Response to the Closing the Gap Refresh process

April 2018

Contents

Introduction

AMSANT is the peak body for the Aboriginal community-controlled health service (ACCHSs) sector in the Northern Territory which has played a pivotal role in addressing the burden of ill health carried by Aboriginal people. The ACCHSs sector delivers a comprehensive model of primary health care that is evidence-based, culturally appropriate and recognises the central impact of the social and cultural determinants in shaping health and wellbeing outcomes.

It is from the perspective of our sector's long history of providing health services to, and under the direction of, Aboriginal communities, as well as working successfully alongside government to meet those needs, that we provide the following submission to guide the refresh of the Closing the Gap (CtG) Strategy and its targets.

This submission provides the blueprint for a new approach to administering the Strategy to ensure the right environment for achieving any targets that are set. This submission also sets out key social and cultural determinants, along with suggested indicators, to inform the selection of targets. We would emphasise however that the selection of final targets should only occur under the direction of Aboriginal leadership (see Recommendation 1).

A new approach

Ten years after the commencement of the CtG Strategy, it is time to reflect on why Australia is on track to meet only three of the targets set out in 2008, and failing to move closer towards health equality between Indigenous and non-Indigenous Australians by 2030[1].

The sentiments outlined in the CtG Statement of Intent remind us that this Strategy was founded on an understanding that population health outcomes are fundamentally the result of underlying structural and social determinants. It also made clear that in order to address these determinants true partnerships are needed, partnerships which ensure that Aboriginal peoples are actively involved in the design, delivery, and control of service provision.

AMSANT supports the continuation of the existing seven targets under a refreshed Strategy while also recommending the addition of new targets that can assist in providing a more holistic picture of Aboriginal health and wellbeing across the social and cultural determinants.

In order to achieve sustainable, long-term improvements across the targets set under CtG, intervention must be sufficient, purposeful and coordinated. This will require leadership, vision, and a willingness to work in genuine partnership with Aboriginal people and their communities.

[1] Mortality and life expectancy gaps are actually growing due to accelerating gains in the non-Indigenous population (AIHW 2017a).

Within this submission we have made six recommendations that set out essential structural reforms to establish a solid foundation on which progress under a refreshed Strategy can be made. Without a strong and functional structure and a clear focus on addressing the root causes of Aboriginal disadvantage we risk another ten years of insufficient progress.

A role for Aboriginal Governance

AMSANT welcomes the commitment made by COAG in their meeting of 9 June 2017 to reform the CtG Strategy, "focussing on a strength-based approach that supports Indigenous advancement, working in partnership with Aboriginal and Torres Strait Islander people". There is no doubt that long-term, well-considered partnership structures between government and Aboriginal leaders that establish an Aboriginal role in governance will be critical in driving outcomes under a refreshed CtG Strategy.

To date there has been no structured Aboriginal participation, oversight or accountability built into the CtG process. This failure to include Aboriginal leadership has undermined progress with the CtG targets.

A formalised structure is required that can provide Aboriginal leaders with a genuine and long-term role in directing and evaluating progress under this Strategy. AMSANT envision that this role would encompass; leading community consultations; developing recommendations on existing and new targets; identifying what action will be required to meet those targets; and overseeing implementation, monitoring and evaluation.

Recommendation 1: That a formal and ongoing Aboriginal governance structure be established to advise and lead the Closing the Gap reform process and to participate in monitoring and implementation of Closing the Gap policies and programs.

Increase equity and efficacy of funding

AMSANT acknowledges that since the establishment of the CtG targets there has been an overall increase in expenditure on programs for Aboriginal Australians, which has gone some way to improving health and wellbeing outcomes. We have seen this success reflected in the indicators for year 12 completion and child and maternal health.

However, while total investment has increased since 2008-09, a recent Productivity Commission report shows that spending has plateaued in recent years, and even more concerning, that the amount of Indigenous specific funding has actually fallen from 22.5% of direct expenditure in 2008-09, to 18% in 2015-16 (Productivity Commission 2017).

Furthermore, in terms of Indigenous health expenditure, the Commonwealth currently spends $1.4 for every $1 spent on the rest of the population (AHMAC 2017). While this may appear to be a significantly higher investment, even on the most conservative estimates Indigenous people

have at least twice the per capita need of the rest of the population due to the higher levels of illness and burden of disease (AIHW 2016). In addition, a much higher proportion of Aboriginal people (18.5% vs 1.4%) live in remote and very remote regions where the cost of service delivery is significantly higher than in urban areas (ABS 2016a). Failing to allocate funds according to need represents a market failure and demonstrates that for the duration of the CtG Strategy to date, health expenditure has not been proportionate with the substantially greater and more complex health needs of Aboriginal people.

