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ABSTRACT

An Australian national task force examined a number of areas related to achieving educational equality for Australia's Indigenous peoples. This paper looks at health issues, particularly during ages 0-8, that may affect the educational outcomes of Aboriginal and Torres Strait Islander children. Chapter 1 discusses the importance of the early years of life in terms of brain development and future potential; the low educational attainment of Indigenous students and low Indigenous participation in early childhood services; population statistics; and the national policy context on Indigenous education, including national efforts to accelerate Indigenous progress and recommendations on interagency cooperation between the health and education sectors. Chapter 2 summarizes findings on nine health issues of concern: the lower life expectancy at birth and higher mortality rates at all ages for Indigenous Australians; low birth weight and failure to thrive; malnutrition and poor quality diet; high rates of infectious diseases and high incidence of educationally significant hearing impairment due to otitis media; social and emotional well-being; substance abuse; adolescent pregnancy; childhood trauma, including that related to family violence and child abuse; and childhood injuries. Chapter 3 describes Indigenous conceptions of health and well-being as encompassing family and community, and current initiatives that link community development and capacity building to childhood health issues. The appendix presents the Adelaide Declaration on National Goals for Schooling in the 21st Century. (Contains 43 references.) (SV)

SOLID FOUNDATIONS:

HEALTH AND EDUCATION PARTNERSHIP

FOR

INDIGENOUS CHILDREN

AGED 0 TO 8 YEARS

MCEETYA TASKFORCE ON INDIGENOUS EDUCATION

DISCUSSION PAPER

JUNE 2001

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EXECUTIVE SUMMARY

Achieving the National Goals for Schooling in the 21st Century poses significant challenges for many Aboriginal and Torres Strait Islander children. Indigenous children who are unwell, tired, hungry or emotionally insecure have less capacity to take advantage of available opportunities to learn. The responsibility for making sure that the needs of these children are met is shared between the family, the community and government.

Internationally and in Australia there has been renewed interest in the first eight years of life and on the quality of child health and development and its relationship to educational attainment. Much of this activity has been given impetus by new research findings that the great majority of physical brain development occurs by the age of three.

This renewed interest and new research evidence has highlighted a range of findings that show that low birth weight, recurrent illnesses, a lack of psychosocial stimulation, acute and/or chronic malnutrition and the stresses of poverty can lead to poor health and a general lowering of intellectual, behavioural and social abilities, often leading to poor school performance and dropping out.

The Taskforce recognises the close relationship between health and educational outcomes and acknowledges the current synergies operating in the education and health sectors to improve the educational and health outcomes of Indigenous children. In the past decade, major progress has been made in Australia to reduce and contain Indigenous childhood mortality and morbidity, and to improve Indigenous educational outcomes. At the same time, the Taskforce is of the view that further work needed to be done.

The Taskforce decided to build on its previous advice to Council on cross-portfolio issues (MCEETYA, 2000) and examined a range of health and educational issues for Indigenous children with a view to promoting a more efficient and effective mechanism for addressing these issues across the health and education portfolios. The Taskforce was already familiar with the impact of otitis media on Indigenous educational outcomes. As part of this work the Taskforce considered more comprehensive advice on a range of health issues that affect Aboriginal and Torres Strait Islander children from birth to 8 years. In addition, the Taskforce considered advice from international and Australian initiatives on how to improve the health, psychosocial and educational outcomes of children at risk.

This discussion paper summarises advice on nine health issues of concern to the Taskforce that affect Aboriginal and Torres Strait Islander children from birth to 8 years and proposes them as the basis for initial discussion with health sector representatives, Indigenous affairs and the family and community services sector at a national, state and regional level. These issues are: lower life expectancy at birth; low birthweight 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; and childhood injuries. The Taskforce acknowledges that there are enormous sensitivities and a 'culture of silence' surrounding many of these issues, which make it difficult to discuss and address them.

In addition, the Taskforce has identified a number of principles relating to community development and capacity building that should underpin any further cross-portfolio work.

Preliminary discussions have been held with a number of health sector and early childhood sector representatives. It has been agreed that the paper provides a useful basis for informing the work of

education jurisdictions, as well as informing further cross-portfolio work with the health sector, Indigenous affairs and the family and community services sector at a national, state and regional level. The Taskforce proposes that a cross-portfolio working group be established to take this work forward and report back to Council in 2002.

Recommendations		
It is recommended that Council:		
1	a)	**note** that an information paper entitled *Solid Foundations: Health and Education Partnership for Indigenous Children Aged 0 To 8 Years* is available for further discussions by jurisdictions with the health sector, Indigenous affairs and the family and community services sector;
	b)	**agree** to forward this paper to the Health Ministerial Council and seek its support to a joint commitment to improving the health and educational outcomes of Aboriginal and Torres Strait Islander children aged from birth to 8 years;
	c)	**agree** to forward this paper to the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and seek its support to a joint commitment to improving the health and educational outcomes of Aboriginal and Torres Strait Islander children aged from birth to 8 years;
	d)	**agree** to the use of the paper to serve as the basis for cross-portfolio discussions as part of the Council action plan to meet the COAG reference of 3 November 2000.

CHAPTER ONE: EARLY CHILDHOOD EDUCATION ISSUES FOR AUSTRALIA'S INDIGENOUS CHILDREN

This chapter summarises the national policy context relating to the educational attainment of Indigenous children, including a description of national work by the education sector to accelerate progress and advice from the previous taskforce report on cross-portfolio issues in health.

Introduction

Internationally and in Australia there has been renewed interest in the first eight years of life and on the quality of child health and development, its relationship to educational attainment, the construction of future potential and supporting dispositions to lifelong learning.

This renewed interest in the first eight years of life have highlighted a range of findings that show that low birth weight, recurrent illnesses, a lack of psychosocial stimulation, acute and/or chronic malnutrition and the stresses of poverty can lead to poor health and a general lowering of intellectual, behavioural and social abilities, often leading to poor school performance and dropping out.

Advice from early intervention studies has indicated that education and health interventions in the early years are likely to be more successful and less costly than remediation and rehabilitation in the later years of childhood and adolescence.

Much of this activity has been given impetus by new research findings that the great majority of physical brain development occurs by the age of three[1].

Brain development before age one is more rapid and extensive than was previously realised. By the time a child reaches the age of 36 months, the neural network of the brain has been developed, depending largely on the stimulation and care the child receives. Later physical, mental, social and cognitive developments and dispositions to learning depend on this network. It is estimated that half of all development potential is established by age four[2].

All young children learn through play and through positive and supportive interactions with others. Children use language to communicate their ideas. They make sense of the world through their first-hand experiences and through interactions with members of their families and communities. Meanings and understandings are shaped every day. It is within these personally experienced social contexts that young children's understandings of their world develops and learning grows.

Children from a very young age are competent active agents of their own development. Growth and development in fine and gross motor skills, understanding and expression of emotional and social competence and developing language capabilities, as well as cognitive changes influence the development of literacy and numeracy skills.

There is evidence that some abilities are acquired more easily during certain sensitive periods or 'windows of opportunity' early in a child's life. Research shows that new knowledge does not accumulate, rather, it transforms the already existing knowledge base and restructures what comes to be known. This process of transformation is fundamental to the changing architecture of the brain and these changes that rapidly occur during early years of life are known as 'critical periods', eg. 'language learning', 'binocular vision', and 'emotional control'. Many commentators argue that if these 'critical periods' are not utilised then they are closed forever. However, evidence for 'critical periods' needs to be interpreted with caution [3,4].

This renewed interest in the first eight years of life and their role in constructing future potential and supporting dispositions to lifelong learning provides an opportunity to examine a related range of issues that are impeding the achievement of educational equality, economic independence and effective participation in Australian society by Indigenous Australians.

Educational attainment issues for Indigenous children

It is well recognised that while there has been considerable progress to date to improve Indigenous educational achievements in Australia, the level of educational disadvantage that Indigenous peoples continue to experience is still too high.

The recent shift to focussing on measuring the effectiveness of schooling and reporting on student educational outcomes, particularly through the national literacy and numeracy benchmarks, have highlighted the difficulties that some Indigenous children continue to experience in achieving national standards, especially in the early years of schooling.

The 1996 National School English Literacy Survey showed that approximately 70% of all students in year 3 surveyed met the identified performance standards in reading and writing. Less that 20% of students in the Indigenous sample met the reading standards and less that 30% of students in the Indigenous sample met the writing standards. In addition the lowest achieving year 3 Indigenous students make little or no progress over the following two years. There was a similar trend for year 5 students. Over time this situation deteriorates to the point where many Indigenous students are often 3 to 4 year levels below other students and students leave school with the English literacy level of a six-year old.

This poor performance is not just a reflection of socio-economic and English language background, since 60% to 70% of Year 3 students from low socio-economic backgrounds and just over 60% with a language background other than English met the reading and writing standards.

The release of the 1999 National Year 3 reading data showed that almost 87% of Australian Year 3 students and 66% of Indigenous Year 3 students met the national standard in reading.

While the 1996 and 1999 results are not directly comparable for Indigenous students because of different sampling techniques, there appears to be a significant improvement on the face of these results. In addition, matched results of students progressing from Year 3 to Year 5 are also showing improvement.

Nevertheless, these results also show that nationally one third of Indigenous students are still below the standard. There is considerable variation across the States and Territories in the proportion of Indigenous students failing to meet the standard, due to geographical and other factors.

Indigenous children are much less likely to participate in formal early childhood services. Low levels of Indigenous participation in formal ECEC are partly to do with limited physical access, but more often with the perceived 'cultural insensitivity' of provision. As a general but not universal rule, Indigenous people value early childhood education for similar reasons non-Indigenous people do, ie. as providing children with a good start to schooling and social participation. Well-established personal relationships and a climate which is 'culture-friendly' are likely to have a significant positive impact on the use of early childhood education centres by Indigenous parents/carers.

The majority of current models of monitoring and reporting outcomes for early childhood education fail to acknowledge the cultural diversity and knowledge which Indigenous children bring to the pre-school setting, as well as their own individual identity. Cultural diversity and knowledge needs to be acknowledged, valued and made explicit in the early childhood education programme. This would encourage Indigenous participation in ECEC and greater involvement of Indigenous parents, caregivers and community members in the education of their children.

Indigenous students are much less likely to continue their education to the end of the compulsory years. Only 83% of Indigenous students remained in schooling to year 10 in 1998, compared to just under 100% for non-Indigenous students. This year 10 retention rate varies considerably across the country and in some parts of the country was just over 50% in 1997.

Indigenous students are also much less likely to continue their education beyond the compulsory years. Only about 36% of Indigenous students remain at school from the commencement of their secondary schooling to year 12, compared to about 73% of non-Indigenous students in 2000. In addition, in some parts of the country, in 1997, only a quarter of these year 12 students may successfully complete year 12, compared to 50% of non-Indigenous Year 12 students.

The 1994 ACER study on subject choice in years 11 and 12[5] and more recent trend data shows that early school achievement is a significant influence on enrolments in particular subject areas and therefore on post–school options. High achievement in the early years of schooling in either literacy or numeracy was associated with considerably higher enrolment levels in the physical sciences, mathematics and LOTE in Years 11 and 12. The reverse was true for technology, The Arts and physical education subjects.

Students who achieve at the highest level of literacy are more than three times as likely to study either physics or chemistry. Students who achieve at the highest level of numeracy are more than eight times as likely to study either physics or chemistry. It is not surprising then that Aboriginal and Torres Strait Islander students are enrolled in higher proportions than other Australian students in the following: the Arts, Technology, Health and Physical Education, with enrolments in physical education more than double for other Australian students.

These continuing difficulties that Indigenous students experience in achieving educational equality impact on their future education, as well as their post-school options and employment rate. The lack of parity of participation by Indigenous students across all subject areas, especially science and mathematics, impacts on the numbers of Indigenous people able to undertake health-related courses in VET and higher education. For example, Indigenous Australians are under-represented in bachelor degree and postgraduate courses and are much more likely than other students to be enrolled in sub-degree courses or enabling (bridging) courses. These continuing difficulties also impact on the number of Indigenous people who hold tertiary qualifications in health, for example. In 1999, about 13% of all Indigenous students were enrolled in health-related fields.

