The Best Opportunities in Life

Background Document

Northern Territory Child and Adolescent Health and Wellbeing Strategic Plan 2018–2028
Acknowledgements

We wish to thank the many youth, adults and organisations (non-government and government) that have contributed to the development of this Plan.

Definitions

Please note that wherever this report refers to Aboriginal people, this is to be taken to include Torres Strait Islanders and also to mean First Peoples.

The most commonly used age groupings and the words used to describe them in this document, particularly for statistical purposes, are:

- child/children = usually 0-9; statistically and legally 0-17 years
- youth = 6 to 24 year olds
- teenagers = 10 to 19 year olds
- adolescents (as in recent research) = 10 to 24 years
- young adults/people = 18 to 24 year olds.

Target group

The main target group for this document is service organisations – both government and non-government. Other significant stakeholders are young Territorians aged 0 to 24 years, families and communities.

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Introduction

This companion document gives background details for the main Child and Adolescent Health and Wellbeing Plan document. It explains the foundation information used to create the plan.

This information includes more detail on: target population statistics; direct consultations with youth; the contributions of our partners across government and in the non-government sector; and other useful information on potential monitoring to be used during implementation. We will work together with our partners to refine and complete the monitoring to be used during the first year of the Plan’s implementation.

It is important to note that this plan has been led by the Department of Health (DoH), but is a whole of NT health and wellbeing, or social sector, plan which can only be completed in concert with the many organisations and agencies involved in looking after the health and wellbeing of youth, including those affecting the social determinants of wellbeing – the social, physical, and economic environments within which children and youth live.

This companion document includes:

- statistics on children, adolescents and young people 0 to 24 years old;
- a summary analysis of consultations with children and youth from 12 to 24 years old
- a table detailing the input received from our partners
- examples of programs that work that are evidence based and consistent with the plan’s principles, particularly those around place based design and local involvement or co-design
- a detailed timeline on implementation and monitoring
- a potential Monitoring Report using a KPI traffic light matrix
- a discussion on data governance and data sovereignty – the key to Aboriginal data sharing
- a full Reference List for both Plan documents.
From the general to detailing the statistics

In general we note that, when looking at the NT population in 2016 (Department of Health 2017), there were 88 173 people aged between 0 – 24 years living in the NT, representing 36 per cent of all Territorians and 50 per cent of all Aboriginal Territorians (41% of this age range were Aboriginal, 59% non-Aboriginal). Of these:

- 19 161 persons were under five years old
- 34 677 persons were five to 14 years old
- 34 335 were in the 15 to 24 year age range.

There were also 4 004 live births in 2015 (being the latest current birth data, Hall and O’Neill 2016).

Where data is available, further detail, including trends, are given below for key statistics from the Summary Statistics at a Glance graphic in the Child and Adolescent Health and Wellbeing Strategic Plan (the main Plan). The detailed section begins with a discussion on strengths-based statistics (also referred to later in the Aboriginal Data Sovereignty section) and relevant research. Some additional important statistics are given e.g. on domestic and family violence and mental health.

Data describing strengths – cultural attachment

When Maggie Walter (in Kukutai and Taylor 2016:80-81) did an internet search for Aboriginal data she found that the top ten entries all focused:

...in one way or another on statistical representations of the dire, and longstanding, socioeconomic and health inequities between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian people...[which could be summarised] as the five ‘Ds’ of data on Indigenous people (5D data): disparity, deprivation, disadvantage, dysfunction and difference. For example, the Australian Human Rights Commission... uses statistical data to highlight overall inequality between Indigenous Australians and the rest of the population; the Australian Bureau of Statistics... entries look at homelessness and education disparities; the Australian Institute of Health and Welfare... discusses the overrepresentation of Indigenous people in the numbers of deaths from preventable causes...
While the data given in the main Plan; and that shown below, is similarly mostly focused on the problems and vulnerabilities experienced by NT child and adolescent population; it is important also to find data on the strengths and positive attributes of the plan’s target population, particularly for those most likely to have experienced vulnerabilities (such as trauma and neglect) i.e. Aboriginal children and adolescents mostly living in remote areas, but also in the urban fringes.

Data of this nature is surprisingly hard to find, particularly by age. Employment, obesity and physical activity data provided in the Statistical Summary in the main Plan are the only positive statistics reported to date. These showed marginally more positive data. Positive NT employment is also, to some extent, a statistical artefact as some “working for the dole” programs run by Aboriginal controlled community organisations are included in the ABS definition of employment.

However, there is some evidence that both the socio-economic status and mental health or wellbeing of the national Aboriginal population (15 years and over) is positively associated with identifying strongly with traditional culture. This is likely to apply to NT children and adolescents, particularly those living in remote areas. Dockery (2011) investigated both the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and the 2008 NATSISS. Evidence from the 2002 NATSISS suggested cultural attachment was associated with improved socio-economic outcomes: self-assessed health, substance abuse, incidence of arrest, employment and educational attainment. In Dockery’s analysis of the 2008 NATSISS “[t]he positive effects of cultural attachment on mainstream socio-economic indicators are confirmed, and now found to extend to subjective wellbeing.” Dockery (2011:10) concludes:

Indigenous Australians who identify more strongly with their traditional culture are happier and display better mental health, but at the same time experience more psychological stress due to stronger feelings of discrimination. The findings suggest that traditional cultures should be preserved and strengthened as a means to both improving the wellbeing of Indigenous Australians and to ‘closing the gap’ on mainstream socio-economic indicators.

The evidence of feelings of psychological stress was mostly found in urban areas where Indigenous people with a strong association to traditional culture had to “walk between two worlds”, or maintain their own cultural identity within another dominant culture.

This finding is possibly consistent with the result in the survey of youth conducted for this Plan which showed that youth consulted who lived in remote, rather than urban areas of the NT, were much more likely to disagree with the statement “going to school and/or going to work is good for my health and happiness”. Fifty per cent of remote respondents disagreed with this statement, compared to 21% of all respondents. The reasons for this response are unclear, but may reflect greater satisfaction and happiness associated with traditional cultural activities in remote rather than in urban areas, particularly for those not working or at school. Work may also be associated with unpopular remote Community Development Project ‘work for the dole’ schemes in remote areas. Schools may also find it harder to meet the needs of young people in remote areas.

When indicators from the planned Prosperity Framework for the Aboriginal and Torres Strait Islander Health Performance Framework Reports become available, these strengths-based indicators will be included in Plan monitoring, reporting and evaluation.
Demographic trends

Demographic trends are available for each age group by Aboriginal, non-Aboriginal, remote and urban regions. Ideally we would do this for each key statistic used in the Plan. However, for most indicators used this level of detail is not available.

Figure 1 shows how the Territorian 0-24 year old population has grown since 1971 (from 45,823 to 88,173 in 2016). The comparison of actuals to trend lines below indicates that there was more consistent annual growth in the Aboriginal NT child and young people population (from 18,965 in 1971 to 36,179 in 2016) than their non-Aboriginal counterparts (26,858 to 51,994). The transient nature of NT’s non-Aboriginal population is possibly the cause of the greater annual variation shown for this group.

However, both Aboriginal and non-Aboriginal populations grew by around 90% over the 45 year period, with Aboriginal children and young people maintaining the same share (41%) of the total 0-24 year old population. While the trend lines show a continuing upward trend, since 2010 population growth in this age group has stabilised; and, since 2013, dropped a little (by 2%).

Looking at the key age group for this plan, 6 to 18 year olds (and having to convert that to 5-19 year olds given ABS groupings), there were 23,255 in 1971 and 50,817 in 2016 (refer Figure 2 below). This age group more than doubled over the time period, increasing (by 119%) at a faster rate than the wider child and young people age group (90%), but not as fast as the general NT population which grew by 186% over the same period. Again most of the 5-19 year old growth was before 2010, when growth started to slow. Aboriginal children and youth made up 44% of the 2016 population aged 5 to 19 (but used to make up 49% in 1971).
The other point of interest is where youth live. The data show very few non Aboriginal 5-19 year olds lived in rural or remote areas (3224 or 6.3%) in 2016. By contrast, almost a third of Aboriginal 5-19 year olds lived in the urban areas of Darwin and Alice Springs (6840 or 30.6%) in 2016.

