

STRATEGIC FRAMEWORK DOCUMENT

Improving development and well-being for Aboriginal children and young people in the far west of NSW



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**Far West Aboriginal Child and Youth
Development and Well-Being Management Group**

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requests for further information or copies of all or part of
this document should be directed to:

Maari Ma Health Aboriginal Corporation
PO Box 339, BROKEN HILL NSW 2880
T: (08) 8082 9888
F: (08) 8082 9889
W: www.maarima.com.au

TABLE OF CONTENTS

Introduction	6
Our Goal	6
The early years – pregnancy to school entry	6
What is child development and well-being?	6
How is it different?	6
What does it mean for future practice?	7
What is the burden of poor child developmental outcomes in Far West NSW?	7
How does this Strategic Framework link with the Far West Chronic Disease Strategy?	8
How is it different to what we're doing now?	9
What are the key components of the strategic framework?	8
Proposed way forward for consideration	8
What are the evidenced-based best buys?	9
Pregnancy to school entry:	9
Predominantly provided by the Health System	9
Universal antenatal care	9
Sustained nurse home visiting	9
Breastfeeding	10
Immunisation	10
Predominantly provided by the Education System and collaboratively with Health	10
Preschool	10
Transition to school program	10
Predominantly provided by multiple agencies (government and non-government) working collaboratively	11
Early literacy	11
Parenting programs	11
Early childhood education and care	11
Community development programs	12
School-aged children and young people	13
What are the key components of the strategic framework for school-aged children and young people?	13
What are the evidenced-based best buys for this group?	13
Primary school to transition into further education, training or the workforce:	13
Predominantly provided by the Health System	13
Triple P program	13
Immunisation	13
Predominantly provided by the Education and Training System	13
Quality teaching, academic achievement and school retention	13
Transition from primary school to high school and high school to further education, training or the workforce	13
Predominantly provided by multiple agencies (government and non-government) working collaboratively	14
Circles of Care	14
Community development	14
Conclusion	15
References	17

INTRODUCTION

In March 2009 Maari Ma Health Aboriginal Corporation published the 'Strategic Framework Document to improve child development and well-being for Aboriginal children in the far west'. The focus was on the period of life from pregnancy to school entry. After three years, when the implementation of a number of strategies were well underway, the Far West Aboriginal Child Development and Well-Being Management Group undertook to extend the framework to include school aged children and young people. This document combines the initial publication with the component focussing on school-aged children and young people.

Our Goal: Optimising the development and well-being of Aboriginal children, young people and their families, from pregnancy through the school years, in Broken Hill, Central Darling, Wentworth, and Balranald Shires and the Unincorporated Far West.

The Early Years – Pregnancy To School Entry

Early childhood is a time of rapid growth and development, faster than at any other time of life, and establishes the foundations for a child's future development, health, learning and social well-being. These early experiences set the stage for later success in school, adolescence and adulthood. Early intervention improves outcomes across a range of physical, emotional and social (including educational) indicators that have a positive effect throughout the life span.

What is child development and well-being?

Child development and well-being refers to physical, emotional, social and cognitive well-being. This concept is similar to the Aboriginal definition of health: **"Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life."**¹

There is well documented evidence that investment in promoting child development and well-being in the early years is more cost effective than addressing ill-health, poor social outcomes and educational deficits later in life.

How is it different?

Child development and well-being has many determinants including genetic and biological influences, but family, community and societal influences are the main determinants. Early

brain development research indicates that there is a window of opportunity in the first 5-7 years of life, particularly the first 3 years of life, to optimise child development. In order to influence all the determinants of development and well-being all organisations working with children and the community need to work more collaboratively rather than within their own boundaries.

The following are a set of principles to guide development of strategies to improve child development and well-being:

1. Promote a health and well-being perspective.
2. Promote a focus on enhancing protective factors and building resilience
3. Promote a population health approach, which focuses on outcomes and strategies that have wide population coverage.
4. Promote a whole of government and community approaches where partnerships are fostered and responsibility is shared.
5. Promote equity and social justice with commitment, effort and strategies (universal and targeted) weighted to address the needs of the most disadvantaged.
6. Promote initiatives that are sustainable and have long-term commitment.
7. Promote age appropriate evidence based strategies, based on the best available evidence, and where the strategies adopted are designed to address multiple health issues and determinants and result in multiple outcomes.

