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- Professor Sherry Siggers, National Drug Research Institute, Curtin University of Technology prepared the Drug and Alcohol Expert Review
- Dr Chris Sarra, Indigenous Education Leadership Institute, Queensland University of Technology prepared the Education Expert Review
- Dr Heather D'Antoine, Telethon Institute for Child Health Research, prepared the Child Health Expert Review
- Mr Tom Calma, Human Rights and Equal Opportunity Commission prepared the Human Rights Expert Review
- Professor Ernest Hunter, University of Queensland, prepared the Mental Health Expert Review
- Professor Helen Milroy, University of Western Australia, prepared the Child Mental Health Expert Review

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THE DANCE OF LIFE



The dance of life painting is the last in a series depicting a multi-dimensional model of health and wellbeing from an Aboriginal perspective. The final painting brings all of the dimensions together to reflect the delicate balance of life within the universe. The dimensions include the biological or physical dimension, the psychological or emotional dimension, the social dimension, the spiritual dimension and finally but most importantly, the cultural dimension. Within each dimension there are additional layers to consider, including the historical context, the traditional and contemporary view as well as our gaps in knowledge.

The potential solutions for healing and restoration of wellbeing come from considering additional factors encompassing issues at the coal face of symptom presentation and service delivery such as education and training, policy, the socio-political context and international perspective. As the final painting

suggests, we can only exist if firmly grounded and supported by our community and spirituality, whilst always reflecting back on culture in order to hold our head up high to grow and reach forward to the experiences life has waiting for us.

The stories of our ancestors, the collective grief, as well as healing, begin from knowing where we have come from and where we are heading. From the Aboriginal perspective, carrying the past with you into the future is, as it should be. We are nothing if not for those who have been before, and the children of the future will look back and reflect on us today.

When we enable a person to restore all of the dimensions of their life, then we have achieved a great deal. When all of the dimensions are in balance, within the universe, we can break free of our shackles and truly dance through life.

Milroy, Helen. 2002. The Dance of Life. Unpublished conference proceedings presented at the AIDA Symposium, Sydney, NSW.

HIA FOREWORD

'A child is a gift to the family – that is to the entire kinship network: he or she is the living evidence that the culture is alive and surviving'¹

As Aboriginal and Torres Strait Islander doctors we live our lives and practise our profession with the utmost respect for the role of children in our society. They truly are our gifts and bring into the world their unique light, love and joy.

It was natural then, that when the Northern Territory Emergency Response (the Intervention) was announced and the various legislations and policies implemented, the Australian Indigenous Doctors' Association embarked on a journey of utmost importance – to document, from the point of view of the families within the prescribed communities, the range of experiences, emotions and effects of the Intervention; and, to work collaboratively to refine the Intervention, such that the safety and wellbeing of children and families was improved both immediately and into the future. Furthermore, we hoped that our journey would contribute to building a stronger evidence base for policy making for Aboriginal and Torres Strait Islander people as well as demonstrate appropriate methodologies for other evidence building endeavours.

To this end, and in partnership with the Centre for Health Equity, Training, Research and Evaluation with funding support from the Fred Hollows Foundation, we conducted this health impact assessment commencing in late 2007. Throughout the HIA we undertook to privilege Aboriginal and Torres Strait Islander peoples' voices, experiences

and knowledge as well as draw on other expertise and literature, in order to produce a document that would be meaningful to *all* of the stakeholders involved. To the credit of all involved, we have achieved this.

And, to all involved – the HIA Steering Committee, the AIDA Board and Secretariat, our AIDA members, the expert reviewers, the key stakeholders, the organisations that supported us and the communities we worked with - a heartfelt thank you for all your time, energy, stories, tears, wisdom and motivation. I would also like to express my sincere gratitude to our community people, elders and organisations who generously shared their experiences of living under the Intervention. I hope our work reflects your ongoing strength, courage and determination as Australia's First Peoples.

The overwhelming message from this project is the fundamental need for respectful and significant engagement between governments, communities, professionals and leaders at all levels.

It is simply not possible to fight oppression with oppression. When we do this, our children suffer and we are lesser for it. Let us, **together**, show the next generation that we can learn from the past and create a future where all children can be inspired by their nation.

Dr Tamara Mackean
Chair
HIA Steering Committee

¹ Franks, Christine. & Curr, Barbara. & University of Wollongong. Centre for Indigenous Development Education and Research. 1996, Keeping company : an inter-cultural conversation Centre for Indigenous Development Education and Research, University of Wollongong, Wollongong, N.S.W: P 72

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ABBREVIATIONS

AIDA	Australian Indigenous Doctors' Association
ATODS	Alcohol, Tobacco and Other Drug Services
CDEP	Community Development Employment Project
CHCI	Child Health Check Initiative
CHCs	Child Health Checks
CHETRE	Centre for Health Equity Training, Research and Evaluation
CSA	Child Support Agency
CYWR	Welfare Reform Agenda in Cape York
ENT	ear nose and throat
FASD	foetal alcohol spectrum disorder
HIA	health impact assessment
NT	Northern Territory
NTER	Northern Territory Emergency Response
OM	otitis media
RDA	Racial Discrimination Act
SAID	Substance Abuse Intelligence Desk
UNSW	University of NSW

GLOSSARY

Aboriginal is the term used in this report to include all the people who were living in the communities prescribed under the Northern Territory Emergency Response legislation – the majority of whom are of Aboriginal descent.

Indigenous: 'Considering the diversity of indigenous peoples, an official definition of 'indigenous' has not been adopted by any UN-system body. Instead the system has developed a modern understanding of this term based on the following:

- Self- identification as indigenous peoples at the individual level and accepted by the community as their member.
- Historical continuity with pre-colonial and/or pre-settler societies
- Strong link to territories and surrounding natural resources
- Distinct social, economic or political systems
- Distinct language, culture and beliefs
- Form non-dominant groups of society
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities'. (United Nations Permanent Forum on Indigenous Issues, 1997).

'This preserves for these communities the sovereign right and power to decide who belongs to them, without external interference' (United Nations. Department of Economic and Social Affairs, 2004).

Community: There are multiple definitions of community. In this report community is defined as:

- groups of people who live in the same geographical area;
- groups of people with a shared history, culture, language;
- citizens for whom governments are responsible and to whom governments are accountable.

Infrastructure: the basic facilities, services, and installations needed for the functioning of a community. It includes the network of communications and utility services such as roads, drains, electricity, water, gas and telecommunication and community or social services such as schools, health services, shops and transport.

EXECUTIVE SUMMARY

In 2006, the 17-year gap in average life expectancy between Indigenous and non-Indigenous people, the extreme poverty in which Aboriginal people in the Northern Territory were living, and problems of abuse and violence towards children, women and other members of communities had been the subject of multiple reviews and reports by governments and communities over decades. In August 2006 the Northern Territory Government established another review to report on ways that all tiers of government and non-government agencies might contribute to preventing and tackling child sexual abuse among Aboriginal children.

The final report of that inquiry was entitled *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' (Wild, Anderson 2007) and was presented to the Chief Minister of the Northern Territory Government on 30 April 2007. The first recommendation of the *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' report was:

'... that child abuse and child sexual abuse be designated as an issue of urgent national significance by both the Australian and Northern Territory Governments, and that both governments immediately establish a collaborative partnership with a memorandum of understanding to address specifically the protection of Aboriginal children from sexual abuse. It is critical that both governments commit to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities.' (emphasis added) (Wild, Anderson 2007, p. 7)

However, the response of the Northern Territory Government was limited. The report was released publicly on 15 June 2007. The Federal Minister for Families, Community Services and Indigenous Affairs, Mal Brough MP, announced his commitment to working with the Northern Territory Government to reduce violence and child abuse in the NT (Brough, 15 June, 2007).

But on 21 June 2007 (less than a week later), the then Prime Minister, John Howard MP, said that the Australian Government was unhappy with the response of the Northern Territory Government. On that day, the Minister (Mal Brough) announced, on behalf of the Australian Government, a 'national

emergency response to protect Aboriginal children in the NT' (Brough, 21 June 2007). Among the eleven emergency measures to be included in the response were compulsory child health checks and significant welfare reforms.

This announcement was followed, in August 2007, with the passage of five Acts:

- the NT National Emergency Response Act 2007;
- the Families, Community Services and Indigenous Affairs and Other Legislation Amendment (Northern Territory National Emergency Response and Other Measures) Act 2007;
- the Social Security and Other Legislation Amendment (welfare payment reform) Act 2007 and
- two Appropriation Acts - Appropriation (Northern Territory National Emergency Response) Act (No. 1) 2007-2008; and Appropriation (Northern Territory National Emergency Response) Act (No. 2) 2007-2008.

It was possible for the Australian Government to enact such legislation under Section 122 in Australia's Constitution that gives full plenary power to them in relation to the Territories. Provisions in three of the Acts were deemed by the Government to be special measures, and therefore, a rationale for the suspension of Part II of the Racial Discrimination Act (RDA), 1975 (Magarey, Spooner, et al, 2007, p 22 - 26).

There was some general support for the levels of political commitment and resources linked to what was called the Northern Territory Emergency Response (NTER). However, many people and organisations were concerned about the processes through which the NTER was developed and implemented, and some of its major provisions. Major concerns included the use of the Army to lead implementation, the suspension of sections of the Racial Discrimination Act (1975), compulsory income management for all adults in prescribed communities who were receiving welfare payments, and compulsory health checks for children.

The Australian Indigenous Doctors' Association (AIDA), in collaboration with the Centre for Health Equity Training, Research and Evaluation (CHETRE)

at the University of New South Wales (UNSW) and with financial support from the Fred Hollows Foundation, undertook a health impact assessment (HIA) of the NTER.

The purpose of the HIA is to predict what are likely to be positive, negative and/or unintended health consequences of the NTER, using a combination of evidence from a variety of sources.

The measures of the NTER outlined in the legislation, in associate media releases, and the *NTER: One Year On* report (Department of Families, Housing, Community Services and Indigenous Affairs, 2008) were assessed for their predicted health impacts based on the findings of community meetings with more than 250 Aboriginal people living in the prescribed communities, interviews with 25 Aboriginal and non-Aboriginal stakeholders, and a series of commissioned expert reviews.

DEFINITION OF HEALTH

In undertaking the assessment the HIA team acknowledged the importance of working within an Aboriginal understanding of health and wellbeing and a global human rights approach.

In 1978 the Declaration of Alma-Ata had established international agreement

‘that strongly affirmed that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.’ (Declaration of Alma-Ata, 1978).

The National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989) went on to define Aboriginal health as:

‘... not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life.’

This was expanded upon in a definition developed by Swan and Raphael (1995).

‘The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to wellbeing. This holistic concept does not merely refer to the ‘whole body’ but in fact is steeped in the harmonised inter-relations which culturally constitute wellbeing. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially it must be understood that when the harmony of these inter-relations is disrupted, Aboriginal ill-health will persist.’

In this HIA a contemporary Aboriginal definition of health has been used. The Dance of Life was developed by Professor Helen Milroy² and consists of five dimensions – cultural, spiritual, social, emotional and physical – within which are a number of layers that reflect historical, traditional and contemporary influences on health. This concept emphasises the intersection of both the layers and dimensions which creates the interconnectedness for a whole of life approach to Aboriginal wellbeing.

In line with Professor Milroy’s model and in keeping with the earlier definitions of the health and wellbeing of Aboriginal peoples, this HIA has used a multi-dimensional schema to define health.

The five dimensions included in the framework are: physical health, psychological health, social health and wellbeing, spirituality, and cultural integrity.

The Australian Government’s proposed intention in implementing the NTER placed heavy emphasis on improving physical health and improving the social and environmental determinants of health as a means to achieve improved child health outcomes (in particular) in Aboriginal communities in the Northern Territory. It is likely that new sustained investments in material resources including education, housing, and health care services and delivery, for example, will make a significant contribution to improved physical health for some people.

However, the ways in which the NTER was introduced and is being implemented are likely to contribute to the high burden of trauma and disease

² Professor Helen Milroy is the Director of the Centre for Aboriginal Medical and Dental Health (CAMDH) at the University of Western Australia.

already carried by Aboriginal people across generations. The HIA predicts that any improvements in physical health may be outweighed by negative impacts on the psychological health, spirituality, and cultural integrity of almost all the Aboriginal population in prescribed communities (and, arguably, in the NT). The loss of trust in government will limit the ability of governments and communities to work together effectively in the future. The NTER does not recognise the need for all Australians to be able to value and work across Aboriginal and non-Aboriginal cultures, and has overlooked the centrality of human dignity to health (Durie, 2008).

The HIA predicts that the intended health outcomes of the NTER (improved health and wellbeing, and ultimately, life expectancy) are unlikely to be fully achieved through the NTER measures. It is predicted that it will leave a negative legacy on the psychological and social wellbeing, on the spirituality and cultural integrity of the prescribed communities. However, it may be possible to minimise or mitigate these negative impacts if the Australian and NT governments commit to and invest in taking the steps necessary to work in respectful partnership with the Aboriginal leaders and organisations responsible for the governance of the prescribed communities in the NT.

The principal recommendations arising from the HIA are based on the evidence (from communities, stakeholders and experts) that it is essential to find ways to work together as equals.

SUMMARY OF FINDINGS

Due to the complex nature of the Intervention and our limited resources we focused on issues that were identified by community members and stakeholders as being likely to have the most significant impacts on the health of the populations in the prescribed communities. These were also issues for which routinely collected data were available to contribute to the assessment. The issues were: external leadership, governance and control, compulsory income management, housing, education, alcohol restrictions, prohibited materials, and child health checks.

The following table summarises our major recommendations in three groups:

- measure should be stopped;
- measure is unlikely to be effective in the long term; and
- proceed with caution where we believe there is the likelihood of health improvement if Aboriginal people are actively engaged, there is sustained investment of resources and there are substantial changes to the implementation of the measure.

The evidence on which this is based is set out in more detail in the main report.

SUMMARY OF RECOMMENDATIONS FROM THE HIA

Rating	NTER MEASURES	POTENTIAL HEALTH IMPACTS	RECOMMENDATIONS
	External leadership, governance, and control	<ul style="list-style-type: none"> - Profound long-term negative impacts on psychological health, social health and wellbeing and cultural integrity. - Profound long term negative impacts on ability of government to work with Aboriginal communities to achieve shared objectives. 	<ul style="list-style-type: none"> - Reinstate Section 9 of the Racial Discrimination Act - Invest in Aboriginal organisations and leaders to establish Aboriginal-defined governance structures and processes - Establish respectful partnerships between communities and government
	Compulsory income management	<ul style="list-style-type: none"> - Profound long-term negative impacts on psychological health, social health and wellbeing and cultural integrity. 	<ul style="list-style-type: none"> - Stop compulsory income management - Target income management for proven abuse or neglect or non-compliance with school attendance or other welfare requirements - Provide a voluntary option for income management (opt in) - Costs to be borne by government, not families
	Alcohol restriction*	<ul style="list-style-type: none"> - Short-term reductions in alcohol supply may not be sustained. 	<ul style="list-style-type: none"> - Acknowledge and invest in successful existing community-driven initiatives - Invest in evidence-based interventions developed with focus on harm minimisation and reduction in demand as well as supply.
	Prohibited materials*	<ul style="list-style-type: none"> - Negative impact on cultural integrity and wellbeing of Aboriginal men 	<ul style="list-style-type: none"> - Change signage - Develop plans with communities - Implement evidence-based interventions with community leadership
	Housing†	<ul style="list-style-type: none"> - Potential for health improvement if communities are involved and if there are changes in the ways programs are implemented. 	<ul style="list-style-type: none"> - Aboriginal communities actively involved in decisions on design, location and construction of new housing - Priority housing given to community members for a defined period - Ensure National Partnership Agreement on Remote Indigenous Housing Agreement benchmarks are met
	Education†	<ul style="list-style-type: none"> - Potential for health improvement if communities are involved and if there are changes in program implementation. 	<ul style="list-style-type: none"> - Have all Aboriginal children enrolled in a school - Engage parents/principals/ children in school retention initiatives - Develop and mentor people on pathways to employment - Ensure that benchmarks in National Education Agreement (COAG) are met.
	Child Health Checks†	<ul style="list-style-type: none"> - Potential for health improvement if communities are involved, if funding for integrated primary health care is recurrent and long-term, and if there are changes in the processes of implementation 	<ul style="list-style-type: none"> - Support and expand primary health care services with increased access to specialist services - Support existing initiatives - Ensure recurrent funding - Engage community leadership in service development, management and review - Continue to invest to achieve the outcomes agreed in the Indigenous Early Childhood National Partnership Agreement

*Measures unlikely to work because they are not based on evidence of (i) which interventions are/aren't effective in Aboriginal communities and (ii) what interventions are required to bring about the desired change.

†Proceed with caution and commitment to long-term investment of resources in building community and organisational capacity.

INTRODUCTION

RATIONALE AND SCOPE OF THE NORTHERN TERRITORY EMERGENCY RESPONSE (NTER)

In May 2006 national media coverage raised public awareness of and concern about sexual assault, in particular child sexual assault, in Aboriginal communities in the Northern Territory. A confidential briefing paper had been prepared by the Crown Prosecutor for Central Australia, Ms Nanette Rogers. (Lateline, ABC TV, 15 May 2006). Based on her experience in handling hundreds of cases of sexual assault in 12 years as a prosecutor she revealed an epidemic of abuse, rape and murder of women and children in Aboriginal communities in Central Australia. Although her paper had been prepared in confidence for senior police, it was leaked to the media which, in turn, sparked national concern about the issue.

There had been multiple reviews, reports and commitments over the previous two decades that had recommended actions to improve the living conditions of Aboriginal communities in the NT; and had pointed to the need for equal access to the material resources and services that are the rights of all Australian citizens, and to the need for Aboriginal-led governance to lead the implementation of actions taken. But the NT Government's response to the issue raised in 2006 was to establish another board of inquiry to research and report on allegations of sexual abuse of Aboriginal children and to recommend better ways to protect Aboriginal children from sexual abuse. The inquiry gathered feedback from more than 260 meetings with individuals, agencies and organisations; and visited 45 communities to talk with local people. The report entitled *Ampé Akelyernemane Meke Mekarle* 'Little Children are Sacred' (Wild, Anderson 2007) was presented to the Chief Minister of the Northern Territory Government on 30 April 2007. It was released publicly on 15 June 2007.

The report pointed out that, although accurate statistics about the incidence of child abuse and other family violence in Aboriginal communities are scarce, they are sufficient to demonstrate that the occurrence of violence in Indigenous communities and among Indigenous people '... is disproportionately high in comparison to the rates of the same types of violence in the Australian population as a whole' (Memmott, Stacy, et al.,

2001, p 6). There had been evidence of this for at least a decade and in 2007 communities were concerned that the responses by governments had been slow and weak.

The first of the recommendations of the *Ampé Akelyernemane Meke Mekarle* 'Little Children are Sacred' report was that child abuse and child sexual abuse be:

'... designated as an issue of urgent national significance by both the Australian and Northern Territory Governments, and [that] both governments immediately establish a collaborative partnership with a Memorandum of Understanding to specifically address the protection of Aboriginal children from sexual abuse. It is critical that both governments commit to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities.' (Wild, Anderson 2007, p 22)

Wild and Anderson had recommended that the Northern Territory Government provide strong leadership on the issue (Wild, Anderson 2007, p. 7).

The response of the Northern Territory Government was limited. The report was released publicly on 15 June 2007. The Minister for Families, Community Services and Indigenous Affairs, Mal Brough MP, announced his commitment to working with the Northern Territory Government to reduce violence and child abuse in the NT (Brough, 15 June, 2007).

But on the 21 June 2007 (less than a week later), Prime Minister, Mr John Howard MP, said that the Australian Government was unhappy with the response of the Northern Territory Government. On that day, the Minister (Mal Brough) announced, on behalf of the Australian Government, a 'national emergency response to protect Aboriginal children in the NT' (Brough, 21 June 2007). The measures announced on that date included:

- introducing widespread alcohol restrictions on Northern Territory Aboriginal land;

- introducing welfare reforms to stem the flow of cash going toward substance abuse and to ensure funds meant to be for children's welfare are used for that purpose;
- enforcing school attendance by linking compulsory income support and family assistance payments to school attendance for all people living on Aboriginal land and providing meals for children at school at parents' cost;
- introducing compulsory health checks for all Aboriginal children to identify and treat health problems and any effects of abuse;
- acquiring townships prescribed by the Australian Government through five-year leases including payment of just terms compensation;
- as part of the immediate emergency response, increasing policing levels in prescribed communities, including requesting secondments from other jurisdictions to supplement NT resources, funded by the Australian Government;
- requiring intensified group clean-up and repair of communities to make them safer and healthier by marshalling local workforces through work-for-the-dole;
- improving housing and reforming community living arrangements in prescribing communities including the introduction of market-based rents and normal tenancy arrangements;
- banning the possession of X-rated pornography and introducing audits of all publicly funded computers to identify illegal material;
- scrapping the permit system for common areas, road corridors and airstrips for prescribed communities on Aboriginal land; and
- improving governance by appointing managers of all government business in prescribed communities (Brough, 21 June, 2007).

On 7 August 2007, the legislation (comprising five Bills, three of which suspended Part II of Racial Discrimination Act 1975³) was introduced into Parliament. On 15 August 2007, the Minister announced that the legislation to authorise the Federal emergency intervention in the Northern Territory would pass in the Senate that day. (Brough, 15 August 2007). The quick passage of these Bills

³ Part II of the RDA prohibits racial discrimination in, inter alia, rights to equality before the law, access to places and facilities, land, housing and other accommodation and provision of goods and services

was considered to be unusual, if not unprecedented (Magarey, Spooner, et al., 2007, p. 6). Despite Wild and Anderson's clear recommendation on the need for genuine consultation with Aboriginal people, '... consultation did not feature prominently in the Federal intervention' (Magarey, Spooner, et al., 2007, p. 14).

The Australian Parliament used its powers under Section 122 of the Constitution to coercively effect the laws operating in the NT in this case. Provisions in three of the Acts were deemed by the Government to be special measures, allowing them to suspend Part II of the Racial Discrimination Act, 1975 (Magarey, Spooner, et al., 2007, p 22 - 26). Not all the measures included in the Northern Territory Emergency Response required legislation to enable their implementation. Some were announced by media release only.

The Australian Government framed the Northern Territory Intervention (NT Intervention) as a response to the issues raised in the Little Children are Sacred report. However this framing was widely contested by different stakeholders. Other factors that were identified as influencing the implementation of the NT Intervention at that time included:

- that the timing coincided with an imminent federal election;
- that there had been an ongoing disinvestment in the Aboriginal self-determination movement by Australian and state governments; and
- that the Australian Government had considerable legislative powers in the NT under the constitution – powers that it does not have in relation to the states although similar problems had been identified in each of the states.

In all, different stakeholders identified multiple reasons for the Australian Government's decision to implement a wide-ranging, multi-sectoral intervention in the NT.

The introduction of the NT Intervention was a shock to the affected communities, and to the wider population of Australia – Indigenous and non-Indigenous, alike. It was a shock, too, to the NT Government. The scale of the proposal, the fact that it included actions that required legislation to set aside some of the provisions of the Racial Discrimination Act (1975), that it was introduced without notice, and that it included a raft of compulsory measures that

applied to no other population group in Australia were some of the major concerns expressed. Many commentators have noted that there appears to be very little overlap between the 97 recommendations of the Anderson/Wild report and the measures that the Australian Government announced and to which it now seeks to give effect (Magarey, Spooner et al., 2007, p. 14). There could be no disputing the proposition that parliamentary consultation was compressed to a significant extent. The matter was treated as sufficiently urgent that it could not await meaningful Parliamentary consideration (Magarey, Spooner et al., 2007, p. 17) and there was no consultation on the proposed legislation with communities and families.

