central Australia - The Tenancy Support Program is specifically tailored to clients with significant mental health issues, who are eligible for public housing in terms of income, but are unable to access other tenancy support services.</p>	<p>Alice Springs</p>	<p>2016/17 - \$203,271</p>
<p>Council for Aboriginal Alcohol Program Services - Integrated case management for clients who have involvement with alcohol and other drugs treatment services, to access accommodation and build capacity to avert the risk of homelessness</p>	<p>Darwin</p>	<p>2016/17 - \$173,432</p>
Education		
<p>Families as First Teachers – early childhood education and parent/carer capacity building.</p>	<p>Ali Curung, Ampilatwatja, Angurugu/ Umbakumba, Arlparra, Barunga, Daguragu/ Kalkarindji, Darwin Ludmilla Primary School Darwin Mimik-ga Centre (Early Intervention Learning Hub), Elliott, Galiwin'ku, Gunbalanya/ Oenpelli, Hermannsburg/ Ntaria Jilkminggan, Lajamanu, Lake Nash/ Alpururula, Larapinta, Maningrida Mataranka, Milikapiti, Milingimbi, Minyerri Nganmariyanga, Ngukurr, Numbulwar, Papunya, Pularumpi, Ramingining, Ski Beach/ Gunyangara, Tennant Creek, Warruwi, Wugularr, Yirrkala Homelands, Yirrkala, Yuendumu</p>	<p>Ends 2018 – exact funding unknown</p>
<p>Baby FAST - a multifamily group intervention model for young parents and toddlers to protect vulnerable families with risk factors.</p>	<p>Darwin / Wulagi Child and Family Centre, Katherine</p>	<p>This information was not provided to the Commission.</p>
<p>Integrated Child and Family Centres - community-driven hubs that provide high quality early childhood services to Aboriginal children and support vulnerable families to access integrated services to improve safety, health and wellbeing of families and communities.</p>	<p>Gunbalanya/ Oenpelli, Larapinta, Maningrida, Ngukurr, Palmerston, Yuendumu</p>	<p>This information was not provided to the Commission, but the Northern Territory Government informed the Commission that this program is still in existence.</p>

Health		
<p>Remote Area Health Services - Healthy Under 5's Check, School Screening, STI Screening, Antenatal Programs, Anti- suicide programs.</p>	<p>Adelaide River, Alyangula Angurugu/ Umbakumba, Aputula, Barkly Mobile, Batchelor, Belyuen, Bonya, Borroloola, Canteen Creek, Daly River/ Nauiyu Nambiyu, Elliott, Epenarra/ Wutungurra Gapuwiya, Gunbalanya/ Oenpelli, Haasts Bluff, Harts Range/ Aitiijere, Hermannsburg /Ntaria, Imanpa, Kaltukatjara/ Docker River, Kings Canyon, Lake Nash/ Alpururula, Laramba Maningrida, Milikapiti, Milyakburra/ Bickerton Island, Minjalang, Mount Liebig, Numbulwar, Nyrippi, Papunya, Pirlangimpi, Ramingining, Tara/Stirling, Tiitjikala, TiTree, Umbakumba, Wadey/Port Keats, Wallace Rockhole Warruwi, Willowra, Wurrumiyang a (formerly Ngiuu), Yirrkala, Yuelamu, Yuendumu, Yulara</p>	<p>Funding for 2 years: 2014/15 – 2015- 2016: \$78,306,627</p>
	<p>Pine Creek, Robinson River</p>	<p>Funding for 3 years: 2014/15 - 2016/17: \$3,394,866</p>
	<p>Alcoota, Ali Curung</p>	<p>Funding for 4 years:2014/15 - 2017/18 \$1,871,663</p>
<p>Alcohol and other Drugs Services Central Australia (ADSCA) is a Northern Territory health service that provides assessment, treatment and support services to people affected by alcohol, tobacco and other drugs in the Alice Springs and Barkly region communities. ADSCA aims to prevent and reduce the negative impact these substances have and thus improve the health and well-being of the community. ADSCA is part of the Central Australia Health Service and operates in accordance with and is guided by CAHS's over- arching policies, procedures and strategies.</p> <p>ADSCA provides:</p> <ol style="list-style-type: none"> ADSCA clinic Volatile Substance Abuse Service (VSA) Banned Drinkers Register (previously the Alice Springs Alcohol Assessment Service until 01 September 2017) under the Alcohol Mandatory Treatment Act Community Education 	<p>Alice Springs and Barkly region</p>	<p>2014/15 – 2015/16 - \$7,813,027</p> <p>Figures for the 2016/17 annual year were not provided, though the Commission understands that this service is still in existence.</p>
<p>Disability In- Home Support Program</p>	<p>Central Australia, Central Desert Shire, excluding Yuendumu and Aitiijere communities</p>	<p>2014/15 - 2015/16 - \$55,342</p>

Mental Health Association of Central Australia – Mental health and life promotions & Pathways to Recovery Program	Alice Springs	2014/15 – 2016/17 - \$3,861,450
Bush Adventure Therapy and Intensive Outreach provided by BushMob	Alice Springs	2014/15 – 2015-2016 \$2,938,867 The Commission understands that the NTG intends to fund until 2020
Top End Health Service – social emotional well-being program.	Borroloola and Robinson River	2015/16-2016/17 - \$2,034,505
Salvation Army – Men’s Hostel Alice Springs to support men with mental health issues.	Alice Springs	2016/17 - \$531,888
Anglicare NT - Delivery of evidence based and evaluated suicide prevention training workshops.	Top End	2014/15 – 2015/16 - \$595,492
Office of Disability		
National Disability Services - Provides physiotherapy, occupational therapy and speech pathology to children who present with a diagnosed disability	NT Wide	2014/15 – 2015/16 - \$489,175
Attorney-General and Justice		
Keeping Women Safe in their Homes - security upgrades to allow women and their children to remain safely in their homes.	Darwin	2017/18 – 2018/19 - \$327,495
Trade, Business and Innovation		
Bushmob - Alcohol Action Initiative Bushmob Project	Titjikala	Funding ended June 2017 – \$25,000
Department of Sport and Recreation		
Australian Red Cross - The SHAK Youth Centre including School Holiday Programs	Darwin	This information was not provided to the Commission, but the SFNT informed the Commission that this program is still in existence.
The Police		
Safety Houses for young people	Alice Springs	This information was not provided to the Commission.

Source: Exh.1229.001, Updated services table to Growing Them Strong, Together Report provided by the Northern Territory Government, tendered 6 November 2017

Table 38.5: Examples of Identified Core Prevention and Early Support Services in the Northern Territory²³⁸

	Prenatal	0-2	3-5	Universal	Targeted	Specialist	Physical	Cognitive	SEWB
Pre-pregnancy care									
School and community based sexual health education				✓					
Contraception & termination services: education & access				✓					
Adult health checks (men and women)				✓					
Public health education (including young women/men programs)				✓					
Youth services and activities				✓					
Quality antenatal and postnatal care									
Antenatal and postnatal care (aiming for first visit in first trimester)	✓			✓			✓	✓	✓
Access to traditional midwives	✓			✓			✓		
Antenatal and postnatal education/classes	✓			✓			✓	✓	✓
(Trial) birthing in remote communities	✓				✓		✓		✓
Case management for pregnant women with chronic disease	✓				✓		✓	✓	
SEWB/AOD support	✓	✓	✓			✓	✓	✓	✓
Smoking cessation support	✓	✓	✓			✓	✓	✓	✓
Home nurse visiting									
Nurse home visitation	✓	✓		✓			✓	✓	✓
Clinical child health care									
Child health surveillance		✓	✓	✓			✓	✓	✓
Child health checks to the age of 15		✓	✓	✓			✓	✓	✓
Primary ear programs		✓	✓	✓			✓	✓	✓
Oral health surveillance/treatment			✓	✓			✓		
Vaccination programs	✓	✓	✓	✓			✓		
Health promotion/prevention as part of PHC	✓	✓	✓	✓			✓	✓	✓
Sick care		✓	✓	✓			✓		
Case management for chronic conditions within PHC		✓	✓			✓	✓	✓	✓
Paediatric services including outreach		✓	✓			✓	✓	✓	✓
Child mental health services		✓	✓			✓			✓
Audiology & ENT services		✓	✓			✓	✓	✓	
Dental services			✓			✓			
Quality early learning									
Enriched learning support; or playgroups & preschool readiness if not available		✓	✓	✓			✓	✓	✓
Preschool (2 year program)			✓	✓				✓	✓

	Prenatal	0-2	3-5	Universal	Targeted	Specialist	Physical	Cognitive	SEWB
Therapeutic childcare for traumatised children		✓				✓		✓	✓
Parenting programs									
[Nurse home visitation]	✓	✓		✓			✓	✓	✓
Parental networks/support groups, e.g. mums groups	✓	✓	✓	✓	✓	✓	✓	✓	✓
Therapeutically oriented group parenting programs			✓		✓		✓	✓	✓
Nutrition									
Public health nutrition programs	✓	✓	✓	✓			✓	✓	✓
Monitoring and support for at-risk children		✓	✓		✓		✓	✓	✓
Failure to thrive/anaemia programs		✓	✓			✓	✓	✓	✓
Obesity programs			✓			✓	✓		✓
Supporting vulnerable families									
Screening (maternal SEWS, DV, child behavioural issues)	✓	✓	✓	✓			✓	✓	✓
Community education re. effects of stress & trauma	✓	✓	✓	✓			✓	✓	✓
Targeted family support for families struggling with complex circumstances (not in child protection system)	✓	✓	✓			✓	✓	✓	✓
Intensive family support services for children in the child protection system		✓	✓			✓	✓	✓	✓
Services (counselling/family support) for children with behavioural problems or signs of trauma		✓	✓			✓	✓	✓	✓
AOD/SEWB services for parents	✓	✓	✓			✓	✓	✓	✓
Family violence & anger management programs	✓	✓	✓			✓	✓	✓	✓
Effective child protection services		✓	✓			✓	✓	✓	✓
Effective DV services; safe houses	✓	✓	✓			✓	✓	✓	✓
Supporting children with physical problems & developmental delay									
Public health approach to reduce impact of infectious diseases	✓	✓	✓	✓			✓	✓	
[Paediatric services Including outreach]		✓	✓			✓	✓	✓	✓
Early intervention programs for children with conditions affecting physical, (soda) and cognitive development		✓	✓			✓	✓	✓	✓
Case management/family support for children with significant physical illnesses		✓	✓			✓	✓		
Hub supports such as PATS	✓	✓	✓			✓			✓
Public health policy & social determinants									
Public health measures (AOD, smoking, violence, nutrition)				✓	✓	✓	✓	✓	✓
Secure housing, including access to emergency accommodation				✓	✓	✓	✓	✓	✓

	Prenatal	0-2	3-5	Universal	Targeted	Specialist	Physical	Cognitive	SEWB
Programs to combat racism				✓			✓	✓	✓
Investment in the education system				✓			✓	✓	✓
Programs that strengthen culture				✓			✓	✓	✓
Environmental health				✓	✓	✓	✓	✓	✓
Education and literacy for adults				✓	✓	✓		✓	✓

ENDNOTES

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- ² Exh.510.000, Statement of Sven Silburn, 12 December 2016, tendered 19 June 2017, para 56.
- ³ Transcript, Fiona Arney, 26 June 2017, p. 5065: lines 8-45; Transcript, Leah Bromfield, 26 June 2017, p. 5067: lines 16-40; Transcript, Colleen Gwynne, 19 June 2017, p. 4479: lines 2-26; Exh.510.000, Statement of Sven Silburn, 12 December 2016, tendered 19 June 2017, para 56; Transcript, Muriel Bamblett, 13 October 2016, p. 200: lines 27-47; Transcript, Frank Oberklaid, 29 May 2017, p. 4016: lines 1-18, 35-45; Submission, North Australian Aboriginal Justice Agency, August 2017, pp. 24-25; Submission, Danila Dilba Health Service, August 2017, pp. 47-48.
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- ⁷ Exh.540.000, Statement of Clare Gardiner-Barnes, 4 June 2017, tendered 21 June 2017, paras 16, 76-78; Exh.535.000, Statement of Robyn Lambley, 6 June 2017, tendered 20 June 2017, paras 28, 42-45; Exh.535.002, Annexure RL-02 to Statement of Robyn Lambley, 6 June 2017, tendered 20 June 2017.
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- ¹³ E Munro, The Munro Review of Child Protection. Final report: A child-centred system, Department for Education, United Kingdom Government, May 2011, p. 69 as cited in Exh.024.026, Child Protection Systems Royal Commission, 2016, The life they deserve – Volume 1 – Summary and Report, Government of South Australia, tendered 13 October 2016, p. 151.
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- ¹⁶ Exh.585.000, Statement of Roslyn Baxter, 15 June 2017, tendered 26 June 2017, paras 25-26.
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- ⁵⁶ Exh.587.000, Appendix 1 to Statement of Andrew Tongue, 21 June 2017, tendered 26 June 2017.
The Commonwealth provided the Commission with a spreadsheet containing information about the activities that they delivered over the last three financial years in the Northern Territory on 21 June 2017 (the initial Commonwealth Services List), and an updated spreadsheet on 16 August 2017 (the Commonwealth Services List). The Commission undertook analysis of the initial Commonwealth Services List prior to being provided with the updated Commonwealth Services List. When the Commission received the updated Commonwealth Services List it reviewed it and considered that the information in the updated Commonwealth Services List would not materially change the analysis that it had undertaken off the initial Commonwealth Services List. Where the Commission considered that amendments contained within the updated Commonwealth Services List would materially affect the analysis (for example, funding figures of programs contained at Table 38.3) the Commission undertook additional analysis of the updated Commonwealth Services List.
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- ⁷⁴ Exh.1137.001, Deloitte Report – Implementing Dual Pathways on Child Protection, Territory Families, August 2017, tendered 1 November 2017, p. 9.
- ⁷⁵ Exh.520.000, Statement of Colleen Gwynne, 29 May 2017, tendered 19 June 2017, para 68; Transcript, Lesley Taylor, 30 May 2017, p. 4118: lines 19-31.
- ⁷⁶ Transcript, Professor Frank Oberklaid, 29 May 2017, p. 4019: lines 7-18.
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- 84 The estimated total population is the ABS census count for the relevant year. In 2016 the net Indigenous undercount was 17.5%. Source: Australian Bureau of Statistics (2016) Northern Territory – 2016 Census Quickstats < http://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/7?opendocument>
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- 199 Exh.661.001, Statement of Luke Twyford, 5 May 2017, tendered 30 June 2017, para 45(b).
- 200 Exh.661.001, Statement of Luke Twyford, 5 May 2017, tendered 30 June 2017, para 45(d).
- 201 Exh.1172.001, (Confidential) Cabinet Submission, 2 October 2017, tendered 2 November 2017, p. 3.
- 202 Exh.1137.001, Deloitte Report – Implementing Dual Pathways on Child Protection, Territory Families, August 2017, tendered 1 November 2017, p. 14.
- 203 Exh.1137.001, Deloitte Report – Implementing Dual Pathways on Child Protection, Territory Families, August 2017, tendered 1 November 2017, p. 16.
- 204 Exh.1137.001, Deloitte Report – Implementing Dual Pathways on Child Protection, Territory Families, August 2017, tendered 1 November 2017, p. 14.
- 205 Unless otherwise indicated the Commission has used the ABS data for Statistical Area 1 (SA1) to provide population statistics for all

Statistical Area 1 (SA1) is not provided.