One of the major labour market disadvantages experienced by Indigenous people is their relatively low levels of education. If Indigenous people had the same level of qualification observed in the rest of the community, then their rate of employment could expect to increase significantly and they would experience greater levels of economic independence.

According to the Australian Bureau of Statistics, the Indigenous population of Australia is younger and growing at a faster rate compared to other Australians[6]. Accordingly, existing concerns about the educational outcomes of Indigenous children are likely to increase as the population expands in proportion to other Australian children.

Population statistics

The Australian population is about 18 million (1996 Census), with about 2.6 million children aged 0 to 9 years. The Australian Total Fertility rate has been declining from 3.6 children per woman (1948-1961) to its lowest recorded level of 1.74 in 1998. For example, the number of children in the 0 to 4 years age cohort dropped by about 13 500 from 1996 to 1998. The rate varies considerably by education level and geographic area, although the trend is to a decline across all social groups, reflecting the delay of family formation and the increase in the percentage of women remaining childless.

In addition, the average size of Australian households has been falling steadily across the last 20 years. The proportion of one-parent families is increasing, but the major component of the overall change is the rise in the proportion of couple-only families. In 1976, 60% of families were comprised of couples with children. By 1996 this group had dropped to 50% of the 7 million households in the nation. Assuming the trend in fertility continues and total migration remains at its current level, these trends would translate into a drop of between 5% to 7% in the population of children over the next decade.

However, Australia's Indigenous population has grown from about 116 000 in 1971 to about 353 000 in 1996 and now comprises about 2% of the total population. The 1996 Census also showed that the Indigenous population is currently expanding at a rate more than twice that of the total population, with an average growth rate of around 2.3%. The population is projected to grow at over 20% to 469,000 in 2001.

The majority of Indigenous Australians live in NSW (28.7%) and Queensland (27.1%). Like the overall Australian population, the overwhelming majority of Indigenous Australians live in either capital cities (26.2%) or in other urban areas (62.9%). Nevertheless, Indigenous Australians are more likely to live outside capital cities than other Australians. 62.9% of the Indigenous population live in other urban areas and 10.9% live in rural areas, cf. 41% and 2.4% for the non-Indigenous population, respectively.

The age structure of the non-Indigenous Australian population is significantly different to that of the Indigenous Australian population. The Indigenous population is comparatively young, while the non-Indigenous population has an older profile with a large concentration in middle-age. 70% of Indigenous Australians are under 25 years of age, compared to about 45% of all Australians, according to the 1996 Census.

In 1996, there were about 98 000 Indigenous children aged 0 to 8 years, with projected estimates of about 147 000 Indigenous children aged 0 to 8 years in 2006, an increase of about 49 000 in a decade. The projected number of Indigenous births is likely to increase from 12 000 in the 1996-7 period to 17 000 by 2005-6.

There are about 107 000 Aboriginal and Torres Strait Islanders in school in 1999 out of a total school population of about 3.2 million, which is more than 3% of the school-aged population. There is considerable variation in the absolute numbers and proportion of Indigenous school-aged children across the States and Territories in terms of the proportion in urban, rural and remote locations, as well as the proportion of Indigenous children in the school-aged population.

National work to accelerate progress

All State and Territory Governments and the Commonwealth Government work at a national level through the Ministerial Council on Education, Employment, Training and Youth Affairs (otherwise

known as MCEETYA). MCEETYA recognises that Australia's Indigenous people are 'the most educationally disadvantaged group in the community' and has undertaken a number of collaborative activities, particularly in the last decade, to address the educational needs of Australia's Indigenous people.

Two important and identifiable phases of work have been undertaken to support the achievement of educational equality for Indigenous students. The first phase was the establishment of national commitment to a raft of policy in Indigenous education, particularly the 1989 National Aboriginal and Torres Strait Islander Education Policy (AEP) and the 1989 National Goals of Schooling (Hobart Declaration).

In the second phase, Indigenous education led the way in establishing an outcomes-based approach in Australian education.

In 1995, MCEETYA established a number of priority areas and agreed to an outcomes focus for this work. The priorities for the Council were in areas such as literacy and numeracy, involving Indigenous parents in their children's education, employment of Indigenous education workers, appropriate professional development of staff, increasing the enrolments of Indigenous students, expanding culturally inclusive curricula and involvement of Indigenous Australians in educational decision-making. Ministers agreed to ensure significant continuous improvements to achieve outcomes for Indigenous Australians similar to those of non-Indigenous Australians.

Further, Ministers agreed in 1997 to a National Literacy and Numeracy Goal, ie that every child leaving primary school should be numerate, and be able to read, write and spell at an appropriate level, and that every child commencing school from 1998 will achieve a minimum acceptable literacy and numeracy standard within four years.

To increase the focus on progressing the national Indigenous education agenda, Ministers agreed in May 1998 to include Aboriginal and Torres Strait Islander education as a permanent item on the Council's agenda. The Taskforce notes that Health Ministers may be considering including Aboriginal and Torres Strait Islander health as a permanent item on their Council's agenda.

In 1999, consistent with MCEETYA's previous decision regarding the National Literacy and Numeracy Goal, Ministers committed to ensuring that all Indigenous children leaving primary school should be numerate, and able to read, write and spell at an appropriate level, and that every Indigenous child commencing school from 1998 should achieve a minimum acceptable literacy and numeracy standard within four years.

In 1999, Ministers also agreed to the Adelaide Declaration on National Goals for Schooling in the 21st Century, which states that 'Australia's future depends upon each citizen having the necessary knowledge, understanding, skills and values for a productive and rewarding life in an educated, just and open society. High quality schooling is central to achieving this vision'. In particular, the Adelaide Declaration underlines the capacity of all young people to learn, the role of parents as the first educators of their children, the achievement of educational standards, especially in literacy and numeracy, and the need for schooling to be socially just.

The Adelaide Declaration addresses the individual child's rights to education in a statement of expectations about what all students should have on leaving school and articulates these to a set of social justice commitments encompassing Aboriginal and Torres Strait Islander education issues. The Declaration also points out that schooling should provide a foundation for young Australians' intellectual, physical, social, moral, spiritual and aesthetic development in a supportive and nurturing environment. The full text of the Adelaide Declaration is provided in **Appendix 1**.

Despite this level of national policy work, progress in achieving equality in educational outcomes has been slower than anticipated.

In its report to MCEETYA on 31 March 2000, the Taskforce identified a number of issues that are impeding the achievement of educational equality for Indigenous Australians. These issues include:

- there are lingering perceptions in some quarters of the Australian community that the gap in educational outcomes between Indigenous and non-Indigenous Australian students is 'normal' and that educational equality for Indigenous Australians is either not achievable, or if possible, only achievable over a long period of time (ie decades or generations);

- there is often a systemic lack of optimism and belief in educational success for Aboriginal and Torres Strait Islander students;

- education of Indigenous students is often not regarded as an area of core business in education systems;

- Aboriginal and Torres Strait Islander teachers and education workers are often denied access to facilities and services that other teachers and education workers take for granted and which are covered by legislation;

- initiatives that develop more effective models of education which build on, replicate and sustain progress in the achievement of equitable educational outcomes for Indigenous students often fail to be implemented systemically and/or at the local level;

- whilst there is a widespread acknowledgement of a close relationship between low levels of Indigenous educational outcomes and poverty, health, housing and access to government services and infrastructure, there is a lack of efficient and effective mechanisms to address cross-portfolio issues for Indigenous students.

At their March 2000 meeting, all Australian Ministers of Education agreed to undertake a third phase of work to accelerate progress and address these issues. This work included the promotion and implementation of:

- a statement of principles and standards for educational infrastructure and service delivery;
- a model for more culturally inclusive and educationally effective schools; and
- a framework for developing more efficient and effective cross-portfolio mechanisms.

The Taskforce report also highlighted a number of health concerns that impact on educational outcomes and Ministers agreed to circulate the Taskforce report to the Health and Community Services Ministerial Council and the Ministerial Council on Aboriginal and Torres Strait Islander Affairs with the view to encouraging discussions on cross-portfolio issues.

Previous Taskforce advice on cross-portfolio issues with health

In its report of March 2000, the Taskforce looked at the background to the education sector addressing cross-portfolio issues with the health sector. The following advice is drawn from Chapter 5 of that report.

The Council of Australian Governments (COAG) in 1992 endorsed The National Commitment to Improved Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres

Strait Islander Peoples. The objective of the 1992 COAG Commitment was to ensure that Aboriginal and Torres Strait Islanders people receive no less a provision of services than other Australians. In particular, the 1992 COAG Commitment was designed to achieve greater coordination of the delivery of programs and services by all levels of government to Aboriginal peoples and Torres Strait Islanders.

The 1992 Commitment provided a framework from which some improved service delivery practices especially in the areas of health and housing have flowed in recent years. In the health area, all governments have agreed to national performance indicators, and with the Indigenous community health sector have entered into framework agreements and in some cases, direct partnerships to improve services and outcomes.

The issue of more effective cross-portfolio mechanisms was raised in the 1995 National Review of the effectiveness of the National Aboriginal and Torres Strait Islander Education Policy in its first triennium. The 1995 MCEETYA Taskforce for the Education of Aboriginal and Torres Strait Islander Peoples attempted to grapple with the complexities of addressing these cross-portfolio issues and finally recommended that individual State/ Territory education and training systems should address these matters separately.

In its March 2000 report, the Taskforce proposed that it was timely for this issue to be reconsidered at a national level. The report noted that there is a close relationship between low levels of educational outcomes and issues in other portfolio areas such as poor health, overcrowded housing and poor access to government services and infrastructure, such as transport and information and communication technology, that other Australians take for granted. Any improvement in these other portfolio areas is likely to generate better educational outcomes.

On the other hand, improvements in Indigenous educational outcomes impact on other portfolio areas and on the total well-being of the Indigenous and national community.

Advice provided to the Senate Inquiry into Indigenous Education (1999) and the House of Representatives Inquiry into Indigenous Health (1999) indicates that Indigenous people are more likely to be sick and less likely to be able to take action in relation to the health of their children, the less education they have relative to the Australian population as a whole. There is also some evidence that the infant mortality rate drops by between 7% and 10% with the addition of a single extra year of education in a population. There is also a great deal of research which shows that education has a positive effect on the health of adults, not just on their children. The effect that education has on people's health occurs to some extent independently of the effect that education has on their income or employment levels. In other words, even if income and employment levels do not increase, there is still a significant improvement in health status, both among adults and especially among their children.

Improvements in Indigenous educational outcomes also impact on other portfolio areas and on the total well-being of the Indigenous and national community. For example, the Royal Commission into Aboriginal Deaths in Custody noted that the formal education system, child welfare practices, juvenile justice, health and employment opportunities were inextricably linked to the disproportionate representation of Aboriginal and Torres Strait Islander people in custody. The Commission highlighted a number of educational problems and concluded that the most significant reason for the disproportionate rate of contact was the severely disadvantaged social, economic and cultural position of many Indigenous people.

Despite the urgency of these issues, there seems to be considerable difficulties in resolving these cross-portfolio issues permanently at a local level for Indigenous Australians. The Taskforce is of

the view that the failure to resolve these cross-portfolio issues constitutes a barrier to achieving educational equality.

Current work

In March 2000, Ministers asked the Taskforce to provide advice to Council at its first meeting in 2001 on making the achievement of educational equality for Australia's Indigenous peoples an urgent national priority in a number of sectors, including the early childhood education sector.

The Taskforce considered the considerable work already underway in a number of jurisdictions to show that a whole of government investment in Indigenous community capacity building can address a range of early childhood and school-based issues. Many of these initiatives are being undertaken as part of the development of integrated whole-of-government service delivery models to provide improved coordinated and coherent services to Aboriginal and Torres Strait Islander communities. One example is discussed in more detail in **Box 1** below.

