Aboriginal Best Start

Status report

Victoria
The Place To Be

Aboriginal Best Start status report

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Cover design

The cover design is by Bangerang/Wiradjuri artist, Gary Saunders. The work depicts a strong healthy Indigenous family in which the child's wellbeing is developed during pregnancy and after birth and both mother and father are involved in raising healthy children.

Gary Saunders has recently completed a traineeship in graphic design at Fraynework Multimedia and the Royal Melbourne Institute of Technology.

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Acknowledgements

Aboriginal cultural beliefs

The Aboriginal Best Start Reference Group developed the following statements of Aboriginal cultural beliefs. They are based on the statements of the Canadian Best Start project. The reference group believes these statements reflect Australian Aboriginal peoples' values about children. These values should underpin any work undertaken in this area.

- Our children are our present and our future.
- Our children should have access to good health, wellbeing and education programs so that they will be empowered to achieve their full potential.
- Our children have the right to an education that strengthens their culture and identity.
- Our children have the right to live in communities that are safe and free from violence.
- Our children have the right to identify as Aboriginal Australians, to be proud of our history, cultural beliefs and practices.
- Our children have the right to maintain connection to their land and country.
- Our children have the right to maintain their strong kinship ties and social obligations.
- Our children have a strong contribution to make to enrich the Aboriginal community and as members of the wider community.
- Our children have a right to be taught our cultural heritage by our Elders.
- Our children should be taught to respect their Elders.

Executive summary

Background

Best Start is a prevention and early intervention project that aims to improve the health, development, learning and wellbeing of all Victorian children from conception through transition to school (usually taken to be eight years of age). Best Start demonstration projects are being funded to explore the additional outcomes that can be achieved for children by bringing together parents, health, education and community services, and government at the local level in new partnerships that concentrate on better meeting the needs of all young children from conception to eight years of age. These improvements are expected to result in better access to child and family support, health services, and early education, and greater parental capacity, confidence and enjoyment of family life and the development of communities that are more child and family friendly.

Best Start is about achieving measurable improvements in the life chances of young children in both the short and longer term by strengthening the existing prevention and early intervention services.

There are two phases of the Victorian Aboriginal Best Start project: the release of this status report and the implementation of two demonstration projects.

Phase one: status report

This status report focuses on:

- providing a better understanding of the specific health, education and wellbeing needs of Aboriginal young children and their families and communities

- providing a profile of Aboriginal children and their families

- combining the evidence base for the importance of early childhood with the knowledge and experiences of Aboriginal parents, communities and organisations

- identifying the specific barriers Aboriginal parents and families with young children face in accessing Aboriginal and non-Aboriginal universal early years services in Victoria.

Phase two: implementation of two demonstration projects

The Aboriginal Best Start demonstration projects will bring together health, education and welfare service providers, parents, community members and other key stakeholders to initiate partnerships between service providers and communities. The partnerships will develop and implement new ways of working together to support service innovation within early childhood services.

The demonstration projects will focus on understanding the health, education, development and wellbeing needs of young Aboriginal children and their families within their community. The projects will identify the range of resources and services being used to provide support and will seek better coordination and innovation to make services more accessible, relevant and supportive to Aboriginal children and their families.

The anticipated outcomes of the Aboriginal Best Start projects are:

- better access to culturally relevant child and family support, health services and early education

- improvement in parents' capacity, confidence and enjoyment of family life

- improvements in children's health, education, wellbeing and cultural identity

- communities that are more child and family friendly.

Context for the Aboriginal Best Start projects

The difficulties many Aboriginal people have in accessing mainstream services stem from many years of oppression and racism, which includes government policies of segregation and removal. Historically, Aboriginal people have not been granted equitable access to mainstream services and they remain uncertain and uneasy about accessing universal mainstream services, which served as government instruments for justifying the removal of Aboriginal children from their families and communities. As a result, Aboriginal children and their families are under-using maternal and child health services, education services and social support services.

Many Aboriginal people are part of the 'stolen generation' or are feeling the impact of those historical government policies. Aboriginal children are today six times more likely to be the subject of a child protection notification, 9.6 times more likely to have the protective concerns substantiated, and 10.9 times more likely to be placed on a protection order than non-Aboriginal children. Despite the efforts of the Aboriginal child care agencies, 45 per cent of Aboriginal children are still being placed in care with non-Aboriginal families.

Consultation summary

For the Victorian Aboriginal Best Start project, consultations were undertaken with Aboriginal families and communities, Aboriginal service providers and mainstream service providers. These consultations helped identify the many

barriers families face in accessing health, education and child and family support services. The major barriers include:

- mistrust of government services based on historical policies of removal of children
- parents' concern that welfare organisations will remove children if they are identified at risk
- lack of understanding of Aboriginal culture and insensitivity among mainstream service providers (such as the use of jargon and judgmental attitudes)
- cultural irrelevance of programs
- cost of services and complexity of seeking fee relief (particularly for child care, preschool, school and medical services)
- poor availability of transport to and from services
- lack of respectful, culturally relevant and accessible information about potential risk factors, such as smoking during pregnancy, poor maternal and infant nutrition, alcohol and substance abuse, and not being immunised
- lack of awareness of the availability of services.

Consultations with Aboriginal Elders reinforced many of these points and added an extra dimension to this report. Elders affirmed the importance of available health, education and child and family support programs, both to them and to their families, children and grandchildren. Elders considered early years programs, particularly programs for young babies, preschool children, the transition to school, and early school years, of great importance to the future of Aboriginal communities. Elders considered that the main issues for Aboriginal children aged from birth to eight years are low school retention rates, hearing disorders, poor nutrition and lack of resources for families.

Status of Aboriginal children in Victoria

In Victoria, the Aboriginal population is growing at 2.3 per cent a year, twice the rate for the non-Aboriginal population. Twenty-six per cent of the Aboriginal population is under the age of 10 years. Given this, the pressure experienced by some Aboriginal early childhood services is likely to continue.

Premature deaths and a life expectancy 20 years less than that of non-Aboriginal Victorians gives the Aboriginal population an age profile similar to some developing countries. It is well documented that Victorian Aboriginal people have poorer health and higher levels of disability, chronic illnesses, disease and injury than non-Aboriginal Victorians. Aboriginal people are more likely to be hospitalised than other Victorians. The profile of Aboriginal children is analysed in more detail in this report.

Aboriginal people also experience higher unemployment and have lower incomes, poorer educational outcomes and poorer health than non-Aboriginal people. When these factors are combined with parenting difficulties and family violence, they can have a negative effect on childhood development.

Such disadvantage in the health and wellbeing of Aboriginal children in Victoria begins early, with poor antenatal care and young maternal age. Low birth weight is an important factor in ill health in infancy and early childhood. Babies born to Victorian Aboriginal women are on average lighter than those born to non-Aboriginal women: they are about twice as likely to weigh less than 2,500 grams. Poor nutrition, smoking, alcohol use, teenage pregnancy, low socioeconomic status and a lack of antenatal care are all factors that influence birth weight. Approximately 15 per cent of Victorian Aboriginal babies born in 1999–2000 were born underweight and therefore at risk of poorer health, development and learning outcomes.

Studies have shown that breastfeeding and the correct introduction of solids are two factors affecting the health of Aboriginal babies. While about 85 per cent of Victorian Aboriginal mothers breastfeed their babies initially, only about 50 per cent continue to breastfeed at 12 weeks. An improvement in breastfeeding rates may significantly improve the health of Aboriginal infants.

Victorian Aboriginal children under four years of age are more likely than non-Aboriginal children to be hospitalised for respiratory diseases, including croup, asthma and pneumonia, and for vaccine-preventable diseases, such as whooping cough and influenza. Acute respiratory disease is associated with the presence of otitis media, which is well documented as a significant risk for permanent hearing loss in Aboriginal children and consequently might increase the risk of educational disadvantage.

Immunisation rates for Aboriginal children in Victoria remain low, with approximately 58 per cent of Aboriginal babies immunised at 15 months. This places Aboriginal children at a greater risk of serious illness and subsequent developmental delays, which might have longer, term implications for optimal levels of wellbeing.

Infant mortality reflects the most serious outcome of disadvantage and illness during pregnancy and infancy.[1] Despite decreases in the death rate for all infants over the last century (in part due to improvements such as better sanitation, a universal immunisation program, health education, improved medical care and better socioeconomic wellbeing), the incidence of peri-natal deaths of Aboriginal infants remains twice that of non-Aboriginal babies. A key

focus of the Aboriginal Best Start project initiatives will need to be on devising strategies to address the factors leading to premature death and serious illness of infants and young children.

Many of the Aboriginal people consulted for this report affirmed the importance of preschool education for their children and expressed concern at the low level of attendance at preschool. Aboriginal children have a lower preschool attendance rate than other children. The attendance rate of Aboriginal children in 2002 was 61.4 per cent compared with 96.4 per cent for non-Aboriginal children. Aboriginal people noted that many of the Aboriginal organisations in rural Victoria have established playgroups for three year old Aboriginal children to enable skills development prior to the preschool year.

Those consulted identified many reasons for poor access to preschool education among Aboriginal children, including cost, lack of transport and poor program relevancy. There is a need for the Aboriginal Best Start demonstration projects to develop strategies to address these and other barriers to access.

Department of Education and Training statistics show a lower educational achievement for Aboriginal children in primary schools than for non-Aboriginal children. For reading, 52 per cent of Aboriginal students in preparatory class ('prep') were consolidating at or below their expected level, compared with 25 per cent for all children, while in year two, the rate was 47 per cent for Aboriginal children, compared with 21 per cent for non-Aboriginal children.[2]

The Elders consulted for this report affirmed their commitment to the education of their children and again felt that more culturally relevant programs and transport would be significant factors in improving the children's access to school and, therefore, the literacy and numeracy rates for young children.

Research in early childhood

Early childhood experiences have long been recognised as laying the foundation for later physical, cognitive and socio-emotional development. Several major reports in recent years in Britain, the United States and Canada have emphasised the importance of early childhood development and parent support programs that improve outcomes for children's education, health, and wellbeing within the context of respect for cultural beliefs and practices.[3] This argument is not new, but there is now strong evidence to indicate that while brain development continues throughout life, it is at its greatest before the age of three years. Deprivation, stress

and neglect in these early years can have significant impacts on later childhood and adult health and educational outcomes.

Some of the factors that protect children and help make them resilient are the characteristics of the children themselves. These include an easy temperament, good health, absence of disability, and the ability to form positive relationships. Other factors that protect children's development are features of their home and community environments. Research shows that we can best promote children's development by providing children with positive and ongoing caring relationships, protection from harm, opportunities and support for learning, and stable, supportive communities.

Conversely, there are factors that place children's development at increased risk. These include factors indicative of poverty and low socioeconomic status, such as malnutrition, low birth weight and chronic health problems. The more risk factors children are exposed to, the more likely it is that their development will suffer.

The more protective factors that are in children's lives, the more likely it is that children will develop well. Both risk and protective factors exist within the individual, the family and the wider community environment.

While optimal environmental influences can allow for optimal early childhood development, there are many environmental risk factors confronting Aboriginal children, particularly factors associated with low socioeconomic status, such as:

• poverty

• family violence

• maternal depression

• child abuse and neglect

• inadequate nutrition both before and after birth.

Many Aboriginal children experience multiple factors that place their health, wellbeing and psycho-social development at risk.

National and international studies have shown that intervention targeting nutrition, health care, parenting and the improvement of education in infancy and early childhood can significantly advance developmental outcomes for children. Studies also indicate that this is more successful and cost-effective than remedial action in later childhood or adolescence.

[1] *Overcoming Indigenous Disadvantage: Key Indicators 2003 Report*

[2] Teacher assessments against CSFII

[3] Department of Human Services 2001a

Key learnings from Aboriginal child enrichment programs in Australia indicate that those programs that focused on the children's strengths rather than on notions of learning deficits have had more success in developing greater social, literacy and numeracy skills. These greater skill levels enabled the children to function more successfully in a formal school setting.

Each of the components of this status report has helped inform the recommendations for best practice strategies and core activities to be considered in the development the Aboriginal Best Start demonstration projects.

Future directions

The Aboriginal Best Start demonstration projects will need to emphasise:

- building new partnerships with Aboriginal and non-Aboriginal services to improve the health and welfare of all Aboriginal people from conception to eight years

- helping vulnerable families with very young children by encouraging their participation in the Aboriginal Best Start project activities

- ensuring information about key health promotion activities, such as immunisation, is provided in a culturally relevant and accessible manner

- highlighting the crucial importance of early child development as part of the community information strategy

- building confidence in parents about the importance of preschool and primary school education to improve the literacy and numeracy ability of Aboriginal children.

Guiding these projects should be the Best Start evidence base that brings together Aboriginal cultural beliefs, knowledge about key elements of child development and the factors that detract from children reaching their full potential, and the Best Start principles of engaging parents, community members and services in the joint planning and implementation of activities.

Introduction

Best Start is a prevention and early intervention project that aims to improve the health, development, learning and wellbeing of all Victorian children from conception to eight years of age. Best Start demonstration projects are being funded to explore the additional outcomes that can be achieved for children by bringing together parents, health, education and community services, and government at the local level in new partnerships that concentrate on better meeting the needs of all young children from conception to eight years of age. These improvements are expected to result in better access to child and family support, health services, and early education, and greater parental capacity, confidence and enjoyment of family life and the development of communities that are more child and family friendly.

Best Start is about achieving measurable improvements in the life chances of young children in both the short and longer term by strengthening the existing prevention and early intervention services. A detailed evaluation and data strategy has been developed to document the progress of the projects.

The implementation of Best Start has commenced with a number of demonstration projects around Victoria. These projects are modelling new partnerships and ways of working. The aim is to provide a number of core activities known to be effective in early years services. These activities will be delivered within a framework of predetermined service delivery principles that include all young children and their parents. Community partnerships will provide these activities in various ways to meet the different and specific needs of families.

This status report has been prepared to inform the development of Aboriginal Best Start demonstration projects and mainstream demonstration projects. Three Aboriginal peak organisations jointly developed this report: the Victorian Aboriginal Community Services Association Limited, the Victorian Aboriginal Community Controlled Health Organisations, and Victorian Aboriginal Education Association Incorporated, in partnership with the Department of Human Services and the Department of Education and Training. The Victorian Aboriginal Child Care Agency was also included in the Aboriginal Best Start Reference Group and contributed valuable expertise. The knowledge and expertise of each partner ensured a collaborative and holistic project.

This report provides:

- a summary of the outcomes of consultations with parents and communities
- a profile of the health and wellbeing status of Aboriginal children aged from birth to eight years in Victoria
- an overview of State, national and international research and models of practice relevant to the Aboriginal community
- an exploration of potential practice solutions to inform the recommendations for the core components of the Aboriginal Best Start demonstration projects and the mainstream demonstration projects.

The report is divided into three main sections. Section one documents the processes and outcomes of consultations with the Aboriginal community and Elders of the community. Section two looks at the project context, focusing on key information about Victoria's Aboriginal children. Section three identifies literature relevant to Best Start projects and presents information (drawn from data, consultations, literature and the project overview) that refines the key issues. This section proposes strategies and core activities.

Information about projects and service delivery models which have been implemented on a state, national or international basis with varying degrees of success and which might provide some guidance for the Aboriginal Best Start projects is in Appendix 1.

Recommendations of the Aboriginal Best Start Reference Group

The following recommendations have been developed by the Aboriginal Best Start Reference Group and informed by the consultations with the Victorian Aboriginal community and the literature overview section of this report. The recommendations are grouped into two categories: those relevant to the Aboriginal Best Start demonstration projects and those relevant to the mainstream Best Start demonstration projects that include Aboriginal children.

Recommendations for Aboriginal Best Start demonstration projects

Recommendation 1:

a) That Aboriginal communities be fully involved in all stages of the Aboriginal Best Start demonstration projects.

Recommendation 2:

a) That the Aboriginal cultural beliefs and the strategies and core activities in this report inform the Best Start demonstration projects

b) That the best practice models in this report inform the Best Start demonstration projects

c) That the profile of Aboriginal children in this report informs the Best Start demonstration projects.

Recommendation 3:

a) That the Aboriginal Best Start demonstration projects analyse the health, education and wellbeing of Aboriginal children aged from birth to eight years within the local community

b) That the Aboriginal Best Start demonstration projects refer to the key health and wellbeing analysis in this report.

Recommendation 4:

a) That the Aboriginal Best Start demonstration projects be selected through a process of expression of interest

b) That all applications for the Aboriginal Best Start demonstration projects be required to have a strong cultural component

c) That all applications for Aboriginal Best Start demonstration projects be required to demonstrate a partnership approach and involvement of all major stakeholders.

Recommendation 5:

a) That the Aboriginal Best Start projects be managed by partnerships representing the health, education, and community child and family service sectors as well as parents, Elders, community representatives and other relevant stakeholders

b) That formal partnership agreements be developed between the organisations overseeing the Best Start projects

c) That these agreements highlight and inform the role and contribution of each agency and organisation.

Recommendation 6:

a) That the partnerships support local agencies to provide culturally accessible services that are culturally appropriate and welcoming to Aboriginal families and children

b) That consideration be given to including a well trained, well supported and culturally appropriate volunteer component in the project

c) That the Best Start projects include the development of local Aboriginal resource material and Aboriginal-inclusive reading materials.

Recommendation 7:

a) That major consideration be given to service accessibility, which might include the availability of transport, outreach services and hours of operation.

Recommendation 8:

a) That the Aboriginal Best Start demonstration projects implement strategies to engage all families, including those that are more vulnerable

b) That current Aboriginal services, such as Multifunctional Aboriginal Children's Services (MACS) centres, local Aboriginal preschools, Aboriginal playgroups, and KODE schools in the area, be engaged as a part of the Best Start demonstration projects.