Recommendation 2: That COAG commit to increasing the absolute levels of Aboriginal-specific expenditure over the period of the next agreement to at least 30% and to increase the total expenditure on Aboriginal health to at least 2.5 times the non-Aboriginal expenditure.

An approach based on equity

There is an increasing body of evidence revealing that inequity is increasing within Aboriginal populations, particularly in line with growing rates of Indigenous identification (up 18.4% since 2011), which is occurring predominantly in major urban centres (ABS 2016b).

Evidence of this growing inequality among Aboriginal people can be seen in the NT where life expectancy in Aboriginal women has decreased whilst overall life expectancy for Aboriginal women increases at a national level (AHMAC 2017). A recent analysis of data from the 2006, 2011 and 2016 census' has also demonstrated that while disposable income levels for Aboriginal people in urban areas have grown by $57 a week, they have dropped by $12 a week for those in remote areas over the same period (Markham and Biddle 2016).

It is imperative that overall improvements measured at the national level do not hide worsening results in more vulnerable groups, such as Aboriginal people in remote areas.

Recommendation 3: That reporting against the Closing the Gap targets is broken down by region and remoteness, and that specific actions are taken to redress the very concerning outcomes among Aboriginal people living in remote areas.

Direct expenditure through Aboriginal organisations

The right to self-determination, including the ability to administer services and programs affecting our communities, is recognised in the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) and contributes to greater control and empowerment which evidence shows are critical determinants of health and wellbeing.

Directing expenditure through Aboriginal organisations will ensure that investment will deliver the best outcomes for Aboriginal people. Since the establishment of the CtG targets, increasing amounts of Aboriginal specific funding has been provided to mainstream, non-Aboriginal service providers which has undermined the effectiveness of overall expenditure.

An independent review of the 2014 Indigenous Advancement Strategy (IAS) showed both the administration and policy direction of this competitive grants process to be significantly flawed. The IAS was found to have disadvantaged Aboriginal and Torres Strait Islander organisations, failed to recognise the enhanced outcomes from Aboriginal led service delivery, and failed to distribute resources effectively to meet regional or local needs (ANAO 2017).

We know that competitive grants funding does not work for Aboriginal service delivery. In fact, it is our experience that increased competition usually leads to suboptimal outcomes by; undermining the effectiveness of individual services; reducing service integration and increasing fragmentation; and weakening existing relationships and knowledge. A refreshed CtG Strategy must acknowledge this and allocate investment wherever possible to Aboriginal-controlled services.

In the health sector, the Aboriginal community controlled model of delivering comprehensive primary health care provides a number of significant additional benefits that are not provided through government, not-for-profit and private sector providers. These benefits considerably add to the cost-effectiveness of investment in ACCHSs, both in terms of the quality of service provision as well as in relation to broader health and health-related outcomes. These benefits include:

- The ACCHSs model engages the community in governance structures and contributes to community and individual self-reliance, participation and control. These factors are known to have positive health and community wellbeing outcomes (Chandler and LaLonde 1998).
- ACCHSs contribute to improved performance of the broader health system in meeting the needs of Aboriginal people, through partnerships with other health professionals, organisations and government, and advocating on behalf of Aboriginal communities to inform health policies.
- The ACCHS sector is the largest employer of Aboriginal people in Australia, and provides training pathways in a range of management, administrative and health careers (NACCHO 2014).
- ACCHSs increase Aboriginal peoples' access to primary health care, including among hard-to-reach populations such as those with mental illness. Multiple studies describe a preference among Aboriginal peoples for ACCHS-delivered care, suggesting this is because it is flexible and responsive, culturally appropriate and delivered by trusted staff in a safe setting (Ibid; Vos T et al 2010).
- The ACCHSs model of comprehensive primary health care spans Social and Emotional wellbeing/mental health and alcohol and other drug services, early childhood services, family support, youth work, aged care support, dental services, and increasingly – disability service alongside clinical service delivery. This facilitates integrated and comprehensive approach to service delivery.

Recognising both the impact of control as a determinant of health, and the benefits inherent to investing in community controlled organisations as reflected above, there must be a systematic focus on increasing investment to Aboriginal controlled services wherever possible.