- ²²⁵ The Commission notes that the Northern Territory Government Bushtel website provides a different population figure for this community. The Commission understands that the difference in population figures is that the Bushtel website incorporates the ABS census count for the relevant year adjusted (up) for the Indigenous net undercount rate in Australia, being 17.5% in 2016 <<http://www.bushtel.nt.gov.au/#!/profile?letter=P>>.
- ²²⁶ The Commission notes that the Northern Territory Government Bushtel website provides a different population figure for this community. The Commission understands that the difference in population figures is that the Bushtel website incorporates the ABS census count for the relevant year adjusted (up) for the Indigenous net undercount rate in Australia, being 17.5% in 2016 <<http://www.bushtel.nt.gov.au/#!/profile?letter=P>>.
- ²²⁷ The Commission notes that the Northern Territory Government Bushtel website provides a different population figure for this community. The Commission understands that the difference in population figures is that the Bushtel website incorporates the ABS census count for the relevant year adjusted (up) for the Indigenous net undercount rate in Australia, being 17.5% in 2016 <<http://www.bushtel.nt.gov.au/#!/profile?letter=P>>.
- ²²⁸ The Commission notes that the Northern Territory Government Bushtel website provides a different population figure for this community. The Commission understands that the difference in population figures is that the Bushtel website incorporates the ABS census count for the relevant year adjusted (up) for the Indigenous net undercount rate in Australia, being 17.5% in 2016 <<http://www.bushtel.nt.gov.au/#!/profile?letter=P>>.
- ²²⁹ This table represents the Commission's analysis of data supplied by the Commonwealth during the Commission's inquiries. Unless otherwise specified in the table, the Commonwealth considers the funding figures used by the Commission are broadly consistent with the amount of Commonwealth funding provided for the relevant programs/services, but was unable to guarantee their accuracy.
- ²³⁰ The Commonwealth does not guarantee the accuracy of the information specified for this program/service.
- ²³¹ The Commonwealth was unable to guarantee the accuracy of the information specified for this program/service prior to the Commission's report going to print.
- ²³² The Commonwealth was unable to guarantee the accuracy of the information specified for this program/service prior to the Commission's report going to print.
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- ²³⁷ The Commonwealth was unable to guarantee the accuracy of the information specified for this program/service prior to the Commission's report going to print.
- ²³⁸ Northern Territory Aboriginal Health Forum, April 2016, What are the Key Core Services Needed to Improve Aboriginal Childhood Outcomes in the NT: Progress and Possibilities, pp. 7-8.



39

CHANGING THE APPROACH
TO CHILD PROTECTION

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CHANGING THE APPROACH TO CHILD PROTECTION

THE CASE FOR REFORM

In the preceding chapters the Commission has set out a case for substantial reform to the child protection system in the Northern Territory. This has been driven by the understanding that the existing approach to child protection has not been effective in lowering the exposure of children to harm and is not sustainable if the rates of reported harm continue to grow as they have.

The problems facing the Northern Territory child protection system are not new and many of the Commission's findings about shortcomings in the system echo issues the 2010 Board of Inquiry identified seven years ago.¹ Some of the recommendations the Commission is making, particularly the need to focus on prevention, reflect the same understanding of the problem:

'[C]hild protection systems have become overwhelmed because their role has expanded without a simultaneous expansion of efforts focused on prevention across the whole of the government and non-government sector.'

Tellingly, the Board of Inquiry said that its report offered 'an opportunity for the Northern Territory to take a new approach to protecting children.'²

*'The Inquiry is unequivocal about its view that addressing child abuse and neglect through effective prevention and treatment efforts is one of the single most effective commitments that a government could make to the health, wellbeing and productivity of society.'*³

The failure to take up that opportunity comprehensively has played out in the intervening years and can be seen in the growing numbers of reports of children at risk, the continuing deterioration in the

lives of children and families coming into contact with the system, and the toll it has taken on the people and organisations working in child protection and children's services.

Without a vision for, and a commitment to a strategy for reform, service delivery will continue to suffer from fragmentation, duplication and unavailability as the statutory child protection system continues to be overburdened. Without an integrated service plan, activities which could provide early support will continue to be targeted at the wrong point in time for a problem, or the pathways to assistance will continue to be through the child protection system, rather than via an option which avoids it.

Any system which limits referral pathways to the point when a family is at real risk, will find that families are receiving services too late to turn their problems around. This cycle undermines the potential effectiveness of the very services which are meant to reduce the burden on the system.

A clear alignment between prevention, early support and tertiary responses is fundamental to reorienting the service system from one that is siloed, with a single programmatic focus, to one that is integrated with the needs of children, young people and families across their life course, at the core.

FUNDAMENTAL REFORM AND IMMEDIATE CHANGE

In developing its recommendations, the Commission has listened to a wide range of stakeholders, including people who have been through the child protection system, families who remain involved, communities, child protection workers, service providers, senior bureaucrats, academics and theorists. It has looked to other jurisdictions embarking on their own child protection reforms to inform its recommendations.

No one has suggested that there is an easy answer, or an off the shelf solution that can be identified and applied. Perhaps nowhere is this more so than in the Northern Territory. With its distinct cultural, demographic and geographic characteristics, the Territory needs its own approach, built from the ground up. The Commission does not wish to reinforce or replicate top down approaches that have failed families and communities in the past and are not the right fit for the Territory and its people.

The Commission's recommendations therefore seek to achieve two goals:

- to lay the foundations for a long term strategy and a new approach to child protection that can reverse the trajectory of children and families in the Northern Territory, and
- to alleviate immediate demand on the child protection system, which itself represents a risk to the safety of children.

The Commission is firmly of the view that child protection in the Northern Territory requires a reorientation to a focus on prevention. A shared vision of the system should be captured in a Generational Strategy for Families and Children in the Northern Territory (the Strategy). The Strategy should be founded on a public health model for protecting children and promoting their wellbeing and be based on genuine partnership, co-design and shared decision making. Considering the number of Aboriginal children in the child protection system⁴ and in out of home care,⁵ there will be a particular need to engage with Aboriginal organisations and communities in designing and implementing ways to keep children safe and remaining where possible with family.

Reform of the kind the Commission is recommending takes time and commitment. However, there are immediate changes to the existing system that need to be put in place to ensure that those children and families already in the system or on the verge of entering it have the best opportunity to improve their lives.

The Commission sees the immediate changes it is recommending as stepping stones towards more lasting reform. The immediate reforms proposed are not an endorsement of the existing child protection system and should not be taken as tacit support for maintaining the status quo with some tinkering around the edges.

It is not surprising that reform efforts in child protection can fail when immediate need is pitted against a long term plan and there is insufficient funding for both. The Commission understands both the preference and the pressure to implement recommendations that can achieve results immediately rather than those recommendations aimed at long term system change that may take several years to be realised. Prevention will often be trumped by the immediacy of investment in better protection systems, and change from that investment will always be more tangible, more visible and more immediate.

However, evidence before the Commission indicates that there is a desire in the Northern Territory to create lasting change and to stop the cycle of crisis and failed reform.⁶ The Commission was told long-term generational investment is needed, with a commitment to ensure that such reforms are prioritised and do proceed.⁷

REFORM PRINCIPLES

The Commission's proposed reforms are underpinned by a number of fundamental principles:

- **Child focused:** based on a child-centred belief that every child has the right to a safe passage through childhood and the right to grow in an environment free from harm. The child's needs and welfare, the best interests of the child, are the primary concern and the primary focus of practice
- **Centrality of the family and community:** acknowledgment of the centrality of the family and community in the present and ongoing life of the child
- **Early Support:** support for children and families available and accessible **as early as possible**, oriented towards prevention
- **Community based:** with the meaningful engagement and participation of families, communities and organisations in decisions that affect their lives and the services delivered to them
- **Evidence based:** strategies, services and programs based upon the latest knowledge, from research and through consultation with local communities about what works and what doesn't work
- **Locally tailored:** solutions tailored to meet local problems and needs, identified by and developed with local communities
- **An understanding that adult adversity and problems result in disruption, distress and trauma for children:** services for adults must acknowledge and be prepared to deal with the effect of adult problems on the lives of children.

LEADERSHIP AND PLANNING

Achieving reform will require strong leadership, good governance, community engagement, adequate time and careful planning. Leadership within and across government is critical, and successful reform is dependent on strong direction.

A recent analysis of the implementation of recommendations from previous inquiries examining child abuse and neglect reported that recommendations focussing on prevention were often the most difficult to implement due to a general lack of political will.⁸ The study surveyed public servants overseeing the implementation of recommendations from inquiries, and noted:

More than one respondent commented on the fact that previous inquiries into child protection systems, especially those that are crisis-driven, have had the effect of concentrating focus and resources on tertiary responses, resulting in increased numbers of notifications and more children taken into care. ... [E]nsuring access to services and support for families at the “front end” was seen as being not only a more logical and cost-effective approach, but also one that helps foster a wider sense of responsibility for the protection of children. Respondents nonetheless recognised the general lack of political will for strategies that require considerable up-front investment for long-term gain. According to some respondents, the recommendations most likely to fall off the implementation agenda are those relating to preventative solutions.⁹

In the Commission’s view, a public health approach needs to be adopted. Public health approaches have been used to address complex health issues that require sustained, multi-prong strategies that can adapt to changes over time. Support for a public health model to prevent child abuse and neglect has been growing outside and within Australia.¹⁰ A public health model should also be considered for situations presenting a complex interplay of problems, which are prevalent, serious and associated with severe long-term effects on individuals and communities.¹¹

The fact that a public health approach will require considerable upfront investment cannot be avoided. But by every measure—the wellbeing of children, safety and contentment of the community and eventual financial return—the investment is worthwhile. Waiting until problems become further entrenched will only require interventions that are more expensive and far less effective.¹² As noted above in Chapter 38 (Early support) a public health approach is needed:

A public health approach to child protection shifts the focus to a service system that provides early support to children and families to prevent entry into the statutory child protection system. This support includes core, universal services to all families and targeted support to vulnerable families. Additionally, such an approach must not only address the spectrum of supports and services needed to promote the safety and wellbeing of children, but also the differing levels of willingness and capacity of individuals to access and receive those supports and services.

Public health efforts systematically examine causes and consequences of problems, based on a clear understanding of prevalence, to design a system of strategies, programs and services, commonly known as ‘interventions’. Central to a public health approach is its emphasis on prevention, early support and the importance of collective action.¹³

Putting in place the necessary reforms to transform the child protection system requires not only the unqualified support of governments from the outset, but leadership at all levels of government and from across all parts of the community. The shift to a public health approach will by necessity, entail a shift in how government undertakes its business, implementing flexible approaches to funding and contract design, fundamental changes in how it interacts with and responds to communities and families, then allowing this shift to inform policy, practice and workplace culture. At a fundamental level, this is a shift from doing things to communities, to working *with* them. Without leadership and the accountability that goes with it, this will not occur, or at the very least, will not be sustained.

If governments are reluctant to invest in prevention, knowing that the results may take years and, in some cases generations to eventuate, then another opportunity to resolve the problems facing children and their families in the Northern Territory could be lost. Long-term intergenerational investment will be needed and strong leadership of the reform is essential to ensure this opportunity for reform is not wasted.¹⁴ Without this investment and leadership, long term reforms will drift and transitional measures could quickly become a substitute for lasting action. As one submission expressed it:

A political and public will must be established in order to challenge the hearts and minds of the community to assert that our most vulnerable children and families are worthy of respect, care and support – whatever it takes.¹⁵

BUILDING A NEW SYSTEM - STEPS TOWARDS REFORM

The Commission’s proposal for reform of the child protection system is not a package of ready-made measures or reforms. In the Commission’s view, no such package of measures can be created until the Northern Territory has a better and more accurate understanding of the problems facing children in the Northern Territory, which are the underlying causes of the challenges facing its child protection system.

Proposed reforms and process

The central elements of the Commission’s recommendation are:

- the development of a Generational Strategy for Families and Children for addressing child protection and the prevention of harm to children
- the adoption of a public health approach to address the problem of child abuse and neglect as the foundation for reforms, covering both prevention and protection, and
- the establishment of a network of at least 20 Family Support Centres, providing place-based services to families across the Northern Territory.

The Commission's recommendations are articulated as a series of steps to underpin the development of new services and statutory systems. The steps should be seen as intertwined parts of a comprehensive suite of reforms, rather than a series of unrelated, standalone recommendations. These steps need to be introduced, understood and implemented through a considered process involving coordination and engagement, research and information, the Generational Strategy, establishing a network of Family Support Centres and oversight and reporting.

A. Co-ordination and engagement

1. Establish a **Tripartite Forum** to advise on and monitor reforms, which includes the Northern Territory Government, Commonwealth Government and Northern Territory community representatives, including representatives of Aboriginal organisations. The forum is discussed further in Chapter 43 (Implementing reform).
2. Establish a **joint Commonwealth-Territory Co-ordinated Funding Framework**, focused on early support and enabling a co-ordinated, flexible and sustainable approach to funding of services and policy initiatives.
3. Establish **formal mechanisms for consulting** with the community sector and Aboriginal communities, which:
 - a. enables local community knowledge about risks, cohorts in greatest need with service gaps to be factored into policy and funding decisions on a place by place basis, and
 - b. integrates the outcomes of this consultation into the planning, design and delivery of services.

B. Research and information

4. Conduct **research and studies to gather essential prevalence, population and needs information**, including:
 - a. participation in a **prevalence study**, either a national study conducted by a Commonwealth Government body, such as the Productivity Commission, or a Northern Territory study
 - b. either separately or as part of the prevalence study, **conducting a needs study** to gather information about family and child needs across the Northern Territory, including the **needs of the sub-populations or cohorts** in each area which are at high risk of involvement in the statutory child protection system, and
 - c. implementing a **broad based research agenda** designed to understand the nature, scale and scope of the problem in the Northern Territory.

5. Conduct a **mapping exercise of all existing services** in the Northern Territory, covering Commonwealth, Territory and non-government organisation services, with:
 - a. a focus on the availability, accessibility and use of the services by specific communities place by place, as well as by risk cohorts
 - b. a mapping of existing networks and referral pathways between government agencies, services providers and communities, and
 - c. the **creation of a Services Register** containing information about all services, including what services are available in specific communities.

6. Using the information from the studies and the mapping exercise, identify:
 - a. the **needs of communities, including specific sub-populations**, which are not matched by existing and continuing services
 - b. a **set of core services** to be available to all families and in all areas of the Northern Territory, and
 - c. a range of **additional services targeting specific issues**, including the needs of specific cohorts, which could be made available on a targeted basis in areas of high need.

7. Establish an **early support research unit, which would:**
 - a. be based in the Department of the Chief Minister
 - b. bring together academic expertise, key Aboriginal and non-Aboriginal stakeholders, and representatives from Northern Territory Government agencies
 - c. identify research priorities and coordinate the development, implementation and funding of a child protection and family support research agenda, to inform policy decisions, and
 - d. oversee and monitor the evaluation of services and strategies, reporting on the evaluation outcomes.

C. The Generational Strategy

8. Develop a **10-year Generational Strategy for Children and Families** for the prevention of harm to children in the Northern Territory, which would be:
 - a. a **new strategic framework** to govern strategies and services for families and children based on local service delivery, covering service location, design, selection, development, delivery, funding and evaluation
 - b. based on a **public health model**
 - c. **led by the Department of the Chief Minister**, with a body such as a Steering Committee responsible for the day to day responsibilities for the design and implementation of the Strategy
 - d. **overseen by the proposed Tripartite Forum**, as discussed in Chapter 43 (Implementing reform), following consultation with community and professional stakeholders
 - e. **endorsed by the Children’s Sub-Committee of Cabinet**

-
- f. **structured around the delivery of both:**
 - i. **core services** that would be available throughout the Northern Territory to all families, and
 - ii. **services targeting high risk cohorts and prevalent risk factors** for involvement in the child protection system.
 9. Set measurable **targets, benchmarks and outcome measures** within the Strategy for measuring the effectiveness of the Strategy and improvements in the lives of children and families.
 10. Finalise its **Outcomes, Reporting and Evaluation framework** for services delivered to children and families, which includes regular measurement, assessment and reporting. The framework should be finalised in light of the recommendations of the Commission. This framework is discussed further in Chapter 41 (Data and information sharing).

D. Establishing a Network of Family Support Centres

11. Establish a place based network of no fewer than 20 **Family Support Centres:**
 - a. in **locations identified** in the Strategy, based on the needs and services information
 - b. with an emphasis on **partnership between government and community**.
12. The roles of the Family Support Centres should include:
 - a. providing or ensuring the **provision of the core and targeted services** identified in the Strategy
 - b. providing information and support to **families engaging with the child protection system**
 - c. acting as **'recognised entities'** under child protection legislation for the purpose of providing views in child protection cases, and
 - d. acting as an **entry point** in the event that the Northern Territory implements a dual pathways model.
13. Collaborative development of a strategy to identify and support families using local networks of referral, information sharing and engagement, including medical professionals, school teachers, police, Centrelink, and sporting organisations.
14. Establish mechanisms and protocols between the Family Support Centres, other service providers and Northern Territory Government agencies, encompassing procedures with respect to notifications, service referrals and information sharing, including the role of the Centres in any 'dual pathways' model.

