DRAFT
National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families

Background Paper
### List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AATSIHS</td>
<td>Australian Aboriginal and Torres Strait Islander Health Survey</td>
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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>ACCHOs</td>
<td>Aboriginal Community Controlled Health Organisation</td>
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<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
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<td>AEDI</td>
<td>Australian Early Development Index</td>
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<td>AHMAC</td>
<td>Australian Health Ministers Advisory Council</td>
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<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<td>AIEW</td>
<td>Aboriginal and Islander Education Worker</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMIHS</td>
<td>Aboriginal Maternal and Infant Health Strategy</td>
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<td>COAG</td>
<td>Council of Australian Governments</td>
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<td>GPs</td>
<td>General Practitioners</td>
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<td>HEREOC</td>
<td>Human Rights and Equal Opportunity Commission</td>
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<td>HIPPY</td>
<td>Home Interaction Program for Parents and Youngsters</td>
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<td>JTAI</td>
<td>JTA International</td>
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<tr>
<td>KBC</td>
<td>Kristine Battye Consulting</td>
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<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NDMB</td>
<td>New Directions: Mothers and Babies</td>
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<td>NFP</td>
<td>Nurse-Family Partnership®</td>
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<td>RCT</td>
<td>Randomised controlled trial</td>
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<td>SCRGSP</td>
<td>Steering Committee for the Review of Government Service Provision</td>
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<td>SNAICC</td>
<td>Secretariat of National Aboriginal and Islander Child Care</td>
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<td>STIs</td>
<td>Sexually Transmissible Infections</td>
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<td>USF</td>
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1 INTRODUCTION

This paper is a companion document to support and inform the development of the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (the Framework). This paper draws on a number of sources to draw out key issues and relevant evidence that differentiates the needs of Aboriginal and Torres Strait Islander children and families to that of non-Indigenous Australians and factors that impact on how services can and should be provided to them. Sources include an unpublished literature review by JTA International (Department of Health and Ageing, 2013) more recent publications, and an extensive national consultation process.

2 NATIONAL FRAMEWORK FOR UNIVERSAL CHILD AND FAMILY HEALTH SERVICES

The National Framework for Universal Child and Family Health Services (USF) outlines a vision, objectives and principles for universal services for Australian children aged zero to eight and their families (AHMAC, 2011).

The USF draws on extensive research and literature to identify core services that should be available to all Australian families, irrespective of where they live and how they access health care. It seeks to establish a platform for the delivery of evidence based services as described through “core service elements” and provide a consistent approach that is applicable across jurisdictions.

The Framework articulates with and builds upon the USF to identify appropriate service responses to meet the needs of Aboriginal and Torres Strait Islander children and families. It aims to provide additional guidance for policy and program design, service development and implementation necessary to address the needs of Aboriginal and Torres Strait Islander children and families. The scope of the Framework extends beyond the period zero to eight years covered in the USF to include the antenatal and pre-pregnancy periods.

2.1 USF health and developmental monitoring

The USF sets out four core service elements:

- **Developmental surveillance and health monitoring**: Services under this element aim to monitor child health, development and wellbeing with a view to develop capacity to identify early disability and delays, or health issues. It also provides an opportunity to support parents and promote wellbeing through clinical observation and assessment. The term ‘surveillance’ can be misinterpreted as health professionals ‘checking up on’ parents. However, use of the term in the USF is meant to reflect the systematic assessment and observation of a child’s health, performed in partnership with parents and families. Identified health monitoring in the USF includes:
  - Physical:
    - Vision and hearing screening
    - Oral health
    - Growth monitoring
  - Socio-emotional and cognitive development.

- **Health Promotion**: The USF identifies a range of opportunities for evidence-based health promotion strategies that encourage families to engage in behaviours and create environments which foster optimal health for children. Health promotion includes the prevention of disease, injury and illness through health education, anticipatory guidance and parenting skill development. It incorporates support for mothers, fathers and other carers; and promotes the health of mothers which is integral to the health and wellbeing of both the child and family. Community capacity building is also an essential health promotion activity which underpins the implementation of the USF.

- **Early identification of family need**: The USF identifies the benefits of early identification of health needs in order to provide support as early as possible.
• **Responding to identified need**: The USF highlights the importance of ensuring that where a health or developmental issue or support need is identified, that an appropriate response pathway is followed.

All States and Territories have a system of universal child and family health services, however the disparity in many health outcomes between Aboriginal and Torres Strait Islander people and other Australians remain. This Framework has been developed to support health services, including universal services, to meet the broad spectrum of needs of Aboriginal and Torres Strait Islander children and families.

### 2.2 Service structures and the provision of care

Australia has a complex health service structure, involving federal, state/territory and local governments, non-government organisations, Aboriginal Community Controlled Health Organisations (ACCHOs) as well as a significant private medical and other health sector, each of which contribute to the provision of child and family health services.

While each jurisdiction is responsible for the provision of universal maternal, child and family health services, the way in which these services are funded and delivered varies across Australia. The system is complicated by the fact that a range of other organisations, including ACCHOs and general practitioners provide similar services, as well as the interface with the tertiary system where the vast majority of women give birth. The complexity of the system leads to fragmentation of services and can make it challenging for families to access the services they need.

A key feature in developing and implementing services for Aboriginal and Torres Strait Islander families is ensuring continuity of care and diligence when care is transitioned between services. Embedding child and family health care within primary health care services supports continuity across life stages and where referrals and linkages to other parts of the health and social service system are required.

### 2.3 Using and building the evidence base

The disparity in health and developmental outcomes between Aboriginal and Torres Strait Islander people and other Australians is based on considerable research and evidence gathering. However the implementation of responses often has had a less rigorous evidentiary base. It is crucial that the delivery of services, from policy development to program design and the development of appropriate services models, is informed by use of the best available evidence.

The now widely used term *evidence based practice* has its origins in the field of medicine and the use of randomised controlled trials (RCT) in clinical settings. Systematic reviews of RCTs are considered to be the highest level of evidence and sit at the top of evidence hierarchies that set out criteria by which the effectiveness or impact of interventions can be assessed. Figure 1 shows an example of a research hierarchy, with increasing levels of validity and reliability moving up the triangle.
Evidence hierarchies are useful as a guide to interpreting the relative merits of different pieces of evidence. However assessing the relevance and applicability of evidence to the implementation of a particular program also should involve consideration of the:

- Type or level of evidence
- Quality of the particular study or studies
- Size of the effect demonstrated
- Relevance or generalisability to other locations or populations.

It is important to note that in the “real world” contexts in which child and family health services operate, there is often debate about the relative merits of different evidence based on the applicability to particular contexts or service environments. The challenge for policy makers and service providers is to interpret and apply the best available evidence while at the same time implementing programs in diverse community settings.

It is unrealistic to suggest that all child and family health programs can be based on interventions with RCT level evidence. However all programs should be planned and implemented to incorporate evidence that is applicable to the setting and context. At the same time a stronger evidence base needs to be developed to identify what is working and what is not. A greater emphasis needs to be placed on robust evaluation that measures programs against defined outcomes, rather than, as is often the case, relying solely on measures of client and provider satisfaction to assess their effectiveness.

**Implementation research** focuses attention on implementation ‘drivers’ to enable implementation of planned activity in a sustainable framework. **Implementation drivers** focus on the key areas of staff/provider competency, organisational supports and systems, and leadership for effective implementation of evidence based programs with fidelity (Fixen et al., 2005). This concept is evident in the delivery and monitoring of evidence-based clinical interventions such as childhood immunisation, and has been applied through the licensing and application of the Nurse-Family Partnership® (NFP) where the described outcome relies on maintaining fidelity to the program elements that ensures participants receive a “full dose” or complete schedule.
3 Context

Aboriginal and Torres Strait Islander communities consist of many different ‘groupings’ based on common kinship and language (SNAICC, 2011). Although commonalities in basic cultural beliefs and practices exist, Aboriginal and Torres Strait Islander peoples are diverse, and community groups vary in terms of beliefs, cultural practices, language and geographical location (Penman, 2006). Aboriginal and Torres Strait Islander people also live across Australia in urban, regional, rural and remote areas which contributes to different health needs and access to health services.

