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POLICY

FUTURES

A Reform Agenda












THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

Winston Churchill Trust
Learn globally, inspire locally.

This publication was edited and produced under the direction of the
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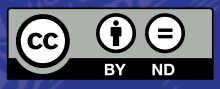

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Preface

Policy Futures: A Reform Agenda is the culmination of the Policy Impact Program – a partnership between The University of Queensland and The Winston Churchill Memorial Trust.

Every year, talented Australians from all walks of life are awarded Churchill Fellowships to travel overseas and investigate inspiring and best practices that could benefit Australian communities. Through their travels, Churchill Fellows access and exchange knowledge and experiences with industry and community leaders from around the world who have insights to offer in relation to the Fellows' areas of focus. They also explore, first hand, international policy development and implementation, reviewing what has been successfully achieved in other countries and most importantly how it might be applied within Australia. Policy practitioners and decision makers could benefit from drawing on such lessons and adapting them to the local context, as well as reducing the risk of unknown consequences when designing and implementing new policy for Australia.

Most Churchill Fellows, however, are not policy experts nor come from a background of public policy. With that in mind, the Policy Impact Program was developed by the Centre for Policy Futures at The University of Queensland and The Winston Churchill Memorial Trust with the intent to help Churchill Fellows draw upon their knowledge in such a way to best inform policy reform. The Policy Impact Program and its flagship publication, *Policy Futures: A Reform Agenda*, combines some of the best of the Churchill Fellows' ideas and insights with the policy and governance expertise of the Centre for Policy Futures. The Churchill Fellows accepted into the Policy Impact Program were chosen by a Selection Committee of 10 highly esteemed members, following a rigorous application process. The articles featuring in this publication were written by the Fellows while participating in the program, and have been independently peer reviewed by academics, policymakers and/or expert practitioners in their relevant fields.

View this publication online, learn more about the Policy Impact Program, or request a presentation by our Fellows, at: **churchilltrust.com.au/policy-futures**

About The Winston Churchill Memorial Trust

The Winston Churchill Memorial Trust was formed in 1965 to honour Sir Winston Churchill's memory through the awarding of 'Churchill Fellowships'. The original funding for the Fellowships came from a highly successful national doorknock appeal shortly after Churchill's funeral, and generous contributions from Australian businesses and government. These funds, along with donations, bequests, sponsorships, and partnerships, provide Australians from all walks of life with the opportunity to travel overseas to investigate a topic they are passionate about, to gain skills and knowledge not readily available in Australia. They also reward leaders and potential leaders in their fields with further opportunities in pursuit of best practice for the enrichment of Australian society. No educational qualifications are required to apply for a Churchill Fellowship and the proposed project topic is limitless, provided a benefit to Australia and willingness to share project findings with the Australian community is displayed. To date, over 4,600 Australians have been awarded Churchill Fellowships.

Read more about our Churchill Fellows and their diverse range of projects at: **churchilltrust.com.au**

About Centre for Policy Futures, The University of Queensland

The University of Queensland's Centre for Policy Futures provides robust, rigorous research to help governments meet the policy challenges of tomorrow, today. The Centre's interdisciplinary team of researchers, affiliates and visiting fellows undertake independent, peer-reviewed research, as well as commissioned reports, discussion papers and policy briefs across its research themes. By working closely with governments, international bodies and not-for-profit organisations, and using the extraordinary wealth of knowledge from the academic community in Australia and abroad, the Centre aims to improve understanding of the complex policy challenges facing society and, most importantly, what might usefully be done to address them.

Read more about the Centre, our researchers and work at: **policy-futures.centre.uq.edu.au**

Acknowledgements

The Winston Churchill Memorial Trust and The University of Queensland acknowledge and pay respect to the past, present and future Traditional Custodians and Elders of this nation and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples.

This publication was produced under the direction of the Policy Impact Program Steering Committee with valuable guidance from the Editorial Committee. We would like to thank all of those involved in bringing the Policy Impact Program and this flagship publication to fruition. To the members of the Selection Committee for their time and efforts to review and shortlist the successful Churchill Fellows for the program – a non-trivial task given the number of high calibre applications received; and to the Policy Peer Reviewers for undertaking professional reviews and guidance in the drafting of the Fellows' articles. For their valuable input through this program, we would also like to extend our thanks to the staff at the UQ Centre for Policy Futures, and the team at The Winston Churchill Memorial Trust.

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Ms Cathy McGowan AO, CF	Former Member of Parliament (Independent for Indi)
Mr Craig Ritchie CF	Chief Executive Officer, Australian Institute of Aboriginal and Torres Strait Islander Studies
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Mr David Trebeck CF	Board Chair, The Winston Churchill Memorial Trust
The Hon. Margaret White AO	Co-Patron and former Board Chair, The Winston Churchill Memorial Trust

*CF – Churchill Fellow

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Women's and Children's Health

Dr Rosemary Wyber
Research Fellow
Australian National University
and Telethon Kids Institute

Policy Impact Program Fellows 2022

Steven Caruana CF (NSW)
To enhance best practice inspection methodologies for oversight bodies with an Optional Protocol to the Convention Against Torture focus – Greece, Malta, New Zealand, Norway, Switzerland, and the United Kingdom.

Belinda Cook CF (WA)
To research the growing global Indigenous fashion industry to support a Kimberley textile industry – Indonesia, Malaysia, Singapore, South Africa, and the United States.

Julie Dunbabin CF (TAS)
The Elvie Munday Churchill Fellowship to investigate the factors that enable school lunch programs to impact positively on student health and wellbeing – Finland, France, Italy, Japan, the United Kingdon, and the United States.

Niroshini Kennedy CF (VIC)
The Jack Brockhoff Foundation Churchill Fellowship to investigate integrated models of care for Aboriginal children in out-of-home care – Canada New Zealand, and the United States.

Rebecca Lyons CF (TAS)
To investigate human relationships to death and ceremony through alternate approaches and technologies – Czech Republic, Italy, Mexico, Sweden, and the United Kingdom.

Clement Ng CF (NT)
To study mental health courts and other justice responses to youth with mental health issues – Canada, New Zealand, and the United States.

Declan Page CF (SA)
To assess natural treatment systems for Australian applications of water supply and water recycling – Germany, Spain, the United Arab Emirates, the Netherlands, the United Kingdom, and the United States.

Angela Rintoul CF (VIC)
To investigate international lessons for public health policy and improved regulation of gambling – Finland, Norway, Sweden, Switzerland, and the United Kingdom.

Maida Stewart CF (NT)
The Bob and June Prickett Churchill Fellowship to examine healthy housing initiatives in the primary prevention of acute rheumatic fever – New Zealand.

Jeremy Wiggins CF (VIC)
To investigate models of health service delivery to transgender and gender diverse populations – Canada, Germany, Thailand, the United Kingdom, and the United States.

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Introduction

The inaugural *Policy Futures: A Reform Agenda* was launched at Parliament House in March 2021 by former Minister for Indigenous Australians, the Hon. Ken Wyatt AM, and was circulated nationally to more than 2,000 policy stakeholders, generating considerable interest.

The Churchill Fellows featured in last year's publication have continued to pursue and advocate for their policy ideas, contributing to policy developments across the country. Updates from these Fellows can be read on pages ix–xii.

On the back of this success, we are delighted to again offer another selection of contemporary perspectives from Churchill Fellows that have the potential to shape best practice and policy reform on some challenging and pressing issues facing Australia today.

The pandemic's long tail of disruption continues to be felt around the world. At the same time, global unrest and climate threats are on the rise. Closer to home, we are gripped by crises in housing, cost of living, health care and skills shortages. These pressures are taking a toll on the collective mental health of our society.

With these challenges in mind, the words of Winston Churchill, 'Healthy citizens are the greatest asset any country can have,' may be reflected upon to provide inspiration from which to inform contemporary policy thinking at all levels of government.

It is encouraging that our Australian Government is adopting a 'wellbeing budget,' which has the potential to focus policy makers on the health of our citizens by measuring the impact on things like social equity, environmental health, and mental wellbeing.

The importance of supporting healthy citizens and healthy communities has emerged as a strong theme from the articles in this edition of *Policy Futures: A Reform Agenda*. Healthy school lunch programs to improve our children's health and education (page 26), better ways of caring for our dying and deceased (page 49), water banking for drought resilience (page 55), preventing harm from gambling (page 37), and supporting families to access transgender health for young people (page 43). These are just some of the policy ideas to stimulate fresh thinking or to consider different ways of approaching issues from a 'health of the citizen' viewpoint, which have been effective in other countries.

Critically, the health of our First Nations People is highlighted as an area where policies have not been working effectively. The Productivity Commission's second annual report, released in July this year, showed progress on several Closing the Gap targets is not on track including children's educational development, rates of out-of-home care and adult imprisonment and deaths by suicide.

There are many ideas that might contribute to improving the health of our First Nations people, from adequate and appropriate housing, culturally safe and appropriate education and health care, to stimulating employment and engagement. They are complex and interlinked issues that work as part of a broader system, as Professor Tom Calma discusses in his introduction (page vii).

It is intended that this publication will serve to increase the accessibility of valuable evidence and experiences to policy makers within Australia. We also hope that it will encourage more partnership approaches toward developing public policy that are informed by broad groups of experts, including Churchill Fellows. And perhaps the articles will inspire more public policy makers to consider opportunities such as Churchill Fellowships themselves to further broaden their ideas and capabilities for the betterment of Australian society.

Adam Davey
Chief Executive Officer
The Winston Churchill Memorial Trust

Professor Greg Marston
Director, Centre for Policy Futures
The University of Queensland

Closing the gap

A note from Professor Tom Calma AO

Policy Futures second edition includes four Churchill Fellow-developed reform agendas that have the potential to not only transform many Indigenous peoples' lives for the better, but also support Australian governments to achieve the 2020 National Agreement on Closing the Gap targets, including:

- Reducing the rate of over-representation of Indigenous children in out-of-home care (OoHC). In *Safe, Healthy and Thriving*, Kennedy proposes integrated OoHC health care hubs to detect and treat complex health, developmental and mental health challenges in OoHC-involved children. The purpose is to help children leave OoHC and turn around potential trajectories towards youth justice. Kennedy's work is informed by her Churchill Fellowship investigation into OoHC health care models, including Indigenous-specific models in Canada, New Zealand, and the United States.
- Reducing the rate of Indigenous young people in detention. In *It's Time to Treat Sick Kids, Not Punish Them*, Ng proposes shifting Indigenous involvement with youth justice to a preventative footing by adopting a 'therapeutic court' model. This reframes justice system contact as an opportunity to address complex mental health needs and reconnect young people to their families and communities. Funded by a Churchill Fellowship, Ng visited 15 youth courts in Canada, New Zealand, and the United States to inform his model.
- Increasing the proportion of Indigenous people living in non-overcrowded housing. In *Healthy Housing Programs,* Stewart makes recommendations to enliven Australia's Rheumatic Heart Disease Endgame Strategy, with reference to New Zealand's Healthy Homes Initiative to reduce acute rheumatic fever and rheumatic heart disease in Māori and Pacific Islander communities. Stewart's recommendations are informed by a Churchill Fellowship to explore this initiative in Auckland on Aotearoa's North Island.
- Increasing economic participation and development of Indigenous people and communities. In *First Nations First*, Cook proposes support packages to grow a thriving First Nations fashion sector that, among other benefits, supports Indigenous community wealth creation. Supported by a Churchill Fellowship, Cook consulted with First Nations and other designers, fashion and textile businesses, and sector leaders in Indonesia, Malaysia, Singapore, South Africa, and the United States to develop her program.

At the 2021 National Convention of Churchill Fellows in Brisbane, I spoke about the transformative power of ideas, and I commend each of the above as exemplars of that potential. As I highlighted at the Convention, 'there is nothing as powerful as an idea whose time has come.'

Indeed, over my decades in public life, I have been fortunate to be involved in promoting ideas that have the potential to transform, or that have completely transformed, the Indigenous Affairs space.

The first I want to talk to is the 'Closing the Gap' program. As the Aboriginal and Torres Strait Islander Social Justice Commissioner in the 2005 Social Justice Report, and subsequently with other Indigenous leaders and peak bodies, I created the 'Close the Gap Campaign' for Indigenous health equality.

'Close the Gap' is shorthand for progressively realising Indigenous equality across a range of indicators. And like elements of Kennedy and Ng's reform agendas, the concept emerged offshore: through the human right to the highest attainable standard of health but applied to the position of Indigenous people in Australia. Its main elements are:

- working in partnership with Indigenous peoples
- quantifying Indigenous–non-indigenous health gaps
- planning to close the gaps
- setting time frames to close the gaps (targets)
- adequately resourcing the responses needed.

It's one thing to promote a transformative idea, but another thing to see it realised. For that to occur, we needed both Indigenous community support and the bipartisan support of Australian governments. Thankfully, that was achieved by 2008 and the program continues in the 2020 National Closing the Gap Agreement whose targets were mentioned above.

Equally potentially transformative is the justice reinvestment concept, which aims to redirect funding away from prisons and into Indigenous community generated solutions that reduce imprisonment. This is particularly for minor offences and innovation can be as straightforward as supporting unlicenced young people who are driving anyway to get their driver's licence and therefore drive legally – potentially avoiding fines and prison.

Justice reinvestment also has offshore origins. Based on United States' models, it was in 2013 that Bourke's Indigenous community, working with Just Reinvest NSW, began to lead a justice reinvestment process. A 2017 evaluation reported significant reductions in both recorded rates of domestic violence and adult days spent in custody coincident with increases in Year 12 retention among younger community members. It calculated the program had saved the NSW economy $3.1 million.

Justice reinvestment is a transformative idea whose time has come. And as a Just Reinvest NSW Champion, I commend the potential of reducing Indigenous young peoples' contact with the justice system in Kennedy and Ng's Policy Futures reform agendas, including through a justice reinvestment lens. I also urge Australian governments to adopt justice reinvestment as a primary response to Indigenous overrepresentation in our prisons.

At the 2021 National Convention, I spoke to how the caravan convoys sent to NSW Indigenous communities to enable people with Covid-19 to quarantine exposed structural inequality – entrenched and unbalanced power relationships within Australian society – of which the housing crisis (the subject of Stewart's Policy Futures paper) is but a symptom.

This leads me to a third transformative idea: the Indigenous Voice to Parliament that Professor Marcia Langton and I have helped lead debate on in recent years and that has the potential to enable the kind of structural change needed to address the housing crisis and a wide range of ongoing challenges.

The Voice is intended to be a mechanism for the Australian Government to meaningfully engage Indigenous peoples in fora on matters relating to us. It will also be able to make representations to government. While Parliament retains legislative power, and ministers their executive powers, the Voice would advise and guide their work in the Indigenous Affairs space. It is structural change in that Indigenous people will have a 'place at the table' with the Australian Government and a say in matters that affect them. Having such a say is essential to the development of effective Indigenous policy.

I define effective Indigenous policy, first, as that supported by Indigenous communities and, second, responsive to Indigenous cultural contexts. This includes strengths-based policy which promotes connection to family, community, Country and spirituality as sources of Indigenous health and social and emotional wellbeing. I also include policy that addresses the intergenerational legacies of colonisation and seeks to deliver reparative or restorative justice as the basis of Reconciliation. Indeed, as Co-Chair of Reconciliation Australia, this is another primary interest of mine. (And I also note that this is what the Closing the Gap program aims to achieve.)

In concluding and reflecting on the value of being exposed to offshore innovation and transformative ideas in any area including Indigenous Affairs, I highlight the great potential of Churchill Fellowships supporting scholars travelling overseas to that end and the dissemination of their work in *Policy Futures.*

I also take pride as Trust Patron to note that Ng, Kennedy, Stewart and Cook's *Policy Futures* reform agendas continue a now half-century long tradition of the Trust engaging positively with Indigenous policy: from Indigenous parliaments and governance mechanisms; to strategies for Indigenous economic engagement; and to cross-cultural education.

I also commend the Trust's active promotion of Indigenous scholars and thought leaders over the past 50-years. Indeed, there have been 71 Indigenous recipients of Trust support since 1967. And in 2022, almost ten per cent of newly awarded Churchill Fellows are Indigenous. This is a fantastic achievement and I encourage these Fellows to continue to meet as an Indigenous alumnus and progress a transformative Indigenous Affairs agenda through The Winston Churchill Memorial Trust.

Professor Thomas Edwin Calma AO
Co-Patron of The Winston Churchill Trust

Tom is an Aboriginal elder of the Kungarakan people, south-west of Darwin, and a member of the Iwaidja people on the Coburg Peninsula in the Northern Territory. Tom has worked in the public sector for 45 years and currently serves on a number of boards and committees focusing on Indigenous affairs.

Policy impact update

Policy Futures: A Reform Agenda 2021: From L-R Trent Nelson, Chair Dja Dja Wurrung Clans Aboriginal Corporation, Katherine Webber CF2018, Katrina Marson CF2018, Scott Falconer CF2017, Jennifer Bowles CF2014, Claire Seppings CF2015, Natalia Krysiak CF2018, Taryn Lane CF2016, Jessica Cocks CF2016, Steve Harrison CF2015, Megan Gilmour CF2016.

The Churchill Fellows featured in last year's inaugural *Policy Futures: A Reform Agenda* have continued to pursue and advocate for their policy ideas, with media and community engagement, stakeholder consultation, government meetings and other advocacy activities. We are proud to have assisted these Fellows during the Policy Impact Program (PIP), and look forward to following their impact journeys.

View their articles and presentations at: **churchilltrust.com.au/policy-futures**

Jennifer Bowles CF (VIC 2014)

The case for effective mandated substance abuse treatment for young people

It was a tremendous privilege to participate in the inaugural Policy Implementation Program (PIP), which provided expertise to assist PIP Fellows to implement their Churchill Fellowship recommendations. The highlights of this unique partnership between The Winston Churchill Memorial Trust (Churchill Trust) and The University of Queensland (UQ) included:

- gaining expertise from UQ specialists in policy development, effective engagement with members of parliament and government advisers, and the media
- the unstinting commitment and imparting of knowledge from those at Churchill Trust and UQ in refining my *Policy Futures* article
- the collaborative and collegiate support of the PIP Fellows and all involved in the PIP.

Evidence of the PIP publicising and highlighting Fellowship recommendations was demonstrated by The Honourable Ken Wyatt AM, Federal Minister for Indigenous Affairs, who when opening the 2021 National Indigenous Drug and Alcohol Conference, commended my *Policy Futures* article. In addition, I have accepted an invitation to present the recommendations in my article at an interstate invitation-only leading health professionals' symposium.

I included the PIP article in submissions made to Victorian and Tasmanian inquiries, to the Queensland and South Australian governments and in discussions with parliamentarians and the media. There are synergies between my recommendations and those of two other PIP Fellows and we intend to publish a joint article.

I am confident my article in *Policy Futures* will be pivotal in effecting the reforms urgently required by our community and desperately needed by our most vulnerable young people. I am forever grateful for this opportunity.

Megan Gilmour CF (ACT 2016)

Don't wait until they're well: School policy and technology to keep sick kids connected

The COVID-19 pandemic provided unparalleled insight into the negative effect of isolation on everyone, especially kids. The PIP arrived right on time. A year on, it continues to deliver results for children in Australia by putting my Churchill Fellowship findings to work via policy proposals that make sense for Australia today.

My policy platform to have school students with a health condition recognised as a priority equity cohort in every state and territory has been covered by The Australian newspaper and Women's Agenda, with national television coverage pending.

All state and territory education and health ministries, and the respective departments, received my policy paper on launch. I have presented to the Commonwealth Attorney-General's Department, Productivity Commission, and Department of Education, and flagged the issue with the Department of Health.

Leading up to the 2022 federal election, I contacted all national members of parliament with a policy backgrounder. I then presented a policy perspective to senior members of the Australian Government, the opposition, and other parties. In response, the Government triggered a process involving state and territory education systems to implement my primary policy recommendation: setting a national 'health condition' absence code for use in schools across Australia. A specific code will enable early detection and monitoring of chronic school absences in children with physical and mental illness, trigger options for school support, and enhance the national evidence base through improved data.

Ten years in the making, this is a catalytic policy achievement. Now our new national initiative – Sick Kids Seen&Heard – is underway.

Katherine Webber CF (QLD 2018)

We need to talk about public toilets: Policy agendas for inclusive suburbs and cities

Participating in the PIP has launched me into the world of radio, amplifying the discussion about the importance of public toilets. Prior to the PIP launch I had spoken only once or twice with journalists about public toilets. With the support of the media training and the promotion of the PIP, I have spoken with journalists across Australia and the globe. Often the interviews and articles have contributed to community discussions around public toilets. I have also increased my network of connections with experts in Australia and internationally so there is an informal group of us calling for policy change. A highlight was being asked to be the 2022 media spokesperson for the Great Dunny Hunt – asking people to update the National Public Toilet Map. Without community awareness and demand I do not see major policy change occurring, but through the continued discussion on the importance of public toilets, the call for change is getting louder.

Steve Harrison CF (TAS 2015)

Employment logic: The cultural shift needed to improve VET outcomes for school students

Participating in the PIP was one of the most professionally rewarding experiences of my long career. While my 2015 Churchill Fellowship was a highlight in that it gave me the opportunity to bring international knowledge back home, and inspired me to deliver vocational training in the context of a socially-simulated workplace, I had little traction in getting wider uptake of my ideas beyond the school in which I worked. The PIP truly supports the concept of 'learn globally, inspire locally,' developing skills, knowledge and networks to take my Fellowship learnings to a wider policy stage.

My PIP paper has informed a national review of vocational education quality assurance, been modelled by national Industry Training Hubs, and informed curriculum reform in three states. Personally, it gave me the confidence to leave education, and my home of 50+ years, as I moved interstate to take up a position of Training and Development Manager with Australia's largest aquaculture company. Now from an industry perspective I work with a range of schools, education providers and workforce development agencies to implement my 'employment logic' model to improve VET outcomes for school students, and provide them with real employment pathways into our industry.

