



Productivity Commission Issues Paper Expenditure on children in the Northern Territory

Danila Dilba Health Service Response

Overview

Danila Dilba Health Service (DDHS) is aware of and supports the detailed submissions prepared by the Aboriginal Medical Service Alliance of the Northern Territory (AMSANT) and the National Aboriginal Community Controlled Health Organisation (NACCHO). This submission seeks only to supplement those submissions based on the experience of DDHS in service delivery and in leading elements of advocacy in relation to the Royal Commission into the Protection and Detention of Children in the NT (the Royal Commission).

About Danila Dilba

DDHS was established in 1991 as an Aboriginal Community-Controlled Health Organisation (ACCHO) providing comprehensive Primary Health Care (PHC) and community services. DDHS currently employs approximately 180 staff and has seven General Practice Clinics in Darwin CBD, Malak, Rapid Creek, Bagot, Fannie Bay and Palmerston. In 2017-18 Danila Dilba provided 55,712 episodes of care and had 7,915 regular clients. As part of our 'whole of life' approach our services include:

- Targeted clinical care for children, women and men's health including outreach services through our mobile clinic and visits to clients in Residential Aged Care Facilities
- Delivering the Australian Nurse Family Partnership Program which facilitates Nurse home visits for pregnant women with an Aboriginal and/or Torres strait islander child from 16 weeks gestation through to 2 years of age
- Specialist and allied health care
- Care coordination for clients with chronic disease and complex health needs
- Social-emotional wellbeing, mental health counselling and support services
- Drug and alcohol services
- Youth programs - school based health education and youth support inside Don Dale Youth Detention Centre

- Darwin has a substantial transient population of people from remote communities often 'living rough' in the area. DDHS provides services to approximately 2500 to 3000 'transient' clients each year.

Danila Dilba programs in child and family services

From children and families at risk through to children and young people in detention, our Health Service works with children and families every day. The NT Aboriginal Health Forum's Core Function of Primary Health Care clearly places child and family services within the remit of PHC.¹ Through our 7 clinics, our mobile team, our community services programs, the ANFPP program and the Don Dale youth support program, we have reached a scale of service where we successfully coordinate integrated care to children and families at both a universal and a targeted level with referrals to programs both within and external to DDHS.

Since 2015, DDHS been actively involved in advocating for reform of the Youth Justice and Care and Protection Systems following the revelations of abuse inside Don Dale and the 227 recommendations made by the Royal Commission which followed. DDHS has been a member of the Legislative Amendment Advisory Committee (LAAC) which was the manifestation of the current Northern Territory Government's commitment to 'co-design' of legislation and policy in partnership with the NGO providers in the sector.

Since 2015 DDHS has also been providing the Youth Social Support program in the Don Dale Youth Detention Centre and is in transition to take over the role of Primary Health Care provider within the facility.

As outlined in the NACCHO submission, as our organisation continues to scale and its remit grows, the network benefit of referring clients to services within our organisation will provide for more efficient delivery of services compared with the current fractured model of small, disconnected service providers.

Principles

The system of provision of services to Aboriginal children and families in the NT should be based on the following principles which were included in those proposed by Aboriginal Peak Organisations NT in its response to the Royal Commission:

- Aboriginal-led and trauma informed solutions which are child and family focused and culturally strengthening.
- Poverty and intergenerational trauma are key determinants of children entering the child protection and youth justice systems.
- A public health model to be adopted for child development, youth justice and child protection.
- The Aboriginal community controlled sector has a leading role in service delivery, particularly in prevention, and early intervention.

¹ Tilton, E., and Thomas, D. (2011) Core functions of primary health care: a framework for the Northern Territory. Northern Territory Aboriginal Health Forum

- Services must be available equitably Territory-wide to meet the needs of young people and communities.
- The Commonwealth and NT governments must work cooperatively to address the recommendations of the Royal Commission and accept and fulfil their respective funding responsibilities.
- The child protection and youth justice systems must ensure every opportunity is given to young people to maintain their connection to family, community, culture, language and country.²

NT Context

Any evaluation of expenditure on children and family services cannot take place without a solid grounding in the unique context of the Northern Territory.

