VULNERABILITY, RISK AND JUSTICE FOR CHILDREN AND YOUNG PEOPLE IN THE NORTHERN TERRITORY

Paper at the Fourteenth Annual Biennial conference of the Criminal Lawyers Association NT, Bali, June 27, 2013.

I'd like to thank CLANT for this opportunity to speak about some of the issues facing children and young people in the NT and particularly those caught up in the child protection and youth justice systems.

It's now been six years since the publication of the Little Children are Sacred Report, the NT Intervention and the NT Closing the Gap policy initiatives (remember them?). The Intervention and its successor, *Stronger Futures*, is now well into its third billion of expenditure.

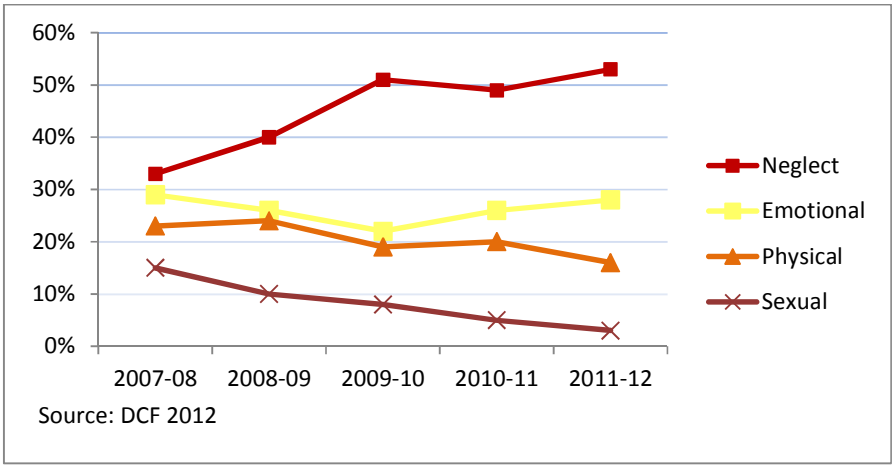
What has changed for children in the NT?

You would remember that the focus of that report and ostensibly of the Intervention, was on the prevention of the sexual abuse of Aboriginal children.

Well, from the official statistics there were not that many child sexual offices in the so-called intervention zone to begin with - in 2006-7 before the Intervention there were 11; in 2007-8 there were 11 again, and in subsequent years there were 12, then 12 again and in 2011-12 it was down to 7 (FaHCSIA 2013).

This represents a failure to actually pick up offences and offenders despite the concerted focus; a continued unwillingness to report or disclose sexual abuse; the possibility that such offences are relatively rare – or a combination of all three.

Have a look at these child protection figures which represent the actual substantiations of harm in the NT.



You can see that the proportion (and actual number) of sexual abuse substantiations has fallen each year over the past 5 years – it was around 15% in 2007-08; now it sits at 3%. It is hard to know why this is the case.

Here are a number of other statistics on child and adult sexual abuse in the NT.

Number of notifications and substantiated cases of child sexual abuse	
4 years prior to the NT Intervention	646 / 147
4 years following to the NT Intervention	2,276 / 307
Increase	252% / 109%
Convictions for child sexual offences	
4 years prior to the NT Intervention	25
4 years following to the NT Intervention	44
Increase	76%
Reported sex offenders	
2006	64
2010	192
Increase	200%

Note: relevant 2011-12 data has been discussed in the body of this speech as well.
(FaHCSIA 2011)

Overall, you can see that there has been an increase in notifications and to a lesser degree, charges and investigations, but the increases, apart from notifications, have not been particularly dramatic. Currently there are over 260 *(262 in community, a further 28 are in custody and 55 offenders who are in custody that upon release will be put on the register)* people on the sexual offenders register – but it does cover both adult and child offenders (NT Police 2013).

My job entails in part, the review of many child protection and youth justice matters. In my experience, the general thrust of the LCSR that sexual abuse is widespread but is not being reported, does hold true, in fact, it is distressingly common. However, all forms of adjudicated abuse are common in areas of concentrated disadvantage and it is difficult to determine just how the numbers in the NT differ from those of comparable areas in other jurisdictions. It is also likely that the problematic sexual activity in the NT often involves young people engaging in consensual peer activities rather than abusive behaviour by adults.

So *is* there or *was* there an emergency?