Jessica Cocks CF (NSW 2016)

Peer parent and family advocacy in child protection: A pathway to better outcomes for kids

Being involved in the PIP has fuelled the impact of my Churchill Fellowship. With the skills I gained and the connections I made, I promoted not only my findings but the 'green shoots' of parent and family peer advocacy in child protection, which are emerging around Australia.

We are now seeing innovative parent advocacy projects pop up in locations around Australia. These initiatives are diverse and receive funding from a range of sources, suggesting we will continue to see them grow and be sustained. Parents with lived experience are now 'at the table' in a range of ways, including in direct services with parents and family, and staff and carer training and service design. Lived experience is increasingly being heard at the policy development level with parent and family leaders playing roles as advisors, activists and researchers in child protection. The number of supportive 'allies' is also growing with many social workers, researchers, lawyers and others joining me to promote parent and family peer advocacy and support parent advocates. This is exactly the kind of change we need to see in child protection to stop the cycle of child removal and prevent children's unnecessary loss of family. We have a long way to go to change child protection for the better in Australia, but momentum continues to build, thanks to the Trust's investment in this important work.

I am continuing to get opportunities to promote my work. For example, I will be publishing a chapter in a forthcoming Routledge International Handbook on child and family social work research.

Claire Seppings CF (VIC 2015)

Breaking the cycle: Straight talking ex-offenders reduce recidivism

The PIP provided me with the unique opportunity to transform my Churchill Fellowship findings into policy. It was a new and invaluable area to me. On return from my Fellowship, I implemented the 'Straight-Talking Peer Mentoring Project', with Deakin University, Department of Justice and Community Safety (DJCS) and philanthropists. When funding ended in 2019, the key was to maintain the interest and attract sustainable government funding. As inaugural PIP Fellows our articles took time, but the level of help provided was amazing. We also had the pandemic to manage. I felt an extra layer of special honour added to being a Churchill Fellow (if that's not enough). Being featured in such a way will continue to enhance my life.

Since the launch of *Policy Futures: A Reform Agenda* at Parliament House, Canberra, the ABC interviewed me and published an article on the 'Straight-Talking' program, and I was interviewed by DJCS as an expert to help inform their cultural review of the adult custodial corrections system. I also presented for The Reintegration Puzzle webinar series, which brings together individuals and organisations working to assist people to successfully reintegrate into the community after prison. I am still a social worker at Services Australia and am doing my voluntary justice work as a member of the Women's Correctional Services Advisory Committee; as chair of the Victorian Custody Reference Group; as a consultant on my Fellowship and 'Straight-Talking'; and in advocating and collaborating with others on what is needed to help reform the criminal justice system. I feature as a case study in the upcoming publication of *Co-production and Criminal Justice* and I am expecting another publication combining the 'Justice, Rights and Empowered Communities' PIP Fellows. A perfect synergy providing innovative solutions to enduring social dilemmas.

Owen Churches CF (SA 2018)

Artificial intelligence and human government

Following the publication of my *Policy Futures* piece, I have further developed the relationships needed to engage in the ethics of artificial intelligence in government. I have presented seminars to the Queensland Department of Environment and Science, the South Australian Commission for Excellence and Innovation in Health, and the South Australian Department for Education.

The peak community for artificial intelligence ethics study that I founded as a book club almost three years ago has now grown to include more than 100 members across four countries. We continue to meet each month with new books on the topic chosen by members. In an important step toward genuine community building and succession planning, I have stepped down as the convener of the group, which is now maintained by two long term group members.

Finally, through my public engagement and reading, I have further developed my understanding of what the problems with artificial intelligence use are and what the solutions could be. I have broadened my critique of governments' use of artificial intelligence to include all quantitative work that forces end uses to change their behaviour for the sake of more efficient control by a central authority.

Taryn Lane CF (VIC 2016)

Zero carbon communities: A blueprint for clean energy transitions

It was really a pleasure to have the support of The Winston Churchill Memorial Trust, The University of Queensland, and the PIP cohort to think through policy ideas more broadly.

In regard to lobbying outcomes in Victoria, the Parliamentary Inquiry into Tackling Climate Change in Victorian Communities has been released, stating 'in principle support' for a Community Energy Target and 'full support' for research into a financial mechanism (like a feed-in-tariff). The Federal Labor party, in the lead up to the election, released their Community Battery and Solar Banks model, to which I provided insights to help ensure the criteria is flexible enough to meet the needs of communities on the ground.

We received funding to expand our zero net emission model to include climate change adaptation, and an additional project to explore community batteries in our local community. I was privileged to be inducted into the Victorian Women's Honour Roll in late 2021 for my climate change work. All of these outcomes help me to be of better service to my community. My effectiveness has been enhanced by firstly the Fellowship and then the PIP.

Natalia Krysiak CF (NSW 2018)

Design and planning policy for family-friendly apartment living

The PIP has expanded my knowledge of local, state and national policy and allowed me to further my understanding of how I can best impact policy change. Since completing the program I have had the opportunity to meet with numerous local and state-based policy makers to discuss how we can achieve better outcomes for families with children living in apartments. My recommendations for updates to the NSW Apartment Design Guide have been taken on board with strong indication that state-based policy will be amended to accommodate these changes. Local governments have also indicated that my recommendations will be pursued, and the City of Parramatta has commissioned me to create a local guide for them based on my research. There has also been interest from media with The Guardian publishing an article on this topic, with quotes from myself and other experts, which has been well received by industry. The PIP has propelled my advocacy work to a new level, with real policy shifts resulting from the knowledge I have gained.

Katrina Marson (ACT 2018)

Ignorance is not innocence: Implementing relationships and sex education to safeguard sexual wellbeing

Since the PIP, my advocacy in the space of relationships and sexuality education has garnered increased traction and attention – both from the public and key decision makers. Having synthesised my Churchill findings into the PIP article, I now have a credible but succinct product to cite, and to provide to stakeholders. For my own purposes, having articulated my findings for a policy-specific purpose has been a useful exercise for targeting my advocacy strategically. Since the article was published, I have had numerous media opportunities, have had a piece published in a journal, and have had a book published by Scribe Publications, *Legitimate Sexpectations: The power of sex*, which details my Fellowship experience. I also helped to found and launch the Relationships and Sexuality Education Alliance ACT.

Scott Falconer CF (VIC 2017)

How self-determination is returning white smoke to Country

Since the launch of *Policy Futures: A Reform Agenda* at Parliament House, I have had numerous media commitments including ABC Conversation Hour, presented at ANZSOG and IPPA Victoria, and been invited to talk to universities and other forums regularly. The uptake of many of my recommendations in Victoria since I published my Churchill report, and subsequently the PIP program and article, has been remarkable. I cannot take all the credit, as Traditional Owners lead in this space, however, I believe I have had significant influence on how this is being led in Victoria to support Traditional Owners through self-determination.

Most significantly, the Victorian Government has invested $22.5 million to reinvigorate Traditional Owner-led cultural land and fire management practices. This has been allocated to Traditional Owner groups in Victoria. This funding will significantly support Aboriginal Victorians' aspirations to implement the Victorian Traditional Owner Cultural Fire Strategy and further enable Traditional Owners to manage Country utilising cultural fire methods. Planned work is being undertaken to provide Traditional Owners with tailored training, and enable groups to more easily nominate, plan, and deliver cultural burning with minimal administrative burden and largely independently so they can burn when, how and where they want.

More than one hundred cultural burns are now listed on the Victorian Joint Fuel Management Plan, nominated by more than half a dozen Traditional Owner groups across Victoria. During Spring about a dozen of these important cultural burns are scheduled, all planned and led by Traditional Owners, with support from Forest Fire Management Victoria.

Boys at Don Dale Youth Detention Centre. Image credit: Eleni Roussos / ABC News.

It's Time to Treat Sick Kids, Not Punish Them

By Clement Ng
Churchill Fellow 2016

Key terms: First Nations, mental health, youth justice, criminalisation, health equity, diversion

'I had a lot of panic attacks at Don Dale. When these attacks happened, I would start breathing quickly and my heart would beat so fast it felt like jumping out of my chest [sic]. My legs would start shaking and it felt as if I was about to drop to the floor. I felt really worried and did not know what was going on ... The counsellor says I have panic attacks and that I have PTSD. Now when I hear keys rattling my heart beats fast. I think it is from my time in Don Dale when I didn't see my family and from what happened to me there.' **– statement of vulnerable witness BQ to the Royal Commission into the Protection and Detention of Children in the Northern Territory.[1]**

This is the testimony of a child struggling with psychological distress in our youth justice system before the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory (royal commission). Mental health issues and developmental trauma are experienced by the majority of young people involved in the youth justice system. More often than not, the social and emotional wellbeing needs of these children are not adequately met and sometimes their poor mental health is being used to justify their further criminalisation and unfair treatment. Investing in community-based, holistic, and trauma-informed mental health care delivered by specialists will help us to divert children with mental health problems from confinement to treatment. Piloting a youth mental health diversion court in a small jurisdiction like the Northern Territory (NT) would be a good start.

The royal commission found 56% of children who gave evidence about their experience in youth detention had a history of self-harm and/or suicidal ideation.[2] Recent studies in Australia and the United States have confirmed the high rate of mental disorders among children involved in the justice system and detention centres.[3]

Figure 1. Children in the youth justice system

33% of youths in custody reported high to very high levels of psychological distress.

60% of young offenders presented with two or more disorders.

Source: National Children's Mental Health and Wellbeing Strategy 2021.

The latest 2019 *United Nations Global Study on Children Deprived of Liberty* (UN Global Study) reported that children in detention centres 'have a remarkedly higher prevalence of mental disorder than their community peers'.[4] Further, justice-involved children are more likely to receive more than one mental health diagnosis or suffer from a dual diagnosis of mental health and substance misuse.[5]

There is little doubt that children with mental health disorders are over-represented in our criminal justice system. But experts say that they are also disproportionately affected by punitive policy and practices.[6] This means they are more likely to be arrested, remanded without bail, detained for a longer period, or subject to repeated isolation in detention. In 2021 in the NT, a 15-year-old girl with a significant history of trauma was charged with a range of criminal offences and remanded in custody, but the judge ultimately dismissed all her charges because the court was satisfied that she either did not understand her conduct was wrong or she could not control her conduct due to her multiple mental health diagnoses.[7] This raises the question: could her unnecessary criminalisation and detention have been avoided if more efforts had been made to identify, diagnose and treat her mental health and developmental trauma in the first place?[8]

Not only is our criminal justice system failing to divert children with complex mental health issues out of the system, but it is also making their mental health worse. The UN Global Study highlights that the psychological impact of detaining children is 'inherently distressing, potentially traumatic, and having adverse impact on mental health, often exacerbated by poor treatment and unsatisfactory conditions'.[9] The royal commission was shown CCTV footage of a young person during his first time in detention repeatedly harming himself after being placed in an at-risk isolation cell for three hours with no natural light, access to water, or supportive staff interaction – an episode that the royal commission accepted was highly disturbing and distressing, and potentially dangerous to the mental health of the young person.[10]

In the NT, the mental health care of young people in detention has continued to be inadequate even after the royal commission.[11]

'We must look behind the offending to the complexities, the cultural background, the reasons why they have offended. Ask, not only what happened, the details of the offence, (that is the easy bit) but what is it that happened to you. We cannot hope to get an answer to this question unless there is full engagement and it is only then that we can we have any hope of redirecting their life trajectories, and reclaiming these young lives for the benefit of all.'[34]

– Judge Walker, Principal Youth Court Judge, New Zealand.

For example, the treatment of a female detainee at Don Dale Detention Centre was found to be unsatisfactory and 'a clear breach of most of Australia's international agreements on human rights'.[12] Children with mental disorders in detention should of course have the same rights as other children in detention. But they are also entitled to specific protections under the *UN Convention on the Rights of Person with Disabilities* and the *Principles for the Protection of Persons with Mental Illness*.

This is not just about children in custody and their human rights. As a society, we need to understand that the inability to identify and treat our children's mental health is not just a problem for the criminal justice system – it can have drastic consequences in the broader community as well. In 2020, the lives of three Indigenous teenage girls in the NT were lost to suicide after government agencies failed to respond to their significant trauma and mental health needs.[13]

Consideration of the issues

Policy frameworks

Almost 95% of children in NT detention are Indigenous,[14] and one of the 17 targets of the *National Agreement on Closing the Gap* is to reduce the over-representation of First Nations young people in our criminal justice system by 30% by 2031.[15] Given the prevalence of complex mental health issues among children in the youth justice system,[16] effective strategies that improve the mental health of First Nations young people will no doubt reduce their criminalisation and in turn, their over-representation.

Furthermore, Australia introduced its first *National Children's Mental Health and Wellbeing Strategy* (National Strategy) in October 2021. For children (including children at risk of entering or involved in the justice system), the National Strategy emphasises two main priorities:

- to provide children with priority access to mental health services[17]
- to adopt a holistic care model for these children.[18]

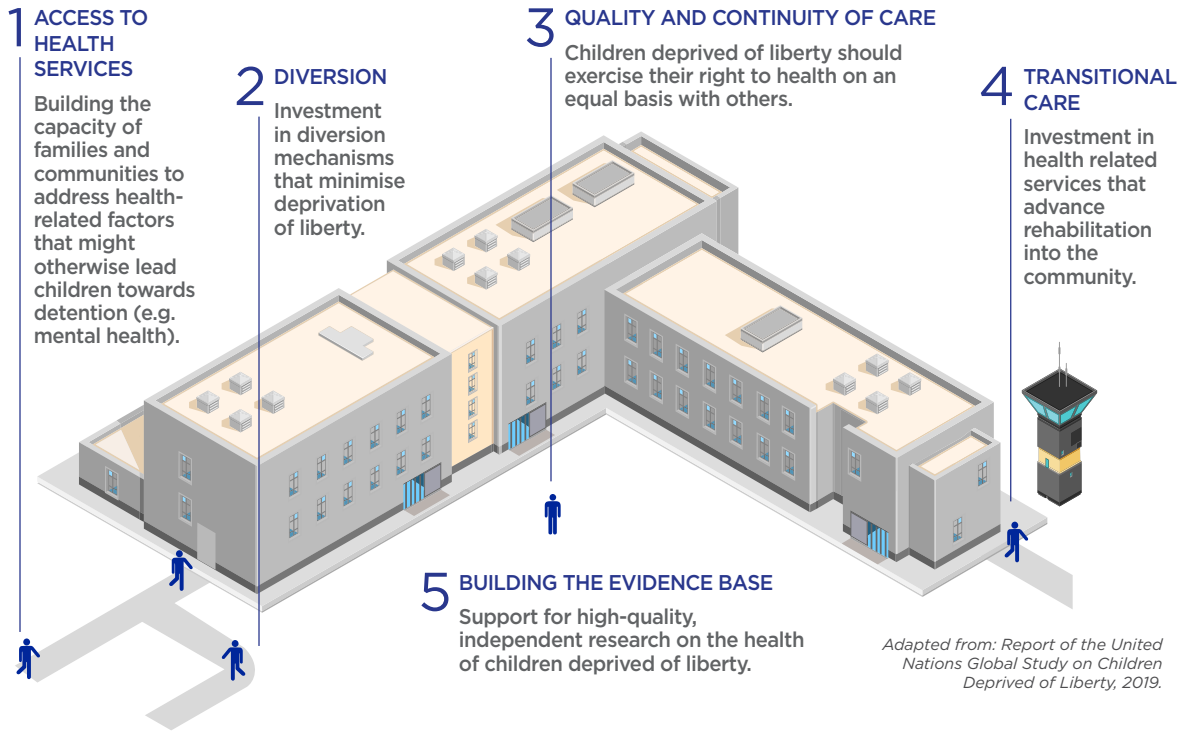
Community mental health care

Priority access and a holistic care model are both good characteristics of quality community mental health care. These characteristics are particularly important for children in the justice system. The Kirby Institute recently found that children who are either at risk of, or in contact with, the criminal justice system are much more likely than other children to use mental health services.[19] So, if we provide these children with better access and quality of mental health care, chances are that their risk of criminalisation and further entanglement in the justice system will be reduced.

To do that, first, we must make sure there are adequate specialist and culturally appropriate mental health services responsive to the unique social, emotional, and spiritual wellbeing needs of Indigenous children in the community. Unfortunately, the current funding the NT receives for mental health services per capita is the lowest in the country and none of the community mental health services at present have capacity to meet demand.[20]

Protesters outside of Don Dale Detention Centre. Image credit: Jane Bardon / ABC News Online.

Figure 2. How to improve the health of children who are at risk or deprived of liberty.



Adapted from: Report of the United Nations Global Study on Children Deprived of Liberty, 2019.

Adequate funding and support for community youth mental health service providers was crucial to the success of the community-based diversionary initiatives I observed overseas during my Churchill Fellowship in 2018. These diversionary programs use appropriate screening tools to identify mental health issues at an early stage to effect timely intervention. When I visited the Juvenile Behavioural Diversion Program (JBDP) in Washington, D.C, young people involved in the program were promptly provided with an assessment for mental health diagnosis by the Child Guidance Clinic and then matched with the relevant services.

In addition to access to and availability of services, the second requirement is to ensure that community mental health care is delivered in a holistic manner. In the JBDP program, young people are able to access not only mental health treatments provided by qualified professionals but also a range of educational and pro-social activities at six drop-in centres.[21]

Therapeutic court model

I also learned from my Churchill Fellowship that it is equally important for youth courts to be supported by mental health experts to make sure the mental health needs of children coming through the justice system are assessed and cared for as part of the court process. In 2018, I visited 15 different youth courts in the United States, Canada, and New Zealand. The common feature of these youth courts is the involvement of mental health professionals to better understand and address the underlying issues affecting the youths concerned (see **case study**). In New Zealand, for example, youth forensic court liaison clinicians are available at different youth court locations around the country to provide referrals to health services and undertake preliminary mental health assessments.[22] By tapping into the expertise of health professionals, courts are able to recognise the relevant mental health vulnerabilities and trauma needs experienced by a child and take immediate action. More importantly, the involvement of qualified mental health professionals often helps to better understand a child's behaviour and in turn, 'therapeuticise' punitive court responses. An example of how assault can be considered differently from a clinical perspective follows:

'A child's behaviour that is far outside the socially acceptable range can be viewed through a legal, moral, or medical lens. Hence, an assault is viewed both as a criminal act, but also as a moral affront against personhood. However it can also be understood as a symptom of a pathological process in the brain, and hence a medical condition, if it is viewed as the outcome of an absence of emotional regulation in the assailant due to absence of self-control in response to provocation from immaturity of the pre-frontal cortex from brain damage in utero from maternal alcohol abuse.'
– John Boulton, Professor of Paediatrics.[23]

Most of the youth courts I visited overseas are known as problem-solving courts. In Australia, the last youth problem-solving court in NSW was defunded 10 years ago.[24] In the United States, there are currently 56 youth mental health courts, as well as many other types of youth problem-solving courts.[25] There is strong evidence to show that they improve the outcomes for child offenders with mental disorders.[26] The two main keys to the success of these courts are:

1. early identification of the causes of offending
2. collaborative solution of the problems.

We might not need to set up specific youth mental health courts such as in the United States. However, we can at least incorporate these two important features into the youth justice system. This can be achieved by introducing court-based clinicians into the Youth Justice Court. The Local Court in Darwin has been doing this for adults since 2016.[27] There are certainly benefits in extending the same service to young people given the prevalence of mental disorders within this vulnerable cohort.

Case study: Behavioural Health Juvenile Justice (BHJJ) project, Ohio, USA.

A statewide Behavioural Health Juvenile Justice (BHJJ) project was established in Ohio in the late 1990s to better assess and treat children with behavioural health challenges with evidence-based programs. Their latest evaluation reveals that less than 4% of children who participated in the program ended up being committed to state-run detention facilities.[28] The recidivism rate was also reported to be lower for those who completed the program, and importantly, it cost $5,140 for each child to participate in the BHJJ project compared to the estimated cost of $177,132 to detain a child in custody.[29] At present, the NT Government spends approximately $3,313 per day or $1.2 million per year to incarcerate a young person.[30] Other countries such as Canada and New Zealand have shown us how to introduce mental health specialists into youth courts and other justice agencies. It is not too late for Australia to do better for our children.

Stakeholder consultation

Preliminary consultation has included the organisations listed below. This is not an exhaustive list and there are other important stakeholders critical to deliberations.

- NT Legal Aid Commission
- North Australian Aboriginal Justice Agency
- NT Children's Commissioner (Acting)
- Criminal Lawyers Association NT
- NT Council of Social Services
- NT Youth Justice Advisory Committee
- Australian Childhood Foundation
- Justice Reform Initiative

Policy recommendations

1. Pilot a youth mental health diversion list in the Northern Territory

The involvement of mental health professionals in early contacts with the criminal justice system and in court processes presents an opportunity to provide children with complex mental needs with effective responses before their untreated mental health problems escalate and it becomes necessary to detain them at exorbitant cost to taxpayers. We can start by piloting a youth mental health diversion list in the NT, with mental health specialists in youth courts and other justice agencies, and commit to acting on the recommendations emerging from the evaluation of the pilot.

2. Involve Aboriginal Community-Controlled Health Organisations (ACCHOs) to co-design and deliver holistic community mental health services

ACCHOs in the NT should be enlisted to co-design and deliver community mental health services. ACCHOs adopt an interdisciplinary, culturally safe holistic framework that enables them to appropriately respond to health needs, not just at an individual level, but also at the family and community level.[31] This would mean using the knowledge and expertise of Aboriginal practitioners in creating place-based models of care that hold a child's cultural wellbeing at the centre in order to respond to their mental health needs. In New Zealand, for example, the bi-cultural model of care is implemented by incorporating the Maori health model of Te Whare Tapa Wha into the service delivery framework.[32]

Acknowledging that families and communities generally offer the best support for children with mental health problems,[33] there is an urgent need for significantly improved provision of community mental health services

for children, and in particular, First Nations children who are already over-represented in our criminal justice system. Health equity principles simply demand that First Nations children in the NT and remote parts of Australia should have access to quality adolescent mental health service in their communities. The same should apply for children in custody, who should not be denied treatment and care by suitably qualified mental health professionals in detention.