Box 1: NSW Schools as Community Centres project

The NSW Schools as Community Centres project was commenced in 1995 in response to the recommendations made in the Report of the Committee of Review of New South Wales Schools (1989). A community development approach is used to ensure that integrated agency services are directed into selected disadvantaged communities to meet the needs of parents with young children.

The aims of the project are:

- to identify needs and gaps in service provision in the local community by consultation with the community;
- to encourage and support families in their parenting role through improving access to local services;
- to promote community involvement in the provision and coordination of services for children and families by engaging them in the planning of projects; and
- to promote the schools as a community centre which links families with education, health and community services that foster the child's development.

The project is to operate at twelve sites in NSW during 2001. Centres are located in government schools and offer playgroups, transition to school programs, toy libraries and parenting groups. Activities for children, parents and the community are designed in response to community needs. A full-time facilitator is appointed to each Centre and works closely with local committees including a local advisory committee to identify and respond to local service needs.

Programs are targeted to issues faced by families with children from birth to eight years with a focus on the years prior to school entry in order to strengthen protective factors and minimise the impact of risk factors.

An evaluation undertaken by an independent consultant in 1997 found that children were being effectively prepared for schools and that families have been supported in their parenting role. For example, in Coonamble, Aboriginal children's participation in transition programs increased by 70%, while in Redfern absenteeism in the early years of school has declined markedly. As an early intervention strategy and because it is well grounded in existing local networks and services, the program has the potential to strengthen families and communities and to ensure that children at-risk are better prepared for schooling.

The Taskforce also considered the considerable work already underway in this sector by the CESCEO Early Childhood Education Working Party and the OECD Thematic Review of Early Childhood Education and Care Provision in Australia, and undertook further work to identify issues and gaps.

The OECD 12 Country Comparative Report on Early Childhood Education and Care is expected to be released shortly. The report identifies a number of key elements of effective national policy in early childhood education and care, including adopting a systematic and integrated approach to policy development and implementation and developing resource strategies to support a sustainable system of services.

The Early Childhood Education Working Party report to CESCEO in June 2001 proposed six 'essential beliefs and understandings' that should underpin the provision of high quality environments for children in the early years. These six 'essential beliefs and understandings' are:

1. all children are capable, resourceful and valuable in their own right;
2. all children have the right to realise their potential and all can succeed given the appropriate support and resources;
3. children learn best when their diversity of experience, in home and community is recognised and built upon in other settings;
4. the role of the family and community is critical in children's learning and development;
5. children's successful development transcends sectoral boundaries and includes children learning and developing in all settings;
6. the role of the early childhood educator and the relevance of early childhood curriculum are critical factors in influencing children's learning and development.

The Taskforce focussed on a number of these 'essential beliefs and understandings' and expanded on them in relation to ongoing concerns about school readiness and transitional issues for Indigenous children 0 to 8 years (which are reported separately). In this paper, the Taskforce focussed on the belief and understanding that 'all children have the right to realise their potential and all can succeed given the appropriate support and resources'.

The Taskforce recognises the close relationship between health and educational outcomes and acknowledges the current synergies operating in the education and health sectors to improve the educational and health outcomes of Indigenous children.

In particular, the Taskforce acknowledges the work undertaken by the health sector to develop and implement the 1989 National Aboriginal Health Strategy. In respect to education, the Strategy stated that it is widely accepted that formal education is decisive in improving health and reducing mortality. Recent studies have shown a clear relationship between levels of education in adults and risk factors for heart disease, stroke and other diseases for which nutrition is a major factor.

The 1989 National Aboriginal Health Strategy has been implemented particularly through the establishment of agreements and direct partnership arrangements in each State and Territory between the public health sector and the Aboriginal community controlled health sector. Under these arrangements, each State and Territory has established a joint planning forum and has undertaken a process of regional planning to identify the priority needs for each jurisdiction and location. Reporting on progress is undertaken in terms of the Aboriginal and Torres Strait Islander Health National Performance Indicators developed by the Australian Health Ministers' Conference and the Australian Health Ministers Advisory Council. The consultation document for the 2001 National Aboriginal and Torres Strait Islander Health Strategy proposes to build on these arrangements.

In addition, the Taskforce notes that Commonwealth Department of Family and Community Services launched the Stronger Families and Communities Strategy in 2000 to support a range of prevention, early intervention and capacity building initiatives to support and strengthen Australian

families and communities. In particular, the Strategy encourage communities to find new ways to strengthen families, with a focus on early childhood development. The Department of Family and Community Services also undertakes a range of other relevant initiatives such as such as The Early Childhood Working Group, Good Beginnings, Bringing Them Home - Parenting and Family Support, and Early Intervention.

COAG decisions, November 2000

On 3 November 2000, the Council of Australian Governments (COAG) commented on the work of the Council for Aboriginal Reconciliation over the past nine years and stated that reconciliation is an ongoing issue in the life of Australians and a priority issue for all governments that will require a concerted and sustained effort over many years.

COAG acknowledged the unique status of Indigenous Australians and the need for recognition, respect and understanding in the wider community. The Council agreed that many actions are necessary to advance reconciliation, from governments, the private sector, community organisations, indigenous communities, and the wider community. Governments can make a real difference in the lives of Indigenous people by addressing social and economic disadvantage, including life expectancy, and improving governance and service delivery arrangements with Indigenous people. Governments have made solid and consistent efforts to address disadvantage and improvements have been achieved. For example, Indigenous perinatal mortality rates have dropped from more than 60 per 1,000 births in the mid-1970s to fewer than 22 per 1,000 births in the mid-1990s. However, much remains to be done in health and the other areas of government activity.

Drawing on the lessons of the mixed success of substantial past efforts to address Indigenous disadvantage, COAG committed itself to an approach based on partnerships and shared responsibilities with Indigenous communities, programme flexibility and coordination between government agencies, with a focus on local communities and outcomes. It agreed priority actions in three areas:

- investing in community leadership initiatives;
- reviewing and re-engineering programmes and services to ensure they deliver practical measures that support families, children and young people. In particular, governments agreed to look at measures for tackling family violence, drug and alcohol dependency and other symptoms of community dysfunction; and
- forging greater links between the business sector and indigenous communities to help promote economic independence.

COAG agreed to take a leading role in driving the necessary changes and will periodically review progress under these arrangements. The first review will be in twelve months. Where they have not already done so, Ministerial Councils will develop action plans, performance reporting strategies and benchmarks. The Ministerial Council on Aboriginal and Torres Strait Islander Affairs will continue its overarching coordination and performance monitoring roles, including its contribution to the work of the Review of Commonwealth/State Service Provision.

Issues of concern

The Taskforce decided to build on its previous report and this further work, and examine a range of health and educational issues for Indigenous children. The Taskforce was already familiar with the impact of otitis media on Indigenous educational outcomes. As part of this work the Taskforce considered more comprehensive advice on a range of health issues that affect Aboriginal and Torres

Strait Islander children from birth to 8 years. In addition, the Taskforce considered advice from international and Australian initiatives on how to improve the health, psychosocial and educational outcomes of children at risk.

The following chapter of this discussion paper summarises advice on nine health issues of concern to the Taskforce that affect Aboriginal and Torres Strait Islander children from birth to 8. These issues are:

- lower life expectancy at birth;
- low birthweight 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 injuries.

CHAPTER TWO: HEALTH ISSUES FOR AUSTRALIA'S INDIGENOUS CHILDREN, BIRTH TO 8 YEARS

This chapter summarises advice on nine issues of concern to the Taskforce and proposes them as the basis for discussion and further advice. The nine issues are: lower life expectancy at birth; low birthweight 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 and childhood injuries.

Introduction

The renewed international interest in the first eight years of life, together with new research evidence, have highlighted a range of findings that show that low birth weight, recurrent illnesses, a lack of psychosocial stimulation, acute and/or chronic malnutrition and the stresses of poverty can lead to poor health and a general lowering of intellectual, behavioural and social abilities, often leading to poor school performance, welfare dependence and not reaching their full potential.

In the past decade, major progress has been made internationally and in Australia to reduce and contain childhood mortality and morbidity. This progress has been achieved through universal childhood immunization, improved antenatal and maternal care, control of diarrhoeal diseases and acute respiratory infections, nutrition programmes (including breast-feeding promotion) and implementation of other primary health care activities. These activities have dramatically reduced mortality and morbidity rates for Aboriginal and Torres Strait Islander children.

There are a range of national and State and Territory initiatives currently underway or recently completed in the health sector that focus on improving the health outcomes of Indigenous Australians. These initiatives include:

- consultations on 2001 National Aboriginal and Torres Strait Islander Health Strategy,
- Aboriginal and Torres Strait Islander Health Review,
- Review of Hearing Health Services to Indigenous Peoples,
- evaluation of four coordinated care trials in Wilcannia (NSW), Tiwi Islands (NT), Katherine (NT), and Perth/Bunbury (WA);
- delivery of accredited Aboriginal and Torres Strait Islander Health Worker Training;
- National Mental Health Strategy;
- Eye Health in Aboriginal and Torres Strait Islander communities (1997);
- implementation of National Indigenous Health Information Plan;
- NH&MRC nutrition report (2000);
- National Child Nutrition Program.

Nevertheless the health of Indigenous children is still poorer than the health of other Australian children.

The Taskforce recognises the close relationship between health and educational outcomes and acknowledges the current synergies operating in the education and health sectors to improve the educational and health outcomes of Indigenous children. The Taskforce also acknowledges existing cross-portfolio arrangements within States and Territories between education and health jurisdictions.

The following sections summarise advice on nine health issues of concern to the Taskforce that affect Aboriginal and Torres Strait Islander children from birth to 8 years and proposes them as the basis for initial discussion with health sector representatives. These issues are:

- lower life expectancy at birth;
- low birthweight 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 injuries.

In summarising these issues, the Taskforce has referred to nationally available advice and at the same time, acknowledges the limitations of current national data sets and the extensive discussions and initiatives that are underway to improve the data sets. At the same time, the Taskforce also acknowledges that the various State and Territory health jurisdictions have different data sets, some of which contain valuable advice on the health of Indigenous children.

Lower life expectancy at birth

Indigenous Australians have lower life expectancy at birth rates and higher mortality rates for all ages compared to other Australians. The life expectancy at birth rates for Indigenous Australians is on par with those in many developing countries throughout the world, such as India and Gambia (see **Box 2** for further details).

Box 2: Life expectancy at birth and mortality rates

Life expectancy at birth represents the average number of years a newborn baby could expect to live if the mortality rates of today were to continue throughout that baby's life. The World Health Report 2000 shows that for 1999, life expectancy at birth for all Australians was 76.8 years for males and 82.2 years for females. However life expectancy at birth (1991-96) for Indigenous Australians was estimated to be about 20 years less: 56.9 years for Indigenous males and 61.7 years for Indigenous females[7]. Life expectancy at birth for the Canadian total population is much the same as for all Australians. However life expectancy at birth for Canadian Indians was estimated to be about 6.5 years less (cf. 20 years less for Indigenous Australians) and continues to approach parity with the general Canadian population (1995)[8]. On the other hand, life expectancy at birth rate for Gambia is 56 years for men and 58.9 years for women; for India, 59.6 years for men and 61.2 years for women (1999).

In addition to lower life expectancy at birth rates, mortality rates for Indigenous Australians for all ages is higher than for other Australians. Between 1991 and 1996, the Indigenous Australian infant mortality rate was three times higher than the non-Indigenous infant mortality rate[9]. In 1996, over 19 Indigenous infants died per 1000 live births (or about 220 deaths per 11 500 live births) compared to 6 per 1000 live births for other Australian infants. By contrast in Canada (1994), the First Nations infant mortality rate was lower at 12 per 1 000 live births, but this was still double the rate for the Canadian population as a whole (just under 6 per 1 000 live births). In addition, the Indigenous infant mortality rate (1991-96) varies according to gender, with the infant mortality rate three times higher for Indigenous boys but four times higher for Indigenous girls than for other Australian infants.

Lower life expectancy at birth and a high premature mortality rate for all ages in a comparatively small population means that 'surviving' Indigenous Australians suffer more earlier deaths in their families and communities, compared to other Australians. The greater number of deaths by proportion of the population has two main flow-on effects for the education of Indigenous children aged from 0 to 8 years.