3.1 Holistic approach to health

This Framework sets out an approach that seeks to draw on the inherent strengths of Aboriginal and Torres Strait Islander cultures to inform how high quality, evidence based child and family health services can be delivered to Aboriginal and Torres Strait Islander people.

The National Aboriginal Health Strategy has described ‘Aboriginal health’ as a holistic view of health and wellbeing (NACCHO, 2012)

“Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.”

The health and wellbeing of Aboriginal and Torres Strait Islander children and families is determined by a complex interplay of factors including culture, socioeconomic characteristics, housing and transport, community capacity, behavioural factors, and social and emotional wellbeing. Along with culture, concepts of social justice, equity and rights are central to wellbeing.

Culture

Culture is fundamental to Aboriginal and Torres Strait Islander families’ health and wellbeing, and is a source of strength and resilience. Further, connection to land, family, culture and spirituality can protect against poor health (physical, emotional) and developmental (school participation and educational attainment) outcomes (AIHW, 2011) (Dockery 2011).

The disruption of cultural beliefs and practices in causing Aboriginal and Torres Strait Islander disadvantage (including poorer health outcomes) has resulted in:

- Ongoing grief, despair and confusion including the disruption of traditional gender roles, cultural values and pride
- Disruption of kinship networks and support systems
- Confusion of people forced to balance between the two, often irreconcilable, cultures.

The importance of culture to the health and wellbeing of Aboriginal and Torres Strait Islander children needs to be acknowledged and understood by all service providers. Central to this is understanding the determinants of the health inequalities experienced by Aboriginal and Torres Strait Islander people, including contemporary and historical factors, such as racism, colonisation and oppression and exploring ways to integrate a holistic approach to the physical, social, emotional and cultural health and wellbeing of Aboriginal and Torres Strait Islander families (Priest et al, 2012).

Conceptions of culture and child wellbeing can be incorporated into core services by:

- Collaborating with local communities including working with Elders
• Adopting client-centred approaches
• Employing Aboriginal and Torres Strait Islander health professionals
• Providing culturally competent care
• Promotion of activities designed to strengthen cultural identity such as cultural events or ceremonies.

3.2 Aboriginal Torres Strait Islander children, families and communities

‘Family’ is broadly defined in Aboriginal and Torres Strait Islander cultures. Typically, an Aboriginal and Torres Strait Islander family encompasses a complex familial structure, comprised of extended family members and important others, known as ‘kin’. The system of kinship “determines how people relate to each other ... their roles, responsibilities and obligations” (SNAICC, 2010; p.21). The importance of family and kinship ties is reflected in, and communicated to children from birth (Kruske et al, 2012). Babies and young children are informed of their relationship to their family, kin and their connection to the country (Kruske et al, 2012; SNAICC, 2011).

Figure 2 Family and kin relationships (adapted from SNAICC 2010)

Child-rearing is considered to be a family and community concern, where key people play different roles in the ‘growing up’ of children and young people (Burchill, Higgins, Ramsamy & Taylor, 2006; SNAICC, 2011). This is depicted in Figure 2, which illustrates the influence of different spheres on a child’s development. Grandparents, aunts, uncles, cousins and members of the community considered to be family are commonly involved (see Table 1). However, the roles and responsibilities of extended family members will differ in each family (SNAICC, 2010). Traditionally, men and women had specific child-rearing roles, however these roles have been eroded or blurred in many communities and families (SNAICC, 2011).
### Table 1 Roles and responsibilities of family and kin

**Mothers and aunts**
- Mothers are the primary caregivers, expected to be “totally unselfish and giving” to their children (SNAICC, 2010)
- In some communities, maternal aunties are also considered to be the child’s mother. Aunties have an obligation to support the mother in the raising of her child (SNAICC, 2010)
- Grandmothers, aunties and older siblings share childcare and rearing responsibilities (SNAICC, 2010; 2011)
- Mothers, grandmothers and aunties are also responsible for passing on and/or teaching young girls traditional knowledge, including important cultural information about being a woman (SNAICC, 2010; 2011)
- Mothers, grandmothers and aunties are also responsible for teaching male babies and young boys respect for women (SNAICC, 2010).

**Fathers and uncles**
- Fathers’ main role is to protect and provide for the family (SNAICC, 2010)
- They also have responsibility for maintaining discipline (SNAICC, 2010)
- Paternal uncles also play an active role, and are considered the child’s fathers in some communities (SNAICC, 2010)
- Fathers and uncles teach young boys traditional knowledge (SNAICC, 2011)
- Older men are responsible for training boys to become providers and protectors of their family (SNAICC, 2010).

**Grandparents**
- Grandparents are the teachers of culture and traditional law (SNAICC, 2010)
- Grandfathers and grandmothers often perform the role of ‘boss’ or protector (SNAICC, 2010).

**Siblings and cousins**
- Siblings help look after their younger kin (Penman, 2006; Malin et al, 1996).
- Mixed group of siblings and cousins often form a child’s peer group, and significantly influence their daily lives (SNAICC, 2010)

Aboriginal and Torres Strait Islander households tend to be larger in size, compositionally complex, with permeable social boundaries (Daly & Smith, 1999). Aboriginal and Torres Strait Islander peoples are more likely to live in multi-generational and multi-family households. In addition, there are often substantial fluctuations in the composition of households, due to mobility and a high number of visitors. These factors contribute to the complexity and dynamic nature of a large number of Aboriginal and Torres Strait Islander households (Gray, 2006).

The unique strengths of Aboriginal and Torres Strait Islander children and families are not widely recognised. Much Government policy (e.g. Closing the Gap in Indigenous disadvantage) and indicators/ outcome measures (e.g. AEDI) are grounded in a deficit, problem-focused model. However, strengths associated with Aboriginal and Torres Strait Islander children have also been identified (Taylor, 2011). These include:

- They are encouraged to be independent from an early age
- They have well developed visual-spatial and motor skills
- They have the capacity to self-judge and take risks.

A core strength of Aboriginal and Torres Strait Islander families is their network of extended family and kin. Infants and young children are often surrounded by family members or kin, and are ‘grown up’ to value their relationship with their family, kin, and everything in their environment (Armstrong, 2012; Priest et al, 2008). These networks provide children and young people with emotional and physical support, and a sense of
security and belonging (Bourke, 1993; Yeo, 2003). As discussed, culture is another source of strength to Aboriginal and Torres Strait Islander children and families (SNAICC, 2010). Core strengths of Aboriginal and Torres Strait Islander families that should help guide service delivery are outlined in Table 2.

Table 2 Summary of strengths

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<thead>
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<th>Potential strengths</th>
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<tr>
<td>Child</td>
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<td>Autonomy</td>
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<td>Sibling and peer relations</td>
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<td>Visual-spatial skills</td>
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<td>Capacity to self-judge and assess risk</td>
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<td>Family</td>
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<td>Extended family/kinship networks</td>
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<td>Community</td>
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<td>Neighbourhood networks</td>
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<td>Available resources/community organisations</td>
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<td>Community events</td>
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<tr>
<td>Culture</td>
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<td>Connections to country, spirituality, family and community</td>
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The ‘growing up’ of Aboriginal and Torres Strait Islander children not only differs from non-Indigenous practices, there are variations within Aboriginal and Torres Strait Islander communities and families (Malin et al, 1996). A review of the available literature suggests that whilst Indigenous families adopt child-specific practices, these approaches are underpinned by a set of common attitudes / beliefs:

- Children make their own choices and decisions from birth, and are viewed as independent, autonomous and self-sufficient (Kruske et al, 2012). Consequently, non-compliance is permissible (SNAICC, 2011)
- Children are capable of determining and communicating their needs from birth. Babies are expected to communicate their need for food, sleep, attention and physical comfort. Thus, a baby’s cry elicits an immediate response from its carer(s) (SNAICC, 2011), and care is provided on a ‘child-led’ basis, rather than set feeding / sleeping routines (Kruske et al, 2012)
- Children are encouraged to be compassionate, generous and helpful. Adults are expected to demonstrate / model “unselfish,” generous behaviours (SNAICC, 2011). In addition, children learn to help / look after younger kin from a young age (Malin et al, 1996), which encourages autonomy and early learning (Penman, 2006)
- Non-interference with a child’s activities unless in distress or causing distress to another child (SNAICC, 2011)
- Indirect behaviour management approaches (e.g. story-telling, modelling, selective attention, or the use of natural consequences) (Kruske et al, 2012; Malin et al, 1996).