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Models Joshua Morris and Shadeene Evans wear the BOONKAJ collection by Waringarri Aboriginal Arts, Country to Couture, Head Stylist – Rhys Ripper, 2021. Image credit: James Giles courtesy of Indigenous Fashion Projects.

Background artwork credit: Jilji and Bila by Mr. T May, paint pen on tin, 2018, ©Mr T May/ Mangkaja Arts.

First Nations First

Targeted investment to grow a dynamic and sustainable First Nations fashion sector.

By Belinda Cook
Churchill Fellow 2016

Key terms: First Nations, Australian fashion industry, designers, textiles

The First Nations fashion sector has seen exponential growth in recent years, employing First Nations people from urban centres to the most remote communities of Australia. It is a multifaceted industry with the potential for extensive and sustained cultural, social, and economic outcomes. To continue to grow sustainably it requires a coordinated approach that effectively resources and meets the needs of First Nations fashion creators and businesses at each stage of the fashion and textile supply chain.

The First Nations fashion movement continues to grow, elevating First Nations voices on the national stage. Top First Nations models and fashion exhibitions are making the First Nations fashion sector a global phenomenon. Major commercial collaborations between remote based First Nations artists and leading Australian brands have set new benchmarks for artists' participation and management of Indigenous Cultural and Intellectual Property (ICIP).[1] First Nations leaders and organisations are carving new pathways for First Nations fashion, and creating a significant investment opportunity for the Australian Government.

The Australian fashion industry contributes $27.2 billion to Australia's economy each year, employing 489,000 people and generating $7.2 billion in exports. The fashion sector is a strong contributor to the nation, worth 1.5% of GDP (2% for telecommunications) and 1.7% of Australian exports – more than double that of wine and beer combined (0.7%).[2]

The First Nations fashion and textile sector's contribution to the economy, and its growing international profile cannot be ignored.

Even comprising a small percentage of the overall fashion industry (3% of $27.2 billion at a value of $816 million)[3] the First Nations fashion sector has the potential to become a multimillion-dollar industry. It is multi-dimensional, and its growth and activity reflect the diversity of First Nations culture, art, expertise, and experience.

The industry includes multiple forms of community-controlled business development, employment, creative engagement, and expression, as well as connecting a range of sectors and creative industries (**Figure 1**). There are increasing numbers of First Nations owned fashion brands and related businesses engaging in the broader fashion industry, with a growing and active audience.

This sector has a significant role to play in addressing the Closing the Gap targets for younger generations. There is a body of evidence showing that participation in arts and culture supports outcomes across the Closing the Gap framework.[4] Participation in fashion is specifically relevant to socio-economic targets for First Nations people including:

- youth are engaged in employment or education (target 7)
- strong economic participation and development of people and communities (target 8)
- maintain a distinctive cultural, spiritual, physical, and economic relationship with their land and waters (target 15)
- cultures and languages are strong, supported and flourishing (target 16).[5]

Opportunities to connect with First Nations arts and culture in contemporary ways engage First Nations youth and help to build a bridge between cultures.[6] Fashion is a highly visible platform for young First Nations people to see First Nations role models and the celebration of culture. Investment in fashion programs is an investment in the social and emotional wellbeing of First Nations young people.

Mainstream investment fails to reach the First Nations sector

There is increased recognition and funding for the broader Australian fashion industry, particularly in the eastern states. The NSW Government has announced plans to deliver a new Centre for Fashion and Textiles Sustainability[7] and $500 million for the Powerhouse Museum to become a world class fashion and design hub.[8] The Australian Government provided the Australian Fashion Council (AFC) with $1 million to develop a national fashion trademark in 2021.[9] However, broader industry funding is not reaching or targeting the First Nations fashion sector.

In 2022, the AFC presented four policy pillars for government to invest in to accelerate the economic impact of the Australian fashion industry. What is missing from those recommendations is any acknowledgement of the First Nations sector, including its diverse needs and the value it adds to the industry.

This is a growth sector lacking any recognition on a policy level, needing government investment directed specifically to First Nations programs.

Mainstream fashion programs are not reaching First Nations fashion designers and businesses, nor are they equipped with the cultural knowledge or capacity to address the First Nation fashion sector's needs. The 'top–down' approach favours funding engagement by non–First Nations providers and limits opportunities for self–determined localised engagement mechanisms.'[10]

Figure 1. The diverse people, businesses, and organisations that connect to create and foster the First Nations fashion sector.

Models wear Magpie Goose featuring 'Lanky' by artist Dominica Williams.
Image credit: Kalumburu Photography Collective, Kalumburu, courtesy of Magpie Goose.

Mainstream fashion organisations need to partner, invest, and advocate for First Nations led fashion programs.

First Nations fashion, like its First Nations creative industry sector counterparts – visual arts, performance, and music sectors – needs coordinated state and federal investment in First Nations led organisations to continue to grow and to be sustainable and resilient.

First Nations First – a sector led by First Nations people

'First Nations First' is one of the five pillars of the Australian Government's new National Cultural Policy development.[11] It is critical that this is central to the development of the First Nations fashion sector.

The proliferation of imagery of First Nations fashion and the amplified attention from the commercial sector gives the appearance of a thriving and well supported First Nations fashion sector. The reality is very different – critical First Nations fashion programs and organisations, presenting one of the most marketable exports for Australia in recent years, largely exist on short-term and sporadic government support and high-risk commercial partnerships.

Successful independent First Nations designers and fashion businesses located in urban centres have leveraged commercial partnerships and capitalised on urban spaces to grow, with little government support. These are high risk partnerships with limited opportunity for experimentation and an imbalance in power and sustained benefit. In collaborations, First Nations businesses carry the load to educate commercial business lacking cultural competency, while commercial businesses benefit from alignment with First Nations artists by gaining social licence and ethical endorsement.

Remote-based First Nations art centres have stretched their Indigenous Visual Arts Industry Support (IVAIS) program funding to develop successful and sustained remote based textile practices over decades. In recent years they have sourced commercial fashion industry partners to create collaborative collections, which government has not funded and yet promote as successful arts pathways.

Funding First Nations institutions to address sector needs

'First Nations organisations offer leadership and play an integral role as incubators and are the safe cultural spaces to mentor talent. Supporting them – as well as individual creatives – has a huge impact on the resilience and sustainability of a sector.'
– Australian Council for the Arts.[12]

A constant setback for the sector is the competition for minimal short-term project funding and commercial partnerships. There is no ongoing funding program for fashion specifically, nor for operational activities and staffing. First Nations fashion organisations are not appropriately resourced to build capacity and grow sustainably to develop their organisational expertise and reach.

State and national First Nations fashion organisations identify and respond to stakeholder issues, providing support to the sector in urban, regional, and remote locations with minimal resources. These organisations doing the work on the ground with First Nations fashion sector members are in urgent need of sustained and substantial resourcing from the Australian Government.

Australia Council has recognised the funding gap, creating the Flourish Fund, an inaugural First Nations fashion specific funding program in 2022. A sum of $500,000 was distributed to 21 successful applicants.[13] It has promised more funding to target this sector in the coming year. This national funding approach should be permanently established, with the funding pool increased and replicated in state government approaches.

Key areas for policy focus as identified by the sector

A consultation undertaken by Indigenous Fashion Projects and AFC in 2019 highlighted key sector issues raised by members of the eastern and northern states of Australia:

- protection and development of First Nations culture and community
- lack of business development support and best practice understanding
- difficulties connecting with industry networks and resources, including supply chain distribution and promotion opportunities
- limited access to industry education and training, particularly for young people.[14]

In 2022, the issues remain the same with some identified gaps and opportunities for federal and state governments to capitalise on.

Recognition and investment in sustainable practice. First Nations fashion industry members are unacknowledged leaders in environmentally sustainable textile practices. There is great opportunity for the fashion industry to learn and benefit from the First Nations sector's environmentally conscious practices.

Scaled funding to target fashion business growth. Scaled funding options for projects and larger business development are critical to business growth and sustainability. Successful First Nations fashion brands are seeking short-term and larger funding options that enable investment in infrastructure, and business development pathways.

Data collection and sector research. There has been no data collected to quantify the value of the sector. Investment in First Nations led research supporting culturally appropriate processes would give a rich sector evaluation considering cultural, social, and economic measures.

ICIP protection. Limited legal protection for ICIP is a significant problem for the sector. Government backing of policy priorities outlined in a submission by Arts Law, Copyright Agency and The Indigenous Art Code would positively impact all First Nations creative Industries.

Manufacturing access – quality and quantity of production. The manufacturing crisis in Australia disproportionately affects the First Nations fashion sector, with predominantly smaller business models looking to local production. Improving manufacturing access and garment quality is critical to be competitive in the international market.

Access to education/training pathways and appropriate resources. Investment in new and existing education models, mentorships, and pathways programs tailored to the needs of regional and remote Indigenous creators is needed to build capacity for the future.

Proven models to foster success

Coordinated sector investment has seen successful and sustained Australian fashion industry growth in the past. In the early 2000s, the WA Government invested in a Designer Fashion Grant Program, which resulted in more than a decade of fashion business and manufacturing growth. A shift in policy in 2016 that merged the creative sectors into one funding program removed the support that had stabilised the sector, leaving the Perth fashion scene a shadow of its former self. There are now no structures equipped to support WA creatives on fashion pathways.

In the NT, the ceasing of fashion and textile courses at Charles Darwin University and Bachelor College has halted progress and pathways for fashion development. Whereas in Victoria, Kinaway Chamber of Commerce's establishment of the Kin Fashion program is seeing an increasing number of Victorian First Nations designers and brands capitalising on opportunities, including a recent runway presentation in Milan by Victorian First Nations brand Ngali.

Nationally, First Nations fashion organisations are creating new First Nations led platforms and faciliting effective pathway programs for designers to grow their business with industry support.[15] First Nations Fashion Design (FNFD) and Indigenous Fashion Projects (IFP) have presented multiple First Nations designers at Australian Fashion Week over consecutive years. Sustained investment in these programs is critical for continued success.[16]

The IVAIS model is a base that would need significant adaption informed by First Nations fashion sector leaders to address the needs of the First Nations fashion ecosystem. Funding programs would require a scaled approach, including opportunities for established businesses to access more significant funding amounts for short-term business scaling and infrastructure, seed and project funding for younger businesses, and sustained operational and event funding for the organisations supporting the sector.

Left: 'Old Laddie' Yarrenyty Arltere on Country to Couture catwalk, 2022. Image credit: Michael Jalaru Torres, courtesy of Indigenous of Fashion Projects. Middle left: Models Georgia King and Hayley Mulardy wearing Nagula Jarndu, Kakaji (Goanna) by Gabrielle Baxter and Magabala (bush banana) by Martha Lee. Image credit: Michael Jalaru Torres, Broome 2022, courtesy Nagula Jarndu. Middle right: Roman wears Linda Puna from Mimili Maku Arts x Unreal Fur, Country to Couture, 2022. Image credit: Michael Jalaru Torres, courtesy of Indigenous Fashion Projects. Right: Model Shaneiva Chatfield wears Gumnut Gown by Paul McCann, National Indigenous Fashion Awards Photoshoot with Marie Claire Australia, 2021. Image credit: Tristan Stefan Edouard, courtesy of Indigenous Fashion Projects.

Independent fashion creatives are disadvantaged when it comes to competing for funding programs that pit them against better resourced and established businesses and art centre supported artists. Resourcing First Nations fashion organisations that support independent designers and resourcing of programs tailored to their specific needs is especially critical for this sector to grow.

As seen on my Churchill Fellowship, internationally, fashion programs that are seeing First Nations fashion businesses rise have coordinated sectors that are multifaceted and provide collaborative funding models that support collective learning and international networking opportunities with a business-to-business training focus. Models in South Africa and Indonesia provide business training with a focus on quality and extending market reach. They mentor designers and get them to the standard needed for national promotional platforms, retail partnership developments, and international markets.

South Africa responded to their failing community industry by shifting their model from institutional training to incubation hubs, taking training to communities, using a strength-based approach.[17] The national organisation, SA Fashion Agent, facilitates local industry growth in the manufacture of specialised products, building designer capacity and encouraging development of niche textile markets for South Africa.[18]

Indonesia has established the Indonesia Fashion Forward (IFF) program in partnership with the British Council to mentor designers through all elements of fashion and business and present at Jakarta Fashion Week. The program has fostered a significant rise in uptake of Indonesian designers into international retailers and nurtured an innovative and economically sustainable Indonesian fashion industry.[19]

State, national, and international models present proven solutions to the First Nations fashion sector's policy issues. With targeted investment and strategic collaborations Australia has the opportunity to lead in the growing global First Nations fashion industry.

Stakeholder consultation

Stakeholder consultation for this paper includes national, state and regional organisations with the core business of fashion and textiles; art-based organisations that support remote community organisations; independent First Nations designers and fashion businesses; First Nations fashion and art curators; First Nations sector leaders and mentors; independent fashion and art specialists; collaborative non-First Nations fashion business partners; and fashion journalists.

Policy recommendations

1. **Recognise the First Nations fashion sector's value and strategically invest in its future**

- Fund First Nations led research and resource development to document the sector's value, prioritise First Nations sector identified outcomes, and measure impacts of Closing the Gap targets.
- Recognise, resource and engage with leading national and state First Nations fashion programs.
- Develop a coordinated and co-designed national strategy with First Nations fashion sector leaders and organisations.

2. **Invest in a federally funded First Nations fashion sector grant scheme**

- Provide funding for all members of the supply chain, including manufacturing.
- Scale and establish flexible funding options that are relevant to the needs of the varied sector business models.

3. **Invest in state funded First Nations fashion programs**

- Recognise and fund the First Nations fashion sector within state based creative industry programs, and appropriately resource by engaging cultural and fashion expertise.
- Fund urban, regional, and remote programs to build capacity through local strength-based initiatives.

4. **Commit to First Nations culture and leadership**

- Action recommendations to recognise ICIP in law. Continue to engage and fund First Nations specialists in ICIP, fashion, and arts law.
- Incentivise and subsidise First Nations led cultural competency training for fashion businesses and organisations, and educate government departments.

5. **Increase First Nations Australians' access to education and training, manufacturing, and fashion business development**

- Resource and incentivise decentralised regional and remote textile and fashion training and business mentoring programs.
- Fund fashion related infrastructure for manufacturing in remote and regional areas to provide training, increase employment, and grow remote and regional industry.
- Invest in urban First Nations led programs and spaces to increase accessibility.

Acknowledgements

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18 Cook, ...*Growing First Nations Fashion Industry*
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Image credit: LittlePanda29 / Shutterstock.

Safe, Healthy, and Thriving

How culturally safe health care hubs can close the gap for Aboriginal children in care.

By Niroshini Kennedy
Churchill Fellow 2018

Key terms: First Nations, out-of-home care, Aboriginal children, integrated care, medical home, child protection

The child protection system is not meeting the health needs of Aboriginal children in care. We need to reorient toward a more integrated health and wellbeing framework that is preventative, supportive, strengths based and culturally safe. This urgently requires a national strategy, a commitment to self-determination and building on the strengths of the ACCHO[1] model, a robust regulatory and reporting framework, and stronger collaboration between the child protection and health systems. By keeping health and wellbeing at the heart of child protection policy and practice, we have the potential to change the trajectories of children in care.

Aboriginal[2] children represent more than one third of children in out-of-home care (OoHC),[3] even though they account for only 5.9% of Australia's children.[4] They are more than ten times more likely to be in care than non-Aboriginal children,[5] and numbers are rising. Projections from current data suggest that the number of Aboriginal children in care could increase by 54% by 2030.[6]

The high health care needs of children in OoHC is well documented in international and Australian literature.[7,8] Yet in Australia these needs are largely unmet with even the minimum standard of health care recommended in national guidelines due to deep deficiencies in the funding and oversight of health for children in OoHC. For Aboriginal children, these factors are exacerbated in part due to an inequitable access to health care.[9] As a result, many Aboriginal chidren in OoHC have undetected health and neurodevelopmental problems[10-12] that affect their ability to productively engage in education, employment, and society.

The child who is disruptive in class might have an undiagnosed hearing impairment due to a treatable middle ear disease. The adolescent who is chronically late to school and always tired might have undiagnosed sleep apnoea and require surgery. The child who is aggressive and dysregulated may never have had trauma-informed therapy to address the family violence he experienced. The child who is failing school may have an undiagnosed speech and language disorder, and may never have had speech therapy, or access to an evidence-based literacy program.

Within the paediatric clinic at the Victorian Aboriginal Health Service, where I have worked as a paediatrician for more than eight years, more than half of the Aboriginal patients I see are in OoHC. In this manner, it has functioned as a defacto OoHC clinic despite limited funding to do so. This is because it is seen as a culturally safe service. In contrast, a nearby state-funded multidisciplinary clinic specifically designed for children in OoHC saw just 17 Aboriginal children over three years of operation, according to published data.[13] This lack of access to health care comes at a high cost to the lives of children in care, and a social and economic cost to both the Aboriginal and broader Australian community. A report by the Telethon Kids Institute examined the cost of late intervention in Australia, finding that the greatest cost (39%) was attributed to OoHC: around $5.9 billion annually.[14] An inquiry found that two-thirds of Aboriginal children in Victoria's youth justice system had been in OoHC and many more were known to the child protection system.[15]

The intergenerational impacts are considerable as well. Graduates of the OoHC system are more likely to have their children enter care,[16] and are four times more likely to remain on income support payments.[17] These trajectories could be changed if we reoriented the child protection system towards strengths-based and culturally safe services that provide integrated health and wellbeing assessments, therapy, and support for children and families.

At a national level, there is a sound framework to achieve this through the detailed health guidelines for children in OoHC, the *National Clinical Assessment Framework for Children and Young People in Out-of-home Care (2011)*[18] (NCAF, **Figure 1**).

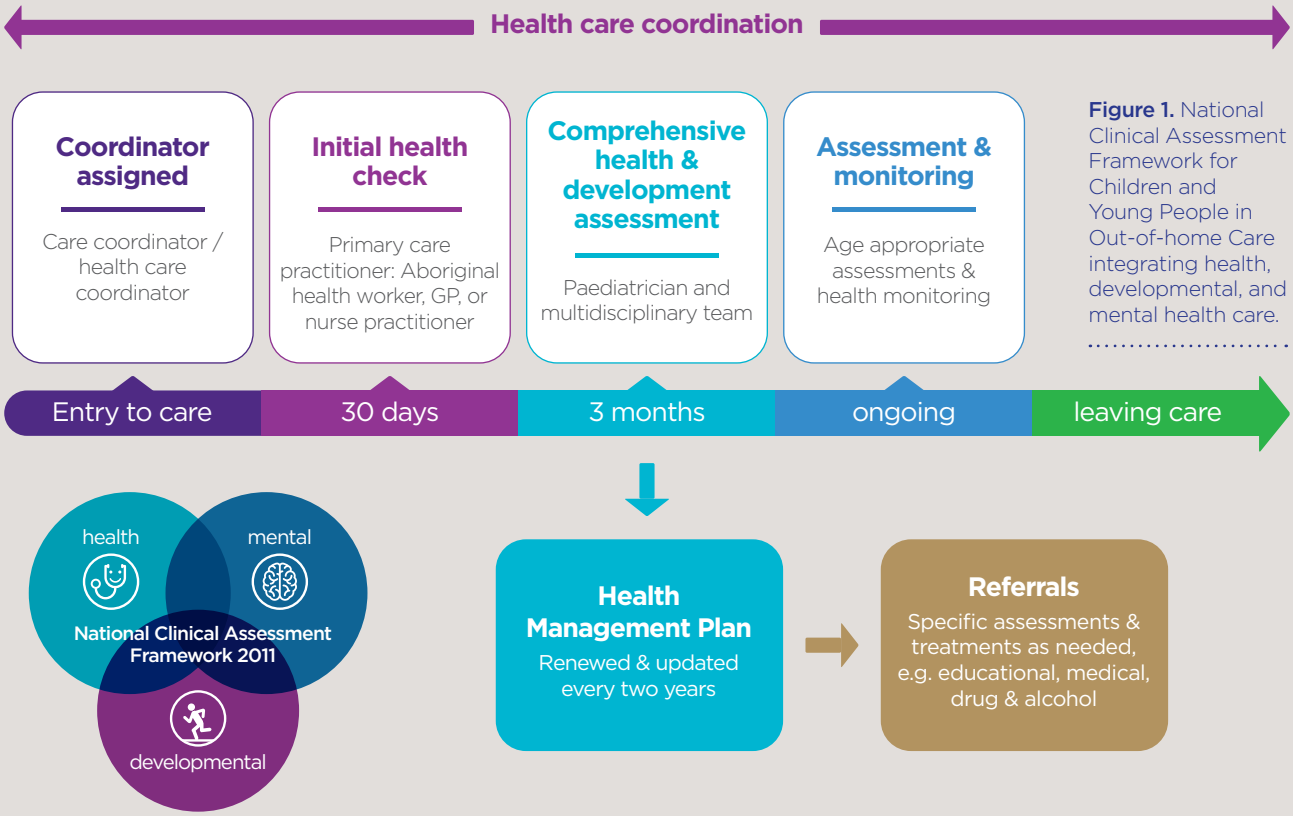

Figure 1. National Clinical Assessment Framework for Children and Young People in Out-of-home Care integrating health, developmental, and mental health care.

The NCAF recognises the need to develop a standardised system of care in order to detect, intervene, and improve health outcomes for all children in OoHC as part of the *National Framework for Protecting Australia's Children (2009)* and *National Standards for Out-of-home Care*. The NCAF contains detailed evidence-based and age-tiered guidelines for preliminary health checks and comprehensive multidisciplinary assessments led by paediatricians across three health domains: physical, developmental, and psychosocial and mental health. The NCAF recommends the development of health management plans and coordination of care.