I've always felt that the focus on sexual abuse in the NT has hampered our understanding of the pervasiveness of the underlying problem. On just about every wellbeing and safety measure (apart from official statistics on sexual abuse) children in the NT are considerably worse off than their counterparts in other jurisdictions. Here is just a sample of the hazards affecting young children at higher rates than anywhere else in Australia:

- Exposure to family violence
- Teen parenting (carer instability, poverty)
- Exposure to alcohol in utero
- Exposure to nicotine in utero
- Parental use of other substances
- Poor nutrition
- Various diseases such as otitis media
- Abuse and neglect
- Poor school enrolment and attendance

They face an overwhelming array of developmental hazards such as high maternal stress during pregnancy, exposure to nicotine and alcohol during pregnancy, exposure to unbelievable rates of family violence, and the highest rates of abuse and neglect substantiations. Weatherburn's compelling research suggests that these abuse and neglect substantiations are the strongest predictor of involvement in the youth justice system. (Weatherburn & Lind, 1997)

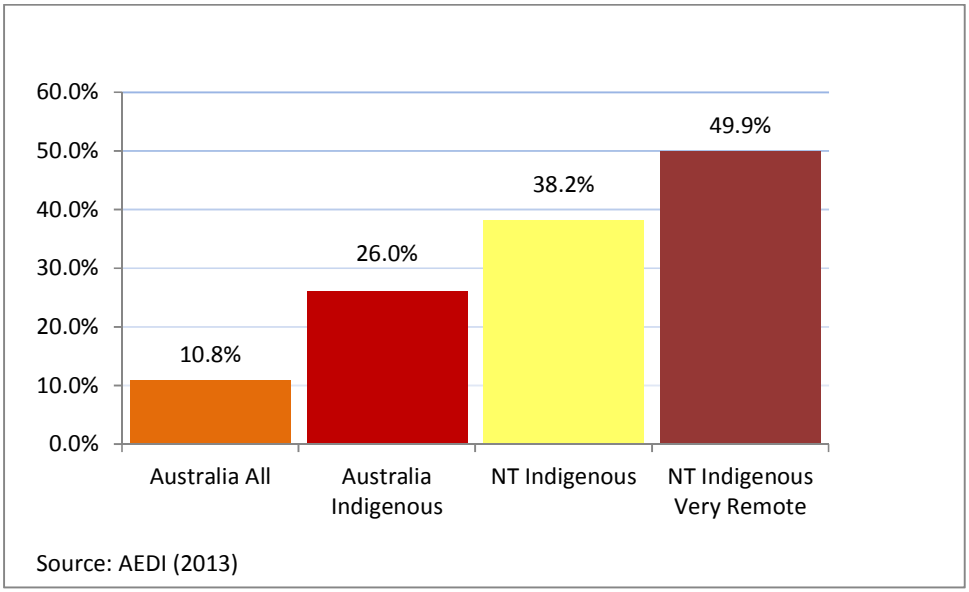
These hazards have a cumulative impact on development and lead to the following predictable outcomes:

- Very high Infant mortality rates
- Child death rates across the age spectrum
- The highest national child and youth suicide rates

- Very high rates of developmental vulnerability on the Australian Early Development Index (AEDI)[1]

Our rates of developmental vulnerability are not only higher than for Australia as a whole, they are much higher than those for Aboriginal children elsewhere.

Percentages who are developmentally vulnerable on two or more domains of the AEDI 2012



Let me just focus for a minute on the latest AEDI scores. These are particularly telling because they suggest that prior to age 5 a perilous course has been set. How can it be possible that half of Aboriginal children in very remote areas (where 60% of all NT Aboriginal children live) have multiple developmental vulnerabilities before they enter school?

So, the official data on sexual abuse may not be particularly compelling but the overall picture for child safety and wellbeing in the NT continues to be of grave concern.

As an aside, there is a glimmer of hope in the most recent AEDI data. When compared with the first tranche of the data from 2009, the latest figures suggest that the overall wellbeing

[1] The AEDI is a population measure of children's development as they enter school (Year 1). It is an adapted version of the Canadian Early Development Instrument (EDI), developed in response to communities' increasing interest in knowing how their children were developing.
Scores ranked in the lowest 10 per cent were classified as developmentally vulnerable. Scores ranked in between 10 per cent and 25 per cent were classified as developmentally at risk. Scores ranked in the highest 75 per cent were classified as developmentally on track. These national AEDI cut-offs will continue to be applied in future AEDI data collections providing a baseline to track children's developmental outcomes across Australia over time.

of Aboriginal children is improving faster than that of other children and this improvement is most apparent in the remote areas. These latest data do suggest that the significant investment in early childhood services by the federal government, may be starting to pay off.

Today, I'd like to focus on just one of the developmental hazards faced by children in the NT but would first like to make some comments on recent research developments.