E. Oversight and Reporting

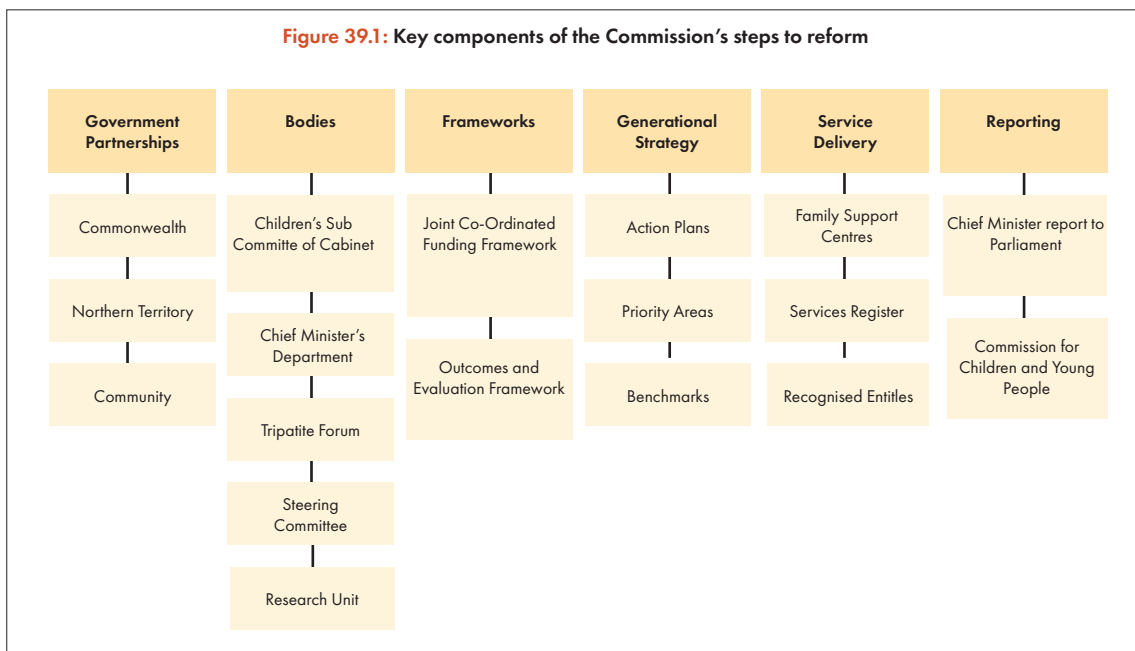
15. Create a new **Commission for Children and Young People**, with broader powers to:
 - a. monitor the position and outcomes for all children in the Northern Territory, and
 - b. report on the overall progress of prevention and protection work, progress under the Strategy, and the implementation of the Commission's recommendations.

16. The Chief Minister to provide **an annual address to the Northern Territory Parliament on Progress under the Strategy**, encompassing:

- a. progress on the implementation of recommendations
- b. changes and developments in the Strategy, and
- c. the impact of the Strategy and the outcomes for children and families.

A number of these steps are discussed in more detail below. Issues relating to the implementation of the proposed reforms are discussed in Chapter 43 (Implementing reform).

Figure 39.1: Key components of the Commission’s steps to reform



Reform process timing

The Commission cautions that it is not possible to carry out all of the steps above in too short a period of time as this would compromise the capacity to deliver well-structured and lasting reforms. The Commission suggests that there would be a number of stages in progressing the recommended reform process and that the pathway to the establishment of the new Family Support Centres and the delivery of new services might be as long as two years. Estimated times for the stages are set out below.

Table 39.1: Timeframes for Reform

Action	Estimated Timing
Establishing new co-ordination bodies	Within 3 months
Consulting with the sector	Within 6 months
Information gathering, research, studies and mapping exercise	Within 12 months
Establishing research unit	Within 6 months
Establishing the Commission for Children and Young People	Within 18 months
Producing the Strategy	Within 18 months
Developing and making available core and additional services	Within two years
Establishing the new Family Support Centres	Within two years

Applying a public health approach

It is the Commission's view that a public health approach should transform the child protection system in the Northern Territory and shift the focus to one of harm prevention, early support and co-ordinated collective action.¹⁶ In the context of the Northern Territory, it is also imperative that the approach should be culturally safe and trauma-informed.¹⁷ In applying a public health approach, co-operative efforts from diverse sectors such as health, education, social services, justice and policy will be necessary.¹⁸

Given the nature of the process set out by the Commission, in which decisions about the deliverable services are dependent on further consultation and information gathering, it is not possible to provide a costing for the proposed reforms. However, the essence of a public health approach is that more effort and resources applied at the primary level of prevention and support will mean less need at the tertiary end. For children and young people this means intervening early in the life of the child and early in the life of a problem. This leads to better outcomes for children and less reliance on tertiary responses such as removal from family. This approach in the long term will ultimately be the most cost effective option for governments,¹⁹ because the economic impact of child abuse and neglect is substantial and has been found to be associated with a range of adverse later life outcomes, including depression, substance abuse and criminal offending.²⁰ Research undertaken in 2015 estimates that the cost to Australian taxpayers of unresolved childhood trauma is at least \$6.8 billion per year for child sexual, emotional and physical abuse alone. When broader definitions of childhood trauma are taken into account, this figure increases to at least \$9.1 billion.²¹

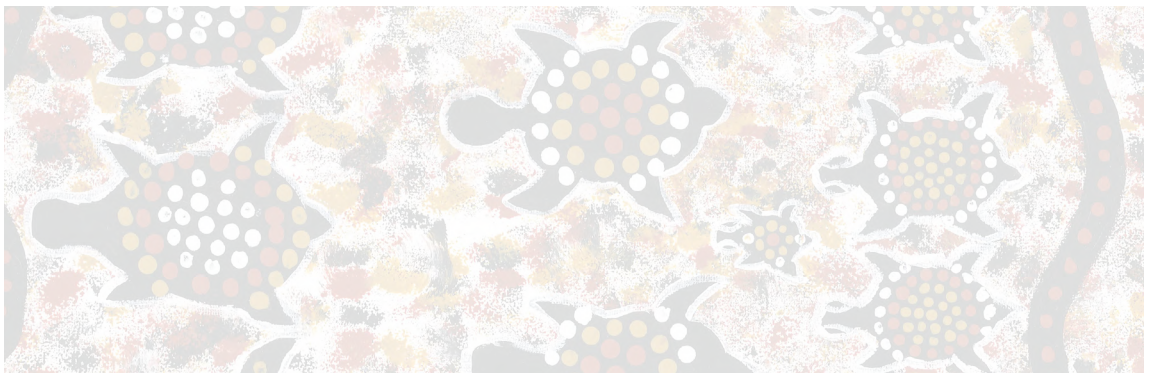
Many of the reform components the Commission has set out are, in practice, components of a well recognised public health model, including understanding the problem at the local level through implementation of a broad based research agenda, identifying the factors that contribute to, and protect against, child abuse and neglect and mapping the accessibility, quality and relevance of services across the Northern Territory.

The Commission intends the steps needed to implement a public health approach in the Northern Territory be included in the plan proposed by the Commission, particularly in the areas of:

- **consultation and information gathering:** engaging local communities to better understand needs of children and families in different communities
- **needs analysis:** understanding the prevalence, scope, characteristics and consequences of child abuse and neglect at the local level through systematic data collection
- **research:** collating and undertaking research to identify the factors that cause, contribute to, and protect against, child abuse and neglect
- **service mapping:** using the results of data collection and research to design, implement, monitor and evaluate support services that meet the needs of local communities. This also involves mapping existing services and testing their accessibility, quality and relevance to see if they match what is needed, and
- **evaluation:** evaluating the impact of programs and services overall at the individual, family and community levels and sharing what has been learned.

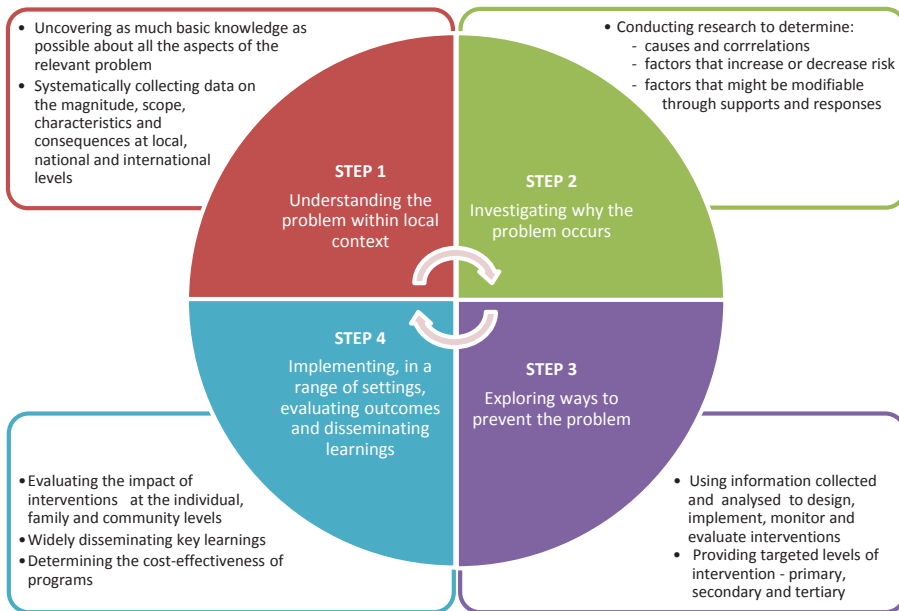
The World Health Organisation defines four key steps to developing an effective service system for addressing the problem of violence.²² The Commission is recommending that the Northern Territory adopt this systematic approach to service system planning and design, as set out in Figure 39.2.

The first step involves uncovering as much basic knowledge as possible about all the aspects of the relevant problem through systematically collecting data on the magnitude, scope, characteristics and consequences at local, national and international levels. The second step involves investigating why the problem occurs, which involves conducting research to determine causes, factors that increase or decrease risk and factors that might be modifiable through supports and responses. The third step is to explore ways to prevent the problem by using the information gained to design, implement, monitor and evaluate interventions. The final step is the implementation of a range of settings, interventions that appear promising, widely disseminating information and determining the cost-effectiveness of programs.



The Commission’s proposed approach reflects these steps.

Figure 39.2: Applying the World Health Organisation (WHO) Public Health Model ²³



ENGAGEMENT WITH ABORIGINAL COMMUNITIES

The reform proposals put forward in this report, both immediate and looking towards the future vision of an effective child protection response, are built around an assumption that consultation and engagement with Aboriginal people, whether through organisations or through more community-focused efforts, will be critical to their success.

The issue of Aboriginal participation and engagement and the fundamental role it should play in improving outcomes for children and families was addressed directly by the BOI report:

As highlighted in the Little Children are Sacred report, it is imperative that government, its agencies, non-government organisations and the wider community commit to and engage with Aboriginal people to promote active participation in improving wellbeing outcomes for vulnerable and at risk Aboriginal children and young people. Government agencies must engage more effectively with Aboriginal people, involve Aboriginal people in all aspects of decision-making relating to Aboriginal children and young people, and establish and adequately resource specialised Aboriginal services.²⁴

The steps proposed by the Commission recognise the importance of participation by Aboriginal communities and organisations in the planning of the new approach to ensure that the reform process and the Strategy is properly targeted and culturally appropriate. To this end, Aboriginal and other community organisations must be involved in the Tripartite Forum, discussed at Chapter 43 (Implementing reform) and recommended by the Commission along with a comprehensive process of consultation with Aboriginal communities.

It is essential for the success of the proposed reforms to build new and stronger connections with communities, who share recognition of the problems and proposed solutions.

INFORMATION GATHERING, PREVALENCE STUDY AND NEEDS ANALYSIS

Consultation

For a public health model to be effective there must be a solid understanding of why child abuse and neglect are occurring in particular situations and circumstances and what preventative measures will be most effective. The Commission is recommending that a place-based approach is embedded in the Strategy, grounded in the idea that the closer one gets to an issue or a problem, the more likely it is that the problem will be understood.²⁵

The Commission also heard that a ‘one size fits all’ approach is unlikely to work because every community is different in terms of demographic profile, mix of services, local structures and aspirations, specific problems and needs. To be effective, solutions need to be planned, developed and implemented across one community at a time.²⁶ The alternative is that programs may fail to meet the needs of families if they are not adapted to local culture and context.²⁷

Families and communities have to be engaged in considering what resources they need and how they should be delivered.²⁸ In practice, this requires identifying the key stakeholders, including community leaders, and then engaging with them to understand the profile of a particular community. This includes its strengths and weaknesses, any available data on outcomes for children and families, as well as mapping the resources and services available or needed to match the identified need. The Commission is of the view that ideally each community should be engaged in designing its own solutions and making decisions around services tailored to their particular community.

So the community owns the whole process, the community owns the outcomes. And that's our best chance of sustainability ... So once a community has a plan they're resourced ... appropriately to deliver on that plan, and then we're helping with evidence and using data, etcetera. We hold them accountable for that plan.²⁹

Prevalence and needs studies

Any strategy focusing on early support and prevention for children, families and communities should be based on an analysis of comprehensive and robust data. Systematic data gathering and analysis across the target population is fundamental to gaining a better understanding of the drivers and outcomes of child protection for children in the Northern Territory.³⁰

The Commission is aware that Australia is one of the few developed countries where there has been no methodologically rigorous, nationwide study of the prevalence or incidence of child abuse and neglect.³¹ The Royal Commission into Institutional Responses to Child Sexual Abuse has released a scoping study to inform the commissioning of a national prevalence study of all forms of child maltreatment,³² its nature and context, health outcomes and risk factors.

A prevalence study would provide detailed information about the current extent of abuse, how it might differ across the population of children in Australia, inform a baseline for measuring the effectiveness of future policies and programs and create a better understanding of the effect of previous policies.³³

The Commission strongly supports a national prevalence study, with the caveat that the methodology must take into account the sensitivities and logistics of engaging Aboriginal people in remote communities.

In the absence of a national prevalence study however, the Commission recommends that the Northern Territory should conduct its own study, together with a needs analysis, which would provide information about the level of vulnerability of children, their exposure to harm, their circumstances, location and needs and the predominant problems in their communities or environments. Such an analysis should be conducted across the Territory, with a focus on understanding the specific needs of Aboriginal people given their over representation in child protection systems.³⁴

This study should also identify and provide a better understanding of risk and protective factors in families and communities across different locations and allow a more detailed examination of the characteristics of specific cohorts of children and young people.

The study should also include a sub-population or cohort analysis to identify the types of families or groups of children most in need and most at risk of repeat involvement, to support better service design and delivery with a focus on early support and prevention. These cohorts are yet to be identified and will vary from place to place, but might include groups such as children involved in criminal offending, children with intellectual disabilities, children with parents with addiction or mental illness issues, teenage girls and the children of teenage mothers.

The findings of such a study are essential to provide an evidence base for the planning of the Strategy. It will also provide the evidence base from which to make decisions about service development, program and service gaps and to identify what programs and support should fall within the core services to be delivered at a universal level to groups or areas of specific need. The benefit of such a study can also be ongoing. The Menzies School of Health Research advised the Commission that good quality longitudinal data had been important to some of the countries with world leading child protection systems.³⁵

Service mapping and a service register

Designing a comprehensive and effective service system requires knowing to what degree the current provision of family and children's support services matches the extent and level of evidenced need, and the reasons why child abuse and neglect is occurring. A process of service mapping is needed to identify what services are currently commissioned and operating in different locations, their levels

of service, and the programs and conditions, under which they are funded, as well as what gaps, overlaps and duplications of service provision currently exist. The mapping should cover all services delivered in the Northern Territory including those delivered by the Commonwealth Government and non-government organisations (NGOs).

Such a mapping exercise would also identify services which exist but are underutilised, geographically inaccessible, not consistently available, or subject to entry criteria which limit their potential value. In the Commission's view, such information is necessary to design a more coordinated approach for services in the Northern Territory.

The Commission recommends that the results be maintained in a Service Register, listing currently funded programs and services available in each area. Funding, contract duration and evaluation information should also be included in the Register. The Register should be updated as services change, to ensure its continued value as an input to planning. The results could also inform a public online service directory.

A Research Unit

The Commission recommends that a specialised unit to conduct research relating to child protection and the prevention of harm to children should be established to inform government investment in programs and services. This proposal adopts a recommendation from the Nyland report³⁶ which proposed that an Early Intervention Research Directorate (EIRD) be established to guide funding priorities and service coordination in each local area through the development of data, monitoring and evaluation systems.³⁷

The EIRD was also to conduct service mapping across the State and the report recommended that child and family assessment and referral networks prepare annual local area needs assessments and submit them to the EIRD to inform funding decisions. The EIRD is now established in South Australia.