By age 10, 4 in 10 Aboriginal Children born each year are expected to be the subject of at least one notification to Territory Families.³ For almost half of these notifications, 'neglect' has been identified as the type of harm the child is suffering.⁴ The Royal Commission into the protection and detention of children noted that the life opportunities of children in the Northern Territory are 'compromised by a complex layering or pervasive disadvantage, poverty, overcrowding, poor parenting, mental health issues, substance misuse and family and community violence.'⁵ These causes and social determinants cannot be uncoupled from the history of colonial settlement and the multiple traumas resulting from dispossession, nor can solving the issue be isolated from the broader task of decolonising relationships between indigenous people and Anglo-Australian society.

Using current data, a typical Aboriginal family in the Northern Territory may experience:⁶

- Overcrowded housing – 53% of Indigenous households in the NT are overcrowded compared to 8.7% of non-Indigenous households.
- Low household income – Indigenous households in the NT have a median household income of \$430 per week compared to \$1,247 for non-Indigenous households. The gap between Indigenous and non-Indigenous is significantly wider than any other state and Indigenous households in the NT have the lowest median income compared to every other state.
- Likely to be reliant on pensions or benefits – Indigenous Australians nationally are almost three times more likely to rely on benefits (60%) than non-Indigenous (21%). This brings a range of additional stresses related to Centrelink requirements including frequent reporting, basics card and the risk of breaches.
- Death and associated grief and loss – Indigenous families are dealing with death in the family and the community at much higher rates than other Territorians. The all-

² APONT. (2017). Principles and Priorities for Implementation of the Royal Commission Recommendations. Retrieved from <http://www.amsant.org.au/apont/wp-content/uploads/2018/01/20181218-APO-NT-Position-Paper-Final-18-Dec-17.pdf>

³ Royal Commission

⁴ RC 3A, 198.

⁵ RC 3A, 197.

⁶ 2017 Health Performance Framework Report (AHMAC, 2017).

cause mortality rate for Indigenous Territorians (1,519 per 100,000) is almost three times the rate for non-Indigenous Territorians (581 per 100,000) and significantly higher than for Indigenous Australians nationally (991 per 100,000).

- In particular, Indigenous Australians are twice as likely as non-Indigenous Australians to die as a result of intentional self-harm.
- Psychological distress – Indigenous Territorians report high levels of distress at more than double the rate (22%) of that reported by non-Indigenous Territorians (8%).
- Challenging child characteristics – low birth weight remains high and one estimate suggests that up to 40% of children on Protection Orders had experienced prenatal alcohol exposure (in some locations this exposure was up to 88%) and 86% of children on Protection Orders had been affected in various ways by parental alcohol use.⁷

Scope of Inquiry

The discussion paper poses the question ‘What services and programs should we look at?’ While it is possible to cast a very wide net in terms of the range of services and programs that are relevant to the safety and wellbeing of children, it would be unproductive to take too wide an approach. In terms of the scope of this inquiry, it would be wise to focus on those services and programs that sit close to the causes of poor outcomes for Aboriginal children. A public health approach looks to the social determinants of children and families needing support, assessing not just the services being offered by why those services are needed and if they are the most effective and efficient services to improve the inequity in this outcome. It is important to consider if there are more effective alternatives that prevent the need for secondary and tertiary interventions all together.

An incomplete picture

Census and population level data is incredibly valuable to decision makers and service providers in the targeting and evaluation of services. There is, however, currently a dearth of credible information and research into the demographic trends, patterns of mobility and migration, including the motivation for and period of relocation into, out of and between communities and regional services centre in the Northern Territory.⁸ It has been noted previously that Census methodology is likely to significantly undercount the population in remote communities, partly driven by the time of year when the census is undertaken coinciding with the dry season in Top End and travel associated with community sports carnivals in the south.⁹ All levels of government should commit to jointly funding research that identifies trends in Aboriginal demographics and mobility in remote communities with a view to establishing a more rigorous data set. An example could be a data linkage between government agencies including Centrelink, NT Housing and other service providers to produce up-to date information on remote populations.

⁷ Walker, P. (2013). Prenatal Alcohol Exposure among Children in the Child Protection System in the Northern Territory. Australasian Fetal Alcohol Spectrum Disorders Conference.

⁸ Ibid, 8.

⁹ Ibid.

Research on what services work for children and families

Emerging research on services for children and families at risk and in need of support has highlighted the need to consider the known risk factors for child maltreatment in a way that acknowledges the historical context, are culturally "safe" and emphasise support for families.¹⁰

Further evidence of 'what works' has revealed the following features that characterise successful community managed programs:¹¹

- the community has ownership of and control over decision-making;
- culture is central to the program, including an understanding of local context, history and community leaders;
- local Indigenous staff work on the program or in the organisation;
- good corporate governance exists;
- Indigenous staff are working on programs and existing capacity is harnessed;
- trusting relationships with partners are established;
- flexibility in implementation timelines.