Although the Australian Government's stated rationale for intervention was to reduce harm among children who had been abused and to prevent child abuse and child sexual abuse, the vast majority of the provisions in the NTER were directed to underlying social and economic measures, all of which, it is arguable, have a bearing on children's health and wellbeing in the long term. However, few of the measures could have been expected to have an immediate impact on children who were already at high risk of abuse or who had been abused already.

In effect, the NTER was framed as a response necessary to improve and protect the health of Aboriginal children (and communities) in the Northern Territory but the legislation (and other provisions) had received limited scrutiny to determine the extent to which research-derived evidence supported the proposed measures. This was important given that there was, for some of the measures, considerable evidence questioning whether the likely health impacts would be positive. At no point in the introduction and implementation of the NTER were Aboriginal community leaders and stakeholders (nor those of other NT-based Indigenous and non-Indigenous stakeholders) engaged in discussion about the specific measures, about the implementation, or about the likelihood that the NTER would achieve its intended health outcomes.

The provisions in the Northern Territory National Emergency Response Act were intended to last for five years, effectively implying that it would take five years for the intended benefits to accrue to the prescribed communities – in keeping with the 'special measures' provisions.

The Government's intention was for the NTER to be implemented in three phases:

- stabilisation – from June 2007 till 30 June 2008;
- normalisation of services and infrastructure – from 2009 to 2012; and
- longer-term support to close the gaps between these communities and standards of services and outcomes enjoyed by the rest of Australia.

CONTEXT

The Northern Territory is one of two Territories in the Australian federation. Although they have limited rights to self government, the Australian Government has the constitutional power to govern directly. It was this power that was used to override the NT Government on a matter considered to be of national importance.

Population and distribution

The total population of the Northern Territory in 2006 was 210 674, of whom 66 582 (31.6%) were Aboriginal and/or Torres Strait Island people. This compares with the 2.5% of the total Australian population that is of Aboriginal and/or Torres Strait Islander descent (Australian Bureau of Statistics 2008).

In all, the Aboriginal population of the NT lives in more than 600 communities, only 81 of which have populations of 100 or more – an estimated 32 000 people. An additional 560 communities have populations of less than 100, totalling an estimated usual population of 10 000 (Kronemann 2007).

Seventy-three communities, each with a population of greater than 100, were 'prescribed' as being the initial focus of the NT Intervention. More than 70% of the Aboriginal residents in the NT live within these communities (which were prescribed in the NT National Emergency Response Act 2007). The Aboriginal population of these communities, in total, was estimated to be 45 500.

Summary reports of the history, current populations, infrastructure and services, and demography of seven major communities prescribed by the NTER were prepared for the HIA (Pascoe 2007).

Social and Economic Infrastructure

Multiple reports had preceded the publication of the *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' (Wild, Anderson 2007) report, describing the extent to which Aboriginal communities in the NT had been deprived of social and economic infrastructure and capacity. However this report once again highlighted the lack of educational, housing, health care and health promotion, employment, family and community support services, and policing in Aboriginal communities in the Northern Territory and the serious consequences for health and wellbeing.

Health consequences

Such significant under-investment by governments (in particular) in enabling Aboriginal people to have equitable access to the social determinants of health continues to have serious health consequences. Among Aboriginal adults in the NT, more than half the males can expect to die before the age of 50 years – and average life expectancy is approximately 18 years shorter than for non-Aboriginal males. The gap in life expectancy between Aboriginal and non-Aboriginal females is 17 years.

Across the life span, from infancy through childhood, adolescence, and adulthood, Aboriginal peoples experience significantly higher rates of morbidity from acute and chronic diseases. High levels of trans-generational and cumulative trauma resulting from the continued social exclusion of Aboriginal people and communities from decisions affecting them and their communities, combined with the continued lack of access to the material resources needed for good health, have meant that the population prevalence of behavioural risks to health is significantly greater than among non-Aboriginal Australians.

The context within which the NT Emergency Response was conceived of and implemented was one in which there was widespread knowledge of and agreement that urgent, large-scale, sustained action was needed by governments and communities if the quality of life and life expectancy of Aboriginal residents of the NT were to become the equal of those of all other Australians, and if Aboriginal people were to achieve their goals and aspirations.

HEALTH IMPACT ASSESSMENT OF THE NORTHERN TERRITORY EMERGENCY RESPONSE

The Australian Indigenous Doctors' Association (AIDA), in partnership with the Centre for Health Equity Training, Research and Evaluation (CHETRE) from the University of New South Wales (UNSW) and financial support from the Fred Hollows Foundation decided that an HIA would provide a structured, evidence-informed method for examining the potential positive, negative and often unanticipated consequences of the NTER on the health and wellbeing of children and people living in the prescribed communities.

AIDA chose to undertake the HIA within an advocacy model that would give voice to the affected communities and facilitate discussion with policy makers and program leaders on ways in which the NTER could be improved and, potentially, negative impacts reduced. No other structures or processes through which communities could report directly on the actual or potential impacts (positive or negative) of the NTER on their health, lives and wellbeing were in place at the time the HIA commenced.

Ideally an HIA is undertaken prior to a policy, program or project commencing. It assesses, prospectively, what are likely to be the impacts

WHAT IS A HEALTH IMPACT ASSESSMENT?

The HIA is concerned with assessing the potential health impacts of a proposed policy, plan, program or project on the health of a population; and making practical recommendations to improve that proposal (WHO European Centre for Health Policy 1999; Quigley, Taylor, 2004). An HIA is a practical methodology that uses evidence to influence policy development, planning and practice.

The HIA is a step-wise prospective assessment process that seeks to predict the impacts on the health of populations in order to inform decision making before a proposal is implemented and before potentially negative effects occur. It is common for an HIA to use multiple sources of evidence in making assessments.

of what is being proposed. In this case the NT Intervention was implemented with no opportunity for assessment prior to implementation. We have therefore needed to define the proposal being assessed and to accept that many of the impacts identified were occurring at the same time that the HIA was being undertaken.

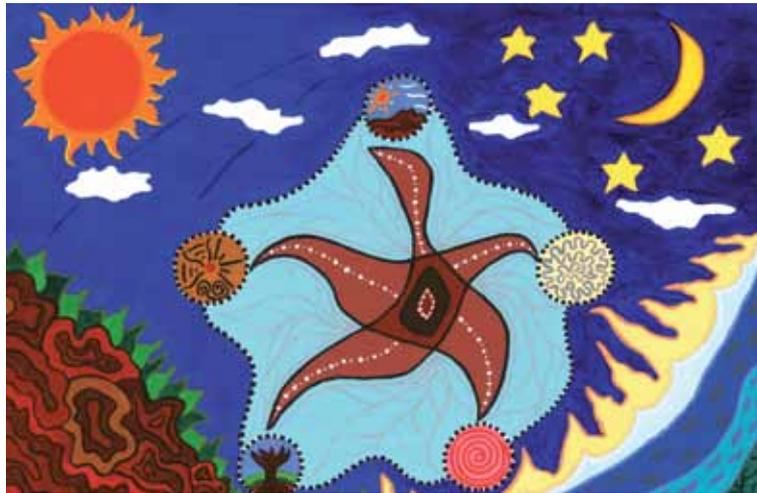
The proposal that was being assessed in this HIA is the NTER legislation, the media releases that were distributed in association with the enactment of the legislation, and a one-year-on report prepared by the Australian Government accounting for progress in implementing the NTER legislation. The focus of the HIA has been on the impacts in the communities prescribed in the legislation, although we recognise that there have been substantial impacts on the Northern Territory and Australia as a whole.

The HIA is not an evaluation of the NTER but is, rather, an assessment of evidence from a variety of sources that has then been used to predict potential positive and negative impacts on the health of the people whose communities were prescribed under the legislation. In this HIA we made a conscious decision to privilege the voices of the people directly affected by the Intervention. This means that we gave equal weight to the reports of the people about

their experiences and perceptions of the potential impact on their lives, health and wellbeing; and to the findings and opinions of experts.

As a result of this HIA being conducted concurrently with the Intervention's implementation there was an additional complexity in assessing potential impacts because we were able to see some of the difficulties and delays in what was proposed that may not have been as evident when the proposal was first announced. The time taken to secure resources to undertake the HIA and to secure ethics approval meant that the HIA was being undertaken in a changing environment.

THE DANCE OF LIFE: AN ABORIGINAL UNDERSTANDING OF HEALTH AND WELLBEING



In undertaking the assessment the HIA Team acknowledged the importance of working within an Aboriginal understanding of health and wellbeing and a global human rights approach.

In 1978 the Declaration of Alma Ata had established international agreement

'... that strongly affirmed that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.' (International Conference on Primary Health Care, 1978).

The National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989) defined Aboriginal health as:

'... not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life.'

This was expanded upon in a definition developed by Swan and Raphael (1995, p.13).

'The Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to wellbeing. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised inter-relations which culturally constitute wellbeing. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially it must be understood

that when the harmony of these inter-relations is disrupted, Aboriginal ill-health will persist.'

In this HIA a contemporary Aboriginal definition of health has been used. The *Dance of Life* was developed by Professor Helen Milroy⁴ and consists of five dimensions – cultural, spiritual, social, emotional and physical – within which are a number of layers that reflect historical, traditional and contemporary influences on health. This concept emphasises the intersection of both the layers and dimensions, that creates the interconnectedness for a whole of life approach to Aboriginal wellbeing.

In line with Professor Milroy's model and in keeping with the earlier definitions of the health and wellbeing of Aboriginal peoples, this HIA has used a multi-dimensional schema to define health.

The five dimensions included in the HIA framework are: physical health, psychological health, social health and wellbeing, spirituality, and cultural integrity.

The contributions of each of these dimensions to the health of Aboriginal people are explained, below. For each of these dimensions, indicators were selected to predict the explicit effects of the multiple impacts of the NTER on the health of the populations of the prescribed communities in the NT.

PHYSICAL HEALTH

Following colonisation and the dramatic changes in lifestyle and degraded living circumstances Aboriginal peoples have been exposed to high levels of childhood infectious disease (such as

⁴ Professor Helen Milroy is the Director of the Centre for Aboriginal Medical and Dental Health (CAMDH) at the University of Western Australia.

pneumonia and gastroenteritis) and, among adults, there are high rates of chronic diseases (including cardiovascular disease, diabetes, and kidney disease) and injuries which have contributed to the unacceptable gap in life expectancy. As well, the degraded living conditions and social exclusion have resulted in the high prevalence of behavioural risks to health – alcohol misuse, poor nutrition, smoking, obesity and interpersonal violence.

Selected indicators of physical health

- premature mortality
- morbidity
- self-reported health
- behavioural risks to health - alcohol and other substance misuse, poor nutrition, smoking, obesity, physical inactivity, interpersonal violence
- use of health care services - preventive and curative services (e.g. immunisation, ear health, and child and adult health checks)

Sources:

Australian Institute of Health and Welfare, 2007.
 Australian Institute of Health and Welfare, 2008a.
 Australian Institute of Health and Welfare, 2008b.
 Australian Institute of Health and Welfare, 2008c.
 Australian Department of Health and Ageing, 2008.

PSYCHOLOGICAL HEALTH

Since colonisation the psychological health of Aboriginal people has been under immense pressure reflected in profound trauma, extreme powerlessness, denial of identity, marginalisation in society and exclusion from mainstream institutions including the right to vote, attend high school or earn fair wages. These sources of trauma persist and are reflected in trans-generational trauma and cumulative trauma, resulting in high levels of psychological distress; anxiety and depression; suicide and experiences of stigma and discrimination, that in turn contribute to substance misuse and violence.

Selected indicators of psychological health

- anxiety and depression
- suicide
- stress
- trans-generational trauma, cumulative trauma
- freedom from stigma, shame, discrimination
- freedom from institutionalised racism

Sources:

Kaufman, 2004.
 Australian Institute of Health and Welfare, 2009a.
 Australian Institute of Health and Welfare, 2009b.
 Australian Department of Health and Ageing, 2008

SOCIAL HEALTH AND WELLBEING

The policies of assimilation, elimination, forced child removal, protection and segregation that were imposed after colonisation resulted in the huge disruption of traditional social institutions and kinship ties. The damage to the intricate kinship systems and community cohesion of Aboriginal people through the Stolen Generations cannot be over-emphasised with many Aboriginal people today still searching for their identity and many Aboriginal lands still calling their people home. For Aboriginal people living today the impacts of these race-based policies and practices, including the enormous dislocation of families and communities, laid the foundation for generational exclusion from mainstream society and resultant impoverishment, resulting in poorer educational outcomes and income levels, high levels of unemployment, incarceration, and poor living conditions. The lack of access to material resources necessary for health (Anderson, Baum, Bentley, 2007) and the lack of opportunities to acquire these have had a major impact on the physical and psychological health of Aboriginal people. Housing and associated health hardware (e.g. water, sewerage and waste disposal), education, employment and income are some of the material resources that are essential for good health and wellbeing.

Selected indicators of social health

- number of new houses built
- number of new houses allocated to Aboriginal community members
- number of houses meeting national quality standards
- number of school places, teachers
- opportunities for employment
- number and location of health services and health care
- number, qualifications, and location of health workforce
- number, location of police and other community safety measures and workforce

Sources:

Australian Institute of Health and Welfare, 2009a.
 Australian Department of Education Science and Training, 2004.
 Australian Department of Health and Ageing, 2008.

In addition to having access to material resources, peoples' and communities' social health and wellbeing are also dependent on ability to be self-determining, to fully participate in every layer and aspect of social decision making to enable their goals, aspirations and needs to be met. The significant social exclusion of Aboriginal people from mainstream society has contributed to their poor health and life expectancy and exposes the high costs associated with lack of access to the

opportunities and resources needed to participate fully in society. The expression of autonomy (personal and collective), access to opportunities to participate in social decision making and action, and the opportunity to be and to feel socially included and trusting (of other people and of governments) are components of social health and wellbeing.

Selected indicators of social wellbeing

- Autonomy – personal and collective
- Opportunities for social inclusion
- Participation in social decision making and social action
- Discrimination
- Trust (in other people and in governments and their services, e.g. health, justice and housing)

Sources:

Australian Institute of Health and Welfare, 2009a.
Australian Institute of Health and Welfare, 2009b.

SPIRITUALITY

All people are spiritual beings. For Aboriginal people this is strongly reflected in an understanding of the origin of life, ways of creation and a philosophical view that considers the interconnectedness of all things. This world view is significantly different from that of mainstream society and the tension between these world views remains strong today. Ongoing intolerance and lack of understanding on the part of mainstream society of differences in knowledges and values contribute to ongoing denial and denigration of Aboriginal world views and contributes to a deep sense of alienation and a collective existential despair. This also limits the capacity of Aboriginal leaders to have their world views incorporated into policy development and implementation.

Selected indicators of spirituality

- recognition and respect for Aboriginal people, world views, knowledge, values and aspirations
- Aboriginal world views incorporated into policy development and implementation
- alienation and despair

Sources:

O'Loughlin, 2008.
Atkinson, 2002.

CULTURAL INTEGRITY

No culture is static. Aboriginal culture includes lore and law, languages, ceremony (including sorry business), kinship and approaches to health and healing, all of which are expressed through song, dance, art, and story telling to create and reinforce social cohesion within communities.

Culture gives people a sense of their roles and responsibilities and place in their society and ensures the continuity and sustainability of both people and the environment. The fundamental differences between the cultural knowledges and practices of Aboriginal people and European settlers resulted in an extreme clash of world views. These misinterpretations continue today and have profoundly influenced our social institutions, creating barriers through institutional racism, marginalisation from political structures and processes, and token understanding on the part of mainstream society of the value and potential contributions of Aboriginal people, culture and knowledge. The recognition of land rights and the relationship to country, and the acknowledgement and promotion of the use of Aboriginal languages are some of the factors central to the cultural integrity of Aboriginal people and through that, to their health.

Selected indicators of cultural integrity

- Evidence of having taken back from government agencies certain rights of self-government
- Steps taken to secure Aboriginal title to traditional lands
- Degree of community control of educational services, health services, police and fire protection services
- Officially recognised cultural facilities to help preserve and enrich cultural lives, including recognition and promotion of Aboriginal languages

Source:

Chandler, Lalonde, 1998, p 209.

THE HIA METHOD

SCREENING

The purpose of the screening step is to determine whether or not an HIA is appropriate. A pre-screening report was prepared on the 24 August, 2007. The pre-screening report set out the five main elements of the HIA. Through the process of preparing and endorsing this report it was agreed that:

- a steering committee would be convened by AIDA, membership of which would include community representatives, AIDA and CHETRE. Broad responsibilities of the steering committee would include: screening and scoping the HIA, discussing progress in gathering evidence, and forming and finalising recommendations;
- four to six health issues would be targeted, rather than an exhaustive analysis of all the potential health issues (and determinants) that could be identified;
- evidence of the potential impacts would be collected in three ways: consultation with nominated communities, consultation with other stakeholders and the commissioning of expert appraisal reports;
- a draft report would be prepared to draw together findings from the evidence collected; and
- a series of recommendations aiming to improve and add value to the NT Intervention and its implementation would be developed.

SCOPING

The purpose of this step is to establish the scope and nature of the HIA, what is going to be done and within what timeframe, identify who will be responsible for each aspect of the work, and decide on project management processes.

The scope of the HIA of the NT Intervention was determined at a meeting held on Sunday 23 September 2007. The scoping report was drafted on 22 October, 2007.

It was decided that a comprehensive HIA rather than a rapid HIA would be conducted. The 'proposal' that was being assessed included NTER measures described in:

- Government media releases, 2007 (Brough 2007⁵; Abbott 2007);

⁵ Multiple media releases by Minister Brough were used to announce the NTER and the specific measures included in the NTER.

- The Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred' report, (Wild, Anderson 2007);
- The NTER: One Year On report, June 2008 (Australian Department of Families Housing Community Services and Indigenous Affairs 2008).

A steering committee was established and terms of reference were developed to provide advice and guidance on the conduct HIA. The committee decided that:

- CHETRE would act as consultants to AIDA;
- ethics approvals would be sought from the Central Australia Aboriginal Health Research Ethics Committee, the Human Research Ethics Committee of the Northern Territory Department of Health and Community Services, and the UNSW Human Research Ethics Committee;
- data collection would involve a legislative analysis, community consultations, community profiles and expert review;
- appraisal and analysis of the evidence would involve assessing the impacts identified from the data collection using a standard matrix, assessing the significance of impacts and prioritising them - if the information from the varying sources diverged or disagreed, the information collected from Aboriginal communities would be privileged;
- recommendations would be agreed after presenting the findings to the steering committee, developing and agreeing on a set of action oriented recommendations, and writing the final report;
- a process and impact evaluation would be conducted and a system would be established to monitor the outcomes of the recommendations over time.

IDENTIFICATION

Ethics approval was gained from the Central Australian Aboriginal Health Research Ethics Committee and the Human Research Ethics Committee of the Northern Territory Department of Health and Community Services.

Information that was collected to identify the major health impacts included legislative analysis, community consultations, key stakeholder interviews, key document analysis and expert reviews.

Legislative Analysis and Analysis of Media Releases

Legislative analysis was conducted to identify the elements in the Intervention, identify the regulatory context, and to ensure that the HIA responded to the complexities of the proposal.

Community Consultations

Community consultations were conducted between July and October 2008 in four communities across the Northern Territory. Perspectives were sought from Central Australia, the Katherine region and the Top End. Where possible, perspectives from both urban and regional parts of these regions were obtained. Community consultations included one-on-one interviews and focus groups. Detailed notes were taken but the interviews and focus groups were not recorded.

Key Stakeholder Interviews

Twenty-one key stakeholder interviews were conducted between July 2008 and January 2009. Most of the interviews were one-on-one conducted by telephone, although eight were conducted face-to-face including three group interviews.

In total, twenty-five individuals were interviewed - fifteen female and ten male. Seven were Indigenous; ten were government employees, six were from non-government organisations, six were service providers, two were academics and one was a senior Commonwealth public servant.

The interviews were all conducted by members of AIDA and CHETRE. Interviews were transcribed verbatim. The transcripts were uploaded onto Vivo. Then, based on decisions of the steering committee at the first assessment meeting (see below), the data were organised around four priority issues: child health checks; safe communities; income management; and external leadership, governance and control. These issues were those raised most commonly in the community and stakeholder interviews and were also raised by most of the expert reviewers. Prosaic coding was carried out by members of the CHETRE team and verified by AIDA. The coding process identified the major themes arising from the interviews and the impacts in relation to each of the four priority issues.

Expert Reviews

Expert reviews were commissioned in the areas of: drugs and alcohol, mental health, child mental health, education, child health, and human rights. These reviews were a summary of research-derived evidence reported in the literature. They were not systematic reviews but were, rather, syntheses prepared by recognised experts in the field.

- Professor Sherry Siggers, National Drug Research Institute, Curtin University of Technology prepared the Drug and Alcohol Expert Review
- Dr Chris Sarra, Indigenous Education Leadership Institute, Queensland University of Technology prepared the Education Expert Review
- Dr Heather d'Antoine prepared the Child Health Expert Review
- Mr Tom Calma, Human Rights and Equal Opportunity Commission prepared the Human Rights Expert Review
- Professor Ernest Hunter, University of Queensland, prepared the Mental Health Expert Review
- Associate Professor Helen Milroy, University of Western Australia, prepared the Child Mental Health Expert Review

ANALYSIS AND ASSESSMENT

Members of the CHETRE team developed a series of questions to guide the analysis and assessment of the evidence.

- What was the proposal?
- What was the evidence for the proposal?
- What was the logic pathway between the measures proposed in the Intervention compared with research-derived evidence about the most effective measures to address the problem?
- What actions were taken to implement the Intervention?
- What health impacts were identified?
- What should be changed to increase the likelihood that the Intervention will have positive outcomes?

When all the evidence had been collected from communities, experts, and key stakeholders, the Steering Committee conducted a preliminary

review of the findings. The Committee decided to proceed with full assessments of the predicted impacts on health of the following measures proposed in the NTER:

- safe communities (alcohol restrictions, prohibited materials, housing and education);
- child health checks; and
- compulsory income management.

Each of these areas had been included, explicitly, in the conceptualisation of the Intervention and in legislation establishing the Intervention. However, the evidence gathered from communities, experts, and key stakeholders pointed to the powerful health impact of the ways in which the Intervention had been conceptualised, adopted and implemented.

Consideration of that evidence pointed to the need for assessment of the health impact of the processes and structures of 'external leadership, governance and control' that had been imposed by governments and their agents in introducing and implementing the Intervention. This became the fourth area that was the subject of the full assessment.

SECOND ASSESSMENT

Following further analysis and assessment, the draft assessments on each of the four priority issues were summarised into one page documents. Both the detailed assessments and these summary pages were used as the basis for discussion at the second assessment meeting held in Sydney in May 2009. This meeting was attended by five members of affected communities in the NT in addition to the AIDA members and CHETRE staff who were responsible for the HIA. The aims of the meeting were to: review the draft assessments in each of the four areas, prioritise the impacts and to make action-oriented recommendations to maximise the potential benefits to the health of the population and to minimise the potential harms to health associated with the NT Intervention.

Following that meeting, this report was prepared. For each of the priority issues an impact assessment has been prepared. Pertinent quotes from a community member, a key stakeholder, or an expert reviewer were included to illustrate and illuminate the impact.