As noted above, ACCHSs can deliver a wide range of services but frequently are frustrated that mainstream providers are funded in preference. In order to provide holistic services, some ACCHSs will need capacity development so that they can build up the range of services that they provide over time.

Recommendation 4: That COAG adopt a policy to guide allocation of Closing the Gap related funds that recognises Aboriginal Controlled organisations as preferred providers of services to Aboriginal people, and which incorporates capacity development for these organisations where necessary.

Establish joint responsibility and commitment to outcomes

Achieving outcomes for Aboriginal people in line with the CtG targets will require a clear and consistent approach across levels of government. Currently there is a lack of transparency regarding Aboriginal-specific expenditure and much cost-shifting occurs between the Commonwealth and State/Territory sources.

This challenge can be addressed however, by pooling all Aboriginal-specific funding allocated to meet the CtG targets, and administering it through Australian Government agencies, with Aboriginal controlled organisations as preferred providers (see above).

To be effective, this will also require the development of jurisdictional and regional implementation plans through planning structures including Australian and State/Territory government and Aboriginal peak representation, such as the jurisdictional Aboriginal Health forums. These plans must allow sufficient flexibility for local priority setting and provide for clear and transparent accountability mechanisms to ensure that money is actually spent where it is allocated.

Recommendation 5: That a policy be established whereby all Aboriginal specific funding, both Commonwealth and State/Territory, allocated to meet Closing the Gap targets is pooled to prevent cost shifting and encourage joint responsibility and commitment for achieving outcomes.

Commit to transparency and accountability

The success of a Strategy such as CtG can only be realised with robust, durable and inclusive processes for implementation and accountability. This process must be undertaken by a statutory authority and oversighted by governance structures that include strong Aboriginal and Torres Strait Islander representation, as set out in Recommendation 1.

Implementation must focus on clearly defined actions linked to the identified targets and indicators and responsibility for these actions must be well-defined. Maintaining accountability against these actions will also require accessible, accurate and meaningful data reported by all governments.

In the 2017 *Closing the Gap Report* to Parliament, the Prime Minister announced that COAG would consider expanding the role of the Productivity Commission to include an Indigenous Commissioner to lead the work of policy evaluation. This Commissioner could play an essential role in monitoring progress against the CtG targets, working closely with Aboriginal leadership.

Recommendation 6: That monitoring of Closing the Gap policies and programs should occur through a formal and ongoing process undertaken by a statutory authority and reporting to a governance body (refer to Recommendation 1) that includes strong Aboriginal and Torres Strait Islander representation.

Social and Cultural Determinants of Health

The contribution of the social and cultural determinants to the health gap is significant, with Australian research suggesting that socio-economic factors account for between one third and one half of the gap in health status between Indigenous and non-Indigenous Australians (Booth and Carroll 2005; AHMAC 2017).

These determinants are multifaceted and interrelated, meaning that true gains in the health and wellbeing of Aboriginal people cannot be achieved by targeting at any one determinant in isolation. Moreover, more than one indicator may be needed to provide a clear picture of progress on any one determinant. This reflects the need for a holistic approach under this Strategy.

AMSANT supports the continuation of the existing seven targets while also recommending the addition of new targets that can assist in providing a more holistic picture of Aboriginal health and wellbeing across the social and cultural determinants.

The targets set within the CtG framework must be consistent with the determinants of health as identified within the National Aboriginal Torres Strait Islander Health Plan (NATSIHP) 2013-23, which provides an overarching plan to achieve health equity for Aboriginal people. Alongside the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social Wellbeing, there must be clear implementation plans that are costed and fully funded.

AMSANT is aware that a significant amount of work has been done through the *My Life My Lead* consultation process to identify opportunities for strengthening approaches to the social and cultural determinants. This work must be considered alongside the determinants identified by through this consultation process. Ultimately the final selection of targets and related indicators should only be made in partnership with a formal Aboriginal leadership structure, as outlined in the first recommendation of this submission.

Control, empowerment and self-determination

Control of life circumstances and empowerment are critical determinants of health and wellbeing, underpinning the ability of individuals to participate and engage productively in the community and for communities to prosper.

The CtG Statement of Intent recognised that "crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services."

Aboriginal control is recognised in the UN Declaration on the Rights of Indigenous Peoples (UNDRIP). Article 23 protects the right to self-determination, including the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them, and as far as possible, to administer such programmes through their own institutions (UN General Assembly 2007).

Conversely, lack of control over life circumstances has been shown to cause stress and anxiety, increased feelings of frustration and is a strong predictor of morbidity and mortality (Daniel et al. 2006) and associated incidence of chronic illness (Lubkin and Larson 2013).