This data is significant due to the practical implications for service providers’ capacity to ensure effective service provision; the costs associated with delivering services increase with the remoteness of the location requiring the service.

**Child mortality**

Historical trends in child mortality show significant improvement for Aboriginal children in the NT. According to the Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report for the Northern Territory (2015:93):


- **There was a decrease in the mortality rate for Indigenous infants, from 21 per 1,000 live births in 1998–2000 to 14 per 1,000 live births in 2010–2012 (Table 1.20.11).**

- **There was a decrease in the gap between Indigenous and non-Indigenous infant mortality rates (from 15 per 1,000 live births in 1998–2000, to 10 per 1,000 live births in 2010–2012).**

Data on deaths of children 0-17 years old are analysed annually in the Northern Territory Child Deaths Review and Prevention Committee (NT CDR&PC) Annual Report. This data shows the disparity characteristic of reported Aboriginal data discussed by Maggie Walters (Kukutai and Taylor 2016:80-81) as it highlights differences between Aboriginal and non-Aboriginal child deaths.

Data from two of these reports (NT CDR&PC AR 2010-11 and 2015-16) is used to compare two time periods: 2006 to 2010; and 2011 to 2015. (Given the small numbers of deaths involved each year e.g. 38 in 2015 and 57 in 2011; it is better to aggregate the data over four year periods when examining trends in order to avoid identification of individuals and reduce year to year volatility.)
Stillbirths are, by convention, separately analysed from child deaths (and thus not included in Figure 4), but are significant in number as shown in Table 1.

This shows that:

- child deaths were more likely to be male than female, although the female proportion increased during the two periods

- Aboriginal deaths were over-represented compared to the population (i.e. in 2011-2015, 74.4%, compared to the 30% to 28% Aboriginal NT population recorded over the period)

- in the second period, 2011-2015, numbers of both child deaths and stillbirths had reduced.

Figure 4 below compares the underlying causes of all deaths for NT children (aged 0 to 17 years) in the time periods: 2011 to 2015; and 2006 to 2010. This shows two principal underlying causes of death amongst NT children aged 0 to 17 years old:

- certain conditions originating in the perinatal period (defined as 20 completed weeks of gestation to 28 days after birth)

- external causes of morbidity and mortality which include injuries, poisoning and adverse effects (including child suicide) that are seen as preventable.

During the period 2016 to 2010 perinatal condition causes were the most significant, causing 32% of all deaths for that period, while external causes made up 25% of all deaths; from 2011 to 2015 external causes of death became the most significant at 35%. Perinatal-related deaths dropped to 29% of all deaths.

### Table 1: 0-17 years old NT child deaths and stillbirths, 2006-10 compared to 2011-15

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Aboriginal</th>
<th>Non-Aboriginal</th>
<th>Total Child deaths</th>
<th>Total Stillbirths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-2010</td>
<td>142 (57%)</td>
<td>108 (43%)</td>
<td>181 (72%)</td>
<td>69 (28%)</td>
<td>250</td>
<td>176</td>
</tr>
<tr>
<td>2011-2015</td>
<td>128 (52.9%)</td>
<td>114 (47.1%)</td>
<td>180 (74.4%)</td>
<td>62 (25.6%)</td>
<td>242</td>
<td>162</td>
</tr>
</tbody>
</table>

**Sources:** NT CDR&PC Annual Reports (2010-2011:11) and (2015-2016:3)
Child suicide

Possibly the most stark statistics about young people in the NT are those on deaths through intentional self-harm or suicide. It is also a key indicator of mental health. As with many health and wellbeing characteristics, NT shows the highest rates in Australia for children and adolescents.

A Menzies School of Health Research report (Robinson, Silburn and Leckning 2011:6) produced for the Child Deaths Review and Prevention Committee, "Suicide of Children and Youth in the NT 2006-2010" (hereafter the Child Suicide review), included a table (reproduced below). This gives statistics for 10 to 17 year olds disaggregated by Aboriginal status, showing Aboriginal youth suicide rates had increased substantially over the previous decade. The rate for young adults (18-24 year olds) had by contrast declined, as had those for all age groups non-Aboriginal youth.

Aboriginal 10-17 year old death rates per 100,000 population rose from 18.8 in 2001-2005 to 30.1 in 2006-2010. Robinson, Silburn and Leckning (2011:41) conclude that: "[t]here is clear evidence that the incidence of child and adolescent deaths has risen over the last ten years, and every indication that this may continue to rise." This continuation appears to be confirmed by more recent Australian Bureau of Statistics (2016) data for 2011-15 showing total a NT 15-17 year old rate of 50.1%.

It should be noted that the ABS data in Table 3 is slightly different to the data cited earlier; it covers a wider age range and is not disaggregated by Aboriginal status. However, the Child Suicide review and the ABS data above together indicate that most of the deaths would be in the older child and adolescent age range and also more likely to be Aboriginal. (The non-Aboriginal 10-17 year old suicide rates per 100,000 shown for 2001 to 2005 and 2016 to 2010 were substantially lower in both periods.)

Table 2: NT suicide rates per 100,000 population by Aboriginal status and age

<table>
<thead>
<tr>
<th>Age</th>
<th>2001-2005</th>
<th>2006-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-17</td>
<td>18.8</td>
<td>30.1</td>
</tr>
<tr>
<td>18-24</td>
<td>99.9</td>
<td>69.9</td>
</tr>
<tr>
<td>Non-Aboriginal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-17</td>
<td>4.1</td>
<td>1.3</td>
</tr>
<tr>
<td>18-24</td>
<td>21.5</td>
<td>13.0</td>
</tr>
</tbody>
</table>

Sources: NCIS deaths data; ABS population data; Health Gains Planning Branch, NT DoH
In the four years from 2011 to 2015 (see Table 3 above) there were six 5-14 years olds whose deaths were recorded as being from intentional self-harm. This represented a rate of 3.5 per 100,000 population; the next highest rate was Queensland with 1.0, the national rate was 0.6. The NT 5-14 year rate was well over five times the national rate. The incidence and rates were higher in the 15-17 year age group with 24 adolescent deaths representing a rate of 50.0 per 100,000 population compared to a national rate of 7.5. The NT adolescent suicide rate was therefore over six times greater than the national rate.

Figure 5 below gives a very clear picture of NT’s much higher child and adolescent death rate of 13.6 per 100,000 population compared to other jurisdictions and to the Australian average of 2.2.
The reasons Robinson, Silburn and Leckning (2011:41) give for Aboriginal child and adolescent suicide from their review of the international and national literature and a qualitative study of 18 cases of suicide by persons under 18 years of age from 2006-2010 in the NT are as follows:

The study [and literature] identifies a number of distinctive patterns of risk in children’s early development, in the functioning of their families and the community contexts in which the young people live. School drop-out or transition from school is highlighted as a common concurrent issue for half of the cases, albeit with some differences in manifestation in remote communities and Darwin. It was evident that there are few if any services able to address the combination of transition from school, poor family functioning and substance misuse for high risk adolescents. In many communities, there is evidence of under-response to suicide risk, that is partly a product of the severity of ongoing conflict in families and the strain associated with the adolescents’ behaviour.

Thus the Child Suicide Report makes it evident that poor family functioning or conflict is a factor in youth suicide. In turn youth suicide impacts on the child’s family, friends and community causing longer term trauma; potentially affecting school attendance and the school’s ability to focus on the curriculum when supporting children affected by trauma.

Child assault injuries

NT child injury hospitalisations for assault also have a relationship to family conflict and violence. During the period 2001-2011, in 59% of Aboriginal cases and 51% of non-Aboriginal cases where the perpetrator was identified, this was a parent; in another 15.4% of Aboriginal and 16.4% of non-Aboriginal cases, the perpetrator was “another family member” (Skov, O’Kearney and Dempsey 2016:71).

Again this was a problem most evident amongst the NT population living in remote and regional areas (as can be seen in Figure 6). The highest age standardised rate of child assault injury hospitalisation per 100,000 population in the NT was seen in the Barkly district followed by Alice Springs Rural and Katherine, with the lowest in the Darwin Urban district.