EXTERNAL LEADERSHIP, GOVERNANCE AND CONTROL

TABLE 1: EXTERNAL LEADERSHIP, GOVERNANCE AND CONTROL: SUMMARY OF THE EVIDENCE FROM COMMUNITIES, STAKEHOLDERS AND EXPERT REVIEWERS

	Positive impacts				Negative impacts			
	Sources of evidence				Sources of evidence			
	Community visits	Key stake-holders	Expert reviews	Other	Community visits	Key stake-holders	Expert reviews	Other
Government commitment and leadership on issue	✓	✓	✓					
Increased financial investment in infrastructure and services		✓	✓					
Government able to respond more promptly and precisely to community needs		✓						
Discrimination					✓	✓		
Political and social exclusion					✓	✓	✓	
Loss of personal and collective autonomy					✓	✓	✓	
Disregard for and disrespect of community-determined governance structures and processes					✓	✓		
Cumulative trauma and anxiety associated with ambiguity/distrust					✓	✓	✓	
Stigma and shame					✓	✓	✓	
Undermining Aboriginal cultural integrity					✓	✓	✓	
Lack of cultural competence on the part of government agencies and agents						✓		

BACKGROUND

The *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' report (Wild, Anderson, 2007. p. 22) recommended, first, that:

'Aboriginal child sexual abuse in the Northern Territory be designated as an issue of urgent national significance by both the Australian and Northern Territory Governments, and both governments immediately establish a collaborative partnership with a Memorandum of Understanding to specifically address the protection of Aboriginal children from sexual abuse. It is critical that both governments commit to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities.' p. 22.

The report's overview said, in part, that:

'... what is required is a determined, coordinated effort to break the cycle and provide the necessary strength, power and appropriate support and services to local communities, so they can lead themselves out of the malaise: in a word, empowerment.' p. 2.

The report outlined concepts that had emerged in the course of their extensive consultations with Aboriginal communities and stakeholders in the conduct of the inquiry, and that reflected their views on the problems and their aspirations: 'dialogue, empowerment, ownership, awareness, healing, reconciliation, strong family, culture, law.' p. 15. The report agreed that '... the underlying dysfunctionality where child sexual abuse flourishes needs to be attacked, and the strength returned to Aboriginal people.' p. 21.

The *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' report also identified the multiple social, economic, environmental and behavioural factors associated with child sexual abuse and most other causes of ill health (physical and mental) and premature death in Aboriginal communities in the Northern Territory. p.15. These had been widely reported in many previous reviews and reports.

The NTER addressed this second group of factors only. The Australian and NT governments invested new resources through multiple sectors, simultaneously. However, the NTER legislation and the mechanisms for implementation removed

control of decision making and action from each of the communities and organisations affected by the Act. Most of the measures included in the legislation (and in related initiatives) are mandatory or compulsory; there is no reference to the need for dialogue, empowerment, ownership, reconciliation, healing, strong family or culture. In short there is no acknowledgement of existing local Aboriginal leadership and governance, and no suggested means to work together to strengthen these in the future.

ASSESSMENT

Positive impacts

The Australian and Northern Territory governments' recognition that the safety and wellbeing of Aboriginal children and their families was an issue of national significance was seen as a positive impact of the NT Intervention. Formal national commitment demonstrated that the Australian Government was committed to providing the services and infrastructure necessary to improve child safety and wellbeing, and was concerned about the plight of Aboriginal children. There is an opportunity for this commitment to be followed up by improvements in the provision of services and infrastructure.

'... at least there was a recognition that there was a problem that needed action and needed money being spent on it. Hopefully that will continue, but hopefully there will be a more informed approach to policy making which will involve listening to Aboriginal people but also be based on evidence rather than ideology.'

Non-Indigenous Doctor

Long-term commitment of funding is an opportunity to improve the delivery of services and infrastructure to Aboriginal communities.

'A \$99.7 million commitment over two years that the Commonwealth have agreed to and increasing [the NT] services system across government and non government to that sort of level, you know, that's not just incremental, that's kind of a great leap forward in terms of funding remote primary health care.'

Non-Indigenous Health Service Manager

Employment of Government business managers in Aboriginal communities has the potential to, and in some instances did, enable the Government to be more responsive to community needs.

'So that was a good example of a more recent one of how that was done with the Government Business Managers from the region and the Indigenous Coordination Centre kind of working together quite closely to be responsive to some extent ... It was a practical thing on the ground... but still the government was still implementing its thing. It was just trying to target a bit more for the circumstances, a bit more of a compassionate way or with a bit more knowledge of the impact on the ground.'

Non-Indigenous Government Business Manager

Getting government agencies to work together:

'I was given very specific direction in terms of my role being to coordinate and synchronise the roll out of government policies, the implementation of these policies ... So much of my work was around the logistic practicalities of getting it out, the de-confliction of different government agencies trying to do their work without any regard to other agencies, and that sort of fire brigade role of finding where things were going right off the rails and getting them back on the rails.'

Non-Indigenous Health Service Manager

Negative impacts

To many, if not most, community members and many stakeholders, the introduction of the legislation and the implementation of its measures felt as if:

'It was all our fault. No [recognition] that we were in deep crisis here and really needed some help ... [This is] all your fault you know, you're drunks, you're lazy, you're undisciplined, uneducated and now you're fucking your kids so just get on with it and cop this into the bargain because we're decent. We're a decent society and you can't do that in our society. So we're going to garnishee your wages. We're going to sort of, you know, examine every orifice of your kids and we're going to find these perpetrators. You know as if that, that's all.'

You know it doesn't work like that.

Aboriginal Community Leader

There is a perception that the NT Intervention represents poor government policy, but that Aboriginal people, rather than government incompetence will be blamed for the failure of the NT Intervention.

Throughout the conduct of the HIA, community members and stakeholders expressed shock, frustration, shame and anger at the discriminatory, racist nature of the NTER – calling up, for most people, memories and experiences of trauma that had been experienced by their families and communities for generations, and by themselves. Many people had thought that the days in which governments would act in this way had passed, that their democratic rights as citizens of Australia were secure. The fact that the level of engagement in planning the NTER and its implementation was much lower than that which would be considered to be normal by all other citizens will have multiple negative, unintended impacts on the health and wellbeing of the residents of the prescribed communities, and more broadly, on Aboriginal Australians across the country.

Suspension of Section 9 of the Racial Discrimination Act 1975 was viewed as highly discriminatory and as 'targeting Aboriginal people in a bad way'. There was outrage at the unfair singling out of Aboriginal people.

'This mob are guinea pigs. Long time ago it was the kitchen: not money. And we weren't allowed outside the fence. It is like returning to the past. Same as ration days; only a little bit of money.'

Aboriginal Community Member

'It felt like the stolen generation was coming back, so I was scared.'

Aboriginal Community Member

'Discrimination has the potential to widen the tolerance and respect gap between Indigenous and non-Indigenous Australians ... I'm fearful that it'll create a rift and if it does happen then people react in strange ways. They can go into their shells or they

can become violent and retaliate ... It takes longer to education [sic] the broader community and say "well this is an infrastructure problem over many years and it'll take many years to readdress".'

Non-Aboriginal Senior Bureaucrat

Multiple people and stakeholders in every community and from almost all professional and disciplinary perspectives expressed shock and outrage at the loss of rights to participate in the decision-making processes of society that had been so hard-won by Aboriginal people in Australia.

'It will take several decades before we can turn this around because I think these kind of policies will stay in the living memory of people and while ever that happens people will think, well, that's where people feel, that is how people think, it's ok to treat us... While ever there is a dominant attitude that thinks it's okay to do this I think these kind of impacts will be long-term.'

Aboriginal Corporation

People perceived that discrimination is caused by a lack of understanding by non-Aboriginal Australians of the culture and values of Aboriginal Australians and a failure to understand that governments cannot act in Aboriginal Australians' best interest without this insight:

'The socioeconomic circumstances that Aboriginal people have been, are faced with, in this country is appalling. It's despicable, and then to turn around and take and displace Aboriginal – to take people's land and to displace them and to control the movement of Aboriginal people, there are really factors that've happened since the start of colonisation and are continuing to happen. I think we really do need to have a good, long hard look at ourselves and actually acknowledge that – hang on a minute, there's just another policy that controls the movement of Aboriginal [people] and I think some of this comes down to what seems to me to be complete ignorance about Aboriginal people and about this sense of being and how they are and their connection to their land and country and some of those basic things. I think if people really did understand some of these things perhaps their policy would sort of reflect this. There's a really widespread

ignorance of some of the issues and governments have been allowed to get away with it.'

Aboriginal Corporation

Many people experienced the implementation of the NTER as a return to the past – perpetuating the trauma that communities have experienced since colonisation.

'We're leaving the community without our dog collar on. It's that kind of mentality for a lot of the old people. In fact the feeling when it [the Intervention was announced] "it's gone back to the old way now". That's what the old people said it's gone back now to the old way ... where the protectorate and where we were told we got to get bread and flower and sugar and Billy tea. It's that dictatorship and it's the controlling of Aboriginal people's lives and how do they expect us to control our lives if they're trying to control it in a culturally foreign manner and totally violating human rights.'

Aboriginal Doctor

Government demonstrated a lack of respect towards Aboriginal Australians. Effective consultation with Aboriginal communities is seen as dependent on political will.

'I would absolutely have changed the way that it was done in the fact that I would've used local people, whether they be Aboriginal I would prefer that but obviously you can't always get Aboriginal people but there are a lot of long-standing people who have worked with Aboriginal people and I would have actually involved those people in a process of discussion with communities about what to do. They have the answers you know, they do have the answers. It just blows me away that they were never asked.'

Health Worker

People questioned the Australian Government's motives in suspending the Racial Discrimination Act and the access permit system. The suspension and the application of the NTER to only Aboriginal people in some communities in the NT resulted in Aboriginal people feeling stereotyped as all being despicable or hopeless and of all Aboriginal men as being corrupt or predatory.

'... having things done 'to' them as opposed to 'with' them - with many new, know-all whitefellas from interstate bossing them around.'

Aboriginal expert reviewer

'It's really shown the NT Government up in a very bad light, worse than I'd even experienced of them before. They've really not handled this at all and they've dealt with it with great incompetence. What worries me is that they're going to say "oh look we've spent billions of dollars on these people and look nothing's happened, they're unhelpable, look at all the money that we've spent".'

Remote non-Aboriginal Doctor

Community members and the existing workforce feel disempowered by the way the Intervention was established and implemented.

'Oh it's soul destroying. It makes you feel as though whatever you do you can't make a difference and that it's all too hard, but in fact there are lots of things you can do, but if you're made to feel that or if you feel that so helpless that you can't do anything well then you become passive and all these things that you allow to happen to you, but you don't need to and you, you can do something you know so it totally reduces the individual.'

Aboriginal Community Leader

There were multiple calls from communities to improve governments' policy approaches to working with Aboriginal Australians. Good governance has four main attributes: legitimacy, power, resources and accountability (Dodson, Smith, 2003). But the implementation of the NTER has:

- lacked legitimacy

'We have our own brains and our own knowledge and our own aims but we were not asked about these. Some things that were already happening in programs were overlooked and ignored. We have our own ways but someone else is coming in and taking away our rights and control.'

Aboriginal Community Member

- denied community power

'It is taking away our self management and autonomy, disempowering us. People are feeling pain in their hearts. There seems to be nowhere to go and all the roads seem to be blocked no matter which way we turn.'

Aboriginal Community Member

- not invested in community-defined governance structures

'It's too hard, no help. Prior community structures have been developed from [Deidentified community's] perspective but now this has been taken away and it's too difficult.'

Aboriginal Community Member

- not attended to the need for accountability to communities

'There has been poor leadership from the Intervention and the new business managers have not been transparent in their decision making or about their roles and goals.'

Aboriginal Community Member

The one-size-fits-all approach doesn't account for regional or local circumstances and needs. The NTER failed to acknowledge that there are multiple community perspectives.

'There won't be a blanket response. I think every community has their own unique experiences and they also have their own issues so I guess that's another reason why I think having these kind of blanket roll out policies without any regard for the context or individuals concerned, or not including the individuals concerned raises question for me about the positive impacts.'

Aboriginal Corporation

'It is really difficult to represent a single view about stuff, and I guess that's probably one of the learnings is that as public servants ... for anybody outside of the community it's really difficult to represent the views of the communities and roll them up and say "there is an overall view" about whatever it is. That is a very challenging aspect.'

That I think until the rest of us get it right... we're not going to make those fundamental differences because we then go 'one size fits all'.'

Government Business Manager

Some communities were able to take greater advantage of aspects of the Intervention than others, contributing to the frustration of communities that had begun with more limited infrastructure and capacity.

'A lot of the Aboriginal communities, its not so much that government people aren't talking to them, its how they're talking to them. We go to some places, you'll find that there's not a lack of services, it's over servicing, there's people tripping over each other. In fact, in Aboriginal affairs, you can almost make a career out of going to meetings. Let's stop that, and start actually properly engaging in a proper manner with Aboriginal people.'

Aboriginal community leader

'Most of the Intervention is actually splintered the services that are already there and have been battling away for years ... It is just so many services now and we seem to be duplicating.'

Health Worker

The implementation of the NTER has contributed to the cumulative trauma experienced by communities.

'[The Intervention] being inflicted on them is really, really traumatising and it makes me cry because them old people, had their kids already taken, they lost their sisters and brothers and now the nation, they're quarantining their money and telling them what to do and I just think whatever happened to empathy and compassion and understanding and respect and culture. Whatever happened to taking into account dispossession and colonisation, ongoing oppression and all those other traumas that our people have gone through and that's what concerns me as an Indigenous person ...'

Aboriginal Doctor

'It will be several decades before we can

turn this around because I think these kind of policies will stay in the living memory of people and I think while ever that happens people will think well that's how people feel, its okay to treat us. So think it's really about, while ever there's a dominant attitude that thinks it's okay to do this, I think these kind of impacts will be long term.'

Aboriginal Corporation

Government agents may lack cultural knowledge and respect.

'I had some expertise particularly in the management of different efforts coming from other parts of government and the coordination of them to produce an outcome and maybe they thought I had credibility. But of course I didn't have any experience or credibility in Indigenous affairs and I didn't know anything about Indigenous affairs. It's shameful really that you can grow up in Australia and really have no insight at all into the problems and issues that confront our Indigenous people. So for me when I got this job ... I didn't know anything about, I didn't know what I didn't know.'

Non-Aboriginal Senior Bureaucrat

'I really hope and pray that the politicians and the key stakeholders who are coordinating the national response and the various stages really do think about culture and law and respect for countrymen and I really hope that the big politicians down south in Canberra and our great leaders of this nation really do think about culture from Aboriginal viewpoints. I know they wouldn't be able to understand it but to appreciate the Aboriginal wealth is different and Aboriginal wealth is diversified depending on country. We're not all the same.'

Aboriginal Doctor

There were multiple calls for government to work in respectful partnerships with communities.

'I think we need to look at ways to try and overcome the possible negative effects of the electoral cycle. The risk is that you might have a benign government who puts in some

long-term policy and issues and then has a change of government and the whole thing changes. So my idea to ... bypass it, [the electoral cycle] is to create a fund that and it would need bipartisan supporters, may be a pie in the sky but a fund out of which Indigenous, while it's funded and it's topped up to a maximum level and it can't exceed that, topped up from time to time and it's – there's an advisory body that gives government advice on how to spend it, where to spend it and it endures through the electoral cycle because I think you know Indigenous affairs is like the poisoned chalice. There's always a blue about it between politicians and what ends up happening is that policies get changed around and people get mucked around and nothing gets delivered but I've only sort of referred to it fairly briefly and I haven't really fleshed out at probably a coherent policy but I, I think we're going to have to look at funding, funding it that way, rather than relying on government to do the right thing for several terms because they're often just not there.'

Non-Aboriginal Senior Bureaucrat

'The question is how we can work together as equals, coming together to understand each other and work out ways to go forward together.'

Aboriginal Community Member

'There are two important views, [Deidentified community's] and [The Government's], and we need to work together to find points of agreement and collaboration. And when we have an agreement then down the track we can review that agreement and check that it's right.'

Aboriginal Community Member

'If politicians and government had sat down with [Deidentified community] we would have given them better ideas of how to proceed and what to do.'

Aboriginal Community Member

SUMMARY

From the perspectives of communities, stakeholders, and expert reviewers, some of the specific measures legislated in the NTER are likely to have positive health impacts on the health of children and communities.

However, the Intervention has diminished its own chances of succeeding in improving the health and wellbeing of children and communities through its failure to engage constructively, respectfully, and fully with the Aboriginal people it was intended to help.

The impoverished notion of governance that the Intervention represented has profound, far-reaching, and serious negative effects on the health (psychosocial, physical and cultural) of the people whose aspirations, knowledge, experience and skills were ignored; and it means that investments in housing or education of health '... are unlikely to pay off because of the lack of a capable governance system in place that can translate plans into action, priorities into concrete strategies, commitments into behaviour, and so forth'.

Cornell views the governance system of an Indigenous nation, community or organisation as the '... principles and mechanisms by which the will of that community is translated into sustained, organised action' (Cornell, 2008). With community-led decision making (Chandler, Lalonde, 1998) based on respectful partnerships between communities and government, and with long-term investment in communities' control of decisions about how to reach their own social, economic, quality of life and health goals, positive health outcomes will be achieved.

TABLE 2: EXTERNAL LEADERSHIP, GOVERNANCE AND CONTROL: SUMMARY OF PREDICTED HEALTH IMPACTS

ASPECT OF HEALTH	POSITIVE HEALTH IMPACTS	NEGATIVE HEALTH IMPACTS
Physical health	- Commitment to, and significant investment in action to improve Aboriginal child and community health	- Impact on developmental antecedents of children's health
Psychological health	- Improved sense of safety in some communities	- Anxiety - Cumulative trauma - Stigma, shame
Social health and wellbeing	- Commitment to and investment in providing basic services including housing, education, food supply, and improved access to health care	- Loss of trust in government - Loss of autonomy - Social exclusion - Undermining self determination
Spirituality		- Lack of recognition of and respect for Aboriginal aspirations, goals and needs - Existential despair and alienation` - Loss of identity
Cultural integrity		- Lack of recognition of existing activities that had been working. - Lack of recognition of and respect for Aboriginal leadership and decision-making. - Having title to land taken away – sovereignty denied. - Having rights denied.

RECOMMENDATIONS

It is recommended that:

- urgent action be taken by the Australian and NT Governments to work in partnership with communities to develop structures and processes that build on and strengthen Aboriginal governance at local and regional levels;
- priority be given to building and supporting Aboriginal leadership and forms of governance at local levels;
- the partnerships be reviewed regularly in terms of purpose and effectiveness using existing tools, such as, for example, the Partnership Analysis Tool (VicHealth, 2005);
- there is investment in identifying markers of cultural integrity in the Aboriginal Australian context.

TARGETS FOR MONITORING

Within one year

- The Australian Government reinstate Section 9 of the Racial Discrimination Act 1975.
- The Australian and NT governments implement the NTER Review Board's recommendations on governance, agreement making and capacity building under the auspice of the National Cultural Respect Framework⁶.
- Communities, in partnership with health and social services, and with the NT Government, establish services and programs to support people recovering from trauma, and more positively, to heal the harms of the past and to restore health for the future.

Within five years

- Partnerships reviewed and problems addressed;
- Markers of cultural integrity defined and used to assess the extent to which the criteria are met in communities in the NT;
- Models of governance that meet the Aboriginal-defined standards of legitimacy, power, resources and accountability are being used in all Aboriginal communities in NT⁷.

⁶ The guidelines would require communities, governments and their agencies to work together to decide on priorities, problems, solutions, investment and implementation and provide scope for Aboriginal Australians to process and project alternative ways to a stronger and smarter future.

⁷ Dodson M, Smith DE (2003) Governance for Sustainable Development: strategic issues and principles for Indigenous communities. CAEPR discussion paper no. 250. Canberra, ACT: Centre for Aboriginal Economic Policy Research, Australian National University.

COMPULSORY INCOME MANAGEMENT

TABLE 3: COMPULSORY INCOME MANAGEMENT: SUMMARY OF THE EVIDENCE FROM COMMUNITIES, STAKEHOLDERS AND EXPERT REVIEWERS

	Positive impacts				Negative impacts			
	Sources of evidence				Sources of evidence			
	Community visits	Key stake-holders	Expert reviews	Other	Community visits	Key stake-holders	Expert reviews	Other
Less pressure from family, improved ability to budget	✓	✓						
Improved food supply	✓	✓						
Discrimination, racism						✓		✓
Stressful, shaming and degrading					✓	✓		
Loss of autonomy					✓	✓		
Problems/cost of using the card					✓	✓		
Lack of development of sources of income other than benefits					✓			
Lack of evidence base for blanket use						✓		
Lack of financial advice						✓		
More difficulties budgeting					✓			
Increased pressure from others for money					✓			
Stigma and shame					✓	✓		
Undermining Aboriginal identity					✓			

BACKGROUND

One of the most contested aspects of the NTER was the introduction of compulsory income management of Aboriginal people on government benefits living in the prescribed communities. In order to introduce the compulsory income management scheme the government needed to suspend the Racial Discrimination Act.

Poverty is common in the communities that were prescribed under the NTER legislation. The *Little Children are Sacred* report had found that children were often going to school hungry and tired after being kept awake all night by adults' drinking and violence.

Under the NTER 50% of welfare payments to parents of children in the prescribed communities were quarantined for use on food and clothing. Parents of children who did not go to school were also liable for further limitations to their benefits.

Universal, compulsory income management for families receiving welfare payments, new standards for licensing of community stores and revised measures affecting community employment were seen as giving greater control to government in the ways in which money could be spent.

The objective of compulsory income management was to ensure that money was available to be spent on feeding, clothing and providing basic living conditions for children. It was also seen as limiting the amount of money available for alcohol use and thereby reducing exposure to violence and community disruption.

The logic pathway between income management, community store licensing and community employment appears to be based on the assumption that children in communities are vulnerable and their families and communities and governments have failed to provide them with the material and psychological security that they need in order to thrive and be safe.

ASSESSMENT

Positive Impacts

Some women reported that income management had significantly improved their lives. There was less pressure from family, relatives and visitors to the community for money, especially money for alcohol.

They were better able to save money and this may have translated into better food for some of the time.

'The good thing about the vouchers were that if people didn't spend their money in one hit it could be added on to their next payment, and sometimes people let it build up so that then when they have the chance to come to Darwin they could get better food in town and even though it cost them to travel it was a bit cheaper than the communities you know.'

Aboriginal Health Worker

'Some families that had been in real trouble have been able to buy some stuff that they hadn't been able to do previously.'

Aboriginal Health Worker

There were many comments in the community interviews on the improvements in food supply that had followed the licensing and auditing of community stores.

Negative Impacts

Not all those interviewed agreed that they had been better able to budget their money. Several women spoke of the hunger their families experienced close to pay day.

'It's been very stressful 'cause with the, like there's money especially on the, you know the financial side with Centrelink holding back our money, half of it and a lot of my family has had to rely on getting into town and when half of their money or some part of it, some, some of it goes into the community store and out in the community stores the prices are pretty, you know they're higher than prices here in town. So that money would often go to just a few items of food or you know anything that they want to get for the house and then they'd have to rely on getting into town and especially if you haven't got a car that would be a really stressful, terrible, worrying time because sometimes they would go without food ...'

Aboriginal Community Member

Many said that that there was actually more pressure over money and as time went by they were being expected to share what little money they had.

There were substantial practical problems in using the cards and the costs of these were borne by the recipient rather than Centrelink. These included the cost of transport and phone calls.

'I think it's an infringement on people's civil liberties that government has to manage and be involved in all those minute aspects of people's day-to-day living. My mother's book for child endowment was not in her house but hers and those of all the other Aboriginal mothers around the country, were held by the Superintendent of Native Welfare and she had to explain why she needed the money and how she was going to use it, etcetera, before he would let her have that month's coupon.'

Aboriginal Community Leader

Rather than enabling Aboriginal families to better manage their money the process of compulsory quarantining was seen as reinforcing beliefs that Aboriginal people were not able to manage their lives. This loss of autonomy about where to shop and what to buy was seen as degrading and shameful. Importantly it did not focus on whether people received enough money to be able to budget appropriately or provide skills in budget management.