Germ theory, trauma and chronic stress

As many in this audience would know, in the middle to late 1800's there was a revolution in medicine as researchers such as Pasteur came to the realisation that a lot of disease was caused by microorganisms such as bacteria and viruses, too small to be seen by the naked eye. This discovery led to what is generally referred to as **germ theory** and opened the door to a new era of health and treatment.

Prior to the mid 1800's it was understood that disease was caused by exposure to miasmas, contagion through touching, by curses, demons, or various folk beliefs. The massive medical and pharmaceutical industries today are largely built on insights relating to germ theory. It makes perfect sense to us today, but prior to the mid 1800's the role of germs was largely unknown.

There is an emerging consensus that the compelling research findings on the developmental impact of childhood trauma represent a similar revolution of understanding – a paradigm shift. We are learning that many adult diseases, mental health issues, behavioural disorders such as substance abuse, and even criminality, have their roots in the toxic effects of childhood trauma and chronically stressful environments**.**

There have been voices here and there over the years that have highlighted the importance of childhood experiences; Sigmund Freud was an early one of these. But the research findings are now becoming irresistible. Sandra Bloom, one of the prominent voices in the field, sums it up this way:

*Trauma theory proposes that the origin of a significant proportion of physical, social, and moral disorder lies in the direct and indirect exposure to external traumatogenic agents (*Bloom & Farragher, 2011 , p. 123)

There are two related branches of this research. The first focuses on the impact of exposure to trauma and chronic stress in childhood and how this plays out over the life course – the *distal* effects, if you will; the second branch focuses on the direct or *proximal* impacts on the developing brain.

Here are just two examples of the life course research. In the late 1990's a large American medical insurance company realised it had collected masses of data on many thousands of

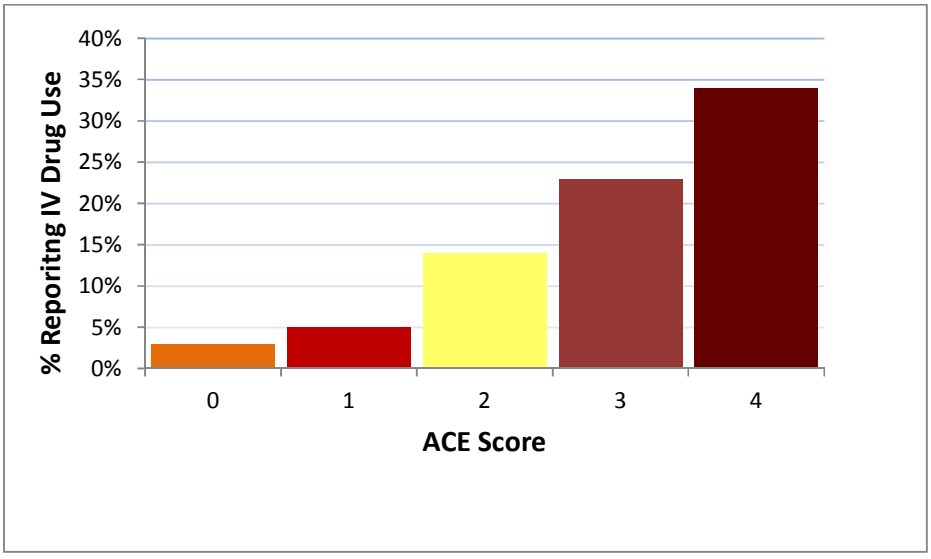
individuals from birth and throughout their lives. They engaged researchers to look at a number of issues including the life courses of adults exposed to adverse experiences as children.

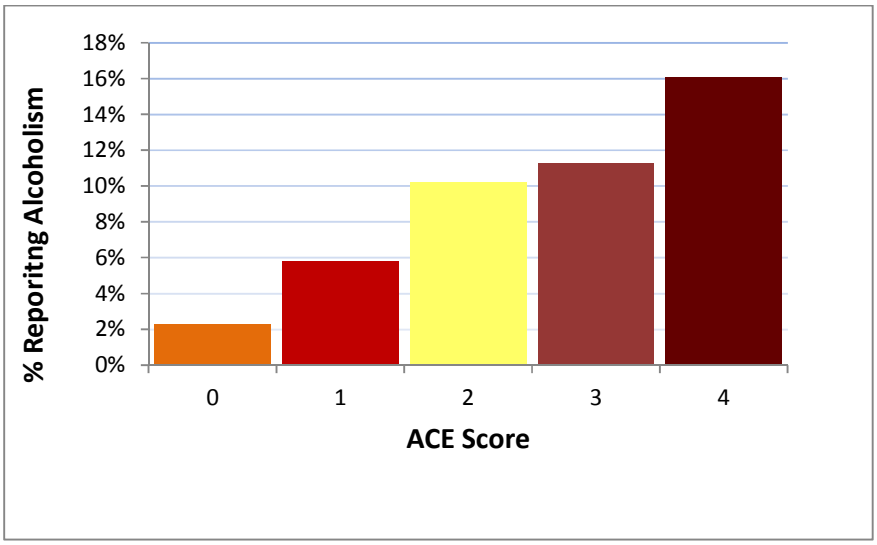
They identified some common adverse childhood experiences and then plotted the risk of later problematic outcomes.