Conceptually, the following figure illustrates the approach to better outcomes.

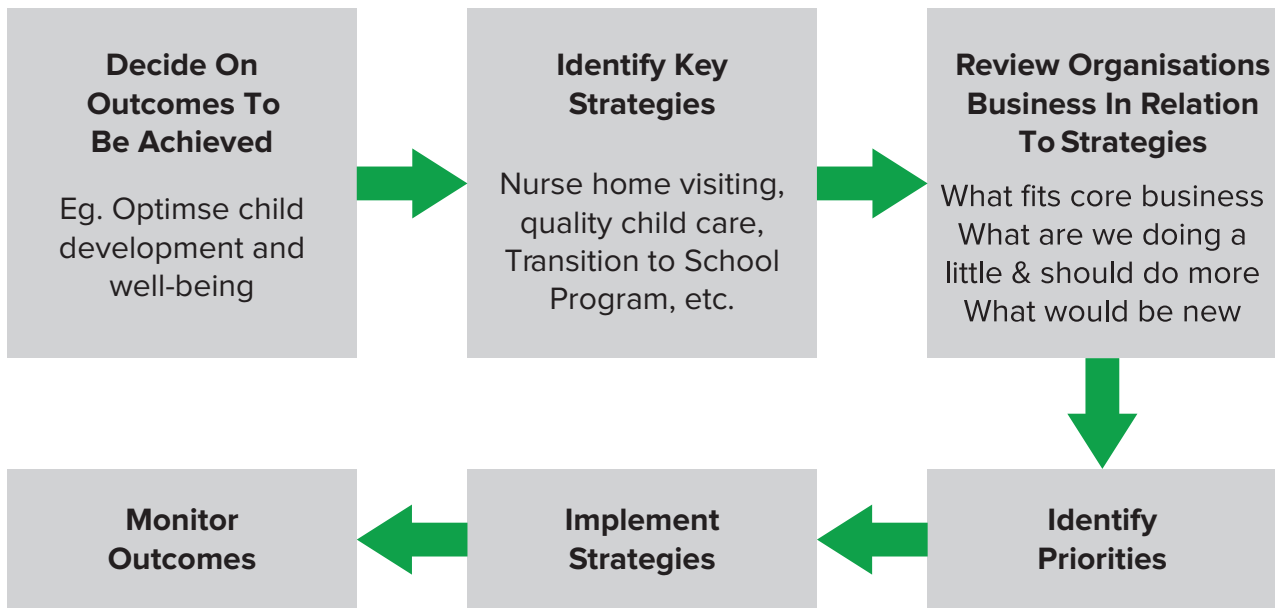


FIGURE 1.0

What does it mean for future practice?

The challenge of creating sustainable systems that support multi-sectoral collaboration over long periods of time will require effort and commitment.

Effective prevention, promotion of health and well-being and early intervention will require:

- better networking between services, and joint planning and implementation of strategies;
- the organisation of services around the needs of families with young children, not the needs of the provider, a particular program or the particular organisation;
- a move beyond the static model of risk to one based on a life course perspective, in particular early life factors;
- good communication between organisations and the families and children with whom they work;
- joint monitoring and evaluation of strategies implemented.

What is the burden of poor child developmental outcomes in Far West NSW?

Aboriginal children aged under 15 make up 16% of the total child population of the region of far west NSW compared to only 4% for NSW as a whole.

Much of the region's people are from socioeconomically disadvantaged communities, with fewer residents completing their secondary education and more people in the social welfare system compared with the rest of NSW. In addition almost the entire region has an ARIA classification of either 'remote' or 'very remote'.

Two in three pregnancies in the region are to Aboriginal women with 23% of these women aged under 20 (20% in NSW). Of positive significance though, up to 80% of Aboriginal women are presenting for their first antenatal check before 20 weeks gestation.