'... stigma of shame attached to going to Centrelink and getting the card and lining up at Woolworths so lack of control in negotiation and consultation when it comes to food supply.'

NGO Program Manager (non-Aboriginal)

'I've seen countrymen in Alice Springs and Katherine getting their vouchers out of their wallets and seeing the shopkeeper looking at them very disgruntled and like "oh, not another one" and then shame job when, sometimes, they don't have enough money on their voucher to pay for all the their tucker.'

Aboriginal Doctor

We could find no evidence that the blanket quarantining of income was an effective strategy in improving child health. In fact there was local evidence that was not effective in achieving its stated aims.

'The experience in Halls Creek, where this was done on a voluntary basis - trying to quarantine Centrelink payments - was that kids did not attend school. It was evaluated by DEWR. It was found to be spectacularly unsuccessful. It did not improve school attendance. It was inordinately expensive for them to do. It begs the question as to how you can do this to 40 000 people across the whole of the Northern Territory in some 600 communities'

Combined Aboriginal Organisations of the Northern Territory, to the Senate Standing Committee on Legal and Constitutional Affairs

While there is little disagreement that the problems that existed in the communities were dire and did require urgent intervention the NTER has not addressed many of the underlying causes of the problems. In the context of income there has been little emphasis on reducing the dependence of these communities on government payments and increasing alternate sources of income or work. This could include a stronger focus on the establishment of small businesses, use of micro-credit or establishment of credit unions to assist with savings and loans.

The blanket application of the management to all residents in the prescribed communities and continued compulsory income management after people have left the communities have had serious impacts on the sense of cultural integrity within these communities. Most importantly the use of this measure is seen by those affected as humiliating, discriminatory and racist. For many people it forces them to re-live past experiences in mission times and reinforces feelings of helplessness and powerlessness. It has undermined their pride and identity in being an Aboriginal person.

No evidence has been found that compulsory income management has been an effective strategy in improving child health or reducing child sexual abuse.

SUMMARY

The positive and negative health impacts of compulsory income support are likely to cancel each other out. High levels of support for increased income to purchase food and other necessities for children, in particular, are likely to translate to improved health outcomes – both direct (as in improved health associated with improved nutrition) and indirect (as in, improved concentration, participation and learning ability and capacity, and improved educational outcomes). However, the compulsory quarantining of income of Aboriginal

welfare recipients will have significant negative effects on the mental health and social functioning of individuals and communities – including children. These are serious health consequences in their own right and will have serious, harmful impacts on the physical health of young people and adults across the life span.

TABLE 4: COMPULSORY INCOME MANAGEMENT: SUMMARY OF PREDICTED HEALTH IMPACTS

ASPECT OF HEALTH	POSITIVE HEALTH IMPACTS	NEGATIVE HEALTH IMPACTS
Physical health	<ul style="list-style-type: none"> - Improved nutrition - increased reliance on bush tucker 	<ul style="list-style-type: none"> - Running out of food - Running out of money
Psychological health	<ul style="list-style-type: none"> - More control over their money for some people 	<ul style="list-style-type: none"> - Anger at universal application of compulsory income management - Cumulative trauma – shame, discrimination - Stress associated with costs and use of ‘basics card’ - Trans-generational trauma – children seeing parents’ control and capacity undermined
Social health and wellbeing	<ul style="list-style-type: none"> - Better access to physical health hardware, e.g. fridges - Some improvements to food supply and food security - Increase in money available for food and other necessities for children’s health and wellbeing in some families 	<ul style="list-style-type: none"> - Increased costs for transport and food - Denial of rights of Aboriginal adults to solve their own problems
Spirituality		<ul style="list-style-type: none"> - Decreased sense of social inclusion and participation - Lack of recognition of Aboriginal goals and aspirations
Cultural integrity		<ul style="list-style-type: none"> - Lack of community and personal control of income management - Denial of universal and constitutional rights of citizenship and access to appeal procedures

RECOMMENDATIONS

It is recommended that:

- the current compulsory income management program be abandoned immediately;
- compulsory income management be used as a strategy only for explicit instances of child abuse, of neglect of school enrolment and attendance, or other relevant behavioural triggers, and then only in conjunction with active case management;
- costs associated with use of the income management card be borne by the Australian Government;
- independent research be undertaken to investigate effective family financial management methods that contribute to improved child health;
- the Australian and Northern Territory governments invest in the establishment of and support for Aboriginal Business Enterprises and financial institutions, including credit unions, to work in partnership with community, volunteers and entrepreneurs, to access to a range of economic development opportunities including micro-credit schemes.

TARGETS FOR MONITORING

At one year

- Universal compulsory income management program abandoned
- Compulsory income management only applied to families where there is clear and agreed evidence of abuse and neglect, of neglect of school enrolment and attendance, or other relevant behavioural triggers and only in conjunction with active case management
- All costs to individuals and families associated with use of the income management card are met by the Australian Government

At five years

- A publicly available report on the links between compulsory income management and child health has been commissioned and published

At ten years

- There will be an annual 40% increase in the number of Aboriginal Business Enterprises in prescribed communities.

HOUSING

TABLE 5: HOUSING: SUMMARY OF THE EVIDENCE FROM COMMUNITIES, STAKEHOLDERS AND EXPERT REVIEWERS

	Positive impacts				Negative impacts			
	Sources of evidence				Sources of evidence			
	Community visits	Key stake-holders	Expert reviews	Other	Community visits	Key stake-holders	Expert reviews	Other
Significant government investment in housing construction and housing repairs	✓	✓		✓				
Potential employment for community members – housing maintenance and construction	✓	✓						
Lack of recognition that land rights and housing are inextricably linked					✓			
Poor organisation of new housing construction and maintenance					✓	✓		
Continued overcrowding					✓	✓		
Little community engagement in decision making and design					✓	✓		
Slow progress in addressing fundamental issues of water and waste disposal					✓	✓		

BACKGROUND

For Aboriginal people the link between health and attachment to country is inseparable. Land is linked to Indigenous identity, beliefs and rights. Land rights are at the heart of the housing issue for Aboriginal people. Land was taken at the time of colonisation and there has been ongoing struggle by Aboriginal people to achieve government recognition of land rights for Aboriginal Australians.

As a result, there has been no cohesive national or state/territory strategy to provide culturally-acceptable housing of a quality or standard conducive to health and wellbeing as governments have been reluctant to invest in infrastructure and buildings on Aboriginal land over which they (governments) do not have control.

The consequence is the seriously inadequate housing and other public infrastructure in Aboriginal communities. The *Little Children are Sacred* report found that the shortage of housing for Indigenous residents of remote, regional and urban communities of the Northern Territory is severe and desperate. In particular, the inadequate numbers of houses leads to overcrowding; and the houses that are in communities are overcrowded and poorly maintained. There has been little opportunity for families and communities to design housing to suit their needs and limited investment in building local workforces with the capacity to construct and maintain housing (and other public infrastructure).

Ownership and control over land and housing have a positive influence on psychological and physical health. Aboriginal identity is tied to land, cultural practices, systems of authority and social control, intellectual traditions, concepts of spirituality, system of resource ownership and exchange. Loss of control over land, a lack of engagement with non-Aboriginal Australia and resulting powerlessness has had ongoing, serious negative impacts on health.

In addition, there is a strong relationship between the quality of housing and health. Overcrowding, and lack of access to the basic 'health hardware' of safe water, electricity, adequate areas for food preparation and storage, washing facilities, adequate waste disposal have contributed to the poor health of Aboriginal children and communities. Overcrowding and poor quality housing increases the likelihood of infectious disease, family and sexual violence and substance abuse. This has 'knock-on effects' including limits to children's educational attainment, tiredness and inadequate cleanliness that has a devastating impact on employment prospects and reinforces social disruption and marginalisation from mainstream society.

Land ownership was intended to provide a platform to support new housing stock and to improve and maintain existing housing. The measures included in the NTER legislation were:

- acquiring townships through five-year leases;
- land compensation;
- constructing new housing stock and repairs to existing stock;
- urgent repairs to infrastructure and community clean-ups; and
- additional accommodation to be built for 45 Government Business Managers and new police and teachers located in the prescribed communities.

ASSESSMENT

Positive Impacts

The main positive impact on housing related to the significant investment promised by governments for housing, and higher number of housing repairs occurring.

'There's money been promised for houses which is great. I mean there are 4000 dwellings need to be constructed right now. They've earmarked it.'

Non-Aboriginal Senior Bureaucrat

Negative Impacts

Most of the community responses to the housing measures promised in the Intervention were restatements of the serious, pre-existing housing problems that the Intervention promised to address. Although there was grave concern about the transference of leases to Australian Government control, many people welcomed the thought of there being, finally, a serious effort to provide the housing they need. However, after 12 months the Intervention had, it seemed, disappointed people who had hoped and expected that action would be quicker, particularly in terms of improved maintenance.

Concern was also expressed at the priorities for building houses with most of the new houses being allocated to Business Managers, police and health staff so that there was no impact on the quality of housing and overcrowding among community families. Also there was a perception that if you lived close to existing infrastructure you were given greater priority and also able to negotiate for more flexible arrangements on the ways in which the projects were implemented.

'Housing has got to be one of the most corrupt and incompetent areas of Indigenous affairs. We're looking at houses that you build for \$100 000 costing \$4 to \$5 to \$600 000 to build and it's just nonsense and they're not, and a lot of them are falling down within a few years. We must look at the type of housing, the material we're using and look at how we can reduce the cost 'cause that is just a bizarre situation. You cannot tell me just because it's in a remote area, or it's in a rural area that it's going to cost that amount of money to build that type of housing.'

Aboriginal Leader

'The Intervention people would have meeting after meeting and people would say the same thing. We want better housing, we want improved housing. There are houses that have been condemned for 10 or 20 years and the council's suggestion was well you just bulldoze the house. But where do the 20 people go, that live in that house? And the Intervention has come round. They have taken films and interviewed the people and they've been inside these houses but nothing has changed. One year down the track, people are still living the same condemned house.'

Aboriginal Community Member

'They sent 120 garbage bins, wheelie bins out to a remote community. They posted out these holders with chains on them, but when they went to put the bins out, they had 120 garbage bins but only 20 sets of wheels. So they put out 20 garbage bins and the rest just sit there. And there is no garbage service... And the rubbish still gets tipped over by the pigs and dogs.'

Aboriginal Community Member

Overcrowding and poor housing affects everyone in the community including Aboriginal Health Workers.

'There are fifteen in my house including kids. I'm living with my parents. It is a four-bedroom house. All paying rent \$400 - 500 per week all together for that house, because it is \$50 each. Plus the power cards.'

Aboriginal Community Member

For many people the proposed building program was seen as a missed employment and training opportunity for Aboriginal people in the design, construction, and maintenance of housing and relevant health hardware

'Rather than having people flying in and flying out to build houses while you've got all these white fellas going in, building a house, and then shooting off. You've got the community, you know 50, or 60 or 100 Aboriginals sitting down watching them build a house.'

Non-Aboriginal Doctor

Some people had ambitious long-term vision on ways in which the community could be involved.

'... learn how to fix houses and the plumbing and how it works ... it could have set up maintenance centres where there was proper training, proper apprenticeships and proper pay.'

Aboriginal Health Worker

This speaks to the wider concern expressed by communities and stakeholders that the long-term maintenance of the housing depended on ownership and on the appropriateness of the housing.

'One of the problems with housing historically ... is that there's no consultation with local people about what their needs are.'

Non-Aboriginal Senior Bureaucrat

'The issue for government is that they were going to invest in housing, make a big investment in housing. Investing in housing is all well and good, but if you build houses that are inappropriate, if you allow contractors to dominate the process of building the houses and delivering the infrastructure, without proper Aboriginal eyes overseeing the process then we go through another historical regression... Building houses is needed but it how you build the inside of that house and the family that lives in that house. It is more about making sure that the house on the inside is a shelter indeed, not a shelter that's a temporary solution to a great social problem.'

Aboriginal academic

SUMMARY

The commitment by the Australian Government to investment in new housing, and to renovation and improved maintenance on existing housing has the potential to have a very positive impact on the health and wellbeing of Aboriginal children and their families. Reduced overcrowding, improved health hardware, improved water supply and other essential services (e.g. electricity, waste disposal) will all have significant positive effects on health – in the short and longer term. Participation of the local community in the design, building and maintenance of the housing will increase the likelihood of the

housing being appropriate, and increased ownership will increase the longevity of quality housing stock.

Delays in providing new or improved housing stock, however, will have a negative impact on the mental health and social functioning of communities.

Increased distrust in government, a sense of disillusionment and powerlessness associated with dashed hopes will, in turn, have a negative impact on the psychosocial health and social cohesion of families and communities.

TABLE 6: HOUSING: SUMMARY OF PREDICTED HEALTH IMPACTS

ASPECT OF HEALTH	POSITIVE HEALTH IMPACTS	NEGATIVE HEALTH IMPACTS
Physical health	<ul style="list-style-type: none"> - Reduced acute and chronic disease as a result of reduced overcrowding - Reduced acute disease as a result of improved water supply and waste disposal 	<ul style="list-style-type: none"> - Limited improvements to waste disposal
Psychological health	<ul style="list-style-type: none"> - Potentially, relief from stress associated with overcrowded, inadequate housing 	<ul style="list-style-type: none"> - Lack of trust in government, e.g. Intervention staff housing built first - Lack of Aboriginal control of decision-making, e.g. not involved in decisions on location, allocation, design and construction of new housing - Increased stress associated with long wait for improved housing
Social health and wellbeing	<ul style="list-style-type: none"> - Building and having access to new housing - Improvements to existing housing - Initial community clean-ups - Increased employment opportunities - increased education and training opportunities including traineeships and apprenticeships 	
Spirituality		<ul style="list-style-type: none"> - Lack of recognition of Aboriginal views and needs in developing and implementing housing policy and programs - Lack of trust in government which did not recognise the link between housing and Aboriginal connection to country
Cultural integrity		<ul style="list-style-type: none"> - Loss of control of land title in Intervention communities

RECOMMENDATIONS

It is recommended that:

- Aboriginal communities be involved actively in decisions on the design, building, allocation and location of new housing;
- Aboriginal communities be provided with education, training and resources to enable them to undertake systematic maintenance and repair of all existing and future homes;
- priority be given to providing new and renovated housing to community members until 2018;
- benchmarks in National Partnership Agreement on Remote Indigenous Housing be met.

TARGETS FOR MONITORING

At one year

- 20% local Aboriginal employment be included as a procurement requirement in new housing (as per COAG National Partnership Agreement) and housing maintenance contracts

At five years

- 75% of the investment in new or renovated housing until 2018 be for people living permanently in communities
- A recurrently funded rolling maintenance program be established in all prescribed communities
- Each prescribed community will have access to water, sewerage, power and waste disposal

- The average occupancy rate per dwelling in prescribed communities will be no greater than the national average
- 80% of all houses identified as needing repairs and renovation be completed as per the COAG National Partnership Agreement

At ten years

- All dwellings in prescribed communities have operating water, sewerage, power and waste disposal

EDUCATION

TABLE 7: EDUCATION: SUMMARY OF THE EVIDENCE FROM COMMUNITIES, STAKEHOLDERS AND EXPERT REVIEWERS

	Positive impacts				Negative impacts			
	Sources of evidence				Sources of evidence			
	Community visits	Key stakeholders	Expert reviews	Other	Community visits	Key stake-holders	Expert reviews	Other
Improved participation			✓					
Improved investment in infrastructure & teachers			✓					
Greater collaboration			✓					
Leadership			✓					
Stigma, social exclusion, psychosocial harm					✓			
Reduced school attendance							✓	
Reduced workforce capacity							✓	
Ineffective strategies					✓	✓	✓	✓

BACKGROUND

The Northern Territory is a small education jurisdiction with 150 schools and 50 homeland centres. It has a relatively young and growing population that is highly dispersed, with a quarter living in remote communities spread over a vast area. Over 40% of school-age children are Indigenous – three-quarters living in very remote locations (Sarraf, 2008).

It is well-known that many Aboriginal students experience episodes of chronic ill-health and their growth and development are impacted by levels of nutrition and overcrowded housing, with significant impact upon students' readiness to learn (Sarraf, 2008).

On the basis of 2006 census data it would seem that, in the NT, some 7500 children aged 3 to 17 years could be missing out on preschool and school. Provision for these students would require an additional 660 teachers and, with accompanying costs, would require an additional \$99 million per annum (Kronemann, 2006). Alongside this, in 2005 there were only 61 Indigenous teachers and executive teachers working for the Department of Employment, Education, and Training and seven Indigenous Principals employed in NT government schools.

There is strong evidence of a positive association between education and the health of individuals and populations (Cornell, 2008). Conversely, the *Ampe Mkelyernemane Meke Mekarle* 'Little Children are Sacred' report pointed out that:

'... lack of education excludes Aboriginal people from confidently and competently participating in either their own culture or mainstream culture, or even the ability to choose when to participate in either culture. A sound education for all Aboriginal children, wherever they live, is now crucial for all of us who live in the Northern Territory.' (Wild, Anderson, 2007)

Ensuring that children attend school, achieve positive learning outcomes, and complete school with knowledge and skills to support them in their ongoing educational, career and life choices, was a central plank of the rationale for the implementation of the NTER. It was widely agreed that this is an area requiring urgent attention.

Criteria for attracting children to school and retaining them have been developed in Australian

Indigenous communities (Campbell, Wright 2005). These include use of Aboriginal languages. Furthermore, much is known about effective strategies to encourage children to attend school and to benefit fully from that experience. However, the implementation of these takes time and trust to develop. Some of these strategies include:

- culturally safe curricula;
- social and learning environments;
- high levels of parental engagement with the school and community;
- community leadership of decisions on priorities and investment (in education and other major areas of public life); and
- community engagement in developing local responses increases the likelihood of positive outcomes (Sarraf 2008; Campbell, Wright, 2005).

Conversely, there is no evidence that compulsory income management results in improved school attendance or in improved educational outcomes (Behrendt, McCausland, 2008).

In order to improve education outcomes funds were allocated for additional classrooms, accelerated literacy programs, school nutrition programs, volunteer teacher initiatives and quality teaching packages. In addition funding was provided for the construction of boarding schools and for the provision of additional teachers. (Department of Families, Housing, Community Services and Indigenous Affairs, 2008).

ASSESSMENT

Positive Impacts

Overall student enrolment appeared to have increased modestly in the first year of the NTER—by about 400 students in the schools within prescribed communities (Sarraf, 2008).

'About 50% in [that] community is the attendance rate and we reckon about another 60 kids that aren't even enrolled. We haven't seen much change to that but the level of scrutiny that is now applied mean that the figures are going to be made publicly available, you couldn't get them before.'

Government Business Manager

Average attendance rates over these communities during 2008 reputedly remain around 65%, albeit with considerable variations across locations (Sarra, 2008). It is not clear whether the nutrition programs have contributed to the increase in enrolments in some schools (Sarra, 2008). Child health checks may also have identified some students with problems at early stages to allow interventions that facilitate school learning (Sarra, 2008). There has been some positive impact upon levels of school engagement, ultimately resulting in improved literacy and numeracy outcomes, as well as student retention in high school.

There has been a substantial increase in investment in school infrastructure including 15 new classrooms and three regional boarding schools. Increased attention is also being paid to the provision of early childhood education. It is not clear to what extent this infrastructure has been delivered and whether teacher numbers have increased.

'Some of these communities don't even have (a school), so it's about how we change those structural issues within education to ensure that we do have the schools, teachers and people.'

Aboriginal Community Leader

Some stakeholders reported greater willingness to make the system work more collaboratively.

'We need to make the public school system work, we need to make the Catholic school system work, and we need the boarding school system to work – so let's stop fighting this stupid argument (about the nature of schools) and say, what's the best outcome we get for these kids?'

Aboriginal Community Leader

Negative impacts

'Compared to the focus on compulsory income management there has been no obvious government commitment to ensuring that children attend school, to providing teachers, to developing appropriate curricula, to ensuring bi-lingual education ... to supporting communities and education sector staff to "do whatever you have to do" to fill classrooms with kids and to give them good teachers.'

'Student mobility across the prescribed communities has been very high, with significant numbers of parents moving from their communities to towns to escape application of the income management program. Interruption in continuity of learning programs for Indigenous students remains a major issue, exacerbated by the intervention. Some schools have registered steep falls in attendance as families move in search of work, medical services and to avoid the tougher alcohol laws.'

'The Intervention has failed to acknowledge that some Aboriginal children do in fact attend school regularly and indeed are very well supported by their caregivers. The efforts and results of such children may be inadvertently affected with the enforced presence of a substantial number of children who have been historically and chronically disengaged from schooling. The temporary spike in enrolments led in some cases to overcrowded classrooms, which in turn led to kids drifting off again.'

Aboriginal academic

Some parents and teachers report that children are becoming angry as a result of other aspects of the Intervention (e.g. being harassed by police, income management), and are becoming more aggressive, rebellious.

'A lot of people in town and increasingly in some of the remote communities are saying that the children are more angry, getting more aggressive, more rebellious. It's something people have noticed in the last year which is quite amazing.'

Non-Aboriginal Doctor

There is concern that good and positive teachers could become disenchanted by the complex challenges that students who have not attended school will bring when they are forcibly coerced to engage in schooling. The growth in the ratio of Indigenous to non-Indigenous students in some town schools has resulted in classroom dynamics becoming more complex for unprepared school staff.

'Teachers have been disenchanted at the process, and they have left because they're committed to try to make a difference'

but because of the way the whole thing's structured, they're not working.'

Non-Aboriginal Senior Bureaucrat

'There is also pressure on local professional staff from Intervention people who "fly in, fly out" and demand local responses that conflict with local priorities.'

Aboriginal academic

It is unlikely that children, especially older children, can be forced to go to school. The Intervention is not addressing the many reasons kids don't go to school.

'It's a combination of so many reasons why the kids don't go to school. It's because they can't, they can't see any benefit in it, and their families can't see any benefit in it. You've got all these often quite inexperienced teachers under a lot of stress out there on their own, they particularly can't cope with the boys and so the boys of course are not going to turn up and they're under resourced so it's not made attractive in any way at all.'

Indigenous health professional

There is an ongoing tension between children being taught their own culture and language while achieving within the mainstream educational system.

'You had this situation where the cultural education was working well. They had elders there. They were there every morning and they had the old people there, it was all in language, and it was all happening. Because of the two-way it was supposed to be 90% of grades 1 and 2 were supposed to be in

Walpiri but the problem was when it came to the actual teaching part of it, because there was not Walpiri teachers or because trained people that had been there in the past had gone. So all they had was the crude sense of the translation which didn't work. So although they had the old people making sure that culture is relevant between generations, and in trying to maintain culture, and the school was heavily involved, there were no educational outcomes.'

Government Business Manager

Concerns were also raised that about the fact that there was no strategy included in the NTER to enhance education infrastructures or capacity.

'I think 97% of remote communities in the Territory don't have preschools.'

Non-Aboriginal Senior Bureaucrat

SUMMARY

Education is a major determinant of health. It is probable that, if the promised investment is made (and sustained) in physical infrastructure, an Aboriginal professional education workforce, improved nutrition for children, and community engagement in schools and teaching/learning, levels of educational participation (and ultimately, health) will improve. However, unintended consequences of other elements of the NTER (e.g. compulsory income management, alcohol restrictions) may reduce the participation of some children in school, and ultimately, have a negative impact on their health status through their childhoods and through their adult lives.