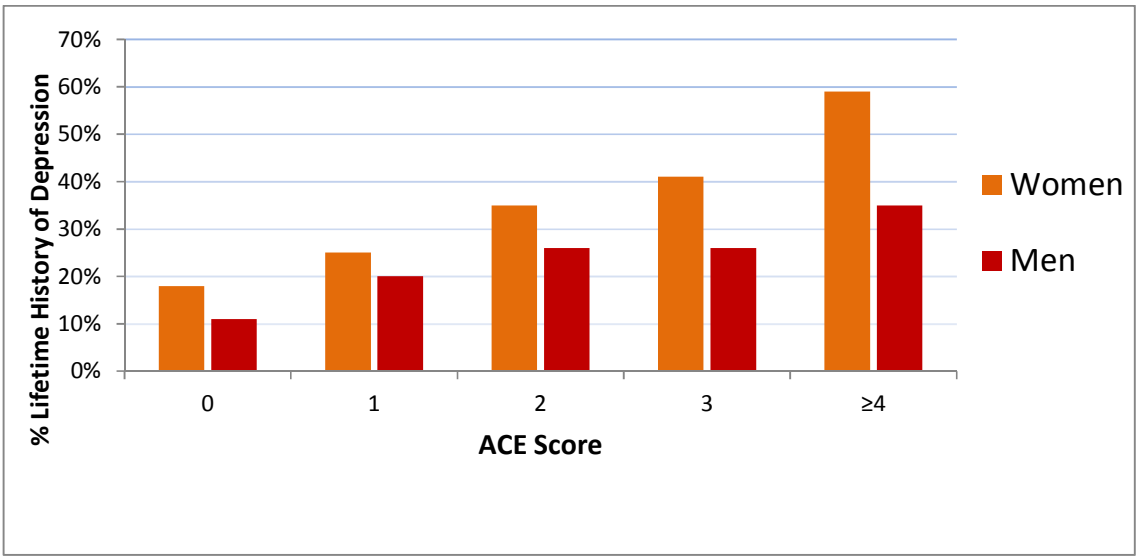
They determined that there were eight adverse experiences that frequently occurred in the childhoods of the people on their files. They were, in the category of household dysfunction - substance abuse, parental separation/divorce, mental illness, battered mother and criminal behaviour. In the category of childhood abuse they included, psychological, physical and sexual abuse. Later they added two types of neglect – emotional and physical.

For each of these experiences (ACE's) that occurred during childhood, a score of 1 was allocated, regardless of the intensity of the experience and the number of times that it occurred.

What they found was a stunning correlation between the number of adverse experiences (ACES) these children had and a range of later behavioural and social difficulties, as well as physical diseases including life threatening conditions. Here is a small sample of the findings:







Source: Adapted from Felitti et al., 1998; Felitti & Anda, 2010.

You can see that there is a strong relationship between the sheer number of adverse childhood experiences and later medical and behavioural difficulties. The more ACE's in childhood, the more risk. For example, for those with zero ACE's the lifetime risk of reporting IV drug use was 2.5%; the risk for those with four or more ACEs climbs dramatically to 34% or one in three.

Consider for a moment the number of ACEs experienced by most Aboriginal people across the NT and the health, social and justice implications.

With over 50 studies now on the lifetime impact of ACES, the authors conclude:

'These findings provide a credible basis for a new paradigm of medical, public health and social services practice…'(Felitti & Anda, 2010, p. 86).

Noting the large number of adolescent and adult outcomes involving alcohol dependence, other drug misuse, chronic smoking, overeating etc, Felitti and Anda go on to observe that:

'Many of our most intractable public health problems are the result of compensatory behaviours such as smoking, overeating, and alcohol and drug use, which provide partial relief from the emotional problems caused by traumatic childhood experiences.' (p. 86)

There are now a plethora of recent studies of this ilk.

One recent Australian data linkage study, for example, has demonstrated that victims of childhood sexual abuse have greatly increased rates of suicide and lethal overdose later in their development. This study was conducted of all confirmed cases of child sexual assault in Victoria between 1964 – 1995, data matched with public mental health records and coroner's suicide data. Comparisons were then made with suicide records for the broader community to establish relative risk.