The public health approach

The Issues paper outlines that a key focus 'will be on improving decision making about how money is spent, rather than how much is provided.'¹² The issues paper discusses the importance of a public health approach therefore it will be important to consider what a public health approach looks like in the context of children and family services.

The AMSANT submission canvasses the public health approach in considerable detail. Danila Dilba strongly supports the adoption of a public health approach to child safety, wellbeing and youth justice. There is a large body of evidence about the social, family and structural factors that put a child or young person at risk of contact with youth justice or child protection. These factors can be modified through interventions at the primary, secondary and tertiary levels. The evidence of this application is well summarised by Higgins in his paper for the Closing the Gap Clearinghouse.¹³

The National Framework for Protecting Australia's Children 2009-2020 encapsulates the value of moving to a public health model by noting that in 2007-08, there were 317,526 reports to child protection services in Australia. The Framework explains that the vast majority of these reports were not substantiated and in most cases led to no action. It goes on to note that other forms of support and referrals would have been a more appropriate response.¹⁴ The evidence suggests that this is the case in the NT and that better outcomes

¹⁰ Higgins, D. J. (2010). Community Development Approaches to Safety and Wellbeing of Indigenous Children. A Resource Sheet Produced for the Closing the Gap Clearinghouse. Australian Institute of Health and Welfare.

¹¹ Morley, S. R. (2015). What works in effective Indigenous community-managed programs and organisations. Melbourne: Australian Institute of Family Studies.

¹² Issues paper, 2.

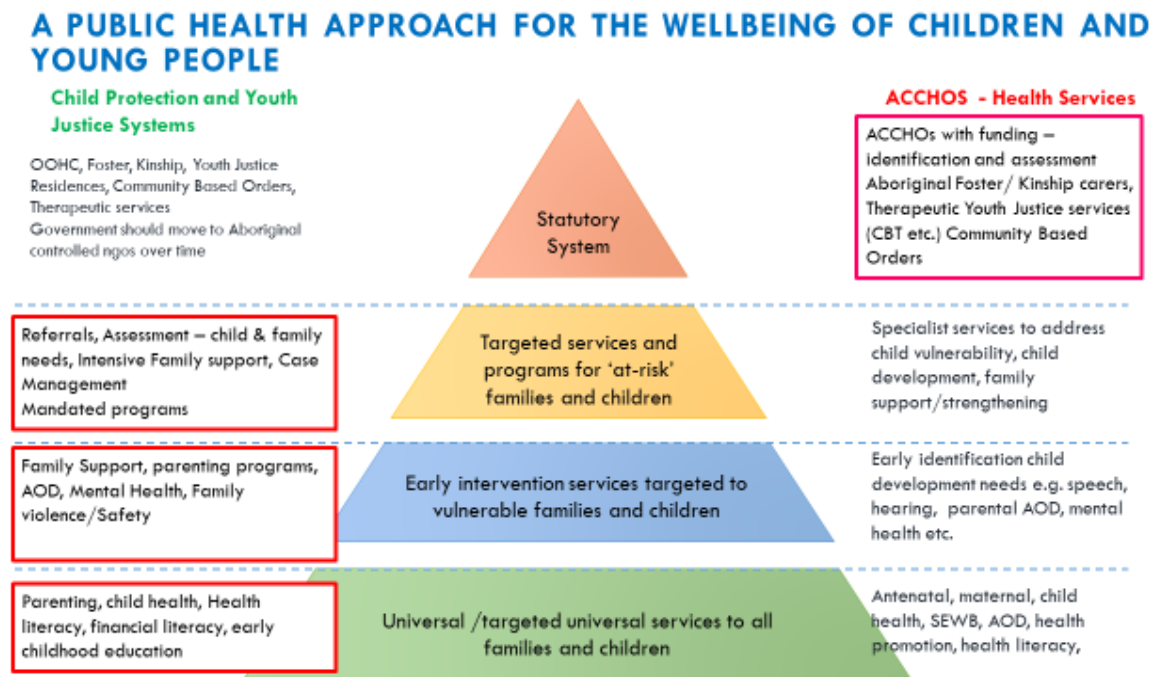
¹³ Higgins, D. J. (2010). Community Development Approaches to Safety and Wellbeing of Indigenous Children.