Similarly, experiences of racism and discrimination are a key driver of ill-health for Aboriginal Australians. It is well established that discrimination increases mental and physical ill health (Williams 2015; Pascoe 2009; Carter 2007), while also impacting on access to health services and treatment and outcomes within the health system (Cunningham et al 2005).

Lack of control for Aboriginal people over their lives is experienced at a number of levels: lack of national and jurisdictional representative institutions, lack of decision making powers at the community level and control over their life circumstances, and individual experiences of discrimination.

This reflects the need for a whole of government response to increasing the sell-determination of Aboriginal people, based on a process of decolonisation. This should include adopting policies that support; the establishment of a national representative structure; the transfer of services and programs to community controlled Aboriginal organisations; and measures to address disadvantage, inequality and discrimination, including by improving access to and quality of services for Aboriginal people.

Ultimate decisions about the many and varied discrete Aboriginal communities across Australia should be made by those communities, and the individuals who reside there, through the decision-making structures that they trust or desire.

Suggested Indicators:

- Establishment of a national representative body for Australia's First Nations people as recommended by the Referendum Council and called for in the Statement from the Heart.
- Increased control of health care, measured by number of ACCHSs and funding level, in absolute terms and as a proportion of total primary health care funding. Access could be measured through the proportion of Aboriginal people who were within a 20 minute drive from an ACCHS service, including satellite services.
- Reduced systemic racism in hospital system as measured by a set of national key performance indicators, such as:
    - Discharge summary timelines
    - Rates of sentinel procedures
    - Take Own Leave (TOL) and Leave Against Medical Advice (LAMA) rates
    - Medication dispensations
    - Cultural safety
    - Employment of Aboriginal staff including in decision making roles,
    - Documented partnerships with Aboriginal communities and their organisations

Tackling poverty and inequality

Aboriginal people today experience unacceptable levels of poverty and inequality. It is well established that the distribution of ill health across a population is strongly correlated with a social gradient, where those with lower incomes tend to be significantly sicker and die earlier than those with higher incomes (WHO 2003).

On average, Aboriginal people receive a personal income two-thirds lower than their non-Aboriginal counterparts (ABS 2016b). They are also considerably more likely to access income support payments (ABS 2016c), especially for those people in remote areas where job markets are thin, with most of these payments falling below the poverty line (ACOSS 2016).

Policies at the whole-of-population level that increase poverty or broaden the gap between rich and poor, such as reductions in income support or policies that make it difficult to access in come support – such as the punitive remote work for the dole scheme currently in place under the Community Development Program (CDP) – will disproportionately impact on Aboriginal Australians and weaken outcomes against targets in other areas. It is therefore important that government policies to reduce poverty among the entire population are seen as important contributors to the CtG Strategy.

Life expectancy remains a useful measure of the overall state of inequality between Indigenous and non-Indigenous Australians. It is extremely concerning that between 2005–2007 and 2010–2012 in the Northern Territory, life expectancy of Indigenous females actually decreased from 69.4 to 68.7 years, compared to an increase for non-Indigenous females, from 81.0 to 83.1 years (AHMAC 2017).

Recent research has also shown that the gap in life expectancy is growing within the Aboriginal population between those who live in remote areas and those who live in regional and urban areas (Markham and Biddle 2016). It is vital that any measure of life expectancy is able to capture these factors so that we can better understand where resources need to be targeted under the Strategy.

Suggested Indicators:

- Life expectancy measured both in absolute terms and as a proportion of the population, and separated for urban, regional and remote status.
- Median household and personal income
- Use of citizenship entitlements in the form of income support and unemployment rates.

Strengthening culture and language

Culture is a universal aspect of human societies that gives meaning and value to individual and collective existence. Connection with culture, language and country (and its manifestation as cultural identity) are protective factors that provide powerful moderating effects against the impacts of racism and discrimination, and provides a foundation for stronger communities and healthier lives.

However, for marginalised minorities, such as Aboriginal peoples in Australia, suppression of the ability to practice and maintain culture is associated with historical and ongoing experiences of trauma, disempowerment and destructive coping practices such as substance misuse, the effects of which can be transmitted across generations (Nadew 2012). Conversely, supporting and nurturing culture and language have been demonstrated to act as protective factors against ill health and should therefore been seen as an important enabling mechanism to achieve the CtG targets.