First, some Indigenous communities across Australia are likely to be in a chronic state of grief and bereavement due to the premature deaths of children and adults. Mental health research into the perinatal period (from conception to 2 years of age) shows that bereavement and grief negatively impacts on the physical and mental development of children[10].

Secondly, Indigenous children are likely to attend more funerals during the year than their non-Indigenous peers. Anecdotal evidence suggests that in some communities there can sometimes be several funerals per week and in other communities, Friday is regularly kept 'free' for funerals. This means that Indigenous children are unable to attend early childhood centres and schools and take advantage of the opportunities available to them, at the same level as other Australian children.

The Taskforce acknowledges that there is likely to be considerable geographical variation in life expectancy at birth and high premature mortality rates for all Indigenous Australians and that these will have varying impacts on the educational outcomes of the under-8 Indigenous population. The Taskforce proposes that it may be useful for the education and health sectors to jointly identify and explore some of this variation and any relevant examples of effective practice with a view to promoting this advice at the local level. There are a number of existing forums and electronic Indigenous health clearinghouses that have been established at a State and Territory level to promote effective practice and these may provide opportunities for further collaboration.

Low birthweight and failure to thrive

It is well recognised that the health and intellectual, behavioural and social abilities of children deteriorate over time with the impact of low birthweight, acute and chronic malnutrition, inadequate care and nutrition depletions caused by repeated bouts of illness.

Many countries report on the proportion of the under-5 population who are underweight, stunted or wasted. UNICEF estimates that almost 40% on average of children in developing countries aged under-5 are stunted (1998)[11]. Low values of height-for-age are referred to as 'stunting' and is a measure of chronic malnutrition. Low values of weight-for-height are referred to as 'wasting' and is a measure of acute or short-term malnutrition.

Acute and/or chronic malnutrition before birth and in the first years of life can seriously interfere with brain development because the great majority of physical brain development occurs by the age of three. The total number of brain cells in an infant is settled by about 6 months, and up to 3 years, the brain cells increase in size and complexity in relation to other cells. Malnutrition reduces the total amount of cellular material in the brain[12]. This situation may be further aggravated by gastrointestinal diseases which reduce the uptake of nutrients from the small intestine.

Australia's Health 2000 report estimates that, in every age group of Indigenous mothers, at least 10% of Indigenous babies are born weighing less than 2.5 kgs. Low birthweight babies have smaller heads and therefore smaller brains. According to projected population estimates for 2000, this means that over 1 300 Indigenous children born in 2000 are likely to be low birthweight babies. The proportion of low birth weight Indigenous babies varies according geographical location[13].

According to the National Health and Medical Research Council report entitled *Nutrition in Aboriginal and Torres Strait Islander People* (2000), approaches to eradicating these issues and their consequences need to be multi-faceted and include improved physical infrastructure, better food supplies, health and nutrition education and access to clinical care[14].

While the national rates of low birth weight are known for Indigenous Australian children, the level of acute and/or chronic malnutrition after birth is known in only some States and Territories.

In some parts of Australia, it is common either for malnourished Indigenous children to be admitted to hospital for nutritional rehabilitation, or for malnourished children admitted for other reasons to be kept in hospital for rehabilitation. Indigenous children frequently lose the weight gained in hospital after discharge. The long-term effects of this weight cycling are unknown[15]. The NH&MRC report entitled *Nutrition in Aboriginal and Torres Strait Islander People* (2000) states that it would seem more sensible to have community-based programmes directed at early detection and intervention than to use the hospital system for intensive crisis care.

In Australia, the Strong Women, Strong Babies, Strong Culture programme is an example of effective practice in improving birthweight (see **Box 3** for further details).

Box 3: Effective practice in improving birthweight

The Strong Women, Strong Babies, Strong Culture programme (1994-96) conducted in NT focused upon improving birthweight[16]. The programme used a family cultural model which was developed by Aboriginal women and health workers and implemented by senior Aboriginal women within the pilot communities.

The programme explored the two main reasons for low birthweight infants: born prematurely and intra-uterine growth retardation. Low maternal weight, pre-pregnant weight and low weight gain during pregnancy are well known risk factors for intra-uterine growth retardation. The programme promoted a number of ways of addressing this issues: increased access to antenatal care in the first trimester; nutritional assessment and monitoring in prenatal care; and improving maternal nutrition and general health.

The programme ran in a number of pilot communities where the low birthweight rate was known to be high. Pregnant women were supported to visit the clinic early in pregnancy, to eat properly, and to take prescribed antibiotics according to schedule. The programme acknowledged and encouraged traditional cultural practices. After the programme began, there was a statistically significant decline in the prevalence of low birthweight from 21% to 13% overall, and this was larger in some of the communities (from 17% to 5%). There was also a decline in the proportion of premature deliveries. The programme showed that improvements in infant birthweight were associated with a decline in premature deliveries and increases in three maternal weight measures: weight at less than 17 weeks of pregnancy, weight gain during pregnancy, and weight at last clinic visit. Seven new communities adopted the programme in 1997.

A number of international targeted early childhood programmes have focussed on improving the birthweight, diet, psychosocial stimulation and health of mothers and young children and enhancing educational outcomes. Reviews of these programmes indicate that children up to 3 years of age living in communities marked by a high prevalence of malnutrition, benefit most - in both health, psychosocial and educational terms - from targeted early childhood programmes[17]. These programmes are linked over time to improved nutrition and health, higher school enrolment, less grade repetition and fewer school dropouts. These programmes highlight the importance of monitoring and reporting in terms of outcomes, and following up effectively on issues of concern.

For example, programmes in the United States, the former Soviet states, and India target very young, low birthweight children as the group most vulnerable and most likely to benefit from an intervention programme. Under the U.S. Infant Health and Development Programme, intensive early intervention was started as early as three months of age and was shown to prevent developmental delay. When compared with randomised controls, the incidence of mental retardation (that is, of IQs measured at less than 70) was reduced by an average factor of 2.7. Similar studies in Asia, the Middle East, and Latin America confirm that early intervention can increase school readiness, promote timely school enrolment, lower repetition and dropout rates, and improve academic skills.

In Australia there does not appear to be any available comparable advice on targeted early childhood programmes in Australia, especially Indigenous children up to 8 years of age in communities marked by acute and/or chronic malnutrition. This area is characterised by sporadic, short-term early intervention programmes and a lack of widespread public reporting on programme outcomes.

The current National Child Nutrition Program recognises that poor nutrition severely limits a child's capacity to concentrate and learn in the classroom setting. This in turn may cause lethargy, disruptive behaviour and absence from early childhood centre and school. Under the program, grants are provided to local communities to allow them to improve the diets and long term eating patterns of young children. As part of the program, specific funds have been allocated to improve the literacy and numeracy capabilities of Indigenous children through nutritional strategies which increase:

- awareness in the community of the link between good nutrition and educational achievement;
- parents', children's and the community's awareness of healthy diets and outcomes in healthy eating patterns;
- the community's capacity to promote better nutritional health and related knowledge and skills in the target population;
- access and availability of nutritious foods in the community; and
- school attendance rates.

The Taskforce acknowledges that there is likely to be considerable geographical variation in the proportion of the under-8 Indigenous population who are underweight, stunted or wasted. The Taskforce proposes that it may be useful for the education and health sectors to jointly identify and explore some of this variation and any relevant examples of effective practice with a view to promoting this advice at the local level.

Poor quality diet

There is increasing evidence that a healthy diet prenatally and in the first months and years of life may play an important role in preventing the development of later disease and in improving mental and physical growth.

A healthy diet means that all the essential nutrients – carbohydrates, fats, protein, vitamins, minerals and water- are available. A lack of any nutrient may result in disease, so every effort should be made to maintain an adequate, balanced daily intake of all the essential nutrients. The Australia Guide to Healthy Eating describes a healthy diet as one which includes enough food from each of the following groups of food every day: bread, cereals, rice, pasta, noodles; vegetables; fruit; milk, yoghurt, cheese; and meat, fish, poultry, eggs, nuts. A healthy diet includes: plenty of water; plenty of plant foods; moderate amounts of animal foods; and small amounts of oils and fats.

The limited information about the diet and nutritional health of Aboriginal and Torres Strait Islander people before European arrival suggests slim, strong people.[18] With the transition from a traditional hunter-gatherer lifestyle to a sedentary Western existence, the Indigenous diet has changed from a varied, nutrient-dense diet to an energy-dense diet, high in fat and refined sugars. This has had a serious negative impact on the health and well-being of Indigenous children, in particular.

It is well recognised that there are serious nutritional problems in many Indigenous communities and they may be very complex. There are a range of socio-economic, geographical, environmental, social factors and government regulations that influence the supply of a high quality diet to

Indigenous children living in urban, rural and remote locations. One of the major issues is the lack of access due to high cost, poor quality and lack of safe storage. The NH&MRC has noted that there is still a lack of well-evaluated nutrition/health programs for Indigenous peoples and has issued a guide for health workers which explores a range of issues relating to the nutrition of Aboriginal and Torres Strait Islander children[19].

The Taskforce proposes that it may be useful for the education and health sectors to jointly identify any relevant examples of effective practice with a view to promoting this advice at the local level.

High disease rates

In 1997, there were over 40 diseases or disease groups which were reportable in at least some Australian States and Territories, including tuberculosis, hepatitis, malaria, leprosy, measles, Ross River fever, mumps, whooping cough and salmonellosis. Despite major shortcomings in the quality of the data, the notification rates for Indigenous people are higher than rates for the total population. Diseases and infections which are more common in children would therefore be expected to have higher rates for Indigenous children[20]. This high disease rate impacts on their general health and levels of school attendance. Children who are unwell and hungry have less energy for the forms of proactive studentship which are most productive of learning.

Iron-deficiency anaemia in infants and children is associated with lower scores on tests of development, learning and school achievement[21]. Available evidence suggests that it is more common in Indigenous Australians than in other Australians, in some cases 12% of Indigenous children compared to an estimated 3% in non-Indigenous children[22]. Some self-reported surveys have found that 31% of Indigenous women aged 14 years and over had iron-deficiency anaemia due to inadequate dietary iron intake[23].

Respiratory diseases are the most common reasons for hospitalisations for both Indigenous and non-Indigenous children (0-14 years), however the Indigenous rate is twice that for other Australian children[24]. In relation to acute respiratory diseases, asthma was the most commonly reported condition nationally for Indigenous children aged less than 5 years (17%) and 5-14 years (23%)[25], though prevalence varies considerable across the country. Bacteria causing fatal pneumonia can often be killed by several inexpensive antibiotics. The widespread use of antibiotics however has resulted in many bacteria becoming partially or completely resistant to some antibiotics.

Vaccines are available to prevent diphtheria, tetanus, whooping cough, polio, measles and tuberculosis. Advice on national immunisation rates for Indigenous children does not appear to be available, however similar immunisation rates were reported in metropolitan, rural and remote areas in 1995 for all major vaccine-preventable diseases in Australia[26]. Further work is underway on a range of vaccines against other respiratory tract infections and ear infections. Currently, conjugate pneumococcal vaccine is being introduced into Australia and being evaluated for use with Indigenous children. There is encouraging evidence from international studies that immunisation of pregnant women with some of these new vaccines may protect their babies against the serious effects of respiratory tract infection in early infancy[27].

According to WHO, Australia is one of 54 countries that still has hyperendemic blinding trachoma, though incidence is subject to substantial geographical variations. Trachoma is a chronic conjunctivitis and the early stages of trachoma (follicular trachoma) can be seen in young children and if long standing and moderately severe, can lead to severe scarring of the eyelids, opacification of the cornea and blindness in later life. There is limited data on the extent of the epidemic among Indigenous children but it appears that the levels could be high. A central Australian study (1995-

96) showed that of over 200 school and pre-school children in the community, over 40% had trachoma, including over 30% with follicular trachoma.[28]

The incidence of otitis media with effusion (OME) among Indigenous Australian children living in remote communities has been found to range from 40% - 70%[29]. OME in advantaged populations around the world is approximately 5% in childhood, falling to less than 1% after age 12. Younger children experience more frequent infectious episodes and eardrum ruptures typically begin within the first three months of life. With repeated ruptures, healing, and re-ruptures, the eardrums become scarred and thickened. In many cases the ruptures become too large to heal and would require reconstructive surgery to repair. Therefore during the early years, which are critical for speech and language development as well as for growth and elaboration of the nerve pathways between the inner ear and the temporal cortex of the brain, the great majority of Indigenous children experience fluctuating hearing loss. Such sensory deprivation during the developmental period subsequently leads to delays in learning and language acquisition.