The broad aim of the NCAF is to improve the health of children in OoHC, a population known to have high health needs, through the early identification and treatment of health, neurodevelopmental and mental health problems. It is aligned with best practice internationally, and the recommendations of professional medical groups in Australia, including the Royal Australasian College of Physicians[19] and the Royal Australian and New Zealand College of Psychiatrists.[20]

Despite having a solid national health care framework for children in OoHC, a key issue has been the NCAF's implementation, which to date has been patchy and variable at best. The states and territories hold statutory responsibility for child protection and health,[21] and as such, are required to provide state specific services. Yet a recent Victorian study found that less than 1% of the state's children in OoHC had received all recommended health care in line with the NCAF within a year of entering care.[22] This low rate of implementation is due to several factors. At a federal level, the NCAF is not supported by specific Medicare rebates, nor Commonwealth funding. At a sub-national level, most states have limited health infrastructure or capacity to run such specialised services.[23] Another issue is oversight. Though Standard 5 of the *National Standards for OoHC*[24] stipulates for health care to be delivered in a timely manner, there is no statutory requirement to comply with the NCAF and subsequently there is poor measurement and reporting of these standards, and little accountability for non-compliance.[25]

To address the complex needs of children in OoHC, it is crucial to have coordinated, integrated, accessible hubs of health and supportive services. However, with the notable exception of Aboriginal Community Controlled Health Organisations (ACCHOs),[26,27] Australia lacks integrated community-based primary health services at scale,[28] in particular those that offer specialist and mental health services delivered in a co-located hub. This is a significant barrier to states and territories implementing the NCAF. At present, child protection case workers and families must navigate a complex, fragmented and under-resourced health system and long waiting lists, particularly for specialised trauma-focused services. This has led to inconsistencies in the level of health care that children receive – some might only have an initial visit with a GP, others might have a one-off assessment at a specialised assessment clinic for children in OoHC, while many might only receive care when they present with a crisis. Most never receive effective evidence-based treatment to ameliorate their trauma.

The current system is failing these children by not identifying their needs early and not providing targeted and evidence-based treatments delivered by specialised integrated services that wrap around the child and family. The NCAF states what children need, now a strategy is needed on how to deliver this successfully in Australia.

Health and wellbeing must be at the centre of child protection policy in Australia

Improving the health and wellbeing of children involved with the child protection system requires collaboration between the health and child protection systems. It also requires more explicit indicators within policy frameworks.

For example, *Safe and Supported: The National Framework for Protecting Australia's Children 2021-2031*[29] (NFPAC) presents an opportunity to address the gaps and inequities for Aboriginal children in OoHC. Developed together with Aboriginal and Torres Strait Islander people, it identifies Aboriginal children, those in OoHC, and those with complex needs as priority groups. The NFPAC embeds the four priority reforms of the *National Agreement on Closing the Gap*,[30] including the urgent need to address the over-representation of Aboriginal children in the child protection system. The NFPAC's first focus area is to develop a 'national approach to early intervention and targeted support' for vulnerable children, through developing multidisciplinary models, improving service navigation, and expanding evidence-based services, and in particular, improving services for Aboriginal children. However, the NFPAC does not reference the comprehensive guidelines for standardised health assessments in the *National Clinical Assessment Framework,*

which was developed in 2011 for this very purpose. The NFPAC does not address the implementation difficulties and poor compliance with the NCAF health guidelines.

Similarly, the *National Agreement on Closing the Gap's* target to reduce the rate of over-representation of Aboriginal children in OoHC by 45%, provides little emphasis on the role of health and wellbeing in achieving this goal. Health related indicators which might be used include the proportion of children who have completed comprehensive health checks on entry to care, the proportion of those identified with a disability, or measurement of those who have received trauma-informed psychological services.

Health care is important. Children with undiagnosed and untreated health, neurodevelopmental, and emotional problems often remain in the child protection system and may have trajectories into the criminal justice system.[31] The lack of diagnosis and treatment can result in intergenerational involvement in both systems.

International lessons

During my Churchill Fellowship, I travelled to the USA, Canada and New Zealand to investigate how Australia could deliver standardised health care using a patient-centred integrated model of care for Aboriginal children in OoHC.[32] The focus of my Churchill Fellowship was:

- to gain an in-depth understanding of patient-centred models of integrated care, including the 'medical home' or 'health home' model of integrated care
- to explore legislative reform which provides for accountable and equitable policies supporting the health care of Aboriginal children in care.

I found that firstly, the right type of health infrastructure is needed: specialised hubs offering integrated and co-located health (primary and specialist) and supportive services, and proportionate and equitable investment in culturally-safe hubs in Aboriginal community-controlled services. Secondly, legislative reform is needed to assign responsibility and ensure monitoring and reporting on the right health indicators to truly implement the NCAF.

Specialised models of integrated care for children in OoHC

On my Churchill Fellowship, I investigated a range of specialised models of integrated care (**Table 1**). Integrated care is the name given to a type of health reform that seeks to deliver patient-centred and efficient care through a connected team of health care providers. The patient-centred medical home[33] is one type of integrated care. I visited seven specialised medical home hubs for children in OoHC and other vulnerable children, as well as integrated care hubs for Indigenous populations, including the remarkable Nuka System of Care at the Alaska Native Health Center.[34]

In the USA, the American Academy of Pediatrics' (AAP) standards of care for children in care, *Fostering Health*, recommends that health and preventative services are delivered through a medical home.[35] I met with Professor Moira Szilagyi, President of the AAP, who led the taskforce that developed these guidelines. She told me that the rationale for this recommendation was that children in care have complex and special health needs, and need specialised, accessible, and intensive health services provided within a one-stop hub. A medical home ensures that care is coordinated, consistent, and trauma-informed, and proactive and preventative, rather than crisis-driven.

The medical homes I visited were one-stop hubs that provided primary and specialist medical care, mental health and social services, as well as care coordination and service navigation to not just children in OoHC, but other vulnerable children. The Violence Intervention Project at the Los Angeles-University of Southern California Medical Center is LA County's largest medical home hub for children in OoHC. It was founded by Dr Astrid Heger, an internationally renowned child abuse paediatrician. Its innovative service model provides integrated, wrap-around services to vulnerable children including a forensic clinic and community-based assessment and treatment in line with the AAP's guidelines. The hub offers evidence-based mental health treatment programs, care coordination, parenting programs, a Foetal Alcohol Spectrum Disorder (FASD) assessment and treatment program, tutoring programs, allied health, school liaison and outreach programs, and social services. Dr Heger opined that to truly make a difference to vulnerable children, 'it's in the details'; they needed more than merely episodic medical care.

I visited ENHANCE Services for Children in Foster Care, in Syracuse, New York State, one of the longest running medical homes for children in OoHC in the USA. They have a specialised and skilled workforce who have built strong relationships with children and families they see. Biological parents often

Table 1. Some international examples of integrated care models.

Model of care	Case studies	Description
Specialised 'medical homes' for children in OoHC *Model of care recommended by American Academy of Pediatrics*	Violence Intervention Program LA County USC Medical Center Los Angeles, California, USA Olive View UCLA Medical Hub Los Angeles, California, USA ENHANCE Clinic Upstate Health Care Centre Syracuse, New York, USA	Staff hub model of integrated multidisciplinary teams provide: • comprehensive initial health assessments and ongoing medical care • specialist, mental health, and allied health services • care coordination • heightened surveillance for vulnerable children • collaboration with child protection and legal systems • wrap-around supportive services, e.g. mentoring programs, school liaison. Teams include: primary care physicians, specialists (eg. mental health, paediatrician, early intervention, and allied health specialists).
Care coordination and a 'conceptual medical home'	Care 4 Kids Children's Hospital of Wisconsin Wisconsin, Milwaukee, USA	Team of care coordinators who provide care to more than 3,000 children in line with American Academy of Pediatrics' *Fostering Health Guidelines* using a network of local providers.
Collaborative Care *A type of integrated care developed at the University of Washington to treat mental health conditions in primary and specialty medical settings.*	Bronx Behavioural Health Integration Program (B-HIP) Montefiore Health System New York, USA	Co-located mental health clinicians and primary care physicians and paediatricians who work collaboratively using population-based screening to promote early identification and referral to evidence-based treatment programs. It has resulted in increased of uptake of mental health referrals, and improved outcomes.
Indigenous-led and self-determined model of patient centred integrated care	The Nuka System of Care Alaska Native Medical Center Anchorage, Alaska, USA	Integrated model of care comprising a primary care team, care coordination, and an integrated care team of specialists and allied health individualised to a patient's needs. Relationships are central to the success of this model and the concept of shared responsibility between patients (who are known as customer-owners) and staff underpins the delivery of care. Health outcomes are now amongst the best in the USA, including a reduction in hospital admissions and specialist clinic visits.

attend their children's appointments, together with their foster carers, which aids in planning for reunification. Fragmented services can replicate the relational impermanence and trauma of a child's early life. Trauma-informed and culturally-safe care is grounded in safe relationships, which is equally important in a child's therapeutic team.

One of the most remarkable centres that I visited was the Indigenous-led Nuka System of Care at the Alaska Native Health Centre. It is renowned as one of the world's leading models of health care redesign, and has transformed the health outcomes of its population. It has won numerous accolades including the USA Congress' Malcolm Baldridge Award for quality in health care twice. Its model is a patient-centred medical home, which has radically reimagined health care delivery by prioritising equity, self-determination, and relationships. Care is delivered through a core primary care team that includes a care coordinator.

Image credit: Adobe Stock.

Care is individualised and coordinated through rigorous screening and stratification to specialist programs. They have achieved a range of improved health outcomes for their population, and have reduced health costs and emergency and hospital admissions. Cultural practices, wellbeing programs, and traditional healing is integrated into their programs.

Access to limited mental health services is a significant problem in Australia. Many of the hubs I visited used models of collaborative care (such as the Bronx B-HIP at the Montefiore Hospital). In this model, psychiatrists and psychologists worked in co-located medical clinics with paediatricians and primary care physicians, using robust screening and evidence based brief interventions to extend the reach of mental health services.[36]

The establishment of medical home hubs would assist the implementation of the NCAF, and would promote standardisation of care and address the fragmentation in the current system. While models of integrated care are not yet common in Australia, several trials and pilot programs are underway.[37] ACCHOs have pioneered models of integrated care in Australia since the 1970s, offering community based primary care, with a range of wrap-around services. The self-determined ACCHO model needs to be recognised and sustainably funded.

Improving the health of Aboriginal children in OoHC and other vulnerable children will require Australian governments to invest in and develop specialised hubs or medical home models of integrated care in Aboriginal community-controlled health services and community hubs. They will align with the NCAF guidelines, offering patient-centred and strengths-based health, wellbeing, and supportive services.

Legislative reform

The USA has successfully enacted strong legislative reform to encourage the states to deliver health care to children in OoHC through a medical home, and has introduced reforms that require states to use evidence-based psychotherapeutic programs and monitor psychotropic medication use (*Child and Family Services Improvement Innovation Act (2011)*.[38] The *Adoption and Safe Families Act (1997, ASFA)* which reorientated the child welfare system towards permanency, resulted in a 27% decrease in children in care in the USA.[39] The *Family First Prevention Services Act (2018)* goes further by releasing federal funds for early intervention and preventative programs to families of children at risk of entering care, including mental health services, substance abuse, and parenting programs, reorienting the child welfare system towards prevention and trauma-informed practice.[40] To be funded, eligible therapeutic services need to meet evidence-based thresholds for effectiveness. The secretary of the Department of Health and Human Services publishes a list of evidence-based and approved services.

During my Churchill Fellowship, I met Mr Bryan Samuels, Commissioner of the Administration on Children, Youth and Families in the Obama Administration. Under his leadership, the USA Congress passed several pieces of legislation including the *Fostering Connections to Success and*

Increasing Adoptions Act (2008) which strengthened the standards and oversight of the health of children in care. These reforms were strongly grounded in evidence-based and trauma-informed approaches, and an understanding of the cost-effectiveness of early intervention. Mr Samuels advised that beyond the crucial benchmarks of measuring safety and permanency, that health and wellbeing had to be the measuring stick for the performance of child welfare systems.

Strengthened legislative oversight combined with targeted and proportionate investment in ACCHOs will help vulnerable Aboriginal children access comprehensive multidisciplinary care. This is crucial in helping them to thrive and shifting their life trajectories.

Stakeholder consultation

My application for a Churchill Fellowship developed from conversations that I had with Mr Andrew Jackomos PSM, inaugural Commissioner for Aboriginal Children and Young People in Victoria, following my participation in the Taskforce 1000 Inquiry, which examined many of the unmet needs of Aboriginal children in state care in Victoria. Mr Jackomos, who was one of my referees, has remained a steady source of counsel and support as I developed my report and recommendations, and disseminated my work. Ms Nicole McCartney, Victorian Department of Health's Chief Aboriginal Health Advisor, who is my policy peer reviewer, has provided invaluable guidance on this paper. I have consulted with Ms Jill Gallagher AO, CEO of VACCHO, and Mr Michael Graham, CEO of the Victorian Aboriginal Health Service, who have both supported my recommendations.

My work has informed policy and advocacy work at the Royal Australasian College of Physicians, where I have been a contributing author to policy papers on the health of Indigenous children, and the health of children in care and protective services. Many of my recommendations have been incorporated into RACP policy documents.

My Churchill Fellowship report has been provided to a range of stakeholders including Safer Care Victoria, the Consultative Council for Obstetric and Paediatric Mortality and Morbidity, State Minister for Health, and department secretaries.

Consultations have been sought with other Aboriginal peak bodies including NACCHO, VACCA, and SNAICC.

Policy recommendations

1. The Australian Government should develop a national health and wellbeing action plan for children in out-of-home care to accompany *Safe and Supported: The National Framework for Protecting Australia's Children 2021-2031.* This will be a roadmap to implement the *National Clinical Assessment Framework for Children and Young People in Out-of-home Care (2011)*.[41] The Plan should be co-designed with the Aboriginal community-controlled sector. The Plan should:
    - mandate health assessments for every child in OoHC in line with the NCAF
    - clarify the statutory responsibility, funding, and resourcing for health care
    - include a robust statutory and regulatory framework that includes national health indicators to measure and report on the health and wellbeing of children in the child protection system, including those in out-of-home care and specifically address the health of Aboriginal children in care, aligning with the socio-economic targets in the National Agreement on Closing the Gap (2020).[42]
2. The Australian Government should invest in and develop specialised multidisciplinary Integrated Care hubs for vulnerable children, including those in out-of-home care, ACCHOs, and community hubs, to deliver integrated, culturally safe, and trauma-informed primary health, specialist, mental health, and supportive care.

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2. The term Aboriginal in this paper refers to both Aboriginal and Torres Strait Islander People. The term Indigenous is retained when it has been used as part of a quotation, or the title of a program or report, or used in an international context. This is consistent with the nomenclature endorsed by NACCHO (National Aboriginal Community Controlled Health Organisation).
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Healthy Housing Programs

For Aboriginal and Torres Strait Islander communities with high rates of acute rheumatic fever and rheumatic heart disease.

By Maida Stewart
Churchill Fellow 2018

Key terms: First Nations, acute rheumatic fever, rheumatic heart disease, health hardware, co-design

Acute rheumatic fever (ARF) is endemic in many Australian First Nations communities. Supporting these communities to develop innovative healthy homes initiatives can provide workable solutions to prevent new cases. Australia will need to spend at least $344 million in direct health care costs if no action is taken to eliminate ARF by 2031. National strategies in partnership with Aboriginal and Torres Strait Islander organisations are urgently needed to address ARF and its causes.

Australia has one of the highest rates of ARF in the world – a condition almost exclusively seen in its First Nations people. ARF is caused by Streptococcal A (Strep A) throat and skin infections that can trigger an autoimmune response, leading to an episode of ARF. Strep A infections are more common in crowded environments with limited access to health hardware.

Recurring Strep A infections and episodes of ARF can lead to valvular damage of the heart known as rheumatic heart disease (RHD).[1] RHD causes heart failure and premature death.

'Our children are having open heart surgery. Our children. Four years old. Eight years old. Twelve years old. And then they're expected to go back to a remote community, live in overcrowded conditions, without the range of support services.' – Pat Turner, CEO, National Aboriginal Community Controlled Health Organisation on ABC Four Corners, 7 March 2022.[2]

The burden of ARF is growing in Australia. The Australian Institute of Health and Welfare reports that the number and rate of notifications increased from 424 (60 per 100,000) in 2016, to 521 (69 per 100,000) in 2020.[3]

'There are massive issues with what we call … health hardware, just the basics of a … working fridge, of a working shower, or a flushing toilet … having access to a washing machine … Many Aboriginal communities, many Aboriginal households don't even have those basics'.[4]

– Prof Jonathan Carapetis, Paediatric Infectious Diseases Specialist, Telethon Kids Institute. ABC Four Corners, 7 March 2022.

If no action is taken to eliminate ARF and RHD, more than 8,000 more people will develop RHD by 2031, accruing at least $344 million in direct health care costs.[5] Improving housing and living environments has been prioritised by Aboriginal and Torres Strait Islander groups, communities, academics, and health experts as the key step to improving health outcomes.

Reducing overcrowded housing and improving access to functional health hardware (taps, showers, and toilets) can reduce high rates of Strep A infections and progression to ARF. These improvements are also likely to reduce the transmission of many other preventable infectious diseases, including COVID-19, and trachoma – an infectious eye disease that has been eliminated in several developing countries globally.[6] A combination of economic development, policy, and regulatory change have been credited with reducing the burden of ARF and RHD in most developed countries.[7]

While there is the commitment, will, funding, policy, and strategy from governments to increase housing stock and reduce overcrowding in First Nations communities, there have been significant delays in delivering housing, particularly in the NT. These delays are the result of an ongoing dispute between the previous Australian and the current NT governments regarding the terms of the *National Partnership Agreement for Remote Housing – Northern Territory (2018–2023).* This has contributed to stasis in other areas of potential housing improvement. There are several place-based healthy homes and environmental health programs underway across Australia, and there are many other opportunities for locally relevant programs to be developed.

During my Churchill Fellowship,[8] I discovered innovative co-design approaches for developing healthy housing initiatives have been used in New Zealand to reduce high rates of ARF in Māori and Pacific Islander communities.[9] These approaches have produced a sustainable supply of housing interventions, improved program service delivery, and have prompted changes to government regulations, legislation, and minimum housing standards.[10] These initiatives have also provided significant cost savings to the New Zealand health care system. However, current housing initiatives and future ones require ongoing support and funding from the Commonwealth, state, and territory governments to ensure their sustainability.

'You've got families living in three-bedroom homes which, you know, is certainly not adequate to house that many people. You've got people sleeping outside on the verandahs, or you know, people in tents. All these people use the same facilities – the same toilet, the same wash bowl, the same showers. So therefore, if there's an infection in the house, it's gonna spread amongst the family.' – Alec Doomadgee, Chair, Waanyi Native Title Aboriginal Corporation. ABC Four Corners, 7 March 2022.[11]

Consideration of the issues

Existing policy frameworks and commitments

Overarching Aboriginal and Torres Strait Islander health and housing policy in Australia

The Australian Government's *Closing the Gap* strategy has provided the overarching framework for Aboriginal and Torres Strait Islander health policy in Australia since 2008. In 2020, a new National Agreement was signed between the Coalition of Peaks and the Council of Australian Governments (COAG). The Closing the Gap strategy identifies healthy living environments and housing as priority areas, in reducing the many health risks associated with poor quality housing, overcrowding, and non-functional health hardware. One of the targets (target 9) outlined in the strategy is to 'increase the proportion of Aboriginal and Torres Strait Islander people living in appropriately sized (not overcrowded) housing to 88% by 2031'.[12]

Image credit: Caro Telfer / Austock.

Health Policy and the Rheumatic Fever Strategy and RHD Endgame Strategy

The revised *National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) 2021* and *Australia's Long-Term Health Plan (2019)* have also identified the elimination of ARF and RHD by 2031 as a key priority area.[13] Priority 7 of the NATSIHP identifies health hygiene and healthy living infrastructure as key to ensuring safe and healthy environments for Aboriginal and Torres Strait Islander people. It also identifies supporting and growing the Aboriginal and Torres Strait Islander environmental health workforce to facilitate resourcing and ensure the development of locally responsive solutions.[14]

The Commonwealth's *Rheumatic Fever Strategy* (RFS) was funded in 2009 to address high rates of ARF and RHD. The strategy includes a National Partnership Agreement with Queensland, WA, SA, and the NT. The strategy initially focused on register-based control programs and education and training resources. It more recently provided funding to the National Aboriginal Community Controlled Health Organisation to support RFS national coordination and implementation for community-led primary prevention and treatment projects.[15]

The *RHD Endgame Strategy – a blueprint for eliminating Rheumatic Heart Disease by 2031* was launched in 2020. The strategy includes a framework with five priority areas for action. They include Aboriginal leadership, community based programs, healthy environments, early prevention, and care and support. The Endgame Strategy report sets out what is required to eliminate ARF and RHD in Australia. It was launched in 2021 and endorsed by 21 peak bodies, including Aboriginal and Torres Strait Islander organisations.[16]

Remote Housing Strategy

Remote housing policy remains in a state of flux. The *National Partnership Agreement on Remote Indigenous Housing 2008-2018* was replaced by the *Remote Housing Strategy* in 2016 through an agreement between the Commonwealth, state, and territory governments. The agreement expired in 2018, with the Australian Government unable to reach an agreement with the jurisdictions on remote housing. In 2018 the NT Government reached an agreement with the Commonwealth through the *National Partnership Agreement for Remote Housing Northern Territory* – with a 50–50 funding arrangement. However, there had been an ongoing dispute between the previous Federal Government and the NT Government regarding responsibilities in this agreement.[17]

'It's primarily because of the living conditions and despite decades and decades and decades of appeals by Aboriginal leaders and Torres Strait Islands leaders, right throughout Australia for our housing situation to be fixed, it hasn't'.[18]

– Pat Turner, CEO, National Aboriginal Community Controlled Health Organisation. ABC Four Corners, 7 March 2022.