¹⁴ COAG. (2009). Protecting children is everyone's business : National Framework for Protecting Australia's Children 2009-2020 : an initiative of the Council of Australian Governments. Canberra: Dept. of Families, Housing, Community Services and Indigenous Affairs.

could be achieved for families with improved universal supports and secondary prevention where it is apparent that a family has risks for poor outcomes.

DDHS has developed the following representation of a public health approach to child protection and youth justice identifying service types at each level including those that are or can be delivered by Aboriginal Community controlled health services:

Figure 1

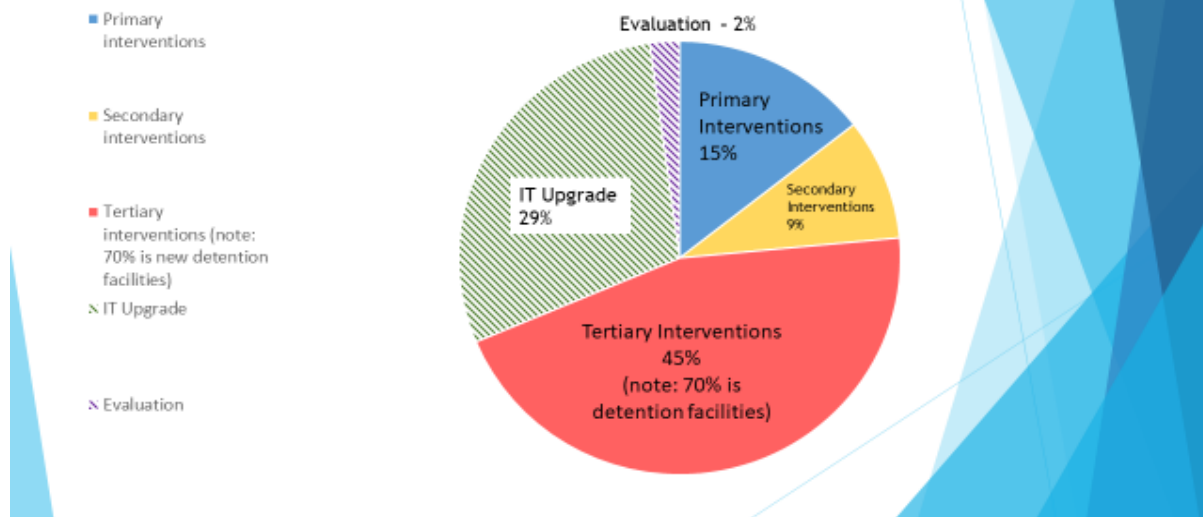


The Northern Territory Government has committed to the public health approach and makes statements to this effect in *Safe, Thriving and Connected* the initial implementation plan for its Royal Commission response. However, a shift to a public health approach will require a shift of resources towards the universal and targeted universal parts of the system response. This shift is not yet evident in the NT. This Inquiry should examine in detail the scope to achieve that shift in a timely way.

Safe, thriving and Connected demonstrates a level of commitment to moving towards a public health approach. However, the allocation of new funding over a five year period under the plan does not take significant steps towards that commitment. DDHS analysis of the expenditure allocated under the plan suggests that only a small proportion of the additional funding committed will contribute to either the primary or secondary prevention layers of a public health approach. The vast majority of the funding is shared across tertiary initiatives and IT infrastructure. The Productivity Commission may wish to examine the detail of these commitments and the opportunities to begin a stronger shift in the balance of expenditure.

Figure 2:

NT Government expenditure - Implementation Plan



Across the Children and Family services landscape, the Commission should be guided by **the public health approach** in defining the scope of the study. APONT published a Background Paper in late 2017 that detailed the services that would be expected and valuable within a public health approach to youth justice and child protection. The framework proposed by APONT is detailed below. This framework would provide useful guidance to the commission regarding scope of the study. The APONT paper proposed that a public health model in child protection and youth justice would feature:

- **Universal interventions** - approaches aimed at large groups or the general population, such as:
 - Ante natal care
 - Child health services
 - Income support
 - Universal parenting programs and education
 - Violence prevention curricula in schools
 - Positive activities for young people,
 - Community-wide media campaigns.
- **Secondary interventions** - approaches for those with heightened risk, such as:
 - Intensive family support for families that come to the attention of child protection
 - Social and emotional wellbeing support for parents and children showing risk factors
 - Targeted parenting skills education