It is difficult to determine the level of 'educationally significant hearing impairment' in the school-aged Indigenous population in Australia. However a school-based project (1998-99) undertaken in Alice Springs, Darwin and a number of remote sites and involving about 1000 students, showed that 79% of Indigenous students were found to have an educationally significant hearing impairment[30] (see **Box 4** for further details).

Box 4: Educationally significant hearing impairment

In 1998-99 the NT Independent Schools Association and the Menzies School of Health undertook a school-based project in Alice Springs, Darwin and a number of remote sites involving about 1000 students.

The project showed that 79% of Indigenous students were found to have an educationally significant hearing impairment. 40% required the services of an ENT specialist to treat active disease and/or need reconstructive ear surgery. 16% had persistent conductive hearing loss that met Australian Hearing (AH) criteria to be issued with individual FM classroom hearing aids. An additional 24% had conductive hearing impairment that did not meet the AH criteria. 38% had Central Auditory Processing Disorder– these students can hear but cannot completely understand running speech against a background of noise and competing messages.

The project suggested a positive correlation between educationally significant hearing impairment and attendance – this was particularly an issue for the project since it could not comment on data from the primary school children because of poor attendance. Across all 6 schools and 1000 students, only 21% or 212 students attended at least 75% of school days in 1998 and were available for both pre- and post-testing and none of them were primary aged students. Higher incidences of otitis media in primary-aged students contributed to poor attendance.

Advice to House of Representatives Inquiry into Indigenous Health (1999) and the Senate Inquiry into Indigenous Education (1999) showed that while hearing health protocols and monitoring mechanisms seem to be satisfactory, there is a general concern about the overall level of health resourcing available to provide adequate follow-up support and to monitor effectively on a long term basis. This means that first of all, even though the appropriate level of medical services is identified through a screening programme to meet the child's requirements, there is often a breakdown in ensuring that the services are provided. Secondly, to ensure that screening is more thorough and follow-up/monitoring of all children with problems is more efficient, fewer children are often included in the screening programme. So children may be screened in the first year of schooling and the last year of primary school. This means that new enrolments or transfers from other schools may not be picked up. Finally, anecdotal evidence indicates that access to the delivery of regular hearing tests is restricted by a number of factors.

There is a range of current initiatives in the early childhood, school and health sectors highlighting the importance of addressing otitis media and other health issues in Indigenous children. At the same time, there is considerable variation in the levels of professional development available across the sectors, with early childhood services, especially in the birth to 3 years area, having lower levels of support.

Sound field amplification units are available for installation in schools, together with training, through Australian Hearing Services.

Evidence-based guidelines have been developed for treating otitis media, together with indicators of hearing loss. Because the evidence of hearing loss in a classroom context is not always readily identified, teachers need to be supported in developing a range of strategies that address the different needs of children with senso-neuro loss, conductive hearing loss and central auditory processing disorder.

In NSW, Aboriginal health workers are receiving professional development in otitis media screening and audiometry training, particularly through OTEN's 1 year Community Audiometry course. A number of education departments have produced professional development packages (*Can't Hear, Can't Learn: Otitis Media and Aboriginal Children*, NSW; *Do You Hear What I Hear*, WA) which highlight otitis media and conductive hearing loss (OM/CHL), focus on the identification of students with OM/CHL and provide classroom strategies to overcome some of the associated problems.

The National Indigenous English Literacy and Numeracy Strategy recognises that the health status of children is a powerful influence on their ability to come to early childhood centres and school and when at school, on their capacity to learn and fully participate in schooling opportunities. For example, under Key Element 2 of the Strategy, a range of initiatives will be supported, including hearing assessments and health screening in preschools and at entry to primary school. In WA, for example, EDWA has commissioned Edith Cowan University to undertake research and develop a teacher training program which addresses both OM and CHL, and looks at reducing CHL through an improved partnership between the health and education sectors.

In addition, work is being supported by the NH&MRC and DETYA to link completion of a particular regime of antibiotic treatment with a reduction in the level of CSOM recurrence, a reduction in the level of school absenteeism due to sickness, and an improvement in school attendance. Further details on the trial are provided in **Box 5**.

Box 5: NACCHO Ear Trial & School Attendance Project

The National Aboriginal Community Controlled Health Organisation (NACCHO) has received an NH&MRC Clinical Trial Research Grant to conduct a trial comparing the effectiveness of two topical antibiotics to treat chronic suppurative otitis media (CSOM) in Aboriginal children. The trial is funded from mid-2000 to mid-2002 and will provide advice on the time taken for the ears to heal and the incidence of CSOM (or runny ears) recurrence. The optimal treatment of CSOM is unclear and there is currently no advice internationally from clinical trials on the healing rate of children with CSOM.

Current treatment includes topical antibiotics or antibiotic eardrops. The current recommended treatment (Australian Antibiotic Guidelines 1999) is to use Sofradex. There have been concerns that current treatments have been found to be toxic in animal studies, but these have not been substantiated in human studies. Now, an alternative antibiotic (Ciprofloxacin) has become available that is non-toxic and is more effective in small pilot studies than the current treatment (Sofradex). The Trial is controlled and will compare both of these antibiotics. It will test whether runny ears dry up more quickly, whether the hole in the ear drum heals and whether there is improved hearing with this new antibiotic. It will also examine if the use of the current treatment of ear drops leads to antibiotic resistance in the organisms that cause runny ears.

The Trial will compare all of these outcomes by treating and following up 300 Indigenous children (3 to 15 years of age) with CSOM over a number of Aboriginal Community Controlled Health services (ACCHs) in WA and Qld. The sites in WA are: Bidyadanga (Broome), Yurayungi (Halls Creek), Wirakamaya (Port Headland) and Geraldton. The sites in Qld are: Dalby (west of Brisbane), Brisbane and Townsville. The final sites have high incidences of CSOM and were chosen by a selection-based process. 300 children will be 'recruited' by mid-2001. The children will be examined and treated on referral, then everyday for 10 days, on day 14 to establish whether the ear is healed, and then at 30 days and 90 days to check for recurrences.

Criteria for recruitment of children include:

- Inclusion criteria: children with CSOM (aged between 3 and 15 years) with runny ears and tympanic membrane perforation for at least 2 weeks (World Health Organisation case definition 1998) with parental informed consent;
- Exclusion criteria: treatment with antibiotics in the preceding 2 weeks; history of adverse reaction to ototopical antibiotics; complicated otitis media; anatomical predisposition to CSOM such as congenital ear malformations; recent ear surgery; children not likely to be resident in the study region over the 4 month follow-up period.

The children and families recruited into the trial will receive free treatment, comprehensive follow-up of their chronic ear problem and education on the management of this condition. The children will be receiving either the trial medication or the standard treatment that they would be receiving anyway.

The recruitment of children will be conducted at each site coordinated by the Aboriginal Health Workers. In additional to opportunistic recruitment from clinic attendances, the Aboriginal Health Workers will also conduct:

- locally appropriate community health promotion activity to encourage clinic attendances;
- enhanced progressive recruitment of children from opportunistic clinic screening;
- if suitable as the service setting, a primary school screen conducted early in the recruitment phase through collaboration and partnerships with school health nurses, or referrals received from school health nurses conducting schools screens.

Through the National Indigenous English Literacy and Numeracy Strategy, DETYA provides further support for this trial to establish a link between effective treatment of CSOM, reduced periods of deafness and school exclusion, and improved school attendance and educational outcomes. Aboriginal Health Workers will encourage school attendance and this is also an important intervention. In the long term, the improved treatment may lead to shorter periods of hearing loss which will help to address the inequalities in education and employment between Aboriginal and non-Aboriginal people. In addition, linking improvements in school attendance to the results of the trial will provide critical advice for school systems and allow schools to more effectively engage with the health sector in addressing hearing problems. The calculation of school attendance rates will require the assessment of school attendance for each individual Indigenous child from the date of recruitment in the trial till the end of the 2001 school year, comparison with that child's school attendance in the last term of the 2000 school year; and aggregation of the data and any comparison with school attendance data of non-Indigenous peers.

The Taskforce acknowledges that there is likely to be considerable geographical variation in the number and extent of various childhood diseases and their impact on educational outcomes of the under-8 Indigenous population. The Taskforce proposes that it may be useful for the education and health sectors to jointly identify and explore some of this variation and any relevant examples of effective practice with a view to promoting this advice at the local level.

Social and emotional wellbeing

The foundations of good mental health are laid down in the social and emotional development that occurs in infancy and later childhood and appear to be dependent upon the quality and frequency of response to an infant or child from a parent or primary caregiver. The parental response to the infant's emotions or expressive behaviours usually results in the formation of an attachment bond between the two. This bond develops in the early months and years of life, and is closely linked to the behavioural response of the parent and the ongoing cycle of parent-child interaction.[31]

Studies have found that there is less interaction between mothers who are depressed and their infants, resulting in less than optimal behaviour expressed by the infant. Several studies point to early maternal depression and adverse outcomes in older children[32]. The adverse outcomes include: poorer mental and motor development in later infancy; emotional difficulties in late infancy, and poorer cognitive outcomes among pre-school aged children.

There is therefore a strong association between parental mental health problems and increased risk for poor child health outcomes. Risks to the infant increase if both parents experience mental health problems and can include low birthweight, impairments in cognitive and language functioning, and in physical and psychosocial development.

Perinatal mental health refers to the social and emotional well-being of a mother, her partner and their infant, from conception until 24 months after birth. Researchers have identified a number of risk factors associated with mental health problems in the perinatal period[33]. During the pregnancy, these can include: maternal age less than 18 or greater than 35 years; mother does not attend antenatal care; low socio-economic status or financial strain; geographical isolation; language difficulties; drug or alcohol problems; bereavement and grief; domestic violence; low self-esteem; and chronic physical problems.

Many of these risk factors are present in the Indigenous Australian population. The forcible separation of Indigenous children from their families, and the disproportionately higher level of Indigenous youth and adult incarceration in prison increases the incidence of these risk factors.

For children with a parent or caregiver on remand or in prison, the emotional effects of separation alone can include anger, depression, grief, confusion and fear. Changes in practical circumstances because a parent or caregiver is on remand or in prison can result in sudden changes in parenting arrangements, financial hardship, new schools and homes and separation from siblings. Children can experience aggression and behaviour problems, lack of trust, defiance of authority and low self-esteem. This is particularly an issue for children of Indigenous parents because of the disproportionately higher rates of incarceration.

Young people with chronic health conditions and their families may experience stressful events which, combined with the stress of living with a chronic condition, place them at greater risk of later psychological problems. Not all young people with chronic health conditions show signs of distress or psychological problems, but there may be warning signs including: lack of attendance at school for over three months, deterioration in school performance, withdrawal from social interactions, a tendency to blame the self, a developing sense of helplessness and hopelessness, a denial of problems and poor compliance with treatment[34].

A number of early intervention projects have been funded under the Second National Mental Health Strategy and the National Youth Suicide Prevention Strategy. These projects include the establishment of the Australian Early Intervention Network for Mental Health in Young People.

As part of this project, the network encourages professionals and health administrators to reorient their own services to focus on clinical approaches to early intervention in child mental health. These approaches include the perinatal period, attention deficit hyperactivity disorder in preschool aged children, early intervention in conduct problems in children and the psychological adjustment of children with chronic health conditions. Resources have been developed that promote a consensus view on a good practice approach to early intervention. The placement of early intervention project officers in service sites across Australia has provided further advice.