'People will say, "oh well, Aboriginal people choose to live like that". But it's not a lifestyle choice. We don't want to live overcrowded, we don't want to live where our house is falling apart, where we can't get repairs on our house'.[19]

– Vicki Wade, Director, RHDAustralia. ABC Four Corners, 7 March 2022.

Lessons from New Zealand – using co-design to develop healthy housing programs and initiatives

In 2013, the New Zealand Government launched its Healthy Homes Initiative to reduce high rates of ARF in Māori and Pacific Islander communities. In 2015, the Ministry of Health engaged Auckland Council's 'The Southern Initiative' and 'Co-design Lab' to undertake a co-design project to develop a sustainable supply of housing interventions and improve the program's services.[20] The project used human centred co-design methods that engaged Māori and Pasifika with lived experiences of ARF and RHD, government agencies, non-government organisations, and other service providers. This project also saw several policy and system improvements, including amendments to the *New Zealand Residential Tenancies Act 1986* and the introduction of the *Healthy Homes Guarantee Act 2017* and the *Healthy Homes Standards*.[21]

An outcomes evaluation of the Healthy Homes Initiative in 2019 found there were around 1,533 prevented hospital admissions, 9,443 fewer GP visits, 6,101 hospitalisations of reduced severity, and 8,764 less pharmaceuticals dispensed. These reductions are expected to result in savings in direct medical costs of $30 million in the third year after referral intervention. With a total program cost of $18.5 million, the expected return on investment for the New Zealand Government is likely to occur within two years.[22]

Healthy Homes Initiatives in New Zealand that enlist local knowledge and expertise have played a critical role in reducing rates of ARF and other preventable infectious diseases. These initiatives have also provided savings in co-design costs that will see a return on investment for government. There is increasing evidence that place-based solutions are effective in addressing the housing needs of Aboriginal and Torres Strait Islander communities. Examples of current programs include Housing for Health (NSW) and Nirrimbuk Aboriginal Environmental Health Program (WA). These programs offer Aboriginal led placed based solutions that are tailored to a community's needs, are locally relevant, and have produced promising results.[23] Exploring innovative approaches to policy reform and service delivery improvements will ensure that the Australian Government meets its targets for Closing the Gap on health disparities for Aboriginal and Torres Strait Islander people, along with the commitment it has made to eliminate ARF and RHD in Australia by 2031.

Stakeholder consultation

The policy recommendations below align with the RHD Endgame Strategy's key priority area on accessing healthy housing and built environments[24] along with other priority areas, including Aboriginal leadership, community-based programs, and early prevention. The strategy was developed in consultation with and endorsed by 21 peak bodies, including Aboriginal and Torres Strait Islander peak organisations.

Aboriginal and Torres Strait Islander community controlled health services, especially in regions affected by high rates of ARF, household crowding, or poor quality housing were included in the consultation of co-designed community led initiatives as outlined in the RHD Endgame Strategy. The consultations recognised the valuable knowledge and expertise that these stakeholders hold about the problem, and the solutions that will work for their communities.

Consultations on the policy recommendations included in this paper have been conducted with key stakeholders, including the National Aboriginal Community Controlled Health Organisation and RHD Australia. Further consultation is needed with Aboriginal community controlled peak health and housing bodies in the NT, Queensland, WA, SA, and NSW to provide leadership and guidance on these issues locally.

Policy recommendations

1. That the National Indigenous Australians Agency (NIAA) and the Department of Health and Aged Care (DoHAC) lead the development of a national Aboriginal and Torres Strait Islander housing and environmental health strategy in partnership with First Nations communities and peak Aboriginal health and housing organisations that focuses on place-based housing solutions.
2. That the NIAA and DoHAC work in partnership with peak Aboriginal and Torres Strait Islander health and housing organisations, and communities with high rates of ARF to develop and implement sustainable healthy housing programs embedding environmental health into primary health care.
3. That the Commonwealth fund the National Aboriginal and Torres Strait Islander Housing Association (NATSIHA) to work with Aboriginal and Torres Strait Islander health and housing peak bodies, along with registered training organisations to:
    a) grow the Aboriginal and Torres Strait Islander environmental health workforce
    b) update and reintroduce the National Indigenous Housing Guide for endorsement by the Australian, state and territory governments to ensure minimum building standards and regulations for the construction of new housing and refurbishments in remote Aboriginal and Torres Strait Islander communities.
4. That state and territory governments fund and support the development of locally relevant healthy homes programs in their jurisdictions.

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Feeding Children Well

The importance of school lunches to education, health, and social outcomes, and impact on local food economies.

By Julie Dunbabin
Churchill Fellow 2018

Key Terms: nutrition, education, school meals system, universal school meals

Most countries recognise school meals as a vital investment in children, and a positive impact on national and local economies. Our current food-based interventions in Australian schools are not achieving their public health and education objectives. Our child obesity rates and school academic results rate poorly when compared with other developed countries. A national approach to universal school meals is needed for our children's health and educational potential, and to positively impact on our agrifood sector.

Australian governments have recognised the importance of good childhood nutrition through a number of national policies. The recently released *National Obesity Strategy*[1] identified that healthy policies and practices in schools and promotion of healthy behaviours in the Australian curriculum would help to prevent obesity. Strategy 1.10 highlighted the need for healthy school canteens and menus. The importance of schools contributing to the success of these policies was recognised in 2019, when the Australian Government released *The Good Practice Guide: Supporting healthy eating and drinking at school*.[2] The guide noted that:

'Australian children are growing up in an environment where food and drink high in added sugars, saturated fats, and added salt are readily available, heavily promoted, and perceived as low cost. This trend results in the low intake of essential nutrients, poor oral health, sub optimal educational performance, and a higher risk of children being overweight or obese.'

While these strategies exist, there is little to no investment in their implementation through action planning, collaboration, implementation, or evaluation. Strong government policy on school food implementation at the national, state,

and territory level is needed to withstand food industry activity that encourages the consumption of highly processed foods. While reformulation efforts to reduce salt or increase fibre in foods to meet school canteen nutrient criteria is important, these changes have not resulted in children eating more fruit and vegetables and fewer foods high in sugar, saturated fat, and salt.

Internationally, school meals have been the norm since the end of World War II. This was instigated to entice children back to school after a long absence and the malnourished status of the population. For the past 75 years, these countries have seen extensive benefits of having a school lunch program – educationally, economically, socially and environmentally.

International experiences

In 2019, I visited seven countries (USA, England, Scotland, Finland, Italy, France and Japan) on a Churchill Fellowship[3] to identify the factors that enable school lunch programs to impact positively on student health and wellbeing. I found:

- All students ate a school prepared lunch.
- Children sat down to eat for at least 20 minutes.
- Plain milk and water were the only drink options.
- Confectionary was not an option.
- Meals were prepared by a skilled workforce who enjoyed cooking for children.
- Local and seasonal produce were proudly used.
- School members and dietitians were involved in menu planning.
- Culturally and dietary diverse food was served.
- Menus and food language were based on the five food groups.
- Appropriate infrastructure was used to prepare and service food.

All seven countries I visited had national policies in place accompanied by resourcing to implement and achieve the objectives to feed all children while at school using sustainability practices. These ranged from cost recovery modelling to the use of local and seasonal produce on the menu.

These countries' school lunch programs have been established to provide an important opportunity for teaching children about nutrition and healthy eating habits. Reported outcomes of well-balanced school meals were improved concentration in class, improved academic outcomes, and fewer sick days. These programs also addressed food insecurity, supported student health and wellbeing through connectedness, and reduced overweight and obesity rates.

In the countries that I visited there was evidence that all levels of government had a role to play in the delivery of effective school lunch programs. In Italy, regional mayors were re-elected on the quality of school lunches provided. They were judged by parents, who had a very strong voice. There was also a regional economic benefit created for the agrifood sector through local sourcing and procurement by the schools.

Countries that developed and implemented dietary guidelines and nutrition standards at a national level utilised a multi-governance approach, with states being responsible for the provision of infrastructure and program monitoring, and local governments responsible for supporting employment and overseeing local schools.

Image credit: Adobe Stock.

Consideration of the issues

Australian children consume at least one-third of their daily food intake at school.[4] This is potentially 2,400 meals over their school years. However, foods consumed during school hours are too often not consistent with *Australian Dietary Guidelines (2013)*.[5] Around 44% of energy is consumed from discretionary foods[6] (foods and drinks not necessary to provide nutrients the human body needs), less than 10% of children meet recommended vegetable serves,[7] and one in four children aged 5 to 14 years are overweight (17%) or experiencing obesity (7.7%).[8]

A robust, universal school meals system is necessary to meet the appropriate food needs of children so that they can learn to the best of their ability, and be nourished appropriately to be able to grow physically and mentally. Schools are charged with providing access to quality curricula and to support physical, social, mental, and emotional health and wellbeing.[9]

The current Australian school meals system is complex, comprising of multiple delivery methods – packed lunches, school canteens/ tuckshops, breakfast programs, fruit and vegetable recess programs, and other emergency food relief programs. Governance of these food delivery methods lacks coherence and a universal overview.

The Australian school meals system is ready for an overhaul. While what is currently done in the school food space is based on *Australian Dietary Guidelines*[10] and *National Healthy School Canteen Guidelines (2011)*,[11] where children have broad choice, they choose what they know and what is on offer, and unfortunately this is too often pies, sausage rolls, and chicken nuggets. Or they are going hungry through being unable to access food.

The Good Practice Guide must become national policy and be adequately funded to support a food systems approach to feeding children well while at school, where lunch time provides time for a sit down meal as well as time for play. National and state food and nutrition policies must be resourced and implemented nationally to support a food system approach.

Like other countries that have established a school lunch program for all children, there needs to be a shift in Australia to provide school lunches that are nutritionally balanced, flavoursome, and cooked from locally sourced foods with minimal processing. International school food history shows that children fed well while at school reach their best educational and social potential. Schools cannot fulfill their educational mandate if students have inadequate access to healthy food during their school day. Children cannot learn on empty tummies.

School food programs can provide access to food for many of those who are currently vulnerable to food insecurity. There is often stigma experienced by children who are most in need to access food. It is also the case that regardless of parental income, the inclusion of high fat, sugar and/or salty foods on the school canteen menu (often at low price points) impacts on children's intake of nutritious food during their school day. Therefore, a successful school meals system needs to be universal, meaning that all children and youth, rather than targeted children and youth, are able to access nutritious and tasty food.

Who supports this call to action?

The World Health Organisation has identified schools as an important setting to enable children to understand what a healthy diet is and understand the importance of nutrition.[12]

A 2020 study conducted by Flinders University[13] engaged a diverse range of stakeholders to generate and rank ideas on how the school meals system could be changed. Of the nine options generated, provision of a school lunch prepared on site was the highest ranked option for both impact and achievability. This school food model was described as 'food prepared onsite by a cook or team of kitchen staff for a sit-down meal, based on a rotational menu reflecting seasonal produce, minimally processed foods, and dishes representing different cultures'. The school food model was considered to reach the greatest number of students.

Numerous NGOs that support schools to provide nutritional food options for children have indicated that our current school food model is not working. There is a growing desire from schools to improve the food that children eat while at school to enable each child to achieve their best potential. This is from an academic, mental, and social perspective. Local sourcing through the procurement of nutritional food also enhances the economic opportunities for our Australian food growers and producers to be consumed by Australian children.

Case Study: a 2020 school lunch trial in Tasmania

The findings from my Churchill Fellowship informed the 2020 school lunch trial in Tasmania, which was funded through a Healthy Tasmania grant and implemented by School Food Matters Inc (formally the Tasmanian School Canteen Association) and evaluated by the Menzies Institute of Medical Research, University of Tasmania.

The pilot occurred in three schools and aimed to determine the feasibility of providing cooked lunches in Tasmania. Due to limited funding, year levels were selected and were provided with free, nutritious, cooked lunches for 20 days. The lunches were prepared from scratch using seasonal produce where possible.

The following findings were made:

- A sit-down cooked meal from scratch at school is possible with the right mix of staff and resources.
- The average food cost was $1.91 per student for ingredients only (without any procurement factored in) and $4.72 for ingredients and labour costs. The cost per lunch would decrease if more students were involved in the lunch program.
- Children enjoyed sitting down with their friends to eat.
- Children enjoyed eating vegetables in the dishes.
- Children were able to concentrate better in class before lunch and after lunch.
- There was a reduced number of behavioural issues after lunch.
- There was an increase in student attendance during the pilot period of a month.
- There was a decrease in food packaging litter.
- Most (89%) parents were willing to pay $3 to $5 for a school lunch, with a discount for families with multiple children.
- Most parents (90%) would like a cooked lunch available every day.
- Use of local and seasonal produce connected with growers and school garden programs.

As a consequence to the 2020 feasibility study, in 2022 the Tasmanian Government provided $1.87 million to expand the school lunch pilot to 15 schools and to a total of 30 schools by 2023. Factored in to this funding is a focus on infrastructure. This is a pilot and therefore identifying what is needed to run a successful lunch program will be paramount and will be useful for informing government at state and federal level about the scaling up to a universal, national school lunch program.

Top: School kids sitting down to lasagna for lunch. Left: Tofu salad. Middle: serving lunch. Right: meatballs, salad and cous cous. *Image credit: Courtesy of Julie Dunbabin.*

Stakeholder consultation

School meals have been shown internationally to be associated with a breadth of benefits for children, families, schools, the economy, and society. As found on my Churchill Fellowship, all of these elements were underpinned by policy commitments and implementation from governments that had strong connections to agricultural industries and a focus on sustainable food systems. Health and education departments were also key stakeholders to the delivery of school meals.

Preliminary consultations as part of the 2020 Tasmanian feasibility study (**case study**) and the results of the study's expansion in 2022 have been circulated widely in Australia. Consultations since have included:

- meetings/discussions with Tasmanian politicians from Liberal and Labor parties
- discussions with state canteen associations in WA, NSW, and Queensland
- discussion with the Director Health Promotion, Department of Education, ACT
- discussions with staff from the Office of the Children Commissioner in SA and Tasmania
- liaising with Caring Futures Institute, Flinders University.

Policy recommendations

1. The National Cabinet should establish and facilitate a key stakeholder roundtable to:
    - identify the benefits and challenges of a universal school lunch program through a whole-of-government policy approach, particularly education, health, community, and agriculture
    - explore extending the Tasmanian School Lunch Project (2020–23) from a state project to a national program, serving nutritionally balanced, safely prepared meals on every school day to all students.
2. The National Cabinet should resource the implementation of current national policies, such as the *National Obesity Strategy (2022-2032)* and guides such as the *Good Practice Guide (2019)* that relate to school meals, through action plans and adequate funding.
3. The Federal Government should resource the implementation of the *2019 Good Practice Guide*, to shape the development, monitoring, and evaluation of a national school lunch program where food is procured locally and seasonally, increasing employment opportunities for our farmers.

'A universal school-provided lunch model could help to ensure ALL children have access to food at school, reduce stigma of children not having lunch or having different types of foods to their peers, and help to ensure children are provided with healthy lunch options.'

– Professor Golley, Flinders University.[14]

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Shining a Light in Dark Places

A once-in-a-generation opportunity to safeguard people in detention and care settings.

By Steven Caruana
Churchill Fellow 2017

Key terms: inspection, human rights, closed environments, detention, OPCAT

Australia has committed to establish a multi-body National Preventive Mechanism (NPM) with responsibility shared among jurisdictions for the prevention of torture and cruel, inhumane, or degrading treatment or punishment. An effective NPM must adopt the UN definition of 'deprivation of liberty', be underpinned by legislation, and be properly funded and resourced. Failure to do this places Australia at risk of potential human rights abuses, compensation claims, rehabilitation costs, and reputational damage.

Image credit: Mak/Unsplash.

Image credit: Adobe Stock.

Australia ratified the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2017, fulfilling a pledge made during its Human Rights Council election campaign.[1] Ratification was also a response to the Royal Commission into the Protection and Detention of Children in the NT which found evidence of widespread mistreatment, verbal abuse, humiliation, and isolation of young people at the Don Dale Youth Detention Centre.[2] The then Australian Human Rights Commissioner, Ed Santow, hailed this 'a once-in-a-generation opportunity to shine a light in these dark places, to cease detention practices we know to be harmful, and to learn from best practice in Australia and around the world.'[3]

OPCAT requires the establishment of an National Preventive Mechanism (NPM) – an independent monitoring mechanism empowered to conduct regular, preventive, and human rights focused visits to all places where the state does or may deprive people of liberty. OPCAT purposefully adopts a broad, open approach to what are considered places of deprivation.[4] This means both traditional places, like prisons and police cells, as well as non-traditional places, like aged care and disability group homes, fall within its scope.

Through its visits, the NPM focuses on identifying shortcomings in rules, procedures, and practices and makes recommendations promoting institutional reform and good practices that reduce the risk of ill-treatment. Unsurprisingly, when announcing the intention to ratify OPCAT, the then Commonwealth Attorney General, the Hon George Brandis MP, acknowledged:

'Had the OPCAT been operational at the time the events of the Don Dale Youth Detention Centre in NT emerged, then it may well be, that … they wouldn't have happened at all …'[5]

A year later, Dr Aaron Groves, the South Australian Chief Psychiatrist, remarked:

'Oakden would not have happened, had we had an NPM in place …'[6]

At the Oakden Older Persons Mental Health Service in SA in 2016, residents were over-medicated, malnourished, injured, bound for up to 10 hours a day, and isolated in squalid conditions,[7] resulting in the Royal Commission into Aged Care Quality and Safety (costing more than $100 million).

After ratifying OPCAT, Australia postponed implementing its obligation to establish an NPM for four years and now is one of only two countries to have been granted a further one-year extension.[8] Australia intends to establish a multi-body NPM with responsibility shared among the jurisdictions. Other countries opting for a similar model include the United Kingdom, Malta, and New Zealand.

In 2018, I undertook my Churchill Fellowship[9] to study OPCAT implementation in the United Kingdom, New Zealand, Denmark, Norway, Switzerland, Greece, and Malta. This confirmed that the effectiveness of an NPM could not be divorced from its operational framework – a view strengthened through my academic work, continued inspection practice, and sustained engagement with the international OPCAT community.

Policy issues

Three urgent policy issues need to be addressed to ensure effective implementation: 1) expanding the scope of the NPM; 2) enacting primary legislation; and 3) providing appropriate funding.

1) Expanding the scope of the NPM

The Australian Government has formally restricted the NPM's focus to 'primary places of detention'. These include:

- adult prisons
- juvenile detention facilities (excluding residential secure facilities)
- police lock-up or station cells (holding people for more than 24 hours)
- closed facilities or units where people may be involuntarily detained by law for mental health assessment or treatment (holding people for more than 24 hours)
- closed forensic disability facilities or units where people may be involuntarily detained by law for care (for more than 24 hours)
- immigration detention centres
- military detention facilities.

It notes this list 'reflects the position that the challenges posed by the deprivation of people's liberty are at their most significant in these places of detention' and that full implementation is to be an 'iterative process.'[10]

Australia is the only country to have taken this approach, and the former UN Special Rapporteur on Torture, Manfred Novak, has said that 'this restricted definition might violate OPCAT.'[11]

The Australian Human Rights Commission in *Implementing OPCAT in Australia (2020)* says '... the Australian Government should ensure that OPCAT applies to all places where people are or may be deprived of their liberty, and all places of detention should be subject to inspection by an NPM.'[12] While supporting 'an approach ... in which NPMs prioritise visits to particular places of detention, where the need is likely to be greatest,'[13] the Commisson argues that this was for the NPM, not the state, to decide.

This limited scope has generated controversy. The Royal Commission into Aged Care Quality and Safety reported that 'the inappropriate use of unsafe and inhumane restrictive practices in residential aged care has continued, despite multiple reviews and reports highlighting the problem.'[14] However, the Australian Government concluded at Supplementary Budget Estimates 2019–20 that:

'... aged care facilities do not fit within the concept of 'places of detention' as set out in Article 4 of OPCAT and there is presently no proposal to include them in any list of primary places of detention.'[15]

The Australian NPM's mandate should not be inhibited in this way, and it should be free to determine its own priorities.

Case study 1: Malta

Malta ratified the OPCAT in September 2003. Its NPM comprises two bodies with authority to visit immigration detention and prison establishments – clearly an insufficient practical mandate.

In 2015, the UN Working Group on Arbitrary Detention recommended the NPM's jurisdiction '... be extended beyond the closed detention centres to other places, such as the mental hospital, elderly care facilities, and even private houses, whenever reliable information exists that individuals are being deprived of their liberty.'[16]

Image credit: Adobe Stock.

2) Enacting primary legislation

In its report, the Australian Human Rights Commission concluded that:

'Primary legislation would safeguard the NPM network, guarantee appropriate resourcing and enshrine its independence, and ensure that any changes that would affect how OPCAT operates in Australia would be subject to parliamentary debate. Legislation also would provide for unfettered powers of access to all places of detention by NPMs ...'[17]

While it considered an Intergovernmental Agreement a possible alternative, it concluded this would 'not present an equivalent, or adequate, alternative to legislation that gives full effect to the key provisions of OPCAT itself.'[18]

The Australian Government has consistently expressed the view that primary legislation is unnecessary.[19] In regard to an Intergovernmental Agreement, it has fluctuated between this being the 'centre' of the implementation process,[20] to being 'not required'[21] and, more recently, to being 'useful' in providing a clear framework for how OPCAT will be implemented in Australia.[22]

Legislation should be drafted through an open and transparent process including consultation with state and territory governments, the Australian Human Rights Commission, Commonwealth Ombudsman, proposed and designated NPMs, and civil society, including the Australia OPCAT Network.