Consistent with the regional and remote picture here, the age standardised assault injury hospitalisation rates for Aboriginal children over the period 2001 to 2011 (122 per 100,000 population) were substantially higher than for non-Aboriginal children (21.9 per 100,000) – over five times higher (Skov, O’Kearney and Dempsey 2016:64).

Figure 6: Age standardised rates of childhood assault injury hospitalisation per 100,000 population by District, NT residents, 2001-2011
Domestic and family violence

The NT data on domestic (and family) violence that is most readily available is the assault (with domestic violence present) offence data from Police Fire and Emergency Services. This indicates that the greatest numbers of such offences occur in the NT Balance area (which includes all the areas outside urban areas i.e. regional and remote communities). In July 2013 there were 115 domestic violence present assaults in the NT Balance area, compared to 105 in June 2017 (see Figure 7 below) and this is clearly the largest category. Alice Springs is next (starting at 115 in July 2013 but falling to 72 in July 2017), followed by Darwin, due its larger population. Trend lines added show that since 2013 numbers of assaults have been falling in the first two areas. Darwin’s domestic violence assault numbers were more stable (47 in July 2013 and 46 in June 2017).

Figure 7: NT assault offences by domestic violence involvement and area July 2011 to July 2017

Source: Department of Attorney-General and Justice (2014; 2015; and 2017)
Figure 8 below makes the remote area predominance even clearer, showing rates of domestic violence offences per 100,000 population in each town centre and the NT Balance area. Tennant Creek consistently had the highest rates, followed by Katherine or Alice Springs (depending on the year as Katherine rates dropped in 2016 and 2017) and then the NT Balance area. In 2017 Tennant Creek’s rate per 100,000 population was 7217.4; Alice Spring’s rate was 3267.7 and Katherine’s 2932.6; NT Balance was 1817.1. All these exceeded the 2017 NT total rate of 1583.0 per 100,000 population.

Many of these assaults would have been witnessed by children and youth, and could also have been carried out by young people.

**Social disadvantage – the primary risk factor for poorer health**

The statistics in the main Plan have focused on familiar modifiable risk factors related to poorer health such as obesity, smoking and alcohol consumption. However, there is peer reviewed evidence (Zhao et al 2013) to show that in the NT the leading risk factor is poverty.

Figure 8: Northern Territory domestic violence involved assault offence rates per 100,000 population by urban and remote areas 2010 to 2017

Source: Department of Attorney-General and Justice (2014; 2015; and 2017)
This gives important support to the social determinants of health approach that is a foundation for action within this Plan. Figure 9 below presents the variation in mortality and hospital admission rates (morbidity) for a range of conditions for which the population has been split into three socio-economic categories – low, medium and high. For most conditions, including circulatory disease, cancer and injury, there is a clear gradient of poorer outcomes from high to low socio-economic category. As Zhao et al (2013:4) state:

This study shows a close correlation between socioeconomic health inequality and Indigenous health inequality. While it is difficult to ascertain causality, it is intuitive to believe the causality is likely to occur in both directions: poverty causes ill-health resulting from poor nutrition, infectious and chronic disease; and ill-health leads to poverty due to loss of productivity, quantity and quality of life. Attempts to modify risk behaviours, such as smoking, alcohol and obesity, without altering socioeconomic disadvantage will have limited success, because the risk behaviours are often embedded within disadvantage, which in turn reinforces the risk behaviours.

Figure 9: Health inequalities by socioeconomic categories and conditions, NT, 2005-2007

Notes:
(a) Age-sex standardised mortality rates by socioeconomic categories and underlying cause of death
(b) Hospitalisation rates by socioeconomic categories and principal diagnosis.
(Source: Zhao et al. 2013:4)
Consulting with youth was vital to writing this plan and consistent with the principles laid out in the main Plan around co-design and involvement. This was carried out in several ways: a young voice competition for primary schoolers; a survey of older youth; and focus groups held with youth with vulnerabilities. Other useful data was also accessed. These sources are detailed further below.

The **Young Voice Competition** asked primary school aged children to submit artwork for prizes of up to $100 in books and software. The word cloud in Figure 10 gives an indication of the topics raised in this exercise. Entrants’ messages (for example on health being about family, friends, exercise or sport and being outside) are included in this plan and parallel those we received in the other consultations with older young people.

The winning entry from the Young Voice Competition shown on the back of the Plan. As can be seen, this entry uses family photos to show what the children think healthy and happy means to them and involves both Aboriginal and non-Aboriginal children.

The **Youth Voice Survey** asked 15 to 24 year olds to give information on what being healthy and happy meant to them and also covered services that had been of use to respondents. In total 118 young people responded in a two to three week period ending 25 September 2017. Thirty-three respondents (or 28%) were Aboriginal.

Figure 10: Word cloud from Young Voice Competition entries
A total of ten targeted focus groups run through youth services and a youth representative organisation reached 91 youth (generally those experiencing vulnerabilities). About 77% (or 70) of these youth were Aboriginal and/or Torres Strait Islander. Where appropriate, the young people were separated into groups for young men or young women. These were:

- Youth Round Table (separate male and female groups) held on 27 August 2017
- Santa Teresa held on 19 September 2017
- Alice Springs (separate male and female groups) held on 20 September 2017
- Darwin Malak (separate male and female groups) on 25 September 2017
- Nhulunbuy Anglicare (separate male and female groups) on 26 September 2017
- Palmerston YMCA held on 27 September 2017.

A report was prepared identifying issues and concerns from the consultations and surveys and including many useful direct quotations from young people.

While there were a broad range of insights and findings contained in this consultation report, six main concern areas were identified. These are set out below.

Healthy eating and staying active are seen by young people as key to health and wellbeing, but sometimes there are barriers

Almost all young people consulted said that their health and happiness is important to them, and many young people identified healthy eating and staying active as fundamental to maintaining their health and happiness. However, there were a number of barriers highlighted, that prevent young people in some locations from engaging in these behaviours.

A significant number of young people raised the issue of not having the resources to purchase healthy food in some regional and remote locations given the high costs of fresh food, and this was seen as a barrier to healthy eating. Further, a lack of affordable and accessible activities for young people in some locations was also seen as a barrier to staying active, and engaging in positive activities, such as sport and exercise.

Young people could identify unhealthy behaviours but the link with future disease was not as clear

While young people consistently identified drugs, alcohol, smoking and eating unhealthy food as being bad for their health, there was not always a connection made between engaging in unhealthy and risky behaviours and how these behaviours can lead to non-communicable and other diseases that are prevalent in the NT.

When asked what would make a difference in improving their health and the health of their families and communities, there were almost no suggestions from young people on measures to reduce these behaviours. There was also a limited understanding of non-communicable diseases, and the behaviours that lead to disease, expressed through the focus groups and survey.

A very small number of young people identified increasing awareness of the effects of drugs, alcohol and smoking in their communities as being important. One participant highlighted the role that schools could play in educating young people on why it is important to live a healthy lifestyle and the factors that can cause diseases (such as diabetes).

This finding suggests that there may be room for more education and awareness on the potential consequences of engaging in unhealthy behaviours during childhood and adolescence, and how these behaviours can contribute to some of the non-communicable diseases that young people see among their friends and families and in their communities.
Place based consideration of needs and priorities

While there were many similarities in the views provided by young people across the Territory, there were clear differences in the priorities of young people in different locations, and different issues highlighted relating to access to health and other youth services.

This indicates that there is a need for a ‘place based’ approach to defining the actions the NT Government will take to improve health and wellbeing through the Child and Adolescent Health Plan. This could also include mapping the existing services that are available in each location to gain a better understanding of the gaps in service delivery, and seeking the views of young people on what they view as priority services in their town or community.

Importance of mental health to young people

Young people who participated in the online survey and focus groups identified mental health as a major factor impacting on the health and happiness of themselves, and their family and friends. Access to mental health services was highlighted as a key issue through the survey and focus groups, including observations about the long wait times experienced in accessing services and some locations not having adequate mental health service provision.

Given the evident importance of mental health as an issue affecting young people in the Territory, mental health is a prominent part of the Child and Adolescent Health and Wellbeing Plan.