Local data suggests that up to 70% of Aboriginal women smoked during pregnancy and this is reflected in the large proportion of babies being born prematurely and of a low birth weight - two to three times higher than the expected percentage in NSW.

Children in western NSW continue to experience worse perinatal outcomes compared to other babies in NSW. Breastfeeding rates are the lowest in the state - only 7% of children are breastfed exclusively at 6 months compared to 17% in NSW. Local children are slightly more likely to have attended early childhood activities and childcare attendances were slightly higher compared with NSW.

While immunisation rates continue to be high, timely immunisation rates are as low as 38%.

Oral health is poor by the State's standards, in part due to most of the region's water supplies not being fluoridated. On average, children have 4.5 decayed, missing or filled baby teeth, which is four times that of all children in NSW. The proportion of children who are overweight and obese continues to increase. Comparative data shows an increase, from 25% of the children in 2005 to 31.5% in 2007.

How does this Strategic Framework link with the Far West Chronic Disease Strategy?

As mentioned in the Far West Chronic Disease Strategy, chronic disorders can be grouped together from a public health perspective as they have common risk factors and strong clinical associations. The origins of many chronic diseases are set in utero and early childhood (most notably through low birth weight, growth retardation, and repeated childhood infections).

The diseases and their risk factors are also inextricably linked with the broader socio-economic determinants of health and quality of life, particularly education and employment. Lifestyle choices are often more reflective of unrelenting socio-environmental constraints rather than personal preferences. Therefore an integrated, intersectoral and whole-of-life approach is needed.

As stated in the Far West Chronic Disease Strategy, the cost of not intervening early is too great. The same applies to early intervention in the early years. For example, for every \$1 spent per child on the Perry Preschool program, at 40-year follow-up, \$17 is returned to society; for every \$1 spent on the nurse home visiting program, at 15-year follow-up, \$5 is returned to society.

Similarly, as stated in the Chronic Disease Strategy, more rapid and substantial progress will, however, be dependent on the commitment of local service providers to the strategy, and on more equitable Commonwealth and State funding for primary level health services and funding for services in the remote communities of far western NSW.

The structural challenges to taking such an integrated approach on a regional, as opposed

to a local, level are undoubtedly larger, but the benefits are potentially great.

How is it different to what we're doing now?

This strategic framework reflects the ongoing commitment by Maari Ma Health Aboriginal Corporation to work in partnership with the community and all the other agencies that have an influence on child development and well-being to encourage healthy living, to create health-promoting environments and to increase the capacity of communities to plan and direct their own services.

Implementation of this strategic framework will lead to improved child development and well-being outcomes in the short to medium term, as well as a reduction in long-term financial costs, but the full impact of all the interventions will not be felt for some years. So this is a staged, long-term strategic approach.

What are the key components of the strategic framework?

Nationally and internationally there has been increased focus on child development and well-being from a primary prevention, promotion and early intervention perspective. The strategies in figure 1.1 (page 9) are drawn from national and international research over the past few decades as key strategies from a prevention, promotion and early intervention perspective to improve child development and well-being. The details of the strategies and the referenced research that supports them can be found in the reference section.

Although for some of the strategies there will be predominantly one lead agency, most strategies involve multisectoral collaboration.

Proposed way forward for consideration

In the Far West, many key activities are already underway, and some already have a long history of successful achievement. In some cases it will be necessary to build on or strengthen these initiatives or better integrate the work with the other organisations and in relation to particular settings (eg schools) and population groups. In addition, new initiatives will need to