The development and implementation of *MindMatters*, a mental health promotion program for secondary schools, has highlighted a range of issues that need to be considered in address Indigenous mental health issues, especially in relation to resiliency development and training in early childhood.

MindMatters is a resource and professional development program to support Australian secondary schools in promoting and protecting the mental health of members of school communities. *MindMatters* uses a whole school approach to mental health promotion and suicide prevention. It aims to enhance the development of school environments where young people feel safe, valued, engaged and purposeful. Social and emotional wellbeing have been linked to young people's schooling outcomes, their social development, their capacity to contribute to the workforce and to the community, and to reducing the rate of youth suicide.

Following on from the initial materials development, work began on an Indigenous framework for professional development in schools. The resulting draft document, *CommunityMatters*, addresses not only Aboriginal and Torres Strait Islander issues but other cultural and social aspects of promoting social and emotional wellbeing of students in secondary schools. It does this by exploring the inter-relationship between identity, culture and community; identifying and suggesting strategies for respecting diversity in school communities and classrooms; and expanding on working in partnership with the community to promote mental health.

Work to develop *CommunityMatters* has found that:

- the mental health (social and emotional wellbeing) of members of a school community will be enhanced by their feelings of connectedness to that community;
- because Australia is characterized by diversity, including a large degree of cultural diversity, it is essential for schools to respect, value and celebrate all students so that they may be able to feel part of the community; and
- the teaching, learning and ethos of the school will be enhanced by its connections and partnerships with the broader community.

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (part of the Second National Mental Health Strategy) provides a framework for a coordinated national approach to the promotion of mental health and prevention and early detection of mental health problems. The Plan addresses separate age groups, such as perinatal and infants 0-2 years, toddlers and preschoolers 2-4 years and children 5-11 years.

Substance misuse

In its submission to the House of Representatives Inquiry into Indigenous Health (1999), the Royal Australian and NZ College of Psychiatrists[35] advised that any substantial improvement in the general mental health of Indigenous Australians will require reduction in the level of substance misuse. Substance misuse cannot be dealt with in isolation and reduction of substance misuse will require efforts at many levels. Efforts to improve the employment situation and the quality of life for Indigenous Australians will be of particular importance. Mental health problems both contribute to and are caused by substance misuse. It will be necessary to provide adequate and culturally appropriate detoxification and rehabilitation facilities. This will be best be done by Indigenous communities working in partnership with community and mainstream mental health services.

In relation to the health of Indigenous children (0-8 years), the Taskforce focused on two main forms of substance misuse: alcohol and solvent sniffing.

In comparison to Australia's non-Indigenous population, a far larger proportion of Aboriginal and Torres Strait Islander people completely abstain from alcohol[36]. Many Indigenous communities ban or restrict the sale of alcohol. Those who do drink, however, are far more likely to drink to excess or to consume alcohol in a harmful way such as binge drinking. There are two important consequences of alcohol abuse for young Indigenous children. First, excessive alcohol consumption diverts the often limited personal expenditure of families away from essentials such as nutritious food, clothing and education. Secondly, one of the links in the substance misuse/mental illness cycle is the mayhem that occurs when an intoxicated person returns home or is 'dumped' at home often in the middle of the night. Safe places for intoxicated people to sober up with appropriate support will serve families and communities well and will contribute to a reduction in the health problems of the next generation.

Solvents of all types such as petrol, glues and paint thinners, are inhaled by young people across Australia. Indigenous community Elders are particularly concerned when solvent sniffing occurs in their communities for two main reasons. First, those involved are often very young and secondly, those involved disrupt normal family life by either spending much of their time in a trance-like state or by becoming violent and disruptive. The neuro-cognitive damage that quickly occurs with solvent sniffing not only limits a young person's ability to take full advantage of schooling, but also limits their ability to learn cultural and traditional beliefs. It is estimated that the per capita mortality rate of young people in those Indigenous communities with a significant solvent sniffing problem is of a similar order to that of non-Indigenous young people in urban areas affected by heroin.

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 provides further advice on the impact of substance misuse on neo-natal development and the 0 to 8 age group. Focussing on this age group provides an opportunity to strengthen their capacity to learn and reduce the risk of later substance misuse.

The Taskforce proposes that it may be useful for the education and health sectors to jointly identify and explore any relevant examples of effective practice with a view to promoting this advice at the local level.

Adolescent pregnancy

When an adolescent becomes a mother, her health and that of her child's are threatened. Children of adolescent mothers are more likely to be underweight and to die within their first month of life compared to those whose mothers are older. If they survive the first month, these children are still more likely to die before their fifth birthday[37].

As a general rule, Indigenous Australian mothers have babies at much younger ages than non-Indigenous mothers[38]. The mean age of Indigenous mothers was 24 years (1994-96), while the mean age of non-Indigenous mothers was 28.6 years. The proportion of Indigenous mothers who were adolescents is much higher than for non-Indigenous mothers. For 1994-96, almost one in four (24% or 10 732) of Indigenous mothers was less than 20 years old, nearly five times higher than for non-Indigenous women (5%). The numbers of adolescent Indigenous mothers varies by ATSIC region, ranging from 739 in Perth, 654 in Jabiru, over 500 in Cairns and Brisbane, to 80 in Ceduna (1991-96).

The Qld Aboriginal and Torres Strait Islander Women's Taskforce on Violence (2000) points out that there is concern that many Indigenous adolescent pregnancies are often perceived as being the result of promiscuity, when in fact the girls may be the victims of sexual abuse[39].

Adolescent pregnancy often leads to poor economic and social outcomes for adolescent girls and their children because girls lose out on schooling. Several countries have introduced national programmes to train parents in the principles of early child development. Many of these programmes focus on mothers because a mother's level of schooling is a better predictor of a child's cognitive growth, health, and reproductive outcomes than are family income, breadwinner's occupation, or other household variables.

For example, since 1969, Israel's Home Instruction Programme for Preschool Youngsters (HIPPY) has trained mothers from disadvantaged families to act as home teachers for their children aged 3 to 6 years. The programme serves 6 000 at-risk families a year and has been found to improve cognitive development and achievement and to decrease participants' chances of dropping out of school. In 1973, Israeli researchers developed the Home Activities for Toddlers and their Families (HATAF) programme to extend home training for mothers of infants aged one to three. Children must be no more than eleven to thirteen months old when they are enrolled in the programme. As at 1996, the HATAF programme serves roughly 2 000 families throughout Israel each year.[40]

There are a number of school-based initiatives in Australia that encourage pregnant adolescent girls to return to school or provide alternative learning environments for them, including NSW, Qld and SA programs.

The Taskforce acknowledges that there is considerable geographical variation in the number of Indigenous adolescent pregnancies and their impact on educational outcomes of the under-8 Indigenous population. The Taskforce proposes that it may be useful for the education and health sectors to jointly identify and explore some of this variation and any relevant examples of effective practice with a view to promoting this advice at the local level.

Childhood trauma

There is a body of emerging research which shows that exposure to trauma during infancy impacts on the development of the brain. Evidence suggests that because the brain is most receptive to environmental input in early childhood, the child is most vulnerable to the impact of traumatic experiences during this time[41].

There are a number of factors that may contribute to the traumatisation of children. These include violence in the child's environment, particularly the violent death of a parent or close family member or friend. Other factors include forced separation from parents and displacement from home, witnessing violent acts or seeing parental or caregiver fear reactions to violence. Poverty and malnutrition are also traumatising experiences for children. In some Indigenous communities, children suffer one or more of these experiences.

The impact of a trauma for a child is different to the impact trauma has on an adult. A trauma in the life of an adult may change the person, eroding the personality already formed or threatening an already formed identity. In contrast, when a child experiences a trauma, the child's developing sense of self and coping mechanisms are overwhelmed[42].

The two main sources of trauma are defined as 'family or domestic violence' and 'child abuse'. Feelings of helplessness, fear of death and a state of constant alertness are the daily burden of children living with chronic family violence and child abuse.

International evidence suggests that children aged five years and under are more likely than older children to be exposed to multiple incidents of family violence over a six month period.

In Australia in 1997/98, over half of the 34 663 children and young people accompanying their mothers to refuges were school-aged[43]. School-aged children face the developmental challenges of adapting to the school environment and establishing relations with peers. These tasks require the ability to regulate emotions, show empathy and attend to increasingly complex cognitive material. Such tasks are best supported by safe, secure relationships with parents. Many children and young people report in qualitative studies that domestic violence adversely affects their school performance and can disable their ability to learn.

There is considerable under-reporting of family violence. One of the main reasons that women find it difficult to seek help and disclose their experience of family violence is their fear that their children will be removed. In addition, many women are unable to leave their home because they have no where to go.

Domestic violence is the main reason cited by women seeking accommodation in refuges (40%), in particular among women with children. Refuges are temporary accommodation and their residents are classified by the ABS as 'secondary homeless'. The absence of immediate access to either short-term or long-term appropriate care, support and treatment services appears to be a major factor in generating homelessness.

The physical health of homeless people are generally poorer than that of housed counterparts ranging from respiratory problems, feet, dental and personal hygiene problems, infectious diseases and poor nutrition. Homeless children are slower in language development, motor skills, fine motor coordination and personal and social abilities, compared with housed children from low income families.

In some Indigenous communities, family violence is said to affect up to 90% of families[44]. Indigenous Australian men are four times more likely to die a violent death than non-Indigenous men, and Indigenous women are six and half times more likely to die a violent death than non-Indigenous women. This mortality rate is higher in some areas.

Research in Indigenous Australian communities indicates a direct correlation between family violence and alcohol and drug misuse, with between 70% to 90% of all assaults being committed while under the influence of alcohol or drugs[45].

A recent study of Indigenous Australians' attitudes to family violence found a very high level of awareness and concern about the effects on children[46]. The Qld Aboriginal and Torres Strait Islander Women's Taskforce on Violence (2000) points out that the trauma of witnessing family violence is compounded for many Indigenous children. They experience multiple traumatic situations such as witnessing community violence, death of loved ones, displacement from home and extreme poverty.

Family violence and child abuse frequently co-exist. Available research suggests that child abuse and family violence co-exist in between 30 and 60% of cases[47]. While children may be abused by the perpetrator of violence towards their mother, women who are being victimised may also abuse their children. Some commentators go further and argue that witnessing family violence is a form of psychological child abuse.

The Qld Aboriginal and Torres Strait Islander Women's Taskforce on Violence (2000) points out that the rising incidence of family violence in Indigenous communities is associated with increases in child abuse. While there is considerable reluctance, to the point of a 'culture of silence', to discuss sexual abuse against children in Indigenous communities, there is also considerable concern about the lack of agency response when cases are reported. At the same time, there are difficulties

in discussing issues of child abuse especially in small communities, because they quickly become public and can exacerbate community dysfunction. In addition, there is concern that Indigenous adolescent pregnancies are often perceived as being the result of promiscuity, when in fact the girls may be the victims of sexual abuse[48].

The Taskforce recognises that the responsibility for making sure that the needs of children are met and that they are safe within their families is shared between the family, the community and government.

All Australian governments have developed a range of services that are responsible for protecting children and for developing strategies that prevent child abuse. In contrast to family violence support services, child protection agencies have a legislative base and deal largely with involuntary clients. When adults caring for children do not follow through with their responsibilities or are abusive, then the child protection agency becomes responsible for taking action. Because of painful past associations with child protection agencies, many Indigenous communities step in to take care of the children.

Available evidence suggests that Aboriginal and Torres Strait Islander children are over-represented in the number of children under child protection orders[49] and that this constitutes a major issue for early childhood services with Indigenous children from birth to 5 years.

Because children are relatively powerless in abusive relationships, they rely on responsible adults to intervene and support them. As an agency responsible for the care and welfare of students, schools have a general interest and in many cases a legislative responsibility to protect the young people in its care from sexual, physical and emotional abuse and neglect. Police checks are now mandatory for teachers and education workers in many jurisdictions, and there are indications that the use of mandatory police checks is becoming more widespread across a range of sectors for adults working with children.