### 3.3 The Importance of the early years

Early childhood experiences – starting in pregnancy with fetal development and continuing through infancy, childhood and adolescence – shape outcomes throughout the lifespan (Eades, 2004; Herceg, 2005). The role of early childhood experiences in the development of problems in adulthood is well established. Adverse childhood experiences have been linked with low educational attainment, poor health outcomes, substance misuse, mental health problems and high rates of incarceration. Research has demonstrated that programs which intervene during the first six to eight years of life are more successful at improving core developmental outcomes (Eades, 2004; Griew et al, 2007).
From conception on, the first three years of life are critically important for establishing healthy physical, emotional and cognitive development trajectories. While the brain’s overall structure is largely established within the second trimester of gestation, peak neural plasticity extends into the first few years of life, with early life experiences exerting considerable influence over an individual’s final neurological architecture (Fox, Levitt, & Nelson, 2010). During this ‘sensitive period’, synaptic connections are readily formed in response to environmental stimuli, but can quickly degrade unless stabilised through repeated stimulation (Fox, Levitt, & Nelson, 2010). Once this period of peak neural plasticity has passed, the young child’s neurological structures become hard-wired, preserving the positive or negative influences experienced during infancy and early childhood for the remainder of the individual’s lifetime (Fox, Levitt, & Nelson, 2010).

The capacities for executive function and self-regulation begin their development in early infancy and form the foundation for the later cognitive functions such as curiosity, impulse control and attentiveness, all of which are important for effective learning (Shonkoff, 2012). An early childhood environment conducive to these healthy neurological developments is a necessary condition for ensuring school readiness and to prevent the cascading negative effects associated with poor educational attainment. Longitudinal studies have found that individuals that exhibit limited self-regulation as early as three years old are significantly more likely to go on to experience negative outcomes such as poor health, depression, substance dependence, criminal conviction, and poverty in adulthood (Poulton, 2011).

Fortunately, there are indications that much of the neurological damage incurred due to early childhood adversity can be repaired if intervention occurs before the end of the period of peak neural plasticity. Studies have found that the neurological deficiencies observed in young children exposed to neglectful institutional environments can be significantly reduced if they are placed into high-quality foster care within the first two years of life (Rutter, 2012). Similarly, efforts to address childhood adversity such as Abecedarian programs and nurse-family partnerships have been found to be most effective if the intervention is focused in the earliest years (Garner, 2013). Each stage of learning and cognitive development in later life is built on the foundational capacities developed in infancy and early childhood. As well as ensuring a solid foundation for later learning, the value from investment in early intervention will be multiplied across the individual’s lifetime, further recommending it on the basis of economic efficiency.

A number of factors affect development. These are outlined below.

**Prenatal environment**

Poor maternal health behaviours can pose a significant risk for fetal development and the later health of the child. Contact with substances such as drugs and alcohol introduced maternally can cause disruption in the regulatory gene networks responsible for fetal brain development, which can have life-long negative impacts on behaviour and intellectual capacity (Fox, Levitt, & Nelson, 2010). Similarly, chronic overstimulation of the fetal immune system by maternal stress hormones can result in the infant developing an altered immune response, leading to an elevated risk of inflammatory disease in adulthood (Johnson, Riley, Granger & Riis, 2013). Poor prenatal nutrition has been linked with compromised metabolic functioning in infancy and later life. Both excessive and insufficient maternal weight gain during pregnancy have been found to cause an elevated risk for the child later developing insulin resistance and obesity (Sloboda, 2011). Minimising these negative maternal health behaviours and protecting the prenatal environment is a crucial component for efforts to improve childhood health.

**Child-caregiver relationship**

Infants need a close child-caregiver relationship in order to experience healthy neurological development and to build the capacities needed in later life. The critical foundations for social and emotional competencies emerge from the early exchanges between infants and their caregivers. These exchanges gradually escalate in
complexity and build towards the development of the more sophisticated cognitive, motor and self-regulatory skills necessary for a successful transition into early childhood (Woudes, Merry & Guy, 2011).

The parental support available in healthy child-caregiver relationships can also serve as a buffer to environmental stressors, moderating the severity of potentially traumatic experiences and allowing the young child to better cope (Shonkoff, 2010). As well as equipping the infant for later physical and social challenges, the child-caregiver relationship is believed to play a powerful moderating role over gene expression in the developing brain. Studies in animal models have demonstrated that levels of maternal care received in infancy have a proportional effect on the epigenetic structure of an individual’s DNA (Meaney, 2010). A similar effect has been observed in children that have suffered significant neglect or abuse in early life (Johnson, Riley, Granger & Riis, 2013). Epigenetic modifications are essentially permanent once established, with some evidence suggesting that their effects can even extend to subsequent generations (Meaney, 2010).

**Toxic stress**

As with adults, environmental stressors can provoke a stress reaction in infants acting through the endocrine and immune systems, which prepare the body for flight or fight (Shonkoff, 2010). This stress reaction can be healthy when it is moderated and short-lived, providing stimulus to overcome physical and emotional obstacles, helping train the infant to deal with the challenges of later life. However exposure to excessive or prolonged stress, through childhood adversity or a lack of parental support, can have a range of negative impacts on infant development. Adults that had been exposed to toxic stress in infancy and early childhood have been found to have stronger and more easily triggered stress response, resulting in a general over responsiveness to environmental stress and an elevated risk of developing inflammatory conditions such as asthma, diabetes, and cardiovascular disease (Shonkoff, 2012). Excessive stress signalling in early childhood can also have a particularly detrimental effect on the developing brain. The areas of the brain associated with aggression and impulsivity have been found to be enlarged in individuals exposed to significant childhood adversity, a symptom shared with post-traumatic stress disorder (Garner, 2013). Conversely, neuron proliferation in the areas associated with learning and self-regulation have been found to be suppressed during episodes of toxic stress, causing delays in cognitive development and impairing the acquisition of healthy coping mechanisms for stress management, essentially exacerbating the infant’s situation (Garner, 2013).

A child’s family and social environment have a significant effect on brain development, with normal development requiring a high level of sustained stimulation (e.g. being spoken or read to, engaging in play). Infants who do not receive appropriate levels of stimulation are likely to experience developmental delays which, in turn, limit their capacity to engage in educational systems, establish good social networks and/or reach their full potential.

**Maladaptive behaviour**

Humans have evolved in the expectation that they will enjoy healthy child-caregiver relationships during infancy and early childhood, and an absence of adequate parental interaction or support can provoke children to develop adaptive behaviours in order to cope (Johnson, Riley, Granger & Riis, 2013). With a lack of parental guidance and the harmful effects of toxic stress on emotional regulation, such adaptive behaviours are often maladaptive, causing long term problems for the individual. In early childhood, maladaptive behaviour can manifest as impulsivity, disruptive behaviour and frequent and violent tantrums, impacting on the individual’s ability to engage in education and form healthy peer relationships. In adulthood, these behaviours often progress into substance abuse, risky health behaviours, and criminality; one study found that members of a sample group that engaged in these activities in adulthood could be clearly distinguished from their peers at as young as three years of age (Woudes, Merry & Guy, 2011). Similarly, childhood neglect has been found to be among the most powerful predictors of later juvenile criminality, suggesting that intervention to prevent the
antecedents of maladaptive behaviour could have significant benefits for wider society (Weatherburn & Lind, 1997).

3.4 Aboriginal and Torres Strait Islander health status

The Council of Australian Governments (COAG) is committed to Closing the Gap in Indigenous Disadvantage and agreed to six targets to address this. Two of these targets aim to improve Indigenous health outcomes: halve the gap in child mortality by 2018 and close the life expectancy gap by 2031.

The recently released National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 (Health Plan) provides an evidence-based policy framework which supports these targets (Australian Government 2013). The Health Plan is currently being updated to reflect the current Government’s approach to and priorities for Indigenous affairs, to recognise the links between education, employment, community, safety and health. The Framework, whilst aligning with the COAG targets and the Health Plan, focuses on the provision of health services to Aboriginal and Torres Strait Islander children and families but also recognises the important links between health and education, employment, housing, and other social services.