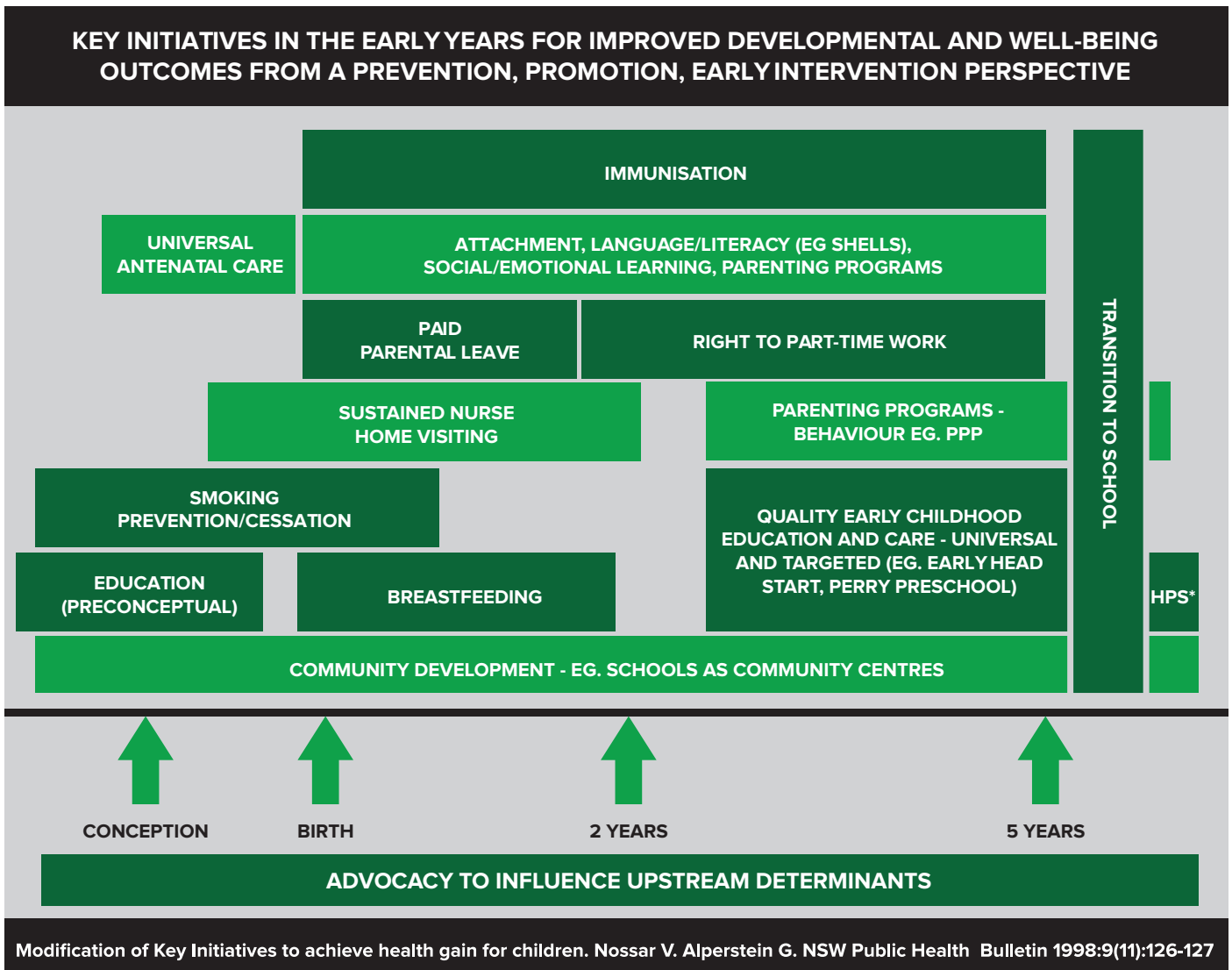


FIGURE 1.1 *Health Promoting Schools (HPS)

be researched and implemented. The process for moving forward would include :

1. Establishment of a multisectoral Management Group to develop a Child Development and Well-being Strategic Plan, drive the implementation of the overall strategic framework and support local efforts to develop and implement specific components.
2. Reaching an agreement on a few priority strategies for Broken Hill and some smaller towns within the region to initiate the process of implementation.

What are the evidence-based best buys?

Pregnancy to school entry

The following are the evidence-based best buys for the age group from pregnancy to school entry. This age group will be the priority age group for initial attention.