The Commission recommends the establishment of a research unit similar to the EIRD to coordinate a research agenda and help build an evidence base which can be drawn on for decision making in relation to child protection, harm prevention, early childhood, education, and family and children's support services. Its functions should include:

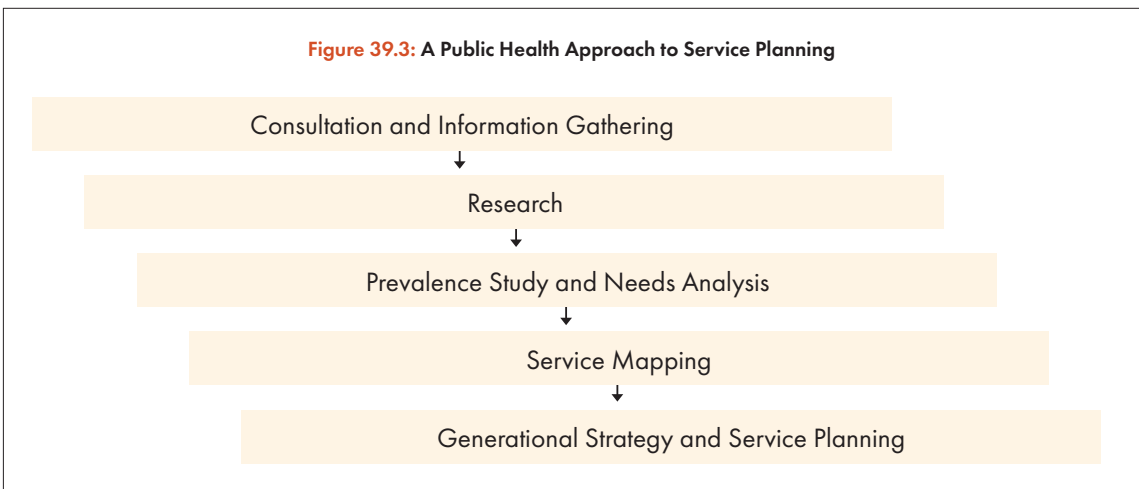
- co-ordinating and commissioning research in the priority areas identified in the Strategy
- identifying research applicable to the Northern Territory context
- supporting the evaluation of new and existing programs and services
- establishing and maintaining integrated data, monitoring and evaluation systems, and
- disseminating research findings to government, organisations and communities within the Northern Territory service system.

The research unit should be based within the Department of the Chief Minister, and operate in partnership with one or more academic institutions. Its work should be planned in consultation with government departments in the Territory and the Commonwealth and Aboriginal and non government organisations. The starting point for this process should be to bring together existing academic and research expertise, such as the Menzies School of Health Research, with local, community knowledge to ensure that this is a key input into government decision-making.

A task of the research unit will be to enhance the focus on outcomes for children. While there are currently national standards that provide a framework for measuring and assessing outcomes for children in out of home care, they do not consider outcomes across a continuum of support including prevention and early intervention. The Australian Health Minister’s Advisory Council highlights the Aboriginal and Torres Strait Islander Health Performance Framework as a best practice outcomes framework. It conceptualises different intervention tiers of a holistic system, much like the universal, secondary and tertiary levels of a public health approach.³⁸ The Framework supports a coordinated effort beyond the health sector to address the factors that contribute to Aboriginal health outcomes and provides a useful model for an outcomes framework for children and family services. The Commission also recommends the research unit’s work feed into and align with the Northern Territory Government’s Outcome, Reporting and Evaluation framework, once it is finalised.

In developing effective child protection policy, governments should be ‘tight on outcomes and loose on inputs’.³⁹ Specific expectations of outcomes can be set, without being too prescriptive on how the outcomes are achieved.

The work of the research unit must feed into the Strategy and the planning process. The Unit should therefore provide updates on its work to the Tripartite Forum on a regular and as needs basis. The findings of the studies conducted, together with the research output, should enable the Northern Territory to develop an evidence-based and coordinated system of integrated support services for preventing child abuse and neglect. The Commission recommends that the development of the Strategy and ongoing service planning be informed by the national prevalence study and needs analysis.



A GENERATIONAL STRATEGY FOR CHILDREN AND FAMILIES

The Strategy

The Commission recommends the development of a 10-year Generational Strategy for Children and Families in the Northern Territory that will articulate the vision for the future of its children and families. The Strategy should set out a new framework for the prevention of harm to children that will drive the

development and delivery of services for children and families. It should be based on a commitment to a local service delivery model underpinned by local design, selection, development, delivery, funding and evaluation.

The Strategy should be developed in partnership with key stakeholders, including the Commonwealth and Northern Territory Governments, Aboriginal Peak Organisations (APO NT) and Northern Territory Council of Social Services (NTCOSS) with its development overseen by the proposed Tripartite Forum. The Strategy will need to take a whole of government perspective and bring greater co-ordination to services across multiple departments with the Chief Minister assuming responsibility for its development and implementation.

The Strategy should cover a series of core actions:

- the adoption of a whole of government public health approach to the issue of the prevention of child abuse and neglect
- the establishment of mechanisms for consultation with key stakeholders across government, community, professional organisations and research bodies
- the establishment of governance structures encompassing implementation and oversight of the Strategy
- identifying a set of core services which should be available to all families and all children
- the development of policies, programs and services that will target high risk cohorts and prevalent risk factors leading to involvement in the child protection system
- setting measurable and reportable targets, benchmarks and outcomes to enable the tracking of success or otherwise of the actions taken under the Strategy
- the development of an evaluation and reporting framework for the Strategy, which is reported publicly annually and at the conclusion of each five-year Action Plan, and
- the development of a funding approach, with an emphasis on flexible, longer term funding arrangements, to support the design and delivery of new, place based services.

The Strategy would be designed based on the needs study and the mapping of the service and support system in the Northern Territory with a focus on children and families. It should also focus on the needs of specific communities, identified risk cohorts and the accessibility of services relating to those needs and map existing networks and referral pathways between government agencies, services providers and communities.

The Strategy should be specific about the needs of children and families in the communities where they live, across a number of domains, setting out priorities and the actions planned to meet those needs. It should present a planned and cohesive framework to prevent harm to children and extend support and assistance for families to minimise pressure on the child protection system. It should articulate a commitment to:

- adopting a place based approach to planning services
- extending the range and reach of services for all families and children
- developing new services in areas of identified need, such as substance abuse services and mental

-
- health services for young people
- working with Aboriginal communities to identify needs and develop solutions
 - encouraging established and new Aboriginal organisations to engage as service providers
 - enabling earlier and broader access to family support
 - improving the co-ordination of service planning and delivery
 - adopting an evidence-based approach to the selection of services
 - measuring outcomes against targets, and
 - streamlining the funding process and moving to greater security of funding for longer periods.

Although vulnerable children have been the focus of the Commission, given the ongoing flow of children into the vulnerable category in the Northern Territory, the Strategy should address the needs of all children and families. Nobody should be excluded from the realisation of a vision for the future of children and families in the Territory.

Targeting sub-populations

Specific consideration of groups shown by the needs study to be most vulnerable or at risk should be included in the Strategy. As previously discussed, it is not possible to identify the cohorts warranting particular consideration in advance of the needs study but examples of possible groups include children with disabilities, teenage girls and teenage mothers, and children with an involvement in the criminal process. Once those cohorts are identified, place-by-place, the Strategy should set out actions for each group, to improve their outcomes.

Action plans, domains and priorities

The Strategy should be implemented through five-year action plans that identify priorities and proposed actions.

The Commission suggests that the Strategy should follow a similar approach to that of the recently released early childhood plan, *Starting Early for a Better Future: Early Childhood Development in the Northern Territory 2018-28*,⁴⁰ (the *Early Childhood Plan*) setting out planned actions mapped across a series of domains, highlighting priority areas and actions within each domain, with clear targets and outcome measures. The agency responsible for the priority actions should also be clear.

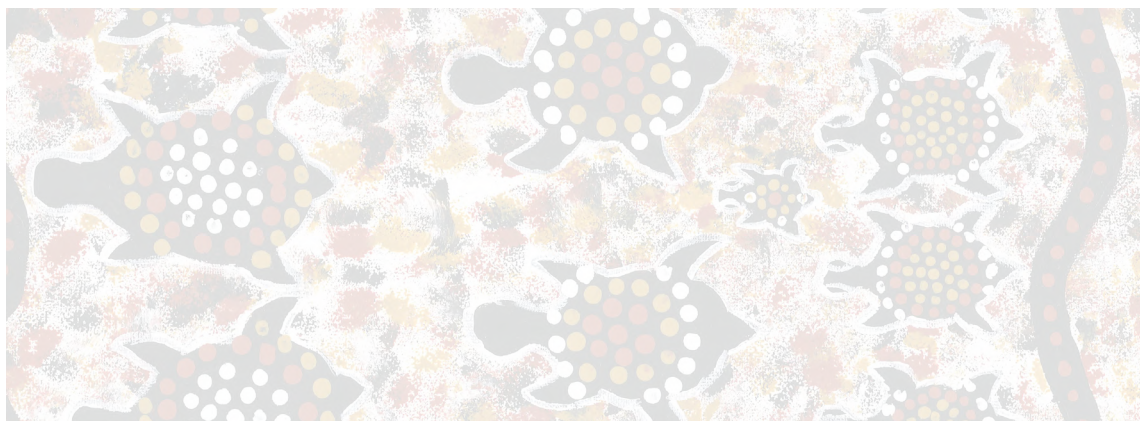
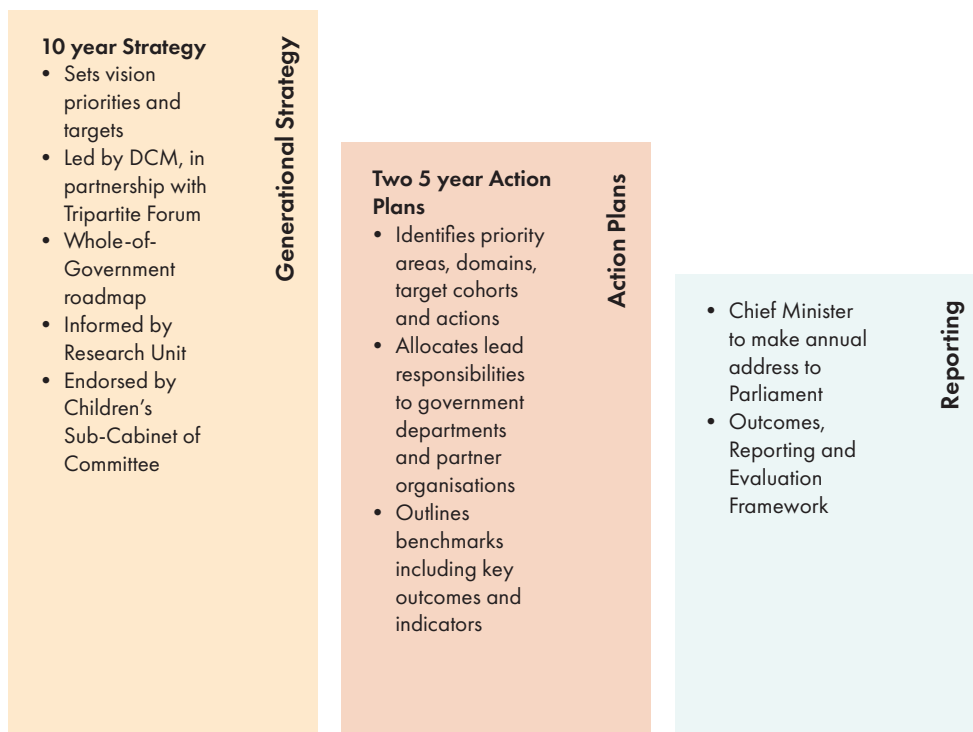


Figure 39.4: Components for developing and implementing a Generational Strategy for Children and Families in the Northern Territory



Benchmark setting

Benchmark setting should be a fundamental component of the Strategy. Benchmarks should establish measures and targets and set, for each priority action, a point of reference from which measurements may be made. Benchmarks carry weight as a fixed standard against which performance can be measured, reported and judged. Specific targets and ongoing monitoring will enable the assessment of the shift in investment toward services that support families early, and should realise positive outcomes for children.⁴¹

The Early Childhood Plan sets preliminary 10-year targets in areas including levels of developmental vulnerability, child health, child learning, and protection from harm. The target indicators proposed in relation to protection from harm include, as examples, reducing the number of children aged 0-4 in out of home care to the national average, or reducing the number of children aged 0-4 who are the subject of substantiations for abuse or neglect to the national average.⁴² The Plan outlines a 10-year approach to increasing investment in integrated services to better support families and ensure greater access to, and easier transitions between, services.⁴³ Given the population size of the Northern Territory, there is an opportunity for this early childhood plan to be a platform for service system reform for children of all ages and their families. The Commission considers that the structure of the Early Childhood Plan, once finalised, could provide a useful basis for the Strategy.

Reporting

The Commission sees the 'Closing the Gap' report to the Commonwealth Parliament as setting the standard for public reporting on the outcomes of programs aiming to assist Aboriginal people. The position of children in the Northern Territory is so important that the Northern Territory Government should adopt the same approach to reporting on the outcomes for children under the Strategy. The Commission proposes the Chief Minister provide an annual address to the Northern Territory Parliament on Progress under the Strategy, which would include its implementation and outcomes against the benchmarks set in the Strategy.

Other review and reporting avenues address related issues in a national context. There would be value in including the relevant Strategy benchmarks in such national review processes if possible. The inter-governmental Steering Committee for the Review of Government Service Provision produces a regular report against key indicators of disadvantage experienced by Aboriginal people. The Overcoming Indigenous Disadvantage report measures the wellbeing of Aboriginal people and provides information about outcomes across a range of strategic areas such as early child development, education and training, healthy lives, economic participation, home environment, and safe and supportive communities.⁴⁴

The Commission recommends that the Council of Australian Governments agree to extend the mandate of the Steering Committee for the Review of Government Service Provision to develop and report against further indicators in relation to youth justice and child protection, as discussed in Chapter 43 (Implementing reform).

The proposed Commission for Children and Young People would also be responsible for reporting on the implementation of the recommendations of this Report, including the Strategy, as discussed in Chapter 40 (A Commission for Children and Young People).

Other jurisdictions

Other jurisdictions have developed generational strategies that recognise the complexities of child protection reform.⁴⁵ Queensland's *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037* is a useful example of an approach to achieve transformational change over a generation. *Our Way* was developed through consultation with more than 800 Aboriginal people across Queensland and co-designed with Family Matters Queensland. *Our Way's* long term outcome is for Aboriginal and Torres Strait Islander peoples to experience parity across the domains of health, safety, culture and connections, mental health and emotional wellbeing, home and environment, learning and skills, empowerment, and economic wellbeing.⁴⁶ A sub-target is that their children enjoy equal access to early support and prevention services as non-Aboriginal children by 2020. Implemented through a series of Action Plans, *Our Way* also identifies key outcomes and indicators and priority actions, allocating responsibility to lead departments and partner organisations. This approach to implementation which has been developed quite recently may be useful to the Northern Territory.

Work done in the community sector should also be considered in developing the Strategy. NTCOSS has developed a vision for a coordinated services system to promote child and family wellbeing for

all children in the Northern Territory.⁴⁷ As the result of more than 18 months of consultation with key stakeholders, it provides a roadmap of system principles and service and systems improvements to achieve key outcomes for children and families.⁴⁸ Examples of proposed improvements include a greater focus on universal services, creating local leadership and consultation processes with Elders and community, increasing Aboriginal controlled services and Aboriginal workforce, extended mental health outreach services, implementation of a dual pathways system, introducing family decision-making models, long term funding contracts and building the local evidence base.⁴⁹

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has been working with APO NT to develop a proposal and strategy for building an Aboriginal community-controlled and family welfare sector in the Northern Territory.⁵⁰ This strategy is focused on reform to support Aboriginal leadership, ownership and consultation,⁵¹ through the establishment of regional hubs in the Top End and Central Australia.⁵² The Commission understands that resources will be provided to APO NT to lead this work in partnership with Territory Families, relevant Aboriginal organisations and other stakeholders. APO NT told the Commission that a national strategy focusing on prevention should also be developed which would include the allocation of Commonwealth supports and resources to family and community strengthening initiatives in the Northern Territory.⁵³

Family Support Centres

A new approach is required to support and engage families in the health and wellbeing of their children.⁵⁴ Statutory measures, alone, without specific infrastructure to embed and implement these practices and provide support to families throughout their life course will do little to enhance outcomes for children.

The Commission is recommending the establishment of a network of 'Family Support Centres' as the building blocks for a model of 'local care' and primary prevention. The Centres would ensure a minimum level or standard of service in regions across the Northern Territory and be central to the early intervention and support model of care. The Centres would establish a child safety net that delivers universal, as well as targeted and tertiary services, to families across the continuum of care.