Recommendation 9:

a) That Aboriginal Best Start demonstration projects develop and conduct research-based evaluation processes based on agreed performance indicators

b) That Aboriginal Best Start demonstration projects participate in the Statewide evaluation of Best Start.

Recommendation 10:

a) That the Aboriginal Best Start partnerships develop a communication strategy informing the Aboriginal community of the services, programs and activities being delivered

b) That the Aboriginal Best Start demonstration projects develop strategies to disseminate information on the importance of early childhood health, education and wellbeing of Aboriginal children aged from birth to eight years.

Recommendation 11:

a) That the Best Start demonstration projects incorporate the promotion of positive parenting practices recognising the contribution of mothers, fathers and communities

b) That the Best Start demonstration projects reinforce children's pride in their cultural identity.

Recommendations for mainstream Best Start demonstration projects

Recommendation 1:

a) That Best Start demonstration projects include the local Aboriginal community in a partnership agreement

b) That these partnerships include representation from Aboriginal health, education, community services and child and family welfare services together with Aboriginal parents and community representatives, including Elders

c) That each partner ensures collaboration, drawing on their specific areas of expertise, emphasising access and overcoming any barriers to service delivery.

Recommendation 2:

a) That the strategies and core activities in this report inform the Best Start demonstration projects

b) That the best practice models in this report inform the Best Start demonstration projects

c) That the data in the profile of Victorian Aboriginal communities in this report inform the Best Start demonstration projects.

Recommendation 3:

a) That staff in early childhood services within Best Start demonstration projects, including management and management board representatives, undertake ongoing cultural awareness training

b) That a recognised cross-cultural trainer delivers the cultural awareness training.

Recommendation 4:

a) That the Best Start demonstration projects consider strategies for ensuring the resolution of instances of discrimination or culturally inappropriate practice

b) That an Aboriginal Elder or respected person plays an active role in dealing with any complaints.

Recommendation 5:

a) That the partnerships support early childhood services to provide culturally accessible, Aboriginal friendly and welcoming environments for Aboriginal families and young children which include, but are not limited to, Aboriginal art, posters, literature and other materials

b) That the Best Start projects include local Aboriginal resource material and Aboriginal-inclusive reading materials.

Recommendation 6:

a) That the Best Start demonstration partnerships develop a communication strategy informing the Aboriginal community of services, programs and activities being delivered. This should include the dissemination of information on the importance of the health, educational and wellbeing needs of Aboriginal children aged from birth to eight years.

Recommendation 7:

a) That the Best Start demonstration projects incorporate the promotion of positive parenting practices through applicable strategies targeted at both men and women

b) That the Best Start demonstration projects give children an appreciation of Aboriginal culture.

Community consultations

This section provides an overview of the consultation process and an understanding of the key issues surrounding the development, health and education needs of children aged from birth to eight years.

Aim of the consultation

The consultation sought to identify Aboriginal and mainstream resources and services that are involved in supporting young Aboriginal children and their families and that could be brought together in innovative ways to better provide the core activities and supports Aboriginal children need as they grow and develop.

Gathering information

The project team met with Aboriginal and mainstream organisations and community members. The following information about Aboriginal children aged from birth to eight years and their families comes from the different geographical parts of Victoria, including:

• Echuca

• Mildura

• Melbourne

• Heywood/Portland

• Bairnsdale, Lakes Entrance and Lake Tyers.

The desire of Aboriginal families in Victoria to provide a stable and culturally rich family and community environment for their children has been widely acknowledged by the Victorian Aboriginal Child Care Agency in the Good Beginnings Indigenous Parenting Project.[4] The Aboriginal Best Start demonstration projects will be well placed to harness identified strengths to develop key strategies and initiatives with local communities.

The consultations identified a number of factors within the service system that Aboriginal people believe do not support the strengths of the Aboriginal community. These factors include:

• services that are not respectful of Aboriginal people

• a poor understanding of the cultural history of Aboriginal people

• the inability of services to work with Aboriginal people in a way that strengthens their ability to participate in mainstream health and educational programs.

In addition, the consultations identified inadequate support for Aboriginal people to access services, including poor transport, inappropriate times of access, and insufficient family support resources.

Issues and barriers to accessing mainstream services

Mainstream services play a key role in the provision of health, education and welfare services to Aboriginal people as the population of Aboriginal people in Victoria is quite small and widely dispersed throughout the State. The consultations identified a number of issues Aboriginal people in Victoria believe act as barriers to their access to health, educational and other support services.

Some issues were identified as common to all services, including:

• a mistrust of government services

• a lack of cultural awareness and an insensitivity to Aboriginal people by services and staff

• low numbers of Aboriginal staff employed in mainstream services

• low numbers of relevant Aboriginal role models

• poor promotion of available services throughout the Aboriginal community.

A number of structural issues were identified which inhibit access to and participation in particular components of the service system, by Aboriginal people. These issues include:

• poor availability of services resulting from limited opening times

• limited physical access resulting from factors such as a lack of available transport to services

• the cost of education and medical services.

In addition, a number of specific issues of direct importance to children's health and wellbeing were identified, such as low immunisation rates, the cost of birth certificates, children attending school without breakfast, and the impact of family violence on children. These issues and the proposed solutions are summarised in Table 1 and discussed in more detail below.

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Table 1: Summary of issues identified and solutions suggested during the consultations

Area of concern	Issue identified	Suggestions offered	Elders' comments
Education	• Cost • Poor and inflexible transport schedules • Difficulty in transition to school • Cultural insensitivity by staff • Inadequate numbers of qualified Aboriginal staff • High absenteeism at school • Children attending school without breakfast	• Change funding criteria for ASSPA and IESEP • Provide cultural awareness programs • Provide a school bus to enable children to get to school • Employ qualified Aboriginal educators	Highlighted: • cultural awareness • education programs aimed at preschool children, early years and babies • school retention rates • the need for young mothers to receive education in child care, nutrition, cooking, basic hygiene and budgeting
Health	• Cost • Cultural insensitivity by staff • Unwelcoming environments • Use of professional jargon that is not understood and is intimidating • Poor knowledge of services • Inadequate numbers of qualified Aboriginal health workers • Inflexible opening hours Specific health issues: • Low immunisation rates for children • High rate of ear infections • Children exposed to family violence • Women smoking while pregnant	• Give greater access to Medicare bulk billing • Conduct cultural awareness programs and training for all staff • Create Aboriginal-friendly environments • Employ qualified Aboriginal health workers • Improve access to programs and design flexible programs in consultation with the Aboriginal community	Highlighted: • the importance of culturally relevant services • poor nutrition • hearing problems • lack of resources
Family services	• Mistrust of services that have previously been involved in polices that removed children and are currently removing children	• Have early childhood service system promoting culturally inclusive program services that engender trust in Aboriginal people • Provide a greater level of support to parents with very young children • Develop culturally relevant parenting programs for both men and women	
Administration	• High cost of birth certificates • Replacement of vaccination certificates • Need for greater sharing of information between services		

Mistrust of government services

Comments made during the consultations underscore the fear and mistrust Aboriginal people feel towards family welfare, education and health services which have in the past implemented government policies that removed Aboriginal children from their parents. It was stated that fear of the Department of Human Services is still very prevalent within the Aboriginal community and acts as a barrier to accessing support services for families. Aboriginal people are still very cautious about what they say and do when attending mainstream services. Parents with issues such as maternal depression and family violence might attempt to hide these issues and, as a result, not receive much needed support and treatment.

The issue of family violence, while not broadly articulated in the consultations, was referred to as a reason why some women might not use support services. There is a fear that disclosure exposes them to a risk of notification to child protection. These concerns extend to the children accessing support services; there is the fear that the family will be exposed to influences considered undesirable.

Clearly this fear acts against Aboriginal people accessing services for support and assistance early, as a number of professionals are mandated to report to child protection services if they believe a child is at significant risk of harm. Aboriginal families remain over-represented in the child protection system. Work needs to be done to instil confidence in families and to ensure family and child support services assist in parenting and support and deflect families from the child protection service. The child protection innovation projects that are in the early stages of implementation are designed to assist in this way.[5]

Lack of understanding of cultural issues

A recurring theme of the consultations was that mainstream services and programs are not always culturally appropriate. Cultural inappropriateness can relate to the language used by staff, the hours of operation and the visual impact of the surroundings, for example. The consultations revealed that the use of professional jargon made Aboriginal people feel intimidated and self-conscious about using the service and highlighted the need for non-Aboriginal staff to engage Aboriginal people using the services in a way that inspires confidence and understanding.

The consultations highlighted that Aboriginal people need to see their own people working in mainstream educational, health and wellbeing services. The consultation participants said that promoting the employment of Aboriginal people in health and educational services would allow Aboriginal people to positively influence the culture of services and therefore attract and maintain Aboriginal people to the service.

In the education system, it was considered the presence of an Aboriginal education worker would better support children (through the transition to preschool and school) and parents (in becoming involved in their children's education). Community members noted that many Aboriginal children do not participate in preschool programs and therefore do not have the benefit of a structured program for the transition to school. They considered that Aboriginal children who have not had any previous experience of the school system might experience difficulty as they go from the safety of the family home to the alien school environment.

For Aboriginal children to experience a positive school environment, the consultations suggested that attention be given to the cost of schooling, the process of transition to school, the employment of Aboriginal workers, and cultural awareness training for non-Aboriginal staff. Those consulted believed that improvements to these aspects would enhance the participation rates and educational outcomes for all the Aboriginal community.

Access to services

Throughout the consultations, many Aboriginal people noted that they and the community were unaware of services available to them. They felt there was inadequate information sharing between mainstream service providers and Aboriginal services and they were missing out on opportunities to access services that would benefit them and their families. They suggested promoting available services as a way of improving awareness of services.

The consultations noted the requirement for greater flexibility in the hour's services operate. The issue of opening hours inhibiting access to services might be partly the result of some services having restricted hours of access and partly the result of the timing and availability of transport.

Access to public transport was identified as a major issue for people wishing to access services, including preschool centres and educational institutions. The consultations noted many people were without access to a vehicle and were not located close to public transport. For some women, particularly those with young children, the physical difficulty and the cost of accessing public transport was noted as a major problem. While it was revealed that in some communities the school bus system is good, the consultations identified a need to review the operation, destination, frequency and timing of departure and arrival services.

5 *An Integrated Strategy for Child Protection and Placement Services 2002*

The cost of services

The cost of services was highlighted throughout the consultation as a major issue that deterred Aboriginal people from using many available services. The services mentioned during the consultations included child care, preschool, school and medical services.

Education was an important issue for the community and children not participating because of the high cost gave rise to great concern. The impact on parents, particularly single parents, not being able to afford to send their children to preschool or school are high absenteeism rates for children, that may perpetuate the low literacy and numeracy levels of Aboriginal children. While fee relief is available, it is understood that some families find the paperwork too arduous and complex to complete.

Diminishing availability of bulk billing is reducing access to quality medical care. Many doctors have made a decision to charge all patients up front rather than to bulk bill. This arrangement places Aboriginal children and families at a great disadvantage as many people have a limited budget which does not readily allow for an up front payment for medical care as well as the cost of prescription medication. The consequence of the lack of bulk billing might be that people do not promptly act on health matters or that they are forced to attend the public hospital system, putting extra stress on families and the system.

General health issues

During the consultations, community members expressed concern about children not being immunised. The community members were not able to say why some children were not immunised, however, they suggested that many parents did not understand the importance of immunisation or believed there are potential side effects that might harm children. Many people consulted believed that the low rate of immunisation was increasing the rate of vaccine-preventable illness in children and placing their health and wellbeing at a greater risk. The consultations confirmed the need for strategies to ensure Aboriginal children receive appropriate immunisation.

Cultural insensitivity

The consultations raised the issue that the public hospital system sometimes makes Aboriginal people feel uncomfortable because staff display little understanding of Aboriginal culture. The reception areas were an example; many community members felt these areas are often intimidating and not culturally appropriate. It was often reported that the reception and response by staff on arrival at these services was not welcoming and many Aboriginal people felt they were treated as a number rather than a person.

In addition, the consultations highlighted a number of specific health issues, including:

- children lacking adequate nutrition and some attending school without having breakfast
- the cost associated with replacing birth certificates and immunisation records. School enrolments are difficult if parents do not have birth certificates, have not had children immunised or have misplaced immunisation records
- children suffering from ear infections
- children becoming accustomed to or hardened by the violence within their communities
- pregnant women smoking.

Community needs

The community identified the need for economic independence, community support, and adequate housing, health and employment. There was an expressed need to strengthen culture to address the issues of family violence, isolation, lack of self-confidence, and stereotyping and racism. Family breakdown was identified as a big problem due to a range of reasons, including the impact of substance abuse and lack of culturally appropriate support for families. Aboriginal people believed there is a victim mentality in much of the community that needs to be addressed.

Previous community consultations by the Victorian Aboriginal Child Care Agency highlighted the need to link families to each other and to Aboriginal and mainstream services. These consultations emphasised the importance of playgroups and parent groups as ways of reaching isolated families. Playgroups were identified as a growing program area for the early years with the potential to give parents the support they need without the formal structures of childcare and preschools. They have the potential to fill a gap for Aboriginal parents between their child's birth and attendance at preschool.

Elder's perspective on education, health and wellbeing of Aboriginal children

Aboriginal Elders are the leaders, role models and teachers of wisdom and culture in the Aboriginal community. When planning, developing and implementing Best Start, it is important to include Elders in the design, development and delivery of the projects because an opportunity for the extended family to participate in the teaching and care of children will enhance the success of the projects.

The consultations with Elders highlighted the following issues:

- the need for cultural maintenance within the communities

- the need for greater cultural relevance of the important mainstream programs currently in place in education, health and wellbeing for Elders and their families (particularly programs relating to babies, preschool, early years of schooling, and transition)

- the health of Aboriginal children aged from birth to eight years

- the rates of school absenteeism and retention

- the lack of resources in the community and poor nutrition

- the need for a higher priority to be placed on the importance of education. It would help if access to tutors was made simpler and the necessary paperwork was reduced

- the important need to develop programs on basic hygiene, budgeting, nutrition and cooking for young mothers

- the importance of cultural awareness programs for mainstream organisations to aid the development of more culturally appropriate services.

Despite many reservations about the services, the Elders saw mainstream service providers as important. In some areas, mainstream services are the only services available. Elders considered access to these services vital to the health and wellbeing of Aboriginal people.

The consultations also noted a number of general issues. While many are beyond the scope of the Aboriginal Best Start project, they are included as key concerns for Aboriginal people in Victoria. There is a need for long term, realistic strategic plans to be put in place for community development in health, education and wellbeing.

The VACCA Good Beginnings Indigenous Parenting Project report also identifies the needs of the community as:[6]

- economic independence

- community support

- the strengthening of culture

- more achievers in the community.

The report identifies these issues:

- a breakdown in the family

- some families suffering from isolation (from the extended family and geographically)

- a lack of self-confidence and self-esteem among family members

- far too much family violence

- a need for awareness and education

- community members being unable to set boundaries

- myths and stereotypes that are being perpetuated by the wider community

- a victim mentality

- the need for a drug-free approach to raising families

- the need for adequate housing, health and employment.

VACCA also identifies strategies for involving vulnerable families:

- volunteerism as a means of using Indigenous skills and knowledge from all sections of the community, including the Elders

- linking families to each other and to Indigenous and mainstream services, particularly through playgroups and parent groups

- passing on knowledge about families and parenting to future generations

- sharing information in formal ways, such as training, and in informal ways, such as learning circles, to give Indigenous families opportunities to learn about their culture, child behaviour and development

- training mainstream organisations in Aboriginal culture

- training volunteers as paraprofessionals.

Conclusions

Two of the key objectives of the Aboriginal Best Start status report project are to identify the specific barriers Aboriginal parents and young children experience when accessing mainstream and Aboriginal early years services and to better understand their health, education and wellbeing needs. The consultations undertaken to inform the Aboriginal Best Start projects offer important insights into the needs and strengths of Aboriginal people in Victoria. Aboriginal people view their children as critical to their future and consider improving children's health and education achievements as crucial. It is clear mainstream services are important to Aboriginal people, but it is also clear there are significant cultural issues non-Aboriginal people need to better understand if Aboriginal people's access to and participation in those essential services is to be improved.

Some of the issues, such as the use of Aboriginal art in preschools, might be able to be resolved at a local level; other issues are much more complex and entrenched and require a more comprehensive response. The Best Start projects encourage innovative ways of trialling new partnerships to improve service responsiveness to Aboriginal children and their families. The identification of issues impacting on service use will assist the projects.

Profile of Aboriginal children and families

Background

The Victorian Aboriginal community comprises a number of communities and extended family networks. A significant number of people within the Aboriginal community have also moved to Victoria from interstate, with many maintaining strong family links to other parts of Australia.[7]

It is acknowledged that past practices have not always had a positive effect on Aboriginal people. Current health and welfare policies acknowledge the impact of past policies and continue the progress towards working collaboratively for a better future.

Victoria's Aboriginal population continues to have lower preschool and school participation rates and higher rates of unemployment than the non-Aboriginal population. Aboriginal people are less likely to own or to be buying their own home, more likely to be admitted to hospital, and more likely to be involved in the child protection system than non-Aboriginal people.

The report, *Bringing them home report, (*1997) highlights the particular issues confronting Aboriginal families and the reasons parenting has become such a challenge. The report highlights the historical emphasis on past government policies and the removal of Aboriginal children that was, and is still to some extent, responsible for eroding the integrity of the family and for undermining the strength and capabilities of the Aboriginal community. The breakdown of Aboriginal family structure and a decline in parenting skills are transgenerational issues. The practice of removing children from their families over several generations has impacted attachment and parenting capacity in the Aboriginal community.