When the child sexual abuse (CSA) victims were compared with the broader community:

- Male CSA victims were 14 times more likely to commit suicide and 38 times more likely to die from an accidental overdose; and
- Female CSA victims were 40 times more likely to commit suicide and 88 times more likely to die from an accidental overdose. (Cutjar et al., 2010)

Here we see that for both men and women (and particularly the latter) the developmental social and behavioural impact of childhood sexual abuse can be profound and long lasting. I would add that this study did not examine the protective capacity of family support or the therapeutic value of treatment for those who have been exposed to sexual assault and how these can change the level of risk.

The childhood trauma perspective then has significant implications for how we understand the causes and development of problem behaviours, behavioural disorders, personality disorders, mental illness, work stability, and criminality along with a host of physical diseases; it has implications for how we work to prevent them; how we understand them; how we treat and ameliorate their effects.

It also has implications for how we respond to those affected by trauma. Again, Sandra Bloom points out it changes our questions and attitudes towards those affected:

'The question should not be what is *wrong with you?* But what has *happened to you?'*

I would suggest that this perspective is also pertinent at a broader policy level – we need to focus on limiting the exposure of children to high risk, toxic environments, to reduce parental stress through employment and training, to provide parent training assistance, to prioritise the safety of women and children, and so on…

I mentioned that the other body of research focuses on the direct impact of trauma and chronic stress on the brain.

We now know that these children have brains that are physically different to other children, for example (summarised from Siegel, 2012; & Shonkoff, 2012):

- the connective fibres, the **communication pathways** that join the two hemispheres of the brain are degraded;
- We know that their **stress management systems** are physically larger than those for other children;
- We know that their memory processing centres are smaller;
- We know that their neurobiology is affected;
- The functioning of their brains differs from those of non-affected children. Martin Teicher's research group (Choi et al., 2009), for example, has demonstrated that chronic exposure to parental verbal abuse alone can affect the integrity of brain regions involved in **verbal intelligence**, **depression** and **anxiety**.
- A recent study has documented the significant impact on later IQ scores of children exposed to trauma at different times during early childhood (Enlow et al., 2012).

There is another key neurological change that takes place in response to overwhelming trauma that has serious behavioural, social and legal implications. The brain's stress management systems, in particular the amygdala, sometimes known as the brain's sentry, can become overly sensitised to the possibility of danger even where objectively, danger does not exist – instead of accurately distinguishing between safety and danger, it becomes permanently switched on to the danger setting. It unnecessarily marshals psychological and physical resources to ensure the safety of the individual who exists in a permanent state of alertness and chronic stress.

'Traumatized children reset their normal level of arousal. Even when no external threats exist, they are in a persistent state of alarm' (Bruce Perry 2006, p.32)

Studies of children exposed to severe trauma reveal that even when they sit in the safety of a classroom, their stress hormone readings suggest an unnecessary level of sympathetic system arousal – for these children, the anticipation of danger has become a chronic condition.

A Cornell University brain imaging study of children who were in the vicinity of 9/11, revealed that six years after the events of a single day, the stress management systems (in

particular their amygdala's) in their brains remained in a significantly aroused, 'kindled' state, when compared to children further away from the events (Ganzel et al., 2007).

Here then is a summary of the more proximal developmental outcomes of exposure to trauma and chronic stress. Cook et al., (2005), describe the pervasive difficulties for children and young people in the areas of:

- social skills and attachment;
- biological systems leading to a range of medical conditions;
- the ability to regulate emotions and impulses;
- the propensity to dissociate with its maladaptive outcomes;
- behavioural control;
- many areas of cognitive functioning;
- self-concept including self-esteem, shame and guilt; and
- hopelessness and a lack of future orientation.

But one of these impacts of trauma stands out – research often points to it as the core outcome – the one you are most likely to come across – the one that tends to cause the most stress and distress. The one that leads to most legal problems; the one that many of you come across in the course of your work.

I wonder what you would identify as the core or central outcome of the exposure of children to trauma and chronic stress?

Here is what the neuroscientists have identified:

'The most significant consequence of early relational trauma is the loss of the ability to regulate the intensity and duration of affects' (Schore 2003, p. 141)

'At the core of traumatic stress is a breakdown in the capacity to regulate internal states like fear, anger, and sexual impulses' (van der Kolk 2005, p. 403)

The most significant impact then, is the loss or impairment of the ability to regulate emotions and impulses in a safe, socially appropriate, and adaptive way. For example, a minor frustration can rapidly escalate into rage; anxiety descends into terror; sadness morphs into overwhelming grief. Add any other dysregulating elements such as alcohol, head injury or group contagion, and the problem is greatly exacerbated.