TABLE 8: EDUCATION: SUMMARY OF PREDICTED HEALTH IMPACTS

ASPECT OF HEALTH	POSITIVE HEALTH IMPACTS	NEGATIVE HEALTH IMPACTS
Physical health	<ul style="list-style-type: none"> - Increased health literacy - Improved nutrition 	
Psychological health	<ul style="list-style-type: none"> - Improved perceived wellbeing associated with educational achievement - improved learning opportunities 	<ul style="list-style-type: none"> - Cumulative trauma linked with discrimination, shame and stigma - Reduced school attendance associated with the lack of relevance of school curricula
Social health and wellbeing	<ul style="list-style-type: none"> - Increased number of schools and associated infrastructure - Greater number of children enrolled in school - Increase in number of children attending school - Improved quality of school curriculum and support - Improved quality of teaching and mentoring 	<ul style="list-style-type: none"> - Reduced school attendance - children and families leaving communities and missing school to avoid Intervention measures - Reduced teaching workforce - Ineffective strategies to increase school attendance and improve children's educational achievements
Spirituality		<ul style="list-style-type: none"> - Denial of Aboriginal goals, aspirations, and contributions to society - Cumulative trauma
Cultural integrity	<ul style="list-style-type: none"> - More active engagement of school communities in school policy making and implementation - Greater community engagement in setting and teaching curricula re language, culture, history 	<ul style="list-style-type: none"> - Lack of Aboriginal governance of schools, curricula, teaching and learning

RECOMMENDATIONS

It is recommended that the educational elements of the NTER be strengthened by collaboration between communities, schools and the education sector:

- to ensure that all Aboriginal children of school age have a place in schools that values Aboriginal people and their culture, engages families and local communities in setting school policies and practices, and provides high quality education through a relevant curriculum, including opportunities for bilingual education;
- to articulate pathways for children, young people and parents early in school experience that link education with training and employment opportunities and provide access to mentoring, work experience, apprenticeships, Vocational Training Accreditation Board (VTAB) qualifications and the full range of post-secondary education opportunities;
- to attract and retain qualified Aboriginal teachers, teachers' aides, and principals, by providing incentives to work and stay in the community, and by providing training and support close to home;
- to ensure that the infrastructure and organisational support provided meet national quality benchmarks;
- to ensure that the benchmarks established in the National Education Agreement under the Council of Australian Governments are met.

TARGETS FOR MONITORING

At year one

- 50% of schools will be able to demonstrate community engagement in setting school policies, curricula and teaching, and evaluation

At five years

- All children of pre-school and school age will be enrolled
- Attendance rates match the national average
- Educational infrastructure, including pre-schools, be built or upgraded in prescribed communities to be the equal of the best in communities of similar size
- All schools be able to demonstrate community engagement in setting school policies, curricula and teaching, and evaluation

At ten years

- School completion rates match the national average
- Proportion of children going on to further training increased by 20%
- 60% increase in the number of Aboriginal teachers and principals

ALCOHOL RESTRICTION

TABLE 9: ALCOHOL RESTRICTION: SUMMARY OF THE EVIDENCE FROM COMMUNITIES, STAKEHOLDERS AND EXPERT REVIEWERS

	Positive impacts				Negative impacts			
	Sources of evidence				Sources of evidence			
	Community visits	Key stake-holders	Expert reviews	Other	Community visits	Key stake-holders	Expert reviews	Other
Problem recognised and addressed	✓	✓	✓					
Support for existing dry community initiatives				✓				
Less drinking in communities	✓	✓						
Discrimination and stigma					✓	✓	✓	✓
Alternative drinking patterns developing, including travelling to drink					✓	✓		
Lack of recognition of and investment in local leadership - infrastructure and capacity					✓	✓		
Investment in ineffective strategies						✓	✓	

BACKGROUND

The *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' report found that alcohol is a significant and widespread problem in Aboriginal communities in the Northern Territory:

'Every one of the 45 places visited by the inquiry indicated that alcohol was having an extremely significant detrimental effect on almost every aspect of community life including the safety of children.' (Wild, Anderson, 2007)

Alcohol misuse is having profound direct and indirect impacts on child, family and community physical and mental health and on the culture of communities. Some of the most common serious health effects are low birth weight babies and babies born with foetal alcohol syndrome, injuries caused by exposure to family and community violence, and mental and social trauma among children. Alcohol misuse by adults can also increase the likelihood that they abuse a child, while alcohol use by children increases their vulnerability to being sexually abused. Alcohol has also been used as a bartering tool to gain sex from children. The quest to obtain alcohol and the involvement in long drinking sessions can result in children being unsupervised, neglected and forgotten.

Alcohol misuse also has direct and indirect negative impacts on educational participation and attainment, and on employment prospects.

Multiple factors determine the misuse of alcohol in Aboriginal communities in the NT. Many, if not most, are a consequence of the cumulative trauma of colonisation and its aftermath, leaving people to cope with severe psychosocial distress and high levels of grief and loss. As well, access to treatment and care has been limited. However, the elements included in the NTER were intended, principally, to reduce the supply of alcohol to, and within, communities.

In the prescribed communities the NTER introduced widespread alcohol restrictions that banned people from having, selling, transporting, and/or drinking alcohol. People across the Northern Territory wanting to purchase more than \$100 worth of alcohol at one time were legally required to show photographic identification to the alcohol retailer, who must also record their address and where the alcohol is to be consumed.

ASSESSMENT

Positive Impacts

Even before the NTER many communities in the NT had already voluntarily declared themselves 'dry' and the NTER reinforced and provided resources to support these existing initiatives.

Many people in the communities reported initial positive impacts of the alcohol bans linked with increased policing in the prescribed communities.

'Some people say "it's sort of stopped people drinking in our community" and in the early stages that did happen, there was a significant change where people said they weren't putting up with people drunk and misbehaving badly in their community.'

Aboriginal Doctor

Negative Impacts

The putting up of signs banning alcohol and pornography was resented strongly by local communities who felt this to be a highly discriminatory action. The cost of the signs is wasteful, especially because they have had to be replaced by smaller signs due to community protest.

'Like them big signs they put up there. It is as though they thought all black fellas are alcoholics and paedophiles.'

Aboriginal Community Member

The banning of alcohol in all prescribed communities will also be seen as racist, particularly because alcohol misuse is not limited to Aboriginal communities.

Banning alcohol will not change behaviour universally, and, many people in the prescribed communities will find alternative places in which to buy and drink alcohol.

'... so basically it changed no behaviour other than people being a little more lateral about how they went about it and the thieves [grog runners] went about their business of selling misery as they've always done.'

Government Business Manager

People will travel to drink. This will cause additional harms including a higher incidence of drink-driving; moving to major centres to drink with long-grassers; and drinking 15 miles away on a highway where there is no water and risk of dehydration, risk of injury from passing cars and no immediate access to health services.

'People leave their community and say come to Darwin, you know travel, to drink somewhere else. Last year we had a death from alcohol, a young girl in my community, because they travelled from that community to another community and in this other community they can buy grog they want ... it was actually a little town that they travelled to, and she died from drinking, from dehydration. It shouldn't have happened.'

Aboriginal Health Worker

There is concern that restricting supply will see consumers change to use more potent spirits or other illicit substances. If the measures lead to an increase in the potency of the alcohol that people consume or to changes in the type of addictive substance used it is likely that greater harm will arise.

Nor do the limited measures intended to reduce supply address, completely, the multiple reasons that people misuse alcohol.

'There's no CDEP and there's no real job opportunities ... there's a lot more country-men who are actually drinking because of boredom, because of their lack of self esteem.'

Aboriginal Health Worker

'They take it [CDEP] away without consultation and not give other workforce opportunities is a huge insult and it has had a huge effect within the community.'

Aboriginal Doctor

Externally driven, universal approaches to address alcohol misuse are known to be ineffective (see Appendix 6 for expert review). Continuing to develop policies and strategies for which there is evidence that they do not work and that actively undermine Aboriginal communities are likely to directly cause harm and ultimately be ineffective.

'One size doesn't fit all. There are some communities that for instance are closer to alcohol outlets, there are some communities that have good permit systems based around alcohol, or good systems based around alcohol sales and consumption and social setting that seem to hold a further

grip on the issues and the trauma that might come out of alcohol consumption. We were concerned that governments had to negotiate and consult with Aboriginal people, leaders in communities before they would go in and for want of a better way, enact its Intervention.'

Aboriginal academic

The implementation of the measures of the NT Intervention needs to take community services, infrastructure and capacity into account and work closely with the Aboriginal community:

'There wasn't necessarily a presence out there so you couldn't get traction on other things like alcohol issues because you didn't have the police out there. You didn't have night patrol. Night patrol was coming. You didn't have safe places for the domestic violence that would result very regularly. So in that sense there wasn't the impact. There wasn't an impact of that initiative. Now you could probably apply that to various degrees, to other ones as well because you didn't have those building blocks, you really didn't have the impact as you would've hoped. So whether that would be if you were doing the Intervention again, make sure you consider what you need in place prior to rolling out.'

Government Business Manager

There appears to have been limited use of evidence of effective interventions. Banning alcohol, as part of the Intervention, will be a waste of resources because there is evidence that externally enforced prohibition does not work.

'They've talked about prohibition which you know most people agree it never works.'

Non-Aboriginal Senior Bureaucrat

In collaboration with individual communities, the Intervention ought to include multiple components to reduce supply, minimise harm, and to reduce demand by addressing the reasons that people binge drink or develop chronic alcohol problems. The introduction of alcohol management plans, developed in conjunction with individual communities, would include a full range of alcohol prevention and treatment options, in addition to the need for access

to things like housing, education, and employment. For example, it is difficult to enforce an alcohol ban if there is not an ongoing police presence in the community.

'In the end alcohol has to be managed at a couple of levels. There's the direct level of dealing with the availability of alcohol and how much is drunk, and that slows down domestic violence, and stops people becoming completely substance abusive and so on. But that's the sort of problem you can see. The longer-term solution is much more about the factors that lead to substance abuse. You know, why people do it? Well it's because they're despairing, often there's nothing else ... People are drinking because, like people abuse alcohol anywhere because it takes them away from the reality of life. Well to make the reality of life a positive thing, not a negative thing, and then of course people won't drink.'

Non-Aboriginal stakeholder

The alcohol measures in the NTER do not address the root causes of why people drink and therefore are ineffective in addressing alcohol misuse.

'But really you know why do people drink? Well it's because they don't have strong lives with good cultural underpinnings or employment opportunities that give them meaning for their lives, houses that they're proud to live in and a place that they love.'

Non-Aboriginal stakeholder

If strategies for addressing alcohol misuse are ineffective then children will continue to be exposed to alcohol misuse.

'I'm scared a lot of our kids are diminished because of what's happened during pregnancies [foetal alcohol syndrome] and what's happened in their early lives. If they've seen dads beating up mums and having fights with other family while they were younger, we now know that the trauma comes back to haunt you when you go into your adult life. Because then there's a double jeopardy if you've had a mum and a dad or you were born into this, you can potentially have children that are born into it as well and then that next generation.'

Aboriginal academic

Restricting access to alcohol is effective if other strategies such as community support for the measures, harm reduction, access to health and other social services, enforcement measures, and improved social and economic status are in place. In addition to reducing supply it is also important to reduce harm arising from the misuse of alcohol, including prevention of the incidence of problem drinking using education and youth diversion programs, and changes in social norms. Reduced access to alcohol and access to evidence-based treatment for people who have a chronic drinking problem are important.

It is also necessary to address the underlying factors that contribute to chronic alcohol misuse - such as inadequate housing, lack of education and training, limited employment prospects, poor governance, and restriction of the sale and supply of alcohol - by reducing the economic availability of alcohol through taxation and pricing, reducing the hours and days of sale for licensed premises increasing legal drinking age for purchases or consumption of alcohol.

None of these measures was introduced as part of the NT Intervention.

SUMMARY

The NTER measures address alcohol misuse principally by reducing the supply of alcohol to communities and individuals. Communities agree with the need to act to reduce the harm associated with alcohol misuse and to prevent the onset of alcohol misuse. But the current measures will undermine existing community actions to address the issue. Some members of communities will be exposed to increased harm as they seek alcohol elsewhere and drink at more dangerous sites. The universal alcohol ban will contribute to a sense of powerlessness in communities that had already taken serious action to address alcohol. Across all communities there will be ongoing anger at the stigma being perpetuated (when the problem of alcohol misuse is far from being confined to Aboriginal communities). There will be ongoing concern at the lack of significant reduction in alcohol misuse, or in associated harms. There will be ongoing episodes of alcohol-related child maltreatment, violence and sexual abuse.

TABLE 10: ALCOHOL RESTRICTION: SUMMARY OF PREDICTED HEALTH IMPACTS

ASPECT OF HEALTH	POSITIVE HEALTH IMPACTS	NEGATIVE HEALTH IMPACTS
Physical health	<ul style="list-style-type: none"> - reduced drinking in some communities - reduced individual and interpersonal harm 	<ul style="list-style-type: none"> - continuing episodes of alcohol-related child mistreatment, violence, sexual abuse - injury and morbidity associated with drinking in more dangerous places - continued risks to health associated with drinking – brain, liver, and gastro-intestinal harm - increased exposure to injury and/or violence - lack of access to treatment, rehabilitation, detoxification services
Psychological health	<ul style="list-style-type: none"> - increased sense of safety from violence 	<ul style="list-style-type: none"> - cumulative trauma - stigma and shame - anxiety and depression
Social health and wellbeing	<ul style="list-style-type: none"> - government recognition of the problem and investment in action to address it 	<ul style="list-style-type: none"> - ineffective strategies being implemented - increased exposure to injury and/or violence - loss of trust in government
Spirituality		<ul style="list-style-type: none"> - alienation
Cultural integrity		<ul style="list-style-type: none"> - undermining of community control and leadership – no acknowledgement of and support for the multiple communities that had already displayed leadership and success in taking action to reduce alcohol-related harm

RECOMMENDATIONS

To prevent and reduce harm associated with alcohol misuse it is recommended that:

- comprehensive approaches to addressing alcohol-related concerns in Aboriginal communities be community-driven, based on evidence of effective interventions, comprehensive in scope, and be sustainably and recurrently funded;
- the approaches address not only the supply of alcohol, but also alcohol use, treatment, management and harm reduction.

TARGETS FOR MONITORING

At year one

- Every prescribed community will have established a mechanism through which to develop a comprehensive, local approach to address alcohol-related concerns using effective interventions
- Recurrent funding and infrastructure support will be in place in each prescribed community (or nearest community able to support the infrastructure required, e.g. detox unit and other health services)

At five years

- Every prescribed community, with the necessary support from governments, will have an agreed, local comprehensive community-government plan to tackle alcohol treatment, rehabilitation, harm minimisation and prevention

PROHIBITED MATERIALS RESTRICTION

TABLE 11: PROHIBITED MATERIALS RESTRICTION: SUMMARY OF THE EVIDENCE FROM COMMUNITIES, STAKEHOLDERS AND EXPERT REVIEWERS

	Positive impacts				Negative impacts			
	Sources of evidence				Sources of evidence			
	Community visits	Key stakeholders	Expert reviews	Other	Community visits	Key stakeholders	Expert reviews	Other
Psychological health – mobilisation of men	✓							
Discrimination, stigma, shame, anger					✓	✓		
Psychological distress						✓		
Portrayal of men as paedophiles					✓	✓		
Loss of trust in government – implementation of ineffective strategies					✓	✓		

BACKGROUND

The *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' report described the link between sex offending and the use of prohibited material. Exposure to pornography may play an important function in facilitating offenders' actions by lowering inhibitions against child sexual abuse, thereby increasing the likelihood of an assault. Exposing children to sexually explicit materials or behaviours is a form of sexual assault in itself, and it can also be used as a means of desensitising

children and normalising sexual activity between adults and children.

The NTER measures are based on assumptions that exposure to pornographic material in the prescribed communities is occurring as a result of poor supervision of the use of the internet, overcrowding in houses and community norms that accept widespread access to the material.

The NTER measures include:

- banning adult material in prescribed areas of the NT, and making it an offence to supply adult materials to people in prescribed areas of the NT;
- requiring filters to be installed on publicly funded computers;
- giving police the power to seize or destroy prohibited materials;
- posting signs at access routes into prescribed areas stating that alcohol and pornography are banned.

ASSESSMENT

Positive Impacts

Aboriginal men mobilised against stigma associated with the legislation:

In retaliation against the prohibited material measures in the NT Intervention, a group of 4000 Aboriginal men mobilised and put out a statement against being portrayed as child abusers.

Negative Impacts

Experiences associated with signage and other aspects of the NTER have resulted in feelings of stigma, shame and anger.

Portrayal of Aboriginal men as paedophiles and sexual abusers to the rest of Australia is likely to contribute to psychological distress, to an increase in health risk behaviours, and to add to feelings of political and social exclusion

‘There’s a collective despair amongst Aboriginal men since they’ve been labelled paedophiles and its proven to have very negative impacts on how Aboriginal men respond to the Government and to the media and ... because they feel ashamed of what they have been called. But they don’t know how to stand up for themselves to get the apology that these men deserved It was being publicised that 50 to 70% of all Aboriginal children had been sexually abused and it also indicated that most Aboriginal men were paedophiles and sexual abusers

and I think that gave an untrue and unfair picture to the rest of Australia which had never been remedied.’

Aboriginal Health Service Manager

‘It was like only our men, Aboriginal men, were interfering with children and I felt really sad about that. I have brothers, I have a son you know, he is a father and I just felt really sorry for our men.’

Aboriginal Health Worker

In particular, the putting up of signs at the entry points to communities were seen as reinforcing incorrect and harmful stereotypes of Aboriginal men as paedophiles.

‘To have those signs plastered throughout the remote community and even around the town communities that I’m currently working in is extremely offensive and it’s humiliating and it’s extremely undignified. I’m sure most Aboriginal people wouldn’t even know what pornography is and it’s all written in English. There’s no Creole or language. There’s no recognition that Aboriginal people have been denied of education for how many years and so everything is in English.’

Aboriginal Doctor

‘When you drive into an Aboriginal community, there is a sign on every Aboriginal community at every access point: no grog, no pornography They cost three million to put the signage up and because it was so offensive to Aboriginal people they said “well we’ll make the sign smaller” so they did but they haven’t taken down the big signs yet and so the three million they allocated for signs is now fifteen million because they got a different contractor to do the second lot of signs but they haven’t got a contractor yet to come and remove the old ones and because they’re smaller they couldn’t use the same posts, so we’re spending fifteen million to say no alcohol and no pornography.’

Aboriginal Health Service Manager

Investment in ineffective strategies

The prohibited material measures in the NT Intervention are not based on evidence or information about the actions that are likely to prevent child sexual abuse in communities. The strategies that have been implemented will add to the psychological distress being caused by other measures in the NTER, and increase the incidence of behavioural risks to health and the sense of political and social exclusion.

'I heard him [Mal Brough] say on television that they just decided to do it and they did it without recourse to anybody, without looking at any kind of information and the problem with that is that there is the view that nothing has happened and it's all you know Aboriginal people are hopeless and all Aboriginal men are paedophiles.'

Aboriginal Leader

There is no evidence that the putting up of public signs will deter people from supplying or viewing pornography.

There is no evidence that filters on computers will prevent people from viewing pornography, but there is evidence that it can stop access to other important internet sites.

SUMMARY

The measures implemented to prohibit access to sexually explicit, exploitive materials are likely to have multiple negative impacts on the health of the male residents of prescribed communities, in particular. The public shaming of Aboriginal men (the signs at the entrances to communities), the universal ban on access to web-based materials, and the lack of research-derived evidence to support these initiatives will add to the psychological distress experienced by communities as a result of these and other mandatory measures implemented by the NTER.

TABLE 12: PROHIBITED MATERIALS RESTRICTION: SUMMARY OF PREDICTED HEALTH IMPACTS

ASPECT OF HEALTH	POSITIVE HEALTH IMPACTS	NEGATIVE HEALTH IMPACTS
Physical health		
Psychological health		<ul style="list-style-type: none"> - anxiety, depression - stigma and shame - psychological distress among men, in particular
Social health and wellbeing	<ul style="list-style-type: none"> - government recognition of the problem and investment in action to address it 	<ul style="list-style-type: none"> - ineffective strategies being implemented - loss of trust in government
Spirituality		<ul style="list-style-type: none"> - alienation and collective existential despair
Cultural integrity		<ul style="list-style-type: none"> - undermining existing initiatives and leadership

RECOMMENDATIONS

It is recommended that:

- Signage at entrances to communities be changed
- Communities develop strategic plans for the prevention and management of cases of child sexual abuse
- There be ongoing investment in creation of opportunities in communities for children to flourish
- Under community leadership, evidence-based interventions be implemented.

TARGETS FOR MONITORING

At year one

- All signs at the entrances to communities have been replaced with positive child health information derived from communities

At five years

- Under community leadership, each community will have prepared a strategic plan based on evidence-based strategies to create positive opportunities for children to flourish
- Evidence-based community education on health and social problems related to pornography will have been conducted across the NT
- Each community will have implemented at least one of the strategies identified in the plan

At ten years

- All prescribed communities will report on the opportunities available to children to ensure their health and well being
- All prescribed communities will have evidence-based measures in place to prevent violence against children and to reduce violence across the whole community

CHILD HEALTH CHECKS

TABLE 13: CHILD HEALTH CHECKS: SUMMARY OF THE EVIDENCE FROM COMMUNITIES, STAKEHOLDERS AND EXPERT REVIEWERS

	Positive impacts				Negative impacts			
	Sources of evidence				Sources of evidence			
	Community visits	Key stakeholders	Expert reviews	Other	Community visits	Key stakeholders	Expert reviews	Other
Substantial investment in addressing child health problems	✓	✓						
Improved access to medical, dental and specialist health care services		✓	✓					
Improved service delivery system – improved cooperation and understanding of the problems among service providers		✓	✓	✓				
Fear and re-traumatisation for adults and children					✓		✓	
No improvement in child health and safety					✓			
Duplication and lack of connection to existing services						✓	✓	
Multiple visits for different assessments						✓	✓	
Stigmatisation of Aboriginal men						✓		
Loss of focus on sexual abuse						✓		
Need for a focus on protective factors and not just risk factors							✓	
Disempowering local services						✓		

BACKGROUND

The *Ampe Akelyernemane Meke Mekarle* 'Little Children are Sacred' report gave voice to the extent of Aboriginal community concern about the scale and seriousness of the child sexual abuse and family violence in their communities. The report included evidence that there were higher levels of child sexual abuse among Aboriginal children living the Northern Territory than was the norm across Australia. Much abuse had been unreported, undiagnosed and untreated. In some communities and among some bureaucracies high levels of child sexual abuse had become accepted as the norm. The report also pointed out that there had been considerable evidence of the scale and extent of the problem available to governments for two decades, and that there had been only slow and limited responses.

The NTER measures were, initially:

... to implement Compulsory child health checks to identify and treat health problems and any effects of abuse. (Brough, 21 June, 2007)

However, the proposal that such health checks be compulsory aroused widespread community and professional outrage at the potentially 'abusive' process of examination, at the implication that all or most Aboriginal men were child abusers, and at the assumption that parents and carers were not sufficiently motivated on their own to ensure that their children received a health check. Other evidence showed that it would not be possible to detect cases of child sexual abuse through a medical consultation and physical examination alone.

The proposal was amended to become *voluntary* child health checks that were to be offered to *all* Aboriginal children aged 0 to 16 years in prescribed communities for the purposes of identifying significant health problems and offering follow-up treatment.

ASSESSMENT

Positive Impacts

Increased investment of resources in the management of child health, in primary health

care services, and in the prevention of child health illness and injury.

Increased access to child health screening, primary health care and specialist health services.

'I think the key positive aspect is a whole lot of additional funding for remote primary health care in the Northern Territory with a key proviso that, at this stage the commitment of \$99.7 million is only spread over two years, our current financial year and the next financial year and that a positive evaluation around its use needs to happen prior to, say 50 million a year or whatever, becoming recurrent.'

Non-Aboriginal Health Service Manager

Stronger relationships among major health service provider organisations - improved services and improved access for communities.