Some Aboriginal communities in Victoria face difficulties with low socioeconomic status, poor health, low levels of educational achievement, poor housing and a number of social and family problems. However, there is an increasing number of Aboriginal families who are in their own homes (more than 40 per cent) and many hold down good jobs and have a sound education.

Population

While statistical data collection has improved over recent years, it is acknowledged that the population Census and other data collection processes might understate the true number of Aboriginal people by up to 10 per cent in the case of the Census and by even greater amounts for some other data collections. Some of the data in this report need to be interpreted with this in mind. In most cases, population counts and population-based rates use the Australian Bureau of Statistics' Experimental Estimates of the Aboriginal Resident Population, which attempts to adjust the Census data for the under-enumeration of Aboriginal people.[8]

The Victorian Aboriginal population has been growing steadily over the past two decades. During the five years between the 1996 and 2001 Censuses, the Victorian Aboriginal population grew from 22,600 to 27,928–an increase of more than 23 per cent. This growth might be attributed to both a high birth rate and an increase in people self-identifying as Aboriginal, particularly in urban areas. A change in the instruments used to identify Aboriginal people might have contributed to this increase. Aboriginal people make up approximately 0.58 per cent of Victoria's total population.

Fifty per cent of the Aboriginal population lives outside the metropolitan areas, compared with 28 per cent of the non-Aboriginal population. Aboriginal people tend to live in the urban areas of Melbourne or in regional and rural towns. In Melbourne, Aboriginal Victorians constitute 0.38 per cent of the population and are widely dispersed across the metropolitan area, which makes it difficult for some Aboriginal families to access Aboriginal-specific services.
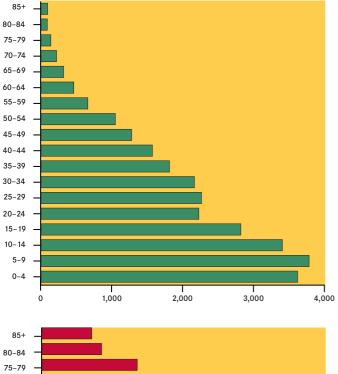
[6] VACCA 2003

[7] *Towards an Aboriginal Services Plan*, July 2001

[8] *Towards an Aboriginal Services Plan*, July 2001, p.5

Figure 1: Population age structure by Indigenous status, 30 June 2001, Victoria

Note: The scale for Aboriginal and/or Torres Strait Islander people has been magnified by 100 for comparison purposes.

Source: Australian Bureau of Statistics' Experimental Estimates of Indigenous Resident Population
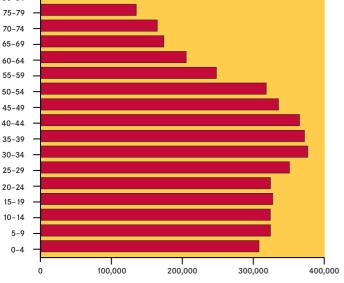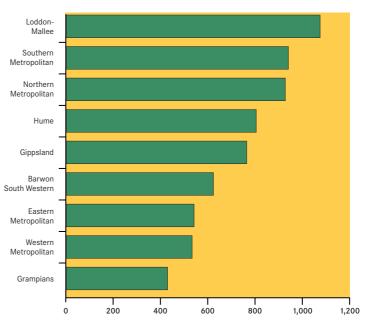
Figure 1 clearly shows the difference between the two groups of Victorians. The Aboriginal population demonstrates a typical developing country profile with a young population (more than half are under 25 years of age) and a lower life expectancy.

The differences between the age structures of the two populations are generally considered to be the result of a number of factors affecting the Aboriginal population, including higher fertility rates, lower life expectancy, higher rates of illness and premature death, and reduced long term wellbeing.

The Best Start target group–Aboriginal children aged from birth to eight years–constitutes a significant proportion of the population. In 2001 there were 6,626 Aboriginal children aged from birth to eight years, constituting 23.7 per cent of the total Aboriginal population. It is critical that this age group is well supported and that steps are taken to redress the health and educational disadvantage experienced by the Aboriginal population as a whole.

Children aged from birth to eight years are located in most areas of Victoria. These broad locations add to the complexity of providing Aboriginal-specific services and challenge mainstream services to be culturally relevant. Ensuring access to a strengthened early years service system is crucial to improving the health and educational outcomes of Aboriginal children.

Figure 2: Aboriginal children aged birth to eight years by Department of Human Services region, 30 June 2001, Victoria

Source: Australian Bureau of Statistics Experimental Estimates of Indigenous Resident Population

Figure 2 shows the distribution of Aboriginal children aged from birth to eight years in Victoria by Department of Human Services region. Loddon–Mallee region has the highest population of Aboriginal children; Southern and Northern Metropolitan regions have the next highest populations.

Socioeconomic status

The Victorian Aboriginal community, with its strong population growth rate and young age structure, experiences substantially higher unemployment rates and a much lower socioeconomic status than other Victorian communities. The Aboriginal unemployment rate is about 17.6 per cent, compared with about 7.3 per cent for other Victorians.[9]

The 2001 Census indicates that the annual median income for Aboriginal Victorians is about $20,000, which is $6,000 less than the median income for other Victorians. This income gap reflects the fact many Aboriginal people depend on government support, while those who are employed experience low occupational status and are predominantly in part-time jobs.

Health status

Significant lifestyle changes have been forced on Aboriginal Victorians since colonisation and have resulted in much higher rates of non-communicable diseases and other conditions. Heart disease, renal dialysis, respiratory diseases, mental disorders, and injuries and poisoning are among the most common causes of hospital admissions. While some of these might not directly involve admissions to hospital of children aged from birth to eight years, their prevalence indicates that these children live in an environment in which poor health is common.

Despite some improvement in recent years, the Victorian Aboriginal population has poorer health, higher levels of disability and earlier deaths than other Victorians. Higher rates of chronic illness and a high burden of disease and injury reduce the wellbeing and quality of life of all Aboriginal Victorians and especially young children who are so dependent on others for their care.[12]

Table 2: Supported Accommodation Assistance Program (SAAP) clients: Indigenous status by financial year, Victoria

Indigenous status	2000–01		2001–02		
	(number)	(per cent)	(number)	(per cent)	(Rate per '000 population)
Aboriginal and/or Torres Strait Islander	1,250	4.8	1,450	5.2	51.9
Neither Aboriginal or Torres Strait Islander	24,750	95.2	26,600	94.8	5.5
Total	26,000	100.0	28,050	100.0	5.8

Source: Australian Institute of Health and Welfare 'SAAP National Data Collection annual report (various years) Victoria supplementary tables.'; Australian Bureau of Statistics Experimental Estimates of Indigenous Resident Population

Historically, low socioeconomic status has made it difficult for Aboriginal people to purchase a home. The home ownership rate for Aboriginal Victorians in 2001 was 43.1 per cent, compared with 74.1 per cent for other Victorians, while 54.3 per cent of Victorian Aboriginal people rented, compared with 22.8 per cent of non-Aboriginal people.[10]

For many Aboriginal children, the low socioeconomic status of their families exposes them to greater risk of neglect and stressful life situations.

The Aboriginal population uses the Supported Accommodation and Assistance Program (SAAP) services more frequently than the non-Aboriginal population. Usage appears to be increasing, with the proportion of Aboriginal people using SAAP increasing from 4.8 per cent of all SAAP clients in 2000–01 to 5.2 per cent in 2001–02, which is much greater than the proportion of Aboriginal people in the population.[11]

Life expectancy

The life expectancy of a population is a good indication of the health and wellbeing of the people. The life expectancy of Aboriginal Australians today is comparable to that of non-Aboriginal Australians about 100 years ago. The major reason for the increase in life expectancy of non-Aboriginal Australians in the early years of the twentieth century was the reduction in peri-natal and infant mortality. In the past few decades, a reduction in death rates in the older age group, especially from circulatory system diseases, has led to increased life expectancy among non-Aboriginal Australians.

The life expectancy of the Aboriginal population in Victoria is currently 20 years less than that for the total population.

[9] *Victorian Government Indigenous Affairs Report 2002:34.*
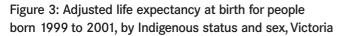
[10] ATSIC Regional Information Systems, 2001

[11] As it is not mandatory to collect data on Indigenous status, the number of Aboriginal clients shown in Table 2 might be an under-representation of the actual number.
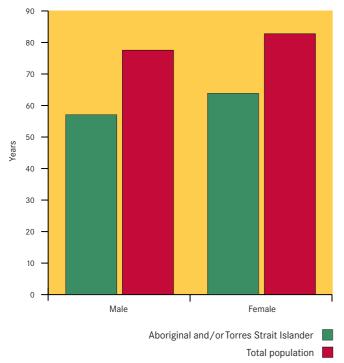
[12] *Victorian Government Indigenous Affairs Report 1999–2002,* p. 19

For Aboriginal males born in the period from 1999 to 2001, the life expectancy is 56.3 years, in contrast to 77.0 years for the total population–a difference of 21 years. For all women in Victoria born in the period 1999 to 2001, life expectancy is 82.4 years; for Aboriginal women it is 62.8 years–a difference of 20 years.[13]

Aboriginal death rates in Victoria in 2001 were 10.9 per 1,000 males and 6.6 per 1,000 females– are significantly higher than the total population death rates of 6.6 and 4.2 for males and females respectively.[14]

Figure 3 illustrates the adjusted life expectancy at birth for people born in the period from 1999 to 2001 to take into account the estimated under-reporting of Aboriginal deaths for the years 1997 to 2001.
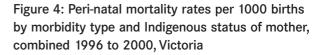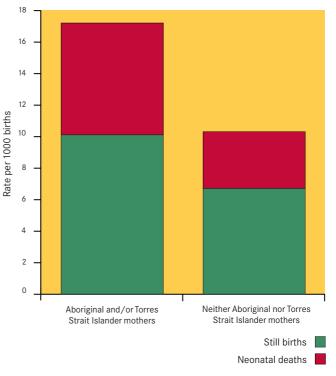
Figure 3: Adjusted life expectancy at birth for people born 1999 to 2001, by Indigenous status and sex, Victoria

Source: Australian Bureau of Statistics 'Births, Australia, Demography Victoria, 1999, 2001'

Peri-natal deaths

The survival of infants in their first year of life is a significant indicator of the general health and wellbeing of a population. A low infant mortality rate is a major contributor to increased life expectancy for a population.

In Victoria, the rate of death for Aboriginal babies in the peri-natal period is markedly higher than for non-Aboriginal babies. The rate of death for Aboriginal infants is 16.8 per 1,000 births, compared with 10.7 per 1,000 births for non-Aboriginal infants.[15]

Figure 4: Peri-natal mortality rates per 1000 births by morbidity type and Indigenous status of mother, combined 1996 to 2000, Victoria

Source: Department of Human Services, Perinatal Data Collection Unit, 'Births in Victoria 1996–2000'

Figure 4 clearly indicates the differences in the rate of peri-natal deaths between the babies of Aboriginal and non-Aboriginal mothers.

The quality of care provided to women in the antenatal period and postnatal periods is very important. There are no data available to illustrate the attendance rate of Aboriginal women at antenatal care; however, the Koori Maternity Services Project evaluation suggests Aboriginal women will attend antenatal care providing it is culturally relevant.[16] Better use of antenatal care, particularly through the provision of culturally relevant services, would improve support for Aboriginal women and provide better outcomes for their pregnancy.

Many women leave hospital within three days of childbirth and need support after returning home, especially to establish breastfeeding. Breastfeeding rates have reached a plateau over the past 10 years. Improvements in breastfeeding rates and greater access to maternal and child health services are likely to improve infant health.

Young maternal age

Aboriginal women in Victoria give birth at younger ages than non-Aboriginal women (Figure 5). In 2001, 51 per cent of Aboriginal babies were born to mothers less than 25 years of age, compared with only 17 per cent of babies born to non-Aboriginal mothers less than 25 years of age.
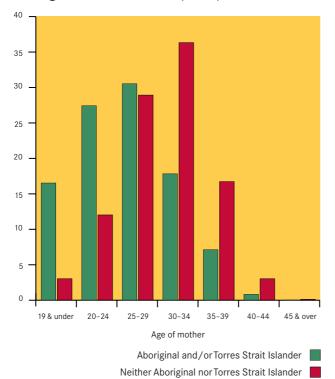
Figure 5: Proportion of births by age of mother and Indigenous status of infant, 2001, Victoria

Age of mother

Aboriginal and/or Torres Strait Islander ■

Neither Aboriginal nor Torres Strait Islander ■

Source: Australian Bureau of Statistics 'Births Australia 2001'

The peak for Aboriginal women giving birth is in the 25 to 29 year age group, which is in contrast to all women, who are commencing childbirth later and whose peak is in the 30 to 34 year age group.

The proportion of young Aboriginal women in Victoria giving birth aged 19 years and under is significantly higher than the proportion for all mothers. The proportion for all mothers giving birth aged 19 years and under has remained relatively stable at between 2.9 per cent and 3.2 per cent from 1998 to 2001. The proportion of Aboriginal mothers giving birth aged 19 years and under has steadily risen from 14.4 per cent in 1998 to 19.4 per cent in 2000, with a slight decline in 2001 to 16.7 per cent.

Table 3: Proportion of births to mothers aged 19 years and under by Indigenous status, 1998 to 2001, Victoria

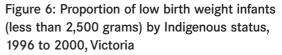| Indigenous status of mother	1998	1999	2000	2001
Aboriginal and/or Torres Strait Islander mothers	14.4	15.1	19.4	16.7
All mothers	3.2	2.9	2.9	3.2

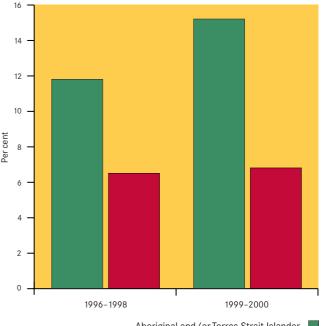*Source:* Australian Bureau of Statistics, 'Births Australia, 1998, 1999, 2000, 2001 (3301.0)'

Birth weight

A key indicator of health status is the birth weight of a baby. Infants with lower birth weights are more likely to die or to have problems early in life. It is accepted that lower birth weight might have a longer term influence on health.

Low birth weight is defined as being born weighing less than 2,500 grams. Low birth weight might be the result of being born prior to term or being born small for gestational dates. Babies are born small for gestational dates for a number of reasons, such as maternal or paternal genetics, maternal complications of pregnancy, or inadequate nutrition during pregnancy.

There are significant differences in birth outcomes between Aboriginal and non-Aboriginal communities. Babies born to Aboriginal mothers are on average lighter than babies born to non-Aboriginal mothers, as shown in Figure 6.

Figure 6: Proportion of low birth weight infants (less than 2,500 grams) by Indigenous status, 1996 to 2000, Victoria

Aboriginal and/or Torres Strait Islander ■

Neither Aboriginal nor Torres Strait Islander ■

Source: Department of Human Services; Perinatal Data Collection Unit 'Births in Victoria 1999–2000'

[13] Australian Bureau of Statistics, *Deaths in Australia 2001*, cat. no. 3302.0, *Demography Victoria*, 1999, 2001, cat. no. 3311.2

[14] Australian Bureau of Statistics, *Deaths in Australia 2001*, cat. no. 3302.0. IDSR = indirect standardised death rate. The Indigenous population used for the ISDR is the 2001 Indigenous population. Standardised using age-specific death rates for the 1991 Australian population in five year age groups from from birth to four years or 75 years and over. The ISDR is derived using the ratio of observed deaths to expected deaths. Due to the under-coverage of Indigenous observed deaths, the ISDRs presented here are likely to be conservative estimates.

[15] The peri-natal mortality rate is the number of peri-natal deaths (stillbirths plus neonatal deaths) per 1,000 births; both live and stillbirths.

[16] Campbell, S., 2000

Achieving better outcomes for Aboriginal babies requires promoting mothers' attendance at antenatal services and identifying and reducing risks early in the pregnancy, such as inadequate weight gain.[18] The Best Start project has identified access to antenatal care as a core activity to improve health and wellbeing.

Childhood illnesses

Aboriginal children more frequently suffer from a number of potentially chronic and debilitating diseases, such as upper respiratory tract infection, middle ear infections and vaccine–preventable illnesses.

Figure 7: Hospital separation rates for primary diagnoses of otitis media and infectious disease, 2001–02, Victoria

Source: Department of Human Services Admitted Episodes Data Set (unpublished) 2001–02

Table 4 illustrates the hospital admissions for all Aboriginal and non-Aboriginal children for otitis media and respiratory infections. The contrast between the two groups for respiratory infections is significant.

Hearing impediments

Table 4, which uses the hospital separation figures for all children aged under nine years, shows 5.2 per cent of Aboriginal children admitted to hospital are admitted for otitis media, compared with 4.6 per cent of non-Aboriginal children admitted. There has been a slight decrease in admissions of children over the past three years.

Table 4: Children aged 0 to 8 years admitted to hospital, proportion with a principal diagnosis of otitis media (a), Indigenous status, by financial year, Victoria.

| | Hospital separations in financial year | | | |
| | 1999–00 | 2000–01 | 2001–02 | 2002–03 |
Indigenous status	(per cent)	(per cent)	(per cent)	(per cent)
Aboriginal and/or Torres Strait Islander	6.3	5.1	5.3	5.2
Neither Aboriginal nor Torres Strait Islander	5.2	5.2	4.7	4.6
Total	**5.3**	**5.2**	**4.7**	**4.6**

Source: Department of Human Services, 'Victorian Admitted Episodes Dataset (VAED)'

(a) Does not include children who were admitted for another condition with a secondary diagnosis of Otitis media. Principal diagnosis of Otitis media includes the following ICD-10-AM Coded conditions:

B053–Measles complicated by otitis media

H65–Non-suppurative otitis media

H66–Suppurative and unspecified otitis media

H67–Otitis media diseases classified elsewhere

The true extent of the problem is difficult to quantify, however, as general practitioners treat most ear infections and there are significant deficiencies in data collection.[19] The deficiencies in collection of national data have been described comprehensively and the issues will be similar for Victorian data collection.[20]

While it was noted as a significant issue during the community consultations, the actual extent of middle ear infections and subsequent hearing loss in young Aboriginal children in Victoria has not been established.[21] Nevertheless, it is a national health issue that requires the development of vigilant prevention strategies.