Just consider for a moment the epidemic of domestic violence in the NT; the general violence in places like Darwin's Mitchell Street; the partner violence; the road rage. So much of this reactive and impulsive violence results from the inability to manage emotions and impulses. Our hospitals and jails are overburdened with the downstream results of this problem.

In a recent news article the anthropologist Prof. Peter Sutton referring to the tri-state area, was quoted as saying 'These are hair trigger communities where people fly into a rage in a second…Resorting to violence is the norm.' (Sutton, 2013)

Exposure to violence

Of all the hazards faced by children in the NT, exposure to violence is the one that is of most acute concern. It has a devastating immediate impact whilst its pernicious distal effects unfold over the lifespan – its perpetrators populate our jails and, unfortunately, many of its victims go on to repeat the cycle.

In a US context the prominent psychiatrist and researcher Bessel van der Kolk maintains that the most pressing public health issue there is the chronic exposure of children to violence and fear. He says this because of the emerging research that I have been talking about.

If childhood exposure to violence and fear is such a problem in the wider society how much *more* of a concern is it in those parts of the NT where the violence is endemic – and where, to borrow Bruce Perry's apt phrase, so many infants and children are 'marinated in fear'?

You would have all seen the press reports of the ongoing feud in Yuendumu which, for more than two years now, has blighted the lives and prospects of over 60 children. Those of you that work across the NT would know that such violent feuds affecting men, women and children are not rare.

…and violence is not just a problem that affects the Aboriginal community. There is a celebration of violence in the mainstream – our movies; our video games; our TV programs; and our newspapers are full of it.

It is glorified in the sporting pages – what used to be a **ball carry** is now a **hit up**. What hypocrisy we have been hearing recently about violence in Rugby League – while it clearly sells papers and fills seats.

Here is Dr Bruce Perry, lamenting the impact of violence in parts of the US – he could be describing our own backyard:

'While the majority of homes, communities and schools are safe, far too many children experience violence in one or more of these settings. For some children, a safe community and school may help buffer the impact of violence in the home. The highest risk children, however, are safe nowhere; their home is chaotic and episodically abusive, their community is fragmented and plagued by gang violence and the schools are barely capable of providing structure and safety from intimidation and threat – these children must adapt to this atmosphere of fear.' (Perry, 2001, p.4)