Predominantly provided by the Health System

1. **Universal antenatal care**
This includes smoking cessation and decreasing alcohol and other drug consumption, and networking and referral between health and non-health services.
2. **Sustained nurse home visiting**
The effectiveness of nurse home visiting programs, including the positive impact on the lives of parents and their children, especially for teenage, first time, unsupported and vulnerable (medium to high risk) populations has been established by credible, high quality studies.^{2,3} For example, in a review of over 4000 papers, the Olds (Elmira PEIP) health home visiting study, which informs the NSW pilot at Miller in Sydney South West Area Health Service, was rated among only 34 studies of the highest quality.⁴

Home visiting is best provided as a component of comprehensive services and linked to family support and neighbourhood development strategies⁵. The following is a summary of outcomes from the home visiting research.^{6, 7, 8}

Short - medium term outcomes

- Decreased rates of smoking in pregnancy, which are associated with lower rates of low birth weight and prematurity, SIDS, otitis media, behavioural problems in children, asthma in children, decreased rates of hypertension in pregnancy, decreased rates of accidental injuries, child abuse and neglect (one sixth of the rate), emergency department visits and paediatric inpatient admissions.
- Increased breastfeeding rates, immunisation rates, benefits for subsequent children for families who participate in these programs with their first child.

Longer-term outcomes

- A significant delay in subsequent pregnancies (approximately half), lower welfare dependency among mothers (approximately half), increased participation in the labour force, lower rates of substance abuse among mothers (approximately half).
- Fewer instances of running away (less than half), arrests (less than half), convictions and violations of probation (one fifth of the rate), fewer cigarettes smoked per day (almost half the mean cigarettes per day), fewer days having consumed alcohol in the last 6 months.
- Increased breastfeeding rates, immunisation rates, benefits for subsequent children for families who participate in these programs with their first child.

It should be noted that while one agency may be responsible for the implementation of a sustained health home visiting model, the benefits would span Health, Community Services, Education, Housing, Juvenile Justice and other human service portfolios.

3. Breastfeeding

The benefits of breastfeeding, particularly for at least 6 months, have been well established and are associated with, amongst others, higher cognitive scores in children, lower rates of Sudden Infant Death Syndrome, otitis media, respiratory infection, gastroenteritis, and improved bonding between infant and mother.

4. Immunisation

The benefits of immunisation have been well documented.

Predominantly provided by the Education System and collaboratively with Health

1. Preschool

The best known preschool program is the Perry preschool program. Follow up of the Perry cohort to age 40 years has revealed significant reductions in crime, arrests and involvement with the law, higher rates of completion of high school, higher earnings, less mental health problems, less use of social services and more likely to be in a stable relationship⁹. Other programs have also been associated with lower teenage pregnancy rates and substance abuse rates in adolescence¹⁰. These improved outcomes are thought to be due to improved emotional and social intelligence more than improved cognitive intelligence.

2. Transition to school program

There is good evidence demonstrating that readiness to start school correlates with academic achievement in high school¹¹, and an easy transition to primary school is strongly associated with self rated health at 33 years of age¹². There are no rigorous high level evaluations of transition programs, however, the indirect evidence and qualitative evaluations would support such programs, particularly in disadvantaged communities.

A set of criteria for best practice for transition programs have been established by Dockett and Perry¹³. The guidelines for effective transition-to-school programs are:

- establish positive relationships between the children, parents, and educators;

- facilitate each child's development as a capable learner;
- differentiate between "orientation-to-school" and "transition-to-school" programs;
- draw upon dedicated funding and resources;
- involve a range of stakeholders;
- well planned and effectively evaluated;
- flexible and responsive;
- based on mutual trust and respect;
- rely on reciprocal communication among participants;
- take into account contextual aspects of community and of individual families and children within that community.

Predominantly provided by multiple agencies (government and non-government) working collaboratively

1. Early literacy

There is a large body of research on the beneficial health and social outcomes of good early literacy input from birth. Early literacy, defined in its broadest sense, comprises aural, verbal, written and communication skills, and is associated with a clear socio-economic gradient.

Programs to enhance early literacy skills include book distribution programs, with or without tips for parents on literacy promotion. For illiterate or poorly literate communities, group programs exist such as the UK Peers Early Education Partnership (PEEP)¹⁴ and the NSW Support at Home for Early Language and Literacies¹⁵ (SHELLS) that start soon after birth and continue for 3-5 years.