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[18] MCEETYA 2003, 5.10

[19] MCEETYA 2003, 203:5.13

[20] MCEETYA 2003, 5.13

[21] Examples of programs can be found in Section 7

Dental health

Oral health has improved dramatically in Australia over the past few decades as the use of dental services has increased.[22][23] However, an Australian Institute of Health and Welfare study indicates 25.7 per cent of Aboriginal children in the six to 12 year age group had not made a dental visit in the last two years, compared with only 7.3 per cent of their non-Aboriginal counterparts. School dental services treat higher percentages of Aboriginal children (79.2 per cent) than non-Aboriginal children (58.8 per cent). While Aboriginal children continue to receive poor levels of dental care, their health and wellbeing will be significantly impacted.

Immunisation

The immunisation rate among Victorian Aboriginal children is low compared with other Victorian children (Table 5).[24] The data indicate Aboriginal children are under-immunised in early childhood and then have a high level of 'catch up' just prior to entering school (approximately two and a half times the expected immunisation encounters based on population). Unfortunately, by this time many children might have contracted the diseases that immunisation at the proper time could have prevented.

Table 5: Proportion of children fully immunised by age group by Indigenous status 31 December 2002, Victoria

Age	Aboriginal and/or Torres Strait Islander	Neither Aboriginal nor Torres Strait Islander
12 – <15 months	48.9	95.0
24 – <27 months	39.6	89.7

Source: Australian Childhood Immunisation Register; ABS, Experimental Estimates of Indigenous Population; Department of Human Services , Projections of Indigenous Population (unpublished); DSE Interim Population Projections 2003.

The low immunisation rate for Aboriginal children for the 12 month to 27 month age group increases their risk of communicable diseases, such as whooping cough. While the correlation has not been established, there is a higher level of hospital admissions for whooping cough for Aboriginal children than for non-Aboriginal children.

The low immunisation status and subsequent ill health of Aboriginal children was highlighted as a major concern during the community consultations and is identified as a major focus for the Best Start demonstration projects.

Smoking

While no current data on the prevalence of smoking in the Victorian Aboriginal community are available, anecdotal evidence from Koori health workers suggests the smoking rate is much higher in the Aboriginal community than in the non-Aboriginal community and has not reduced greatly in the past ten years.

A recent small study of 25 Aboriginal clients by the Women's Business Service at the Mildura Aboriginal Health Service found 60 per cent of the women smoked during pregnancy. Women are encouraged to stop smoking during pregnancy to improve their own and their infant's wellbeing and health outcomes.[25]

Alcohol and drug misuse

The impact of drug and alcohol misuse on the health and wellbeing of people is significant and is a well-documented contributor to the rate of family violence and child protection interventions. Aboriginal people comprised 7.2 per cent of all persons admitted to alcohol and drug treatment services in Victoria in 1998–99, which contrasts with the 0.58 per cent of Aboriginal people in the general population (Table 6).

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[22] Australian Institute of Health and Welfare, 2002, p.1

[23] Australian Institute of Health and Welfare, 1999 research report on access to dental services of Australian children and adolescents

[24] Indigenous mothers might not identify themselves as Indigenous at the time the infant is immunised.

[25] Campbell, S and Brown, S 2002

Table 6: Clients and epidsodes of care in alcohol and drug treatment services by Indigenous status, 1998 to 1999, Victoria

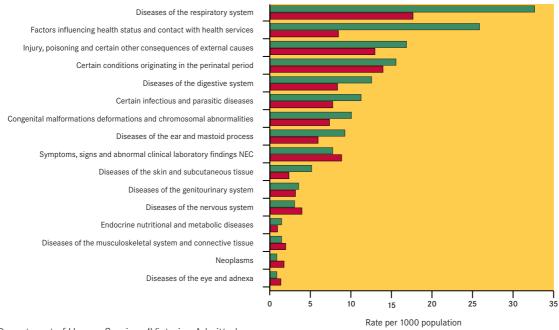| Indigenous status	Individuals			Episodes of care (a)		Mean episodes of care per individual
	(number)	(per cent)	Rate per 1000 population) (b)	(number)	(percent)	
Aboriginal and/or Torres Strait Islander	1,298	7.2	50.9	2,407	7.6	1.85
Neither Aboriginal Nor Torres Strait Islander	16,833	92.8	3.6	29,235	92.4	1.74
Total	18,131	100.0	3.8	31,642	100.0	1.75

Source: Department of Human Services, 'Alcohol and Drug Information System (Interim ADIS) Annual Report 1998–99'. See footnote (b) for population sources.

(a)   An episode of care is defined as: 'a completed course of treatment undertaken by a client under the care of an alcohol and drug worker, which achieves significant agreed treatment goals'.

(b)   Indigenous population sourced from Australian Bureau of Statistics, 'Experimental Projections of the Aboriginal and Torres Strait Islander Population, 30 June 1996 to 30 June 2006 (3231.0).' The 1999 'high' series figure of 25,496 was used.

Total population (4,712,200) sourced from Australian Bureau of Statistics, 'Population by Age and Sex, Victoria 30 June 1999. (3235.2)'. Non-indigenous population of 4,686,704 was derived from these figures.

Hospital admissions

Hospital admissions can be considered an indication of the general health and wellbeing of the community. The number of hospital separations with a principal diagnosis of infectious diseases for children aged from birth to four years is significantly higher for Aboriginal children than for non-Aboriginal children, as indicated in Figure 8. The rate of admission of Aboriginal children for upper respiratory tract infections is 32.6 per 1,000 compared with 17.6 per 1,000 for non-Aboriginal children.

Figure 8: Hospital separations of children aged zero to eight years by principal diagnosis of selected diseases of the respiratory system, by Indigenous status, 2001–02, Victoria

Source: Department of Human Services 'Victorian Admitted Episodes Data Set' Australian Bureau of Statistics Experimental Estimates of Indigenous Resident Population, 2001-02.

Mental illness

The rate of admissions for mental health disorders is higher among Aboriginal people than non-Aboriginal people and is likely to have a disruptive effect on the development of the young children in affected families. These effects would be particularly acute if the patient is the parent of young children. Admissions of Aboriginal people for mental health problems (which include drug and alcohol related admissions) are particularly high among men and women aged 25 to 44 years and it is this group that is likely to have children in the from birth to eight years age group.

Child and family wellbeing

Maternal and child health

While many Aboriginal mothers are registered with the maternal and child health service, they do not attend the key ages and stages visits. Of the estimated 4,339 Aboriginal children aged from birth to five years, 39.3 per cent were active clients of the maternal and child health service. This compares with 56.4 per cent of the total population being active clients of the service.

Table 7: Active(a) and enrolled children in maternal and child health services: Department of Human Services region by Indigenous status, 2001 to 2002, Victoria

Department of Human Services Region	Aboriginal and/or Torres Strait Islander					All children				
			Proportion of enrolled who were	Estimated Resident Population	Proportion of population who were			Proportion of enrolled who were	Estimated Resident Population	Proportion of population who were
	Active (number)	Enrolled (number)	Active (per cent)	Age 0–5 (number)	Active (per cent)	Active (number)	Enrolled (number)	Active (per cent)	Age 0–5 (number)	Active (per cent)
Eastern Metro	146	182	80.2	363	40.2	40,098	69,396	57.9	69,992	57.3
Northern Metro	286	442	64.7	589	48.6	35,420	63,286	55.8	60,257	58.8
Southern Metro	197	254	77.6	614	32.1	47,793	86,225	55.4	85,805	55.7
Western Metro	83	118	70.3	352	23.6	27,877	50,803	55.3	49,309	56.5
Metropolitan regions	**712**	**996**	**71.5**	**1,918**	**37.1**	**151,188**	**269,710**	**56.1**	**265,363**	**57.0**
Barwon South Western	161	187	86.1	401	40.1	13,957	25,115	57.0	26,528	52.6
Gippsland	200	291	68.7	507	39.4	9,550	17,372	55.0	17,989	53.1
Grampians	162	217	74.7	287	56.4	9,566	15,531	61.3	16,565	57.7
Hume	133	273	48.7	528	25.2	11,036	20,019	54.9	20,373	54.2
Loddon-Mallee	337	552	61.1	698	48.3	13,511	23,575	57.3	23,720	57.0
Rural regions	**993**	**1,520**	**65.3**	**2,421**	**41.0**	**57,620**	**101,612**	**56.7**	**105,175**	**54.8**
Victoria	**1,705**	**2,516**	**67.8**	**4,339**	**39.3**	**208,808**	**371,322**	**56.2**	**370,538**	**56.4**

Source: Department of Human Services, 'Maternal and Child Health Database'; Australian Bureau of Statistics, Experimental Estimates of Indigenous Resident Population

(a)   An active enrolment is counted if the enrolled child attends the centre at least once during the reference period.

There is some variation between attendance rates across Department of Human Services regions and the participation rate declines, as children get older.

Education

Children from Aboriginal families are less likely to enrol and to participate in preschool than their non-Aboriginal peers. Preschool attendance is generally regarded as greatly important in preparing children for their more formal school life and the lower participation rate in preschool places Aboriginal children at a great disadvantage when they commence school.[26] The consultations indicated that the low

preschool attendance rates compound the difficulty many Aboriginal children face when they enter school as they have not experienced a structured program. This in turn might have a negative impact on their ability to learn.

The attendance rate for Aboriginal children in preschools in 2002 was 61.4 per cent, compared with 96.4 per cent for non-Aboriginal children. There are significant variations between the regions, but preschool participation by Aboriginal children in all regions was less than that for non-Aboriginal children.

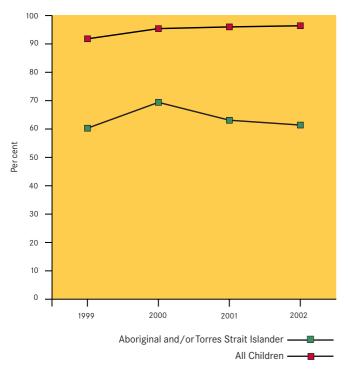[26] Department of Human Services 2002, p. 24

Figure 9: Preschool participation rates by Indigenous status, 1999 to 2002, Victoria

Source: Department of Human Services, Preschool Program 2002.

During the past four years, preschool participation rates for both Aboriginal and non-Aboriginal children have been relatively flat or have shown some minor improvement; however, preschool participation among Aboriginal children is much lower than among non-Aboriginal children.

Literacy rates

Aboriginal children achieve lower rates of literacy than non-Aboriginal children.

The Statewide testing in 2001 of children in 'prep' and year two for reading, speaking and listening, writing and numeracy indicated that Aboriginal children are not achieving as well as their non-Aboriginal peers.[27]

For reading, 52 per cent of Aboriginal students in 'prep' were consolidating or below their expected level, compared with 25 per cent of all children. In year two, it was 47 per cent for Aboriginal children, compared with 21 per cent for non-Aboriginal children. For the areas of speaking and listening, and writing, the results were similar, with Aboriginal children having lower levels of proficiency. For numeracy skills, 40 per cent of Aboriginal children in 'prep' were

consolidating or below their expected level, compared with 20 per cent of their non-Aboriginal peers, while at year two level, the results were 51 per cent for Aboriginal children, compared with 24 per cent for non-Aboriginal children. The testing was repeated in 2002 and the results again indicated much lower levels of achievement by Aboriginal children compared with non-Aboriginal children.

Much more research is required to identify factors that act as barriers to Aboriginal children achieving higher levels of literacy and numeracy. The National School English Literacy Survey undertaken in 1996 showed while about 70 per cent of all year three students surveyed met the identified performance standards in reading and writing, less than 20 per cent of Aboriginal students met the reading standards and about 30 per cent met the writing standards.[28]

The poor literacy and numeracy skills among Aboriginal children might be partly attributed to their families' low socioeconomic status and language background, but also to the inability of mainstream education to provide a culturally relevant teaching program.
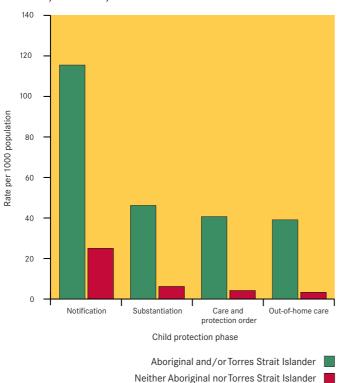
Child protection

The Child Protection Service is a statutory service that responds to and investigates notifications of children and young people aged from birth to 17 years who are considered to be at risk of significant harm from child abuse and neglect. These services can provide support for children and families and where necessary initiate intervention, which can include seeking care and protection orders and placing children and young people in out-of-home care.[29]

The data for first investigations show there were significantly more Aboriginal clients first investigated in 2001–02 (6.4 per cent) than in 1996–97 (4.0 per cent).

Aboriginal children are over-represented in the child protection system. The data for 2001–02 indicate that, compared with non-Aboriginal children, Aboriginal children were:

- almost five times more likely to be the subject of a notification
- more than seven times more likely to be investigated
- almost eight times more likely to be substantiated as experiencing abuse or neglect
- 14 times more likely to have spent some time in out-of home care during the year.[30]

Figure 10: Children aged zero to 16 years in selected phases of the child protection system, by Indigenous status, 2001–02, Victoria

Source: Institute of Health and Welfare.

The figures for children aged from birth to eight years show that, proportionately, Aboriginal children have continued to enter the child protection system at a higher rate than non-Aboriginal children with little change in the rate over the past eight years.
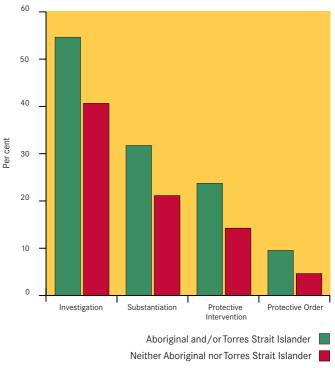
Figure 11: Proportion of child protection notifications of children aged zero to eight years that reach selected child protection phases, by Indigenous status, 1 July 1995 to 30 June 2002, Victoria

Source: Department of Human Services Child Protection Unit Data 1995–2002

Out–of-home care

The number of Aboriginal children placed in out-of-home care has increased significantly from 297 in 1999–2000 to 489 in 2001–02. Victoria has the highest rate of Aboriginal children being placed in out-of-home care in Australia. The rate of out-of-home care for Aboriginal children in Victoria was 41.5 per 1,000 at 30 June 2001, compared with an average of 21.1 per 1,000 Aboriginal children for Australia as a whole.[31]

Table 8: Aboriginal and/or Torres Strait Islander children in out-of-home care: relationship and Indigenous status of caregiver, 2001 to 2002, Victoria

Indigenous status and relationship of caregiver	30 June 2001		30 June 2002	
	(number)	(per cent)	(number)	(per cent)
Indigenous relative/kin	89	19.6	87	17.8
Non-Indigenous relative/kin	52	11.5	64	13.1
Other Indigenous caregiver	115	25.3	100	20.4
Indigenous residential care (a)	na	na	20	4.1
Total placed in accordance with the Aboriginal Child Placement Principle	**256**	**56.4**	**271**	**55.4**
Other non-Indigenous caregivers	154	33.9	176	36.0
In non-Indigenous residential care	44	9.7	42	8.6
Total not placed in accordance with the Aboriginal Child Placement Principle	**198**	**43.6**	**218**	**44.6**
Total Indigenous children in care	454	100.0	489	100.0

Source: Australian Institute of Health and Welfare 'Child Protection Australia (various years)'; Productivity Commission 'Report on Government Services (various years)'

(a)   This item was incorporated with 'Other Indigenous Caregiver' in 2001.

At 30 June 2002, of the 489 Aboriginal children in out-of-home care, only 55 per cent were placed under the Aboriginal Child Placement Principle[32], with 87 being with Aboriginal relatives, 64 with a non-Aboriginal relative, 100 in other Aboriginal families and 20 in Aboriginal residential care. Of the 45 per cent not placed under the Principle, 176 were with non-Aboriginal families and 42 were in non-Aboriginal residential care (Table 8). While the numbers of children aged from birth to eight years in out-of-home care are not known, on a pro rata basis it is estimated that approximately 200 children have experienced the trauma of family breakdown and removal.

Summary

The health, education and wellbeing status of Aboriginal children aged from birth to eight years falls well below that of their non-Aboriginal peers and is a concern expressed by many of the community members consulted for this project.

The analysis of the socioeconomic, health, education and child protection data for Aboriginal children and families in Victoria has highlighted a number of points:

- Aboriginal infants are more likely to die during pregnancy, to be stillborn, and to die in the first 28 days of life than non-Aboriginal children.

- Aboriginal children are more likely to suffer from a range of vaccine-preventable infections and other infections, such as ear and respiratory infections, than non-Aboriginal children.

- Aboriginal children are over-represented in the child protection system.

- Aboriginal children are less likely to achieve relevant literacy and numeracy standards than non-Aboriginal children.

- Aboriginal children are more likely to experience poverty during their life than non-Aboriginal children.

- Aboriginal people have a predicted life expectancy approximately 20 years less than the predicted life expectancy of all Victorians.