The Northern Territory and Commonwealth Governments should jointly fund a minimum of 20 Centres. The Commission is not recommending specific locations for the Centres, which should be determined after undertaking a process of information gathering, community consultation and engagement to identify the areas of greatest need. Importantly, that process should also identify where there is capacity to build on existing infrastructure and networks.

The Commission is acutely aware of the often dramatic differences between remote communities and the major centres of Darwin and Alice Springs. The differences encompass:

- existing infrastructure and relationships
- the needs of local families and children, as well as the risk factors that can lead to child protection involvement
- the strength and depth of community connection, and
- the nature of entrenched and historical disadvantage.

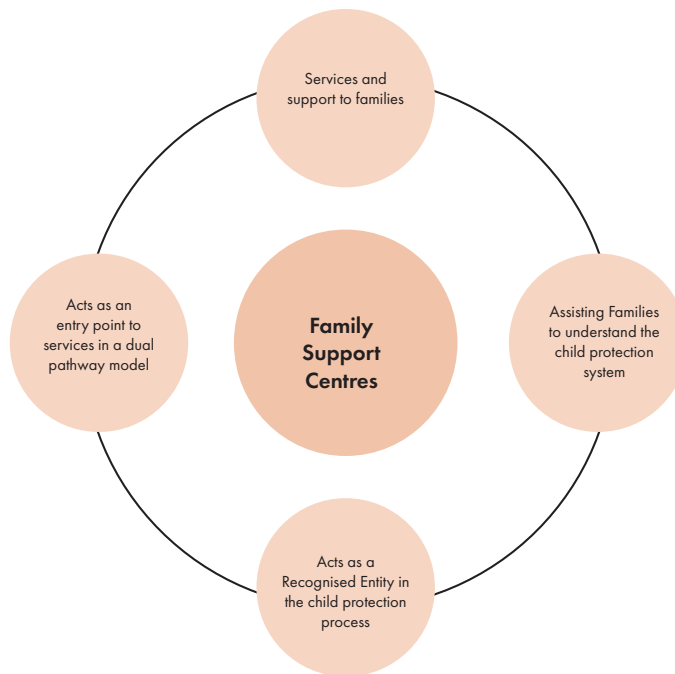
In many locations, what is most keenly felt is the absence of local services combined with short term funding and transitory professional populations with no connections to community.

Family and services

Each Family Support Centre would have a number of functions:

- providing services and support to families, including core and targeted services
- helping families understand the child protection system
- acting as a 'Recognised Entity' in the child protection process,⁵⁵ and
- acting as an entry point in the event that a Northern Territory-wide dual pathways model is implemented.

Figure 39.5: Functions of the Family Support Centres



The Commission is not prescribing the complete range of specific services that would be provided by any Family Support Centre. The mix of services delivered in any region would be informed by a combination of local community knowledge about priority needs and the outcomes of the research recommended by the Commission as a foundation of the public health model.

Access to services would be flexible and not tied to specific entry points into a rigid system. The Commission strongly advocates a 'no wrong door' approach for access to services and supports, and the establishment of the Centres should be built around this principle. The Centre would not need to provide all of the programs itself. A case management approach to the needs of families

might connect families, for example, with services addressing drug and alcohol abuse, mental health and suicide prevention, housing needs and family violence. Importantly, the Centres should be a non-stigmatising point of engagement and support, linking vulnerable, and potentially vulnerable, families with programs, services and relevant government supports. At all points, the focus on these services would be centred on the child and their family and not be seen as an extension of the Northern Territory Government and its statutory functions.

However, each Centre would provide, directly or by referral, a minimum standard of local care and a core set of services, tailored to needs identified in consultation with the community and informed by research and evidence. Those services should range from the universal through to tertiary or statutory levels.

- At the **universal** level, services should encompass:
 - maternal health, parenting skills, newborn care and early childhood care, building on existing requirements set by the Commonwealth Government and reflecting the agenda set through the Northern Territory Early Childhood Strategy
 - informing school aged children about health, hygiene, nutrition, wellbeing and parenting
 - specific services addressing the impact of Fetal Alcohol Spectrum Disorder (FASD), sexual health needs, and social and emotional wellbeing, and
 - services addressing intergenerational trauma and healing.
- At the **secondary** or early support level, targeted services would be available to families who have been identified as being in need of support, but without relying on involvement in the statutory child protection system. The targeted services would vary from community to community, depending on identified need. Services might include:
 - family support that aims to keep children with their families
 - parenting skills programs aimed at different age groups and cultural groups
 - family violence programs
 - child behaviour services
 - support and education programs for teenagers, particularly teenage girls
 - drug, alcohol and addiction programs
 - mental health and suicide programs
 - sexual health programs
 - housing and emergency accommodation referrals, and
 - services to address the impact of FASD.

Families would be able to access therapeutic support at the Centre, particularly for children with behavioural or emotional issues.

- For families who have reached crisis point, who require **tertiary services**, are engaged in the statutory system or have had children removed, the Centres would provide access to services focused on supporting children and families negotiating the child protection system.
 - This would include intensive family preservation services, aiming to assist the family and avoid the need to remove any child

- Connection with services that address specific requirements identified in a care plan or a reunification plan
- Supporting the foster and kinship care system, from identifying and working with potential carers, to providing support for community members who have already taken on a foster or kinship carer role, and
- It would include providing support and advocacy for families in the child protection system.

The Commission has noted with interest the 2015 Northern Territory Aboriginal Forum’s Primary Health Care workshop as an example of a consultative process where attendees collectively identified and agreed on a core set of early childhood services needed to improve Aboriginal childhood outcomes in the Northern Territory.⁵⁶ Their proposed set of services is listed in Table 38.5 of Chapter 38 (Early support).

Supporting families in the child protection system

The Commission has heard from families who have engaged with the child protection system that they need to be better supported and informed. This may entail ensuring that the expectations and obligations placed on families when children are removed are properly understood, or that families are aware of the services and options available to them when they are at their most vulnerable.

The services offered by the Family Support Centres should include providing assistance and information for families already engaged with the child protection system. Given the makeup of the population in the system, these services will be most acutely needed by Aboriginal families. The Commission envisages that this package of services would include:

- assistance in understanding the child protection system
- access to interpreters
- referrals to legal advice
- assistance dealing with Territory Families
- family group conferencing support and facilitation
- assisting with kinship issues, including help identifying possible kinship carers, and
- helping families take the necessary steps to have children returned from care.

The Centre would also play a specific role relating to child protection statutory decisions as a Recognised Entity.⁵⁷ The Centre should be made aware of any new substantiated notifications in its region, or any families referred to services through the statutory process. If Territory Families makes a decision to seek to remove a child, it must notify the Centre, in the region where the family lives, of the decision. The Centre would either act as the Recognised Entity for the case, or refer it to another Recognised Entity if more appropriate.

Establishing the Centres

As far as possible, the Centres would be based in and deliver services to families in their communities. Having services located near families is important for the Centre to understand the problems facing families in the area and to ensure assistance and support is easily available and accessible, on a day to day basis.

Based on 2016 Census data, placing Centres in the largest 30 towns and communities across the Northern Territory would cover around 89% of the total population of the Northern Territory and 88% of the Aboriginal population.⁵⁸ This is more ambitious than the Commission has recommended but does indicate the potential for coverage.

The Centres should not be operated by the Northern Territory Government, but by selected service providers. The Centres could be provided by different entities in different places. Some towns and communities already have child and family centres which might be extended to provide the proposed services. Other towns and communities may propose that an existing organisation with an interest in family and children's services take on the role, such as the health service in the area. It may also be possible to have established organisations auspice the new centre for a period, during the initial stage of its establishment.

In other locations, there may be no suitable centre, organisation or infrastructure and the Centre may need to be established and built from the ground up.

The Commission believes the engagement of operators of the Centres should not be by a tender process, but decided by a panel made up of representatives from the Northern Territory and Commonwealth Governments and the community, including necessarily, representatives of the Aboriginal community. The panel would assess and select interested parties against strict criteria.

Once selected, the government, communities in the particular area of coverage and the organisation would determine the types and level of services required and able to be delivered. This would include the core services as well as additional services appropriate for the Centre and location.

The minimum criteria for selection to provide a Family Support Centre should include:

- experience in service delivery
- in-depth knowledge and understanding of the Northern Territory child protection system
- an extensive track record of working effectively with Aboriginal children, families and communities
- the trust of the Aboriginal community as a culturally safe and competent service
- the capability to be declared as a Recognised Entity, and
- the highest standards of corporate and administrative governance.

The Family Support Centres must be grounded in their local communities, not based on a fly-in fly-out model of service provision. It will be critical to their effectiveness that they are a part of the community, that they come to know the families, the issues and the strengths of the community, and that they are easily accessible when required.

Recognised Entities

It is the Commission's view that for an organisation to be selected to provide a Family Support Centre, it must also be able to be declared a Recognised Entity. The Centres should all be Recognised Entities, but the Commission's view is that other organisations could apply to the Chief Executive Officer of Territory Families to become Recognised Entities if they met criteria in the legislation. A variety of organisations may meet the criteria, work with families and want to be involved in a child protection case.

The Commission is recommending that the Northern Territory child protection legislation be amended to give Recognised Entities the right to participate in court processes, as well as engaging with Territory Families before and after court proceedings, in relation to decisions about individual children. When a court exercises its power to make a child protection order, it should be required to have regard to any views expressed by a Recognised Entity.

The role of a Recognised Entity would include:

- participating in child protection proceedings, to inform the court of its view of the best interests of the child, including where and with whom a child should live
- participating in court-ordered conferences, mediations or case conferences relating to a child, including family group conferences, and
- participating in Chief Executive Officer arranged conferences relating to a child, including family group conferences. This could include ongoing involvement after the removal of a child, in relation to contact and reunification.

The legislation should provide that Territory Families consult and seek their views generally from time to time about the operation of the child protection system. Recognised Entities on their own initiative should also provide Territory Families with information about the general experiences of families in the child protection process. The role of Recognised Entities is dealt with in Chapter 34 (Legislation and legal process).

Aboriginal involvement in service delivery

The Centres should be accessible to and provide services for all Northern Territory children and families. However, as the majority of children involved in the statutory system are Aboriginal, the Centres need to be effective at engaging with Aboriginal children and families. The development of a culturally safe, Aboriginal community-led sector with the capacity to engage families in family support services that meet their needs is a priority.⁵⁹

As discussed in Chapter 31 (Engagement in child protection), the involvement of Aboriginal people in delivering services such as the Family Support Centres is essential. The Commission is aware of the view that community-control and ownership create more effective and lasting solutions to problems in Aboriginal communities and that culturally competent services lead to increased access to services by Aboriginal children and families.⁶⁰ Overall Aboriginal community-controlled organisations would be well-placed to overcome barriers such as a lack of understanding, mistrust of mainstream services and an understanding of cultural or community pressures effecting Aboriginal families.⁶¹

The Commission is conscious of the need to encourage investment in Aboriginal enterprise and the cultural and social significance of Aboriginal ownership of services being delivered to Aboriginal people. At the same time, the Commission does not believe that Aboriginal owned services should be seen as the only model capable of delivering services to Aboriginal people.

Service commissioning

The Commission offered its analysis of the current service commissioning approach in the Northern Territory in Chapter 38 (Early support), raising concerns that there are deficits in strategic planning, coordination and a systematic evidence base.

Adopting a public health approach requires a fundamental shift away from a service-driven system where a patchwork of services are funded in groups, program by program and activity by activity, towards a more comprehensive and centred system where the needs of children and families within the communities in which they grow up are understood and responded to appropriately.

The Commission has highlighted the service system fragmentation which is the consequence of a lack of coordination between the Northern Territory and Commonwealth Governments. To address this and build an effective and sustainable system of support, the Commission is recommending the following series of improvements:

- the engagement of communities, who along with government, will determine local needs and priorities as recommended in Chapter 7 (Community engagement)
- the establishment of the Tripartite Forum, for coordination and engagement, which involves the Northern Territory and Commonwealth Governments and the community sector which would be a vehicle for planning services
- that service commissioning occurs in line with the overarching Strategy, endorsed by both governments
- that a Joint Co-ordinated Funding Framework be developed in relation to prevention and protection services delivered under both the various intergovernmental agreements between the Northern Territory and Commonwealth Governments, and directly by the Northern Territory Government
- that new investments in prevention and early support services be agreed and allocated under the Joint Co-ordinated Funding Framework and through the forum, following consultation with Aboriginal community controlled organisations, the NGO sector and local communities
- that a central register of existing services funded by either the Northern Territory or the Commonwealth Government be developed and maintained by the Department of the Chief Minister, showing the locations in which prevention and protection services are available, and
- that for each service in a location the register would show the nature of its presence, such as a continuous presence, regular visits, or attendance as required.

A new Joint Co-ordinated Funding Framework

Previous child protection inquiries have made recommendations about funding frameworks to:

- take account of prevalence and needs mapping⁶²
- build on existing services⁶³
- utilise evidence of what works⁶⁴
- include longer term funding agreements⁶⁵
- have a greater focus on evaluating outcomes,⁶⁶ and
- provide for greater coordination between the Northern Territory and Commonwealth Governments.⁶⁷

Chapter 6 (Funding and expenditure) and Chapter 38 (Early support) address the complex funding arrangements for child protection and youth justice in the Northern Territory. The Northern Territory has responsibility for child protection and youth justice⁶⁸ and expends significant funds to fulfil these obligations. In addition, it has approximately 58 national partnership agreements and project agreements with the Commonwealth in place,⁶⁹ a number of which relate to the areas of child protection and youth justice.

The Commission heard evidence from the Northern Territory of little co-ordination between the child protection funding and services provided by the Northern Territory and Commonwealth Governments.⁷⁰ The lack of a central register identifying child protection and youth justice services provided across the Northern Territory and the Commission's concerns arising from this is addressed in Chapters 6 (Funding and expenditure) and Chapter 38 (Early support). Commission analysis of Commonwealth funding and service delivery identified 16 different overarching strategies, plans or initiatives overseen by five Commonwealth Government departments.⁷¹ The Commission understands each of these strategies and frameworks have particular goals and implementation plans. Services delivered under each may have different impacts on child protection and youth justice, but it is not clear to the Commission if or how these programs interact with each other and whether there are links or over-laps between different strategy objectives.

Chapter 38 (Early support) notes the value of a public health approach to child protection and the need for prevention efforts to be coordinated across all government agencies, the Aboriginal controlled health sector, the non-government sector and local communities. To build an integrated service system, the Commission recommends that the Northern Territory and Commonwealth Governments develop a new Joint Co-ordinated Funding Framework for prevention and protection services that would cover the various Commonwealth and Northern Territory agreements to provide a unified, coherent and cohesive approach for child protection.

Such a framework would build on the current collaborative structures already established between the Northern Territory and Commonwealth Governments under the various partnership agreements and under the National Framework for Protecting Australia's Children 2009-20 and would be an extension of that framework to cover on the ground delivery of services.

The Joint Coordinated Funding Framework should be informed by experience and the processes of the Northern Territory and Commonwealth Governments and designed in a way which will meet the managerial capacities of non-government service providers. The Framework is intended to ensure coordinated cross-government and inter-departmental cooperation in overseeing the delivery of services for children and young people under the Strategy. Once in place, the Joint Co-ordinated Funding Framework should inform all new funding agreements and where long term funding agreements are still in place these should be amended to transition services over to agreements that align with the new framework. The framework would:

- provide an ongoing mechanism for consultation and co-ordination between governments in funding decision making
- agree in so far as possible on policies which govern the funding of prevention and protection services in the Northern Territory, covering:
 - the evidence base for the service

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- service sustainability
 - capacity building
 - funding cycles
 - reporting
 - evaluation
 - data collection and provision
 - other appropriate matters, and
- better inform service and funding allocation processes to ensure they are aligned with the Strategy and appropriately targeted to meet demand.

The purpose of the framework is to:

- provide a process through which service providers and communities can contribute to service planning
- promote longer term funding commitments, to improve recruitment and retention and provide certainty for staff
- better leverage resources across government departments through increased coordination
- to reduce the complexity of funding arrangements for service providers, and
- to improve data collection and evaluation to build an evidence base for service commissioning.

COSTING

The Commission is aware that implementing the reform proposals set out above will be a costly exercise. Substantial new funding would need to be identified for the establishment of the Family Support Centres, the establishment of new services, and for the overall management and implementation of the Strategy.