Health and wellbeing is heavily influenced by friends, family, community and culture

Young people highlighted the influence that family, friends and other relationships have on their health and wellbeing. Maintaining a strong connection to culture was also seen as important and as providing young people with a sense of belonging.

Many of the young people spoken to during focus group sessions said that they have exposure to both good and bad role models in their families, communities and in schools, and that having bad role models can lead them to engage in unhealthy and risky behaviours.

This demonstrates the importance of young people having positive role models and acknowledging the role that parents, family members, communities and schools play in young people’s health, wellbeing and development. It also highlights the importance of young Aboriginal people being able to access mainstream services (including education, health and youth services) while maintaining their culture and identity and being confident to “live and walk in both worlds”.

The health and wellbeing of young people needs to be considered in the context of their community, culture and surrounding environments.

Increasing outreach and awareness of existing services

A number of young people who participated in focus groups thought that existing services could do more outreach and awareness work to promote their services among young people. For example, where services did promotional work in schools, young people felt more confident to access these services than other services. This indicates the important role of schools in reaching young people and their families. However, it is often those in most need of services (experiencing the most disadvantages) whom have poor school attendance rates. This limits their exposure to support services and information provided at schools. In addition, many young people thought that some services could be more tailored to the needs of young people, including making their spaces more comfortable for young people, and less clinical.
There appears to be an opportunity for better promotion and outreach of existing services, and reflecting on how these services could be made more appropriate for young people.

Data on youth opinions about health and wellbeing was also available from consultations run with Aboriginal youth by the Aboriginal Health branch of the Commonwealth Department of Health in the Top End in early 2017. The themes identified were reflected in these later consultations detailed above.

Youth saw mental health and wellbeing as both a priority and a concern. Positive influences were sleep, eating well and being active. Good role models also helped. Negative influences were alcohol and other drugs, relationship issues, violence and abuse, smoking, overcrowding and poor hygiene in the home. Exposure to bad role models was a concern, so was ill health, death and suicide in the family and community.

Data from the NT Health consultations was shared with the Commonwealth to inform both.

**Reflecting youth consultations in the main Plan**

The results of the competition, focus groups and survey, including the areas of concern described immediately above, were used to develop the vision, priorities, themes and priority actions of the main Plan. As the Plan is necessarily strategic in nature – seeking to affect actions across government and non-government sectors that affect the health and well-being of children and young adults – the detail of how this is achieved may not be readily apparent.

For example, the first area of concern described above says an identified barrier to achieving a healthy lifestyle was inability to source and pay for healthy food. This was not specifically addressed in the main Plan. However, it is covered by the Nutrition and Physical Activity Strategy 2015-2020 listed in Priority Action 3.2.

More detail reflecting these youth consultations is likely to be used in the Implementation Plan developed during the first year of the Plan.

Consultation with and involvement by children and young people, particularly those experiencing disadvantage, will continue to be a cornerstone of this Plan as:

- improved representation will be sought for this group in the governance structures used to implement the Plan
- further consultations with children and young people will occur at key points in the 10 years of the Plan’s life as detailed in the Implementation timeframe given at page 37 in this document
- the Plan’s priority actions (for example, 2.1 Services are child and youth friendly) support children and young people being involved in the design and implementation of services.
This plan reflects the need to address child and adolescent health and wellbeing by action across government and non-government social services. Health and wellbeing does involve hospitals, GPs, mental health services and health centres, but it is also very much about the environment that children and young people experience. Family and living conditions, schooling, access to employment, sport and leisure activities are all important to youth health and wellbeing. This was clear from all the consultations held with NT young people and children. This means the Department of Health is working with partners across sectors and government to develop and implement this plan. These partners and their contributions are summarised below.

Table 4: Partner input

<table>
<thead>
<tr>
<th>Organisation</th>
<th>What contribution</th>
<th>Why</th>
<th>How</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Medical Services Alliance NT (AMSANT)</td>
<td>Governance and plan development; direct contributions on plan from members</td>
<td>AMSANT members run essential services for children and young people.</td>
<td>Working Group and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Aboriginal Peak Organisations NT (APONT)</td>
<td>Governance and plan development; direct contributions on plan from members</td>
<td>APONT members run essential services for children and young people.</td>
<td>Working Group and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Central Australia Health Service (CAHS)</td>
<td>Plan governance and development</td>
<td>Run primary to tertiary health and wellbeing services</td>
<td>Project Planning, Working and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>City of Darwin</td>
<td>Service and facility provision</td>
<td>Consultations with youth on child friendly spaces</td>
<td>Direct request – Drafting Group member</td>
<td>During Working Draft development</td>
</tr>
<tr>
<td>City of Palmerston</td>
<td>Service and facility provision</td>
<td>Consultations with youth on child friendly spaces</td>
<td>Direct request – Drafting Group member</td>
<td>During Working Draft development</td>
</tr>
<tr>
<td>Organisation</td>
<td>What contribution</td>
<td>Why</td>
<td>How</td>
<td>When</td>
</tr>
<tr>
<td>--------------------------------------------</td>
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</tr>
<tr>
<td>Department Attorney General and Justice</td>
<td>Governance and plan development.</td>
<td>Initially Youth Justice, but transferred to TF; also domestic and family violence</td>
<td>Working Group and Drafting Group member as required</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Department of Education (DoE)</td>
<td>Governance and plan development; direct contribution on relevant services</td>
<td>Run services essential to children</td>
<td>Working Group and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Department of Housing and Community Development (DHCD)</td>
<td>Governance and plan development; direct contribution to actions from election commitments/strategies</td>
<td>Housing integral to health and wellbeing of children</td>
<td>Working Group and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Department of Infrastructure, Planning and Logistics</td>
<td>Land management affecting youth and families</td>
<td>In response to youth consultations</td>
<td>Drafting Group member</td>
<td>During Working Draft development</td>
</tr>
<tr>
<td>Department of the Chief Minister (DCM)</td>
<td>Governance and plan development</td>
<td>Developing Early Childhood Development Plan - Starting Early for a Better Future which this Plan links into</td>
<td>Working Group and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Department of Tourism and Culture (DT&amp;C)</td>
<td>Sport and art activities; library strategy affecting remote communities</td>
<td>In response to youth consultations</td>
<td>Drafting Group member</td>
<td>During Working Draft development</td>
</tr>
<tr>
<td>Department of Trade, Business and Innovation (DTB&amp;I)</td>
<td>Aboriginal and youth employment generally</td>
<td>In response to youth consultations</td>
<td>Drafting Group member</td>
<td>During Working Draft development</td>
</tr>
<tr>
<td>Kidsafe NT</td>
<td>Safety initiatives</td>
<td>Foundation dedicated prevention of unintentional childhood accidents and injuries</td>
<td>Direct request.</td>
<td>During Working Draft development</td>
</tr>
<tr>
<td>NT Council of Government School Organisations</td>
<td>Assisted with youth consultation publicity</td>
<td>Community-based, not-for-profit organisation - provides advocacy and representation at the local school, NT and federal government levels</td>
<td>Direct request</td>
<td>During youth consultations</td>
</tr>
<tr>
<td>Organisation</td>
<td>What contribution</td>
<td>Why</td>
<td>How</td>
<td>When</td>
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</tr>
<tr>
<td>NT Council of Social Services (NTCOSS)</td>
<td>Governance and plan development; member contributions on services.</td>
<td>NTCOSS members run essential services for children and youth</td>
<td>Working Group and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>NT Royal Commission into Protection and Detention of Children (RCP&amp;DC)</td>
<td>Final RCP&amp;DC report recommendations</td>
<td>Key issues for NT youth with vulnerabilities</td>
<td>Through reference to the Report’s recommendations</td>
<td>During draft development.</td>
</tr>
<tr>
<td>Office of Digital Government, Department of Corporate Information Services (DCIS)</td>
<td>Digital strategy</td>
<td>In response to youth consultations and NTG direction</td>
<td>Drafting Group member</td>
<td>During draft development.</td>
</tr>
<tr>
<td>Office of the Children’s Commissioner</td>
<td>Statistics and research on child protection and deaths; direct contributions.</td>
<td>Ensures the wellbeing of vulnerable children in the NT</td>
<td>Drafting Group member</td>
<td>During Working Draft development</td>
</tr>
<tr>
<td>Police Fire &amp; Emergency Services (PFES)</td>
<td>Governance and plan development; crime statistics</td>
<td>PFES services are important to children, youth and their families</td>
<td>Working Group and Drafting Group member</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Territory Families (TF)</td>
<td>Governance and plan development; a little direct contribution, Mainly used Strategic Plan, Annual Report and Royal Commission implementation report</td>
<td>Government direction - TF to assist DoH; essential child and adolescent services run by TF.</td>
<td>Working and Drafting Group member.</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Top End Health Service (TEHS)</td>
<td>Plan governance and development; adolescent (and child) friendly services content</td>
<td>Run primary to tertiary health and wellbeing services</td>
<td>Project Planning; Working and Drafting Group member; and direct request</td>
<td>During plan development.</td>
</tr>
<tr>
<td>Youth Round Table, Office of Youth Affairs</td>
<td>Opinions of members obtained on youth needs</td>
<td>Represent youth to the NTG.</td>
<td>As youth consultation focus group. Youth Round Table meetings.</td>
<td>During plan development.</td>
</tr>
</tbody>
</table>
### Other expert individuals consulted

A few key experts were contacted for their valuable knowledge, as described below.