Aboriginal youth in remote areas who speak an Indigenous language are less likely to experience risk factors associated with poor wellbeing (ABS 2011a). Bilingual education programs have also been shown to create a strong link between the community and its culture, and decrease the alienation felt by Indigenous students in schools where teaching is by members of the dominant community and takes place in a language which is not the students' mother tongue (Simpson et al 2009).

Living on and accessing ancestral lands is also associated with better health and wellbeing. Australian research suggests that people who live in decentralised remote communities and outstations are healthier (Rowley et al. 2008). Census data also shows that a higher proportion of Indigenous people in remote areas reported feeling happy some or most of the time, compared with those in non-remote areas, and that in remote areas, feeling happy was associated with engagement in cultural activities (ABS 2011b).

Suggested Indicators:

- Proportion of Aboriginal people reporting that they speak an Aboriginal language
- Identification with a clan, tribal or language group and/or participation in cultural events, ceremonies or organisations.

Early Childhood Development

Extensive research over many years has provided evidence that the early years of life are fundamental to both the physical and emotional health of children, for their social and cognitive development, and for later educational achievement and life chances (Center on the Developing Child at Harvard University 2010, CDC 2013).

Furthermore, investment in early childhood development have been recognised by the OECD as the single most important thing Australia can do to grow its economy and be competitive in the future (Hutchens 2016).

Adverse childhood events have been causally linked to poorer long-term outcomes in terms of health, education and employment. It is concerning therefore that data from the Australian Early Development Census (AEDC) demonstrate that Aboriginal children, particularly in remote areas, have very high rates of vulnerability across the five AEDC domains. In some communities, up to 40% of Aboriginal children are vulnerable on two or more domains at school entry (AEDC 2015).

Importantly however, it has also been well documented that intervention in early childhood can improve long-term outcomes across a range of areas including education, employment, health and wellbeing (Center on the Developing Child at Harvard University 2016).

Access to quality early childhood development services for Aboriginal families is therefore critical to addressing disparity as well as improving the long-term determinants of health and wellbeing.

Suggested Indicators:

- Mortality and hospitalisation rates for Aboriginal children under five
- AECD results measures at a regional level disaggregated by Aboriginality
- Participation in evidence-based early learning programs.

Education

All schools should implement evidence-based teaching including individual student plans that identify the learning needs of each student and require teachers to adapt their teaching, track individual progress and provide feedback and additional support if needed to the student (Goss and Hunter 2015).

In line with the need to strengthen control and empowerment as a key determinant of health, evidence from research examining schooling and education has found that projects characterised

by a high degree of Aboriginal involvement and control produced significant benefits for participants, and that engaging parents in children's learning was of critical importance (Closing the Gap Clearinghouse (AIHW, AIFS) 2013).

Similarly, prioritising Aboriginal employment in schools has also been demonstrated to be essential in increasing overall Aboriginal involvement and cultural competency and responsiveness within schools (Perso 2012). Furthermore, International and Australian research indicates better educational outcomes for children learning at school initially in their first Indigenous language (Commonwealth of Australia 2012).

While standardised tests such as NAPLAN have a role in assessing student learning, these kinds of tests are not refined enough to make decisions around improving learning outcomes. In order to measure gains against the CtG targets for education, there is a need to measure how children are progressing across a range of attributes that will engage them in school, and assist them to be more confident and successful students. Collection of the right data could be used to inform practice and to continuously improve performance of schools (Dreise 2016).

Improving adult literacy is also critical to addressing drivers of disadvantage and to developing fundamental literacy practices within families, which then support children to better engage and perform well at school.

Formal adult literacy courses are often successful for individuals, but there is also need for support of population-level campaigns, such as the Literacy for Life model, which is able to reach much larger numbers of people and build a culture of community literacy that supports all people to value learning (Boughton et al. 2011).

Suggested Indicators - early childhood:

- AECD scores
- NAPLAN scores for basic writing and literacy up to year 3
- Development of a more culturally appropriate and holistic test of educational progress for Aboriginal students.

Suggested Indicators - schooling and higher education:

- Detailed performance measures through a broader range of assessments at primary and high school.
- Year 12 attainment
- Numbers of Aboriginal people completing higher education, including TAFE.