3) Providing appropriate funding

Funding has emerged as the most significant stumbling block to the establishment of the Australian NPM.[23] In March 2021, the NSW Attorney General stated:

'The implementation of the ... [OPCAT] is an initiative of the Commonwealth Government. NSW did not support the ratification of OPCAT before resourcing concerns were addressed and does not support implementation until those concerns are addressed.'[30]

Similar concerns about the need for dedicated Commonwealth funding have also been expressed by Tasmania, Victoria, and Queensland.[31]

In July 2021, the Australian Government pledged 'funding over two years from 2021–22 to support states and territories.'[32] However, it also said 'jurisdictions are responsible for funding their own oversight and detention arrangements on an ongoing basis.'[33]

The Commonwealth Ombudsman emphasised the importance of properly resourcing OPCAT implementation in its 2019 Baseline Assessment of Australia's OPCAT Readiness, stating that:

'In order to have an effective and regular preventive inspection regime, bodies will require new or expanded methods of operation. These will need commensurate increases in resourcing over time in most, if not all, jurisdictions.'[34]

The costs of Australia's NPM needs to be weighed against the cost of taking OPCAT seriously. In mid-2021, $35 million compensation was awarded to those ill-treated at the Don Dale Youth Detention Centre. The associated Royal Commission cost around $70 million. The cost to Australia's international reputation and the impact on the lives of those ill-treated in detention is overwhelming.

Case study 2: The United Kingdom

The United Kingdom ratified the OPCAT in 2003, establishing its NPM (UK NPM) in March 2009.[24] Existing monitoring bodies were designated, with three additional bodies subsequently added.[25] John Wadham, Independent Chair of the UK NPM, noted:

' ... the only kind of official status of the NPM is a Ministerial Statement saying we have designated the following organisations, so there's no guarantee of our independence as an NPM. There may be guarantees of the independence of the particular parts but that varies from body to body. Some of those organisations have something in their legislation about the NPM but most don't.'

The UK NPM 'has held a longstanding goal to be placed on a statutory footing in order to strengthen and protect its work,'[26] raised repeatedly since 2011. The absence of primary legislation has been criticised by the European Committee for Prevention of Torture (CPT)[27], the UN Committee against Torture (CAT),[28] and the UN Subcommittee on Prevention of Torture (SPT).[29]

Case study 3: New Zealand

New Zealand ratified the OPCAT in 2007, designating four existing monitoring bodies and the New Zealand Human Rights Commission as the coordinating body (NZ NPM).

In 2017, Professor Judy McGregor said under-resourcing had impacted the NPM's '... capacity to carry out monitoring to the extent required by the protocol, and, by diverting resources from other work streams, also impacts on their core functioning'. It had led to 'non-coverage by the NPMs of some places of detention in New Zealand, and concern by the SPT of the scope of the NPMs' mandates.'[35]

'The overarching challenge faced by NPMs is how to function most effectively within the limited resources they have available ... maintaining independence and continuing to build credibility ... The potential costs of not investing in OPCAT prevention include compensation claims for breaches of rights; legal, medical and rehabilitation costs; and wider detriment to public trust and confidence in the detention systems.'[36] – NZ NPM.

Policy recommendations

To fulfill its ambitions to establish an effective NPM to meet its OPCAT obligations, it is recommended that the Australian Government should:

1. accept the interpretation of 'deprivation of liberty' adopted by the UN SPT
2. enact primary legislation, developed in consultation with relevant stakeholders, to give practical effect to OPCAT in Australia
3. ensure the NPM is properly funded and resourced.

Stakeholder consultations

During my Fellowship I engaged with 21 NPM bodies, 11 peak organisations, six human rights commissions (or similar), four current or former UN mandate holders or treaty body members, and other torture prevention experts. I undertook field observations in the UK and Greece. I have served as Coordinator of the Australia OPCAT Network – a coalition of more than 200 stakeholders with interest in OPCAT implementation. I have made presentations to the Australian Red Cross, Victorian Equal Opportunity and Human Rights Commission, Danish Institute against Torture, Irish Penal Reform Trust, Inspector of Custodial Services WA, University of Tasmania, and the Disability Royal Commission. I have consulted with the SA, Tasmanian, Queensland, NSW, and the NT governments, resulting in amendments to draft bills, including the OPCAT Implementation Bill 2021 (Tasmania), Correctional Services (Accountability and Other Measures) Amendment Bill 2021 (SA) and the draft Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Amendment Bill 2022 (NT).

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Universal Registration is Key to Preventing Gambling Harm

By Angela Rintoul
Churchill Fellow 2018

Key terms: gambling, harm reduction, wagering, pre-commitment, EGMs, online gambling

Inquiries into multiple casinos across Australia[1] have raised serious concerns about unlawful and predatory operator practices, accentuated by the inherent dangers of the products they sell. Yet the harms associated with gambling are not unique to casinos, they can be seen across community poker machine venues and wagering operators. At least 1.33 million Australian adults who gamble experience adverse effects.[2] Many unused interventions can prevent harm regardless of where the gambling takes place. Key among these is a system whereby people who gamble establish a unique account, enabling use of harm reduction tools, including binding limits on losses. By their nature, such systems do not affect those who gamble at no-risk levels.

'I'd kill to be able to set limits … It [would] really make me walk away.' – Male (40 years) and study participant who has survived multiple gambling related suicide attempts.[3]

Gambling is highly accessible and heavily promoted in Australia. While rates of participation are falling,[4] gambling expenditure has remained high, meaning a smaller proportion of people who gamble contribute higher average gambling losses, and experience harm. Australians are known as the largest per capita gambling 'losers' in the world: in 2019, we lost $25 billion on all forms of gambling,[5] or $1,277 on average per adult.[6] Harm is concentrated in areas of social stress and disadvantage.[7]

Among those who gamble, some experience enjoyment and little if any harm, particularly on lower risk products like lotteries. However, the greatest share of gambling harm in the aggregate accrues to 'low risk' and 'moderate risk' gamblers.[8] Electronic gambling machines (EGMs) and online wagering are higher-risk products, where the regulation of gambling has not kept pace with advances in technology and marketing strategies.

The Victorian Government receives around 8% of its tax revenue ($2 billion in 2018–19) from gambling.[9] However, the social costs of gambling in Victoria alone are estimated to be $7 billion a year.[10] Relationship breakdown, emotional, psychological and physical ill-health, crime, loss of productivity, and financial distress are all consequences of harmful gambling. These harms are not distributed equally across the population. Furthermore, it is estimated that for every person who gambles at problematic levels at least six others are directly affected.[11] Thus costs significantly outweigh the revenue captured by state governments through gambling taxes.[12] The profits obtained from gambling have created a powerful industry lobby, with capacity to fund significant campaigns to resist effective regulatory reforms.[13,14]

'Perhaps the most damning discovery by the Commission is the manner in which Crown Melbourne deals with the many vulnerable people who have a gambling problem. The cost to the community of problem gambling is enormous. It is not only the gambler who suffers. It also affects many other people, and institutions.' – The Report of the Victorian Royal Commission into the Casino Operator and Licence 2021 (Crown Royal Commission).[15]

At its extreme, gambling harms manifest as suicide and suicidality.[16] A recent Swedish study reported a 15 fold increase in risk of suicide mortality for those with a gambling disorder compared with the general population.[17] The first Australian study to review gambling-related suicides this century has identified 184 gambling-related suicides in Victoria between 2009-2016,[18] or 4% of all suicides in that state. However, even this substantial number is likely an underestimate given systems for identifying, investigating, and reporting gambling-related suicide are underdeveloped.

A public health approach to preventing and reducing gambling harm is urged by academics and many responsible for gambling policy and regulation.[19] Such an approach would adopt population-wide interventions and warning messages about the harms associated with these products. Instead, to date there has been a reliance upon individual consumer level 'responsible gambling' strategies, such as flawed self-exclusion programs and operator self-regulation strategies.[20-22] Industry has adopted ineffective slogans such 'gamble responsibly' (Australia) or 'when the fun stops, stop' (Britain).[23] These may do more harm than good, constituting a 'dark nudge' by linking gambling with fun.[24-26]

Shifting to a comprehensive public health approach would assist in reducing stigma for those who experience gambling harm.[27] Rather than stigmatising the behaviour of individuals harmed, a multilayered public health approach would equip people who gamble with technology to limit time and money spent gambling, and provide warnings about harmful potential consequences of gambling. The use of machine, session, and operator provided data should inform modifications to harmful characteristics of gambling products.

Policy context

The Australian public has a strong appetite for gambling reform.[28,29] Four recent inquiries into Australian casinos have recommended reviews of gambling legislation, and specific interventions, to improve regulation and prevent harm.[30-33] Public health protection measures introduced in response to COVID-19 disrupted the gambling behaviour of many Australians following the closure of EGM venues across the country. However, upon reopening, use of these products remains high. Growth in online gambling was reported during the pandemic, further demonstrating the need for greater regulation of these products.

The Productivity Commission's most recent inquiry recommended a reduction in the maximum bet limit on EGMs and a mandatory pre-commitment system in relation to EGMs.[34] However, despite attempts by Andrew Wilkie MP and others to enact these between 2010 and 2013, calls for their implementation have thus far been unsuccessful overall. A well-funded campaign by industry groups[35] resulted in the *National Gambling Reform Act 2012* being renamed the *Gambling Measures Act 2012* via the *Social Services and Other Legislation Amendment Act 2014*. Few measures remained from the original reform-focused legislation. This experience highlights the ways in which political donations laws in Australia undermine the capacity of lawmakers to act,[36,37] creating a major barrier to effective reform.

Community sentiment has driven some AFL clubs (Melbourne, Western Bulldogs, North Melbourne, Geelong, Greater Western Sydney Giants) to distance themselves from EGM operations by divesting their poker machine licenses. Large supermarket chains have also eliminated or reduced their exposure to gambling revenue for similar reasons.[38] However, the promotion of wagering advertising during sports remains controversial, particularly as it relates to exposure of children to adult products.

In 2018, in response to a review of illegal offshore wagering,[39] the Australian Government in partnership with the states and territories, announced the introduction of 10 measures to improve consumer protection for online wagering.[40, 41] While an improvement on the status quo, the measures could readily be strengthened through the introduction of a centralised, universal (or mandatory) pre-commitment system across terrestrial and online wagering providers and platforms.

Although a pre-commitment system for EGMs is a recommendation of the Crown Royal Commission, similar measures to improve the safety of EGMs in hotels and clubs – the most widespread and harmful form of gambling in Australia – are currently lacking. A royal commission into gambling regulation in Australia that explores predatory practices, operator duty of care, and product design would further strengthen the case for reform. Giving voice to those who have been harmed by gambling may also provide a platform for people to contribute to the improvement of regulation in this country. Notably, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Financial Services Royal Commission) was particularly influential in highlighting unethical and illegal practices in this sector and in achieving progress in financial regulation and reform.

International lessons

During 2019, a Churchill Fellowship provided me with the opportunity to visit a number of countries to investigate the ways in which other jurisdictions had responded to gambling harm.[42] Those that had introduced successful reforms had focused on product rather than individual level measures, and were conscious of minimising any interference by vested interests when setting policy.[43] To achieve reforms, there was strong public support, either through research showing large numbers of people harmed, and/or media coverage that showed the experiences of those who had been harmed by gambling. In Britain, the advocacy of the lived experience organisation Gambling with Lives had been effective in raising public awareness of gambling-related suicide, and achieved bipartisan support for reform by working with the media, politicians from all persuasions, and the British regulator.

Norway provides a notable case study for major, effective reforms (see **case study**). Finland introduced universal loss limits for high intensity online gambling in 2018. Research undertaken with more than 18,000 Veikkaus[44] customers found that introducing a limit setting system for high intensity online gambling products[45] was effective in reducing losses across all risk categories.

Case study: Norway's policy response measures to tackle problem gambling

In 2003, the Norwegian Government responded to public and professional concern about harm linked to 19,000 slot machines operated by 100 private operators across the country.[46] A national prevalence survey had reported that 49,000 Norwegians were experiencing high levels of harm from gambling – in a country of five million people, this was considered unacceptable.

They created a national gambling monopoly, Norsk Tipping. In 2007, a national recall of slot machines was announced, and all electronic gambling machines (EMGs) run by 100 private operators were recalled. Slot machines were banned until 2009, after which fewer interactive video lottery terminals (Multix) were reintroduced by the government's Norsk Tipping. Machines were loaded with a range of harm reduction features, including universal registration. People who gamble are required to set personal loss limits through their registered account and can track losses against a regulated maximum universal limit designed to prevent 'catastrophic' losses.

Pictured left: a pre-2007 Norwegian slot machine. Middle: A poster, distributed by the Norwegian Gaming Authority, promoting the 2007 recall of slot machines. Right: the Norwegian Multix machine requires users to verify their account registration before accessing games. *Image credit: Courtesy of Angela Rintoul.*

Forty-three percent of people classified as 'problem gamblers', and 42% of moderate risk gamblers reported that the limits helped them to control their gambling (**Figure 2**). Furthermore, 75% of respondents reported that when their limit was reached they stopped gambling until it reset. The remainder either reset their loss limit (23%), moved to other unlimited games (6%) gambled on international sites (6%), or moved to unidentified accounts (3%).[47] Those who circumvented this system were in the minority. Thus, the majority of users successfully adapted to the introduction of a limit setting system.

This research demonstrates the value of providing account level data to regulators and researchers to assist in identifying points of preventive intervention, and to refine measures introduced to prevent harm. Operators should also be required to provide such data as a condition of licensing.

Principal policy options

Voluntary or optional pre-commitment systems are non-binding so a gambler can choose to participate or not, and can also continue to gamble beyond a nominated limit by simply removing their card. Optional pre-commitment systems are inherently flawed and evaluations of these have repeatedly shown less than 1% usage.[48] Optional systems have also been found to be stigmatising; they are perceived to only be useful for people experiencing harm. YourPlay was introduced in Victoria in 2015, providing a fleet of 'pre-commitment ready' EGMs across the state. The Victorian scheme was unsurprisingly also evaluated as unsuccessful, with registered cards used in only 0.01% of turnover in hotels and clubs.[49] Nonetheless, YourPlay (like similar systems operated at casinos and some clubs and hotels throughout Australia) could readily be converted to an effective universal system. If deployed effectively, universal systems could be a powerful harm prevention tool for those not yet experiencing gambling problems.

Effective reforms will inevitably reduce gambling revenue, however, this money is not 'lost' from the economy, for instance, savings will arise through reductions to social costs. Furthermore, the goal of preventive reforms is to stop harm from developing, meaning that some reductions in revenue may accrue over time.

Reforms should be led by the Australian Government, as was the case with the online gambling consumer protection framework referred to above. If states are able to introduce common reforms (as occurred with that framework), there is less likelihood of regulatory competition. If states are unwilling to regulate, the Australian Government has the jurisdiction to regulate a common framework (with powers under the *Corporations Act 2001*), even if states continue to regulate gambling operations.

Policy recommendations below have been adopted in part by the Crown Royal Commission, and in some cases by the Productivity Commission and many international researchers. Reforms will require some lead in time in some jurisdictions.

Figure 2. Finland Veikkaus research demonstrates the value of setting loss limits.[47] Many users across the spectrum of risk experienced benefit from loss limits. Those experiencing the most harm (those with a problem gambling severity index [PGSI score of 8+] and moderate risk of harm [PSGI of 3–7]) derived the most benefits from limit setting.

However, most Australian jurisdictions (and all casinos) require all EGMs to be connected to a centralised monitoring system. These allow for 'loyalty' and in some cases pre-commitment systems to be operated with modest investments. All online wagering and lottery systems can be adjusted to allow introduction of pre-commitment systems; they are already account based and rely on identity verification. A phase-in period of 18 months to two years may be reasonable depending on the circumstances of industry and regulators. This has occurred in some jurisdictions where reforms such as reduced maximum bets have been required.

Stakeholder consultation

Relevant stakeholders include community and lived experience groups who have been harmed by gambling, organisations that provide treatment and support to those experiencing harm, academic researchers, and industry. Advice from all groups should be weighed against their potential for conflicts of interest. Declarations should be sought prior to consultation to identify whether they receive funding from the gambling industry or its affiliates. The most useful role for the gambling industry would be to identify the technical and practical feasibility of policies. Given their incentives to avoid regulations that reduce revenue and history of resistance to reform,[50–52] industry groups and their affiliates should not play an active role in policy design.

Policy recommendations

- Through legislative amendments to the *Commonwealth Electoral Act 1918*, prohibit political donations from gambling industry actors (and other designated classes of donors), and their affiliates, to remove disincentives for policy makers to enact meaningful reforms.
- Establish a federal anti-corruption commission to ensure that untoward influence on policy makers by gambling industry actors can be detected and deterred.
- Establish a royal commission into gambling regulation in Australia to enquire into the nature and extent of operator duty of care and practices, provide a platform for those affected by gambling, and to document the ways in which product design influences harm. This royal commission would further examine important issues of regulation, harm prevention, and enforcement raised by the multiple inquiries and royal commissions into Crown Resorts Ltd and their subsidiaries, The Star, and NSW clubs and hotels.
- Transition to a centralised, universal, account registration system across Australia for wagering and EGMs. The Commonwealth has constitutional power to enact such a system nationally via the *Interactive Gambling Act 2001* (or other legislation as appropriate) – noting that such a system relies on communication between EGMs and centralised monitoring systems – and a general power under the *Corporations Act 2001*. This would provide the architecture for the deployment of a range of harm reduction measures, particularly a pre-commitment system with binding loss limits. In states such as Victoria where the infrastructure is already available this could be achieved in the next one to two years.
- As with the consumer protection framework for online wagering, coordinate state legislation to prohibit predatory promotions and practices, including inducements to gamble. This could be achieved through a progressive reduction in gambling advertising, including during sport and on social media. This may involve financial support, modelled for instance on the QUIT campaign tobacco advertising buyout.

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Angela Rintoul is a public health policy specialist with expertise in health inequities and harm reduction. Her research takes a population-based approach and has explored the relationship between place, social circumstances, and gambling harm and involved reviews of interventions to prevent gambling harm.

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The Critical Role of Family Support in Accessing Gender Affirming Health Care

A pathway to better outcomes for transgender youth.

By Jeremy Wiggins
Churchill Fellow 2016

Key terms: transgender, gender diversity, suicide, young people, family support

Overburdened and underfunded gender clinics, underfunded family support organisations, and discriminatory medical consent procedures are driving poor health outcomes for transgender youth. The Australian Government must act by developing a national health and wellbeing strategy. To not do so will lead to increasingly fatal consequences for transgender youth.

Image credit: Penny Ryan courtesy of Transcend.

In Australia and across the world, it is estimated that 2–3% of young people identify as transgender and/or gender diverse (trans).[1,2] The number of trans young people and their families seeking access to gender affirming medical services rises each year. This is attributed to a 'growing acceptance from parents, doctors and peers'[3] about gender diversity. Increasing levels of media visibility, social policy improvements, and some level of protection in anti-discrimination legislation has created a supportive environment for young people to disclose their feelings and seek support.[4,5] Despite some being able to access care, many trans youth face discrimination, bullying, and barriers to care resulting in one of the highest rates of suicide attempts and depression in Australian society.[6]

Risk factors for trans youth

Substantial evidence points to what helps trans young people fare better with their mental health and wellbeing.[7–10] It includes school, family and peer support, and timely access to gender affirming treatment. Trans Pathways, the largest Australian study into the mental health of trans young people found that almost two thirds (68.5%) report low levels of family support. Experiencing low levels of family support was associated with '... higher rates of suicidal thoughts, wanting to hurt themselves, suicide attempts, self-harming, reckless behaviour, and diagnoses of eating disorders, anxiety, depression, and PTSD ...' compared to those reporting higher levels of family support.'[11]

Other related risk factors include stigma and discrimination, homelessness, bullying, and harassment.[12–14] Almost half (48.1%) of transgender and gender diverse people aged 14 to 25 have reported that they had attempted suicide in their lifetime.[15] It is a matter of urgency to consider the early interventions available to prevent the high incidence of poor mental health and suicidality. This will not only benefit trans young people, but there is considerable benefit to the public health system by intervening with early service provision to avoid the creation of long term mental health and other issues.

Image credit: Penny Ryan courtesy of Transcend.

The largest study ever conducted on trans adults who reported seeking gender affirming treatment during adolescence has shown that when younger trans people are able to access gender affirming health care, their later life mental health experiences are improved significantly. The study of nearly 28,000 participants showed that early treatment was associated with better mental health outcomes and significantly reduced levels of suicidal ideation.[16]

'Helping young people by referring them to gender clinics and acknowledging their gender identity is not just being nice, it's preventing harm and improving their mental health in the longer term.'[17] – Dr Fiona Bisshop, former President of the Australian Professional Association for Trans Health.

What is gender affirming medical care in Australia?

'Patients with gender dysphoria require access to expert care and treatment. Withholding or limiting access to care and treatment would be unethical and would have serious impacts on the health and wellbeing of young people.'[18] – Associate Professor Mark Lane, former RACP President.

Gender dysphoria is defined as significant distress or functional impairment associated with incongruence between the internal sense of gender and the sex assigned to someone at birth.[19–22] While social affirmation (changing names, pronouns, gender expression) is the first step for many trans children and adolescents in gender affirmation, medical affirmation may be necessary for adolescents approaching puberty. The decision to undergo medical affirmation is carefully considered and involves detailed multi-disciplinary assessments to attain a diagnosis of gender dysphoria.