The school is often involved in reporting cases of child abuse and in ensuring that students in vulnerable situations receive the immediate help and support that they need. In some States, schools have a mandatory requirement to report on abuse and neglect. This responsibility of the school can pose considerable personal difficulties for teachers and education workers, especially in schools on small islands, small towns and in remote communities. Anecdotal evidence suggests that in many cases, Indigenous teachers and education workers are forced to leave their community once they have reported cases of abuse of children in their school.

The impact of family violence and child abuse on children can be exacerbated or ameliorated by the structures, policies and procedures of responsible government agencies. For example, the separate histories and development of the child protection and family violence systems pose particular challenges for the development of child protection responses for children affected by family violence and vice versa. Community consultations show that many Indigenous Elders are concerned about the level of child malnutrition in their communities[50]. In many cases, malnutrition is linked to alcohol and drug misuse, gambling and dysfunctional communities; however, it is difficult to address malnutrition either within the family violence or child protection systems. Finally, there is concern that the different requirements regarding family violence and child abuse under the relevant education, health and family and community services legislation may not be compatible.

As part of the Australian Early Intervention Network for Mental Health in Young People, trial work is underway to offer treatment to children and parents who are showing the early signs of abusive behaviour but are not currently engaging in physical abuse. This work helps to identify parents and

children who are at risk of developing abusive patterns, and teaches them more adaptive parenting skills before their behaviour becomes fully abusive. There has been marked interest from community and school advertising, with parents wishing to receive instruction on how to manage parenting behaviours that are perceived as potentially becoming abusive.

As part of the National Partnerships against Domestic Violence initiative, funding has been provided under the National Indigenous Family Violence Grants Programme to trial new community-based initiatives to reduce family violence in Indigenous communities. Many of these initiatives are exploring new approaches to family violence based on customary law practices and principles of restorative justice. Many of these new initiatives focus on community development models that emphasis self-determination and community ownership. In addition, these new initiatives are directed at health, drug and alcohol misuse and are linked to community capacity building and family healing.

The Taskforce acknowledges that there are enormous sensitivities and a 'culture of silence' surrounding childhood trauma issues, which make it difficult to discuss and address them. The Taskforce proposes that it may be useful for the education, health and family and community services sectors to jointly identify and explore any relevant examples of effective practice with a view to promoting this advice at the local level.

Childhood injuries

Injuries to children, usually through accidents, are a serious problem in Australia. We are among the worst countries in the world for this problem. Injury is the most common cause of death between the ages of one and 14. The death rate from injury for Indigenous children is nearly 4 times that of non-Indigenous children[51]. Injury deaths rates were 4 times higher for Indigenous boys and 2 times higher for Indigenous girls compared with other Australian children. Country children are at much greater risk than those from metropolitan areas. The most common causes of injury deaths are motor accidents, drowning, suffocation/asphyxiation (choking), burns and poisoning. There is a range of initiatives in place across a number of agencies to reduce the causes of injury deaths, such as road and water safety education.

The Report of the National Inquiry into Racist Violence in Australia found that racist violence was an endemic problem for Aboriginal and Torres Strait Islander people[52]. Violence associated with racism occurs in Australian schools, either as part of the racist harassment or in retaliation to it. This violence can take different forms, ranging from pushing and shoving, property damage and fights between individual students to serious physical assaults and even concerted attacks by racist gangs.

Evidence indicates that violence associated with racism is more likely to occur in secondary schools than in primary schools and that it is not unknown in early childhood services. Studies show that in primary schools, incidents were quickly manageable whereas secondary schools were more likely to be affected by external gangs and the students were more likely to be influenced by home discussions and racial hatred than younger students. Many accounts show that violence often occurs in retaliation to racist taunts, when the victims fight back against their tormentors. This issue is of critical importance for Indigenous students, who report that getting involved in fights as a result of racist insults is the most common cause for them being injured and suspended.

Studies of self-harming behaviour in Australia over the past 10 - 15 years indicate that Indigenous children who are at risk in their childhood and adolescence, continue to be at risk into their adult years[53]. This is a particularly concerning trend given that the Australian Indigenous population is

comparatively young, with 70% of Indigenous Australians under 25 years of age, and that in some States, the largest age group of Indigenous people is from birth to 12 years old.

International studies suggest that the diagnosis of physical injury and child abuse is influenced by perceptions about the family's racial background and socio-economic status[54]. US studies suggest that physical injuries may more frequently be diagnosed as 'abuse' in poor families and more frequently characterized as 'accidents' in more affluent families. In addition, in a US sample of suspected abuse and neglect cases, hospitals tend to under-report 'white' families and tend to over-report 'black' families to child protection agencies.

The Taskforce acknowledges that there are enormous sensitivities surrounding childhood injury issues, which make it difficult to discuss and address them. The Taskforce proposes that it may be useful for the education, health and family and community services sectors to jointly identify and explore any relevant examples of effective practice with a view to promoting this advice at the local level.

CHAPTER THREE: SUPPORTING COMMUNITY DEVELOPMENT AND CAPACITY BUILDING

This chapter summarises advice on the nature of successful community development and capacity building initiatives, the mixed success of previous work and the principles that need to be addressed in future work, as well as providing advice on a way forward.

Introduction

In developing this paper the Taskforce considered advice from international and Australian initiatives on how to improve the health, psychosocial and educational outcomes of children at risk. While the Taskforce has not recommended any particular range of initiatives, it is of the view that there is a need for cultural sensitivity and compromise in relation to the health and education of Indigenous children in a model which explicitly values Indigenous concepts of health and seeks to support community development and capacity building.

Self-determination and empowerment are the cornerstones of Indigenous community development and capacity building approaches. Supporting these processes are likely to be more effective in the longer term in promoting positive social and emotional wellbeing and resilience. Promotion of well-being and resilience in such a framework thus requires community-centred early intervention across the whole ecological context in which Indigenous children live and grow. From an Indigenous perspective, such interventions are necessary to ensure the maintenance of strong and resilient communities, which support families in the task of 'growing up solid kids'.

Indigenous concepts of health

Indigenous conceptions of well-being rely on a sense of wholeness and balance in which the individual (and people more generally) are an element of a broader conceptualization of the cosmos, which includes a network of reciprocal relationships between people, land and spirit. Within this world-view, illness is seen to result from a disturbance to the harmony of this broader whole.

Given the inter-active nature of the 'whole', greater strength and resilience in one aspect of country, society, community, family or individual is considered to have a flow-on effect for general community well-being, but enough of the 'whole' needs to be resilient and strong in order to ensure maintenance and promotion of individual well-being.

Within such cultural contexts it would seem more appropriate then to adopt the concept of 'communities at risk' rather than 'individuals at risk'.

Aboriginal and Torres Strait Islander concepts of health accord more with the approach of community development which encompasses the broader conception of well-being as it relates to the spiritual, cultural, emotional social and physical well-being of the whole community.

Community development and capacity building

Indigenous people see community development and capacity building processes, and the programs which give expression to these processes, as bridges to the wider exercise of their rights as citizens and as Indigenous people. They believe that when Indigenous families and communities can

exercise their rights more widely, this will lead to those families and communities taking a greater and more equitable part in the social and economic life of the wider communities in which they live.

Community development and capacity building is the process by which individuals, groups, organisations, institutions and societies increase their abilities to perform core functions, solve problems, define and achieve objectives; and understand and deal with their development needs in a broad context and in a sustainable manner. Intrinsic to these processes are the processes which build the capacity of individuals, families and communities to contribute to sustainable improvement in the social and economic circumstances of their families and communities.

Capacity building is an approach to community development, not something separate from it. It is a response to the multi-dimensional processes of change, not a set of discrete or pre-packaged technical interventions intended to bring about a pre-defined outcome. In supporting organisations working for social justice, it is also necessary to support the various capacities they require to do this: intellectual, organisational, social, political, cultural, material, practical, or financial.

Some commentators argue that the emphasis should be more on 'community development' than on 'capacity building' since considerable capacity already exists[55]. Hence more attention can be paid to further developing existing capacity that on building new capacity.

The dimensions of a community development and capacity building framework are: the individual; the entity; the relationship between entities; and the enabling environment. If all these dimensions are not addressed in the analysis or in the capacity assessment process, all that is happening is that an existing or a new program or project is being re-labelled with a capacity building element. The ultimate performance indicator for capacity development would be when a community no longer needs the program, or at least needs less assistance.

This framework should encompass at the macro level, the adoption of a clear and unequivocal policy of augmenting the service delivery approach of the past by adopting a capacity development approach. This approach would include:

- acknowledgment that such a move would entail a complex process of institutional change;
- securing of commitment to implement that process;
- examination of program activities from the perspective of capacity development, so that the way programs, projects and services are administered is developmental of the capacity of the recipients of the benefits of those programs;
- examination of program activities from the perspective of long-term sustainable improvement in quality of life for people.

This framework also points to the need to address the functioning of the bureaucracy, as well as addressing the issues of dysfunction in the community. Community development and capacity building also involves institutional transformation in the funding agency. The OECD has published a useful checklist for agencies to conduct a self assessment on the implementation of capacity development activities.[56] Some of the questions suggested are:

- does the agency have a clear strategy to promote and integrate community capacity development into day-to-day operations?
- to what extent has the agency adapted its administrative procedures to fit the requirements of community capacity development?
- what incentives for change have been introduced to promote and integrate community capacity development into day-to-day operations?

- to what extent has the agency developed mechanisms to measure impact, and what results have been recorded?

Success in community capacity building and development is more likely when agency initiatives focus on the community's wellbeing and are based on partnerships with the individuals, families and the community, with shared responsibilities for processes and achieving outcomes.

Policy context

The 1989 National Aboriginal Health Strategy stated that in its consultations, Indigenous communities consistently spoke of the impact on health and well being of poverty, unemployment, poor housing, lack of educational opportunity, poor essential service provision, social dysfunction and dislocation caused by culturally inappropriate policies and programs, cost of living, transport, isolation and other socio-economic factors. To address these issues, the Strategy stated that co-operation between, and where appropriate, integration of different development programs offered by the different service agencies is essential.

The Royal Commission into Aboriginal Deaths in Custody (1991) confirmed this view and pointed out that the source of these problems lay in the history of government policy and practice of non-Indigenous Australia, which was postulated on the inferiority of Indigenous people and which has developed on the assumption that government knew what was good for Indigenous people.

The objective of the 1992 COAG Commitment was to ensure that Aboriginal and Torres Strait Islander peoples receive no less a provision of services than other Australians. In particular, the 1992 COAG Commitment was designed to achieve greater coordination of the delivery of programs and services by all levels of government to Aboriginal and Torres Strait Islander peoples.

On 3 November 2000, COAG highlighted the mixed success of past efforts to address Indigenous disadvantage and committed itself to an approach based on partnerships and shared responsibilities with Indigenous communities, programme flexibility and coordination between government agencies, with a focus on local communities and outcomes. COAG agreed to priority actions in a number of areas, including investing in community leadership initiatives.

Previous Taskforce advice

The Taskforce's report of March 2000 supported the development of partnerships with the individuals, families and the community, with shared responsibilities for processes and achieving outcomes. The report pointed out the need to generate a climate of shared responsibility where school principals, teachers, education workers, parents, caregivers, and the wider community expects and supports Indigenous children to achieve equitable and appropriate educational outcomes.

The Statement of Principles and Standards for More Culturally Inclusive Schooling in the 21st Century (MCEETYA, 2000) further highlights the rights and responsibilities of parents as the first educators of their children and the responsibility of the school to support those rights. The principles state that schooling must acknowledge the role of Indigenous parents by:

- providing a climate that welcomes Indigenous parents and caregivers as valuable members of the school community;
- actively increasing public confidence in education and training through a process of explicit involvement of Indigenous parents/caregivers and community in the achievement of equitable and appropriate educational outcomes;

- supporting parents and caregivers of Indigenous students in their responsibilities to ensure that their children attend school regularly.

The 'Model for More Culturally Inclusive and Educationally Effective Schools' (MCEETYA, 2000) points out that a strong partnership between the school and community will closely support Indigenous parents and caregivers to jointly progress the standards of education and to be actively involved in the decision-making processes and planning for the introduction of new programs.