<table>
<thead>
<tr>
<th>Individual and Organisation</th>
<th>What contribution</th>
<th>Why</th>
<th>How</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joy McLaughlin, Senior Project Officer, Danila Dilba Health Services</td>
<td>Advice on NT primary health care in the ACCHO sector.</td>
<td>Much government and non-government experience in NT primary health care policy.</td>
<td>Direct request</td>
<td>During draft development.</td>
</tr>
<tr>
<td>Sinon Cooney, Manager PHC, Katherine West Health Board</td>
<td>Advice on NT primary health care in the ACCHO sector to be received.</td>
<td>Much government and non-government experience in NT primary health care.</td>
<td>Direct request</td>
<td>During draft development.</td>
</tr>
<tr>
<td>Lucas De Toca, Chief Medical Officer, Miwatj Health Services</td>
<td>Advice on NT primary health care in the ACCHO sector to be received.</td>
<td>Much government and non-government experience in NT primary health care.</td>
<td>Direct request</td>
<td>During draft development.</td>
</tr>
<tr>
<td>John Boffa, Chief Medical Officer, Central Australian Aboriginal Congress</td>
<td>Advice on NT primary health care in the ACCHO sector</td>
<td>Much government and non-government experience in NT primary health care policy.</td>
<td>Direct request</td>
<td>During draft development.</td>
</tr>
</tbody>
</table>
Programs that work/could work detailed

Programs that work (evidence based)

Programs included in this section have some support from national and international evidence publications and often involve randomised control studies. Those included in the next section on “Programs that may/could be working” are evidenced locally, or have been running in the NT for some time.

Ideally evidence of programs that work should consist of articles from well-known reliable journals (e.g. BMJ and Lancet) which contain a systematic team (not a single author) review of the existing research, including existing meta-analyses, or a meta-analysis of the research found. Then the articles should contain a reliable randomised control trial of sufficient breadth and number of people in the population to be representative of the population and issue under study run by researchers of repute.

It is recognised however, that many local NT studies, while useful, cannot reach this level of evidence due to the low numbers of clients/patients involved. Best substitutes are the type of research studies just discussed that also cover conditions similar to those found in the NT, often across the world, and show consistent evidence of effectiveness across many research studies and sites.

Reducing smoking (example of research on programs that work - suggestions for NT )


Regarding interventions for preventing youth smoking in this context, future activities need to focus on changing social normative beliefs around smoking, both at a population level (through smoke-free policies and laws and social marketing campaigns) and within young people’s immediate social environments. Such activities would complement other effective initiatives to prevent youth smoking, such as increasing the price of cigarettes [74].

Currently, all Australian States and Territories have banned smoking in enclosed public places, particularly workplaces and restaurants. The Northern Territory has traditionally lagged behind other jurisdictions in implementing smoke free areas. For example, if a majority of staff at a Northern Territory school campus agree, the school can designate a discrete outdoor area for smoking if it is not in the line of sight of children. This is in contrast to all other States and Territories in Australia, which ban smoking on all government school grounds. The Northern Territory Department of Education and Training should consider following other jurisdictions in making
the whole of school campuses smoke free. The Northern Territory Tobacco Control Regulations should also be amended to remove this exemption relating to Northern Territory schools. (Note that the latest NT legislative review affecting tobacco supports these changes.)

Another avenue through which schools might intervene to reduce youth smoking is to further explore interventions designed to alter social norms within established peer groups and harness the power of positive peer influences to reduce youth smoking. This has been successfully trialled in the United Kingdom. Drawing on ‘diffusion of innovation’ theory, the Stop Smoking in Schools Trial utilised trained influential school students to act as positive peer supporters during informal (out of-classroom) interactions to encourage young people not to smoke [75]. The study found a 22 per cent reduction in the odds of being a regular smoker in intervention, compared to control schools for two years after its delivery [15], making it one of the most successful recent examples of school based programs to reduce smoking among youths. Another obvious area for attention is the family unit, where interventions could be targeted to encourage positive parenting practices, both general and smoking-specific practices [8]. A review of the effectiveness of interventions to help family members strengthen non-smoking attitudes and promote non-smoking by children or adolescents found that although the evidence base is limited, some well-executed randomised controlled trials show family interventions may prevent adolescent smoking [16] (p23)

NPY Women’s Council’s ‘Uti Kulintjaku’ project – an innovative Aboriginal-led, bi-cultural approach to understanding mental health and wellbeing.

The Uti Kulintjaku (UK) Project is an innovative, Aboriginal-led mental health literacy project initiated by NPY Women’s Council (NPYWC) in 2012. Senior Anangu women were concerned about the wellbeing of the young people in their communities and wanted to do something about it. Mental health issues affect many families, and all communities, in the NPYWC region in Central Australia.


The Abercedarian program is an evidence-based approach to early literacy and numeracy learning that develops and builds adult-child interactions and, in turn, improves the educational and health outcomes for vulnerable and disadvantaged children.

In addition to being used by a number of Aboriginal Community Controlled Organisations including Central Australian Aboriginal Congress, it is fundamental in the Families as First Teachers (FaFT) program delivered by the Department of Education. FaFT provides quality early child and family support for children aged from birth to five years and their families. The program aims to build parents’ capacity through support and adult learning activities that are linked to children’s learning and development.
Australian Nurse Family Partnership Program

The Australian Nurse-Family Partnership Program was created from the evidence-based Nurse Family Partnership: Helping First-Time Parents Succeed program. This model of home visiting was developed by Professor David Olds in the USA over the last 30 years. A randomised control trial (RCT) is planned for the Australian version using an urban Queensland program.

The Nurse Family Partnership (NFP) model is an evidence-based community health program that helps transform the lives of vulnerable mothers pregnant with their first child. The NFP is one of a small number of social programs that has been assessed by the United States Coalition for Evidence-Based Policy as meeting ‘top tier’ evidence standard of effectiveness and it is the only program rated as ‘top tier’ in the early childhood category.

However a recent RCT from the UK (Robling et al) found no effect on the study’s primary outcomes of no smoking in pregnancy, birthweight, child emergency hospital attendance and admission, and subsequent pregnancy for the Family Nurse Partnership (FNP) compared to universal mothering care. Some secondary outcomes showed small positive impacts including improvements in language and cognitive development, level of social support for the family, partner-relationship quality and general self-efficacy. The NFP program in the UK was adapted for the context (e.g. selection was based on youth) and may have lost some fidelity.

Robling notes that adding the FNP Program to an already functioning health and social service system provides limited additional short-term benefit. The US has no universal program. Australia, like the UK, has a good health system, although it is under-funded for the needs of Aboriginal people in the NT. Levels of support for vulnerable families and for Aboriginal people in the NT vary widely (Gador Whyte et al, 2014). Social services are fragmented, not provided equitably, and are often not culturally appropriate. Currently, very few remote communities have family support programs.

Antenatal access for Aboriginal women in the NT has improved slowly. In addition, most very remote communities rely on visiting midwifery outreach which has inherent limitations in that if a woman is away when the midwife visits, she must wait till the next visit which may be several months away. There is also a lack of Aboriginal trained staff to work with midwives to increase cultural safety.