Although most programs have not been rigorously evaluated using randomised control trials, they have been associated with significantly improved literacy outcomes for the children, improved parenting and social outcomes for parents.

2. Parenting programs

Parenting has been described by Hoghugh as one of the most powerful and important determinants of good health and social outcomes for children¹⁶. There is biological and epidemiological evidence to support

this. Neglectful and/or abusive parenting has been shown to be associated with chronically elevated cortisol levels in children¹⁷ with resulting emotional and behavioural problems that can persist into adulthood.

Parenting associated with nurturing, good attachment and bonding and attunement results in resilience and improved health and well-being. The importance of play as a strategy in building relationships between very young children and their parents, and as a foundation for literacy, has been recently documented¹⁸.

Supporting parents with programs to improve attachment, bonding and attunement between caregiver and baby, and family behavioural programs such as Triple P^{19, 20}, to assist parents to manage normal developmental behaviours or problem behaviours in infants and young children have been demonstrated to reduce childhood emotional and behavioural problems, and oppositional behaviours and conduct disorder.

This is in keeping with Richard Tremblay's research indicating that humans do not learn to become aggressive during adolescence but learn not to aggress during the preschool years through a good social environment and 'good enough' parenting²¹.

3. Early childhood education and care

The area of early childhood education and care is a more controversial area, since there is evidence that poor quality care, using poorly qualified and trained workers, and care to those too young and for too long a period per week can result in a greater risk of cognitive, emotional and behavioural problems for the children that persist into the school years²². This is in keeping with the research demonstrating chronically elevated cortisol levels in children subjected to poor quality child care²³.

Quality early childhood education and care can result in substantial health and social benefits, universally as in Sweden and targeted as in the USA, with the Tulsa Pre-K Program²⁴, and for disadvantaged

communities as in the USA, with the Perry Preschool program⁹, Early Head Start²⁵, Head Start^{10, 26}, Chicago Child-Parent Centres²⁷, Abecedarian Project²⁸ and many others.

Those programs for disadvantaged children that have good outcomes include components of parental involvement in the preschool and workers going to the home to facilitate an improved environment from a learning perspective.

In NSW, the Schools as Community Centre programs which focuses on the preschool years, have not been rigorously evaluated as in a controlled or randomised controlled trial. However, an early qualitative evaluation²⁹ and on-going monitoring of the programs have demonstrated that, by and large, they have been very successful in enhancing social capital, promoting early literacy and readiness to start school and a number of other positive outcomes.

4. Community development programs

Community development in its many shapes and forms has been used in multiple settings for many years with variable success. Development from the 'bottom up' and supported from the 'top' with investment and support for a sustained period of time has been the most successful model.