Suggested Indicators – adult education:

- Adult literacy levels
- Enrolment in adult literacy courses/campaigns

Housing

Overcrowding and poor living conditions are unacceptably common in Aboriginal communities, particularly in remote areas, and have a wide range of health social and wellbeing consequences, including:

- Impact on physical health especially through the incidence of communicable diseases and common infectious and parasitic conditions, which contribute to poor growth and development, while also exacerbating existing chronic disease (Bailie and Wayte 2006)
- Reduced mental health and social and social and emotional wellbeing including family and domestic violence (AIHW 2011, Bailie & Wayte 2006)
- Reduced early childhood development and school attendance (Silburn et al. 2014)
- Increased smoking related illnesses related to exposure to tobacco smoke (Thomas and Stevens 2014)
- Increased respiratory illnesses due to exposure to particulates from wood fires for cooking, dust unsealed roads etc. (Clifford et al. 2015).

In 2008, over half of all Aboriginal Territorians (57%) were living in overcrowded houses (ABS 2016). Despite significant government programs delivering new and refurbished housing in remote communities in the NT, including the Strategic Indigenous Housing and Infrastructure Project (SIHIP), National Partnership Agreement on Remote Indigenous Housing (NPARIH), levels of overcrowding have improved only slightly to 52% (Ibid). This is mainly due to the rate of building new houses falling behind population increases and attrition of existing housing stock.

In addition, there are high rates of housing of unacceptable standard in the NT (30%) with 18% of people not having access to facilities for washing clothes and bedding, 19% of people not having access to facilities for cooking food and 5% not having access to adequate working toilet facilities (AIHW 2017).

AMSANT welcomes the Commonwealth Government's recent commitment to provide $550 million over five years to support remote housing in the Northern Territory, and were pleased to hear Senator Scullion's statement that "our focus will be ensuring Aboriginal community control is at the heart of our investment." This is a promising start but will not go far enough to providing the estimated 4,500 additional three bedroom houses needed by 2028 in the NT in order to address current housing shortfalls and the health and wellbeing impacts of overcrowding (Commonwealth of Australia 2017).

Land tenure reforms introduced by the Commonwealth Government removed Aboriginal control as a consequence of passing ownership and control of housing from Aboriginal community-controlled organisations to state public housing authorities. This is in contravention of the right to administer housing and other programs that is afforded under Article 23 of the UN Declaration on the Rights of Indigenous Peoples.

Suggested Indicators:

- Rates of overcrowding at a regional level
- Rates of adequate housing, measured by ability to wash clothes and people, store and cook food and with working toilet facilities.

Employment

Participation in employment significantly impacts on health, social and emotional wellbeing and living standards for individuals, families and communities (Bambra 2011). Employment and job security can also have negative impacts on health, including the level of psychological stress and anxiety caused by the lack of control over one's work, work demands, job insecurity, unemployment and financial pressures.

In 2012-13, the employment rate for Aboriginal people in the NT aged 15–64 was 44%, however, in remote areas the employment rate was only about 35% (ABS 2016). Long-term unemployment was higher for Indigenous Australians living in remote areas (42% of unemployed persons) compared with those living in non-remote areas (29% of unemployed persons) (AIHW 2014).

Strategies to improve employment outcomes for Aboriginal people, particularly in remote areas, should be incorporated in the CtG Strategy. This should include reform of the Community Development Program (CDP) to enable greater participation of Aboriginal community organisations, with a greater focus on job creation through social enterprise development and locally relevant economic development[2] (APO NT 2017). There are serious concerns that this program is currently exacerbating poverty and food insecurity as a result of unreasonable compliance requirements and financial penalties, and increased disengagement with the program (Jobs Australia 2016).

Suggested Indicators:

- Unemployment and participation rates.

Law and Justice

Justice reinvestment is increasingly being recognised as a real alternative to overly punitive and ineffective approaches for Australian communities seeking to tackle problems around offending and incarceration and should be considered as a key approach to reducing incarceration rates under the CtG Strategy.

The basic premise behind justice reinvestment is that funds for imprisonment should be diverted to local community services in order to address the underlying causes of crime, lessening the future incidence and impacts of crime and incarceration.

[2] For more information see: http://www.amsant.org.au/apont/remote-employment/

These kind of preventative and diversionary approaches are is needed particularly in the area of youth justice, where young Aboriginal people are held in criminal detention at significantly higher rates than their non-Aboriginal counterparts (AIHW 2015). A preventative approach to youth justice would see increased investment in; identifying 'at risk' children and families to provide them with the support and interventions they need; and strengthening protective factors, including culture, language and connection to land, within communities.

The recent *Royal Commission into the Protection and Detention of Children in the NT* revealed that there is a need to transform the youth justice system away from current punitive approaches to a therapeutic approach that acknowledges the underlying causes of offending for young people, and effectively facilitates healing and rehabilitation.