In contrast, the UK provides a very robust system of community midwifery and health visitors for all families with enhanced access for vulnerable families. The study control groups had access to this service and had almost the same number of community midwife visits as the FNP group. Importantly, the control group received almost twice as many health visitor contacts (routinely undertaken in the family home) as the intervention group (16.3 v 8.6). However, the FNP group received 39-28 FNP nurse visits.

NFPP involves registered nurses visiting first-time low-income mothers during pregnancy and for the first two years of the child’s life. As part of the program, each mother is partnered with a registered nurse during the early stages of her pregnancy and receives ongoing nurse home visits that continue through to her child’s second birthday.

Aboriginal community-controlled and government health services within the NT run ANFPP. The most well established ANFPP in the NT (run by Congress), offers the program to all Aboriginal mothers.
Maternal Early Childhood Sustained Home-visiting (MESCH)

This is a home-visiting program delivered to pregnant women who are considered at risk of adverse maternal and/or child outcomes. The MECSH model has some commonality with Family Nurse Partnership (FNP), but involves a broader population than the NFP model including: older mothers, later enrolment and a wider range of other factors including being embedded in the universal service. The program is delivered by MECSH trained Health Visitors within a proportionate universal healthy child program. The program begins before birth and ends when the child is two years old. The antenatal home visits occur fortnightly. Postnatal visits begin within one week of birth and occur weekly until the child is six weeks old, every three weeks until the child is six months old, every six weeks until the child is one year old, and bi-monthly until the child is two years old. Each visit is between 60 and 90 minutes. The antenatal component focusses on coping, problem solving, parents’ aspirations for themselves and their children and positive parenting skills. Mothers are also encouraged to access community resources and increase their social networks. The postnatal component focusses primarily on increasing parents’ capacities to parent effectively and support their child’s development. MECSH also sponsors group activities and community links to facilitate parent networking.

MESCH has so far been found to have no effect on child outcomes in one rigorously conducted study (Kemp et al 2011) using data between 2005 and 2008. However, this randomised controlled trial (in Sydney) found statistically significant effects on mothers, including increased breastfeeding duration and parental responsivity.

The Australian Research Alliance for Children and Youth are currently evaluating a version of MESCH being run in Victoria called right@home. Phase 1 results are now available.

Programs that may/could be working

NPY Women’s Council Kultinja Payaringkuntjaku project (no evidence base available). The Kulintja Palyaringkuntjaku project means ‘to get better thinking’. The project is one of the ways that the NPY Youth team provides support for young people – specifically for those facing both drug and alcohol problems and mental illness (often referred to as co-morbidity or dual diagnosis).

NPY Women’s Council Child Nutrition and Well-being Program (no published evidence base available). The Child Nutrition and Well-being Program originated in 1996 as the Nutrition Project Awareness Project for Young Mothers and babies; with a six-month Commonwealth Health grant to teach young mothers how to cook nutritious meals for their children. At the time NPYWC members and Directors saw this as a solution to the high number of children failing to thrive – commonly called ‘skinny kids’ – and the ‘welfare’ intervention that often resulted in their removal to predominantly non-Aboriginal foster care in major centres far from NPY communities. The program now seeks to address the wider social issues that affect child well-being and failure to thrive, such as domestic and family violence and Foetal Alcohol Spectrum Disorder (FASD) as well as combining prevention and intervention strategies to offer practical help to clients.

Warlpiri Youth Development Aboriginal Corporation (WYDAC) (no evidence base available). Both Youth and Client Services assist youth, for example:

WYDAC Client Service teams utilise professionally qualified, on the ground and local staff to provide early intervention, counselling and rehabilitation support for Warlpiri youth at risk. These issues may variously include drugs and alcohol, relationship and family violence, suicidal ideation, criminal behaviour, depression, neglect and sexual health, all which impact on a young person’s sense of safety and wellbeing.
The program applies a wide range of professional, evidence-based and culturally appropriate activities to promote individual, family and community health and well-being. There is a strong partnership between the WYDAC Client and Youth Service teams, all ultimately focused on positive pathways for young Warlpiri people. This includes the Mt Theo outstation program.

**Bushmob** (no evidence available) is a community based service for high risk Young People aged 12 – 25 years who use alcohol and other drugs and engage with the youth justice system. Bushmob is described by its funders as either a youth alcohol and other drug service, or Sentenced Youth Camp. It is more accurately described, however, as a therapeutic service for high risk young people whose complex needs generally include alcohol and other drug use and recidivistic engagement with the youth justice system.

The Centralian Middle School Clontarf Academy is part of a network of 61 academies nation-wide. As at 2015, the NT operated 15 such academies. There was one 2011 evaluation by the Australian Centre for Education Research of 87 projects including 32 academies and at least three NT academies with mixed results, good on engagement and attendance, educational outcomes not clear. A 2016 evaluation of the NSW Clontarf academies program undertaken by the Centre for Education Statistics and Evaluation found a statistically significant ‘Clontarf effect’ on school level attendance among Aboriginal boys in Years 7, 8 and 9, but not in later Years. It also found that within two years of leaving school, Clontarf graduates were more likely to be working or studying (and less likely to be ‘looking for work’) than the general trend for Aboriginal males in non-metropolitan areas across NSW. (Insufficient evidence base – may be working.)

This program was established in 2007 and [in the NT] is operated out of Centralian Middle School in Alice Springs. The Academy caters for students from Years 7 to 9. The Centralian Middle School Clontarf Academy engages its members through activities which build leadership, well-being and self-esteem and has seen positive outcomes in many areas including increased attendance. During Clontarf contact time the boys enjoy a number of activities aimed at achieving the Academy’s mission statement which included a work program around fencing and stock work aimed at developing life and work-ready skills, distributing used football boots to remote communities and volunteering at the Old Timers fete which sees more than 3000 people attend annually.

**Safe4Kids**, as noted by the Australian Institute of Family Studies, has not been evaluated but has been supplied in the NT for some years. The program provides child abuse prevention education with a focus on the prevention of exposure to pornography and cyber-abuse and their effects on children aged 2-17 years. Educating the whole community plays an important role in the program. Target groups include women’s groups, men’s groups, police, teachers, childcare workers, government and non-government agencies based in the community.

The program is not exclusive to Aboriginal and Torres Strait Islanders. However, over 76% of the program’s clients are reported to be of Aboriginal and Torres Strait Islander descent. The provider is a private company based in WA.

**Health Habitat** work on environmental health and design involves teams implementing projects based on their guidelines called The Healthy Living Practices. The organisation’s history and supporting evidence for intervention in housing maintenance, health hygiene hardware and individual hygiene practices is given in The Health Story. This program was previously part of federal government National Partnership Agreement on Remote Indigenous Housing within NT, now ceased. A report on this is given under Health Habitat’s Housing for Health section.
DHCD Tenancy Support Program (may work, not evaluated)

Program service providers offer case management and support for people living in accommodation where their tenancies may be at risk, including in public or private housing, and for people living in other alternative accommodation types. Service providers have the flexibility to respond to clients living in any tenancy type who are at risk of homelessness, without being limited to servicing a specific accommodation facility or engaging only with those who are eligible for public housing. Service providers are able to take a proactive and comprehensive approach to client support needs that allows for integrated arrangements between service providers, or within the functions of the principal provider, so that clients can access a wider range of specialist support areas and enhance their prospects of achieving lasting housing outcomes. Case management services can be tailored to the changing needs of clients, who may move from one type of accommodation to another before their particular housing requirements are met e.g. from transitional accommodation to a private tenancy.

Current support services providers who directly contribute to helping individuals and families sustain their tenancy are:

- Anglicare
- CatholicCareNT
- Larrakia National Aboriginal Corporation
- Mental Health Association of Central Australia
- Mission Australia
- Tangentyere Council Aboriginal Corporation
- Somerville Community Services Inc.
- St Vincent de Paul Society (NT) Inc.
- The Salvation Army (NT) Property Trust
- YWCA of Darwin.