The Commission is aware that the Northern Territory Government has already indicated its commitment to the introduction of new services to address the position of children and families. It is not possible to cost the proposals at this stage, as the details of the locations and services to be provided will not be known until the Strategy is prepared. Costs will then depend on the location of Centres, and the number and types of new and additional services and programs which are required. Nonetheless, it goes without saying that the cost of establishing and maintaining the reforms proposed will be considerable. However, the cost of not implementing the reform proposals, or doing nothing, is also high. As is stated above:

... the essence of a public health approach is that the more effort and resources applied at the primary level of prevention and support will mean less need at the tertiary end.

The Commission would expect the issue of funding the proposals to be a matter for the Northern Territory and Commonwealth Government to determine, within the Joint Co-ordinated Funding Framework proposed. While the Commission does not resile from the reality of these costs, it is expected there would be substantial savings from a coordinated approach to funding decisions, reducing purchased home based care payments and from a reduction in the number of children coming into the statutory system. While such savings would not meet the additional costs in the short term, over a five to ten year period the overall benefit to every measure of wellbeing and prosperity

will justify the commitment to fundamental reforms. Despite the cost, the Commission believes there is simply no option if governments are to exercise their responsibilities to children.

SYSTEMS DATA

Central to a public health approach is making evidence-based decisions about the development and delivery of policy and programs and relying on on-going monitoring and evaluation of the impact and outcomes of measures. This requires both the availability of data outlining the level and scope of need to ensure that services are appropriately targeted, as well as the collection of information and data showing the effectiveness of measures and whether outcomes are being achieved or not.

Several chapters in this Report have explored the paucity of data collection and evaluation practice in the Northern Territory.⁷² Improving government practice in these areas will therefore be a crucial part of the broader reform agenda.

The Northern Territory Government should establish the necessary infrastructure to:

- improve the collection and use of data
- develop data analysis capacity
- embed a data-driven approach at all levels of the system, and
- measure common outcomes for children and families.

The Commission heard that the Northern Territory Government needs to ensure it has integrated data across agencies.⁷³ Notably, the Menzies School of Health Research is currently undertaking a project that integrates separate data sets to investigate the early determinants that shape children's developmental outcomes in the Northern Territory.⁷⁴

Territory Families have indicated they will develop an Outcomes, Reporting and Evaluation Framework detailing the measures of success for reform and the mechanisms for monitoring and evaluating reform. The framework will be developed in conjunction with the Northern Territory Government and the Menzies School of Health Research Data linkage research partnership.⁷⁵ The framework should align with the full range of outcomes, benchmarks and targets outlined in the Strategy previously discussed in this Chapter. There should be also be careful consideration of what tools and methods will be most suitable to analyse the culturally diverse and geographically remote Northern Territory context. A re-conceptualisation of outcomes for some programs may be required to ensure they align with local and cultural concepts of the desired outcomes.

It is currently unclear how the mechanisms in the Outcomes, Reporting and Evaluation Framework will be held to account or how evidence-based solutions are going to be assessed as suitable for implementation in the Northern Territory. The Commission has previously discussed the role of a research body in collecting data on the prevalence of abuse and neglect and why it occurs. This research body should also be utilised to investigate, monitor and evaluate the impact of programs and services on outcomes for children and families. Resources should also be invested in services in order to build their capacity to participate on the ground in data collection and analysis.

Evaluation can often be used to demonstrate that investment is delivering value for money. However, the Northern Territory Government must take a long-term view in this regard and ensure that assessments of value for money acknowledge the significant future social, economic and fiscal savings that can be achieved by preventing children and families from contact with the child protection system and ensuring children reach their full potential.

IMMEDIATE MEASURES

The Commission is conscious that until reforms relating to the Strategy take effect, the vulnerable children and families of the Northern Territory will continue to be caught in a system so overwhelmed by demand that it is itself a risk to their safety and wellbeing. It is therefore crucial to consider and implement any immediate measures that can assist in improving that system and ameliorating risks.

The Commission's detailed recommendations across all areas of child protection are set out in the preceding chapters, with the most significant of the changes proposed brought together below.

Crossover of children between care and detention

The Terms of Reference of this Commission linked two issues often considered separately, child protection and youth detention. As a result, the 'crossover group' of children who spend time in both out of home care and detention was a focus for the Commission. These children are amongst the most vulnerable, often needing urgent and intensive support and assistance to help break the cycle of rotating between care and youth detention and, all too often, into adult prison.

One of the outcomes of this inquiry is an appreciation of the degree to which care and detention are inter-related and that time spent in care can lead to time in detention. Focussing on the situation of the 'crossover group' and trying to find a form of intervention and support which will help divert them from this path should be a high priority for the Northern Territory. Designing and implementing services for this group should begin as soon as possible.

The Northern Territory Government should establish a Crossover Unit within Territory Families, responsible for both the management of these children and the design of new programs to address their specific needs. The Unit would need specialised case managers trained across both fields to coordinate and deliver services aimed at reversing the trajectory from care into custody. Services would need to be intensive, based on therapeutic models focused on meeting individual needs and changing behaviours. Caseworkers responsible for a child in the 'crossover group' should have a continuing responsibility for a child going from care to detention, including transition planning, to maximise the opportunity to exit detention into a stable care arrangement which lasts.

One of the priority tasks of the Crossover Unit will be to work with Family Support Centres, the Northern Territory Police and out of home care providers, together with young people in care and their representatives, to develop a joint protocol governing criminal behaviour in care and service provider and police responses. The protocol would outline ways to deal with criminal conduct while in care, to avoid the child or young person being charged and possibly entering or returning to detention.

A dedicated mentoring or visitor program should be introduced for the crossover group. A relationship with an adult who is outside the care, detention or family environment of the child might prove to be a source of support and advice, a model for alternative behaviour and a circuit breaker in the child's life.

Further research should continue to be undertaken in relation to the 'crossover group', including research into the shape and character of the group and research into the skills, strategies and techniques needed to intervene successfully with children facing the dual challenges of living in care and being in detention.

Legislative reform and legal process

The Commission has heard many calls for reforms to the child protection legislation in the Northern Territory. Aboriginal Peak Organisations, Northern Territory (APO NT) and Danila Dilba Health Service in particular have advocated for legislative reform which shift the focus to a broader early support and referral framework, similar to that operating in New Zealand.⁷⁶

Territory Families has reported that it plans a major reform of child protection and youth justice legislation.⁷⁷ Those reforms will be progressed through consultation across the government, the non-government sector and the community through the production of consultation papers, inter-jurisdictional research and community forums.⁷⁸ Territory Families has indicated that legislative reform will be considered in light of the national agenda for child protection including nationally consistent principles for early intervention⁷⁹ and the transformative reform agenda in New Zealand.⁸⁰

As set out in Chapter 42 (Further structural and legislative considerations), the Commission is recommending that consideration be given to replacing both the *Care and Protection of Children Act* (NT) and the *Youth Justice Act* (NT) with an Act covering both areas.

Any legislative reform should be informed by community consultation. For the area of child protection, there should be consultations similar to those undertaken by the Queensland Government as part of *Supporting Families Changing Futures*.⁸¹

The Commission suggests that careful thought and some caution should be exercised in expanding the scope of the statutory scheme too far beyond the tertiary response framework. In some instances, early support and prevention systems are best served by the flexibility and adaptability of policy, not law, to avoid undue intrusion and coercion in the lives of families and children.

The Commission is specifically recommending a number of immediate amendments to the legislation, including the amendment of sections 121 (applying for a protection order), and 129 (when the court must make an order), of the *Care and Protection of the Children Act* in order to change the language of the statutory test for making a child protection order. The current term 'best means' does not have the precision required to provide a clear threshold against which the court can consider the evidence. The provisions should therefore be changed so that a court:

- can only make the child protection order that is the most appropriate order and the least intrusive in the circumstances, and

-
- where the order allows the removal of the child from the family, may not make the child protection order unless it has considered, and rejected as being contrary to the best interests of the child, an order allowing the child to remain in the care of his or her parent.

Section 130 of the *Care and Protection of the Children Act* should also be amended to ensure the court, before making a child protection order, must consider whether all steps have been taken by the government agency to provide the services that are necessary in addressing any risks of harm to the child.

The Commission is of the view that contested litigation in child protection matters should be avoided wherever possible and that all reasonable opportunities must be given to people and organisations involved in the life of a child to meet and attempt to address any risks or problems in a productive way. To this end, the Commission has recommended that full effect be given to the mediation provisions at sections 49 and 127 of the *Care and Protection of the Children Act* which must be brought into force together with the development of comprehensive family group conferencing. This would allow the courts and Territory Families, as well as parents, separate representatives and Recognised Entities to invoke a family group conference facilitated by an independent convenor to discuss and resolve issues concerning the best interests and future of the child, as was the apparent intention of the legislature when the Act was passed in December 2007.

Mandatory reporting

Section 26(1) of the *Care and Protection of Children Act* imposes a legal responsibility on every person in the Northern Territory to report child abuse and neglect. Since 2006, the Northern Territory has experienced an increasing number of child protection notifications. In 2015-2016, notifications reached 20,465. Of these, 38% of notifications were investigated. Of those notifications investigated, 23% were substantiated.⁸² Despite this substantiation rate, the Commission does not recommend changing the universal mandatory reporting requirements in the Northern Territory. It does however recommend steps to improve the reporting process.

As outlined in Chapter 32 (Entry into the child protection system) although notifications from police make up nearly 40% of all notifications received, many of these do not proceed to investigation.⁸³ To better understand the basis and nature of the reports being made by police, the Commission suggests that Territory Families review the screened out notifications received from the Northern Territory Police in 2015-16 to assess why so many did not meet the threshold or criteria for proceeding to an investigation.

Given the volume of police reports, the Commission proposes that Territory Families and the police consider the option of having a central point within the Northern Territory Police to receive notifications from police and then refer them to Central Intake as appropriate. This central contact point within police could also refer cases to a family support referral point or Family Support Centre where appropriate.

Further training for professionals who make notifications should also be prioritised. The monthly meetings initiated by Territory Families and the police to improve the information reported to the Central Intake Team are said to be having a positive outcome in terms of appropriately reducing the

number of children entering care.⁸⁴ This model could be extended to other categories of professional notifiers such as health professionals and educators, to help them better understand reporting obligations and assist Central Intake with more comprehensive information.

Dual pathways process

The Commission supports Territory Families' proposal to develop a dual pathways model for the Northern Territory to provide an avenue for seeking the referral of families to services outside contact with a child protection intake centre. This dual pathways model aims to connect families, who may not meet the threshold for a statutory response to be referred to family support services, to a referral gateway to seek support. The Commission is of the view that any referral gateway should be functionally separate from Territory Families.

Territory Families is proposing a phased implementation of the dual pathways model.⁸⁵ This is intended to allow for further consultation and co-design, to be transitioned and delivered by a non-government organisation by 1 July 2019.⁸⁶ The proposed Family Support Centres should be integrated into that planning.

Prior to the implementation of a dual pathways model, Territory Families should ensure that a range of services commence operation, sufficient to meet the level of possible referrals. The Commission cautions that a dual pathways model can only be as successful as the range, quality and availability of the services to which referrals can be made. To enable the effective operation of this model, amendments to the *Care and Protection of Children Act* will be required about mandatory reporting and information sharing.

An independent evaluation of the dual pathways process should be carried out two years from its introduction. This evaluation should include outcomes for children and families as well as system outcomes, and evaluate the capacity of the services available to meet referrals in a timely and effective way.

Entry into the child protection system

A number of changes need to be made to address the capacity of the Central Intake Team to manage the reports it receives:

- All notifications to Central Intake, whether by hotline or email, should be consolidated into a single queue to ensure that they are properly recorded, assessed and given appropriate priority.
- Territory Families should establish a specialist team to address the current substantive and administrative backlog of investigations. This team could be similar to an earlier specialist team established in the Northern Territory to reduce a backlog of investigations in response to the BOI Report.

In the longer term, the Commission has recommended an independent audit of the assessment and outcomes of notifications reported to the Central Intake Team, including those screened out. The

outcome of this audit should be used to review the level of identified abuse and neglect, refine the intake and assessment process, adjust or further examine the appropriateness of decision making tools, identify reporter training needs, and inform the proposed dual pathway system.

Structured Decision Making Tools

The Commission is not recommending that the existing suite of Structured Decision Making (SDM) tools currently in use in the Northern Territory be abandoned or replaced. While the Commission is aware of the shortcomings with the current application of SDM tools in the Territory, it has some concern that replacing them with anything not specifically designed for use in the Northern Territory, and particularly with Aboriginal families, will not result in better outcomes.

Instead, the Commission has identified a number of improvements that should be made to the application and understanding of the existing SDM tools. As discussed in Chapter 32 (Entry into the child protection system), in 2016 Territory Families engaged the Children’s Research Centre to validate its use of its family risk assessment tool.⁸⁷

As a result of the validation process, the Children’s Research Centre recommended a number of changes to the use of the tools. Territory Families should prioritise its consideration of the recommendations made by the Children’s Research Centre. Territory Families should also consult with other Australian jurisdictions that have implemented SDM risk assessment tools.

The issue of the cultural appropriateness of the tool also arose, and Territory Families, in conjunction with the Children’s Research Centre and in consultation with Aboriginal communities and organisations, should review the SDM tools to ensure that they are culturally appropriate to the Northern Territory.

A consistent approach to cumulative harm

Fundamental to a shift to a more effective response to the problems of child abuse and neglect is a consistent approach to cumulative harm. The Commission has concerns that Territory Families’ current practice regarding repeat notifications for open cases actively works against an effective response to cumulative harm. The Commission therefore recommends data recording processes be amended so that subsequent substantiated notifications in relation to a child are separately recorded and dealt with as such, even if the investigation into the initial notification is ongoing.

The inconsistency of the definition of cumulative harm across policy and practice used by Territory Families needs to be addressed.⁸⁸ Priority should be given to reaching a consistent definition of cumulative harm across policy and staff training.

Referral to support services

One possible outcome of an assessment or investigation involves Territory Families referring a family to support services in an effort to avoid further statutory intervention.

The services offered through the child protection system, statutory support services, typically become available to a family by referral, after their child has become known to the statutory child protection agency.⁸⁹ In the Commission's view, this timing for the provision of services to a family is much too late. The Commission has heard that this process is not ensuring that children at risk, and families approaching, or at, crisis point, are receiving the responses and services they need.

A service response to vulnerable families requires services actually responding to identified need. Services need to be available to a range of families and in various environments, not only for those at highest risk or in the deepest crisis, if the system is to reduce the demand on the statutory system and support better outcomes. Access to a family support service must be timely and agile, to capitalise on the desire to seek support by families, and before families teeter over into crisis.

While the establishment of the Family Support Panel and Remote Family Support Service is a shift towards providing earlier support, the Commission is also proposing that the Northern Territory work with the Commonwealth to expand referral pathways from other services as well as self-referrals. This includes removing criteria which limit access to services, such as income management restrictions in relation to Intensive Family Support Services.

Caseworkers and caseloads

As discussed in Chapter 32 (Entry into the child protection system), work capacity issues and high caseloads severely impact the achievement of best practice in child protection. Recent inquiries have considered caseloads in detail:

- In Queensland the 2013 Carmody report recommended that front-line child safety officer caseloads should be reduced to an average of 15 for each officer.⁹⁰
- The 2016 Nyland report from South Australia considered that an acceptable caseload would depend on the complexity of the needs of the children concerned, and while it was not possible to set a fixed recommended caseload, evidence suggested a total of 14 cases was likely to be at the upper level of acceptability, allowing for cases where a child had especially complex needs.⁹¹

The Commission considers that caseloads need to be reduced in the Northern Territory and recommends Territory Families review workforce requirements for caseworkers. The Commission is recommending that Territory Families work towards a set ratio that assigns a fixed number of cases for each worker. This will take into account the complexity of the child and family as well as issues of remoteness. It will likely require additional staff.

Despite the provision of cultural awareness training, some caseworkers lacked knowledge, skills and experience working within Aboriginal communities.⁹² The Commission is therefore recommending that Territory Families conduct a review of cultural awareness and competence training in consultation with relevant stakeholders to ensure it remains current and appropriate.

Removal of children

There will always be a need for a system of child welfare that has the power to remove children for their own safety, where remaining with their parents is no longer a viable option. The reasons why

parents, and wider families, are unable to provide a safe and nurturing home for children are many and varied and in many cases the result of generations of trauma, poverty, neglect and dysfunction.

Given this, and the acute suffering following the removal of a child which can reverberate through the lives of those around them, and on through generations, there is a responsibility on the part of government child protection agencies to ensure that every measure is taken to support all parties to the process. The Commission has heard evidence throughout its inquiry about the shortcomings of the removal process, and how it systemically works against the participation of the most vulnerable. The impact of the Stolen Generation is still raw for many Aboriginal people, and the removal of children compounds this trauma.