Similarly, while the USF encompasses core services for all children aged 0-8 years and their families, a number of broad contextual factors, as well as several specific health indicators, demonstrate the value in seeking to develop a more focused systemic framework for the delivery of services to Aboriginal and Torres Strait Islander children and families. A key component of the Framework is the inclusion of antenatal care and preconception, which are not addressed under the USF. The following sections of this scoping paper seek to identify relevant information and evidence about the needs of, and provision of support to, Aboriginal and Torres Strait Islander children and families.

Overall the health status of Aboriginal and Torres Strait Islander people is poorer than that of non-Indigenous Australians. This is important because the health status of women and children has direct implication for services that are needed and how these should be delivered.

3.4.1 Overall health of Aboriginal and Torres Strait Islanders

Despite efforts to close the gap in health outcomes, Indigenous Australians continue to experience poorer health than other Australians (AHMAC, 2012b; AIHW, 2011a), although there have been some notable improvements.

- There has been a small reduction in the life expectancy gap. Between 2005-07 and 2010-12 the gap reduced by 0.8 years for males and 0.1 years for females. The gap is currently 10.6 years for males and 9.5 years for females (Australian Government, 2014).
- For the period 2008-2012, the leading causes of the mortality gap between Indigenous and non-Indigenous Australians were cardiovascular disease (26%), diabetes and related endocrine conditions (18%), cancer (15%) and respiratory diseases (11%) (ABS, 2014a, unpublished).
- Mortality in young and middle-aged Indigenous adults is particularly high (e.g. five times that of non-Indigenous Australians in the 35-44 year age group) (ABS, 2014a, unpublished).
- The Indigenous child mortality rate declined by 32% from 1998 to 2012 which has led to a 37% narrowing of the gap in child mortality between Indigenous and non-Indigenous children during this period(Australian Government, 2014).

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- There has been a significant decline in the proportion of low birthweight babies born to Indigenous mothers and a significant narrowing of the gap between low birthweight babies born to Indigenous and non-Indigenous mothers (AIHW, 2013a).
- Current daily smoking rates for Indigenous Australians (aged 15 years and over) have declined significantly over the last decade by seven percentage points (from 49% in 2002 to 42% in 2012-13) but rates remain high at 2.6 times the rates for non-Indigenous Australians (ABS, 2014b).

3.4.2 Health of Aboriginal and Torres Strait Islander women

The median age of Indigenous women who registered a birth in 2012 was 24.8 years, almost six years lower than the median age of all mothers (30.7 years). In 2012, 19% of births to Indigenous mothers were to teenagers. Only 3% of births to non-Indigenous mothers were to teenagers (ABS 2013).

Aboriginal and Torres Strait Islander women often experience poor maternal health and common occurrence of conditions such as anaemia, poor nutrition, hypertension, diabetes or glucose intolerance, and genital and urinary tract infections (Eades, 2004). They are also more likely to engage in risky behaviours such as tobacco use and hazardous alcohol consumption during pregnancy (AIHW, 2013a; Josif, Barclay, Kruske & Kildea, 2013).

3.4.3 Pregnancy and birth outcomes

Data indicates that Aboriginal and Torres Strait Islander women have:

- Higher rates of preterm births (AIHW, 2013a; Bar-Zeev, Barclay, Farrington & Kildea, 2012; Josif et al, 2013)
- A greater likelihood of babies born with low birth weight (e.g. twice as likely in 2011) as a consequence of poor fetal growth and/or preterm birth (Li et al 2013))
- Higher rates of perinatal mortality. During 2006 to 2010 the perinatal mortality rate for Aboriginal and Torres Strait Islander babies was about 12 per 1000 births, compared with eight per 1000 births for other Australian babies (AHMAC, 2012b).

3.4.4 Health of Aboriginal and Torres Strait Islander infants and young children

Aboriginal and Torres Strait Islander children are likely to experience poor health outcomes. For example, compared with non-Indigenous Australians, Indigenous children experience:

- Higher rates of infant mortality. Specifically, mortality rates for Aboriginal and Torres Strait Islander infants (aged 0-4 years) are twice those of other Australian infants (AHMAC, 2012b)
- Higher rates of hospitalisation. Between 2008-09 and 2009-10, Aboriginal and Torres Strait Islander children under five years of age were 1.4 times more likely to be hospitalised, with respiratory disease the most common reason for hospitalisation (AIHW, 2013a)
- Numerous conditions which impact on educational attainment (e.g. respiratory conditions, asthma, skin disease, otitis media, trachoma, nutritional anaemia and malnutrition, dental caries) (Priest, MacKean, Davis, Briggs & Waters, 2012).

According to 2012 Australia Early Development Index (AEDI) data, Aboriginal and Torres Strait Islander children are more than twice as likely to be developmentally vulnerable on one or more AEDI domain(s) compared with all other children (Australian Government, 2013). These domains include, physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge (Royal Children’s Hospital, 2013)

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2 From 1 July 2014, the AEDI was renamed the Australian Early Development Census (AEDC). The AEDC measures five important areas (or domains) of early childhood: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills; and communication skills and general knowledge.
3.5 Contextual factors impacting on health status and service delivery

**Racism and discrimination**

Racism is a “set of beliefs ... that asserts the natural superiority of one group over another, and which is often used to justify differential treatment and social positions” (HREOC, 2001). Racism can occur at individual and institutional levels. Institutional racism refers to the ways in which racist beliefs or values are built into the operations of social institutions in ways that discriminate against, control and oppress various groups (Henry et al, 2004). Discrimination refers to situations in which a person receives unfair treatment as a result of being an Aboriginal and/or Torres Strait Islander person.

Institutional racism historically has and continues to contribute to the ongoing marginalisation experienced by Aboriginal and Torres Strait Islander peoples (Sherwood & Edwards, 2006). Systemic discrimination and racism have led to a multi-cycle of poverty reflected in the significant levels of disadvantage experienced by Aboriginal and Torres Strait Islander people, which is perpetuated by lack of self-determination, and inequitable access to education, employment, housing and basic health services (Dugdeon et al, 2010; Kruske et al, 2012; Sherwood, 2009).

Racism and discrimination are associated with a range of adverse health conditions and behaviours including psychological distress, risky drinking and using illicit substances (AIHW, 2011a). Aboriginal and Torres Strait Islander people who have experienced racism and discrimination are less likely to trust police, schools, doctors and hospital staff which has significant implications for the delivery of health services.

**Violence and the cycle of abuse**

Violence is a significant health risk factor. In 2008, 24% of Aboriginal and Torres Strait Islander people reported they were the victim of physical or threatened violence in the previous year. Aboriginal and Torres Strait Islander men were 1.6 times and women 2.5 times more likely to report being a victim of physical or threatened violence than non-Indigenous men and women (AHMAC, 2012b).

According to Atkinson (1990b) violence is a “learned behaviour, passed from one generation to another by example.” Exposure to violent/ abusive behaviours increase the risk of repeating the behaviours with their own families (Atkinson, 1990a). For many Aboriginal and Torres Strait Islander people this is compounded by the absence of positive role models and/or parenting experiences from whom behaviours are learnt (SNAICC, 2010). These factors combined with the significant pressures experienced by Aboriginal and Torres Strait Islander families (e.g. socio-economic factors, unemployment, overcrowded housing, lack of basic essential services) perpetuate violent situations (Atkinson, 1990b).

**Child protection.** Aboriginal and Torres Strait Islander children are over-represented in the child protection system. In 2011-12, Indigenous children (0-17 years) were eight times as likely to be the subject of substantiated child abuse or neglect (42 per 1,000 compared to five per 1,000). In addition, Indigenous children are more likely to be placed on care and protection orders (10 times more likely), and in out-of-home care (almost 10 times more likely) than non-Indigenous children (AIHW, 2014)

**Community safety.** Being and feeling protected from harm is an important part of physical and mental wellbeing. For instance, physical and threatened violence are significant health risk factors. Stressful life events experienced by individuals and families (such as the death of a family member of close friend, alcohol or drug-related problems) can also contribute to a community’s sense of safety (AIHW, 2011; SCRGSP, 2011a).