National guidelines describe options including:

- **Under 18 years:** Stage 1: puberty suppression with puberty blockers; and Stage 2: gender affirming hormone therapy
- **18 years and over:** Stage 3: gender affirming surgical procedures (in some cases a 16 or 17 year old trans masculine person may benefit from a chest reconstructive procedure, however, it is national and international standards to not perform any surgery on a person under the age of 18).[23]

Throughout this process, psychological support for the young person and families is essential.[24,25] Family and parental support is one of the key protective factors for trans youth. Yet a key policy issue is the limited amount of funding available to community led family support organisations who can provide this critical support. Other policy issues include under-resourced medical services, limited workforce capacity to deliver gender affirming care, and discriminatory consent procedures for trans youth, which in the event of a parental dispute, involve an application to the Family Court.

Policy inaction and its impact on trans young people

Despite mounting evidence pointing to a health crisis among trans youth and calls to act from the Royal Australasian College of Physicians (RACP), there has been a lack of a coordinated national response from the Australian Government. National mental health strategies and policies and the *National Action Plan for the Health of Children and Young People* omit the needs of trans youth.[26,27] Meanwhile, the number of trans young people and their families presenting at medical clinics who require support from the public health system is growing rapidly and their health disparities remain in need of national attention. The Royal Children's Hospital Gender Service in Melbourne has seen an increase in new referrals from one in 2003, to 821 in 2021 and these numbers continue on an upward trend.[28]

The medico-legal landscape regarding consent for the treatment of trans young people in Australia

Competence to consent to medical examination and treatment by children under the age of 18 years is known as *Gillick*-competence.[28] This is determined by a clinician who has assessed the child as having sufficient maturity and intelligence to understand the nature and implications of the treatment proposed.[29]

Since 2004, decision making with regards to gender affirming medical and surgical treatment for trans young people has not been determined by a clinician's assessment of the young person as *Gillick*-competent, as is the case for all other medical treatments, but by a legal process involving the Family Court of Australia. While the law has evolved since the first case, known as Re Alex (2004), recent developments prompted by a case

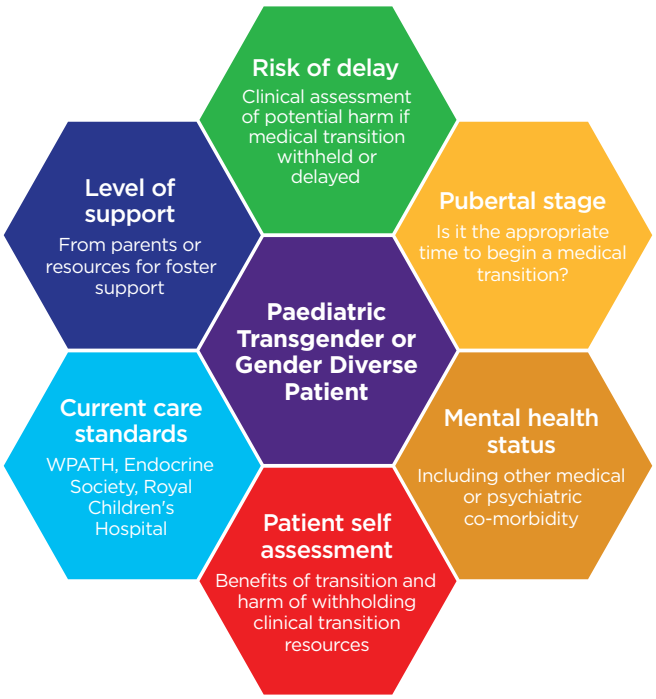

Figure 1. Areas to consider when assessing a paediatric transgender or gender diverse patient. WPATH, World Professional Association for Transgender Health. Source: Dubin, S., Lane, M., Morrison, S., et al. (2020). Medically assisted gender affirmation: when children and parents disagree *Journal of Medical Ethics*,46: 295-299.

decided by a single Judge of the Family Court in 2020, known as Re Imogen (No 6) [2020] FamCA 761 have set back the legal rights of trans young people significantly, to the extent that those trans youth who have an absent parent, or a parent who objects, now face significant hurdles and delays by being required to go through the court process to obtain court authorisation, even if they are deemed '*Gillick*-competent' and treatment is determined to be in their best interest (**Figure 2**).[30] No other form of therapeutic medical treatment is subjected to those hurdles, which gives the application of Re Imogen discriminatory impact.

In the face of increasing numbers of young people identifying as gender diverse, and demanding treatment services, it is time that the legislature took responsibility for developing a sensitive, humane, and practical system for decision making around their access to potentially life-saving medical treatment.[31] *– Hon Justice Steven Strickland, Judge of the Appeal Division, Family Court of Australia and President, Australian Chapter of the Association of Family and Conciliation Courts.*

Reform is urgently required to reverse inequity. Furthermore, while family support organisations play a key role in early intervention, including provision of support

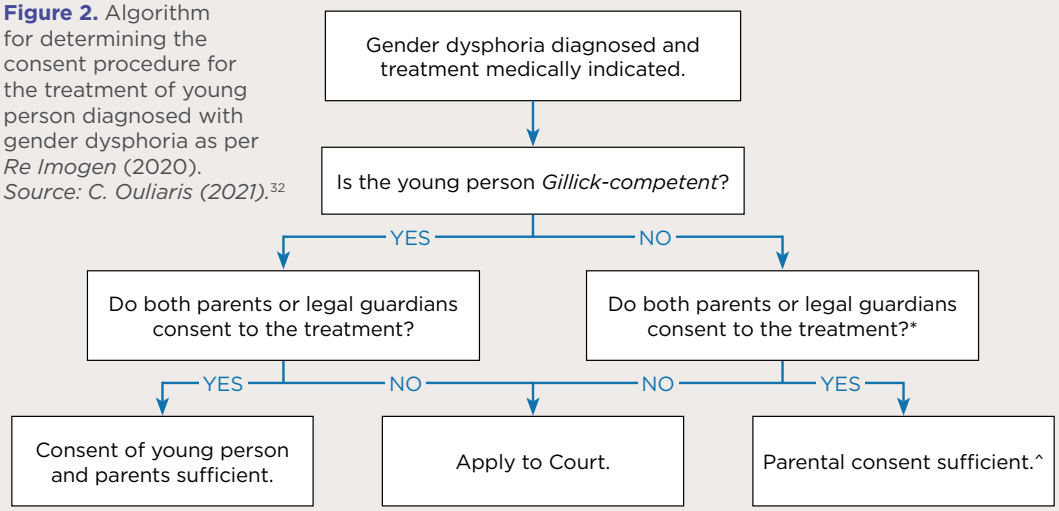

Figure 2. Algorithm for determining the consent procedure for the treatment of young person diagnosed with gender dysphoria as per *Re Imogen* (2020). *Source: C. Ouliaris (2021).*[32]

and information to families which can avoid unnecessary court applications, funding for family support organisations is insufficient.

International cases of best practice

My Churchill Fellowship[33] explored best practice models of trans health care and the importance of respecting and valuing people of lived experience and affirming them at every level – socially, culturally, medically, surgically, and legally. I visited the United Kingdom, Thailand, Germany, Canada, and the United States. Recent legal cases in Canada (**case study 1**) and the United Kingdom (**case study 2**) demonstrate the importance of enabling lifesaving gender affirming care for trans young people, recognising that *Gillick*-competent trans young people under the age of sixteen can provide informed consent to medical treatment.

Supporting families into the future

The role of families in achieving lasting, lifelong, positive outcomes for transgender children is critical.[34] Families need support to help navigate the difficult pathway to locating and accessing the limited number of professionals and services presently available in Australia. Without appropriate integrated care and family support in place by services such as Transcend Australia (national) or the Gender Centre (NSW), access to gender affirming care can be jeopardised. Moreover, the Family Court's current requirement for dual parental or legal guardian consent has the effect of delaying or denying access to treatment. Increasing funding to family support organisations to scale up these services nationally may serve to mitigate this risk, providing immense benefit to families and trans young people's long term outcomes.

The Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents, published by The Royal Children's Hospital,[35] have been heralded as world leading by the prestigious medical journal The Lancet and were endorsed by AusPATH, the peak body for professionals working with trans people in Australia. Yet the current inconsistent application of the law in Australia relating to *Gillick-competence* hinders the ability for that

Case study 1: Canada – AB v CD and EF (2019)

In 2019, a transgender youth (AB) sought gender-affirming medical treatment at age thirteen. The consulting endocrinologist recommended stage 1 treatment to suppress puberty. The young person's father (CD) disagreed, and the parties went to court – AB seeking to retain their right to consent to medical treatment and the father seeking to prevent it.[36] The law stipulated that:

'if a minor understands a proposed treatment and its consequences, and the minor's medical provider finds the minor competent and the treatment to be in the best interest of the minor, the minor has the exclusive right to consent to the treatment. The court found in favour of AB as having exclusive right to consent and dismissed the father's claim. On appeal, the Court upheld the original decision.'[36]

Case study 2: United Kingdom

In 2021, the England and Wales Court of Appeal overturned the London High Court decision in the case of Bell vs Tavistock. The judges in Bell v Tavistock doubted that anyone under the age of 16 would be able to provide informed consent to starting puberty blockers as a gender affirming medical intervention and must instead apply to the court for permission.[37] This decision effectively reversed an earlier decision (Gillick v. West Norfolk and Wisbech Health Authority) which had provided a mechanism for minors to consent to their own medical treatment if judged by the treating medical practitioner to be competent to do so. This had the effect of limiting the application of Gillick solely in cases involving gender affirming care.

The Court of Appeal, however, found against the decision in Bell v Tavistock and 'reinstated the test of *Gillick* and re-emphasised that it is for the clinician together with the patient and the family to make decisions on a case-by-case basis. It was not for the court to make generalisations about consent at different ages, nor should the court be routinely part of the consent process for puberty blockers.'[38]

high quality care to be delivered. To support families and young trans people into the future, Australia must not ignore the current crisis of care experienced by trans young people. Urgent action is needed to scale up family support services for this vulnerable and underserviced part of the Australian community and to draft legislation so that trans young people can access medical treatment on the same terms as non-trans children and in a timely manner.

Recommendations

1. **Australian, state, and territory governments provide appropriate funding to community led trans family support organisations to meet the growing demand of families requiring assistance.**

   This will enable early intervention, support and appropriate referral through dedicated case work and peer support to families of trans young people and help to create a better pathway for timely access to care, avoid unnecessary court applications, and reduce long term public health costs associated with poor mental health.

2. **State and territory governments appropriately fund multi-disciplinary gender services for young people.**

   Ensuring timely access to gender affirming health care requires adequate funding and appropriately trained staff. Trans young people deserve access to quality and timely gender affirming health care close to where they live, including in regional and rural areas.

3. **The Australian Department of Health ensures that trans young people and their families are meaningfully included as priority groups in health and wellbeing strategies and hosts a national roundtable meeting of trans and family led organisations to identify the key issues impacting communities, including:**

   - workforce gaps, training, and capacity building needs for generalist and specialist practitioners
   - accessibility issues related to gender affirming medications that are not listed on the Pharmaceutical Benefits Scheme
   - the needs of communities in regional and rural Australia
   - review of Medicare item numbers to comprehensively assess trans youth for medical interventions and item numbers for specific surgical gender affirming procedures
   - access to gender affirming surgery in the public health sector
   - national data collection and outcome monitoring to analyse productivity
   - fund research to build an evidence base
   - develop evidence-based facts sheets.

4. **Change the law to stop medical consent discrimination for trans young people.**

   Legislation is required to codify *Gillick-competence* so that trans young people are afforded the same medical consent rights as non-trans young people in Australia. The standard model of care should respect the medical decision-making rights of the young person in a manner which is consistent with the common law principles of *Gillick-competence*, preferably through legislative reform, to ensure that trans young people can consent to health care on the same terms as non-trans young people, in a timely manner and in a way that recognises their inherent dignity and human rights to health care and equal treatment by the law, without discrimination.

Stakeholder consultation

Thank you to all the stakeholders for their engagement and contribution to this article, and to the following organisations who consented to be listed. This list is not exhaustive and I would recommend policy makers engage with experts in the field who have credible academic, clinical or lived experience.

Transcend Australia, Health Law Partners, Australian Professional Association for Trans Health, Suicide Prevention Australia, Academy of Child and Adolescent Health, Australian Association for Adolescent Health, Telethon Kids Institute, A Gender Agenda, Equality Australia, Twenty10, TransFolk of WA, Transgender Victoria, Zoe Belle Gender Collective, Youth Affairs Council of Victoria, Foundation for Young Australians, Gender Centre, LGBTIQ+ Health Australia, ACON, The Gender Centre, Murdoch Children's Research Institute, and TransFamily.

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Jeremy Wiggins is CEO of Transcend Australia, a national charity working to support families and their transgender children. Jeremy has worked for over 15 years on health system reform and innovation to improve health outcomes for marginalised communities.

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Image credit: Courtesy of Rebecca Lyons.

Reimagining Death Care for Our Ageing Population

By Rebecca Lyons
Churchill Fellow 2018

Key terms: death literacy, end of life doula, home funeral, family led funerals, palliative care

'Together we can fix the crisis in aged care.'[1] – Prime Minister Anthony Albanese, 21 May 2022.

As many as 70% of Australians want to die at home and yet comparatively few achieve that.[2] Overwhelmingly people are not achieving the end of life they desire. Australian society would benefit from community-centred and family-focused approaches to both the care of the dying and the dead, and the integration of these with existing health care approaches.

To this end, Australia needs a national interdisciplinary roundtable to develop strategies for the integration of informal (that is, non-medical based services that focus on social and spiritual wellbeing) and formal (that is, medical services) supports and services in end of life and death care. The purpose of the roundtable is to provide wider options and greater support for the growing numbers of people predicted to die in the next four decades.[3]

The formal and informal systems of care are inextricably linked. People who are nearing end of life require both kinds of supports and services to achieve the death and death care they prefer, including the ability to die at home and to be able to remain there, in the care of their families and friends. The integration of formal and informal services at end of life (and in death) is an important step toward meeting the growing demand on existing services in the future.

Background

By 2066, it is estimated there will be more than 430,000 deaths per year, compared to about 163,300 deaths registered in 2020.[4] Not only is Australia's population ageing, but so is our workforce. If current procedures are continued, Australia will need to significantly increase numbers of doctors, nurses, palliative care wards, places in nursing homes, aged care workers, hospice programs, hospital beds, non-medical supports, providers, workers, equipment-hire schemes, and potentially funeral homes, to support the numbers of people projected to die. This is not something that can be done easily or quickly, so these issues require an urgent response, particularly in professional fields where high levels of training are required.

Currently Australia's dying and death policies are split across several domains. The portfolios of health care are state based, while aged care and other public health measures fall within the purview of federal government, and services such as home care packages receive a mix of funding. To develop and implement a comprehensive national strategy on dying and death, both levels of government need to come together to look at how both the formal and informal services across all sectors can be integrated to provide better overall end of life and death care for Australians.

In 2014, the Grattan Institute released a report[5] that highlighted the limitations of the medical system alone in addressing all the needs that arise at end of life, and found that there was a need for non-medical care at the end of life. In 2017, the Australian Productivity Commission released a report[6] that also recognised people's access to services they wanted at end of life were limited, including people not being able to die where they wanted. The Grattan Institute report three years earlier had focused on good death outcomes and went as far as proposing where funds could be found to introduce the formal and informal supports to allow home based death.

The recent Royal Commission into Aged Care Quality and Safety (Royal Comission into Aged Care) highlighted the suffering that can come with long waits to access needed services, echoing the Australian Productivity Commission findings. There are eight National Palliative Care Principles,[7] which have been designed specifically for aged care facilities. This is helpful to those who reside in care, however, they do not adequately or comprehensively address the access to and provision of integrated formal and informal supports and services in care facilities, nor do they address the needs of those people residing in the community. The Australian Commission on Safety and Quality in Health Care has also established the need for an increase of services. None of these frameworks, however, address a holistic approach to end of life and death care. At present, there is no public policy that addresses the integration of formal and informal approaches to end of life and death care.

Consideration of the issues

In dying

Australia's hospice and palliative care services have the majority of their focus placed in health care. Successful end of life care requires both formal and informal services to be available regardless of the location – home, hospital or care facility.

At present there are 31 Primary Health Networks in Australia working to streamline health services. They also deliver a program called Greater Choice for At Home Palliative Care.[8] This program acknowledges that access to community based services is required to address wellbeing at end of life; what is missing is the acknowledgement that palliative care in the home is more than just a medical service.

The funding of hospice/palliative care at home programs should enable people to access formal and informal services to support them to die at home. The subsidising of access to private carers, hospice services, community care, social support, spiritual comfort, and medical outreaches would ease the burden on hospitals, nursing home facilities, and aged care services and their workers. Further, the integration of informal services such as end of life doulas (EOLDs) into formal end of life care models would add a valuable layer of support to a person's ability to experience the end of life they want.

The health care system has not yet fully recognised the validity of the role of EOLDs. Current research endeavours to both define the role of EOLDs and carve out a space for their services. A study by Krawczyk and Rush (2020) on the role of EOLDs and their practices undertaken in four countries found that:

'For some, EOLDs offer a promising way to 'suture' the current division of health and death care which have been enshrined within end of life care in the global North … [It is] important not to prematurely foreclose inquiry into how EOLDs may continue to develop alongside, but separate from, formal bureaucratic frameworks of professionalised care in the global North.'[9]

Figure 1. What home funerals can look like: The gentle care of the deceased done by the family in a home setting. *Image credit: Courtesy of Rebecca Lyons.*

This resonates with the Australian experience. EOLDs potentially have a significant role in providing much needed informal support at end of life and can be a valuable addition to palliative care and other formal models of care. EOLDs can provide a range of informal supports and services, including advance care planning. At present, this is a missed opportunity – while EOLDs can be funded through aged care and NDIS packages, there is a critical lack of public education around EOLD services. The uptake of these services depends on how effective an advocate the individual doula is.

Another consideration is around service provision. There is a distinct lack of actual end of life and palliative care services providing tangible support to people at home and within the community. This has only begun to be addressed through the Primary Health Networks and there is a long way to go. The Australian Productivity Commission Report in 2018 found that people's needs at end of life were not being met and community based palliative care services needed to be expanded.[10] Services are underfunded and overburdened, and people can die while waiting for service availability. Most recently, the Royal Commission into Aged Care found that:

'The effect of a lengthy wait can be profound – there is a clear danger of declining function, inappropriate hospitalisation, carer burnout, premature admission to a residential facility, or even death ...'[11]

The Australian Commission on Safety and Quality in Health Care has also acknowledged the need for increased service provision and developed tools[12] to assist in bettering end of life outcomes, which are a part of their Comprehensive Care Standard.[13] This standard and the tools do address the need for 'wellbeing' but do not consider the integration of formal and informal services.

In death

When considering the increased number of people estimated to need end of life care in the next four decades, there is another question yet to be addressed – how will we cater and advocate for 'wellbeing' in death and death care in a climate where people are regularly making choices based on their economic circumstances more than their social and emotional needs.

In some cases, funerals are becoming increasingly unaffordable and funeral poverty is a concept people are rapidly becoming acquainted with. Still, the ritual and ceremony of a funeral plays a vital role in grief and bereavement within our society and this has led to people searching for more affordable, environmentally friendly, and personal alternatives. In 2017, reporting on their investigation of death care and the funeral industry in Australia, van der Laan and Moerman highlighted the increasing costs of the funeral industry.

They recommend that government:

'Develop guidelines for the information disseminated to those with authority to make arrangements that includes alternatives, such as direct committal, not-for-profit and community providers, as well as do-it-yourself options.'[14]

At present, there is a gap in the information provided to the public, and as such, people are not always making informed choices. Without equal representation of not-for-profit, community based, and family led options, people are left to choose from a limited set of offerings.

As a direct result of the findings of my Churchill Fellowship report,[15] the Australian Home Funeral Alliance (AHFA) has been established to address this gap. AHFA exists as a peak body with a view to educating and empowering people to seek out alternative approaches to conventional funerals, and skilling them to achieve it.

One of the ways AHFA promotes addressing the wave of death to come and the often unrealistic cost of funerals, is to move all or part of the after death process back into the hands of family and community using a family led home funeral approach (**Figure 1**). This informal service of home funeral is designed to empower and skill a family to care for their person in death as they often have in life, and it has emotional, social, and financial benefits.

AHFA define a home funeral as being –

'... where a family, community and/or executor of a person deceased stay involved in the arrangements and give care to their person ... A home funeral occurs when family, friends or community are involved with conducting any aspect or ritual in caring for a person's body ... Participation in a home funeral can be as much or as little as any one person is comfortable with and prepared to do ... The duration of a home funeral may be hours or days, and each one is unique.'[16]

The modern funeral industry is only about 120 years old and in that time we have shelved more than 5,000 years of knowledge about caring for the dead. There is now a growing movement aimed at reclaiming this community knowledge.

As I found on my Churchill Fellowship, this is a sentiment echoed by an increasing number of people worldwide. Normalising home funeral and after death care has been largely grass roots led, but is gaining traction as people's awareness of end of life options increase. As conversations about advance care planning are becoming normalised and death literacy levels are improving, people are slowly beginning to realise they can have agency and control over decision making about both their dying and after death plans.

Stakeholders for consultation

Alongside the major state and federal government departments and national health care organisations, various informal grassroots and national bodies exist to promote community based approaches to end of life and death care. These should all be invited to participate in the roundtable proposed in this paper.