'I think it's certainly strengthened the NT Government's relationship with AMSANT and ... we've put our heads together on issues that we haven't managed to come together on before because of the sense of urgency and the understanding that we both share, that the main game is capturing this investment, turning it into something really, really valuable for the whole of the Northern Territory.'

Non-Aboriginal health professional

'I think the relationship under the circumstances between the Commonwealth, the Northern Territory government and certainly the Health Department and AMSANT strengthened and became even healthier, I think, in terms of health policy, health planning and health delivery. It was testing but the relationships withstood the tests of various agendas and views of the world and how things should work.'

Aboriginal Senior Bureaucrat

Negative Impacts

Discrimination creating stigma, shame, and psychological distress among Aboriginal men

'But you know the men who have worked hard in the Northern Territory to you know get to a level of, I suppose status within society then all of a sudden had everything withdrawn from the work that Aboriginal leaders had done, by being told that you know you rape your children, you're not allowed to drink in your house, you're not allowed to because you beat your wife and we're going to stop you from doing that, and a lot of men were ... ashamed because of those comments.'

Aboriginal Health Service Manager

Loss of trust in government

Lack of recognition of existing services

'It disheartened a lot of people who'd been doing a lot of hard work in the Northern Territory for a long time. I think that was negative. People feeling, you know who've worked for 10, 15 years, working very hard suddenly felt that you know their contribution wasn't valued. I think that was, that was a negative impact.'

Aboriginal senior bureaucrat

Duplication of services

'I think people actually genuinely want the best thing for their kids and so of course they've turned up to have them checked and the majority of them are feeling now "how many times do we have to bring our kids in to be checked" because they've been checked for the phase 1, then dental, ENT, dragged in again for something else, phase 2 then we come along so they're dragged in again and the feeling that I'm getting is why are you keeping on checking on all these kids and what are you checking them for 'cause we keep bringing them and the health workers are sick of getting them, and the people are sick of coming and some of those kids have had seven checks over the last year of various bits.'

Non-Aboriginal remote doctor

Lack of certainty about recurrent investment

'Children's health can't be done, or focused on, in a finite period. It is a continual source of requirement, I suppose and you can't say, "well in phase 1 we're going to do this, and in phase 2 we're going to do that" and what happens at the end of phase 1 and the end of phase 2 and phase 3 is all about infrastructure so there should be no phases. There should be regular, ongoing investigation with children as part of primary health care.'

Aboriginal Health Service Manager

Lack of action to protect children at risk of neglect, maltreatment, or sexual abuse in the short term and to support their carers

'I still question the fact that you know we've got these health checks happening, children are being seen maybe once, maybe twice and then they've been sent straight back into the environments that gave rise to their illnesses and conditions in the first place.'

Aboriginal Corporation

SUMMARY

Increasing access to child health checks that are followed up routinely and quickly is likely to have a positive impact on children's health. Increased investment in child health checks, and in primary health care (infrastructure and capacity), and in access to specialist services is also likely to have positive health impacts.

There will be negative health impacts arising from the discrimination implicit in the NTER, and the public shaming of Aboriginal men (as paedophiles) that underpinned the Intervention. There will also be negative health impacts arising from the loss of commitment from the leaders and organisations whose work and advice were ignored in the implementation of the NTER.

There were no measures in the NTER (beyond child health checks) focusing on increasing/improving/ revising the role of the health sector in preventing child abuse/child sexual abuse and nor in managing the cases of the children who have already been abused or who are at high risk.

TABLE 14: CHILD HEALTH CHECKS: SUMMARY OF PREDICTED HEALTH IMPACTS

ASPECT OF HEALTH	POSITIVE HEALTH IMPACTS	NEGATIVE HEALTH IMPACTS
Physical health	- increased access to child health checks	- duplication of services and lack of integration and continuity - lack of secondary and tertiary services available for referral and follow up
Psychological health	- increased access to health services	- anxiety and depression - stress associated with visiting health services on multiple occasions
Social health and wellbeing	- governmental recognition of the problem and investment in action to address it - improved provision of health services - improved access to health services	- significant concerns re possible removal of children - loss of trust in government
Spirituality		
Cultural Integrity		- lack of acknowledgement of and support for existing community and health service action

RECOMMENDATIONS

It is recommended that:

- Governments work with the Aboriginal Medical Services Alliance of Northern Territory to support and expand initiatives to strengthen the integration of primary/secondary/tertiary care services;
- Integrated services be developed to include case management explicitly to manage the complex problems of children and families who are at risk of violence or abuse, and require continuity of care;
- Governments ensure recurrent, long-term investment in action to address the underlying poverty and despair in communities;
- Governments continue to invest to achieve the outcomes agreed in the Indigenous Early Childhood National Partnership Agreement under the Council of Australian Governments.

TARGETS FOR MONITORING

At year one

- 75% of children and families in prescribed communities who are at risk of violence or abuse have case management services in place

At five years

- 85% of proposed government investment in PHC services, infrastructure and workforce is delivered
- 85% of referrals to specialist services are seen within three to five months

At ten years

- 90% of children and families in prescribed communities who are at risk of violence or abuse have case management services in place

FINAL SUMMARY

The Australian Government's proposed intention in implementing the NTER placed heavy emphasis on improving physical health and improving the social and environmental determinants of health as a means to achieve improved child health outcomes (in particular) in Aboriginal communities in the Northern Territory. It is likely that new investments in education, housing, and health care, for example, will make a contribution to improved physical health for some people.

However, the ways in which the NTER was introduced and is being implemented are likely to contribute to the continuation of the high burden of trauma and disease already carried by Aboriginal people across generations – a cumulative burden to which the NTER is likely to add. The HIA predicts that improvements in physical health may be outweighed by negative impacts on the psychological health, spirituality, and cultural integrity of a high proportion of the Aboriginal population in prescribed communities (and, arguably, in the NT). The loss of trust in government will limit the ability of governments

and communities to work together effectively in the future. The NTER does not recognise the need for all Australians to be able to value and work across Aboriginal and non-Aboriginal cultures, and has overlooked the centrality of human dignity to health (Durie, 2008). The HIA predicts that the intended health outcomes of the NTER (improved health and wellbeing, and ultimately, life expectancy) are unlikely to be fully achieved. It is predicted that it will leave a negative legacy on the psychological and social wellbeing, on the spirituality and cultural integrity of the prescribed communities.

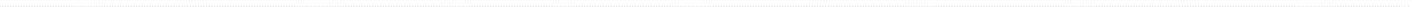
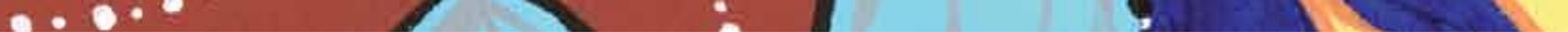
However, it may be possible to minimise or mitigate these negative impacts if the Australian and Northern Territory governments commit to and invest in taking the steps necessary to work in respectful partnership with the Aboriginal leaders and organisations responsible for the governance of the prescribed communities in the NT. The principal recommendations arising from the HIA are based on the evidence (from communities, stakeholders and experts) that it is essential to find ways to work together as equals.

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APPENDICES

APPENDIX 1: EDUCATION EXPERT REVIEW

Prepared by Dr Chris Sarra

Executive Director, Indigenous Education Leadership Institute, Queensland University of Technology

In your opinion, do you believe there are any elements of the NT Intervention that will improve educational outcomes for Aboriginal children?

The Northern Territory is a small education jurisdiction with 150 schools and 50 homeland centres. It has a relatively young and growing population which is highly dispersed, with a quarter living in remote communities spread over a vast area. Over 40% of school-age children are Indigenous – three-quarters living in very remote locations. Service delivery is ultra expensive for the relatively small numbers of students.

An additional 15 new classrooms are being provided under the Intervention for remote communities, at a cost of about \$340 000 each and with completion expected for the final school term of this year. Since the Intervention was focused in such centres, there have undoubtedly been some further direct and collateral benefits. It remains to be seen whether these effects are significant and sustained, or short-term and transitory.

During the early stages of the intervention, there was some evidence that overall student enrolment appeared to have increased -- by about 400 students in the schools within prescribed communities. Average attendance rates over these communities during 2008 reputedly remain around 65%, albeit with considerable variations across locations.

It is well-known that many Aboriginal students experience episodes of chronic ill-health and their growth and development are impacted by levels of nutrition and overcrowded housing, with significant impact upon students' readiness to learn. Under the intervention, school nutrition programs have been established in 49 communities and seven town camps to provide children with breakfast and lunch at school. It is not clear whether the nutrition programs have contributed to the increase in enrolments in some schools. Health checks may also have identified some students with problems

at early stages to allow interventions that facilitate school learning.

Are there elements of the NT Intervention that may inadvertently detract from educational outcomes for Aboriginal children? How and why?

The NT intervention completely fails to acknowledge that some Aboriginal children do in fact attend school regularly and indeed are very well supported by their caregivers. There is scope for the efforts and results of such children to be inadvertently affected with the enforced presence of a substantial number of children who have been historically and chronically disengaged from schooling. The temporary spike in enrolments led in some cases to overcrowded classrooms, which in turn led to kids drifting off again.

Student mobility across the prescribed communities has been very high, with significant numbers of parents moving from their communities to towns to escape application of the income management program.

The inadequate follow through with the income management program appears to have created further mistrust of the genuineness of a variety of actions conducted in the intervention. This has the potential to be further exacerbated by the scope for good and positive teachers who potentially could become disenchanted by the complex challenges that such students bring when they are forcibly coerced to engage in schooling. Continuity in learning programs for Indigenous students remains a major issue, and this appears to have been exacerbated by the intervention. Ultimately this has the potential to see already challenged levels of quality teachers leaving from an education system that needs more quality teachers, not less. The growth in the ratio of Indigenous to non-Indigenous students in some town schools has resulted in classroom dynamics becoming more complex for unprepared school staff.

Is there any available evidence to suggest that any of the measures covered under the NT Intervention will improve educational outcomes and Aboriginal people's quality of life?

The recently released National Assessment Program results confirm what has been known for many years: Northern Territory school students are well

behind the rest of the nation's children in the basics of reading, writing and numeracy. For example, over a third of NT children in Years 3, 5 and 7 fail to meet the national benchmark in reading and 33% of Year 5 students did not reach the national benchmark in writing. Numeracy results were also poor, with 21% of Years 3 students and 29% of year 5 students not reaching the national benchmark. At the high-achieving end of the spectrum, NT had only 4% of students falling within the highest band, compared with 6% in Queensland, 7% in Western Australia and 12% in New South Wales.

The education history of NT is littered with pilots, projects, programs and other experiments that have withered on the vine for variety of reasons. So doing what's already been tried and failed in schools is unlikely to alter the above pattern of student performance in the basics. Long-term commitment to transformative schooling models by both communities and governments is needed. Sustained application of evidence-based national and international approaches by educators is also required to turn around this pattern of significant under-performance. The well-researched and Australian Government-funded Accelerating Literacy Program is starting to gain some traction in NT schools. It is also linked to a Quality Teaching Package, which aims to provide additional professional development to teachers in prescribed communities. But it is far too early for any evidence-based success to have been documented from the intervention.

Perhaps the most obvious and positive collateral effect of the intervention in education to date has been the strengthening of investment in NT schooling infrastructure - especially the additional 15 new classrooms and 3 regional boarding facilities. These facilities may improve the chances of at least some Indigenous young people gaining a primary education, give others a chance of lasting through to Year 12 and thereby improve their chances for employment and hence a higher quality of life. However, this is a 'long bow' argument and the level of infrastructure investment is only a limited start - \$500 million is a conservative estimate of what is needed for parity of schooling infrastructure with the rest of Australia, not including additional teacher housing.

Is there evidence to suggest that the NT Intervention measures will not improve or may diminish Aboriginal people's quality of life?

Anecdotal evidence asserts unquestionable evidence that the NT Intervention measures have diminished the quality of life for many Aboriginal people. Negative feedback from Aboriginal people has been related to several issues, but especially to:

- questioning of government motives involved in the suspension of the Racial Discrimination Act and the access permit system;
- Aboriginal people feeling stereotyped as all being despicable or hopeless and of all Aboriginal men as being corrupt or predatory; and
- having things done 'to' them as opposed to 'with' them - with many new, know-all whitefellas from interstate bossing them around.

In your opinion, what are the likely and/or unintended consequences of the NT Intervention in the short, medium and long term?

Given just the level of Intervention and investment in this strategy one would hope that there would at least be some positive impact upon levels of school engagement, ultimately resulting in improved literacy and numeracy outcomes, as well as student retention into high school. Reflection on the way the NT intervention emerged, in a way that was not particularly strategic and/or well thought out, and furthermore with questionable motives, I am not so optimistic about what this Intervention might deliver short, mid or long term within the context of the delivery of quality schooling in the Northern Territory. Unquestionably there will be some value in terms of resources to back locally developed solutions to quality school delivery, such as that devised by Minister Marion Scrymgour. As signalled earlier there is good reason to monitor the level of teacher morale, particular of those in more remote locations, to ensure they do not become disheartened and leave the NT Education system as a result of the complex teacher/student relationship challenges created as a result of enforced student engagement in schooling of those who have been historically and chronically disengaged.

If the intervention could be changed, what should be changed to deliver better outcomes for Aboriginal people, their families and communities?

Overall, I suggest five key ways of investing in Aboriginal people, their families and communities in any intervention. These are ways that:

- acknowledge and build upon existing capacity, agency and commitment in Aboriginal communities;
- are tied to locally established priorities that have integrity, rather than by imposing external priorities that force conformity;
- provide scope for Aboriginal Australians to process and project alternative ways to a stronger and smarter future, rather than wallow in a sense of victim status and powerless entitlement;
- engender hope and a sense of self-efficacy in moving forward, building on the ideas and skills of many community leaders; and
- acknowledge and embrace Australia's Indigenous identity with respectful and rightful admiration for its resilience and strength.

Regarding education more specifically, in April 2008 Minister Marion Scrymgour set new directions via a package called Transforming Indigenous Education. This involves establishing two Community Partnership Education Boards - one in the Warlpiri Triangle and the other in Yolngu-Matha speaking communities in the Miwatj region. These Boards will provide strong and authentic community ownership and management of education and training services in these regions, and will build on work already underway through the Remote Learning Partnership Agreements. This partnership model is based on outcomes from community-based Health Boards. I have undertaken to be formally involved in mentoring and developmental processes for members of Community Partnership Education Boards. I envisage that there will be considerable customisation required to best serve regional needs, and that some larger centres may act as 'service hubs' for smaller settlements.

Attracting and retaining quality principals, teachers, teacher aides and assistants will remain challenges, as will providing training in flexible ways (including online) that allow Indigenous trainees to learn within their own community. Most Indigenous students do not speak English as a first language and for many the opportunity to speak English only occurs at school. Additional programs and resources are urgently required for these students - including EFL/ESL specialist support and bilingual programs, accelerated literacy, transition programs and Indigenous culture and language programs. If the Australian Government seriously wants to intervene to support remote Indigenous children in the NT then most should qualify for the national literacy support program that currently applies to refugee kids - with a 10:1 staffing ratio, including a training teacher and an Indigenous teacher in training for every remote area classroom, especially in the early

primary years.

If the intervention could be changed, what should be changed to reduce the negative impacts on Aboriginal people, their families and communities?

I agree with the seven foundational platforms for Indigenous outcomes and as the basis for community support for schooling renewal, as identified by Dr Ken Henry, Secretary of the Treasury at the Australian Institute of Health and Welfare conference in Canberra in December 2007, viz:

1. Security: basic protection from violence is fundamental for Indigenous parents and children.
2. Early childhood focus: early interventions, coupled with parental support, develop appropriate at-home learning environments and provide a critical foundational base for young children.
3. Home environments: these need to be conducive to regular patterns of sleep and study, free from overcrowding and distraction.
4. Access to primary health infrastructure: healthier children are more likely to attend school, and are better able to learn once they are there. As well, better educated mothers are less likely to engage in behaviours that cause low birth weight, putting their babies at greater lifetime risk of a range of diseases, including Type II Diabetes.
5. Targeted welfare incentives: particularly in an environment where real jobs are not currently the norm, incentives in the welfare system cannot be allowed to work against the promotion of investment in human capital, particularly of children through the provision of safe and healthy living environments and their attendance at school. Nor can those incentives be allowed to work against the active participation of parents and other role models in communities.
6. Realistic prospects of paid employment: there must be a realistic prospect of an educated Indigenous person securing a real job, with the support of appropriate employment services. Where remote locations simply cannot produce sufficient job opportunities for local people, a better strategy is to ensure that people have the opportunity to move to take up work if that is what they want to do.
7. Indigenous engagement in policy development: governance systems have to support the 'political freedom' and 'social opportunities' of local Indigenous people (both men and women) to be engaged in policy development.



APPENDIX 2: CHILD HEALTH CHECKS EXPERT REVIEW

Prepared by Dr Heather D'Antoine

Senior Research Officer, Telethon Institute for Child Health Research, Perth, WA

Background

Improving Child and Family Health was one of the key measures for the Northern Territory Emergency Response (NTER). There are three components to this measure:

- child health checks and follow-up treatment for children;
- specialist support for children who have been abused;
- extra drug and rehabilitation and treatment services.

This paper focuses on the Child Health Checks (CHCs) aspect of the Improving Child and Family Health measure.

At 13 June 2008, approximately 11 000 child health checks (children up to 16 years) had been undertaken in 70 communities: 47 by CHC teams and 23 by Aboriginal Medical Services / Northern Territory Department of Health and Community Services, representing 64% of the 17 182 children who are eligible for the checks. For the most part, these health checks were carried out as part of the NTER; however, some Medicare checks are included.

In summary, this has probably been the largest 'burden of disease' study of Aboriginal children in Australia. The Taskforce emphasised that the child health checks should not be seen as a one off but that they should be accessible by all children on an annual basis and that this requires adequate resourcing by the primary health care system (Northern Territory Emergency Response Taskforce, 2008). The question that ought to be asked is 'is this strategy value for money?'

Are child health checks value for money?

Three requirements need to be fulfilled in achieving value for money in health services. Services need

to be inexpensive (economy), we want each service to produce perceptible health gains (effective), and if we can achieve the same outcome with different procedures or programs, we would rather the least expensive procedure to be used (efficient) (Clewer, Perkins, 1998). This part of the paper will focus predominately effectiveness and efficiency.

The Economy

In regards to the economy, health services need to be an inexpensive part of the overall economy. The Department of Health and Ageing had appropriated \$83 395 000 to NTER – Improving child and family health for 2007 – 08 (Health and Ageing Portfolio, 2007).

Brown, Brown (2007) expressed strong concerns about the strategies adopted by the NTER. They stated that 'it remains unclear how any of the intervention measures will create sustainable, safe and nurturing communities, or whether or not they will protect Aboriginal children at all, particularly in the face of decades of under-investment in the basic building blocks of healthy societies' (Brown, Brown, 2007). These concerns ought to be considered in reviewing whether or not the CHCs is an appropriate approach for advancing the health of Aboriginal children in the Northern Territory (NT).

Effectiveness of Child Health Screening

At first glance the benefits appear to be self evident. It is not until one begins to systematically review the evidence for screening and surveillance, topic by topic, that the complexity of this endeavour becomes apparent. (Royal Children's Hospital, Melbourne, 2002).

For a screening program to produce health gain, that is to be effective, the conditions that are screened should meet the criteria for screening. The criteria for screening programs and the characteristics of an ideal screening test are:

- Important
- Natural history understood
- Acceptable treatment
- Latent or early symptomatic phase
- Suitable test or examination

- Facilities to diagnose and treat
- Agreed policy on whom to treat
- Treatment early is better than treatment started later
- Cost effective
- Continuous
- Simple, quick and easy to interpret
- Acceptable
- Accurate
- Negative
- Sensitive
- Specific (Paterson, Nossar, 1998).

Australian Context

Annual screening of children in Australia has undergone recent reviews in both the Aboriginal (Royal Children's Hospital, Melbourne, 2002) and non-Aboriginal population (Paterson, Nossar, 1998). The evidence for screening children in Australia was reviewed for twenty conditions/topics. Many of these conditions would be a 'one-off' screen in a relatively health population. The reviewers found that there was fair or good evidence for screening four conditions. The conditions included congenital hypothyroidism, cystic fibrosis, universal neonatal hearing screening and phenylketonuria.

The reviewers found that there are major issues of program quality, monitoring of compliance with referrals for assessment, and whether facilities exist in many communities for assessment. They expressed concerns that much attention is paid to the test or procedure listed and little to the main elements of a community-wide program.

Aboriginal Context

There are at least three studies that question the effectiveness of screening in the Aboriginal population in the NT (Paterson, Nossar, 1998; Morris et al, 2005; Bailie et al, 2008). The effectiveness of annual screening of Aboriginal school children (of all age) was evaluated in 11 of 18 communities in a rural district in the Top End of the NT Paterson, Nossar, 1998). The screening consisted of assessment of weight and height; and for leprosy,

skin infections, anaemia, strabismus, trachoma, vision and hearing defects, abnormalities in the urine, undescended testes, and heart disease. The screening found rates for anaemia, malnutrition and trachoma reaching 39%, 22% and 26%, nearly one third failed the hearing screening, urinalysis was abnormal in 19%, 3% failed visual acuity and 6% were considered to have abnormal heart auscultation (Paterson, Nossar, 1998).

Although the screening revealed high levels of morbidity, they found that many of the health problems were either not amenable to screening or they are more suited to detection during frequent review, i.e. surveillance. In addition, important health areas such as injury prevention, tobacco smoking, nutrition, hygiene, sex education, sport and exercise and substance misuse are not included in the screening program but need to be addressed in order to improve child health and prevent adult chronic disease (Paterson, Nossar, 1998).

They concluded that the benefit of a single annual screening examination for the health of Aboriginal children must be seriously under question given the difficulty in ensuring adequate follow-up and treatment, and the progressive, recurrent or fluctuant nature of many of these problems (Paterson, Nossar, 1998).

An audit of health services in the NT (4), Far West New South Wales and Western Australia (7) found that existing systems are not providing for adequate follow-up of identified medical and asocial problems for children living in remote Aboriginal communities (Bailie et al, 2008). They concluded that without effective systems for follow-up, screening children for disease and adverse social circumstances will result in little or no benefit.

Morris et al. (2005) screened 709 Aboriginal children aged six to 30 months living in 29 communities from four health regions in the NT in 2001. They found that 91% of the children were affected by otitis media (OM). In concluding, they highlighted the importance of Primary Health Care. They also, stated that the rates of OM would remain high unless extreme poverty, the paucity of educational opportunities, and high unemployment in remote communities were addressed. This would require substantial investment into a range of services that include health, education, housing, transportation, and recreation (Morris et al, 2005).

In summary, although the conditions that are often screened for in the Aboriginal population are important, many of them do not fit the criteria for screening. Two of the main reasons for this are that facilities to provide follow-up are limited, and that other issues need to be addressed to improve the health of children including extreme poverty.

The Northern Territory Emergency Response Child Health Checks

Although the term child health checks in the NTER have been used, the elements are the same as a screening program.

The information provided in this report relates to 7733 children for whom the Australian Institute of Health and Welfare (AIHW) had entered information from the CHC form into the Child Health Check Initiative (CHCI) database.

Findings and Referrals

Although the overall findings highlighted the already known poor health of Aboriginal children, there were three key findings that were startling; although probably not unexpected:

- 77% of Aboriginal children live in a house with a smoker;
- 71% of Aboriginal children under 1 year of age is at risk of SIDS (sudden infant death syndrome); and
- 44% of Aboriginal children had untreated caries.

Sixty seven percent (5170) of Aboriginal screened has resulted in at least one referral. They include:

- Primary Health Care clinic follow-up just under 38% (2916) were referred;
- dental referrals were made for 32% (2481);
- other referrals 12% paediatric (912), 12% tympanometry and audiology (891), 8% referral to an ear nose and throat (ENT) specialist (633), 3% were to a cardiologist or for cardiac investigations (216), eye specialists (89), dietician or nutritionist 0.5% (37);
- vaccination - overall, 6% of children received a vaccination during their health check and were due rather than overdue.