**Contact with criminal justice system.** Relatively high rates of incarceration among Aboriginal and Torres Strait Islander people is likely to affect the health and wellbeing of those imprisoned, and their families and children. Furthermore, incarceration also has the potential to erode Indigenous communities through adverse employment outcomes and absence of positive role-models in the community (AIHW, 2011a).
Historical, collective and intergenerational trauma

Historical trauma refers to “the subjective experiencing and remembering of events … passed from adults to children … over the life span and across generations.” Historical trauma is transmitted through the same mechanism as enculturation, and overtime becomes ‘normalised’ within a culture (Atkinson et al, 2010; p.138). Intergenerational trauma is a form of historical trauma that is unresolved and “passed on” to future generations (Atkinson et al, 2010; SNAICC, 2010).

Aboriginal and Torres Strait Islander children may experience secondary exposure to trauma (for example stories of trauma), and/or may be directly exposed to traumatising events/ situations for example when people who have themselves been traumatised people engage in violent or dysfunctional behaviours (Atkinson et al, 2010). Such experiences have the potential to interrupt normal development, including brain development and attachment to caregivers, with many children growing into adults who exhibit emotional and behavioural difficulties such as substance abuse and antisocial behaviours (Healing Foundation, 2013).

Socio-economic factors

Socio-economic factors refer to variables such as education, employment and income. Socio-economically disadvantaged people tend to have poorer health and shorter life expectancies. This is often compounded by limited choices and/or opportunities to improve these outcomes. Socio-economic factors may also influence health-related factors, such as diet and access to health care.

- **Education.** Low education levels are linked with poverty, unemployment, poor housing quality and reduced access to health services. The importance of education in closing the gap on Indigenous disadvantage is reflected in three (of the six) COAG targets which relate to education (AIHW, 2011a). Historically, Aboriginal and Torres Strait Islander students have had lower retention and attainment rates (AHMAC, 2012b)
- **Employment.** Aboriginal and Torres Strait Islander people have relatively low levels of labour force participation. This can be attributed to few employment opportunities available to those living in remote locations (e.g., due to lack of viable industries), and the negative impact of low educational levels on employment opportunities. In addition, unemployment rates of Indigenous Australians is more than four times the unemployment rates of non-Indigenous Australians (AHMAC, 2012b; AIHW, 2011a; SCRGSP, 2011)
- **Income.** Low levels of labour force participation and higher unemployment rates are reflected in Indigenous households’ overrepresentation in the lowest income bracket (AHMAC, 2012b; AIHW, 2011a).

Housing and transport

Inadequate or poorly maintained accommodation and poor access to public utilities can pose serious health risks. In addition, access to reliable transportation is an important resource for individuals and the community (AIHW, 2011).

- **Functional housing.** Access to basic household amenities (washing and laundry, safe storage and preparation of food, and safe waste removal) are often of poor quality or absent in Indigenous households. This is especially the case in remote communities where access to housing, water supply, electrical supply and sewage disposal is limited (AIHW, 2011; SCRGSP, 2011)
- **Overcrowding.** Aboriginal and Torres Strait Islander people are more likely to live in multi-family households, often resulting in overcrowding. Overcrowding has been linked with poorer self-reported physical and mental health, higher rates of tobacco use and hazardous drinking. Further, overcrowding may also have an indirect effect on education (e.g., limiting the space to study) (AIHW, 2011; SCRGSP, 2011)
- **Homelessness.** Indigenous Australians are more likely to be homeless as a result of a range of factors, including limited access to affordable and secure housing, overcrowding and lack of adequate temporary accommodation (AIHW, 2011a).

- **Transport.** Transport provides communities with opportunities to pursue employment, educational, social and health outcomes. Limited or no public transport options can significantly impact on the ability to receive goods, services, and access timely health care (AIHW, 2011a). Indigenous Australians are more likely to report difficulties “getting to places they need to go” (AHMAC, 2012b; p.99).

An analysis of data from the *Footprints in Time: Longitudinal Study of Indigenous Children* showed that children who experienced any housing problems in the previous 12 months were more likely to experience ear problems, skin infections, diarrhoea, colitis or intestinal problems, or other health problems. They were also less likely to have experienced no health problems. Similarly, overcrowding was associated with children experiencing asthma and eczema, and children living in homes that needed repairs were more prone to skin infections and hospitalisations. (Brandrup, 2013).

**Community capacity**

Community capacity refers to a community’s ability to support the health and wellbeing of its members. It includes provision of resources (human or other), leadership and fostering a sense of community/community togetherness. Strong communities support family structures, inter-generational care and social networks, which in turn leads to improved health outcomes (AIHW, 2011a).

**Family structure/systems.** As highlighted previously, Aboriginal and Torres Strait Islander people often have more extensive and complex family relationships. In 2008, 94% of Indigenous Australians aged 15 years and over had contact with family and friends outside the household at least once per week, 75% had friends to confide in and 89% felt able to have a say with family and friends (AHMAC, 2012b). While Indigenous households are larger than other Australians, Indigenous children are twice as likely to live in one-parent families. One-parent families are often associated with low socio-economic status, poor educational attainment and a lack of social support (AIHW, 2011a).

**Behavioural factors**

Individual behaviours also play an important role in health and wellbeing outcomes. These include risky behaviours such as tobacco use, physical inactivity, poor nutrition, alcohol and illicit drug use. The most recent study of the contribution of risk factors to Indigenous disease burden (illness, disability and premature death) suggested that tobacco smoking contributed the greatest burden (12% of total health burden), followed by overweight / obesity (11%) and physical inactivity (8.4%). Alcohol was responsible for 5.4% of the total burden through alcohol abuse and harmful use, homicide, violence and suicide. Low fruit and vegetable consumption was responsible for 3.5% of the total burden of disease. About 1.2% of the total burden was attributed to unsafe sex practices, primarily through cervical cancer, chlamydia and HIV/AIDS (Vos et.al, 2007; AHMAC 2012b).

- **Substance use.** Alcohol, tobacco and illicit substance use play a significant role in the health gap between Indigenous and non-Indigenous Australians. Tobacco use is more prevalent among Aboriginal and Torres Strait Islander people aged 15 years and over who are 2.6 times more likely to be current daily smokers (ABS 2014b). Aboriginal and Torres Strait Islander people are more likely to abstain from alcohol. However, those who do drink are more likely to drink at risky levels (ABS 2014c) In 2012-13, 22% of Indigenous Australians aged 15 years and over had used substances in the last 12 months (ABS 2014c). Substance use is a major contributing factor for illness (respiratory, mouth / throat / lung cancer, liver damage), accidents and injury. In addition, alcohol and illicit drug use may have severe social and economic impacts on the community, including domestic violence, crime and assaults (AIHW, 2011a).
Physical inactivity. According to the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS), Indigenous Australians in non-remote areas were 1.3 times more likely to be classified as sedentary (ABS 2014c). Physical inactivity is associated with several preventable chronic diseases prevalent in the Indigenous population – cardiovascular disease, hypertension and diabetes. Inactivity is also related to overweight and obesity, which are important risk factors for multiple diseases (AIHW, 2011a).

Dietary behaviour. The 2012-13 AATSIHS revealed that, overall, Indigenous Australians aged 15 years and over were slightly more likely to report inadequate daily fruit intake (1.1 times) and similar rates of inadequate daily vegetable intake compared with non-Indigenous Australians (ABS, 2014b).

Unhealthy body weight. Aboriginal and Torres Strait Islander adults are more likely to be overweight. Data also suggests that a higher proportion of Indigenous adults and children are underweight. These findings have implications for the health and wellbeing of Indigenous Australians, as a number of health problems (e.g. coronary heart disease, Type 2 diabetes, some cancers, knee and hip problems and sleep apnoea) are related to being over or underweight (AHMAC, 2012b; AIHW, 2011a).