The Best Start demonstration projects are designed to strengthen the coordination of universal services and to better support children and families throughout the first eight years of life. Recommendations for addressing the issues through the Aboriginal Best Start demonstration projects are on pages 6 and 7 of this report.

[27] Teacher assessments against CSFII, 2001

[28] MCEETYA 2001, Special Indigenous survey

[29] In 2002 the Department of Human Services, the Child Protection Service and the Victorian Aboriginal Child Care Agency signed a new protocol and funded a new service to provide consultation to child protection when an Aboriginal child is notified. The Victorian Aboriginal Child Care Agency operates the Aboriginal Child Specialist Advice and Support Service (ACSASS) Statewide, except in the Mildura Local Government Area, where the Mildura Aboriginal Corporation operates the service. As of October 2002, the Child Protection Service is required to consult with ACSASS about every Aboriginal child notified to ensure an Indigenous perspective on risk is considered. The ACSASS assists the Child Protection Service in their decision to investigate the notification and, where this is the case, will attend with the Child Protection Service to assist the family to prevent the need to proceed to court or to have the child placed away from the home. Where the risk warrants the child to be placed for a period of time away from home, the ACSASS assists the Child Protection Service to identify a suitable kinship placement.

[30] Australian Institute of Health and Welfare 2002.

[31] Department of Human Services, Child Protection data 2002.

[32] Many of the issues surrounding the child protection service have been addressed by the implementation of a new protocol between the Department of Human Services, the Child Protection Service and the Victorian Aboriginal Child Care Agency. The Child Protection Service is required to consult with the ACSASS about every Aboriginal child notified to ensure an Indigenous perspective on risk is considered. The ACSASS assists the Child Protection Service in their decision to investigate the notification and, where this is the case, will attend with the Child Protection Service to assist the family to prevent the need to proceed to court or to have the child placed away from the home. Where the risk warrants the child to be placed for a period of time away from home, the ACSASS will assist the Child Protection Service to identify a suitable kinship placement.

Overview of the literature

Introduction

There appears to be significant gaps in the knowledge about ways to improve the health and wellbeing of Aboriginal children in Victoria. This includes formal documentation of the process of program development and details and outcomes of programs. Government has undertaken much of the research into the Indigenous community on a national level. Government-sponsored taskforces, such the Ministerial Council for Employment Education Training Youth Affairs (MCEETYA) Taskforce on Indigenous Education 2001 and the recent *Overcoming Indigenous disadvantage report 2003* (MCEETYA 2003) highlight the health and education issues nationally and provide extensive national statistical reporting.

The MCEETYA Taskforce on Indigenous Education 2001 developed a discussion paper, which examined a range of health, education and wellbeing issues for Aboriginal children. Following high level advice, the report summarised nine health issues that affect Aboriginal and Torres Strait Islander children aged from birth to eight years. Those issues are:

- lower life expectancy at birth
- low birth weight and failure to thrive
- poor quality diet
- high disease rates, especially chronic ear and respiratory infections
- social and emotional wellbeing
- substance misuse

- adolescent pregnancy
- childhood trauma
- childhood injury.[33]

The MCEETYA report highlights the impact of new evidence of the importance of early childhood and the impact a poor beginning to life has on children. It proposes strategies to improve outcomes for children aged from birth to eight years. The general evidence base does not separate the needs of Aboriginal and non-Aboriginal children; however, research notes the risk and resiliency factors and the impact of multiple risk factors on child development which many Aboriginal children in Victoria experience.

Child development

The renewed emphasis by government on the importance of the early years is a result of evidence gained from national and international research, which has been broadly recognised by government and well documented in the Best Start project documentation.[34] *The review of the early years: the evidence base* (DHS 2001) will not be replicated in this document, but is available from <www.beststart.vic.gov.au>.

The research has significant implications for program planning to lower risk factors and to improve the resiliency of Aboriginal children in Victoria. As highlighted in the profile of Aboriginal children and their families earlier in this report, Aboriginal children in Victoria have higher rates of illness, lower life expectancy, are exposed to the child protection system, and have lower rates of attaining literacy and numeracy standards than non-Aboriginal children in Victoria.

Table 9: Risk factors in early childhood associated with adverse outcomes[35]

Child characteristics	Parents and their parenting style	Family factors and life events	Community factors
- Low birth weight - Birth injury - Disability - Low intelligence - Chronic illness - Delayed development - Difficult temperament - Poor attachment - Poor social skills - Disruptive behaviour - Impulsivity	- Single parent - Young maternal age - Depression or other mental illness - Drug and alcohol abuse - Harsh or inconsistent discipline - Lack of stimulation of child - Lack of warmth and affection - Rejection of child - Abuse or neglect	- Family instability, conflict or violence - Marital disharmony - Divorce - Disorganisation - Large family size/rapid successive pregnancies - Absence of father - Very low level of parental education	- Socioeconomic disadvantage - Housing conditions

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[33] MCCEETYA 2001, p.15

[34] Department of Human Services 2001a, 2001b (and the Best Start program outline)

[35] Centre for Community Child Health 2000

Table 10: Protective factors in early childhood associated with prevention of adverse outcomes[36]

Child characteristics	Parents and their parenting style	Family factors and life events	Community factors
• Social skills • Easy temperament • At least average intelligence • Attachment to family • Independence • Good problem solving skills	• Competent, stable care • Breastfeeding • Positive attention from parents • Supportive relationship with other adults • Religious faith	• Family harmony • Positive relationships with extended family • Small family size • Spacing of siblings by more than two years	• Positive social networks (for example, peers, teachers, neighbours) • Access to positive opportunities (for example, education) • Participation in community activities (for example, church).

Antenatal care

It is clearly documented that high quality and culturally relevant antenatal care is essential to improving maternal health and to increasing the birth weight of infants.[37] Aboriginal babies in Victoria are more likely to be born with a low birth weight than non-Aboriginal children.

The National Council of Health and Medical Research reports a lack of culturally appropriate maternity services for Aboriginal women. Aboriginal mothers living in an urban setting are less likely to attend antenatal clinics than other Australian mothers and to attend such clinics later in their pregnancy because of the perceived cultural insensitivity of many of the services. The report indicates that Aboriginal mothers 'were found to have adverse pregnancy outcomes at one and a half to two times the rate experienced by the non-Aboriginal population'.[38]

Other reports have drawn attention to the strong link between poor use of antenatal services among urban and rural Aboriginal women and poor pregnancy outcomes.[39]

Findings from these reports point to the need for antenatal services that specifically target Aboriginal women and employ the services of Aboriginal health or liaison workers as well as midwives who are accepted by the Aboriginal community. In many parts of Australia, there is an almost total lack of culturally appropriate antenatal care or birthing services for Aboriginal women. Male doctors who, for many Aboriginal women, are culturally unacceptable provide many antenatal and obstetrics services.[40]

Low birth weight

The significance of being born with a low birth weight (which results from either premature delivery or from poor intra-uterine growth) is a major risk factor and a significant cause of death or illness among Aboriginal children. Very low birth weight might be linked to developmental problems in early childhood, such as delayed physical and intellectual growth. Low birth weight might also be linked to long term health problems, such as Type 2 diabetes and cardiovascular and kidney disease.[41]

International research highlights the need for health and nutrition education programs, which promote maternal health, nutrition and weight gain in pregnancy.[42] It is suggested that in Australia Aboriginal community members design and implement such programs so that they are tailored to meet the needs of particular communities (that is, urban, rural and remote).

There are a number of programs developed in Australia that are quoted in the literature as being effective in improving birth weight. The most notable one is the Strong Woman, Strong Babies, Strong Culture program conducted in the Northern Territory.[43] As this program covers remote areas in the Northern territory, it might have limited applicability to Victoria.

Closer to home, the Koorie Maternity Services project in Victoria has sought to improve the antenatal and postnatal care of Aboriginal women in high need locations.[44] Early evaluation of the Women's Business Service at the Mildura Aboriginal Health Service indicates the women who participated (including two grandmothers) had a high level of satisfaction with the service.[45] The study underlines the importance of providing relevant and culturally sensitive maternity services for Aboriginal women.

Social isolation is another risk factor in relation to low birth weight and a recent international study in the United Kingdom has identified that the provision of support and a reduction in isolation among pregnant women might reduce the likelihood of at risk women having low birth weight babies.[46] It has been widely accepted over many decades that good antenatal care improves the health and wellbeing of mothers and babies and most mothers and babies are well cared for in the mainstream health system. For a small group of Aboriginal women in Victoria, a more flexible and

relevant maternity service that provides a holistic approach to care might improve the outcomes for mothers and their babies.

Child health

The major reports discussed in this section are national reports. Some of the key findings of these reports relate primarily to remote communities and might only be useful as indications of child health in Victoria. It is clear from the Victorian data on hospital admissions and the child protection data that the health and wellbeing profile of Aboriginal children is not as good as that of non-Aboriginal children.

Infections

High rates of infection are frequently associated with unsatisfactory, overcrowded and unhygienic living conditions.[47] Among Aboriginal infants and young children, acute infectious diseases, including gastroenteritis and acute respiratory disease, are a cause of major illness and suffering from infancy onwards. 'The cycle of 'bowel' infections, diarrhoea, malabsorption, failure to thrive and decreased resistance to infection leading to malnutrition is well recognised'.[48]

This issue appears to be of much greater significance nationally. The Victorian data discussed earlier in the report, while concerning, are not as alarming as the national data. The national figure for hospital separations for a diagnosis of intestinal infectious diseases for children less than four years of age is 46.6 per 1,000, whereas in Victoria for children less than eight years of age it is 6.0 per 1,000.[49] The rate of hospital admissions for non-Aboriginal children aged less than eight years in Victoria for this diagnosis is 3.9 per 1,000.

The hospitalisation rate for respiratory disease for Aboriginal children nationally is twice that for non-Aboriginal children.[50] In Victoria, the rate of admission to hospital for respiratory infections for Aboriginal children is also twice that for the non-Aboriginal population. It is considered that repeated infection in conjunction with poor nutrition and unhygienic conditions affects not only the general health of Aboriginal children but also contributes to growth failure in early childhood.[51]

Acute respiratory disease is also associated with otitis media. Otitis media is a major cause for concern among Aboriginal children and as Nienhuys (1988) has reported: 'Australian Aboriginal infants, pre-schoolers and school-aged children suffer alarmingly high rates of conductive hearing loss due to early, recurrent otitis media'.[52]

Repeated ear infections, typical among Aboriginal children, place children at high risk of permanent hearing loss and disadvantage them both as children at school and as adults seeking employment. A school-based project undertaken in 1998–99 in Alice Springs, Darwin and at a number of remote sites and involving about 1,000 students showed that 79 per cent of Aboriginal students were found to have an educationally significant hearing impairment.[53]

While to date no definite cause has been found for otitis media in Aboriginal children, Coates et al. (2002) draw attention to the role played by limited access to appropriate health services. While otitis media can affect children of all ages, it is the younger children who are more likely to experience repeated infection. Typically, among Aboriginal children, rupture of the eardrum begins within the first three months of life and repeated infections are the rule rather than the exception. Constant inflammation and perforation of the eardrum can cause permanent damage.[54]

In the Victorian population, the rate of admission to hospital for ear infections is greater for Aboriginal children (7.7 per 1,000 children) than for non-Aboriginal children (5.5 per 1,000). However, the key message from the *Overcoming Indigenous disadvantage* report is that data deficiencies, particularly in the birth to three year age category, make the real extent of the problem difficult to ascertain (though hospital admissions for ear infections on a national level indicate a significantly higher rate for Aboriginal children).[55]

[36] Centre for Community Child Health 2000

[37] Najman, Williams, Bor et al. 1994

[38] National Health and Medical Research Council 2000, p. 91

[39] National Aboriginal Health Strategy Working Party 1989; de Costa and Child 1996; Chan et al. 1997; National Health and Medical Research Council 2000

[40] National Health and Medical Research Council 1996b

[41] Australian Parliament 2000; Australian Institute of Health and Welfare 2002b

[42] MCEETYA 2001, p.19

[43] MCEETYA 2001, p.19

[44] Campbell, S. 2000

[45] Campbell, S. and Brown S. p48

[46] Department of Human Services 2001c

[47] Australian Parliament, 2000

[48] Engeler et al. 1998, p. 9

[49] MCEETYA 2003, 5.4

[50] MCEETYA 2001a

[51] MCEETYA 2001a

[52] Quoted in Higgins 1997, part 2:2.

[53] MCEETYA 2001a, p.22

[54] Australian Parliament, 2000

[55] MCEETYA 2003, 5.23

In its report for the Council of Australian Governments, the Productivity Commission commented that identifying risk factors for otitis media might increase the chances for prevention and early intervention. The report concluded that possible risk factors might include:

- relatively higher bacterial colonisation in Indigenous infants

- a link between the early first onset of otitis media and the increased risk of recurrent infections (the link has been found in some studies)

- the fact infection in adults might increase the risk of ear infection in children

- high rates of smoking within the Indigenous population, which might contribute to the prevalence of ear infections.

The report cautioned that while few studies had been undertaken to evaluate the relationship, malnutrition and the development of otitis media might be related.[56]

Childhood trauma – abuse and neglect

The two main sources of trauma for children are family violence and child abuse and neglect, and the two have been found to co-exist in 30–60 per cent of cases.[57] The numbers of Aboriginal children notified to the child protection system in Victoria have increased much more over the past few years than the numbers of non-Aboriginal children and young people notified. For example, between 1996-97 and 2001-02, the number of Aboriginal children notified to the child protection system increased by 84 per cent while the number of non-Aboriginal children and young people notified increased by only 17 per cent. The rate of notification for Aboriginal children is at 120.5 per 1,000 children, compared with 24.9 per 1,000 children for the non-Aboriginal population.[58]

The child protection outcomes report, *Protecting children: The child protection outcomes project 2003*, notes that involvement of Aboriginal children and families in Victoria's child protection system indicates there are 'serious and entrenched' child protection concerns in the communities.[59] The Department of Human Services also tracks 'parental characteristics of concern' involved in child protection matters, including mental illness, intellectual and physical disability, alcohol abuse, substance abuse and domestic violence. The percentage of all parents with these characteristics increased significantly between 1996–97 and 2001–02. These characteristics are associated with higher levels of involvement with the child protection system.[60]

Finally, the report notes that 'based on current experience, it is projected that 19.9 per cent of the cohort born in 2003

who group up in Victoria will be notified at some time during their childhood or adolescence'.[61] Clearly, the area of child abuse and neglect is the most dramatic demonstration of the need to strengthen prevention and early intervention services and family support services.

Family violence

The National Child Protection Clearing House for the Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities prepared a comprehensive research paper on child abuse and family violence in 2002.[62] The report noted that, as in the broader Australian community, the extent of family violence in the Aboriginal community is unclear, although it is known that violence levels are much higher in the Aboriginal community than in the non-Aboriginal population.[63] The issue of family violence for Aboriginal people is complex, due to the overlay of social and economic disadvantage over the past traumas of dispossession and the large scale removal of Indigenous children from their families.[64] The Aboriginal community in Victoria has expressed concern that their children are 'becoming hardened to the issue of family violence', highlighting the risk that family violence is becoming a normal part of life.[65]

Family violence and child abuse frequently co-exist, as evidenced by the Victorian child protection data which indicate that in 40 per cent of the families investigated for alleged abuse or neglect, the parents were identified as having been subjected to family violence. While family violence occurs in both the Aboriginal and non-Aboriginal communities, research indicates that in some Aboriginal communities such violence affects up to 90 per cent of the families, with 70–90 per cent of the assaults committed under the influence of drugs or alcohol.[66]

A recent Queensland study found a 'very high level of awareness and concern about the effects [of violence] on children'.[67] The Queensland Aboriginal and Torres Strait Islander Women's Task Force on Violence has pointed out that 'the rising incidence in family violence in Aboriginal communities is associated with increases in child abuse'.[68] They also reported that many Aboriginal children experience multiple traumatic situations because, as well as witnessing family violence, they are also exposed to general violence within the community, family deaths, extreme poverty and displacement.[69]

Strategies to address the barriers for risk families include the Victorian Family Violence Strategy which led to the establishment of an independent Indigenous Family Violence Task Force to support, empower and enable Aboriginal

communities to examine family violence issues and to develop solutions appropriate to local conditions and needs. It is anticipated that this will occur through raising community awareness and understanding, building community capacity and engaging communities in the development of local responses, as well as recommending the content of a Statewide response. Under the Indigenous Family Violence Strategy, Indigenous local action groups have been established and Indigenous family violence support officers are located in the nine Department of Human Services regions of Victoria.

Nutrition

Early childhood development is enhanced by the breastfeeding of infants. For many Aboriginal infants who are particularly vulnerable as a result of being born with a low birth weight, adequate nutrition through breastfeeding provides an important 'kick start'.