Health checks had turned up 42 cases of suspected child abuse and neglect in 73 communities – 14 had qualified as abuse notification (Northern Territory Emergency Response Taskforce, 2008). Scrymgour said that this was no different to any other year (Scrymgour, 2007).

Follow-Up

ENT specialist treatment has been provided to children in Central Australia. Audiological assessments of 669 children have been completed, 46 have received ENT survey with 227 children receiving non-surgical ENT follow-up treatment (Northern Territory Emergency Response Taskforce, 2008).

Non-surgical dental services have been provided to 350 children. A block of dental survey commenced at Katherine Hospital from 10 June with up to 40 children expected to receive surgery.

What was notably missing in the AIHW report was information on antenatal screening. This screening may have been carried out but not included in the report.

The child health checks raise the question of NT health services being able to respond to these referrals in a timely fashion. This concern was raised in the audit of NT health services. This has been recognised by the Taskforce. In their final report they identified and described several elements of the existing health services in the NT that need to change to accommodate these child health checks. Several of their comments focused on the role of the primary health care workforce and visiting specialists. They stated '... that the greatest risk to the improved health outcomes for this phase of the intervention is a lack of an adequate work force' (Northern Territory Emergency Response Taskforce, 2008).

Efficiency of Child Health Screening

Once a condition or conditions meet the criteria for screening, then providing we can achieve the same outcome with different procedures or programs, we ought to adopt the least expensive procedure or program.

Aboriginal Context

Although the evaluation of school health screening in the NT questioned the benefits of annual screening, they also acknowledged that there is a limited role for some screening and annual surveillance for conditions for which there are reliable tests as well as acceptable and effective interventions (but the conditions were not specified). As a consequence of this local evaluation a new school-age child health surveillance program is being developed for the NT, promoting greater participation by communities, families and schools, as well as a revised screening schedule with guidelines for referral, treatment and feed-back of information to communities (Paterson, Nossar, 1998).

The Northern Territory Emergency Response Context

It was noted that 67% of the CHCs had been undertaken by CHC teams comprising health professionals from interstate and 33% had been undertaken by existing health services. Currently the capacity within the existing health services in the NT is limited. The final report from the Taskforce recognised 'that enhancement of primary health care, with both work force and infrastructure, represents the most urgent part of the current implementation of the health initiative' (Northern Territory Emergency Response Taskforce, 2008).

Poor growth, particularly stunting in early childhood is closely associated with poor child development. When 5% of children were considered to be stunted, 10% underweight, 12% showed signs of wasting and 5% were overweight but only 0.5% (37) children were referred to a dietician or nutritionist is an interesting observation (Grantham-McGregor, et al. 2007).

Sixty four percent of the 17 182 children who are eligible for the CHCs in the NT have been screened. The Taskforce have recommended that these CHCs be continued on an annual basis. The Taskforce have also identified a number of changes that need to occur within the existing health services to accommodate the CHCs. In reviewing the literature on child health screening, the continuation of the CHCs in its current form is questionable and probably not good value for money.

What would be value for money?

The burden of suffering for Aboriginal children is well documented and reducing this suffering is a national priority. However, resources need to be allocated to areas where they will make the biggest difference. The Aboriginal community needs to be involved in this decision-making process.

International Context

Engle et al. (2007) examined the effectiveness of intervention programs in developing countries for children under five years of age. They showed that early interventions promote child development and prevent or ameliorate developmental loss. Child development refers to the ordered emergence of interdependent skills of sensori-motor, cognitive-language, and social-emotional functioning. Early child development programs are designed to improve the survival, growth, and development of young children, prevent the occurrence of risks, and ameliorate the negative effects of risks.

The most effective interventions are comprehensive programs for younger and disadvantaged children and families that are of adequate duration intensity, quality and are integrated with health and nutrition services. Providing services directly to children and including an active parenting and skill building component is a more effective strategy than providing information alone.

Aboriginal Context

In regards to screening, each topic of the CHCs should be considered according to the criteria for screening, and in the context of the Aboriginal population which already suffers from high rates of morbidity. However, in reviewing some of the literature relevant to child health screening (Royal Children's Hospital, Melbourne, 2002; Paterson, Nossar 1998; Morris et al, 2005; Bailie et al, 2008), it would seem that wholesale screening of all Aboriginal children aged 0 – 16 years, for all of the conditions in the CHCs, is not good value for money.

Engagement of the Aboriginal community is essential in advancing the health of Aboriginal children (Brown, Brown, 2007; Boffa et al, 2007). The Aboriginal Medical Services Alliance Northern Territory (the Alliance) had concerns about the NTER

in the beginning. They have now engaged with the process and they see that despite its serious reservations about other aspects of the intervention, the Alliance considers that sustained improvements in primary health care can be achieved via genuine engagement of government with Aboriginal communities. Furthermore, they state that the intervention has provided an opportunity for health professionals from mainstream Australia to work in the NT, and we hope they will return to work again with our dedicated teams in the bush (Boffa et al, 2007).

Concluding Comments

Whatever approach is taken to reduce the burden of suffering for Aboriginal children, it needs to be done in partnership with the Aboriginal community, and it needs to build on successful programs that are already in place in the NT. Anything less than this would further disempower an already disadvantaged population and diminish currently effective programs and services.

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APPENDIX 3: HUMAN RIGHTS EXPERT REVIEW

Prepared by the Australian Human Rights and Equal Opportunities Commission

Thank you for the opportunity to contribute to the expert review for the Health Impact Assessment of the Northern Territory Emergency Response (NTER) being conducted by the Australian Indigenous Doctor's Association (AIDA) and Centre for Health Equity Training Research and Evaluation (CHETRE).

To assist you in your assessments I refer you to the Social Justice Report 2007, which was tabled in Parliament in 2008.⁸ This report considered the human rights compliance and impact of the NTER with reference to Australia's international obligations and specifically the Racial Discrimination Act 1975 (Cwlth) (RDA).

Review of the Intervention Elements

The Social Justice Report 2007 found that the Government has an obligation to take measures to address family violence and child abuse in Indigenous communities. However, the NTER is not a situation that justifies introducing measures that place restrictions on the rights of Indigenous peoples such as over-riding the principles of non-discrimination and just compensation or safeguards for procedural fairness. The NTER legislation cannot be legitimately exempted from the RDA or Northern Territory anti-discrimination legislation, or deemed to be a 'special measure' under the RDA, as aspects of the NTER negatively impact on Indigenous people's rights and the NTER was not introduced with proper consultation or consent. Specific elements of the NTER such as the income management scheme, the abolition of the Community Development Employment Project (CDEP) scheme and the introduction of alcohol bans in prescribed communities were found to raise human rights concerns.

Evidence

I note that the health impact assessment you are undertaking of the NTER may be constrained by the lack of benchmarking and monitoring data collected by the government to date. At the commencement

⁸ Available at: http://www.humanrights.gov.au/social_justice/sj_report/sjreport07/index.html.

of the NTER I noted that there were insufficient baseline measures in place to allow a comparison of the circumstances of Indigenous peoples before and after the NTER. I find that this has still not been rectified to date, making it difficult to determine the level of improvement achieved by the NTER.

I have also noted that much of the monitoring data collated by the government to date has been limited to collating the level of resources committed and feedback from government agencies and service providers on activities implemented.⁹ There is no indication that the government has developed monitoring mechanisms that directly consult Indigenous children and young people affected by the NTER, about the impact on their lives with regards to their rights to food, housing, education, and safety from violence and conflict.

It will be important for future implementation to develop better monitoring mechanisms that collate information directly from affected communities. Children and young people that are affected should especially be included in monitoring mechanisms. Specific indicators of children's wellbeing could be developed to monitor improvements in children's right to protection from violence or abuse and rights to participation, health, housing and education.¹⁰

Health Impacts

I am concerned that the NTER will not achieve sustained improvements in Indigenous health unless it implements programs that abide by the commitments made in the Close the Gap Indigenous Health Equality Summit in 2008. At the Summit, the Australian Government made accountable and measureable commitments to achieve equality in health status and life expectancy between Indigenous and non-Indigenous Australians by 2030, which included:

- developing a comprehensive, long-term plan of

⁹ Examples of reports relied on to date include: Northern Territory National Emergency Response (NTER): Stores Post Licensing Monitoring Report – Early Indications of Impact of Income Management in Community Stores – First 20 stores (available at: <http://www.facsia.gov.au/nter/reports.htm>); Northern Territory Emergency Response (NTER) Taskforce, Final Report to Government (available at <http://www.facsia.gov.au/nter/reports.htm>).

¹⁰ For examples of equality targets in the area of health see HREOC, *Close the Gap National Indigenous Health Equality Targets: Outcomes from the National Indigenous Health Equality Summit, Canberra, March 18-20, 2008*, HREOC Sydney, 2008 (available at: http://www.humanrights.gov.au/social_justice/health/index.html).

action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services;

- ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs;
- Working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples;
- respecting and promoting the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and of good quality;
- measuring, monitoring and reporting on our joint efforts, in accordance with benchmarks and targets, to ensure that we are progressively realising our shared ambitions.¹¹

Reports from some health organisations in the Northern Territory indicate that these commitments are currently not being met.

Further, due to the lack of appropriate consultation and engagement with Indigenous people to date in the design and implementation of the NTER measures, some community organisations reported a sense of disempowerment and re-traumatisation among affected communities. I am concerned that this trend could contribute to further physical, mental and emotional health problems.¹² Associate Professor Helen Milroy advised HREOC that:

'If the emergency measures in the NT result in further disempowerment or a sense of extreme powerlessness, then this is a re-traumatisation and will have negative consequences on:

- Mental health including possibly higher rates of depression, stress and anxiety;

¹¹ Close the Gap, Indigenous Health Equality Summit Statement of Intent, Canberra, 20 March 2008 (available at: http://www.hreoc.gov.au/Social_Justice/health/satement_intent.html)

¹² Alex Brown and Ngiare J. Brown, The Northern Territory intervention: voices from the centre of the fringe, (Ref. Medical Journal of Australia 2007; 187(11/12): 621-623, available at http://www.mja.com.au/public/issues/187_11_031207/bro11318_fin.html; Chandler, M.J. and Lalonde, C., Cultural continuity as a hedge against suicide in First Nations youth, 2000, available at <http://web.uvic.ca/~lalonde/manuscripts/1998/TransCultural.pdf> accessed 9 August 2007.

- Social and emotional wellbeing through increasing anxiety and uncertainty and hence this may precipitate family and community despair and dysfunction, poor or maladaptive coping and contribute to substance use and possible violence as well as loss of trust;

- Physical health as there is a strong relationship with chronic stress and poor health outcomes including diabetes and cardiovascular disease.¹³

The Ten Point Plan and Recommendations

The Social Justice Report 2007 outlines a ten-point action plan that identifies measures for amending the NTER to ensure its consistency with Australia's human rights obligations and with equal treatment of Indigenous children and their families before the law. This ten-point plan is as follows:

- Action 1:** Restore all rights to procedural fairness and external merits review under the NT intervention legislation
- Action 2:** Reinstate protections against racial discrimination in the operation of the NT intervention legislation
- Action 3:** Amend or remove the provisions that declare that the legislation constitutes a 'special measure'
- Action 4:** Reinstate protections against discrimination in the Northern Territory and Queensland
- Action 5:** Require consent to be obtained in the management of Indigenous property and amend the legislation to confirm the guarantee of just terms and compensation
- Action 6:** Reinstate the CDEP Program and review the operation of the income management scheme so that it is consistent with human rights

¹³ Milroy, H. (Associate Professor, Centre for Aboriginal and Dental Health, University of Western Australia) personal email correspondence with the Aboriginal and Torres Strait Islander Social Justice Commissioner, 9 August, 2007.

- Action 7:** Review the operation and effectiveness of the alcohol management schemes under the intervention legislation
- Action 8:** Ensure the effective participation of Indigenous peoples in all aspects of the intervention – Developing Community Partnership Agreements
- Action 9:** Set a timetable for the transition from an ‘emergency’ intervention to a community development plan
- Action 10:** Ensure stringent monitoring and review processes¹⁴

This ten-point plan has three main aims. First, it articulates how to remove formal discrimination under the NTER legislation (Actions 1 – 5). Second, it proposes a method for ensuring that schemes for income management and alcohol control are undertaken in a manner that is consistent with the RDA and that qualify as a ‘special measure’ (Actions 6 - 7). Third, it identifies an approach to transition from a crisis/emergency approach to a community development approach through ensuring participatory processes, the creation of community development plans and rigorous participatory-based monitoring and reviews.

¹⁴ Aboriginal and Torres Strait Islander Social Justice Commissioner, Social Justice Report 2007, HREOC, Sydney, 2008, p.294.

At the launch of this report earlier this year, I commented that this action plan identifies:

*‘... changes to the current framework for the intervention to ensure that the legislation is applied fairly with the ordinary protections that apply for all other Australians ... I challenge anyone to explain how providing these basic democratic protections could possibly hinder the goal of protecting children. The only possible answer is ‘short term expedience’ prevailing over guarantees of access to justice. And that is not a good enough answer’.*¹⁵

I further noted that:

‘... measures that violate the human rights of the intended beneficiaries are more likely to work in ways that undermine the overall wellbeing of the communities in which they live in both the short and the longer term.’

For example, the Government has clearly stated that the NT Intervention seeks to address a breakdown in law and order in Aboriginal communities. And yet it potentially involves introducing measures that undermine the rule of law and that do not guarantee Aboriginal citizens equal treatment to other Australians.

¹⁵ Aboriginal and Torres Strait Islander Social Justice Commissioner, ‘Essentials for Social Justice: Protecting Indigenous children’, Launch of the Social Justice Report 2007 and Native Title Report 2007, HREOC, Sydney, 31 March 2008, (available at: http://www.humanrights.gov.au/about/media/speeches/social_justice/2008/20080331launch_sjnrtr07.html)



APPENDIX 4: MENTAL HEALTH EXPERT REVIEW

Prepared by Professor Ernest Hunter

Regional Psychiatrist, Remote Area Mental Health Services, Queensland Health and Adjunct Professor, Psychiatry, University of Queensland

In your opinion, do you believe there are any elements of the NT intervention that will improve the mental health of Aboriginal people?

To answer this question one needs to ask what those factors are that compromise the mental health of Aboriginal people in areas impacted by the NTER, and what the relationship is of elements of the intervention to those factors. In terms of the proximal factors the most obvious is substance use and reducing the immediate impact of substance use on communities almost certainly relieves a major stressor – in the short term. There are now many examples (including from north Queensland) of short-term improvements (for instance, in terms of primary care presentations for trauma), and there has been considerable research done looking at the difference across varying approaches to controlling alcohol access (d'Abbs & Togni, 2000; d'Abbs, 2003) giving guarded support to the dry areas legislation approach in the NT in the past. The key issues, relate to the sustainability of the NTER provisions locally, and the impact of these provisions on population movements (which both take people at risk away from communities AND increase the proportion of such people in areas where alcohol availability is less constrained – thus, potentially, increasing 'risk status' of certain town settings).

My impression is that for these short-term benefits to continue will be entirely contingent on maintaining a very aggressive approach to alcohol control AND policing generally. That is likely to be resisted by some and has consequences in terms of perceived control that are important. However, there is, I argue, an even more important mechanism linking substance use and the behaviours associated with it to mental health – the impact of the environment resulting from substance misuse on child development. We now have hospital-based data from Far North Queensland suggesting a significant increase in serious psychological problems that result in more and longer admissions for Indigenous residents of

the region. We believe that this is also associated with an increase in levels of intellectual disability (and there are data supporting higher levels of such disability in the Indigenous population generally). I believe that a key driver for that group of young adults now presenting with serious disorders (primarily psychoses) is what might be considered as 'developmental risk' arising from substance-misuse affected environments – including foetal exposure, exposure to stress through pregnancy and infancy, and the consequences of family and community 'dysfunction' on child development and education generally. The NTER *may* provide benefits in this regard but, again, *only* if the changes are sustainable.

In terms of other elements that have had positive effects – clearly there will be benefits to wellbeing with improvement in housing and services – if that, indeed, is occurring. I have not seen any documentation of service level input (mental health specific) in relation to the NTER – in terms either of clinical mental health or Alcohol, Tobacco and Other Drug Services (ATODS).

Are there elements of the NT intervention that may inadvertently detract from the mental health of Aboriginal people? How and why?

Practically, while there MAY be some inadvertent negative effects, I don't think that these will be easily directly attributable to the NTER. Given the longstanding problems of disempowerment, paternalism, dependence and so on, I don't think that the degree to which these MAY be amplified by this intervention (which it probably is) will translate into a worsening of mental health. HOWEVER, it might be considered in terms of opportunities lost. In that regard, it might be argued that a more collaborative approach, undertaken in a less dramatic but more sustainable fashion, could have had significant benefits in terms of perceived agency and control. That might have positively influenced both community and family capacity and responsibility.

The impact of the NTER on communities (both positive and negative) includes direct effects of the intervention and collateral forces. Among the latter is the media attention that has been unremitting and reinforced by events elsewhere (for instance the coverage of the events in Aurukun). In these representations (for instance in relation to child sexual assault) Indigenous people are portrayed in

ways that suggest people are necessarily victims, perpetrators or bystanders. The implicit messages are particularly negative in relation to Aboriginal men, which probably has negative consequences in terms of self-esteem and self-confidence in relation to family roles, and may even contribute to tensions and violence (the very behaviours that the intervention seeks to reduce). There is often a naïve polarisation of demonising and romanticised representations presented (for instance by The Australian) which, under the guise of 'balanced' reporting enables unfettered negative commentary. This, of course, is not new – the Sydney Morning Herald was taken to the National Press Council over the same issues some fifteen years ago.

Is there any available evidence to suggest that any measures covered under the NT intervention will improve Aboriginal people's mental health?

There is clearly evidence that a range of GOALS of the NTER is associated with improved mental health outcomes (from other populations, such as substance use reduction, developmental sufficiency and housing). However, I am unaware of evidence that could be used to answer this question in relation to the NTER itself. Furthermore, a failure to demonstrate positive outcomes can be interpreted either in terms of a failed paradigm - or a failed implementation. There is clear evidence of the importance of early childhood, family-based interventions (Olds et al., 2004) in relation to improving mental health outcomes in vulnerable populations. There have been some variants of this approach trialled in Australia that have shown some benefits. This also appears to be the case for approaches that seek to support agency and local empowerment (which may be driven from outside the health sector). For any such interventions (and for the NTER) a critical limitation in terms of the evidence base is that the timeframe necessary to reasonably demonstrate positive outcomes is long.

On a practical note – while I firmly believe that mental health services are a *very small* contribution to overall mental health and wellbeing, the data available so far from the NTER from the child health checks demonstrates two points of importance. The first is that there are very few referrals to the NT Family and Community Services (0.5%). This may be because screened children (63% of eligible children) are less likely to be at risk. However, if I am reading the report correctly, this compares to 1.68% for Indigenous children in the NT generally

for 2006/07. While these figures are clearly open to being challenged, what this appears to confirm is that such screening is NOT a good way to go about identifying and responding to child sexual assault – one of the key precipitants to the NTER. The second point is that, given this precipitating concern one would expect there to be a significant number of referrals for mental health interventions or some kind of social/emotional support. However, there are NONE documented. This may reflect the paucity of services, BUT, one presumes that there would be a focus on NEED not simply on what can be delivered – and the silence about mental health issues in the report is significant.

Is there evidence to suggest that the NT intervention measures will not improve or may diminish Aboriginal people's mental health?

Similarly, the evidence from the NTER does not exist. If the investments of the NTER are not sustained I don't see any reason why any immediate benefits will persist. However, that is different to suggesting that the intervention might diminish mental health. I think the latter is unlikely, BUT, it could be argued that this approach has further diminished the sense of control that Aboriginal people in communities impacted by the NTER experience. It has clearly been divisive and does run the risk, particularly if investments are not sustained and expectations deflated, of reinforcing fatalism. It may also be argued that if population shifts occur in response to provisions of the NTER, it may have consequences in those places to which people move with more overcrowding, pressures on resources and so on.

In your opinion, what are the likely and/or unintended consequences of the NT intervention in the short, medium and long term?

I think that it is necessary to consider the issue of unintended consequences more broadly than the impact of the NTER in the Northern Territory itself. While it may be argued that the debates that have occurred in the wider Aboriginal and Australian populations have useful in bringing critical issues to the surface, it has also provided a platform for reactionary rhetoric and victim blaming. To that end, I think that it has reinforced divisions and probably been harmful to the development of long-term cooperative relationships between government and Indigenous organisations/communities. Furthermore, while there are protestations to the contrary, it has

been alleged that the NTER has diverted funds from health sector investments in other areas of Indigenous Australia. My gut feeling is that that is probably true.

In terms of local effects – the answer to this question MUST be preceded by – ‘it depends’. The outcomes will depend on many things but, to exemplify extremes informed by the critical issue of sustainability, I suggest two scenarios. In the first there is a commitment to sustain resources and effort for at least a decade (the minimum time I would think one could reasonably anticipate being able to make considered judgements about ‘success’). Over that time the investments in infrastructure and services promised, actually occur. Further, there is a process of continuing feedback and adaptation to evolving circumstances that incrementally shifts control of ongoing activities to local councils and organisations (which are provided with the training, resources and support necessary to take on those roles). In this scenario I think there would be gradual (but not dramatic) improvements, particularly as the cohort of children and young people (and babies born through this period) grow (reflecting the critical importance of early development to optimising potential). A potential downside of this scenario is that although there is sustained investment, it relies on external inputs and, consequently, does not ‘empower’ locally. This is an issue that Richard Trudgen touches on – that interventions, often with the best intentions, can have untoward outcomes if they reduce the roles and responsibilities that would otherwise be assumed locally. How one maintains the external inputs and investments while ensuring local agency and empowerment is the challenge.

In the second scenario the investment is not sustained and responsibilities are handballed without adequate preparation to local organisations. Unsupported and facing increasing local criticism, these floundering agencies provoke more divisiveness and increased reliance on external, reactive, crisis-driven ‘solutions’. The situation returns, in effect, to status quo ante, with increasing resentment about imposed and failed ‘solutions’. It becomes harder for government to act in these areas with the confidence and trust of local communities.

In essence, I think that there is some potential for benefit, and a very real potential for stagnation and harm. While there are multiple factors that will influence how the scenarios develop – two necessary elements to support positive outcomes will be

sustained investment and development of local capacity and control. Without those it will fail.

If the intervention could be changed, what should be changed to deliver better outcomes for Aboriginal people, their families and communities?

In some respects it is the implementation rather than the intervention that one would want to change – that is, that this investment would be undertaken under Indigenous leadership in an empowering way. Given that now is a *fait accompli*, it can be argued that we have the opportunity to follow two fundamentally similar interventions in Indigenous north Australia which, while both being imposed (and certainly both being divisive) are differentiated by the degree to which Indigenous leadership has been involved in development and implementation. These are the NTER and the Welfare Reform Agenda in Cape York (CYWR). Sadly, I don’t think that there has been sufficient early consideration of how these will be evaluated AND, at least in terms of the CYWR, the timeframe being touted is unreasonably short. Perhaps there would be some benefit in having an overarching monitoring process that would seek to reflect on how the commonalities and differences between these two interventions play out. That would be very complicated but doable.

I am not familiar with the communities of Central Australia so I am not in a position to comment with any experience or expertise about local factors. However, I have made the point already that I believe investments in early childhood are essential AND that these should have a family focus. That is, it is one thing to ensure children are safe (itself difficult in socially disadvantaged settings) but a much more complex challenge to provide the nurturing family environment that is essential to optimise developmental potential – safety is fundamental but only one part of that enterprise. To that extent we need to be careful not to undermine family capacity in pursuit of child safety.