Social and emotional wellbeing

Positive wellbeing. The 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) positive wellbeing module aimed to identify positive emotional states, such as happiness and vitality. According to the NATSISS, the majority of Aboriginal and Torres Strait Islander people aged 15 years and over felt “happy” (72%), calm and peaceful (59%), and full of life (57%) all or most of the time in the four weeks prior interview” (ABS, 2009). Subjective levels of happiness have been associated with age, geographical location, employment, educational attainment and substance use. Specifically, the NATSISS found rates of happiness were higher among younger Indigenous people, and those living in remote areas. Indigenous adults who were employed, and who have completed Year 12 were also more likely to report experiencing higher levels of happiness. Further, Aboriginal and Torres Strait Islander adults who felt happy “all or most” of the time were less likely to be a current daily smoker and to have used illicit drugs in the previous 12 months (AIHW, 2011a).

Psychological distress. According to the 2012-13 AATSIHS, Indigenous adults (aged 18 years and over) were 2.7 times as likely to experience high/very high levels of distress compared with non-Indigenous Australians (ABS 2014c). The 2012-13 results indicate that Indigenous women were more likely to report high/very high levels of psychological distress (24%) than Indigenous men (24%). Psychological distress was also linked with poorer health outcomes, including subjective experiences of health (fair/poor), and engagement in risky behaviours (tobacco use, alcohol and illicit drug use) (AHMAC, 2012b; AIHW, 2011a).

Life stressors. Stressful life events can have a detrimental effect on social and emotional wellbeing. Recent data (2012-13) suggests that a high percentage of Indigenous adults (73%) aged 15 years and over reported experiencing at least one life stressor in the previous 12 months. Common stressors reported by Aboriginal and Torres Strait Islander adults were the death of a family member or close friend, serious illness or disability, and inability to get a job (ABS 2014c). Data from the 2008 NATSISS for Indigenous children, show that typical stressors included death of a close family member/friend, problems keeping up with school work, and being scared/upset by an argument or someone’s behaviour (AIHW, 2011a).

Discrimination. Discrimination and racism have been found to negatively affect health and wellbeing. For instance, ABS data suggests that Indigenous Australians who have experienced discrimination reported high/very high levels of psychological distress and fair/poor health, and are more likely to engage in binge drinking and use illicit drugs (AIHW, 2011a).

The Footprints in Time: Longitudinal Study of Indigenous Children (FAHCSIA, 2013) has been following the development of a group of Indigenous children (including their emotional development) and examines the factors contributing to their individual and collective outcomes. As a group, Footprints in Time children were at higher risk of emotional and behavioural difficulties in Wave 4 than at Wave 3, with the greatest increase in
the emotional symptoms domain. However, *Footprints in Time* children also had significantly higher scores in the prosocial domain in Wave 4 than in Wave 3. This indicates that they were increasing in their ability to interact positively with peers.

*Footprints in Time* also examined the relationship between major life events and social and emotional outcomes. It identifies key factors that impact upon social and emotional outcomes for children. The findings from Wave 4 indicate that the following major life events did not have a significant relationship with social and emotional difficulties scores:

- pregnancy or a new baby to someone in the household;
- a carer of the study child within the household getting a job or returning to study;
- a carer of the study child within the household losing their job;
- someone in the household being mugged, robbed or assaulted;
- one of the study child’s parents or carers leaving because of a family split.

On the other hand, children who experienced the following life events were more likely to have higher social and emotional difficulties scores:

- children who had been badly hurt or sick or who had a family member in the household being hurt or sick;
- where the primary carer had significant money worries for three or four years;
- where someone in the household had been harassed for money for three or four years;
- children in families experiencing housing problems or overcrowded or where they had moved in the last year, experienced in three or four years;
- children with a close family member with drug or alcohol problems living in the same household; and
- children in families experiencing housing problems or overcrowded or where they had moved in the last year, experienced in three or four years;
- children with a close family member with drug or alcohol problems living in the same household; and
- If a close family member had been arrested, been in jail or had problems with police where this had been experienced in two or three years.

In addition to major life events which affected various family members, *Footprints in Time* asked about events that have a direct impact on children in the household: whether they have been involved in or upset by family arguments; whether they had been badly scared by other people’s behaviour; and whether they had been cared for by someone else for at least a week.

- Children involved in or upset by family arguments had higher social and emotional difficulties scores than those who did not experience this type of event.
- Having been scared by other people’s behaviour had significantly higher scores, particularly for children who had experienced it in three or four years, compared to those who had only experienced this event in one or two years.
- Children who had been cared for by someone else other than their regular carer (for at least a week) also tended to have higher scores than those who had remained constantly with their regular carers. This effect was considerably higher for those who had experienced this over three or four years, compared to those experiencing it in one or two years.

Many of these events only have a significant impact on children’s social and emotional difficulties scores if experienced over more than one year. This has potential implications for service delivery and the potential for prevention and early intervention on these factors.
Summary

These factors have the potential to impact on the health and wellbeing of mothers, fathers and other carers, and to adversely affect their capacity to provide a safe and healthy environment for their children. These issues are important contextual considerations in the development of the Framework. A recent descriptive analysis of the New Directions: Mothers and Babies (NDMB) Services (Department of Health, 2014) showed that many services and service providers find they are dealing with these complex social issues beyond the scope of traditional health services, in order to appropriately address the needs of their clients and communities.
4 Framework Responses

4.1 Underpinning components

A number of components underpin the effective functioning of the service system.

4.1.1 Workforce

According to the Australian Health Ministers’ Advisory Council (2011), professionals who provide maternal, child and family health services must possess the relevant knowledge, technical skills and attitudes to work with adults and children. In addition, health professionals must be competent in identifying, assessing and managing a range of health issues faced by children and families (Herceg, 2005; McHugh, Bradley & Hornbuckle, 2011). Attracting and maintaining a skilled workforce involves the provision of adequate training, competitive incentives, remuneration and support (i.e. locum relief, accessible training and professional development) (Commonwealth of Australia, 2009; Stewart et al, 2011).

The role of knowledgeable and skilled health professionals in the delivery of effective maternal and child health services is evident in successful programs. For example, a major strength of the NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) identified in the NDMB review was the “high level of skill and expertise” exhibited by the AMIHS team (Aboriginal health workers / Aboriginal Health Education Officer and midwife) (Department of Health, 2014). In addition, the employment of health professionals with strong interpersonal skills facilitated the establishment of positive relationships between NDMB services, and their client and other service providers (Department of Health, 2014).

Technical skills and competencies required to deliver child and family care include (AHMAC, 2011; Kemp, Anderson, Travalgia & Harris, 2005; Department of Health and Ageing, 2013):

- Knowledge of child development, social determinants of health, and broader outcomes for Indigenous children and families
- Skills in assessment and monitoring / observation of child and family health; and provision of a range of interventions (physical, psychological, social)
- Ability to work in multi-disciplinary teams
- Interpersonal and communication skills (e.g. which help establish partnership with families)
- Cultural competence
- Knowledge of relevant ethical guidelines and legislation / policies.

The health workforce is facing workforce shortages as a result of an ageing population. This presents challenges for Aboriginal and Torres Strait Islander primary health care services in sustaining and building an appropriately skilled maternal and child workforce (AHMAC, 2012b).

The capacity to attract and retain suitably qualified staff was one of the key barriers identified in the NDMB analysis. Factors contributing to the difficulties of recruitment and retention include:

- High staff turnover
- Shortages of child and maternal health nurses and midwives
- Lack of suitably qualified Aboriginal and Torres Strait Islander staff
- Staff stress due to challenges of working with women and families with complex and challenging needs

Difficulties in recruiting and retaining staff have an impact on services’ capacity to provide coordinated, multi-disciplinary care.
In remote areas and sometimes also in larger centres, services are often provided by health workers with diverse responsibilities. Child and family services may be only one component of their work. This presents a challenge, not only in providing high quality targeted services but also in many cases in providing the universal services identified in the USF. Similarly there are likely to be few, if any, local referral services which mean either that staff have to provide whatever level of additional support they can, or clients have to travel long distances to access additional services.

4.1.2 Infrastructure and Resources

Service access is enhanced by the availability of services, and their capacity to meet the needs of Indigenous children and families. Service availability and capacity is dependent on resources and infrastructure. Resources include levels of funding, human resources and equipment. Infrastructure refers to the physical and organisational structures (buildings, all-purpose roads, water, sewerage, information systems) necessary for service delivery.