- Interventions for young people coming to police attention and their families
- Practical skills in money management, nutrition, homemaking
- Programs for young people – school engagement, drug and alcohol services, behavioral self regulation.
- **Tertiary interventions** – approaches that target “treating” the problems once they have occurred to lessen their impact and facilitate a return to a positive situation. Examples might include:
 - Intensive interventions for families whose children have been removed
 - Intensive interventions, family therapy, anger management, drug and alcohol services for families at imminent risk of child removal or with young people who are offending
 - Orders that require parents and young people to participate in programs to address their parenting issues and, for young people, their offending.
 - Excellent quality, culturally safe care for children who need to be removed from families incorporating therapeutic services.
 - Formal sentencing for young people who have offended including community service orders, diversion or detention. But these interventions must include therapeutic, trauma informed care and be oriented to improving the wellbeing of the young person and his/her capacity to participate safely in society and reduce the likelihood of further offending. (APONT, 2017)

Current resource allocation Issues

In 2017-18, a total of \$137m was spent on Out of Home care services, \$25m on Protective intervention services, \$4.8m on Intensive family support services and \$45.8M on Family Support Services in the NT.¹⁵ Spending on Out of Home Care Services constituted around 65% of all spending on Children and Families in the ROGS definition of ‘Child Protection’ services.¹⁶ More importantly, spending on Out-of-Home care services have expanded consistently each and every year since 2008/09. Spending in OOHC is now 3 times what it was in 2008/09, despite the number of children in OOHC doubling over the same period.¹⁷ It is clear that current resource allocation is weighted towards the ‘tertiary/statutory’ system. DDHS does not believe that the system or the current resource allocation reflects that of a ‘Public Health’ approach as outlined above.

DDHS has been particularly concerned about the costs of certain OOHC placement types. A review of the Territory Families Annual Report for 2017-18 reveals that certain placements attract disproportionately high resource allocation. For example, in 2017-18, a total of 1061 children were in Out of Home Care, the breakdown of children in each placement type was as follows;¹⁸

- Foster: 288
- Kinship Care: 223
- Purchased Home Based Care: 358

¹⁵ Review of Government Services 2019, Child Protection Services, Table 16A.7.

¹⁶ Ibid.

¹⁷ ROGS 2019, 16 Child Protection, Table 16A.2.

¹⁸ TF Annual report, 29.

- Residential Care: 119
- Other Care types: 73

Importantly, the number of children in purchased home based care has grown by about a third since 2014 despite the total number of children in OOC remaining stable. The costs of Purchased Home Based care are high and funding to external parties reveals that a total of \$27.5m was spent on Purchased Home Based Care resulting in a cost per child of \$76,600 per annum. The vast majority of Purchased Home Based care funding is provided to non - Aboriginal NGOs. We also have concerns over the structure and transparency of the arrangements between the NGOs and the individuals providing care in this placement type. Some organisations funded to provide this placement type require their carers to supply an ABN and 'operate a small business from their home'.¹⁹ There is also a lack of transparency over the identity and qualifications of the 'small business' the NGO has placed a child with. The assessment team from Territory Families does not assess the carer prior to placement in this placement type. Instead the appropriateness of the placement for the child has been determined by the NGO.

The monetisation of the OOHC sector in the territory has not created better outcomes for children and is an inefficient and ineffective model to look after children in need of care and protection. We suggest the Commission evaluate how investment in the recruitment, assessment and training of kinship carers compares with the costs of Purchased Home Based Care and other models. We also believe there should be a thorough review into the appropriateness of placements made through Purchased Home Based Care including what proportion of Aboriginal children have been placed with Aboriginal carers in line with the Aboriginal Child Placement Principles.

Social Determinants of Demand for Child and Family Services

Based on available evidence and on the ground observations, DDHS suggests that the Commission consider the following social determinants that are causing poor outcomes for our children:

1. The impact of **low labour force participation** among young Aboriginal men and the consequent impact on household incomes. Noting the concerns above regarding the accuracy of Census data for Aboriginal people in remote communities, according to the 2016 Census, 53.6% of the Aboriginal people over the age of 15 in the Northern Territory were considered 'Not in the labour force'.²⁰ It should be noted that programs such as the Community Development Program (CDP) have not been successful in remote communities in the Northern Territory due to a range of factors, many of which can be held in stark contrast to the factors which characterise successful programs for Aboriginal people. These issues included; poor connection with community aspirations and lack of community buy-in, complex administrative arrangements, program inflexibility and the financial penalties issued under the

¹⁹ <https://www.kentish.org.au/out-of-home-care/>

²⁰ ABS Census 2016,

https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/IQS7

CDP.²¹ In some cases the financial penalties resulted in the ‘irretrievable loss of income and in some cases leave individuals without money for essentials, including food.’²² The Commission should include consideration of services and programs that seek to improve labour force participation. These issues could be explored at a community level in the case studies proposed below.