The Commission sees an urgent need to improve practices around engaging with families about the legal aspects of the child protection system, including the possibility of removing a child from an unsafe environment. Territory Families must make efforts to improve its communication with parents and families about how decisions are made, the expectations and obligations upon all parties, and the actions that are to be taken. This is particularly important where a child has been or is being removed. It is incumbent upon caseworkers, acting as an agent of government, to go to whatever lengths necessary to ensure that parents and families understand the process they are involved in and what they can do.

The Commission has heard numerous examples of parents, particularly Aboriginal parents for whom English may not be a first language, who simply do not understand what they must do in order to have their children returned to them. This improvement in communication can only occur where it is supported by information available in multiple languages that clearly sets out what parents, families and children need to know in order to participate fully in legal and care processes. Caseworker practice must also be updated to ensure that informative, culturally competent and sensitive communication is a key element of the support and training all caseworkers receive.

The Northern Territory and Commonwealth Governments must also make an immediate investment in growing the pool of available and accessible interpreters for Aboriginal people, supported by improvements in process and policy around the circumstances in which an Aboriginal community worker must be consulted, and the services of an interpreter are called upon. As mentioned in Chapter 3 (Context and challenges), the Commonwealth's initiative through the Ministry of the Arts to preserve and extend the use of Aboriginal languages can be considered here.

Aboriginal and Torres Strait Islander Child Placement Principle and Kinship Carers

The Aboriginal and Torres Strait Islander Child Placement Principle prioritises options that should be explored when an Aboriginal child is placed in out of home care, to support the child's ties to family and culture. This aspect of the Principle is legislated in section 12(3) of the *Care and Protection of Children Act*.

The Northern Territory Government should undertake periodic reviews of its policy and practice compliance with the Principle, to ensure it supports an Aboriginal child's connection to community and culture while the child is in out of home care.

A significant challenge is the fact there are not enough Aboriginal foster carers available in the Northern Territory.⁹³ Having dedicated individuals within Territory Families with responsibility for the overall oversight of kinship care should improve the processes for finding and approving more kinship carers. The Commission recommends the creation of at least two senior positions, to be filled by Aboriginal people, with responsibility for overseeing kinship care decision-making and supporting steps to extend kinship care.

To further help increase the number of kinship carers in the Northern Territory, Territory Families should consult with Aboriginal organisations to improve training for Territory Families staff undertaking kinship care assessments and to streamline assessment processes. Territory Families should also work with Aboriginal organisations to implement a program dedicated to increasing the number of Aboriginal carers in the Northern Territory.

This should be done, in the longer term, with the Strategy in mind, to ensure that recruitment and retention strategies align with a full understanding of the needs of children and families and the strengths and vulnerabilities of communities.

The Commission has made a number of recommendations linked to increasing the numbers of kinship carers and improving the kinship care process to support Territory Families' compliance with the Aboriginal Child Placement Principle. The Commission has recommended Territory Families works closely with Aboriginal communities and representatives to:

- increase the numbers of Aboriginal foster and kinship carers through community awareness and engagement with individuals in the community
- agree on a model of kinship care assessment where Aboriginal organisations and communities are involved in the kinship care assessment process, and
- implement improved and specific training for Territory Families' staff engaging in kinship care assessments.

This will be particularly important for improvements to kinship care recruitment and assessment, to ensure timely assessments of prospective kinship carers to address the shortage of appropriate carers.

Supporting reunification

Where removal is necessary, safe reunification with family should be a priority. Key to ensuring the safe return of children to their families is communicating what is required for reunification to occur. A care plan, which sets out the needs of a child and what must be done to address those needs, provides clarity for a family on how to achieve reunification. The Commission has found that there has been a failure to ensure timely care plans are prepared for children in out of home care.⁹⁴ To address this, legislative amendments should be made to the *Care and Protection of Children Act* to strengthen provisions relating to the creation and oversight of care plans. Given the high number of Aboriginal children in out of home care, the amendments should expressly require cultural care plans to be included in all care plans.

Another essential element of the reunification process is a child's contact with their family while they are in care. In recognition of this, Territory Families has established a Child and Family Contact

Centre which largely services families in the Greater Darwin area.⁹⁵ The work of this Centre should be evaluated to determine its effectiveness in facilitating positive outcomes for children and their families across the Territory. Subject to the evaluation, further centres should be established to support ongoing contact between children and their families. Territory Families should also consult with Aboriginal agencies and communities to determine the best models of contact arrangements for different communities.

To support the improvement of reunification processes, Territory Families' Reunification Teams should also identify issues that impede the reunification process and provide their findings to the Chief Executive Officer of Territory Families. Ensuring there is appropriate oversight will support the availability of quality and accessible reunification services. The proposed oversight and annual reporting of reunification services by the Children's Commissioner, pending the establishment of the new Commission for Children and Young People, will enhance reunification processes.⁹⁶

Territory Families should also improve the information maintained about reunification and address the absence of data showing the number of children returned to the families from whom they were removed.

Supporting children in care

A child's experience in care is greatly affected by engagement with and decisions made by their caseworker. Territory Families' policy requires caseworkers to have face-to-face contact with children in care once every four weeks.⁹⁷ However, this does not happen in practice.⁹⁸ Failure to ensure regular contact with a child in care puts a child at direct risk of harm. In the Northern Territory, caseworkers manage high caseloads, an average of 39.3 cases per caseworker as at March 2017.⁹⁹ As noted above, Territory Families must ensure caseworkers do not exceed a maximum caseload as high caseloads unsurprisingly play a key role in the lack of compliance with Territory Families' face-to-face contact policy.¹⁰⁰ It is suggested that a case management audit be undertaken to identify why caseworkers are not having regular face-to-face contact with children in care and in particular how caseworkers can be supported to ensure they do. In the interim, Territory Families should partner with locally based organisations in remote communities to ensure children have regular face-to-face contact with a support worker.

Children who enter out of home care have a range of needs that should be supported. To ensure the needs of children with disabilities are met in out of home care, adequate screening and assessments must be undertaken when these children enter care. It is recommended that Territory Families standardise and improve screening for children with FASD and other disabilities when they enter care and provide automatic referrals to relevant medical professionals.

Some children in out of home care may be facing substance abuse issues, whether it is because they were exposed to substance abuse in their homes or have themselves developed substance abuse dependency. In some cases, substance abuse problems begin in care. It is important that children are appropriately supported to manage these issues. Territory Families should improve children's access to effective rehabilitation and counselling services and programs to prevent and address substance abuse.

The Commission has heard that children in out of home care placements often abscond and leave their placement, sometimes to return to family or kin.¹⁰¹ In the Northern Territory, this is a notable issue.¹⁰² When children self-place they are more likely to be exposed to risks of harm and may not have access to necessary support services. Concerningly, the Children’s Commissioner identified a lack of appropriate planning and action to address the safety of children who self-place.¹⁰³ More needs to be done to reduce the level of absconding and to locate promptly and monitor children who self-place. To assist with this, there should be clear procedures to respond to absconding with a collaborative interagency approach involving Territory Families and the police working together to find and support these children.

Concerns about the education of children in out of home care were raised with the Commission, including low school attendance and a lack of support.¹⁰⁴ Education can have significant long-term effects for children and it is therefore essential that Territory Families seek to improve educational outcomes for children in care. A first step includes reviewing and streamlining the process by which educational enrolments for children in out of home care are approved.

Finding and supporting carers

The Commission believes foster carers need more recognition and acknowledgement for the role they play in supporting Territory children at risk. The Northern Territory has a major shortage of foster and kinship care placements and there are continuing difficulties retaining existing carers and recruiting new carers.

It is important that carers are adequately supported to manage the increasingly complex needs of children entering out of home care. Respite care plays a critical role in reducing stress on long-term carers, allowing them to take a short break. The Commission heard concerns about the respite available or provided to carers and recommends Territory Families examine the quality and availability of respite care available for carers.¹⁰⁵ The Commission also heard that carers were not provided an appropriate level of financial support and therefore recommends Territory Families commission an independent review of financial support provided to carers.

The Northern Territory Government should also consider how it can improve communication with carers, to support a better understanding of roles and obligations and the operation of the system. Importantly, the Commission believes that regular forums for consultation with carers should be established in partnership with Foster Carers Association NT, to give carers a place in which to raise issues with Territory Families relating to the experience of being a carer.

The Commission also considers that there should be mechanisms that enable foster and kinship carers, and those seeking or applying to be foster or kinship carers, to have a legal right to a review of any adverse decisions made by Territory Families. The Northern Territory Civil and Administrative Tribunal is an appropriate body for this process and should be given review powers to do so.¹⁰⁶

The Commission considers the recruitment of additional carers as one of the highest priorities of Territory Families and therefore recommends Territory Families develop and implement a campaign in conjunction with Foster Carers Association NT to raise awareness of the shortage of carers and increase the number of carers in the Northern Territory.

Supporting young people leaving care

Evidence before the Commission suggested that better provision could be made for young people leaving care in the Northern Territory, which can affect their transition to adulthood and future life outcomes.¹⁰⁷ For example, while all children in out of home care must have a leaving care plan, in many cases leaving care plans were not developed.¹⁰⁸

Accommodation was identified as a primary issue affecting young people leaving care. Given the scarcity of safe and stable accommodation in the Northern Territory, Territory Families and the Department of Housing and Community Development should prioritise the development of a new accommodation service model to meet the specific needs of children leaving out of home care to live independently.

There have also been calls for providing better information about post-care support for young people, who can be given ongoing assistance to the age of 25.¹⁰⁹ As is previously discussed in this Report, young people leaving care should receive more information about the post-care support they can seek, including help with accommodation, education, employment, health and counselling.

There is little available data on young people leaving care and a limited understanding of their transition experience although the CREATE Foundation has done some valuable work in this area.¹¹⁰ Research should be commissioned to gather information about the needs and problems of young people leaving care, taking into account the needs of Aboriginal young people and those in remote areas. The Northern Territory Government should also continue working with the Australian Institute of Health and Welfare to develop a dataset for reporting on outcomes for children transitioning from out of home care up to the age 25.

Residential Care

The Commission has listened to the experiences of former children in residential care. Their stories are characterised by disengagement with support services, education and pro-social influences and dislocation from family, culture and community. Territory Families should ensure it is adequately supporting the needs of children in residential care and limit use of residential care as a therapeutic placement option for children with complex behavioural needs and disabilities.

Purchased home-based care

The Commission had very significant concerns about the use of purchased home-based care in the Northern Territory.

In 2006, less than 1% of children in out of home care were in purchased-home based care. By 2016, this figure had risen to 32%.¹¹¹ These carers are licensed long day care providers, usually sub-contractors of a commercially operated umbrella care provider.

Such qualifications are inappropriate for carers in the child protection system. Further there is limited assessment and oversight by Territory Families of purchased home-based carers. The department has no direct oversight of whether the carers are suited to meet the needs of children in their care.¹¹²

Even more surprising, the Commission found that the payments to purchased home-based care are much higher than the payments to foster and kinship care, creating considerable inequity. These payments not only consume a major part of the system resources but reinforce the view that Territory Families does not sufficiently recognise and support foster and kinship carers.

Purchased home-based care, as it currently operates, should be phased out over a two year period, with greater investment during this period in the recruitment of kinship and other carers.

Input from children in care

Territory Families is working with the CREATE Foundation to establish a roundtable process for children in out of home care. The Commission supports this effort to allow children to provide their views and contribute to the development of policy and services.¹¹³ It is crucial that children can participate in decision-making that affects their lives. Territory Families should therefore ensure mechanisms are in place to enable children in care to communicate with Territory Families and have input in decisions about their care.

Changes to the out of home care system

Given the increasingly complex needs of children in out of home care, the Northern Territory Government should develop and establish a professional stream of foster carers, capable of responding to the therapeutic needs of children and to care for children with complex needs. Professional foster carers should have training or qualifications that enable them to be more appropriate carers for children with complex needs.

The Northern Territory Government is planning to outsource out of home care service provision to the non-government sector within the next seven years.¹¹⁴ This will involve establishing an out of home care accreditation system and outsourcing services through contractual and funding arrangements.¹¹⁵

These concerns relate to the capacity of the non-government sector to expand sufficiently to take on these responsibilities, without compromising its stability or quality of service. The Commission is concerned that, without sufficient investment in the further development of Aboriginal organisations to provide child protection related services, this decision by the Northern Territory Government opens the door to either an increase in non-Aboriginal service providers, or the growth of existing large providers. This would occur just at the time when the Northern Territory needs greater participation by Aboriginal organisations and communities at all levels of child protection. Furthermore, the presence of such an “industry” will inevitably require more and more resources and may deflect funds from prevention and the realisation of the Family Support Centres.

The Commission is of the view that the provision of care for children whom the state has removed from their families is a core function of government and should not be outsourced. The Commission urges the Northern Territory Government to reconsider outsourcing out of home care services to the non-government sector.

Oversight and monitoring

The need for improved internal oversight within Territory Families was identified. Oversight processes could be improved by establishing a review team or teams to oversee departmental operations and monitor the quality of the services in relation to the wellbeing of children. Sections 294-298 of the *Care and Protection of Children Act* already provide for this but have never been implemented.

The fact that when establishing a team or teams, the Chief Executive Officer of Territory Families is required to include members from other agencies offers a genuine mechanism for facilitating better interagency work across the Northern Territory. This is recognised as being essential for improving the outcomes for children in child protection systems.

To enhance external oversight, the Commission has recommended the Children's Commissioner have additional monitoring and reporting responsibilities, pending the establishment of the proposed new Commission for Children and Young People.¹¹⁶ Extra duties for the Commissioner include monitoring the preparation of care plans, reporting on reunification services, conducting audits of substantiated and unsubstantiated allegations, consulting with children, and monitoring the Charter of Rights.

The work of the Office of the Children's Commissioner provides it with a specialised and comprehensive understanding of vulnerable children in the Northern Territory and this knowledge base should lead the work of the Child Deaths Review and Prevention Committee (CDRPC). The powers of the CDRPC should be expanded to include case-specific reviews and in the Commission's view, the CDRPC responsibilities should not be transferred to the Coroner's Office¹¹⁷ but should be auspiced by the proposed Commission for Children and Young People.

A COMMISSION FOR CHILDREN AND YOUNG PEOPLE

The Commission proposes the creation of a new oversight body, the Commission for Children and Young People, to replace the current Office of the Children's Commissioner. It would have two Commissioners, one of whom must be Aboriginal. The staffing of the Commission for Children and Young People should increase to 20-25 people.

The Commission is also of the view that the oversight body for children in the Northern Territory should have a role covering all children and that the Commission should be provided with a number of additional legislative functions, including:

- **Consultation:** including children, parents, carers, relevant peak bodies, service providers, relevant experts, government agencies and other states and territory governments.
- **Investigations and Inquiries:** the capacity to conduct investigations and inquiries into systemic issues that concern children and issues raised in relation to children in care or detention or at risk of entering care or detention.
- **Complaints:** Receive complaints about police and children presently within the Ombudman's powers.
- **Inspection:** The Commission for Children and Young People should have unfettered access to inspect detention centres, residential facilities and places that are required to comply with the

Optional Protocol to the Convention against Torture, as well as any other place where a child resides if the child is in the child protection system and a complaint is raised.

- **Review and monitor legislation:** The Commission for Children and Young People should be required to review and monitor the *Youth Justice Act* as well as the *Care and Protection Act*, or any replacement legislation.
- **Research:** The Commission for Children and Young People should have an additional function to undertake and commission research and data collection in relation to issues relevant to children in the Northern Territory.

The powers of the Commission for Children and Young People should be expansive enough to make them OPCAT compliant and that the Commission would be an ideal body to undertake OPCAT monitoring in relation to children in the Northern Territory as part of the National Preventative Mechanism.

The Commission is recommending that the Commission for Children and Young People should be responsible for an expanded Official Visitors Program, which would not only visit detention centres but also environments where children in care live. An outline of the proposed functions and powers of the Commission can be found in Chapter 40 (A Commission for Children and Young People).

A NEW APPROACH

The Commission's objective in this Chapter has been to set out a pathway to a new child protection system, while at the same time identifying a number of immediate measures that can be put in place to alleviate the pressures on the current system. As other inquiries and jurisdictions have found, there are no simple answers to the problems facing child protection systems. What is clear is that the Northern Territory needs a new approach to the problem of protecting children from harm to stem the growing number of notifications and children in care.