Current accommodation and support service providers that directly support young people who are homeless or at risk of homelessness are:

- Alice Springs Youth Accommodation and Support Services
- Anglicare N.T. Ltd.
- YWCA of Darwin Inc.
- Somerville Community Services Inc.
- CatholicCare NT
- Mission Australia.

Fathering Programs and Resources – may work, not evaluated

The Father Inclusive Practice aims to value and support men in their role as fathers (biological and social), actively encourage their participation in the HU5K-PF program and ensure they are appropriately and equally considered in all aspects of service delivery, (FaHCSIA 2009) and is being delivered out of the Palmerston’s Community Care Centre by a Child and Family Health Nurse.

Dads WA – Hey Dad! Fatherhood for the first 12 months. While a great deal of emphasis is placed in managing the wellbeing of mothers after birth of their child, there is less emphasis given to what fathers need. NGALA is a program based in Western Australia that helps up to 40,000 families a year to access help with children, advice and access to professionals. The Dad booklet can be found here:

http://www.mengage.org.au/Life-Stages/Becoming-A-Father/Hey-Dad-Fatherhood-For-The-First-12-Months

Central Australian Aboriginal Congress – integrated primary health service model.

Congress provide a comprehensive and systematically delivered suite of programs that support child health and development (using a population health approach, primary and secondary prevention, as well as assessment and diagnosis. This includes support for parents/carers and families, in a culturally
secure and community based way. Services are planned for individuals and families after needs assessments and are driven by data. While this is part of Congress core services, Congress has a number of partnerships (e.g. education, specialist paediatric services) so that services are holistic and coordinated.

Child-Friendly Service example (Yet to be fully evaluated service – could be working.)

Royal Darwin Hospital Adolescent Health Service

The Adolescent Health Service at Royal Darwin Hospital aims to provide high quality youth friendly health services for young people in the Northern Territory.

Over the past 18 months, work has been undertaken to improve the service by implementing the World Health Organisation (WHO) framework, Making Health Services Adolescent Friendly. Developing National Quality Standards for Adolescent-Friendly Health Services (2012) and adapting this approach to meet the needs of youth in the Northern Territory.

Characteristics and Approach

The characteristics and approach to delivery of services, based on the WHO framework, is summarised in the table below.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Approach</th>
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</table>
| **Engagement:** Meaningful and ongoing engagement with young people to find out what works for them | • Policies and services delivered take account of the needs, rights and best interests of young people.  
• Efforts are continuously being made to involve children and young people in policy and decision-making processes. |
| **Access:** Young people can access the services available to them | • There has been an effort to increase the number of young people who can access age appropriate health care at RDH. The goal is to ensure that quality care is provided in an environment that is safe and appropriate for age and stage of development of the child or adolescent.  
• Where youth friendly environments are unable to be accessed, specialised training of service providers and strong partnerships across multiple sectors can ensure that services continue to work to meet the needs of young people. |
| Acceptable: Services are youth friendly and meet the needs of the young person | • The Paediatric ward was re-designed to include allocated adolescent beds and an adolescent lounge to achieve a 'youth friendly' environment. |
| Appropriate: The right health services are provided to meet the needs of young people | • Collaboration and partnerships with health services across the NT, including the delivery of Adolescent Health training to ensure services meet the needs of young people and are culturally appropriate  
• A Youth Health Partnership Group has been established to ensure provide a forum for collaboration across different health services to better meet the needs of young people. |
| Equitable: All adolescents can obtain the services they need and services meet the needs of all service users | • Delivering a culturally appropriate service, through ongoing engagement with youth and other service providers.  
• Ensuring young people do not face discrimination of any kind, and feel culturally safe, secure and understood. |
| Effective: Providers have the knowledge and skills required to deliver effective health care to adolescents | • Training and upskilling of professionals to ensure staff are able to understand the needs of young people and better support these needs at the time of contact.  
• Delivery of Adolescent Health Education, based on the Core Competencies in Adolescent Health for Primary Care Providers (WHO, 2015), open to all healthcare professionals working across TEHS. |
Adolescent health training has been vital in changing the culture of the environment in which young people are being treated. Training and upskilling of professionals' aims to ensure staff are able to understand the needs of young people and better approach these needs at the time of contact. It has taken time to embed this cultural change with the key being that young people are a source to be encouraged, that professionals’ preconceptions of young people are being challenged and in return young people are made to feel safe, secure and understood.

**Early Outcomes**

While the Adolescent Health Service is in its infancy and has not yet been formally evaluated, a number of positive outcomes are emerging:

- from 2014-2015, 58% of patients aged between 12-16 years of age were discharged from the paediatric wards
- from the same period in 2016-17, 83% of adolescents aged between 12-16 years were discharged from the paediatric wards
- a 25% increase in the number of patients aged 12-16 years discharged from paediatric wards from 2014-15 to 2016-17, demonstrating increased access to appropriate bio-psychosocial services for this cohort
- although the overarching goal is to target admission of those aged 16 and under, patients up to their 18th birthday, where suitable, can be admitted to paediatric wards (The general trend in data continues, when considering the percentage of patients discharged from 5A included 17 and 18 year olds. This rose from 46% in 2014-15 to 69% in 2016-17.)
- anecdotal evidence to suggest that less young people are having repeat presentations to hospital and taking their own leave from hospital
- more young people are feeling safe in the health service environment.

Feedback from young people who attended the service has included:

“*They look at all of me – not just my illness*”.

“I *like being engaged in my care- it makes me feel respected, like they understand, this makes me feel good*”.

“*Being able to access specialist services in my hometown, knowing my team knew what to do, meant I could access treatment and stay in the place that I love*”.

These outcomes will form the basis of Key Performance Indicators for the service as it continues to develop.
This plan is inevitably linked to NT National Partnership Agreement funded programs in both NT government and non-government sectors and through this, it is linked to many national strategies. These links have not been spelt out in the main Plan for the sake of brevity. Instead, these are referenced through the NT plans included.

For example, NT strategies and frameworks on Chronic Conditions and on Reducing Domestic, Family and Sexual Violence share these features. A few of the national strategies, plans and frameworks we have been asked to reference include the:

- National Drug Strategy 2017 – 2026
- Australian Secondary School Students’ use of tobacco, alcohol, and over-the-counter and illicit substances report in 2014
- National ATSI Peoples Drug Strategy 2014 – 2019
- National Alcohol and other Drug Workforce Development Strategy 2015 – 2018
- National Guidelines for Medication-Assisted Treatment of Opioid Dependence

During the implementation phase, particularly during KPI development, more explicit links may be made.

Similarly, the findings for the Commonwealth Royal Commission into Institutional Responses to Child Sexual Abuse are likely to be included in Territory Families strategic plans for this area which are referenced within this Plan.
## Implementation – detailed time frame

Table 5: Implementation time frame and actions

<table>
<thead>
<tr>
<th>Activities</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
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<tbody>
<tr>
<td>Advisory structure(s) set up</td>
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<td>links with other relevant NTG plans and identifying any gaps.</td>
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<td>Develop Aboriginal Data Governance protocol</td>
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<td>Clarify outcomes &amp; outputs: review reporting framework.</td>
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A potential Monitoring Report using a KPI traffic light matrix

This table provides an example of how activities, monitored annually as part of this Plan, may be reported. An annual report to Cabinet is anticipated. Each activity or program will have one or more indicators with appropriate targets and progress to date. The progress to date will be given a traffic light rating: red being target challenge(s) remain; amber, target still being achieved; and green, target achieved. What is given below are examples only, monitoring processes will be finalised between plan partners in the first year of the Plan.

Over time, the Plan’s evaluation and monitoring framework will become more sophisticated and able to report on intermediate and final outcomes, rather than reporting on simpler process indicators as shown below. Organisations providing programs within the Plan’s scope will be encouraged and supported through data sharing and the Plan’s evaluation and monitoring and governance frameworks to conduct effective evaluation of program outcomes. Evaluation should be built into the planning of any new programs so that all stakeholders can know whether a program worked and why or why not it met desired outcomes. Ideally, evaluations would be designed in line with Aboriginal data sovereignty principles as described later in this document. Evaluation results would be reported back to the communities involved, in formats that ensure community members can understand the results and then use them to inform input into further services aimed at making a difference in their community.