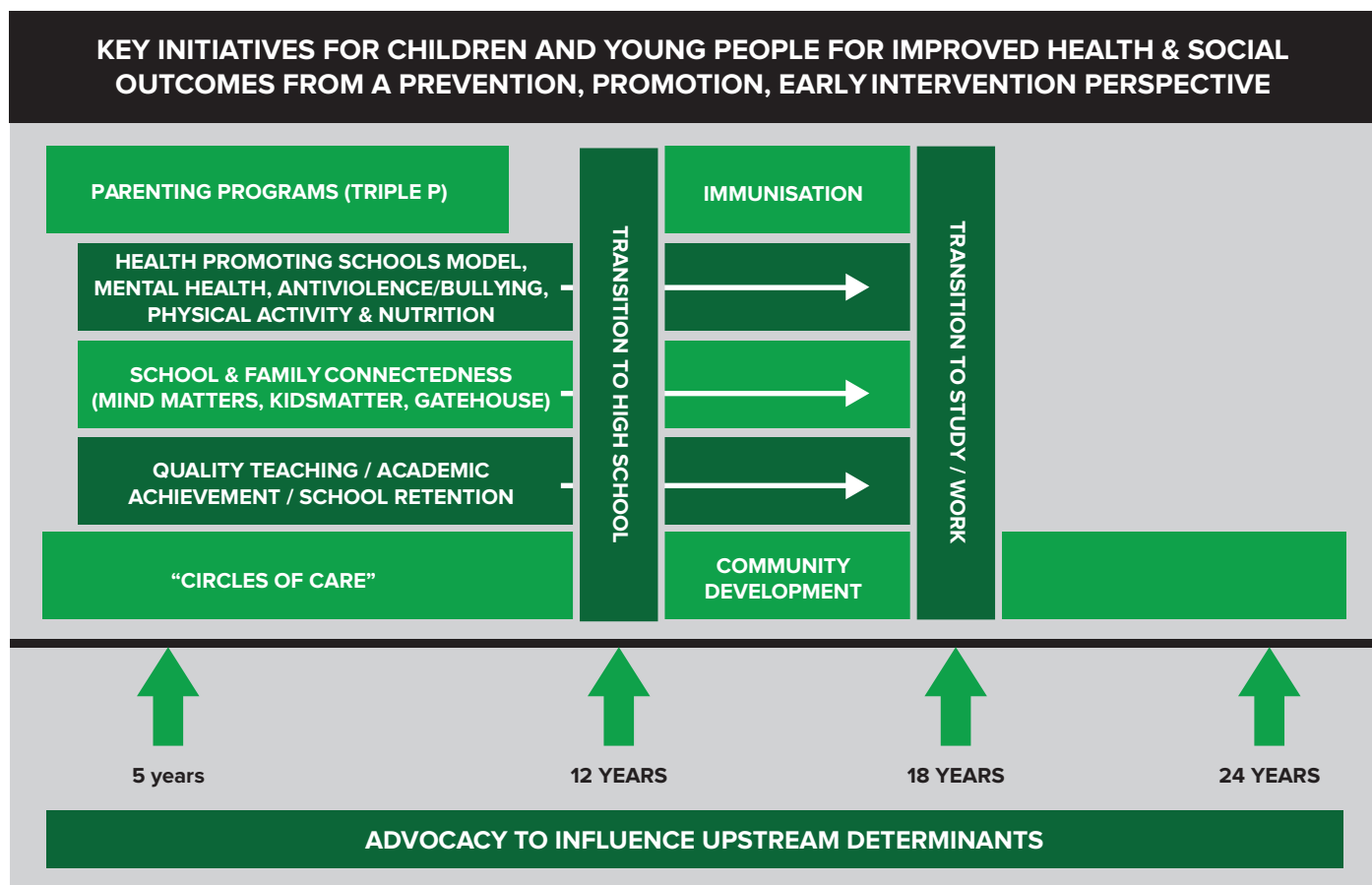


FIGURE 1.2

School-aged children and young people

During this phase of development, school-aged children's outcomes are further influenced by factors such as pubertal development, continued brain maturation, particularly the prefrontal cortex (responsible for functions that include the ability to differentiate conflicting thoughts, determine good and bad and future consequences of actions, and social "control"), connectedness to family and school, and academic achievement and school attendance.

What are the key components of the strategic framework for school-aged children and young people?

See Figure 1.2 (page 12)

What are the evidence-based best buys for this group?

Primary school to transition into further education, training or the workforce

The following are based on fair to good evidence and include a population and early intervention approach.

Predominantly provided by the Health System

1. Triple P Program

The Triple P program previously described also has components for primary school-aged children and teenagers.

2. Immunisation

The benefits of immunisation have been well described. At age 12 – Hepatitis B, Varicella (Chicken pox) and Human Papilloma Virus. At age 15 – Diphtheria, Tetanus and Pertussis.

Predominantly provided by the Education and Training System

1. Quality teaching, academic achievement and school retention

There is extensive evidence of the benefit of education on adult health and social outcomes, and particularly education level of women and their offspring's health and

social outcomes. In addition to decreasing child mortality with each additional year of school education in developing countries, there is also improved mental health, self rated overall health status, and better preventive health behaviours (eg. wearing a seat belt, preventive screening) and reduced health risk behaviours (eg smoking)³⁰. It has also been calculated that a year of education raises earnings by about 10% (~\$80,000 over the lifetime – US costings). One more year of education increases life expectancy by 0.18-0.6 years and the health returns to education increase by 15-55%. In estimating the number of averted deaths attributable to medical advances and the number of deaths that would have been averted if mortality rates among adults with lesser education had been the same as those among university educated, there would be less deaths associated with the higher level of education by a ratio of 8:1³¹.