Suggested Indicators:

- Reduced numbers of Aboriginal people in criminal detention, with rates of children and young people in detention measured separately, both in absolute numbers and as a proportion.

Alcohol

Harmful alcohol consumption is associated with a wide range of physical and mental health problems and contributes to social problems such as crime, violent and anti-social behaviour, increased incarceration rates, family breakdown and violence, unemployment and impoverishment.

Approaches to tackling alcohol-related issues should be focussed on reducing availability and increasing the minimum or floor price at the population-level. Such approaches have shown to be effective in reducing consumption amongst disadvantaged and young populations (Stockwell T. et al. 2012), and preventing FASD (National Indigenous Drug and Alcohol Committee 2012). Screening early intervention and access to treatment are also an essential element of an effective response.

Suggested Indicators:

- Reduced population level alcohol consumption and related harms, measured by a range of regional indicators, separated by Indigenous status wherever possible. Indicators could include:
    - apparent per capita consumption,
    - hospital separations for alcohol-related conditions,
    - alcohol-related deaths,
    - proportion of population consuming alcohol at risky and high-risk levels; and
    - estimated acute and chronic hospital separations attribute to risky and high-risk drinking.

References

Aboriginal Peak Organisations NT (APO NT) 2017, *Fair Work and Strong Communities: Proposal for a Remote Development and Employment Scheme.*

Australian Bureau of Statistics (ABS) 2011a, Education and Indigenous Wellbeing, 4102.0 - Australian Social Trends. Australian Bureau of Statistics, Canberra.

Australian Bureau of Statistics 2011b, *Census of Population and Housing, 2011*. Australian Bureau of Statistics, Canberra

Australian Bureau of Statistics (ABS) 2016a, Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians, 2016. Accessed 12/04/18 http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2075.0Main%20Features202016?opendocument&tabname=Summary&prodno=2075.0&issue=2016&num=&view=

Australian Bureau of Statistics (ABS) 2016b *Census 2016: what's changed for Indigenous Australians?*

Australian Bureau of Statistics (ABS) 2016c, *National ATSI Social Survey*

Australian Council of Social Services (ACOSS) 2016, *Poverty in Australia 2016*. ACOSS

Australian Early Development Census (AEDC) 2015, *AEDC data explorer*, Australian Early Development Census, Commonwealth of Australia. https://www.aedc.gov.au/communities/accessing-community-results

Australian Health Ministers' Advisory Council (AHMAC) 2017, *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, Canberra

Australian Institute of Health and Welfare (AIHW) 2011, *Australian Burden of Disease Study: Impact and causes of illness and deaths in Australia 2011.* AIHW

Australian Institute of Health and Welfare (AIHW) 2014, *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, AIHW Canberra

Australian Institute of Health and Welfare (AIHW) 2015, *Youth detention population in Australia 2015.* AIHW

Australian Institute of Health and Welfare (AIHW) 2016, *Healthy Futures – Aboriginal Community Controlled Health Services: Report Card 2016*. Cat. No. IHW 171. Canberra: AIHW

Australian Institute of Health and Welfare (AIHW) 2017a, *Trends in Indigneous mortality and life expectancy 2001-2015*

Australian Institute of Health and Welfare (AIHW) 2017b, *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report: Northern Territory*. AIHW

Australian National Audit Office (ANAO) 2017, *Indigenous Advancement Strategy*. Report no. 35, 2016-17. Canberra: Commonwealth of Australia

Bailie RS, Wayte KJ 2006, Housing and health in Indigenous communities: key issues for housing and health improvement in remote Aboriginal and Torres Strait Islander communities. *Australian Journal of Rural Health*, Vol 14 No. 5, pp. 178-183

Bambra C 2011. Work, worklessness, and the political economy of health. Oxford University Press.

Booth A. and Carroll N. 2005, *The health status of Indigenous and non-Indigenous Australians*, Discussion Paper No. 486, Centre for Economic Policy Research, ANU, Canberra.

Boughton B et al 2011, A*n Aboriginal Adult Literacy Campaign in Australia using Yes I Can.* Literacy and Numeracy Studies, Vol 21 No 1, pp. 5-32.

Carter R T 2007, Racism and psychological and emotional injury: Recognising and assessing race-based traumatic stress. *The Counselling Psychologist*, pp.13-105 doi: 10.1177/0011000006292033.