The following entities have been consulted and/or agreed to be stakeholders at the roundtable:

- The Australian Home Funeral Alliance
- The Natural Death Advocacy Network
- Holistic End of Life and Death Care Australia (HELD)
- End of Life Doulas and Allies (ELDA)
- Social Health Australia
- Flinders University – Research Centre for Palliative Care, Death and Dying
- La Trobe University – Public Health Palliative Care Unit
- The GroundSwell Project
- Melbourne University – Death Tech
- Death Literacy Institute
- University of Western Sydney – Caring at End of Life Research Team
- Palliative Care Australia

Other potential stakeholders who should be extended an invitation, include:

- Meaningful Aging Organisation
- Aged and Community Services Australia
- Leading Aged Services Australia
- Australian Aged Care Collaboration
- Australian Centre for Grief and Bereavement
- Council of the Aging
- Royal Australian College of General Practitioners
- Carers Australia

Policy recommendations

It is recommended that the Commonwealth Department of Health and Ageing engage the Primary Health Network[17] to establish and facilitate a national interdisciplinary roundtable to develop strategies for the integration of formal and informal supports and services at end of life and death care. Both formal and informal service providers

should be represented. This roundtable, when considering the growing demand on end of life and after death care services (and taking into consideration our aging population and workforce), can be tasked to formulate an integrated model of service delivery for end of life and after death care, including:

- investigating the infrastructure needs to adequately support people to die at home, meaning, at-home services and with end-of-life doula support
- developing the resources and education required to support families and communities who choose community and family led home funeral and after death care
- formulating strategies to promote the inclusion of EOLD services as part of aged care and NDIS packages
- expanding the scope of existing death literacy and advance care planning programs and services to include the non-medical supports for end of life care, such as end of life doulas and the option of home death care and home funeral.

This policy initiative of integrated end of life care would be an Australian first. Undertaking a roundtable would demonstrate the Australian Government's commitment to supporting public health and wellbeing in ageing. Following a roundtable and development of an integrated and inclusive plan, a combined commitment from federal and state governments is recommended to fund the implementation of a launch of Australia's first integrated model of care project.

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Bec Lyons is an advocate, educator, TEDx Speaker, funeral director and end-of-life-doula, not necessarily in that order. The subjects of death and dying, natural burial, and the DIY approach to death care are her passion and she loves being out in the community raising awareness and promoting good honest conversations. She is a dedicated advocate for positive change.

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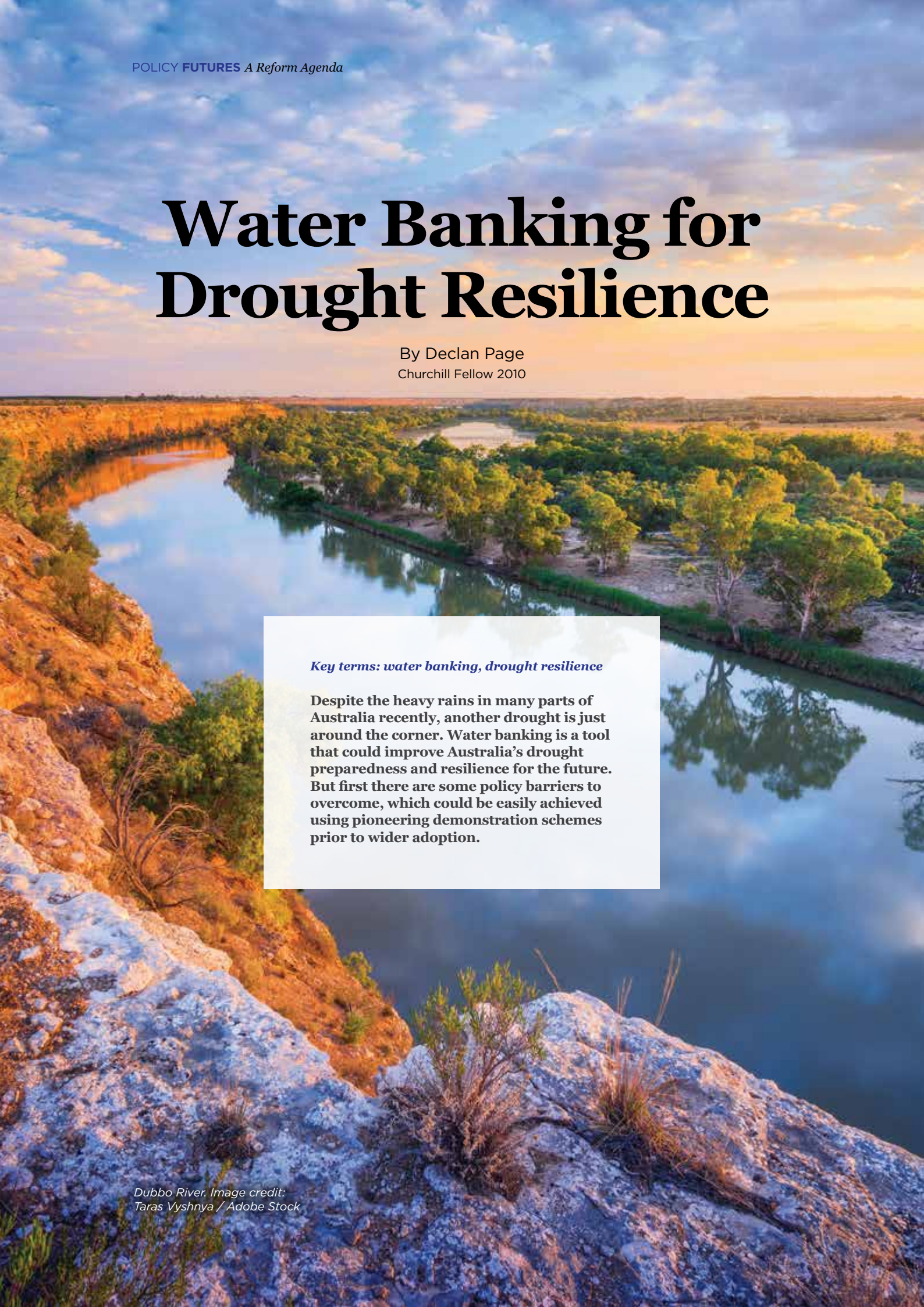
Water Banking for Drought Resilience

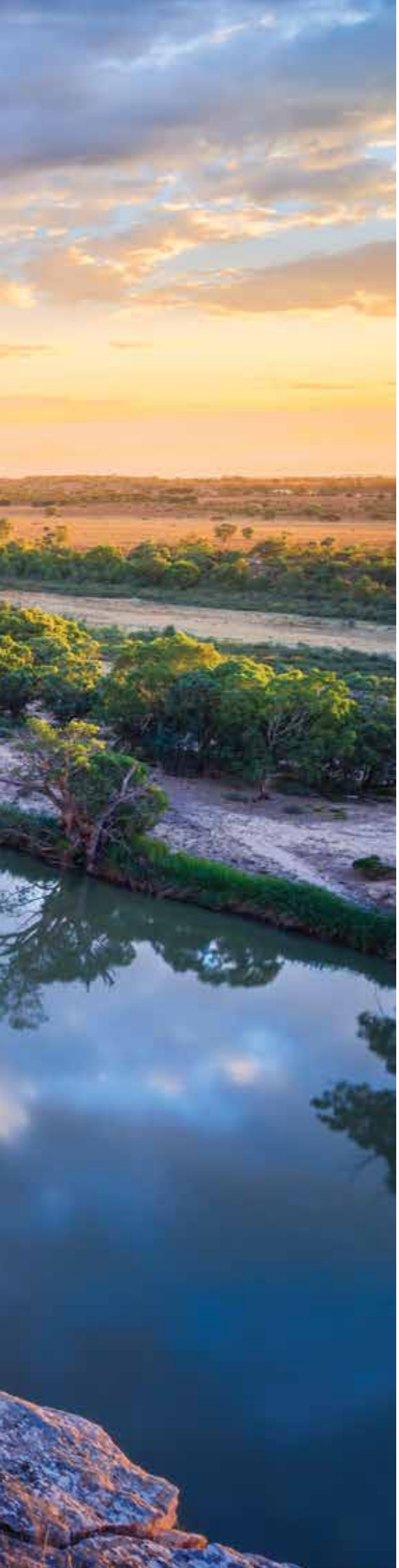
By Declan Page
Churchill Fellow 2010



Key terms: water banking, drought resilience

Despite the heavy rains in many parts of Australia recently, another drought is just around the corner. Water banking is a tool that could improve Australia's drought preparedness and resilience for the future. But first there are some policy barriers to overcome, which could be easily achieved using pioneering demonstration schemes prior to wider adoption.

Dubbo River. Image credit: Taras Vyshnya / Adobe Stock



Southern Australia is experiencing a widespread drying trend and has recently experienced several harsh droughts. While droughts are a natural part of Australia's seasonal cycles, they are predicted to become more severe and frequent.[1] Considering this, Australia needs new options to improve regional water security.

In the 2020 drought, the Queensland towns of Stanthorpe and Clifton both reached day zero and ran out of water. Another fifty other regional communities across NSW and Queensland had less than twelve months of water left. Costs of emergency water carting would likely exceed $1 million per day for larger regional communities.[2]

Drought impacts tend to be most felt in Australia's regional communities where they have a disproportional impact on agricultural industries. With one in seven Australian jobs dependent on farming, the economy relies heavily on agriculture. Drought has been shown to significantly reduce agricultural profitability and productivity. The total value of national welfare lost in the 2019–2020 drought has been estimated to exceed $63 billion.[3]

Irrigation water allocation prices have also skyrocketed during past droughts before declining to a small fraction of these high prices following the 2011, 2012 and 2017 floods.[4] Perennial plantings (e.g. almonds, citrus) are at particular risk if growers cannot afford to purchase water during droughts. Building resilience into these agricultural systems requires new water management tools. One promising approach is water banking.

Why water banking?

Water banking requires investment in infrastructure to realise its benefits. Just as dams are infrastructure required to store water in reservoirs, infiltration basins (**Figure 1**) are infrastructure to recharge surface water to a suitable aquifer where it can be stored.

The principle of water banking is simple – the existing surface water right holders can forgo using some of their water allocation in a wet year, and instead, voluntarily transfer their allocation to a water bank. The unused water allocations are deposited into an aquifer allowing for the allocation to be carried over to future years. These carried over allocations (or recharge credits) can then be recovered as groundwater allocations later. Water banking is like an underground off-stream dam with the advantage of minimal evaporation and can be used in regions where carryover in surface water dams is currently limited, like the northern Murray-Darling Basin. The higher value horticultural industries have not been established in these regions to date due to water security risks. To establish water banking in these areas, investment in infrastructure such as recharge basins and recovery wells and monitoring will be required to further develop water accounting policy and methodologies.

It is estimated that in the Murray-Darling Basin between 2,000 to 4,000 gigalitres of additional aquifer storage potential could be utilised for water banking.[5] This is equivalent to 16% of the total accessible surface water storage, meaning no new dams would need to be built.

Figure 1. Infiltration basins during recharge of the Arizona Water Banking Authority. They remain dry at other times as water is stored in the underlying aquifer. *Image credit: Central Arizona Project.*

This aquifer storage exists in the northern basin where there is limited opportunity to carry over allocations across years. Importantly, water banking uses the existing water management framework and extends the carryover provisions for dams in the southern basin to wider areas than is currently available. Water banking is an unexplored tool for investing in water security in the northern basin and is potentially more efficient than flood plain harvesting and farm dams.

Currently there are no policies to prevent appropriate recharge, but there are no policies to assure banked water can be withdrawn when needed. Hence there is no incentive to bank water as a drought mitigating strategy. Policy reform is needed to realise the benefits of water banking.

Consideration of the issues

Policy context

In 2004, the then Council of Australian Governments (COAG) endorsed the National Water Initiative (NWI). The NWI is a shared commitment by governments to increase the efficiency of Australia's water use, enable equitable sharing among urban and rural communities, and restore the environment. The NWI built upon the 1994 COAG Water Reform Framework and governments committed to prepare comprehensive water plans; achieve sustainable water use in over-allocated basins; introduce registers of water rights and standards for water accounting; expand trade in water rights; improve pricing for water storage and delivery; and better manage urban water demands.

In May 2019, in response to the Productivity Commission's 2017 inquiry into national water reform,[6] the Australian Government agreed to renew the NWI. Previous adoption of water planning and entitlement frameworks had created the foundations for efficient and sustainable water resource management. Water planning had established transparent processes for determining how much water is available in a system and for sharing between people, industry, and the environment. Creation of water entitlements, separate from land, provided secure long-term property rights to water for both consumptive users and the environment. And together, these developments provided the essential prerequisites for the current water trading and water markets.

Water trading and markets have become increasingly important to irrigators to adapt to seasonal variability and climate change. It is now necessary to consider the addition of policies to allow the use of aquifers to provide secure long-term carryover of banked surface waters from existing unused allocations. This builds on the existing framework and decades of water markets and trading experience to provide new opportunities to develop drought resilience.

International lessons

In the United States, there are numerous examples of water banks working to reduce drought effects. For example, Arvin Edison Water Bank in California has been operated by the local water district since the 1960s. Over a 20-year period that spanned two small droughts, it banked 1,100 gigalitres by recharging a depleted aquifer through

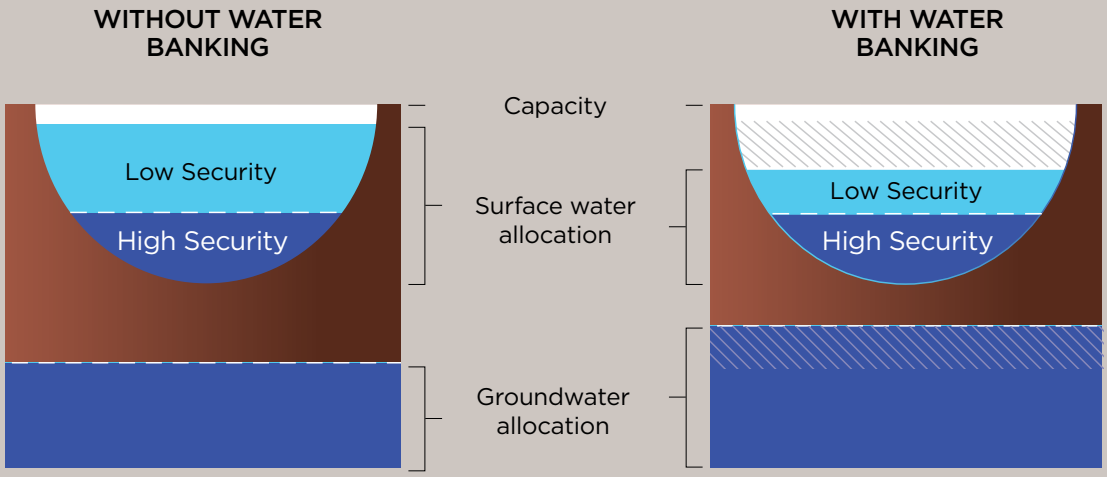


Figure 2. Conversion of low security surface water to higher security groundwater allocations through water banking.

infiltration basins.[7] During drought periods the bank recovered from 100 to 190 gigalitres per year of recharged groundwater to support local irrigators.

Similarly, the Arizona Water Banking Authority established by the government of Arizona can draw upon their 4,378 gigalitres of water stored.[8] The Arizona Water Banking Authority has been able to rely upon this water to support indigenous water rights, urban water supplies, and irrigation, and is expected to withdraw a further 82 gigalitres per year as the current drought continues. The water management framework for this is discussed by Megdal et al. (2014).[9] These established water banks have proved extremely valuable to communities, irrigators, and the environment during a drought, such as the one currently affecting many parts of the southwest United States, which has led to visibly dry vegetation, increased wildfires, and lower water levels in lakes and reservoirs.

Principal options for Australian policy makers

A similar water management framework for water banking in Australia has been proposed by Ward and Dillon (2012).[10] These ideas, while not new, have yet to gain traction in Australia. With the continuing drying climate, new water management tools are needed to manage increasing effects of drought. The following policy reform should be considered to realise the benefits of water banking.

Incentives to invest in water security

The incentives for water banking have already been demonstrated by significant increases in water trading prices during dry periods. For example, the average water price across the southern Murray-Darling during the 2019–20 drought was $587 per megalitre, compared to the recent price of $154 per megalitre in 2020–2021.[11] By having the option to carryover unused water allocations across years in dams, irrigators in the southern basin can create a strategic reserve for themselves to buffer market volatility, all within the existing water management framework. Irrigators in the northern basin are currently more limited in their carryover options.

Irrigators with existing water entitlements would carryover unused water allocations in a similar way to surface water storage carryover in dams. This represents the capacity of water that can be stored and is limited by the specific aquifer characteristics. Each water allocation that was banked would then be recoverable during drought, determined by the volume of water allocation banked subject to depreciation. With policy reform, recharge using lower security surface water allocations during a wet year to a water bank will allow additional carryover and conversion to higher security groundwater allocations in a dry year (**Figure 2**).

It will be essential to develop clearly defined rights for irrigators to recover a high security groundwater allocation during drought, with guarantees to access and use of the recharged volume. This would have the effect of giving another storage and carryover tool (particularly where there are no dams), but would need to demonstrate that there were no third-party impacts to existing users or the environment.

Establishment, funding, and operations

Water banking in aquifers complements dams by allowing for additional carryover across years. However, aquifer storage has several distinct advantages over dams, including natural treatment, and minimal evaporation loss, algae, and mosquitoes. Pioneering water banking demonstration projects are needed that are well designed, monitored, and managed to provide evidence and confidence that water banking can be effective; has no third-party impacts; sustains the environment; and creates a basin-wide economic benefit. Demonstration projects are important for gaining experience in operation and in governance, community acceptance, and in communicating broadly on performance, costs, and impacts.

In operating a water bank, three components are needed:

- Source water – allocations of water to be recharged already exist. Policy to determine volumes available also already exists.
- Recharge – the infrastructure to recharge water into an aquifer does not yet exist but is simple to construct. The policies to limit adverse impacts on third parties or the environment, including land salinisation and waterlogging, already exist.[12]
- Recovery – the infrastructure to recover the banked water from an aquifer does not yet exist but is simple to construct, and any additional energy required for pumping in water banking should be sourced from green energy. The policies to provide carryover of water in water banks do not yet exist. This is the crucial policy element that would encourage investment in water banking infrastructure and water allocations to be carried over within water banks.

Additional policy rules would require characterisation of aquifers to prevent localised decline of groundwater levels, water quality deterioration, and interference between any nearby water banking schemes.

Carryover and transfers between surface water flows and groundwater storage

Carryover is used to enable a deferred allocation, subject to local rules. It reflects the opportunity to build future water security by foregoing current use of water and retaining that water in storage. Not using water does not necessarily mean all of it will be physically available for future water use (for example, due to loss by evaporation, or spill from a reservoir, or mixing with saline water or groundwater discharge for an aquifer). These losses can be minimised through scientific site selection for water bank operations and verified by monitoring.

Corellas having a drink. *Image credit: CSIRO.*

Water banking accounts would need to be kept for recharge and recovery volumes and depreciation, with periodic calculation of residual accrued groundwater allocations. Depreciation of these credits should occur because of finite retention time of water in the aquifer and loss (for example, through mixing with brackish groundwater), but not by declining groundwater storage (where excess of other licensed extraction over natural recharge should not diminish credits of those who have actively banked water).

This will result in the conjunctive management of water resources, enabling users to take from the cheapest source and use this to reduce uncertainty over current allocations while sustaining groundwater storages at levels that will enable buffering during droughts.

Stakeholder consultation

I undertook my Churchill Fellowship in 2010 to assess natural treatment systems for Australian applications in water supply and water recycling.[13] My focus shifted over the past ten years, from natural systems used for water treatment, to natural systems such as aquifers and water banking for drought resilience. Over the past decade I have had preliminary consultations to further explore water banking opportunities in Australia. These include with federal government departments, organisations including the Murray-Darling Basin Authority, National Water Grid Authority, state government water agencies, local governments, and the irrigated agricultural industry. There has been strong interest in water banking by state agencies, industry, and the community. It is noted that this is not an exhaustive list and there are other important stakeholders that will be critical to deliberations and implementation of water banking.

Recommendations

Water security is a critical challenge for Australia, driving policy reform and innovation for new tools such as water banking. It is recommended that state governments undertake a three-stage process towards a unified national water banking system:

1. Carryover and transfers between surface water flows and groundwater storage

Develop policy to allow the carryover of unused surface water allocations via water banking with secure title to recover the water under clearly specified rules and conditions. Develop a transparent accounting system that extends from current practice to verify banking operations.

2. Establish demonstration water banks

Allocate funding to validate several water banking sites and undertake preliminary field investigations. For promising sites, form alliances with local water entitlement holders, state government, and the community. Build the recharge infrastructure to establish pioneering water banking demonstration sites and operate allowing sufficient time for recharge and recovery to occur, costs to be documented, risks to be addressed, and prove that no adverse third-party impacts occur.

3. Scale up

Use the demonstration water banking sites to report on the hydrologic and economic effectiveness, risks, and any impacts. Use these learnings to develop additional models to invest in water banking infrastructure and scale up across other jurisdictions.

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Dr Declan Page is a Principal Research Scientist at the Commonwealth Scientific and Industrial Research Organisation, Adelaide, Australia. Declan's major research interests are in the water quality management with a particular focus on the science to underpin managed aquifer recharge or water banking.

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Irrigation channel at Griffith, NSW. 1989. *Image credit: CSIRO.*

Bedhan Lag: Land of the Kaiwalagal (2019)

Black and white linocut print showing Captain Cook, the Endeavour, several fish, space invaders and a cartographic map of Australia.

By Brian Robinson

It is ironic that the place of possession for the Australian Mainland was a small island in the north of the country, a place called Bedhan Lag. From this island all of Australia's recent land control battles started.

In 1770, the British navigator Lieutenant James Cook sailed northwards along the east coast of Australia in the Endeavour. At Bedhan Lag (Possession Island) he once more hoisted English colours and, in the Name of His Majesty King George lll, took possession of the whole Eastern Coast under the name of New South Wales.

The Kaurareg people of the Kaiwalagal nation have maintained links with Bedhan Lag through traditional lore and customs since Bipotaim, the time before. They have continued to live on or close to their traditional country, making use of the land and sea resources, according to their traditional customs and knowledge.

About the artist: Brian Robinson is a descendant of the Maluyligal people from the Western Islands of Zenadh Kes, the Wuthathi people from the silicon sand dunes at Shelburne Bay on Cape York Peninsula, the Dayak people of Sarawak, the Malay state on Borneo, the Villaflor family of the Philippines, and a Scotsman from the Salmon Family of Scotland.

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