Funding levels influence the ‘life’ of a program. Thus, recurrent, long-term funding is needed to address the health needs of Indigenous children and their families and to achieve the COAG targets of closing the life expectancy gap within a generation (by 2031) and halving the gap in mortality rates for Indigenous children under five by 2018 (AHMAC, 2011; Griew et al, 2007).

Poorly organised systems can have a detrimental effect on access to and/or receipt of appropriate care. This was evident in Bar-Zeev et al (2012) study of Indigenous maternity care where a lack of co-ordination between services resulted in “missed opportunities” to provide postnatal and newborn checks, parenting support and the ongoing management of postnatal complications.

This problem may be overcome through the development of collaborative models of care which are responsive to community needs, thereby ensuring “the right initiatives are implemented for the right people at the right time” (Stewart et al, 2011; p.7). Collaborative models of care enable resources and systems to be – first, flexibly delivered to meet the needs mothers, children and their families (e.g., non-prescriptive organisation of resources and application of interventions); second, integrated to maximise opportunities for access (e.g. ‘one-stop-shop’ where families are able to use multiple services at one location), and third, support the development of strong partnerships and referral pathways.

Collaboration between professions and services is hindered by incompatible information technology systems, which limit information and data sharing. In response to this challenge, the AHMAC (2011) called for the development of information technology systems which support communication / transfer of information between professionals and services (e.g. electronic national child personal health record).

4.2 Approaches to care

An approach to care refers to the way in which services are delivered. These approaches have been highlighted as important ways in which culturally appropriate services can be provided that better meet the needs and expectations of Aboriginal and Torres Strait Islander children and families. It is important to note that the value in these approaches is not exclusive to Aboriginal and Torres Strait Islander people, and have application to socially disadvantaged groups and culturally diverse populations.

Strengths-based approach

A strengths-based approach focuses on identifying and building on the existing abilities, knowledge, capacity and resources of children, families and communities (Armstrong, 2012; Kazelman & Stavripoulos, 2012). This approach is based on the assumption that individuals / families are basically functional and healthy, and have the capacity to learn, grow and change (Armstrong, 2012; Darbyshire & Jackson, 2004; Usher et al, 2005). It
therefore allows for a more balanced understanding of Aboriginal and Torres Strait Islander children, families and communities, rather than focusing on deficits / problems (Brough et al, 2004).

Six principles underpin a strengths-based approach (Saint-Jacques et al, 2009; Scerra, 2011):

- A focus on strengths, rather than pathology
- Community is a rich source of resources
- Individuals and families are empowered to make decisions about care
- The relationship between individuals/ families and service providers/ health professionals is “primary and essential”
- Outreach is the preferred mode of service delivery
- People are seen as able to learn, grow and change.

**Trauma-informed approach**

As a result of the traumatic legacy of colonisation, a trauma-informed approach is needed to facilitate healing and recovery, and minimise re-traumatisation. Trauma-informed services consider all aspects of their operations through a ‘trauma lens’ (Atkinson, 2013; p. 7), and draw on the following guiding principles in the development and delivery of services:

- **Understanding trauma and its impact on individuals, families and communal groups** through trauma-informed policy and training
- **Promotion of safety** through the provision of physically and emotionally ‘safe spaces’
- **Ensuring cultural competence** where services are respectful of, and specific to cultural backgrounds; and staff are aware of their own cultural attitudes and beliefs, and those of the individuals, families and communities they work with
- **Supporting client control** by rebuilding a sense of control over their daily lives and the competencies to strengthen a sense of autonomy; and actively involving families in informed decision making processes
- **Sharing of power and governance** across all levels of the organisation
- **Integrating care** by linking all services involved
- **Supporting relationship building** to assist in healing and recovery
- **Enabling recovery** by empowering individuals, families and communities to take control of their healing and recovery.

**Reflective Practice**

Reflective practice supports the development of health professionals who are self-aware, and able to engage in self-monitoring and self-regulation. (Mann, Gordon & MacLeod, 2009). Reflective practice is often stimulated in response to complex presentations, and typically involves:

- Critical reflection – purposeful analysis of experience and knowledge to achieve deeper understanding, and identify learning needs. Critical reflection also requires health professionals to examine their personal beliefs, attitudes and values, in the context of professional practice (professional standards and ethics, organisational expectations, beliefs and attitudes towards cultures which are different to their own) (Mann, Gordon & MacLeod, 2009).

- Reflective learning – retrospective examination of experiences, including consideration of ‘what could have been done differently,’ and possible gaps in the health professional’s skills / knowledge. The lessons learnt from such experiences are used to guide future practice (Mann et al, 2009).
Reflection-in-action – formulation of informal theories based on knowledge of the individual and their specific situation, which are continuously tested, modified and re-tested. The focus of attention is on the here-and-now, and the uniqueness of each person (Rolfe, 1997).

The complexities and challenges of working with Aboriginal and Torres Strait Islander families require health professionals to continuously examine and learn from their experiences. An understanding of the following is also important:

- Ongoing effects of colonisation, including discrimination and institutionalised racism
- Assumptions and attitudes towards Aboriginal and Torres Strait Islander peoples
- Potential cultural differences (e.g. role of family and kin, holistic definition of health)

Professional and peer supervision often involves reflection on personal assumptions and beliefs and the lessons learnt from experiences. As such, supervision can be used to promote and support the application of reflective practice.

Multi-disciplinary care

The literature suggests the provision of health care to Indigenous mothers and children “should be multi-disciplinary and involve a collaborative, team based approach” (Commonwealth of Australia, 2009; p.18; Herceg, 2005). Multi-disciplinary care “occurs when professionals from a range of disciplines work together to deliver comprehensive care that addresses ... the patient’s health and other needs” (Mitchell, Tieman & Shelby-James, 2008; p.S61). Within an Indigenous maternal and child health context, multi-disciplinary teams typically include general practitioners (GPs), nurses, midwives, Aboriginal health workers (AHWs) and allied health professionals.

Multi-disciplinary care is generally provided through community-based primary health care services. Aboriginal Community Controlled Health Services (ACCHS) are primary health care services designed to provide holistic, culturally appropriate care for Aboriginal and Torres Strait Islanders. ACCHSs “largely provide team-based multidisciplinary care across a range of health areas,” including maternal and child health (Larkins, Geia & Panaretto, 2006; p.2).

Enablers of multi-disciplinary care include:

- Clearly defined goals (client-centred and outcome focused)
- Clearly articulated and negotiated roles of each health professional (Mitchell et al, 2008)
- Clear communication pathways and feedback mechanisms
- Ongoing, regular communication and information sharing
- Established guidelines for the provision of multi-disciplinary care to Indigenous mothers and children.

4.3 Services across the continuum

4.3.1 Antenatal

Antenatal care provides the foundation for health and wellbeing for both mothers and their babies. Antenatal care often involves physical examinations, screening tests, health advice and support (e.g., nutrition, smoking cessation, and alcohol / drug use during pregnancy). It is recommended antenatal care include tests for common conditions among Indigenous women, such as glucose intolerance, and breastfeeding interventions (AHMAC, 2012a) as well as screening for psychosocial issues. The AHMAC Clinical Guidelines for Antenatal Care also recommend 10 visits for a woman’s first pregnancy and seven visits for subsequent uncomplicated pregnancies.
The provision of antenatal care involves a 'team' of health professionals including, obstetricians, GPs, midwives, AHWs, nurses, and sonographers. Antenatal care is often led by obstetricians, midwives and GPs. However it may be shared between a combination of professionals, working in a variety of settings (private practice to public hospitals). In rural and remote communities, antenatal care is typically provided by local or outreach services, in the local health centre (Bar-Zeev et al, 2012).

Indigenous women are less likely to access antenatal care in the first trimester of pregnancy. They also access and/or receive less antenatal care (Commonwealth of Australia, 2009; Josif et al, 2013). These patterns of antenatal care have implications for maternal and perinatal health and wellbeing. For instance, antenatal care can facilitate the identification, treatment and management of infections (STIs), hypertension, gestational diabetes and other risk factors (Commonwealth of Australia, 2009; Eades, 2004). Furthermore, good antenatal care has the potential to reduce the incidence of low birth weight (SCRGSP, 2011).