In this regard, the roles that have been most seriously compromised are those of male roles in family life and child development. This is not to suggest that there are not men who have failed in those roles – that certainly has been the case and may well be more common in the socially disadvantaged communities of Central Australia. However, interventions that rely solely on a ‘protection’ paradigm *cannot* be supporting family functioning (in small communities, that there are safe houses for children, for women and

for men suggests profound breakdowns in mutual trust - these may be necessary steps but not end points). Clearly the alternatives to the protection paradigm need to be considered carefully and need to support roles (particularly for men) and mutuality. Men's groups are obviously important. It may be that locally developed alternatives to criminalising family violence (including Child Support Agency [CSA]) need to be considered and the experiences and responses of other indigenous populations (for instance Canada and the US) explored.

Having said all of this, I have a personal conviction that *nothing* will make much difference in terms of improving the future for Indigenous people into the second half of this century unless there are real educational outcomes. This was driven home to me by a comment from the US Surgeon General, David Satcher, to Michael Woolridge in Central Australia a decade ago. Confronted with the tragic backdrop of remote communities he said to the Minister: 'You don't have a health problem here - you have an education problem'. If we are going to provide fair equality of opportunity for Indigenous Australians regardless of location, we MUST provide equity in terms of educational outcomes (which may mean investments more broadly in early childhood). I personally do NOT think governments can do this and the experience of Kamehameha schools in Hawaii is a sobering reminder that this takes more than tinkering with existing educational systems. Kamehameha is a private school system which has had astounding results, but operates off an endowment base (for fiscal year 2005/06) of \$US7.7billion (that for 7000 full-time and 23 000 extension students). I would argue that we need a scaled-up investment of the same order to make any discernible difference in Indigenous Australia. I don't think governments are up to that. I think it is also important to remember that schools exist to generate *educational* outcomes - despite some improvements in attendance, the WA Child Health Survey clearly demonstrates that educational outcomes are not improving.

If the intervention could be changed, what should be changed to reduce the negative impacts on Aboriginal people, their families and communities?

To answer this requires, first, that it is clear whether the question relates to changing the NTER at its inception - or now. I am presuming that we are talking about NOW - that is, over a year after the NTER commenced. Given the foregoing comments in relation to potential harms (unsustainability,

undermining local agency and control, shifting the burden of problems to town populations, challenging roles - particularly of men, reinforcing dependency, increasing the stigmatisation of Indigenous people, parents and communities ...) my personal opinion is that undoing or preventing same requires addressing their common determinants. There are numerous but, to note two that stand out:

- I believe that it is important to address uncertainty and disempowerment. By uncertainty I mean two things. First, there is ambiguity about the role and purpose of the NTER and, consequently, of those people representing it. The NTER is, in essence, about policing and control on the one hand, and supporting the development of nurturing, health affirming, empowering environments on the other. There is an obvious conflict which needs to be resolved.
- Second, the NTER has brought a sudden infusion of resources and services and, I presume, there is likely to be considerable uncertainty about whether this will continue or not.

By disempowerment I mean the undermining of local authority and roles, particularly for Indigenous men. Addressing these two issues would clearly be complex but I think any successful approach would demand transparency and meaningful dialogue that provides control to the communities themselves. Thus, I believe it would be helpful if there were a mechanism by which communities could be assured about the continuity of investments with a reasonable timeframe that give security and allow sensible planning (*at least* five years). Of course, sustained investment does *not* equate to maintaining the current approaches and, in terms of empowerment, there should be a similarly transparent mechanism by which the controls and drivers of the intervention at a local and Territory level are devolved to Indigenous authority. I'm not sure how that is undertaken *but*, I think there should be a stated and generally agreed on plan - the NTER cannot be ER forever. It may, for instance, necessitate developing a regular forum in which aggregated and local data are presented along with some kind of process evaluation, allowing Indigenous input into (and ultimately control over) program development. This may well be being done.

Finally, I think we compound harm if we do not learn from experience (and mistakes). If it is not already happening I think that there should be resources made available for an ongoing social

impact study, undertaken independently. As mentioned earlier, I think an opportunity is lost if that is not undertaken in a way that also allows consideration of and comparison with the CYWR initiative in Queensland.

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APPENDIX 5: CHILD MENTAL HEALTH EXPERT REVIEW

Prepared by Professor Helen Milroy

Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia

Are there any elements of the NT Intervention that you think will preserve or improve the mental health of Aboriginal children?

There are numerous factors many of which are inter-related that can impact positively or negatively on mental health across a lifespan. Mental health results from the complex interplay of biological, psychological, social, spiritual and cultural dimensions, is progressive over time with experiences building a repertoire of potentially adaptive and maladaptive responses. For children in particular, the family has much greater influence as are other environments such as day-care or school to which the child is exposed. The monograph by Swan and Raphael, 2005 on promotion, prevention and early intervention in mental health gives an excellent overview and divides the impact of factors into individual, family/social, school, life events and situations, and community and cultural factors.

Those aspects of the NTER which potentially enhanced protective factors and reduced risk factors could have improved mental health for children. For example, one could argue the health screening identified those children with developmental problems, hearing loss and language delay and hence by adequately treating these issues, mental health will be improved. As well, providing greater protection and safety, improving education, housing, reducing alcohol misuse and violence will also improve mental health. What is not clear from the NTER is exactly how much was directly attributable to the NTER and what was already in place. As well, only identifying children with health problems may identify the risk to mental health but if not adequately followed up with appropriate treatment, for example with hearing loss and language delay, the actual risk is not reduced. As well, it is also unclear what elements of the NTER were directly responsible for protecting children or reducing the risk of abuse. For those families/communities where alcohol and violence, school attendance, welfare management and health checks were not major issues, the NTER is unlikely to have had any

positive impact on mental health.

Are there elements of the NT Intervention that may inadvertently detract from the mental health of Aboriginal children? How/why?

Any aspect of the NTER which compromised family and community cohesion, created threat or uncertainty and disempowered individuals would have had a negative impact on mental health. In particular, children rely on their families to act on their behalf and it is important for children to see family and community members actively involved in decision making, leadership and as role models in the community. Placing all families under the same rulings due to race would have impacted negatively on their sense of agency, responsibility, control and cultural identity. This type of action would result in individual, family and community level anxiety and this would have a negative impact on child mental health. As the historical legacy of the Stolen Generations is ever present, the fear of further child removal may have impacted significantly on some children and their families.

From the literature on child abuse, it is clear that the aftermath of what happens to the child following disclosure of abuse can be equally as traumatic if the child is left with numerous losses, lack of support and appropriate intervention or is subject to further trauma. As there was no concerted mental health response as part of the initial NTER, it could be argued that some children and families would not have been adequately protected or treated following disclosures of abuse and could have suffered further as a result. It is well known that after a disclosure of significant sexual abuse, unless there is adequate mental health support and treatment, the risk of suicide, mental health problems and breakdown is likely. As well, disclosures from children often trigger the rekindling of traumatic events for the parents and if the parent's mental health becomes compromised, this will directly impact on the mental health and wellbeing of children. The treatment of child sexual abuse is complex and requires expert advice, consultation, assessment and intervention across a variety of services. The fact that no child mental health services (as opposed to child protection and basic counselling services) were substantially involved in the NTER is a dangerous oversight and is yet to be rectified. When dealing with mental health problems or illness, it is especially important not to create further harm.

Is there any available evidence to suggest that the NT Intervention measures will improve Aboriginal children's mental health?

There did not appear to be any direct measure aimed specifically at improving mental health for children. Indirectly as discussed above, those aspects that generally reduced risk and promoted protective factors would improve mental health. There does not appear to be any direct link to changing of the permit system or native title legislation that would reduce the risk of sexual abuse nor improve mental health.

Health screening in general is unlikely to identify many of the younger children at risk of mental health problems unless a comprehensive assessment is sought from several sources including school. Health screening in youth may identify mental health issues and be a source of referral to mental health services. In some cases, providing care and protection alone is not sufficient to improve mental health problems or illness. There is little data on the mental health of Aboriginal children and there is almost a complete absence of national data on any Australian child under five years of age, hence measuring any change will be difficult.

Current evidence suggests there is under-reporting, under-utilisation and a general lack of availability of mental health services for Aboriginal children throughout Australia but particularly deficient in the Northern Territory. It is likely that a greater use of mental health services for Aboriginal children in the NT would be seen initially as a positive step forward in identifying the issues. According to the Western Australian Aboriginal Child Health Survey data¹⁶, too many stressful life events was seen as the strongest predictor for Aboriginal children being at high risk for emotional and behavioural problems as well as for school failure. Chronic stress is also linked with later poor mental and physical health outcomes in adulthood. Those measures aimed at reducing stressful life events for families and children would improve mental health.

Given the high level of concern over the magnitude of trauma children were experiencing, of note there

is no mention of mental health in the report on the child health checks, no identification of any mental health problems within the child health checks, nor any referrals to mental health professionals. Given the level of chronic disease identified, the need for mental health services is obvious. As well, strong attachment in infancy is highly protective for good health and mental health outcomes, there is no specific measure aimed at maternal health and mother-infant services.

Is there evidence to suggest that any measures covered under the NT Intervention will not improve or may diminish Aboriginal children's mental health?

For those families that experienced fear and uncertainty, this will directly impact negatively on child mental health. It would be difficult to measure the full impact of the NTER on mental health as the effects can accumulate over time and, for children, may not become manifest until adolescence or early adulthood. Those measures that increased the levels of stress on families and children would have a negative impact on mental health.

In general, the lack of inclusion of any mental health issues shows a complete disregard for the mental health and wellbeing of Aboriginal children and their families as part of the NTER and draws into question the aim of the exercise.

In your opinion, what are the likely and/or unintended consequences of the NT Intervention in the short, medium and long term?

The focus on the health, care and protection of Aboriginal children in the Northern Territory was very welcome. However, the first rule of any health or mental health intervention should be to do no harm. Poorly planned, rushed and blanket interventions are at best likely to produce bandaid responses and unlikely to lead to the generational changes required to improve the health and wellbeing of Aboriginal children, families and communities.

The short-term consequences would have been the disempowerment, anxiety and sense of uncertainty that was created by the NTER.

The imposition of governance arrangements, the labelling of all Aboriginal people in the NT as one and the same in regard to welfare payments, alcohol restrictions and child abuse would have damaged

¹⁶ Zubrick SR, Silburn SR, De Maio JA, Shepherd C, Griffin JA, Dalby RB, Mitrou FG, Lawrence DM, Hayward C, Pearson G, Milroy H, Milroy J, Cox A. (2006). The Western Australian Aboriginal Child Health Survey: Improving the Educational Experiences of Aboriginal Children and Young People. Perth: Curtin University of Technology and Telethon Institute for Child Health Research, ISBN 0-9579494-9-9.

individual and collective identity, self-esteem and pride. Nationally, the damage to reputation and identity of Aboriginal Australians has been significant. The very nature of the NTER given the historical legacy of trauma, would have resulted in a re-traumatisation of the NT Aboriginal population and in some cases this would have had a very negative impact on mental health, placing some individuals at increased risk. In the medium to long term, if the investment in health infrastructure and services is improved, there may be benefit over time.

However, to date, there is still no concerted mental health response as part of the NTER and the unintended consequences of dealing poorly with the mental health issues associated with childhood trauma could be devastating. Not treating or inappropriately treating significant childhood trauma issues in children, youth and the aftermath in adults can lead to many health and mental health problems including mental illness such as post-traumatic stress disorder, depression, anxiety disorders, personality disorders, substance misuse, suicide, poor educational outcomes, chronic ill-health, poor employment outcomes, family relationship problems and breakdown as well as poor attachment in infancy, and increased risk for subsequent child abuse.

If the intervention could be changed, what should be changed to deliver better outcomes for Aboriginal children, their families and communities?

There is ample evidence to support the need to improve the care and protection, health and nutrition, education and opportunities for Aboriginal children in the NT. How this is brought about in a sustainable way is the key to effective intervention. Any program should be empowering of families and communities, focused on recovery using a strengths based approach with an expectation of change, be understanding and inclusive of Indigenous knowledge systems and culture (including an understanding of a collectivist society), promote Indigenous pride, identity and cultural renaissance and be prepared to work in true partnership. There must be an acknowledgement of the historical legacy, especially in light of the Apology. There should be an emphasis on early intervention especially in maternal and child-health with a strong focus on attachment and the early years of development. Dealing with racism and discrimination should also

be part of improving services for Aboriginal people in the NT and cross-cultural education and cultural security in line with the National Cultural Respect Framework should be adopted. All programs should have an overarching healing framework as the next step on from the Apology to promote better relationships.

Without a sense of community ownership and control, there will be more of the same and no real progress over time. Children need to see their parents taking responsibility so they can themselves grow up to be responsible. Generational cycles are difficult to change but not impossible and the commitment must be generational whilst still addressing the very real acute need within communities. Mental health literacy especially in understanding child mental health is deficient in most communities across Australia and major improvements in mental health services are urgently needed to address the current demands.

If the intervention could be changed, what should be changed to reduce the negative impact on Aboriginal children, their families and communities?

Participation, decision making and governance arrangements should be reviewed immediately to restore community responsibility and promote self-determination. All blanket programs should also be reviewed to allow for the allocation of resources to those in greatest need. For those families that do not require welfare quarantining or restrictions to alcohol or other issues, they should be exonerated, compensated in some way or receive incentives for the harm caused and to restore a sense of justice and pride. An appropriate mental health response should be developed as a matter of urgency and failure to do so could result in further harm.

Developing better community consultations, longer-term planning and allocation of resources, as well as an effective capacity building program and communication strategy would be of benefit. There needs to be an effort to re-define the NTER from this point onwards away from the political football to a very real and sustainable investment in the lives of Aboriginal children and their families to promote real change over time and showcase their value and importance to the rest of the nation.



APPENDIX 6: DRUGS AND ALCOHOL EXPERT REVIEW

Prepared by Professor Sherry Siggers

National Drug Research Institute, Curtin University of Technology

In your opinion, do you believe there are any elements of the NT Intervention that will reduce the misuse of alcohol amongst Aboriginal people?

In 2008 the Australian Government summarised the NTER 2007 alcohol measures as follows:

'The former Australian Government legislated to modify the Northern Territory Liquor Act, creating new obligations, penalties and requirements. The intention was to ban the sale, possession, transportation, and consumption of alcohol on Aboriginal land and to monitor takeaway sales across the Northern Territory.'

The new laws have been in force since 15 September 2007.

Some clubs (licensed premises) in communities have been allowed to operate under strict conditions, and existing liquor permits remain, though their operation has been closely examined.

The Australian Government has recently announced an additional activity under this measure. The establishment of a new Substance Abuse Intelligence Desk (SAID), to be based in Katherine, will help improve community safety and law enforcement.

A package of measures has also been developed and rolled out to address the need for increased alcohol and other drug withdrawal, treatment and rehabilitation services across the Northern Territory.

The Northern Territory Government has also made significant legislative changes including extending public restricted (dry) areas in Darwin and Alice Springs and supporting communities in the development of Alcohol Management Plans and Liquor Permit Systems <http://www.facsia.gov.au/nter/docs/reports/taskforce_report.htm>.

It is not clear how the above measures have been implemented. Attempts to contact the NT Liquor Licensing Commissioner to clarify the measures were unsuccessful.

As I indicate below, while there is good research evidence that restricting the availability of alcohol in remote and regional communities will reduce the misuse of alcohol, there are important qualifications which may limit the potential to affect change. Most importantly, these include community support for such measures, the availability of demand and harm-reduction strategies, and attention to the social determinants of harmful drinking practices. There is no evidence that the NT initiative of 'local dry areas' (which, unlike 'dry community' declarations, relate not to whole communities but to restrictions on alcohol in designated public places or areas) in Darwin and Alice Springs have been or will be effective. While such areas are associated with decreased public order offences in designated areas, there have been no reductions in alcohol-related hospitalisations or police detentions, or overall reductions in public order offences. For these reasons the measure is not recommended (NDRI 2007, p.205).

Are there elements of the NT Intervention that may increase the risk of alcohol misuse amongst Aboriginal people? How and why?

- Displacement of drinking to unsafe environments. An Alice Springs town camp resident claims that 'People go out of town to drink outside of the town area, then drive back drunk - dangerous' (Tangentyere Council, n.d.).
- Possible substitution of harmful substances other than alcohol
- Negative community sentiment. There is widespread evidence throughout the NT of Indigenous people's anger and shame of being stigmatised in this manner and of responding counter to the new laws 'why should I be stopped from drinking? I know that I'm breaking the law - I want to break the law' (Tangentyere Council, n.d.)

Is there any available evidence to suggest that any of the measures covered under the NT Intervention will reduce the misuse of alcohol amongst Aboriginal people?

The National Drug Research Institute, Curtin University of Technology recently completed a comprehensive study on the evidence and outcomes of restrictions on the sale and supply of alcohol (NDRI, 2007). Based on available evidence both internationally and in Australia, each restriction was

rated on a mutually exclusive scale of effectiveness (√√ strong evidence for effectiveness in Australian context, √ evidence for positive outcomes, evidence unclear or insufficient, x absence of reliable positive effects, or evidence of possibly counter-productive effects). Those measures attracting the highest rating (√√) include restrictions on the economic availability of alcohol through taxation and pricing; hours and days of sale for licensed premises; reduction in the legal drinking age for purchases or consumption of alcohol. None of these measures was introduced as part of the NTER.

The measure that was introduced as part of the NTER – mandatory packages of restrictions for remote and regional communities – is rated √ and has been shown to be effective in reducing alcohol consumption, and alcohol-related harm in the form of fewer police incidents and presentations to health services and improved levels of community amenity when supported locally and enforced adequately. It should be noted, however, that since 1979 more than 100 Indigenous communities in the NT have voluntarily introduced bans on alcohol prior to the NTER (Racing, Gaming and Licensing Northern Territory 2006). Table 1 below sets out the circumstances for the effectiveness of such measures.

The international and Australian evidence to support this rating is discussed in detail in NDRI (2007).

Is there evidence to suggest that the NT Intervention measures will not positively impact levels of alcohol misuse amongst Aboriginal people?

This is currently unclear. As indicated elsewhere in this report, restrictions on the availability of alcohol is not a silver bullet and needs to be seen as part of a broad, complementary strategy tackling supply, harm and demand-reduction measures. Chronic alcohol misuse will not significantly change unless the social and structural determinants of unproblematic use – quality child care and early intervention, parenting support, adequate housing, transition to school support, appropriate education and training, realistic employment options, proper governance, and alternatives to drinking and other substance misuse for children, young people and adults – are in place.

The primary alcohol measure chosen – mandatory restrictions on alcohol in specific communities – can be effective but is limited by various factors (see Table 15 below) and is not as effective as restrictions

on the price, hours and days of sale, and increasing the legal age of drinkers. Community support for these measures in the Australian population varies, with almost a quarter (24.1%) supporting price increases, 38.9% supporting reduced trading hours, and 46.3% in favour of raising the legal drinking age (AIHW 2008). No evidence is available on Indigenous views of these measures.

TABLE 15: MANDATORY PACKAGE OF RESTRICTIONS FOR REMOTE AND REGIONAL COMMUNITIES

Suitable target populations	Licensed premises, including hotels, taverns, and takeaway stores Premises particularly associated with high level of problems
Responsible authority	State/Territory
Suitability for short-term implementation	Low for affecting changes in chronic alcohol-related harm High for affecting changes in acute alcohol-related harm
Suitable for long-term implementation	High, when supported by the general community, the Indigenous community and organisations such as police Must be responsive to changing community needs, adequately resourced and enforced in conjunction with other strategies
Likely positive outcomes	Reduction in per capita consumption Reduction in alcohol-related harms Improved community amenity Improved community safety
Possible negative outcomes	Substitution of harmful substances other than alcohol Negative community sentiment Displacement of drinkers to unsafe drinking locations
Potential limiting factors	Lack of community support Inadequate enforcement Circumvention by drinkers, licensees and producers Alcohol available in surrounding areas not affected by restrictions
Recommendation	An important strategy for reducing consumption and related harms in discrete communities but should be supported by harm and demand reduction strategies and long-term commitment to improving underlying social determinants of substance misuse.
Source:	Adapted from National Drug Research Institute (2007, p.201)

In your opinion, what are the likely and/or unintended consequences of the NT Intervention in the short, medium and long term?

- There should be some reduction of overall consumption and acute alcohol-related harm (hospitalisations, public safety) in most communities.
- There may be substitution of other harmful products, such as petrol or methylated spirits.
- There may be displacement of drinkers to unsafe environments such as public places out of the view of police. Verbal reports by Alice Springs town camp residents claim riskier drinking is resulting from the ban on drinking on town camps, including increased drink-driving as people are drinking in licensed premises and then driving home intoxicated (Tangentyere Council, n.d.).
- Increased resentment by Indigenous drinkers and non-drinkers about the discriminatory nature of the alcohol measures. Interviews of Alice Springs town camp residents reveal strong resentment against what are effectively bans on drinking in their own homes:

'There are a lot of mixed messages coming out of the alcohol restrictions, town camp residents believe that if they go home and drink they are doing the right thing, but in the eyes of the government it's not a right at all, it's now the law not to drink in your home. It's really confusing that there is one rule, one law for town campers not to drink in their homes and there is one rule, one law for residents of Alice Springs to drink in their homes. No wonder residents do it, it's a risk they are willing or going to take.' (Alice Springs town camp resident 2007, Tangentyere Council, n.d.)

- Deteriorating relations between Indigenous communities and police because of the way in which enforcement of the alcohol measures are allegedly taking place in some communities. Current research on Alice Springs town camps reveals considerable resentment:

'People go home and drink at home, and police just chase them like cattle, police go a lot of times when we don't call them, they go into houses without asking – they don't care. It's just like trespassing.' (Alice Springs town camp resident 2007, Tangentyere Council, n.d.)

If the Intervention could be changed, what should be changed to deliver better outcomes for Aboriginal people, their families and communities?

- Adopting 'best buys' for alcohol controls would benefit both Indigenous and non-Indigenous families and communities, especially around taxation and pricing of alcohol, and reducing hours and days of sales of alcohol.
- Consulting with individual communities to achieve ownership of alcohol controls - recommended by the NTER Taskforce.
- Attention to the social determinants of substance misuse: antenatal and early intervention to detect foetal alcohol spectrum disorder (FASD); early learning and care opportunities for children and families; transition to school programs; diversionary sport, art, leisure and cultural programs; whole of community literacy programs; adequate housing; appropriate education and training; employment options in all communities, including CDEP; support for cultural programs focused on restoration and healing; respect and support for Indigenous governance and community control. Some of these elements (e.g. upgrading of housing) are part of the NTER.

If the intervention could be changed, what should be changed to reduce the negative impacts on Aboriginal people, their families and communities?

- Work with individual communities to introduce a package of evidence-based restrictions and other strategies to reduce demand and harm. The NTER Taskforce has recommended replacing bans with Alcohol Management Plans. The effectiveness of these is dependent upon a number of factors, including support and ownership by the community. A review of the Queensland experiment in AMPs claims that meaningful change is dependent upon a longer time frame for implementation, and increased commitment and effective partnering among government departments and other organisations (Queensland Government, 2005).
- Ensure each community has adequate access to the full range of preventive and treatment options: outreach counselling; night patrols; sobering up shelters; safe houses; residential rehabilitation; pharmacological therapies. The NTER Taskforce supports the announced expansion of alcohol and drug services and recommends the establishment of additional rehabilitation centres in remote areas accessible to families of affected clients. To date it is unclear how many new services have commenced.
- Remove bans on drinking on town camps, unless specifically requested by Indigenous organisations. The bans are clearly discriminatory and their effectiveness not established by the evidence.