2. Lack of access to affordable, nutritious **food**. In the NT 43% of all child protection substantiations are due to neglect.²³ It is also important to note that a disproportionate number of substantiations relate to families and children in remote and very remote areas where families are characterised with lower incomes and face high food prices.²⁴ The NT Government’s Market Basket Survey revealed that a basket of healthy food costs 60% more in remote supermarkets compared with urban supermarkets.²⁵ The higher costs, coupled with the low household incomes illustrate just one of many barriers that prevent a parent from being able to provide a child with the basic necessities to live. The Royal Commission into Protection and Detention of Children revealed that ‘poverty is often mislabelled as neglect’, with several witnesses making the observation that ‘if you don’t tackle poverty, you’re always going to be taking [Aboriginal] children away’²⁶. Services that support families to meet the basic needs of children and those that seek to ameliorate the combined impact of high food costs and low income have the potential to make a significant difference to the involvement of children in the child protection system.

Funding

Funding inappropriate providers does not build local capacity

An issue which was noted in the report by the NT Coordinator General for Remote Services in 2011 and remains relevant is that:

‘a very significant amount of funding in this sector is given to third party non-Indigenous, not-for-profit organisations who do not receive the level of scrutiny and accountability that might reasonably be expected of multi-million dollar, multi-year contracts. These third parties are not accountable to parliaments and too often are unaccountable to the communities in which they operate. Funds are being diverted to build the capital base and operational capacity of non-resident agencies rather than funding and building the skills and capabilities of local Aboriginal people and organisations.’²⁷

Central to the right of self-determination for Aboriginal and Torres Strait Islander peoples as encapsulated in the UN declaration on the Rights of Indigenous Peoples is that:

²¹ Jobs Australia. (2016). What to do about CDP?, 6.

²² Jobs Australia. (2016). What to do about CDP?

²³ RC 3A, 198.

²⁴ AIHW. (2019). *Child Protection Australia 2017-18*. AIHW.

²⁵ Northern Territory Market Basket Survey Summary Report - 2017

²⁶ RC 3A, 198.

²⁷ Report by the Northern Territory Coordinator General for Remote Services 2011-2012, page 5.

‘Indigenous peoples in exercising their right to self-determination, have the right to autonomy ... in matters relating to their internal and local affairs as well as ways and means for financing their autonomous functions.’²⁸

In line with this Article, funding for services that target, disproportionately affect or are used by Aboriginal people should build organisational capacity and governance capability for local community-controlled organisations to deliver those services. This should happen with particular focus on capacity building for small or new community-controlled organisations in remote communities.

It is well established that ACCHOs are better placed to deliver cost-effective, equitable and effective primary health care services to Aboriginal and Torres Strait Islander people.²⁹ The ACCHO model has been shown to be 23% better at attracting and retaining Aboriginal and Torres Strait Islander clients compared with other providers.³⁰ In the provision of ‘child and family services’ however, Aboriginal organisations have been historically sidelined due to their inability to compete with large non-indigenous organisations in tender processes. Only the best equipped and resourced ACCHO’s have been able to compete with these providers in recent times, predominately for service delivery in urban areas. As outlined in the NACCHO submission, services for Aboriginal and Torres Strait Islander people should be delivered by ACCHOs and further, grant conditions should facilitate the building of capacity and preference local employment in remote communities for sustainable, place-based development.