The importance of appropriate nutrition in infancy and early childhood is well established and is being addressed by the OATSIH strategy, which was introduced in the late 1990s to encourage continued breastfeeding and appropriate introduction of solids. It is a well established fact that breastfeeding during the first 13 weeks of infant life is strongly recommended because of the considerable advantage it generally provides for an infant's healthy development, a reduction in gastrointestinal illnesses and, to some extent, a reduction in respiratory illness. However, a baby needs to be breastfed for at least three months to obtain these benefits.[70] OATISH implemented a strategy because of a concern about a 'possible trend for urban and young mothers to stop breastfeeding, the associated introduction of inappropriate foods to infants at an early stage, and delayed introduction of additional solid food to infants in other areas where prolonged breast feeding is still common and/or mothers may be malnourished'.[71]

For Aboriginal women living in more settled or urban areas, their babies' nutritional problems often revolve around the introduction of solids too early in life. Recent reports indicate that among Aboriginal women living in urban areas there is a decrease in the prevalence and duration of breastfeeding, with Aboriginal women tending to breastfeed for about as long as non-Aboriginal women of similar socioeconomic background. Engeler et al. (1998) cites evidence from an urban study carried out by the Victorian Aboriginal Health Service which 'found that while 85 per cent of infants were breastfed initially, only 50 per cent continued to breastfeed at three months of age'.[72]

Maternal mental health

Maternal mental health is an important variable in early childhood development, with a recent study concluding that poor maternal mental health has a significant impact on the physical and the mental health of children.[73] Maternal depression is one factor found to lead to a lower level of interaction between mother and child, which can result in poor attachment. It can also lead to other adverse outcomes, such as 'poorer mental and motor development in later infancy, emotional difficulties in late infancy, and poorer cognitive outcomes among pre-school aged children'.[74]

Many risk factors have been identified as being associated with maternal mental health problems. These include the age of the mother, lack of antenatal care, low socioeconomic status or financial hardship, isolation with little social support, problems with alcohol or other substance misuse, violence within the family, low self- esteem and bereavement or grief.[75] While many of these risk factors are relevant to Aboriginal women, bereavement and grief are ever-present in the Aboriginal community because of the high number of premature deaths of Aboriginal children and adults. Such grief and bereavement can also affect children. 'Mental health research into the peri-natal period shows that bereavement and grief negatively impacts on the physical and mental development of children'[76] and can affect their social and emotional wellbeing.

56 MCEETYA 2003, 5.14
57 MCEETYA 2001a
58 DHS, 2003
59 ibid, p.7
60 ibid, p.10
61 ibid, p.12
62 Gordon, S 2002
63 ibid, p.3
64 ibid
65 Community consultations
66 MCEETYA 2001a, *citing Partnerships against Domestic Violence*, *Projects with Indigenous Communities 2000*
67 cited in MCEETYA 2001a, p.29
68 cited in MCEETYA 2001a, p.29
69 cited in MCEETYA 2001a, p.29
70 National Health and Medical Research Council 2000
71 Groos et al. 1998, p.1
72 Engeler et al. 1998, p.6
73 Department of Human Services 2001b
74 MCEETYA 2001a, p.25
75 MCEETYA 2001a
76 Kowalenko cited in MCEETYA 2001a, p.18

Early childhood education

Early childhood education is defined internationally as education occurring in that period of life from birth to eight years of age and includes children's learning and development at home with their families, family day care, long day care, occasional day care, sessional preschool and kindergarten, and the first years of school. Parents play the major role in fostering conditions which allow for optimal development; this is of crucial importance to the developmental needs of their children.[77] Good parenting skills are vital to this task; however, there are many parents who lack appropriate parenting skills because of a lack of appropriate role models in their own life, isolation, maternal depression and the existence of single parent families in low socioeconomic circumstances. Research reinforces the need for parents to pay attention to the developmental needs of their young children.

Preschool is important because it provides developmentally appropriate programs that further the social, emotional, cognitive, physical and language development of children and encourages the involvement of families. International and Australian research indicates that attending preschool improves the quality of children's experiences in their later schooling. Participation in preschool ensures children establish foundations to assist them for life. Unfortunately, a disproportionate number of Aboriginal children do not have this early experience of such literacy precursors. They do not attend playgroups, early child care or preschools and might be severely disadvantaged in comparison with other Victorian children when they enter school after the age of five.

Universal community agencies, such as preschools and schools, are uniquely positioned to effectively support parents in the task of raising children. To fully realise this potential such agencies must be attractive, accessible and responsive to the needs of the families.[78] The many early childhood service providers and agencies in Victoria endeavour to create a network of relationships as a way of strengthening the community links that support families[79] and in doing so make communities more family and child friendly.

This process of ensuring the community networks around early education are strengthened involves identifying and overcoming barriers to engagement, developing effective communication practices, making the physical environment welcoming, encouraging parent participation, and developing the skills of staff in working with parents and families.[80]

As noted earlier in this report, a significant amount of research has been undertaken into the importance of early childhood. There has been less emphasis on the early childhood programs that link child-focused activities with adult-focused activities. Those that have believe they produce the best results for children's development.[81]

Research in New Zealand points to the benefits for parents of holistic early childhood programs that expand 'the parent's ability to take on work and further education and increase their self-esteem and skills'.[82] It is programs that provide a holistic approach to childhood education that might have the greatest relevance for the Aboriginal community. The National Australian and Torres Strait Islander Education Policy endorses this principle and the Aboriginal Student Support and Parent Awareness Program makes resources available to Aboriginal parent committees to enable them to be involved in their children's education.[83]

Generally, Aboriginal parents want their children to attend some form of early education and care because of its recognised value in giving children a good start in primary school.[84] However, Aboriginal four year olds in Victoria are less likely than non-Aboriginal four years olds to attend preschool.[85] This is concerning, and while this lower level of participation in early education and care might relate to availability and access, Aboriginal parents perceive many of the services as culturally insensitive.[86] An additional factor for parents highlighted in the consultations for this report is the cost of preschool, despite the fact many people are eligible for financial assistance.

The need for culturally acceptable early childhood and care services is widely recognised; however, many factors must be considered in providing such services for Aboriginal children. A recurrent theme in the literature relates to the need for better preparation of non-Aboriginal teachers during pre-service training, with greater emphasis on cross-cultural understanding and the factors involved in teaching in a cross-cultural situation.[87] In particular, early childhood teachers need an awareness and understanding of the qualities and attributes Aboriginal children bring with them when they enter preschool or other early childhood settings.[88]

The Department of Human Services has made significant attempts to improve the level of preschool attendance by Aboriginal children and has developed the Koori Early Childhood Education program which aims to support Aboriginal children and their families in accessing and participating in preschool.[89]

Barriers to service access

Improving Aboriginal people's access to Aboriginal and mainstream services remains a challenge for many health, wellbeing and educational services. In Victoria, where mainstream services dominate and the Aboriginal population is relatively small and scattered throughout the State, the challenges for service planning and resource distribution are paramount. Of equal importance is the requirement to highlight the need for cultural sensitive practices within the entire service system.

National research indicates many obstacles hinder Aboriginal Australians' access to health services. They include:

• geographic factors, such as distance

• lack of personal transport and inadequate public transport[90]

• physical factors, such as the size and complexity of the building in which the health service is housed, combined with a lack of signs providing directions which allow the service to be easily located

• financial cost of medical services for those on a low income, unless bulk billing is provided [91]

• perceptions that the mainstream service is unapproachable[92]

• previous negative experiences which lead Aboriginal people to perceive mainstream services as coldly formal or racist and unwelcoming[93]

• feelings of distrust and discomfort often experienced by Aboriginal people in relation to mainstream health services [94]

• culturally inappropriate provision of 'women's services' by male doctors, especially antenatal and birthing services [95]

• lack of cross-cultural training or an understanding of cultural and lifestyle differences among medical and paramedical staff and a failure to appreciate the range of non-medical/ lifestyle factors which can be giving rise to physical or psycho-social disease among Aboriginal people [96] lack of child friendly waiting rooms.[97]

The overview of the literature and evidence highlights that the three levels of government in Australia now clearly understand the overwhelming importance of the early years and the evidence base that underlies it. Many new policies and programs are based on this evidence. The Best Start project is one example.

The literature highlights the concerns about the health and wellbeing of Aboriginal children, particularly when contrasted with non-Aboriginal children, at the national and Victorian levels. The solutions proposed to deal with the identified issues are at times not well documented or evaluated and often consist of one-off programs or one staff member from a generic service working as a specialist.

77 Department of Human Services 2001c

78 Department of Human Services 2001c, p. 29

79 Department of Human Services 2001c, p. 29

80 Department of Human Services 2001c, p.35

81 St. Pierre etal. and Yoshikama 1995, cited in Kirby and Harper DHS, 2001:35

82 cited in Kirby and Harper, p.12

83 Organisation for Economic Cooperation and Development 2000

84 Glover 1994; McRae et al.2000

85 Kirby and Harper 2001, p.43

86 Glover 1994

87 Kirby and Harper, 2001.

88 Kirby and Harper, 2001

89 DHS 2003

90 Department of Human Services 2001c

91 Department of Human Services 2001c

92 ibid

93 Najman et al. 1994

94 National Health and Medical Research Council 2000

95 Department of Human Services 2001c

96 ibid

97 Department of Human Services 2001c, p.7

Strategies and core activities for the development of best practice projects

National and international research and experiences indicate that some core activities are essential elements of a comprehensive, inclusive and accessible early years system. While the components of Best Start projects should be decided at the local level, it would seem essential that each project operates holistically and incorporates core components focused on health, education and wellbeing activities to meet the needs of children and their families.

The following list is to be used a guide when determining Best Start projects. Its compilation results from the profile of Aboriginal children and their families, the community consultations, and the review of the literature and best practice models in this report.

Core components for Aboriginal Best Start projects

Health – access to quality care

Core activities

- improve access to relevant quality antenatal care
- improve access to postnatal support
- improve access to health care for child and parent
- develop health promotion information strategy.

Practice principles

- respect Aboriginal history and acknowledge family and cultural strengths
- ensure services are culturally accessible, Aboriginal friendly and welcoming of Aboriginal families by providing environments that are culturally inclusive and include Aboriginal art, posters and literature
- improve coordination between universal and specialist services
- inform practice with information about quality programs that are known to be successful
- provide accessible information about services.

Child and family welfare

Core activities

- strengthen support services for parents in caring for their children
- improve support for parents to strengthen their skills and capacity to provide for the development and early learning of their children

- provide outreach and home-based services for those most in need
- promote safe, nurturing and child friendly community environments.

Service delivery principles

- use evidence-based concepts from quality programs
- build individual service responses about the strengths of parents, grandparents, carers and significant others to ensure the responses are culturally relevant
- promote understanding of and reinforce positive aspects of Aboriginal parenting and provide appropriate methods of parent education
- promote an understanding of the impact of family violence on child development
- promote the use of early intervention services for children and families at risk.

Education and child development

Core activities

- develop opportunities for good quality play, learning, child care, preschool and early education experiences for children before school and during the first three years
- provide support for all children and families in the transition from preschool to school with particular focus on those with special needs
- promote the use of outreach and home-based services for those in need
- promote access to culturally relevant parenting education in child development
- promote opportunities for parents to improve their literacy and further education.

Service delivery principles

- consult with Elders on relevant cultural and social activities
- use schools and school networks to connect families and community resources to promote the wellbeing of children and their families
- use best practice models as a guide.

As well as the core components, the following activities should be considered:

- information and support for families facing issues such as unemployment, housing problems, drug and alcohol abuse, domestic/family violence and child removal

- cultural and social activities, such as story telling by community Elders, camping, fishing and visits to local sites of significance

- transport for families to go to and from play centres and for older children to attend preschool and the early years of school

- agency assistance and training for health workers involved with family assessment

- activities that will smooth the transition from home to preschool and from preschool to formal schooling, such as language or literacy nests

- preschool intervention and enrichment programs, with follow-through programs until children are eight years of age.

Appendix 1

Review of best practice strategies and programs

The rationale for providing intervention programs for young children and families are threefold:

(1) Social, economic and demographic changes have placed an increasing number of families with young children in vulnerable and inadequately supported situations.

(2) The existing universal services are unable to meet all the needs of such families.

(3) The evidence clearly indicates that, without early intervention and support, the health, education and developmental outcomes for many of the children from such families will be adversely affected.[98]

This section explores potential practices that could be considered in developing strategies for the Aboriginal Best Start demonstration projects. It presents a review of specific programs that pose solutions to problems; however, it is not exhaustive and not all programs have been comprehensively evaluated.

The literature and community consultations highlight that effective practice needs to include Aboriginal practice principles and to be culturally relevant, child focused and informed by evidence.

Victorian programs

Rumbalara Medical Clinic, Goulburn Valley Koori Women's Resource Group, Shepparton

This is a birthing program that was originally a pilot program but now has recurrent funding from the Commonwealth Government. The program provides both antenatal and postnatal care, antenatal education, birthing support and a health service for children in early childhood. Transport is provided to help mothers access the clinic.

Aboriginal women still have their babies in the local hospital, but it is not uncommon for them to be discharged after only two days. The birthing program is able to provide support for mothers in this situation, particularly in continuing breastfeeding after discharge from hospital.

Strengths of the program

The self-assessment of the program's strengths identified its cultural appropriateness, flexibility, reliability, and assurance of confidentiality, and the fact it is community-based, owned and controlled.

It was clear that further service development, such as the inclusion of a birthing centre staffed by an Aboriginal midwife, more Aboriginal health workers or pregnancy support workers, would increase the level of support for women.[99]

Aboriginal Children's Health Promotion Project – Victorian Aboriginal Health Service

This research-based project, which began in 1992, is a joint initiative of the Victorian Aboriginal Health Service and the Koori community and has involved the production of health related educational materials. These materials were produced to highlight key health promotion initiatives to reduce the level of recurrent respiratory infection among young Aboriginal children, possibly exacerbated by exposure to passive smoke. The health promotion activity also sought to promote the advantages of breastfeeding and to encourage support for breastfeeding in the community. One of the other aims of the project has been increasing the level of support for women during the antenatal and postnatal periods and when their children are very young. The support was seen as the key to alleviating stress of parenting and to increasing women's self-esteem and wellbeing.[100]

Key initiatives of the project are the establishment of boorai (baby) classes, the provision of country camps for Aboriginal women to give mothers time out from their problems and time to relax, and the production of educational materials. Health worker training was also a part of the project and was intended to provide the workers with the necessary skills and knowledge to give mothers comprehensive information about breastfeeding. It was anticipated that this educational strategy would provide mothers with the knowledge to make informed choices about breastfeeding.

Effectiveness of the project

Various factors have contributed to the effectiveness of this project's services, including its community base and ownership, the thoroughness of the original research, which ensured the project was targeted, the use of local women in the posters and video, and a 'conscious attempt to engage the community in the process of cultural development'.[101] A major problem has been securing ongoing funding for the women's camps.

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[98] Engeler et al. 1998, p.57

[99] Engeler et al. 1998, p.103

[100] Engeler et al. 1998, p.104

[101] MCEETYA 2001a, p.37

The Koori Maternity Services Project

The Koori Maternity Services Project in Victoria was developed by the Victorian Aboriginal Controlled Health Organisations and funded by the Department of Human Services. The project, based on extensive consultation and identification of service gaps, informed some key recommendations which led to the implementation of Koori maternity service projects at a number of sites. These projects offer important services not currently available to many Aboriginal women in Victoria. The services offer a holistic and flexible model of care to respond to client needs as they occur. Early indications are that the project has been able to deliver better service satisfaction for pregnant Aboriginal women.

Multifunctional Aboriginal Children's Services (MACS) centres

MACS centres are based in Thornbury, Mooroopna, Lakes Entrance, Bairnsdale, Echuca, Robinvale and Morwell. They were established out of the recognition that many Aboriginal children are disadvantaged as a result of factors such as the denial of their cultural identity, poverty, and an educationally deprived background.

The centres' philosophy is based on the right of Aboriginal children to access culturally appropriate learning centres that can nurture and monitor their educational progress. The centres meet the needs of Aboriginal children by providing programs that enhance cultural, physical, socio–emotional, language and learning development. MACS centres provide a cultural awareness program, long day care, and out-of-school-hours care.

Happiness, Understanding, Giving and Sharing (HUGS) program

The HUGS program is an early intervention program developed by Alys Key Family Services in the 1990s to support vulnerable families in the West Heidelberg area. It is designed for parents who have difficulty relating to their babies and preschool children.

The HUGS program aims to develop attachment behaviour by encouraging more positive interaction and enjoyment between parents and children. The program seeks to identify why interaction is not occurring and uses a range of activities and strategies to change the situation. Families who are most likely to benefit from the HUGS program are families under significant stress. They might have had their first child during their mid to late teens, be single mothers, lack self-esteem, or be grieving over a range of issues, including the legacy of stolen generations and family violence and abuse.

Sing and Grow Program structure and outcomes

The Sing and Grow Program sessions, part of the HUGS program, are conducted within a family–centred model of care. The program goals focus on providing opportunities for improved and increased interaction between parents and their children and opportunities for infants and young children to receive appropriate developmental stimulation. The session plans use music–based interactive activities and are devised to increase opportunities for the playful interaction of parents and babies within a structured yet flexible environment.

Roots of Empathy

Roots of Empathy is an evidence–based model of intervention designed as a classroom–based parenting program targeted at children. It aims to reduce aggression by fostering empathy, emotional literacy and positive social behaviour. It strives to break the intergenerational transmission of poor parenting and violence and to build the parenting capacity of the next generation of parents.

The goals are to:

- foster the development of empathy (compassion and understanding)
- develop emotional literacy (an understanding of relationships)
- prepare students for responsible and responsive parenting
- reduce the levels of bullying, aggression and violence in children's lives and build peaceful societies
- increase knowledge of human development, learning and infant safety.

Aboriginal Playgroups in regional areas of Victoria

Winda-Mara Aboriginal Corporation

The Corporation has a number of functions aimed at improving the wellbeing of Aboriginal people. Among the many activities the corporation organises is a playgroup that aims to strengthen, revive and develop Aboriginal culture. Other aims are to:

- improve the health, housing and education of Aboriginal people
- create employment for Aboriginal people and foster the establishment of Aboriginal enterprise
- develop a working relationship with the Kirup Jmara Corporation with regard to the Lake Condah Mission

- own Gunditjmara traditional homelands, sites and articles of material culture.

The Corporation covers the geographical areas of Portland, Heywood, Hamilton, Lake Condah and surrounding areas.