2. Transition from primary school to high school and high school to further training, education or the workforce

As with transition to primary school other key transition points include the transition from primary to high school and then high school to further training, education or the workforce. There is limited research on transition from primary to high school, but it is highly likely that a smooth transition would facilitate better educational, health and social outcomes. There is research to indicate that on completing school, particularly among disadvantaged students, programs that assist students into further training, study or the workforce have more positive trajectories.

Predominantly provided by the Education and Training system and collaboratively with Health

1. Health promoting schools

A recent WHO review³² of health promotion in schools and health promoting schools revealed that the most successful programs were those that:

- Adopted a universal approach
- Adopted a whole of school approach

- including the local community
- Promoted changes to the school environment and school ethos
- Were of longer duration and greater intensity
- Promoted personal skills development

The most effective programs were:

- Promotion of healthy eating and physical activity
- Promotion of mental health & well-being (more effective than preventing mental illness)
- Conflict resolution & reduce violence & aggression

Moderately effective programs were:

- Improve self esteem

Ineffective programs were:

- Suicide prevention (potential harm)
- Prevention of depression and self harm
- Prevention of substance abuse (including tobacco smoking)
- Sexual health programs
- Driver education

2. School and family connectedness and social inclusion

Based on research indicating a relationship between students' perception of connectedness to family and school, and mental health outcomes and health risk behaviours³³, a few studies (cluster randomised controlled trials) have been conducted in the US (Aban Aya project³⁴) and Australia (Gatehouse project³⁵ and MindMatters³⁶) to improve school ethos and student connectedness to school. Both studies demonstrated improved mental health outcomes and risk taking behaviours. These programs, addressing the determinants of mental health and lifestyle risk behaviours were more successful than those programs targeting and addressing specific behaviours or mental problems. Furthermore, by addressing the determinants, one will achieve outcomes in multiple areas of health and social domains³⁷. In Australia the KidsMatter program is available for primary schools and MindMatters for high schools.

Predominantly provided by multiple agencies (government and non-government) working collaboratively

1. Circles of Care

Circles of care is an early intervention program from Queensland in which families, school and community services and agencies work together. It is a program organised around the concept of a developmental pathway and is based on a comprehensive team approach providing a clear 'road map' for students in schools having difficulties. The team includes the school, the family and including extended family, health services, social services and other relevant community services³⁸.

2. Community development

A number of community development models exist for improving community functioning and building social capital which have been associated with multiple improved health and social outcomes.

Conclusion

The 'best buys' proposed for young children (0-5 years) and children and young people of school age in this strategic framework are based on evidence determined through research available in peer-reviewed literature. It is acknowledged that not all approaches work across all populations, and applicability of the proposed approaches and/or programs to high risk or at risk populations in particular should be considered in conjunction with appropriate professionals.

Another factor that often underpins the successful implementation of a new program (or undermines a new program where it is absent) is interagency communication. The value of communicating with other agencies and services that interact with high risk/at risk children/young people and/or families – health, schools, welfare/support agencies – cannot be overstated.

Interagency communication can assist in getting the best value from new programs and seeing real or accelerated improvements for children, young people and their families.

The Far West Aboriginal Child and Youth Development and Well-Being Management Group Members

- Maari Ma Health Aboriginal Corporation (Co-Chair)
- NSW Department of Education and Communities (DEC), Broken Hill School Office (Co-Chair)
- Far West Local Health District (FWLHD):
 - Mental Health/Drug & Alcohol
 - Maternal, Child and Family Health
- Department of Family and Community Services (FACS)
 - (Aboriginal Child, Youth Family Strategy)
- NSW Police
- Centacare
- Sydney University Department of Rural Health, Broken Hill (UDRH)
- Save the Children, Australia
- St Therese's Community School, Wilcannia
- NSW Ageing, Disability, Home Care
- Dr Garth Alperstein

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