Finally, the 'Partnership and the Education Systems Cube' (MCEETYA, 2000) provide a cross-portfolio mechanism to implement coordinated programs which specify the responsibilities of each government, identify funding arrangements and provide a framework for the planning and delivery of services and programs in specific functional areas. The Partnership Cube is designed to enable attention and resources to be focussed on specific elements. The Cube allows an element to be isolated and analysed in detail, agencies to be involved, strategies to be developed and achievement of outcomes to be monitored.

Current work

In Australia, a number of initiatives are proposed or underway to show that a whole of government investment in Indigenous community development and capacity building can address a range of childhood health issues. Many of these initiatives are being undertaken as part of the development of integrated whole-of-government service delivery models to provide improved coordinated and coherent services to Aboriginal and Torres Strait Islander communities. Further details on initiatives in Qld, NSW and SA are provided in **Boxes 6, 7** and **8.**

Box 6: Qld Partners for Success Program

The Qld Partners for Success Program is designed to enable schools and their communities to develop solutions responsive to local circumstances. As part of the implementation of this program, compacts or local agreements will be developed between Aboriginal and Torres Strait Islander communities and their schools to identify key strategies to improve educational outcomes and to identify cross-agency service delivery requirements to meet what is needed to improve student outcomes. The program is being trialled in 35 pilot schools across Queensland. The compacts are being developed as part of a model of community-based management of schooling. Because of the high turnover of school staff, the community is the most consistent partner in the agreement and is the key owner of the vision of schooling for the local children.

Box 7: NSW Rekindling the Spirit Program

In the northern rivers area of NSW, education, health, community services and corrective services departments are participating in the Rekindling the Spirit Program. The program aims to address the needs of families with a history of violence, abuse of alcohol and other drugs, offending behaviour and neglect of children. The program aims to show that the reconstitution of Indigenous culture can reconnect traumatised children to intergenerational care and guidance in a contemporary and relevant way. The program focuses on shaping a positive cultural identity for Aboriginal boys who are not attending school, and offending when away from school. Each boy is paired with an Aboriginal mentor. This puts to use the community and educational traditions of the Elder system to shape positive and contemporary Aboriginal identities for young people, in partnership with their communities and government agencies.

Box 8: SA Local Child Development and Parenting Centres

In SA, child development and parenting centres will be developed in four communities as centres of excellence. The centres will coordinate developmental, educational and health strategies and provide an integrated framework for service delivery for infants, young children and their families. The centres will:

- provide both centre-based and outreach services for parents/caregivers and children;
- enhance the community professional skill base;
- provide parents/caregivers with opportunities to learn about child development and parenting skills;
- provide opportunities and experiences that will involve and support parents/caregivers and assist children in the early foundations of literacy and numeracy;
- provide a centre for community relationship building and participation.

A special multidisciplinary, multi-agency clinic will be set up as part of the centre to focus on delivering a range of primary health/education intervention services.

Principles of effective practice

Current work across the sectors to analyse current and past efforts to address Indigenous disadvantage has identified a number of principles to support future work. Based on this advice, the Taskforce is of the view that the following principles should underpin any further cross-portfolio work to improve the health and educational outcomes of Indigenous children and invest in community leadership:

1. the responsibility for making sure that the needs of children are met and that they are safe within their families is shared between the family, the community and government;

2. the health and educational development of Indigenous children especially in the first eight years of their life are intrinsically related, and impact on the quality of their future health and educational attainment, the construction of future potential and dispositions to lifelong learning;

3. there is a close relationship between the effective functioning of Indigenous communities, their social, cultural and environmental contexts, and the health and educational outcomes of Indigenous children;

4. the health and educational outcomes of Indigenous children can be effectively improved through direct partnerships between health and education jurisdictions and Indigenous communities;

5. Indigenous health and education cross-portfolio initiatives work best when they ensure that Indigenous communities are responsible partners in policy development, design and delivery of programmes and services, as well as monitoring and evaluation processes;

6. while early intervention initiatives are important for the immediate and longterm health and education of Indigenous children, these need to be balanced in relation to prevention, diversion, rehabilitation and reactive programmes and services to ensure effective coverage of transition points across the lifespan;

7. Indigenous health and education cross-portfolio initiatives work best when funding is longterm, is sufficient to ensure maximum sustainability of service delivery, is linked to

community capacity building and supports the lifelong learning requirements of the community;

8. at the local level, cross-portfolio community development and capacity building programs need to be explicitly inclusive, responsive, reflect a deeper understanding of their rich cultural heritage and incorporate advice at the individual family level;

9. Indigenous health and education cross-portfolio initiatives need to address all Indigenous communities in need, and cannot just be concerned with those communities that seem to have needs, as well as the capacity to respond;

10. coordination of services across all levels of government, government agencies and funded services, together with the use of 'Indigenous impact statements', are essential to effective Indigenous health and education cross-portfolio initiatives;

11. Indigenous health and education cross-portfolio initiatives work best when health and education outcomes are reported publicly, and health and education programs are evaluated to ensure that the reasons for effectiveness or lack of effectiveness are known, understood, acknowledged by all parties, and used to inform strategic planning and service delivery.

Way forward

The Taskforce is of the view that this paper provides a useful basis for informing the work of education jurisdictions, as well as informing further cross-portfolio work with the health sector, Indigenous affairs and the family and community services sector at a national, state and regional level.

There are a number of existing forums and electronic Indigenous health clearinghouses that have been established at a State and Territory level to promote effective practice and these may provide opportunities for further collaboration.

Recommendations	
It is recommended that Council:	
1 a)	**note** that an information paper entitled *Solid Foundations: Health and Education Partnership for Indigenous Children Aged 0 To 8 Years* is available for further discussions by jurisdictions with the health sector, Indigenous affairs and the family and community services sector;
b)	**agree** to forward this paper to the Health Ministerial Council and seek its support to a joint commitment to improving the health and educational outcomes of Aboriginal and Torres Strait Islander children aged from birth to 8 years;
c)	**agree** to forward this paper to the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and seek its support to a joint commitment to improving the health and educational outcomes of Aboriginal and Torres Strait Islander children aged from birth to 8 years;
d)	**agree** to the use of the paper to serve as the basis for cross-portfolio discussions as part of the Council action plan to meet the COAG reference of 3 November 2000.

The Adelaide Declaration on National Goals for Schooling in the 21st Century (1999)

The State, Territory and Commonwealth Ministers of Education met as the 10th Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) in Adelaide, 22-23 April 1999, chaired by the Minister for Education, Children's Services and Training in South Australia, the Hon Malcolm Buckby MP. Conscious that the schooling of Australia's children is the foundation on which to build our future as a nation, Council agreed to act jointly to assist Australian schools in meeting the challenges of our times. In reaching agreement to address the following areas of common concern, the State, Territory and Commonwealth Ministers of Education made an historic commitment to improving Australian Schooling within a framework of national collaboration.

Preamble

Australia's future depends upon each citizen having the necessary knowledge, understanding, skills and values for a productive and rewarding life in an educated, just and open society. High quality schooling is central to achieving this vision.

This statement of national goals for schooling provides broad directions to guide schools and education authorities in securing these outcomes for students.

It acknowledges the capacity of all young people to learn, and the role of schooling in developing that capacity. It also acknowledges the role of parents as the first educators of their children and the central role of teachers in the learning process.

Schooling provides a foundation for young Australians' intellectual, physical, social, moral, spiritual and aesthetic development. By providing a supportive and nurturing environment, schooling contributes to the development of students' sense of self-worth, enthusiasm for learning and optimism for the future.

Governments set the public policies that foster the pursuit of excellence, enable a diverse range of educational choices and aspirations, safeguard the entitlement of all young people to high quality schooling, promote the economic use of public resources, and uphold the contribution of schooling to a socially cohesive and culturally rich society.

Common and agreed goals for schooling establish a foundation for action among State and Territory governments with their constitutional responsibility for schooling, the Commonwealth, non-government school authorities and all those who seek the best possible educational outcomes for young Australians, to improve the quality of schooling nationally . The achievement of these common and agreed national goals entails a commitment to collaboration for the purposes of:

- further strengthening schools as learning communities where teachers, students and their families work in partnership with business, industry and the wider community
- enhancing the status and quality of the teaching profession
- continuing to develop curriculum and related systems of assessment, accreditation and credentialling that promote quality and are nationally recognised and valued
- increasing public confidence in school education through explicit and defensible standards that guide improvement in students' levels of educational achievement and through which the effectiveness, efficiency and equity of schooling can be measured and evaluated.

These national goals provide a basis for investment in schooling to enable all young people to engage effectively with an increasingly complex world. This world will be characterised by advances in information and communication technologies, population diversity arising from international mobility and migration, and complex environmental and social challenges.

The achievement of the national goals for schooling will assist young people to contribute to Australia's social, cultural and economic development in local and global contexts. Their achievement will also assist young people to develop a disposition towards learning throughout their lives so that they can exercise their rights and responsibilities as citizens of Australia.

Goals

1. **Schooling should develop fully the talents and capacities of all students. In particular, when students leave school, they should:**

   1.1 have the capacity for, and skills in, analysis and problem solving and the ability to communicate ideas and information, to plan and organise activities, and to collaborate with others.

   1.2 have qualities of self-confidence, optimism, high self-esteem, and a commitment to personal excellence as a basis for their potential life roles as family, community and workforce members.

   1.3 have the capacity to exercise judgement and responsibility in matters of morality, ethics and social justice, and the capacity to make sense of their world, to think about how things got to be the way they are, to make rational and informed decisions about their own lives, and to accept responsibility for their own actions.

   1.4 be active and informed citizens with an understanding and appreciation of Australia's system of government and civic life.

   1.5 have employment related skills and an understanding of the work environment, career options and pathways as a foundation for, and positive attitudes towards, vocational education and training, further education, employment and life-long learning.

   1.6 be confident, creative and productive users of new technologies, particularly information and communication technologies, and understand the impact of those technologies on society.

   1.7 have an understanding of, and concern for, stewardship of the natural environment, and the knowledge and skills to contribute to ecologically sustainable development.

   1.8 have the knowledge, skills and attitudes necessary to establish and maintain a healthy lifestyle, and for the creative and satisfying use of leisure time.

2. **In terms of curriculum, students should have:**

   2.1 attained high standards of knowledge, skills and understanding through a comprehensive and balanced curriculum in the compulsory years of schooling encompassing the agreed eight key learning areas:

   - the arts;
   - English;
   - health and physical education;
   - languages other than English;
   - mathematics;
   - science;
   - studies of society and environment; and
   - technology.

   and the interrelationships between them.

   2.2 attained the skills of numeracy and English literacy; such that, every student should be numerate, able to read, write, spell and communicate at an appropriate level.

   2.3 participated in programs of vocational learning during the compulsory years and have had access to vocational education and training programs as part of their senior secondary studies.

   2.4 participated in programs and activities which foster and develop enterprise skills, including those skills which will allow them maximum flexibility and adaptability in the future.

3. **Schooling should be socially just, so that:**

   3.1 students' outcomes from schooling are free from the effects of negative forms of discrimination based on sex, language, culture and ethnicity, religion or disability; and of differences arising from students' socio-economic background or geographic location.

   3.2 the learning outcomes of educationally disadvantaged students improve and, over time, match those of other students.

3.3 Aboriginal and Torres Strait Islander students have equitable access to, and opportunities in, schooling so that their learning outcomes improve and, over time, match those of other students.

3.4 all students understand and acknowledge the value of Aboriginal and Torres Strait Islander cultures to Australian society and possess the knowledge, skills and understanding to contribute to, and benefit from, reconciliation between Indigenous and non-Indigenous Australians.

3.5 all students understand and acknowledge the value of cultural and linguistic diversity, and possess the knowledge, skills and understanding to contribute to, and benefit from, such diversity in the Australian community and internationally.

3.6 all students have access to the high quality education necessary to enable the completion of school education to Year 12 or its vocational equivalent and that provides clear and recognised pathways to employment and further education and training.

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