Ballarat and District Aboriginal Co-operative

The Co-operative has a children's services officer who has been operating from the Co-operative for approximately ten years. The venue provides a weekly junior and senior youth club, after school activities, holiday programs, cultural and family camps, sport, art and craft activities, and day trips (excursions of a cultural, educational and recreational nature). The children's services officer also assists with the pre-kinder centre as needed.

Wathaurong Aboriginal Co-operative

The Co-operative is a vital meeting place for women and children. The children are provided with an educational playgroup where they can meet other Aboriginal children and learn about their culture. The playgroup provides a venue for mothers to meet and provides mutual support. The mothers have developed a support group which plans outings for children, mothers and Elders.

Health and wellbeing programs are also provided from the Co-operative and they include immunisation, health promotion, diabetic and hearing screening, and speech therapy. Support and practical assistance is available to parents. The children's services worker plays a vital role as she is in touch with children's needs and is in a position to assist parents, especially single parents.

Goolum Goolum Aboriginal Co-operative

The Co-operative's preschool worker and children's services worker have developed programs at different kindergartens for Aboriginal children. There is liaison with parents and the workers are accessible to the Aboriginal community for advice.

The Co-operative area is from Stawell, Murtoa and St Arnaud in the east to Kaniva on the South Australian border and up to Rainbow and Warracknabeal in the north and half way to Hamilton in the south. The majority of the community lives in the Horsham District.

Batdja Aboriginal Corporation

Batdja provides a preschool and playgroup for three year old Indigenous children. The playgroup aims to give Indigenous children the opportunity to attend a structured program before they go to preschool. The playgroup gives parents the opportunity to meet in an informal, culturally inclusive setting. It allows parents to see the preschool experience is positive for their children. Family involvement in Batdja is essential to the program's success and families are encouraged to participate in the playgroup and preschool experience of their children.

National models

South Australian programs

South Australian Local Child Development and Parenting Centres

In South Australia there are child development and parenting centres in four communities known as 'centres of excellence'. Each centre provides:

- outreach services to parents and children as well as centre-based services
- opportunities for parents to learn about parenting skills and child development
- opportunities/experiences for involving and supporting parents
- assistance to children for the development of early literacy and numeracy skills
- a centre for community relationship building and participation.[102]

Northern Territory programs

Alice Springs Women's Council, Nutrition Awareness Project for Young Mothers

This program addresses the introduction of solid food in infancy ('every body breastfeeds'!). Senior women in the area initiated the program because of their concern about the high rates of hospitalisation of young infants due to failure to thrive. The service provides a home visiting service as an alternative to centre-based services and a nutrition officer who speaks the language of the community. The service also has a 'broad-based, advocacy role in addressing the problems (for example, the lack of nutritious foods available in stores)'.[103]

Strengths of the service

The project is acceptable to the community as it was initiated and is controlled and owned by the women of the community. A major weakness is the lack of ongoing funding and the need to 'juggle funding from numerous sources'.[104]

Strong Women – Strong Babies – Strong Culture (SW–SB–SC) Project

The SW–SB–SC project (1992–96) was introduced into selected Aboriginal pilot communities in the Northern Territory as a result of research indicating that maternal nutrition was a significant factor determining the outcome of pregnancy, particularly low birth weight infants. The Northern Territory Health Service and the Commonwealth Department of Human Services and Welfare funded the project.

The project was developed jointly by senior Aboriginal women and health workers and adopted a cultural family model, rather than a medical model, for antenatal care. The implementation of the project in the selected communities was also in the hands of senior Aboriginal women and the appointment of a respected older Aboriginal woman as coordinator is believed to have facilitated the project's implementation.

The project objectives involved the production of a 'strong women's story' and a resource kit. The illustrated narrative story highlights the importance of nutrition during pregnancy and identifies factors which interfere with a healthy pregnancy and healthy birth. It also looks at the specific factors within the existing health system which act as barriers to obtaining appropriate antenatal and birthing care and the way in which women can regain control over their own and their children's health. The importance of cultural affirmation and revival of traditional women's ceremonies was an integral part of the narrative.

Outcome of project

As a result of the project, traditional women's ceremonies have been revived, especially those relating to young women, pregnancy and childbirth, and antenatal services have been modified to provide effective high quality care delivered in a culturally appropriate manner.

An evaluation of the program in the three pilot communities[105] revealed a significant drop in the prevalence of babies born with a low birth weight following the introduction of the SW–SB–SC program, with some communities showing a decline in infants born with a low birth weight from 17 per cent to 5 per cent. There was also an increase of 141 grams in the mean birth weight of babies and women were found to be participating earlier in antenatal care.[106]

A second evaluation[107] found that while initially there had been a reduction in the prevalence of low birth weight babies as a result of the SW–SB–SC program, it seems to have reached a plateau. It was suggested that a further reduction in the incidence of low birth weight babies was likely to depend on effective smoking programs to reduce the incidence of smoking during pregnancy.[108]

The program evaluation indicates that the program had been well received by the women in the different communities, that it could be tailored to local conditions and cultures, and that the short term success could be seen in improvements to the health of the children. The reported weaknesses relate to a lack of funding and to the need for more nutrition workers and in-service nutrition training for workers.[109]

Yipirinya School

The Yipirinya School in Alice Springs has adopted a holistic approach to meet the many needs of the preschool children who come to the school. This approach focuses on the whole child, not just on his or her academic needs and addresses all the needs of the child at preschool level: 'health, nutrition and emotional welfare as well as familiarity with routine tasks in preparation for formal learning'.[110]

In addition, Yipirinya has embarked on a whole year scaffolding literacy project to improve literacy among its Aboriginal students. The project, which targets all students from preschool through to the new post-primary class, has been designed specifically to address the needs of Aboriginal students who do not speak standard English as their first language, who come from a low socioeconomic background, and who have a hearing impairment or visual or social/emotional problems which impact on their ability to acquire literacy skills.[111]

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[102] Engeler et al. 1998, p.63

[103] Engeler et al. 1998, p.63

[104] Mackerras 1998

[105] National Health and Medical Research Council 2000; MCEETYA 2001a

[106] d'Espaignet and Measey 1998

[107] National Health and Medical Research Council 1996; Butlin et al. 1997; Engeler et al. 1998; MCEETYA 2001a

[108] Butlin et al. 1997; Engeler et al. 1998

[109] Australian Parliament Senate Employment, Education and Training Reference Committee 1996, p.166

[110] Australian Parliament Senate Employment, Education and Training Reference Committee 1996; Gray 1998

[111] Engeler et al. 1998

Anyinginyi Congress Aboriginal Corporation, Tennant Creek

This Aboriginal-controlled service offers a wide range of services, including a playgroup and health services. The health service employs a midwife who, together with the Aboriginal health workers, provides antenatal care for women, support during birth, and postnatal care. During the antenatal period, women receive advice (usually on an individual basis) about infant feeding. Growth and development screening is carried out on infants. Those infants born with a low birth weight or underweight or whose weight gain is not satisfactory are given special attention and support. Home visits are conducted and transport is provided for those attending the clinic.

Outcome of the health service

The self-assessment of the service highlights its strengths as the cultural appropriateness of the services and the accessibility of the service for local residents and those living 'out bush'. However, the need for continued education and support of Aboriginal health workers in the area of maternal and child health is emphasised.[112]

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council: Nutrition Awareness Project for Young Mothers and Children

The NPY nutrition project was initiated in 1996 by a group of senior community women because of their serious concern about the welfare of young mothers and their babies, many of who were malnourished. The principal aim of the project, which targets young mothers and children aged less than five years, is to 'develop an awareness and knowledge of young mothers about solutions to the problem of failure to thrive (FFT) in their young children and also to provide health practices and strategies to maintain better health'.[113] The focus is on improving mothers' knowledge and understanding of the nutritional needs of their children.

Nutritional workshops are a major feature of the project. A senior health worker and a nutrition project officer conduct week-long workshops in communities. A nutrition manual for young mothers and an audio tape (in language) about food has been produced as part of the nutrition education program. The project also focuses attention on children who are at risk and provides crisis intervention for infants (and their mothers) who are hospitalised in Alice Springs.

Outcomes of the program

As at 1997 there had been no formal evaluation of the project; however, the workshops, which were run as part of the outreach and nutrition program in eight different

communities in the cross-border area of Western Australia, South Australia, and the Northern Territory, attracted more than 200 mothers and children. One of the important side benefits of the workshops, which were held in the clinic, was that mothers were more confident about taking their babies to the clinic at other times.

In relation to the crisis support service, by early 1997, ten families had been actively involved with the program and had received intensive support when their babies were in Alice Springs hospital.[114]

Queensland programs

Ngua Gundi – Mother/Child Project, Woorabinda, Queensland

This project, which is funded by the Commonwealth Birthing Services Project on a year-to-year basis, was introduced in 1993 to address the serious under-use of antenatal services by young Aboriginal mothers in the area. Some mothers presented at the hospital when their baby was due, having attended no antenatal care.

The initial goal of the project was to improve the antenatal attendance of adolescent mothers; it has since expanded its range of services to include older mothers, birthing support and the health needs of children in the from birth to five years age group.

An initial needs analysis indicated that the Aboriginal women in the area were reluctant to attend the Rockhampton Hospital for antenatal classes and or have their babies in the hospital.[115] The women indicated they wanted a service of their own which provided 'full maternal and childcare, with particular emphasis on antenatal and post natal care, nutrition, immunisation and family planning'.[116] The preference was for the service to be staffed by female doctors and Aboriginal health workers.

The promotion and support of breastfeeding and provision of education and support for improved infant nutrition were integrated into the maternal and child health care service. Transport is provided for mothers wanting to attend the clinic, or the midwife will visit mothers in their own homes. Adolescent mothers who do not attend for antenatal care are visited by the midwife in their homes.

Outcome of the service

There is a high level of acceptance of and involvement with the program. The program evaluation at 18 months found that women were seeking antenatal care earlier than previously, as well as attending more frequently. There has also been a significant increase in the number of women

using the antenatal service. The evaluation also found 'a declining rate of [hospital] admissions of children in the 0–5 age group with severe health problems'. [117]

The evaluation attributed the success of the project to many factors, including:

- the provision of a holistic approach to health care

- the good relationships which the Aboriginal health workers have built up with the community and the trust they have engendered in the mothers

- the fact women have been involved in all aspects of the service from the initial needs analysis, through the planning stage to its final development and implementation. [118]

Kuranda Early Childhood Personal Enrichment program (KEEP)

The aim of KEEP is to provide children who have minimal or no previous experience of 'formal early childhood groups with opportunities to participate in educational processes/activities to develop their social, literacy and numeracy skills so that they can function successfully, confidently and independently as learners in their school community'. [119] The program, which targets children from preschool to year three, was developed as a result of lengthy collaboration between teachers, parents and children at the Kuranda preschool in North Queensland, where 40 per cent of the students are Aboriginal. It is based on a positive approach to early childhood education, avoids negative stereotypes and, rather than focusing on learning deficits, concentrates on the strengths which each child brings into the classroom setting. 'As part of KEEP, extensive 'hands on' activities were designed to reinforce and enhance the children's primary Aboriginal culture, building on existing skills and recognising the appropriateness of an oral mode of learning'. [120]

The program not only seeks to tailor teaching practice to the individual needs of the child, but incorporates activities which involve gross motor skills, such as dancing, as well as bush survival skills and awareness of the environment. Culturally appropriate activities are provided in both one–to–one and small group situations and are reported to have provided the most successful learning experience for children in the program. [121]

New South Wales programs

Durri Aboriginal Corporation Medical Service – DjuliGablan Project, Kempsey

The DjuliGablan program was introduced in 1992 to enhance the wellbeing of women and children and to reduce the morbidity associated with pregnancy, childbirth, the postnatal period and childhood. It operates within the Aboriginal Health Service and provides primary health care services to the Aboriginal population in Kempsey, as well as an outreach service to outlying settlements.

The aims of the program are to:

- increase the rate of breastfeeding and improve the level of nutrition among pregnant women and children in the from birth to five years age group

- increase Aboriginal women's levels of attendance at the antenatal clinic and women's health screening programs

- increase the immunisation rate of children.

Two Aboriginal health workers and a part-time midwife staff the service. The antenatal service targets women who are identified as high risk and who are in need of extra care during their pregnancy. In addition to the antenatal classes, the service also provides birth support to women who seek such assistance. Nutrition and breastfeeding classes are a regular part of the antenatal service, with special attention paid to the importance of the introduction of appropriate solid food when a baby is between four and six months old.

A postnatal service is also provided with home visits made daily during the first week after a woman is discharged from hospital and several times a weed during the subsequent five weeks. A monthly immunisation day is also a part of the service, with transport provided for those who need it. At the six week postnatal checkup, the women are reminded of the importance of the introduction of appropriate solids at the appropriate time, as well as the importance of the baby's nutritional status once solids have been introduced. These issues are also addressed in the infant feeding support group.

[112] Engeler et al. 1998, p.32

[113] Engeler et al. 1998

[114] National Health and Medical Research Council 1996

[115] Engeler et al. 1998, p.95

[116] National Health and Medical Research Council 1996

[117] National Health and Medical Research Council 1996; Engeler et al. 1998

[118] Buzzacott 1994, p.66

[119] Buzzacott 1994, p.67

[120] Buzzacott 1994

[121] Engeler et al. 1998, p.106

Effectiveness of the service

'Data on three-year trends for breastfeeding rates indicate an encouraging increase in breastfeeding rates at discharge and at six weeks. The increase has been from 29.8 per cent in 1993–94 to 43.64 per cent in 1995–96. The rates at six weeks include those women who are both breastfeeding and formula feeding'.[122] The increase in the rate and duration of breastfeeding is attributed to the intensive support provided postnatally.

There has also been an increase in the immunisation rate and an increase in the number of parents using the early childhood services from 16.58 per cent in 1994–95 to 33.17 per cent in 1995–1996. The success of the service relies heavily on the work of the Aboriginal health workers. Their knowledge of local conditions and of culturally correct protocol is a key factor in the success of the service.

Thallikool

The first stage of this project was introduced in 1983 with the original aim of training Aboriginal women to become breastfeeding specialists and preparing them for employment. The initial training was based on the model of Nursing Mother's Association of Australia, which was assessed to be an inappropriate one. The model was later altered and adapted for use by Aboriginal women. In 1987, educational materials were produced, including a video, *Babies of the Dreamtime.*

The second stage of the project involved the development of the *Thallikool mother and child pregnancy care and infant nutrition resource kit*. This comprehensive resource kit, which was developed with the Aboriginal Health Promotion section of the New South Wales Department of Health, targeted Aboriginal parents and focused on breastfeeding. It included a series of videos–*Babies of the Dreamtime*, *Pregnancy care*, and *Close to the heart*–as well as booklets and leaflets. A 'Statewide education program was also developed, which targeted Aboriginal health workers and contained information about infant nutrition and breastfeeding'.[123]

The program has been effective and achieved its aim of preparing Aboriginal women for employment, with six of the eight who enrolled over the two stages of the project either gaining employment or enrolling in health related courses. The resource kit for Aboriginal health workers has also been a success; it has been distributed widely and is still used by various health organisations. One of the main factors cited in relation to the success of this kit is that its style and presentation of educational materials is culturally appropriate. In hindsight, however, it was recognised that a more holistic approach would have been more appropriate

with greater attention given to the actual life situation of mothers and babies. For instance, whether a mother uses drugs or alcohol makes a difference to the approach taken by Aboriginal health workers in the promotion of breastfeeding.[124]

North Coast Aboriginal Breastfeeding Project

This project, which began in 1994 with funding for 12 months, is a community response to concern about high levels of infant morbidity and mortality and to the belief that low rates of breastfeeding might be the cause. A five-member steering committee was formed with an Aboriginal health worker as the project officer. Before initiating any education programs, the committee consulted with community members in selected areas to assess the barriers to breastfeeding.

The aim of the service is to 'promote breastfeeding, encourage Aboriginal mothers to attend antenatal classes, promote better eating habits, and encourage Aboriginal mothers to access breastfeeding support groups such as the Nursing Mothers' Association of Australia'.[125] The program is run in many different venues.

Effectiveness of the service

The service has been successful because it was developed in response to community needs, involves community members who are committed to its success, and has an Aboriginal health worker as project officer.[126]

Literacy Nest program, Armidale

A literacy nest program is operating at the Minimbah preschool in Armidale, which has a predominance of Aboriginal students, a majority of whom are three and four year olds. One of the principles of the preschool is to provide a bridge between home and school for Aboriginal children and to facilitate their transition to primary school.

Since the preschool was handed back to the community in 1987, the principal has promoted parent and community involvement in all aspects of the preschool's program. 'The preschool activities are designed to complement the attitudes, values and expectations of home to help the children build their basic sense of trust, security, and stability on cultural foundations learned at home'.[127]

The aim of the Literacy Nest program, which is only one component of the overall curriculum, is to provide the children with culturally appropriate support to assist in their development of language and literacy. There is heavy reliance on parent and community participation in the delivery of the program. Responsibility is shared between staff and community and is perceived to be a key factor in the success of the program.[128]

In addition to the preschool program, Minimbah has recently included an otitis media awareness program, a nutrition program and a program of parental workshops. It is also planning a culturally appropriate health education training program which will target children in the from birth to seven year age group with a focus on dietary habits, diabetes, heath and respiratory diseases, as well as otitis media and nutrition.[129]

Support at Home for Early Language and Literacy (SHELLS)

This project is an early literacy intervention designed to empower the families of young children aged between from birth and three years of age in their role as their children's first literacy teachers. SHELLS content is based on particular interests and current knowledge about children's literacy learning in the first three years of life. SHELLS began in 1997 and currently operates with both Indigenous and non-Indigenous families in rural and regional areas of New South Wales. It has the potential to assist families from a range of social, cultural, economic and geographical settings in supporting their children's early literacy learning.[130]

Western Australian programs

Best Start program

The Best Start program in Western Australia was first initiated in 1993 and is a joint project between the Department for Community Development, the Department of Health and the Education Department in Western Australia. The program focuses on Aboriginal children from birth to five years of age, with the aim of improving their wellbeing and life opportunities and preparing them adequately for preschool and the first year of schooling by improving their participation in early childhood education programs.[131]

In 1994, on the basis of level of disadvantage and remoteness, six locations were identified as fulfilling the criteria for the Best Start program, and, following consultation, seven communities at these six locations were selected to pilot the program. In subsequent years, other communities became part of the pilot program and in 1996–97 there were 16 sites in operation. All Best Start programs are owned and managed at the local Aboriginal community level.