The fundamental building block for change is the move to a public health model for responding to child abuse and neglect. This would see the prioritising of developing a local knowledge base that reveals the nature of the problem, its causes, its scale and ways to respond, particularly targeting the most vulnerable cohorts. This knowledge needs to be built before services are designed and delivered. Not to do so risks perpetuating the current model of investing in services and responses that will not improve the lives of children and families, and ultimately squander scarce resources and goodwill.

The public health model lays the groundwork for the proposed Strategy, which would set out the Territory's plans and aspirations for its children and families. The priorities and benchmarks set in the Strategy, with new approaches to service commissioning, should shift the focus to long-term prevention and measurable outcomes.

The ambition of the Strategy will require leadership and commitment. There will still be the same obstacles to be faced that have prevented reform in the past, cost, geography, the history of mistrust and disempowerment, the influence of political cycles and shifting priorities. The necessary changes will only happen with leadership from within the Northern Territory Government, collaboration with the Commonwealth, partnership with the organisations and communities that play a role in

child protection and family and child services and the whole hearted support of the people of the Northern Territory and those who are agents of influence.

There will need to be a long term commitment to achieving change. The Strategy will take time and can only be expected to deliver results slowly. Even so, this approach is seen by the Commission as having the best chance of enabling each child to thrive and reach their full potential.

Protecting children from harm under a statutory system that is effective, adequately resourced and culturally appropriate remains a challenge. Maintaining and managing that system in a period where child protection reports are sharply increasing has inevitably imposed strains.

As a result, changes are also necessary now. The out of home care system can be better structured, better regulated and more inexpensively operated. Children can be better cared for in foster and kinship care and when leaving care. Foster and kinship carers can be better supported and families can be better informed and assisted. Parents and children need to be appropriately involved in court processes and proper opportunities for mediation provided. Oversight should be enhanced. The Commission has recommended these immediate changes in the preceding chapters, to improve the current system.

Recommendation 39.1

The Northern Territory Government:

- **commit to a public health approach to child protection and the prevention of harm to children**
- **establish consultation procedures with the sector, organisations and communities**
- **carry out prevalence, needs, service mapping and service referral studies (the studies) to gather information about the needs of children, families and subpopulations, and what services are currently available to meet those needs**
- **create and maintain a Services Register containing information about the services available in communities**
- **establish an early support research unit, which would implement a research agenda relating to risk factors, service needs and evaluated outcomes, and**
- **develop and implement an outcomes and evaluation framework.**

Recommendation 39.2

Develop a 10-year Generational Strategy for Children and Families, to be led by the Chief Minister. This Strategy be based on the information gathered in the proposed studies and be overseen by the proposed Tripartite Forum and endorsed by the Children’s Sub-Committee of Cabinet.

The Generational Strategy for Children and Families include a strategic framework to govern services for families and children based on local service

delivery, covering service location, design, selection, development, delivery, funding and evaluation and:

- plans for the delivery through the Family Support Centres of core services available to all families and services targeting high risk cohorts and prevalent risk factors for involvement in the child protection system, and
- targets, benchmarks and outcome measures.

Recommendation 39.3

Establish a network of no fewer than 20 Family Support Centres, their location to be based on information gathered in the studies and specified in the Generational Strategy for Children and Families, to:

- provide services to and support families and children
- help families understand the child protection system
- act as Recognised Entities, and
- act as an entry point in a dual pathway model.

Recommendation 39.4

The engagement of operators of the Family Support Centres not be by tender, but by a panel made up from the Northern Territory and Commonwealth Governments, including representatives of the Aboriginal community.

The minimum criteria for selection to provide a Family Support Centre include:

- experience in service delivery
- in-depth knowledge and understanding of the Northern Territory child protection system
- extensive experience of working effectively with Aboriginal children, families and communities
- the trust of the Aboriginal community as a culturally safe and competent service
- the capability to be declared as a Recognised Entity, and
- the highest standards of corporate and administrative governance.

Recommendation 39.5

Establish a joint Commonwealth-Territory Co-ordinated Funding Framework, setting policies for an agreed approach to the planning, funding and delivery of services for families and children in the Northern Territory.

Recommendation 39.6

The Commonwealth Government participate in the funding of the Family Support Centres.

Recommendation 39.7

The Chief Minister of the Northern Territory to deliver an annual address to the Northern Territory Parliament on progress under the Generational Strategy for Children and Families.

ENDNOTES

- ¹ Exh.013.001, Board of Inquiry Report – Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory’s Children – Summary Report , 18 October 2010, 12 October 2016; Exh.014.001, Board of Inquiry Report- Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory’s Children – Volume 1, 18 October 2010, tendered 12 October 2016; Exh.014.002, Board of Inquiry Report – Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory’s Children - Volume 2, 18 October 2017, tendered 12 October 2017.
- ² Exh.014.001, Board of Inquiry Report- Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory’s Children – Volume 1, 18 October 2010, tendered 12 October 2016, p. 81.
- ³ Exh.014.001, Board of Inquiry Report- Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory’s Children – Volume 1, 18 October 2010, tendered 12 October 2016, pp. 81, 95.
- ⁴ As highlighted in Chapter 4 (Challenges for Aboriginal people in the Northern Territory) of the 20,465 child protection notifications received in the Northern Territory in 2015–16, 78% related to Aboriginal children.
- ⁵ Exh.680.002, Annexure ST-1 to statement of Sven Thormann, 4 January 2017, tendered 30 June 2017, table 16. The Commission received two statements which gave differing accounts of the number of children in out of home care at 30 June 2017 (Exh.680.001, Statement of Sven Thormann, 4 January 2017, tendered 30 June 2017 (1,020 children), cf. Exh.613.000, Statement of Kim Charles, 12 May 2017, tendered 28 June 2017 (1,032 children). The Commission sought clarification as to reason for the discrepancy and for which number was most accurate. The Northern Territory Government confirmed that the numbers of Mr Thormann should be preferred and that the reason for the discrepancy was that the figures had been prepared using slightly different methodologies used in the collection of the data.
- ⁶ Transcript, Lesley Taylor, 30 May 2017, p. 4130: lines 7-11; Submission, Aboriginal Peak Organisations Northern Territory, 31 July 2017, p.43.
- ⁷ Transcript, Frank Oberklaid, 29 May 2017, p. 4017: lines 11-44; Exh.471.001, Statement of Lesley Taylor, 20 May 2017, tendered 30 May 2017, para 63.
- ⁸ Parenting Research Centre, 2015, *Implementation of recommendations arising from previous inquiries of relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse. Final Report*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 108.
- ⁹ Parenting Research Centre, 2015, *Implementation of recommendations arising from previous inquiries of relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse. Final Report*, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 108.
- ¹⁰ Brown, J & Saied-Tessier, A, 2015, ‘Preventing Child Sexual Abuse: Towards a national strategy for England, *National Society for the Prevention of Cruelty to Children*, London, pp. 9-11; Quadara, A, Nagy, V, Higgins, Siegel, N, 2015, ‘Conceptualising the prevention of child abuse: final report’, *Australian Institute of Family Studies*, No. 33, pp. vii-viii; Exh.590.000, Annexure B to Statement of Roslyn Baxter, National Framework for Protecting Australia’s Children 2009-2020, 2009, tendered 26 June 2017; Australian Research Alliance for Children and Youth, 2008, *Inverting the Pyramid: Enhancing Systems for Protecting Children*, Australian Research Alliance for Children and Youth, Canberra, p. ix, Fortson, B.L, Klevens, J, Merrick, M.T, Gilbert, L.K & Alexander, S. P, 2016, ‘Preventing Child Abuse and Neglect: A technical package for policy, norm and programmatic activities’, *National Center for Injury Prevention and Control*, Centers for Disease Control and Prevention, Atlanta.
- ¹¹ For more on the impacts on childhood abuse, see Forston, B.L, Klevens, J., Merrick, M.T., Gilbert, L. K., & Alexander, S.P, 2016, ‘Preventing Child Abuse and Neglect: A technical package for Policy, Norm and Programmatic Activities’, *National Centre for Injury Prevention and Control*, Centers for Disease Control and Prevention, Atlanta, pp. 8-9.
- ¹² Transcript, Frank Oberklaid, 29 May 2017, p. 4016: lines 36-45.
- ¹³ World Health Organisation, Krug, E, Dahlberg, L, Mercy, J, Zwi. A. and Lozano, R. 2002, *World Report on violence and health*, Geneva, pp. 3-4; Zimmerman, F & Mercy, J, May, 2010, ‘A Better Start: Child Maltreatment Prevention as a Public Health Priority’, *Zero to Three*, vol. 30, p. 5.
- ¹⁴ Transcript, Frank Oberklaid, 29 May 2017, p. 4017: lines 11-44; Exh.471.001, Statement of Lesley Taylor, 20 May 2017, tendered 30 May 2017, para 63.
- ¹⁵ Submission, Australian Red Cross, 20 December 2016, p. 21, citing Boyle, C., 2013, *Imagine: A system willing and able to protection children and support families*, The Winston Churchill Memorial Trust of Australia, p. 6.
- ¹⁶ World Health Organisation, Krug, E, Dahlberg, L, Mercy, J, Zwi. A. and Lozano, R. 2002, *World Report on violence and health*, Geneva, pp. 3-4; Zimmerman, F & Mercy, J, May, 2010, ‘A Better Start: Child Maltreatment Prevention as a Public Health Priority’, *Zero to Three*, vol. 30, p. 5.
- ¹⁷ Submission, Aboriginal Peak Organisations Northern Territory Submission, 31 July 2017, p. 51.
- ¹⁸ Krug, E, Dahlberg, L, Mercy, J, Zwi. A. and Lozano, R. 2002, *World Report on violence and health*, World Health Organisation: Geneva, pp. 3-4.
- ¹⁹ Transcript, Frank Oberklaid, 29 May 2017, p. 4016: lines 1-18.
- ²⁰ Exh.511.000, Statement of Sven Silburn, 18 May 2017, tendered on 19 June 2017, para 5.
- ²¹ Australian Institute of Family Studies, The economic costs of child abuse and neglect, Child Families Communities Resource Sheet, September, 2016 viewed on 30 October 2017 .
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- ²⁴ Exh.014.001, Board of Inquiry Report- Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory's Children – Volume 1, 18 October 2010, tendered 12 October 2016, p. 100.
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- ²⁶ Transcript, Frank Oberklaid, 29 May 2017, p. 4019: lines 18-31.
- ²⁷ Exh.459.001, Annexure 1 to Statement of John Burton, SNAICC submission to Royal Commission into the Protection and Detention of Children in the Northern Territory, February 2017, tendered 29 May 2017, p. 22; Transcript, Fiona Arney, 26 June 2017, p. 5058: lines 33-45; ACIL Allen Consulting, 21 October 2016, *Part I: Communities For Children Facilitating Partners Program. Post Implementation Review*, Department of Social Services, Canberra, p. iii.
- ²⁸ Transcript, Frank Oberklaid, 29 May 2017, p. 4024: lines 38-42.
- ²⁹ Transcript, Frank Oberklaid, 29 May 2017, p. 4019: lines 37-42.
- ³⁰ Exh.014.001, Board of Inquiry Report- Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory's Children – Volume 1, 18 October 2010, tendered 12 October 2016, p. 176.
- ³¹ Mathews B et al., 2016, Scoping study for research into the prevalence of child abuse in Australia: report to the Royal Commission into Institutional Responses to Child Sexual Abuse, Social Policy Research Centre (SPRC Report 13/16), UNSW Australia in partnership with Australian Institute of Family Studies, Queensland University of Technology and the Australian Centre for Child Protection (University of South Australia): Sydney, p. 9.
- ³² Mathews B et al., 2016, Scoping study for research into the prevalence of child abuse in Australia: report to the Royal Commission into Institutional Responses to Child Sexual Abuse, Social Policy Research Centre (SPRC Report 13/16), UNSW Australia in partnership with Australian Institute of Family Studies, Queensland University of Technology and the Australian Centre for Child Protection (University of South Australia): Sydney.
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- ³⁹ Exh.455.000, Precipis of evidence of Frank Oberklaid, 25 May 2017, tendered 29 May 2017, para 7.
- ⁴⁰ Northern Territory Government, 2017, *Draft Plan Starting Early for a Better Future: Early Childhood Development in the Northern Territory 2018-2028*.
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- ⁵¹ Submission, Aboriginal Peak Organisations Northern Territory, 31 July 2017, p. 115.
- ⁵² Submission, Northern Australian Aboriginal Justice Agency, August 2017, p.37.
- ⁵³ Submission, Aboriginal Peak Organisations Northern Territory, 31 July 2017, p. 115.
- ⁵⁴ Transcript, Fiona Arney, 26 June 2017, p. 5065: lines 8-45; Transcript, Leah Bromfield, 26 June 2017, p. 5067: lines 16-40; Transcript, Colleen Gwynne, 19 June 2017, p. 4479: lines 2-26; Exh.510.000, Statement of Sven Silburn, 12 December 2016, tendered 19 June 2017, para 56; Transcript, Muriel Bamblett, 13 October 2016, p. 200: lines 27-47; Transcript, Frank Oberklaid, 29 May 2017, p. 4016: lines 1-18, 35-45; Submission, North Australian Aboriginal Justice Agency, August 2017, pp. 24-25; Submission,

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- 62 Carmody, T, 2013, *Taking Responsibility: A Roadmap for Queensland Child Protection*, Queensland Child Protection Commission of Inquiry, recommendations 5.1, 5.6; Exh.014.001, Board of Inquiry Report- Growing them strong together, Promoting the Safety and Wellbeing of the Northern Territory’s Children – Volume 1, 18 October 2010, tendered 12 October 2016, recommendations 8, 10; Exh.024.026, Child Protection Systems Royal Commission, 2016, *The life they deserve – Volume 1 – Summary and Report*, Government of South Australia, tendered 13 October 2016, recommendation 51.
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- 73 Exh.456.000, Statement of Donna Ah Chee, 22 May 2017, tendered 29 May 2017, para 27.
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- ⁸⁹ Exh.656.001, Statement of Jeanette Kerr, 9 May 2017, tendered 30 June 2017, para. 10.
- ⁹⁰ *Taking Responsibility: A Roadmap for Queensland Child Protection*, Queensland Child Protection Commission of Inquiry, 2013, Recommendation 10.4.
- ⁹¹ Exh.024.026, *Child Protection Systems Royal Commission Report: The life they deserve – Volume 1 – Summary and Report*, August 2016, tendered 13 October 2016, p. 244.
- ⁹² See Chapter 32 (Entry into the Child Protection System).
- ⁹³ See section 'Factors contributing to the shortage of Aboriginal kinship and foster carers' of Chapter 33 (Children in out of home care).
- ⁹⁴ See section 'Returning children to family and community' of Chapter 33 (Children in out of home care).
- ⁹⁵ Exh.476.000, Statement of Marnie Couch, 18 May 2017, tendered 31 May 2017, para. 23(c).
- ⁹⁶ See section 'Reunification services and support' of Chapter 33 (Children in out of home care).
- ⁹⁷ Exh.553.067, Annexure BT-67 to Statement of Bronwyn Thompson, 9 June 2017, tendered 22 June 2017.
- ⁹⁸ See section 'Supporting decision-making through regular contact with caseworkers' of Chapter 33 (Children in out of home care).
- ⁹⁹ Exh.657.001, Statement of Jeanette Kerr, 12 May 2017, tendered 30 June 2017, para. 54.
- ¹⁰⁰ See section 'Supporting decision-making through regular contact with caseworkers' of Chapter 33 (Children in out of home care).
- ¹⁰¹ Transcript, Colleen Gwynne, 12 October 2016, p. 131: lines 16-20.
- ¹⁰² See section 'Supporting the complex needs of children in of home care' of Chapter 33 (Children in out of home care).
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- ¹⁰⁷ See section 'Supporting the needs of children in care into adulthood' of Chapter 33 (Children in out of home care).
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- ¹¹¹ Exh.680.002, Annexure ST-1 to Statement of Sven Thormann, 4 January 2017, tendered 30 June 2017, Table 15.
- ¹¹² See section 'Less oversight by Territory Families of carer training, assessment and performance' of Chapter 33 (Children in out of home care).
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- ¹¹⁴ Exh.661.001, Statement of Luke Twyford, 5 May 2017, tendered 30 June 2017, para. 60.
- ¹¹⁵ Exh.661.001, Statement of Luke Twyford, 5 May 2017, tendered 30 June 2017, paras 62b-c.
- ¹¹⁶ For example Chapter 33 (Children in out of home care) and Chapter 37 (Child Protection Oversight).
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