Center on the Developing Child at Harvard University 2016, *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families*. www.developingchild.harvard.edu

Chandler M. and LaLonde C. 1998, *Cultural Continuity as a Hedge Against Suicide in Canada's First Nations.* University of British Columbia, Vancouver.

Closing the Gap Clearinghouse (AIHW, AIFS) 2013, What works to overcome Indigenous disadvantage: key learnings and gaps in the evidence 2011-12. Produced for the Closing the Gap Clearinghouse. Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies, Canberra.

Commonwealth of Australia 2017, *Remote Housing Review: A review of the National Partnership Agreement on Remote Indigenous Housing and the Remote Housing Strategy (2008-2018).* Department of Prime Minister and Cabinet.

Commonwealth of Australia 2012. *Our Land Our Languages: Language Learning in Indigenous Communities.* House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, Canberra.

Cunningham J, Cass A and Arnold PC 2005, *Bridging the treatment gap for Indigenous Australians. Demans for efficiency should not be met at the expense of equity.* Medical Journal of Australia, Vol. 182 No. 10, pp. 505-6.

Daniel M, Brown A, Garnggulkpuy Dhurrkay J, Cargo MD and O'Dea K 2006, *Mastery, perceived stress and health-related behaviour in northeast Arnhem Land: a cross-sectional study*. International Journal for Equity in Health Vol. 5 No. 10.

Dreise T 2016, *Closing the Gap: Indigenous students and NAPLAN.*

Goss P and Hunter J 2015, *Targeted Teaching: how better use of data can improve student learning.* Grattan Institute, Carlton.

Hutchens G 2016, OECD: G20 Commitment to boost GDP by 2 per cent in doubt, in *The Age.*

Lubkin IM and Larson PD 2013, *Chronic Illness: Impact and Intervention*. Jones and Bartlett Learning, Burlington MA, USA.

Markham F and Biddle N 2016, *Income, poverty and inequality.* 2016 Census paper 2. CAEPR, ANU, Canberra

Nadew GT 2012*, Exposure to traumatic events, prevalence of posttraumatic stress disorder and alcohol abuse in Aboriginal communities.* Rural and Remote Health 12: 1667.

National Aboriginal Community Controlled Health Organisation (NACCHO) 2014, *Investing in Aboriginal Community Controlled Health Makes Economic Sense.* NACCHO

Pascoe EA. and Richman SR. 2009, Perceived Discrimination and Health: A Meta-Analytic Review, *Psychological Bulletin*, Vol 135, No 4, pp 531-554

Perso TF 2012, *Cultural Responsiveness and School Education: With particular focus on Australia's First Peoples; A Review and Synthesis of the Literature*. Menzies School of Health Research, Centre for Child Development and Education, Darwin Northern Territory.

Productivity Commission 2017, *Indigenous Expenditure Report*. Steering Committee for the Review of Government Service Provision

Rowley K. O'Dea K. Anderson I. McDermott R. Saraswati K. Tilmouth R. Roberts I. Fitz J. Wang Z. Jenkins A. Best J. Wang Z. and Brown A. 2008, 'Lower than Expected Morbidity and Mortality

for an Australian Aboriginal Population: 10-year follow-up in a decentralised community', *Medical Journal of Australia*, vol. 188, no. 5, pp. 283–7.

Silburn S, McKenzie J, Gutheride S, Li L and Li SQ 2014, *Unpacking Educational Inequality in the Northern Territory.* 2009 - 2017 ACER Research Conferences*. 5.*

Simpson J, Caffery J and McConvell P 2009, *Gaps in Australia's Indigenous language policy: dismantling bilingual education in the Northern Territory*. AIATSIS Research Discussion Paper No. 24.

Thomas DP, Stevens M 2014 Aboriginal and Torres Strait Islander smoke-free homes, 2002 to 2008. Australia and New Zealand Journal of Public Health. 38: 147-153.

UN General Assembly 2007, *United Nations Declaration on the Rights of Indigenous Peoples: resolution / adopted by the General Assembly*, 2 October 2007

Vos T et al 2010, *Assessing cost-effectiveness in Prevention (ACE-Prevention): Final Report,* ACE Prevention Team: University of Queensland, Brisbane and Deakin University, Melbourne

World Health Organisation (WHO) 2003, *The Social Determinants of Health: The Solid Facts*. Wilkinson R and Marmot M (eds) WHO

Williams MT. 2015, *The Link Between Racism and PTSD*. Viewed online on 22/01/2018 at https://www.psychologytoday.com/blog/culturally-speaking/201509/the-link-between-racism-and-ptsd