A range of activities is offered through the program, including nutrition programs for parents and carers, an immunisation clinic, regular weekly playgroups for young children, as well as cultural camps for children, parents and other significant members of the extended family. In addition, drinking fountains have been installed in communities to provide clean drinking water.

While several interim evaluations have been undertaken, the final evaluation noted that the 15 sites operating between September 2000 and February 2001 had provided services to approximately 166 families, with playgroups the most frequently used service.

Problems related to the continuing 'pilot' status were noted and a recommendation made that this status should be removed to overcome the insecurity it generates among staff, families and communities. Other concerns centred on the adequacy of resources available, the selection, training and support of suitable staff, problems related to the provision of transport and the suitability of venues.[132]

Ngunytji Tjitji Pimi (NTP) Corporation, Kalgoorlie

The NTP, which has operated since 1993, currently employs four Aboriginal health workers and a coordinator. The corporation provides a primary health care service for Aboriginal mothers and babies in the Goldfields region of Western Australia. The project was implemented in this region as a pilot project because Aboriginal women in the region had been found to have 'some of the worst outcomes of pregnancy in Australia. Geographic, educational, linguistic, and cultural reasons contribute to a lack of knowledge and access to health resources, information and education'.[133]

The aims of the NTP project are to 'reduce mortality, morbidity and hospitalisation of Aboriginal expectant mothers and infants in the goldfields region of WA; and offer quality maternal and infant health care during antenatal, postnatal and infant periods, delivered by specialised Aboriginal health workers working in a truly culturally appropriate and community owned agency'.[134]

The objectives of the project relate not just to bringing about a reduction in Aboriginal maternal and infant morbidity and mortality through the provision of high quality health care, but also to empowering Aboriginal women to allow them to make informed decisions about their own and their children's

[122] Engeler et al. 1998, p.100
[123] Engeler et al. 1998
[124] Engeler et al. 1998, p.98
[125] Engeler et al. 1998
[126] Watson and Roberts 1996, p.1
[127] Watson and Roberts 1996
[128] Watson and Roberts 1996; Engeler et al. 1998
[129] PsycINFO database abstract (original source Makin and Spedding 2001)
[130] Gillam 2000, p.1
[131] Gillam 2000
[132] Engeler et al. 1998, p.84
[133] Engeler et al. 1998, p.85
[134] Butlin et al. 1997, p.170

health. This latter objective is to be achieved through the provision of culturally appropriate education and support.

The 'NTP trains Aboriginal health workers to provide effective and culturally acceptable care for Aboriginal women during pregnancy and until infants are one year of age'.[135] The health workers are local to the area, known to the women and able to communicate with them in their own language. Generally, the main focus is on home visits and individual support, with regular outreach service to expectant mothers, new mothers and babies under the age of one. Counselling and encouragement of breastfeeding is mainly done on an individual basis, either in the woman's home or during her regular visits to the clinic.

Group activities are used to promote nutrition, parenting skills and baby care. Cooking demonstrations and picnics are held, and the service provides a regular playgroup, which gives mothers the chance to socialise, while allowing further opportunities for Aboriginal health workers to provide education to parents on self-care and child wellbeing.

Outcome of the project

A self-reported weakness of the service relates to 'the need for specific training for health workers in breastfeeding and infant nutrition'.[136]

[135] Engeler et al. 1998, p.39

[136] www.wcer.Wisc.edu/fast

International best practice models

United States programs

Families and Schools Together (FAST), Wisconsin

FAST is a multifamily group intervention designed to build protection factors for children aged four to 12 years and to empower parents to be the primary prevention agenda for their own children. The trained, parent–professional, collaborative FAST team supports parents as the primary prevention agents for their own children by developing interdependent support networks of parents which include other parents, the school and the community.

The program's three components include:

1. outreach to parents
2. positive, multifamily engagement groups
3. two years of parent–facilitated, monthly community development planning meetings.

FAST applies a number of psycho-social theories to support its work, which aims to enhance family functioning, to prevent the target child from experiencing school failure, to prevent substance abuse by the child and other family members, and to reduce the stress that parents and children experience from daily life situations. The emphasis is on a building relationships program and multifamily support group process for building multi-systemic, caring long-term relationships for children. Activities include occasions where multiple families have fun as a family, eating and playing at their own family table, network opportunities with peers, and parent to child quality time.

Family outcomes include:

• parents feeling they are not alone
• an increase in family closeness
• improvement in family communication
• parents feeling more respected by their children
• decreased family conflict
• increased parental friendships
• increased parental leadership in school and the community.

Child outcomes include:

• increased social skills
• increased obedience
• respectful communication with parents and teachers
• improvement in attention span, impulse control, and academic performance
• reduced aggression, violence, and anxiety both at home and in the classroom.

These outcomes cross over several domains (child, family, school, and community), reduce the impact of multiple risks, and correlate with preventing substance abuse, violence, delinquency, and school failure.

Outcomes

The organisation states there is a statistically significant improvement in FAST children compared with children who have not been involved with FAST across race and culture, as well as in behaviours reported by parents and teachers. There are also improved social skills, improved attention span, academic performance and competence, and reduced aggression and anxiety depression.

FAST has increased parental involvement in school, improved family cohesion, and reduced family conflict. Eighty-six per cent of participating parents reported new friendships and 44 per cent of FAST parents return to pursue further education.[137]

Carolina Abecaderian Project

'This project was a combined early intervention for children of poor and minority families with child care'[138] and used an experimental design project involving experiment and comparison groups. The experiment ran for eight years and followed children from birth until they were eight years old. Children were selected at birth by reference to a high risk index for family risk factors and allocated to either a treatment group or to a control group.

The treatment program involved preschool intervention, which began before the children were three months old. The control group had no early preschool intervention. Just prior to preschool entry, both the treatment group and the control group were 'split into two equivalent groups of children making four groups in all for the school stage of the experiment'.[139] The first treatment group received both preschool intervention and intervention from school entry to the age of eight years. The second treatment group received preschool intervention, but no intervention at school entry. The third group (the first of the control groups) received only intervention when they entered school, while the fourth group received no intervention at all.

Results of the experiment indicated that children who received preschool intervention subsequently performed better academically, than those who had no preschool experience. 'The preschool treatment group effects

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[137] Department of Human Services 2001a, p.46
[138] Department of Human Services 2001a, p.46
[139] Department of Human Services 2001a, p.47

continued into the second year of school, particularly for the group of children who continued to receive additional assistance at school. The follow-through program in primary school avoided the decline in intellectual gains that had been found in other preschool intervention programs'.[140]

Even Start program

The objective of the Even Start program is to break the cycle of poverty. The program provides literacy programs for families and children under the age of seven years who are classed as disadvantaged. In addition to early childhood education, the program provides parenting and adult education. The early childhood and adult education programs and the parenting programs are integrated into a unified literacy program. 'The overall finding was that Even Start improved parent's academic skills and children's language development'.[141]

Head Start program

The Head Start program was introduced in the United States in the mid 1960s as part of the 'war on poverty' and targeted the children of the poor and minority groups. It has always taken a 'whole child' approach, with interventions which included 'education and encouragement of language skills, self reliance and self esteem; a health program; a program of parental involvement as teacher aides, and support groups for parents on a range of subjects including parenting, nutrition program and meals for children; and referrals that gave families access to social and psychological services'.[142]

The early evaluations of the program focused almost exclusively on intellectual and cognitive gains and concluded that the gains that were apparent by comparison with control groups tended to fade over the first three years of school. Later evaluations that were better designed and made an examination of the broader aims of Head Start found that while the early cognitive gains did fade over time, other more subtle benefits were apparent in the long term. Head Start children were less likely to be kept down a grade or to be placed in special education classes. In addition, the evaluation found that Head Start had provided more general help for families 'by providing health, social and educational services and had linked them into other services in the community'.[143]

Early Head Start program

This program, which began in 1995, grew out of the recognition that if intervention in early childhood was to be maximally effective it needed to start in the first three years of life and even before this, with the mother. 'The goal of Early Head Start is to provide intensive and comprehensive services from before birth and continuing through the first three years to improve the child's development with regards to health, resilience, social competence, cognition and language'.[144] The program also includes education and activities for parents, home visits to families, as well as both home-based and centre-based child care for children.

An evaluation of the program found that by the age of two, those children who had attended Early Head Start were 'functioning significantly better than non Early Head Start peers across a range of cognitive, language and social-emotional development measures'.[145]

Nurse Home Visiting program

The Nurse Home Visiting program in the United States 'involved three research based trials, over a twenty year period, which aimed to improve pregnancy outcomes, to promote children's health and development, and to strengthen families' economic self sufficiency through home visits. Home visits by nurses started prenatally and continued until the children were 24 months of age. The samples were drawn from disadvantaged families because the study was designed to address problems such as poor birth outcomes, including low birth weight and prematurity, child abuse and neglect'.[146]

The results of the study showed that it was the neediest families who benefited most from the home visiting program; that is, the unmarried mothers who were on low incomes. Children in this needy population also benefited, with the program resulting in a reduction in the incidence of child neglect and abuse.

The Perry Preschool Program

The Perry Preschool program, which targeted three and four year old children from poor and minority families, was a longitudinal study which used an experimental design and randomly assigned children and their families to either a treatment group or to a control group. The treatment group were exposed to an intensive preschool program while the control received no additional support. A follow-up study 20 years later found a strong and lasting effect for those children who had received the benefit of early intervention through a preschool enrichment program. These benefits included 'an increased likelihood of completing secondary school, increased likelihood of employment, avoidance of teenage pregnancy and of a criminal record'.[147] An additional finding related to the benefit of including home visits in the original program during which 'mothers were taught how to engage in preschool education with their children through structured play'.[148]

United Kingdom programs

Sure Start Program

This program, which was introduced in the United Kingdom because of a growing concern about the negative effects on children of growing up in disadvantaged circumstances, is based on principles similar to those of Head Start. The aim of Sure Start is 'to work with parents-to-be, parents and children to promote physical, intellectual and social development of babies and young children–particularly those who are disadvantaged–so that they can flourish at home and when they get to school, and thereby break the cycle of disadvantage for the current generation of young people'.[149] The program seeks to improve children's health, social and emotional development and ability to learn, and to strengthen families and communities.

Social support to improve birth weight

Anne Oakley's (1992, 1996) research in Great Britain 'emphasised the importance of social support and connectedness to specific short and long term health outcomes for both mothers and children'. The aim of Oakley's study was to reduce the incidence of low birth weight by providing social support to women who had already had one low birth weight baby and who were, because of this, considered to be at risk. These at risk women were randomly assigned to either a treatment group or to a 'no treatment' control group.

The social support element of the study involved midwives visiting the women in the treatment group in their homes. Three home visits were made to the women in addition to two telephone calls. The women were also provided with a 24-hour contact phone number for the midwife, who also gave practical advice to the women, provided information as needed, and made extra home visits as required.

The results of this study showed that the social support provided to the women in the treatment group had been effective in improving health outcomes compared with the 'no treatment' control group of women. In the treatment group, there was a reduction in the number of low birth weight babies and less need for neonatal and intensive care. Further, the health of the mothers and babies was better than it was in the control group. Subsequent follow-up at one and seven years found that there were continued health gains for the mothers and children in the treatment group.

Canadian programs

The Early Years Study, Ontario

This study highlights the importance of early intervention to promote a child's readiness for entry to formal schooling. In particular, it points to the importance of parental nurturing of children because of its long lasting effect on a child's ability to learn, as well as to the importance of parents being involved in early childhood development programs.

Canadian Aboriginal Head Start Urban and Northern Program

The Canadian Aboriginal Head Start (AHS) Urban and Northern Program, which began in 1995, is an early childhood intervention program funded by Health Canada. It focuses on meeting the needs of First Nations, Metis and Inuit children and their families who live either in urban areas or northern communities.

There are many parental problems which present challenges to those delivering Aboriginal Head Start programs. 'A lack of parenting skills and issues related to living in poverty are the most common challenges that parents face, according to AHS sites. Other common ones include issues related to family alcohol or drug addiction and family violence'.[150] While the program targets children six years of age and younger, the major emphasis is on preschool children aged between three and five years. More than 3,000 children, a majority of whom had had no other experience of an early intervention program, were enrolled in Aboriginal Head Start programs at one of the 100 project sites in 1999–2000. All Aboriginal Head Start programs are organised around six components: culture and language, education, health promotion, social support, and parental involvement.

All sites offer programs in each of the six components and the local community at each project site decides how it will be done. Active parental and community involvement is a key aspect of the Aboriginal Head Start program, as is parent committees, as these local groups are responsible for the design, development and delivery of their AHS program.

[140] Department of Human Services 2001a, p.51

[141] Department of Human Services 2001a, p.51

[142] Department of Human Services 2001a, p.51

[143] Department of Human Services 2001b, p.214

[144] Department of Human Services 2001b, p.214

[145] Department of Human Services 2001a p45

[146] Department of Human Services 2001b, p.211

[147] Department of Human Services 2001b, p.211

[148] Department of Human Services 2001b, p.215

[149] Health Canada 2001, p.4

[150] Health Canada 2001, p.3

This means that while all Aboriginal Head Start sites are similar, each site is unique.

The program provides a structured preschool environment for the young 'students' and operates four days a week. The delivery of education and care to children is coordinated with other services, which are provided by territory or provincial governments. 'The primary goal of the AHS initiative is to demonstrate that locally controlled and designed early intervention strategies can provide Aboriginal children in urban and northern settings with a positive sense of themselves, a desire for learning and opportunities to develop fully and successfully as young people'.[151]

The success of the program is demonstrated by the fact that demand exceeds supply, with 64 per cent of AHS sites reporting that they are unable to enrol all the children in the community in need of the Aboriginal Head Start program.[152]

New Zealand programs

Language nests

Early childhood language nest programs in New Zealand play an important role in the affirmation and preservation of Maori culture. They are aimed mainly at four year old children, provide a culturally rich and nurturing environment, and rely heavily on the support and involvement of parents and community members in teaching Maori culture and language to preschool aged children.

[151] Health Canada 2001, p.11
[152] Health Canada 2001, p.4

Appendix 2

The project team

A coordinator was employed to oversee the project and three individual project officers (one from each of the peak Aboriginal organisations) were engaged to gather relevant information and data through Statewide consultations at the following sites recommended by the Aboriginal Best Start Reference Group:

• Echuca

• Mildura

• Metropolitan Region

• Heywood/Portland

• Bairnsdale/Lake Entrance/Lake Tyers.

An independent consultant was engaged to prepare the status report for the project.

Aim of consultation

To identify the range of community Aboriginal and mainstream resources and services that are currently involved in providing support to young Aboriginal children and their families that could be brought together in innovative ways to better provide the core activities and supports that Aboriginal children need as they grow and develop.

Within the designated areas, the project team met with Aboriginal and mainstream organisations and community members, including:

> *Victorian Aboriginal organisations*: chief executive officer of the organisation and health workers employed by the organisation

> *Education workers*, including LAECG's, Koorie educators, home school liaison officers, Koorie Education Development officer, and Koorie early childhood field officers

> *Welfare workers*: social workers, hostels workers, child care workers, and supervisors within Aboriginal organisations working with children aged from birth to eight years

> *Victorian Aboriginal community members*, including Elders and families that have children aged from birth to eight years

> *Mainstream service providers* currently working with Aboriginal organisations within the region, including Department of Human Services employees.

Fieldwork tools

Six questionnaires or discussion guides were developed to gather relevant information and data from:

1. chief executive officers of Aboriginal organisations

2. health workers

3. education workers

4. welfare workers

5. mainstream service providers

6. Elders and families.

The questionnaires were developed as group discussion guides and for completion by the project officers; however, some consultation within the regions did not eventuate as one-on-one, face-to-face discussions which meant that respondents completed a number of the questionnaires without the project officers present. Also, in some cases the respondent preferred to complete the questionnaire in isolation and return it by fax or post. At the time of completing this report, some questionnaires had not been forwarded to the project team; however, some of the issues about accessing services within those communities have been recorded in this report.

One issue the project team noted during the consultations is that many Aboriginal organisations are already overworked and under-resourced. Given the very limited timeframe for the consultations, it was not possible to give the community extra time to meet, discuss and complete the questionnaires. We are grateful to those Elders, families and organisations who found time in their already busy schedules to provide information.

Focus of consultations

Discussions about the health, education and wellbeing of children aged from birth to eight years in the areas visited covered:

• issues related to accessing mainstream services from a Koorie perspective

• issues related to accessing services from a mainstream perspective

• programs for children aged from birth to eight years

• resources associated with the programs for children aged from birth to eight years

• suggested recommendations for accessing services for children aged from birth to eight years

• suggested ways to enhance the relationships between current programs for children aged from birth to eight years and their families

• liaison between Aboriginal organisations and mainstream services within the region

• liaison between the mainstream service providers within the area

• suggested recommendations for Best Start demonstration projects

• Elders' perspectives on education, health and wellbeing of children aged from birth to eight years.

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