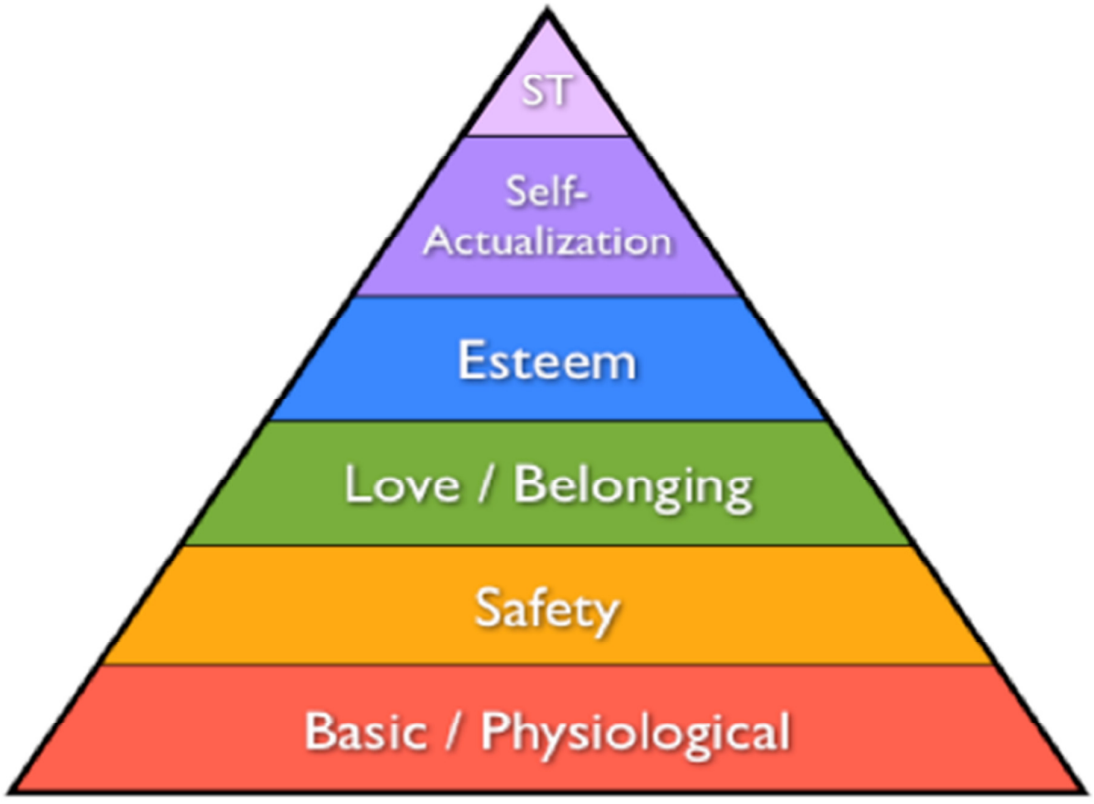
The primacy of safety

Can I take you back for a moment to **Child Development 101** – we seem to have lost sight of some of the early wisdom.

Most of the major developmental theorists acknowledged the primacy of safety. Remember **Abraham Maslow** and his hierarchy of needs.

Humans first need air, water and shelter from the elements – basic survival needs. These basic survival needs are available to most children, even in the most troubled remote communities.

What is the next fundamental platform for development?



Adapted from: Koltko-Rivera, M. (2006)

Safety is a precondition if optimal development is to take place. Erik Erickson and John Bowlby said much the same thing.

The safety of children in the NT

The implication of all this is that the guarantee of safety should be a central, if not *the* central, goal of public policy relating to the health and wellbeing of children and families.

But what do we know about the safety needs of children in the NT and their prospects for healthy and productive lives?

I have to say that I still get shocked and sometimes overwhelmed when I see some of these statistics – please bear with me as I quickly review just a little of the NT data on violence and safety.

First a caveat: Much (but not all) of this data relates to issues affecting the Aboriginal community. There is no time to explore in detail the various reasons for the high levels of violence but I want to affirm they are not intrinsic to being Aboriginal – they largely reflect the overwhelmingly stressful conditions that prevail in many remote communities; the over-crowding, the lack of unemployment opportunities, and poor amenities. These are, of course, also related to colonisation and the historical appropriation of traditional lands, the radical changes to roles and lifestyles, the onslaught of new diseases, and relentless challenges to their systems of meaning including the marginalisation of traditional law and decision-making.

In addition, the mainstream poisons of alcohol, tobacco, ganga (and gambling) which have always been problematic for a minority in the mainstream, have caused devastation amongst vulnerable populations.

I apologise if this appears to be another 'misery index' but this is the reality of children and families across the NT:

- Aboriginal people in the NT are twice as likely to be hospitalised for assault as are Aboriginal people in the rest of Australia (AIHW, 2011, p. 24)
- The latest *Closing the Gap* report for the Northern Territory reveals that the night patrols which were set up as a first response to violence or potential violence, dealt with over 84,700 incidents in the last 6 month reporting period, a yearly projection of over 160,000 incidents – that is in a target area of around 30,000 adults. (FaHCSIA, 2013, p. 69)

For the women, the numbers are even more confronting:

- The AIHW tells us that whilst Aboriginal women in the NT make up only 0.3% of all Australian women, they account for 14% of all the female hospitalisations for assault in the entire country.

- In terms of population risk, the mothers of these NT children are 48 times more likely to admitted to hospital for reasons of assault than all Australian women, Indigenous or otherwise (Source: AIHW, *National Hospital Morbidity Database*, 2010).

- In 2009/10 in our numerically tiny jurisdiction, 27 non-Aboriginal women were admitted to hospital for treatment after being assaulted. In the same period and for the same reason, over 840 Aboriginal women were admitted. (Source: AIHW, *National Hospital Morbidity Database*, 2010).

- Compared to the rest of the female population in the NT, Aboriginal women are 80 times more likely to be hospitalised as a result of assault.

  Those used comparative statistics in this arena of Indigenous disadvantage would be used to rate ratios of 3:1, 5:1, or even 10:1, but 80:1 is beyond belief. (Source: AIHW, *National Hospital Morbidity Database*, 2010)

After a while we start to glaze over statistics such as these. I believe they reveal that the situation is much more serious than the rest of the country realises.

I understand that 'Emergency' has become a tainted word but what do we call the circumstances that are highlighted by these data? At the very least it is a catastrophe for the women and children? While the national debate about the pros and cons of the Intervention goes on, the human devastation continues unchecked.

…and it is easy for this human reality to be lost in the numbers. In the majority of the incidents reflected in these statistics, children are present, helplessly observing, experiencing the terror, and learning how relationships work. You may have heard how young kids picked up late at night by the police on the streets of Alice Springs and other urban centres often plead to not be taken back to their homes because they feel safer on the streets.