The Plan itself will also be evaluated. This could involve sophisticated research on service outcomes using data from across government and sectors through the SA/NT Datalink service and the Child and Youth Development, Research Partnership with Menzies School of Health Research. Data linkage on children and youth will allow longer-term outcomes to be evaluated. The benefits of most early interventions are likely to be realised only at the end of this 10 year Plan.
<table>
<thead>
<tr>
<th>Theme Activity No.</th>
<th>Activity</th>
<th>Indicator (provisional only)</th>
<th>Target (provisional only – to be negotiated)</th>
<th>Progress to date (as at July 2017 where available)</th>
<th>Traffic Light Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Healthy Under 5 Kids (HU5K) and similar well child health programs (DoH)</td>
<td>% of 0-5 year olds in community that have completed all age appropriate checks within last 12 months</td>
<td>50% by 2020; 75% by 2028</td>
<td>Remote government managed Health Centres: around 33%</td>
<td>Target challenge remains</td>
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<tr>
<td>1.2</td>
<td>Australian Nurse Family Partnership Program (ANFPP) in, for example Alice Springs, (DoH and Congress)</td>
<td>% of targeted mothers receiving regular visits</td>
<td>70% by 2020; 100% by 2028</td>
<td>60%</td>
<td>Target being achieved</td>
</tr>
<tr>
<td>2.1</td>
<td>Enrolment and attendance in quality early childhood education and care programs (DoE)</td>
<td>number of children and families enrolled and attending FaFT</td>
<td>“x no.” enrolled by 2020; and 2028 and “x%” attending by 2020 and 2028 for FaFT</td>
<td>Target being achieved</td>
<td></td>
</tr>
</tbody>
</table>
Discussing Aboriginal data governance and data sovereignty

the key to Aboriginal data sharing

Why discuss Aboriginal data sovereignty?

The issue of Aboriginal data sovereignty is raised as it is central to enable data sharing in the area of health and wellbeing. It is consistent with the:

- direction from the NTG on using technology and information to improve the lives of children and young people through this plan
- call for data hubs for sharing information across government in the Early Childhood Development Plan
- recommendation in this Plan for creating NT community data profiles, for local, place based action
- very similar call for local information to be provided to communities to promote place based solutions to social issues, and for Aboriginal data governance by Aboriginal people by Professor Ian Anderson, Deputy Secretary Aboriginal Affairs in the Department of Prime Minister and Cabinet during the 2017 Menzies Oration.

For some years, even before the initial introduction of the NT Aboriginal Health KPIs (NT AHKPIs), AMSANT has been ensuring each Aboriginal Community Controlled Health Services (ACCHS) has direct control over their own service or operational data. For example, the current NT AHKPI Data Management Policy (2015:3) says:

Each service provider organisation owns the NT AHKPI community level data that they have collected, and has a designated Community Data Sponsor responsible for their data …. Each provider organisation will have the opportunity to validate and comment on their community level data prior to finalising the reports.

More recently there has been global action to ensure control over data on Aboriginal people culminating, in Australia, with the ANU publication of a collection of essays on Aboriginal data sovereignty (Kutai and Taylor eds. 2016) and a symposium organised by the University of Melbourne and AIATSIS on 11-12 October 2017. AMSANT CEO, John Paterson spoke at the symposium.

Over 28% of any NT data publication, data sharing hub, or community profile will involve Aboriginal data. As Aboriginal and Torres Strait Islanders made up 41% of the NT 0 - 24 year old population in 2016 any child and adolescent specific publication is likely to have over 40% of its data being about Aboriginal people. When talking about the NT 0-24 year old population experiencing vulnerabilities, that proportion can rise sharply. As a result...
Aboriginal data sovereignty should now be considered, particularly in any new NT Government action involving Aboriginal data.

The Department of Health has begun a discussion about how to begin to incorporate principles addressing Aboriginal data sovereignty, both with a respected Aboriginal epidemiologist and the Aboriginal peak organisations (AMSANT and APONT) represented on the Plan’s Working Party. This is a complex issue requiring much consideration and discussion right across the NT Government and with its NGO partners. This should be resolved within the first year of this Plan’s implementation.

Definitions

The concept of data sovereignty ...is linked with indigenous peoples’ right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as their right to maintain, control, protect and develop their intellectual property over these. (Kukutai and Taylor 2016: xxiii)

This is consistent with the United Nations Declaration on the Rights of Indigenous Peoples 1997 (UNDRIP) which was ratified by Australia. Paraphrasing Kutai and Taylor (2016:2), Aboriginal data sovereignty is about the inherent and inalienable rights and interests of Aboriginal peoples relating to the collection, ownership and application of data about Aboriginal people themselves, their lives and their lands or territories.

It is also linked to the need to move away from deficit or deficiency reporting on Aboriginal health and wellbeing, to considering Aboriginal strengths and assets – to build on strengths to achieve progress, rather than solely concentrate on addressing disadvantage, while still taking disadvantage into account. Professor Maggie Walker (2016:80) talks about the ‘five Ds’— how Aboriginal data currently reported can be catalogued under: disparity, deprivation, disadvantage, dysfunction and difference.

Potential government commitment to facilitate data sharing

working towards Aboriginal data sovereignty

The NT Government will commit to considering the principles of Aboriginal data sovereignty in its work under the Child and Adolescent Health and Wellbeing Plan.

As a result, the NT Government will work to achieve the following actions.

Aboriginal participation in data governance structures representative of the population

Committee(s) set up to govern the creation of data hubs and/or community data profiles will have at least 41% representation nominated by Aboriginal organisations including community organisations at the peak level, or representation equal to the target group being examined.

This committee would negotiate the creation of data governance structures and protocols (and where needed at the local level with any existing community structure/ACCHOs/elders) on collection, analysis, sharing or reporting any data obtained about community members.
Using data on strengths rather than deficits

This (These) Committee(s) will seek to use/find ways collect and report on community strengths such as relationships with country, spirituality and rituals which have been found to positively affect health and wellbeing (Dockery 2010). It will also use indicators from the proposed new Prosperity Framework for the Aboriginal and Torres Strait Islander Health Performance Framework reports (as reported by Professor Anderson in the Menzies 2017 Oration). Further, the use of strength based methodologies to analyse this data will be explored.

Aboriginal involvement in decision making

Where possible, the NT Government will commit to involving Aboriginal and Torres Strait Islander people in decisions on what data to collect, and then to collect, analyse and report on Aboriginal data.

Training in Aboriginal data sovereignty for non-Aboriginal people

The NT Government will ensure that when any non-Aboriginal people are involved in data collection, analysis and reporting, they are “aware of the current concerns about the statistical construct of our lives and how some analyses are currently being conducted and reported to our detriment.” (Lovett in Kutai and Taylor 2016:214) or are trained to be so.

The adjacent box gives an example of Aboriginal data governance processes that could be used by the NT Government.

Panel: Governance processes for use of routinely collected health data with Indigenous identifiers at the Institute for Clinical Evaluative Sciences (ICES) in Ontario, Canada

1. Access to and use of data with Indigenous identifiers are approved by data governance committees organised and populated by the relevant Indigenous organisations*

1. Linked datasets with Indigenous identifiers are not routinely available to researchers and analysts, who must make specific application and seek approval from the relevant data governance committee before they can access them†

1. Researchers are required to discuss their projects with Indigenous community representatives, who may collaborate in the planning, conduct and reporting of the studies

1. Researchers and staff at ICES participate in ongoing initiatives to orient them to Indigenous world views, research principles, and historical and social contexts

1. Staff at ICES are working with representative organisations to build capacity among Indigenous organisations and communities to train Indigenous analysts and epidemiologists

1. Study results are co-interpreted with the communities and their representatives, who have a lead role in deciding how the results will be communicated more widely.

(Source: Walker, Lovett, Kukutai, Jones and Henry 2017:2023)


NT Department of Health (2013) NT Department of Health Annual Report 2012-13, NT DoH, Darwin, NT. Accessed 27 April 2018:


Territory Labor, (2016b) *Healthy, Strong Communities*, ALP, Darwin, Northern Territory NT.


Summary Statistics at a Glance - References
(to most references used in both documents of the Plan)