Appropriate funding sustainability for ACCHOs

As outlined in the NACCHO submission, the funding provided to NACCHOs through the Indigenous Australian Health Program (IAHP) is not structured in a sustainable manner. Established ACCHO’s have to reapply for funding every year which has follow on consequences that impair the services we can provide. Such short funding contracts are administratively burdensome for ACCHOs and result in the organisation’s only being able to offer short term employment contracts. This hampers the sector’s ability to retain key staff and plan for the future. We reiterate our call for implementation of the Productivity Commission’s 2017 recommendation for 10-year grant funding be given to Aboriginal and Torres Strait services.³¹

Overlapping Funding and Service Provision

From our experience, there is still much work to be done mapping service provision within and between funding bodies. In DDHS’ experience, Primary Health Care programs have been funded through the Northern Territory Primary Health Network (NT PHN), The NT Department of Health, Territory Families, the Commonwealth Department of Social Services

²⁸ United Nations Declaration of the Rights of Indigenous Peoples, Article 4.

²⁹ Campbell, Megan Ann, Jennifer Hunt, David J Scrimgeour, Maureen Davey and Victoria Jones. 2017. Contribution of Aboriginal Community Controlled Health Services to improving Aboriginal health: an evidence review, Australian Health Review 42(2) 218-226.

³⁰ Ong, Katherine S, Rob Carter, Margaret Kelaher, and Ian Anderson. 2012. Differences in Primary Health Care Delivery to Australia’s Indigenous Population: A Template for Use in Economic Evaluations, BMC Health Services Research 12:307.

³¹ PC. 2017a. Introducing Competition and Informed User Choice into Human Services, Report #85, Canberra

and the Department of Prime Minister and Cabinet. There is no efficient mapping of services between these funding agencies. For example, DDHS has been funded to provide Alcohol and Other Drug treatment and prevention related services though NT Department of Health, NT PHN and Territory Families. Each of these funding agencies requires different KPIs to be met and adopts different methodology in how the program is evaluated. These variations can be administratively burdensome and divert resources away from the provision of services and towards administration. Furthermore, there is also a lack of service coordination even where services are being funded through the same agency. All of these services need to be mapped to adequately assess where services are sufficient, comprehensive and effective and where they are deficient. For example, in 2011 the Commonwealth Department of Education, Employment and Workplace Relations was running 7 separate activities in Groote Eylandt focussing on school/community engagement, all at the same location, undertaken by multiple providers, and none of which were integrated.³² This highlights the need for the Commission to establish a comprehensive map of services being delivered and make recommendations on a framework for their future provision.

Community views and place-based analysis

Throughout the Discussion Paper, questions are posed regarding the best way to obtain community views on a range of issues ranging from gaining input and comment as part of this inquiry through to engaging communities in the identification of service needs and in service planning. The Commission may wish to consider in this context, the community feedback obtained by AMSANT in community consultations in 2018. The report of those consultations, while focussed on content of the discussions, also draws out the views of community members and organisations regarding ways of consulting and talking with communities. The AMSANT report on the process and findings of the consultations which can be accessed at <http://www.amsant.org.au/wp-content/uploads/2018/07/Listening-and-Hearing-are-Two-Different-Things-Final-Report-6-July-2018.pdf> The report contains important feedback from Aboriginal communities and service providers across the Northern Territory about aspects of the Commission's current inquiry. Importantly, it also contains lessons and feedback about effective engagement of Aboriginal communities through consultation.

Use of case studies

The best way to undertake the service mapping and place based analysis canvassed in the Discussion Paper is through a case study approach. Case studies should explore and document with community members and organisations the following points:

- Service needs
- Service availability
- Service gaps
- Whether referral pathways are effective

³² Report by the Northern Territory Coordinator General for Remote Services 2011-2012, 55.

- Capacity of Aboriginal controlled organisations to take an active role.

In selecting case studies, the Commission should consider several factors including:

- A mix of urban, regional and remote settings
- A mix of capacity within the community and organisations
- A mix of existing service coverage.

Considering those points, it might be helpful to look at the following suggestions for case studies:

- **Tiwi islands** as a remote area with a number of challenges including remoteness and lack of organisational capacity for service delivery. The Tiwi's also have the Communities for Children program in place. It has been subject to some commentary relating to fragmentation and duplication.
- **Tenant Creek** as there have been significant child safety concerns along with some improvements in service delivery.
- **Alice Springs** as an urban town. Services in Alice can leverage off each other across the system to ensure clear and effective referral pathways. Alice springs is also unique in having a range of early childhood services delivered in an integrated way by the community-controlled health service.
- A **remote Central Australian community** such as Yuendumu might be considered given the high rate of notifications and investigations of harm to children in the community.

We look forward to the Productivity Commission commencing its study in this important area along with the development of the 'whole-of-government evaluation strategy for policies and programs affecting Aboriginal and Torres Strait Islander Australians.