The research is in, unless we can turn the tide of violence, the future for children in the NT is bleak indeed.

Policy implications

In 2007 a new set of policies was developed in the NT in response to the *Little Children Are Sacred* report – this was called 'Closing the Gap' (CTG, not to be confused with the COAG inspired CTG that came a little later).

Closing The Gap NT was centred on the protection of Aboriginal children from abuse. **We clearly need a re-articulation of priorities in the NT** that squarely focus on the wellbeing

and safety of children in those vulnerable early years – to protect them not just from sexual abuse, but from all the developmental hazards to which they are exposed and in particular, the scourge of violence.

The centrepiece of the NT Closing the Gap was the safety and wellbeing of Aboriginal children. That clear vision has been lost, or at least has been subsumed in other more economically-related priorities. You will not find any targets around child and family safety in the current COAG *Closing the Gap* Targets.

Jack Shonkoff from Harvard, a leading authority on the impact of early experiences, points out that most public policy in disadvantaged areas focuses on the importance of engagement and achievement in education. It's the same here with respect to the effort to improve school attendance and NAPLAN scores.

However, the emerging research suggests that if we are to improve the outcomes for children in very vulnerable areas we need to focus as much on protecting their brains from early insult as we do on stimulating learning:

'advances in neurobiology suggest that socioeconomic disparities in educational achievement could be reduced more effectively by (focusing on interventions that) prevent, reduce, or mitigate the disruptive effects of toxic stress on the developing brain…' (Shonkoff, 2011, p. 982).

A child from a chronically violent family who does happen to attend school, may be physically present but psychologically absent in class - the neuroscientists tell us that the child will be more focused on managing his rumbling anxiety and scanning the social environment for threats, than on attending to the teacher.

I do acknowledge that both the Commonwealth and NT governments have been active in addressing the issue of violence, primarily through alcohol management schemes but also through various 'law and order' initiatives including mandatory reporting around domestic violence. I've heard a lot of criticism about the Intervention, but not a lot about the extra policing that it brought, the safe houses that have been set up in the growth towns, the extra alcohol counsellors, and the expanding corps of remote health workers and child protection workers.

The effective management of alcohol is, of course, the central policy target if we are to make an impact on violence. Social drinking may indeed be a 'core social value' to quote our Chief Minister, but the ready availability of the 'beverage of mass destruction' (to use Bob Beadman's colourful words), comes at a horrific cost for women and children in the NT. It appears to be involved in two thirds of all violent episodes. The issue of supply restriction must be part of the solution as any substance dependent person knows, just as it is with all the other addictive substances.

It's not as if nothing is being done. I acknowledge that across the NT There is a small army of service providers, both in government services and the NGO's working to address the scourge of violence. There are the women's refuges in the major population centres, the safe houses (for both women and men) brought by the Intervention, the mobile child protection teams; the counselling services such as SARC and MOS (also resulting from the Intervention), the various alcohol treatment initiatives such as CAAPS, Strong Bala and Peace at Home in Katherine, the Alice Springs Interagency Domestic Violence Group, Bush Mob, the 'No more' program from Catholic Care, and many others.

But the available statistics tell us that **the situation around violence is stubbornly resistant** and has not significantly improved, except perhaps, where some of the new police stations have been established; that itself is worthy of note.

Given that we have such extreme levels of family violence and such poor developmental outcomes for children, **we need government to take the lead again** in setting out a coherent vision for ensuring the safety and wellbeing of women and children and investing in a viable 'whole of community' action plan to achieve it.

I started off by mentioning the Intervention and some of the statistics on child safety and wellbeing. Many mistakes have been made along the way and it's sometimes hard to see where the money went. However, I do find it intriguing that the actions of the federal government in attempting to address the problems blighting so many lives, can continue to attract so much venom in the NT and elsewhere, but the confronting reality of the violence that is being perpetrated against women and the devastating impact it is having on the future prospects of our vulnerable children, raises barely a murmur.

I'd like to end with a short vignette recounted to me by an NGO service provider who works in partnership with women from remote communities.

The organisation periodically organises training programs and brought in their remote workers for some training and recreation in Darwin. They finished with a celebratory meal. At the end of the meal one of the women stood up on behalf of the others to thank the Agency for providing the training and hospitality. There's nothing remarkable in that. But what was unusual was what she said. She did not focus on the actual training or the meals or the opportunities for shopping. She simply said 'Thank you for the training, we all felt safe here'.

I'm sure that you all would share with me the vision of a time when everyone in the Territory can say, 'we feel safe here'.

Howard Bath
Children's Commissioner NT
June 2013

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