Many factors may influence an Aboriginal woman’s engagement in antenatal care, including availability of culturally appropriate services, and financial issues. The features that have been identified for quality primary maternity services in Australia include high quality care that is enabled by evidence-based practice, coordinated according to the woman's clinical needs, based on collaborative multidisciplinary approaches, continuity of care, woman centred, culturally appropriate and accessible at the local level (AHMAC, 2012b). Reviews of the literature have identified the following key success factors in Aboriginal and Torres Strait Islander maternal health programs to complement the features detailed above: a specific Aboriginal and/or Torres Strait Islander program; a welcoming and safe environment; outreach and home visiting; flexibility in service delivery and appointment times; transport; continuity of care and carer integration with other services; e.g., AMS or hospital; a focus on communication, relationship building and trust; respect for Aboriginal and Torres Strait Islander culture; family involvement and child care; appropriately trained workforce; Indigenous staff and female staff; informed consent and right of refusal; and tools to measure cultural competency (Dudgeon et al., 2010; Reibel et al, 2010; Herceg, 2005; AHMAC, 2012b).

The cultural concept of ‘shame’ described by Ireland and colleagues (2011) and Wilson (2009) has also been implicated in remote Indigenous women’s “willingness” to participate in antenatal care. For example, young Aboriginal women may feel “great shame when their pregnancy starts to show, and may isolate themselves and not attend care until this new role of being pregnant is integrated into their social identity” (Ireland, Willili Narjic, Belton & Kildea, 2011; p.638).

4.3.2 Birthing

The majority of Australian women deliver their babies in a ‘conventional’ hospital-based setting (Commonwealth of Australia, 2009; Josif et al, 2013). A range of health professionals are involved in the provision of maternity care including, obstetricians, midwives, GPs, maternal and child health nurses, AHWs, and anaesthetists. In rural and remote settings, procedural GPs (obstetricians and/or anaesthetists) play a central role in the provision of maternity care (Commonwealth of Australia, 2009).

Hospital birthing services will not be a direct part of the Framework, however they do form part of the continuum of care. The NDMB analysis highlighted the benefits of strong links between antenatal, birthing and postnatal services (Department of Health, 2014). Several NDMB services provide direct support for clients during the birthing process as well as visits to hospitals both in the antenatal and postnatal periods.

4.3.3 Postnatal (0-6 weeks)

Following birth most mothers and newborns move from hospital-based maternity care to community-based primary health care. Postnatal care is typically provided by a GP, midwife, child and family nurse, or AHW. Standard postnatal care includes postnatal and newborn checks, breastfeeding education and support, parenting support, and the ongoing management of postnatal complications (Bar-Zeev et al, 2012).
Knowledge of common risk factors which threaten the health and wellbeing of Indigenous mothers and newborns, and the important role of protective factors and early intervention has led Indigenous postnatal care to include a focus on:

- **Maternal health and wellbeing** (adult health check) to improve the capacity of Aboriginal and Torres Strait Islander mothers to nurture and care for their new baby (Eades, 2004)
- **Advice and support with breastfeeding** to ensure the nutritional, health, and psychological benefits of breastfeeding are maximised (Eades, 2004).

### 4.3.4 Early Years (6 weeks to 5 years)

A scan of the available literature suggests the following health services are recommended during a child’s early years.

- **Mother and child health checks** (Adult Health Checks, Aboriginal and Torres Strait Islander Child Health Check between three and five years or Healthy Kids Check at four years of age) (SCRGSP, 2011)
- **Infant ear health monitoring** to detect and treat middle ear infections (otitis media), and prevent speech and language delays (Griew et al, 2007)
- **Nutritional advice and support** which encourages breastfeeding (up to six months), and provides information on when to introduce solid foods and the dietary guidelines necessary for healthy growth and development (Eades, 2004; Griew et al, 2007)
- Ensuring all infants and children are appropriately immunised (Griew et al, 2007)
- **High quality childcare** (with an educational component) has been found to protect against some risk factors that affect healthy child development during the early years. The evidence suggests that access to structured playgroups and quality childcare services is particularly advantageous for disadvantaged children (Griew et al, 2007)
- **Parent education and family support** to address possible risks (e.g., preventable injuries and illnesses, passive smoking, substance abuse, neglect) experienced by Indigenous children (SCRGSP, 2011; Griew et al, 2007).

Given the diverse nature of core services provided during the early years of a child’s life, a number of health professionals are involved such as GPs, child and family nurses, AHWs, child and family centre staff / childcare workers, and allied health professionals (Griew et al, 2007).

### 4.3.5 Preschool, school and beyond

During a child’s preschool years (3-5 years), the following core services are necessary to ensure they are healthy and ready to learn:

- **School readiness assessment** (Australian Early Development Index, AEDI). The AEDI measures, at a community level, a child’s development in five domains (physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge) (SCRGSP, 2011)
- **Nutrition and health promotion services** which are integrated into early childhood education and care, and family support programs (Griew et al, 2007).

### 4.3.6 Core services during the school and beyond years (6 years onwards) include:

- **School-based nutrition programs** have been found to improve school performance and attendance in Indigenous communities. Programs may distribute nutritious meals to children at school, and/or disseminate information on health and nutrition to students and families (Griew et al, 2007)
- **School based ear examinations** (Griew et al, 2007)
- **Adolescent life skills programs** such as the Core of Life’s National Indigenous program which provides sexual health, reproductive and parenting education to young people aged 12 to 17 years ([www.coreoflife.org.au](http://www.coreoflife.org.au)). Schools and other educational facilities (TAFE) also offer opportunities to educate young Indigenous people about reproductive and sexual health (SCRGSP, 2011).

- **School engagement, retention and attainment** (Silburn, 2012).

Core services are provided by a variety of primary health care providers (GPs, child and family nurses, AHWs, childcare workers, and allied health professionals), and school principals, teachers, and Aboriginal and Islander Education Workers (AI EW).

4.3.7 **Youth and Pre-pregnancy**

There is a lack of a systematic or universal approach to health services for young people, once they pass beyond the universal child health services that typically end at either five or eight years. There are many programs targeted at young people and their health, however these are not universally available and there is a lack of evidence about their impact on measures of health and wellbeing. Unlike in early childhood, young people do not tend to have regular engagement with health services, except for the treatment of acute illness and injury.

Adolescence can be a time of considerable change and, often, stress both for young people and their families. It is a time when patterns of behaviour can begin that potentially have serious implications for both individuals and their children.

While there is no universal approach to meeting young people’s health needs, primary health care services are best placed to assist young people achieve their optimal health and wellbeing. Research has shown that young people experience barriers to accessing healthcare and that these barriers exist across both genders and in all socioeconomic groups (Cummins and Kang, 2012). Certain subgroups of young people, such as young men and Indigenous youth may be exposed to a higher risk of poor health outcomes because they are not accessing healthcare. Barriers cited by young people include fears about confidentiality and embarrassment about discussing health concerns while barriers cited by health professionals, including GPs including communication difficulties, time and uncertainty about medicolegal status for those under 18 years.

To overcome these barriers, seven principles for youth-friendly health services have been proposed (NSW Health, 2010):

1. **Accessibility**: health services should be easily accessible, flexible, affordable, relevant and responsive to the needs of all young people.
2. **Youth participation**: young people should be actively involved in developing, implementing, reviewing and evaluating youth services and programs.
3. **Collaboration and partnerships**: service providers develop working relationships with other groups that share similar service goals and target groups.
4. **Professional Development**: developing the workforce’s knowledge, skills and attitudes to enable them to work confidently and effectively with young people.
5. **Evaluation**: effective evaluation engages staff, young people using the service or program and other stakeholders in providing feedback and suggesting improvements.
6. **Evidence-based approaches**: considering and learning about what works in responding to young people, meeting their health care needs, and developing approaches to address youth health issues.
7. **Sustainability**: sustainable programs and initiatives become self-maintaining in the long term or can become everyday practice. Sustainable programs support long-term improvements in health and wellbeing for young people.
Other national youth health initiatives include immunisation (e.g. the *National HPV School Vaccination Program*), health checks (e.g. the Medicare Health Assessment for Aboriginal and Torres Strait Islander People or MBS item 715) and mental health and drug and alcohol services (e.g. *headspace*).

The evidence emerging from epigenetics research highlights the importance of the physical (in-utero) and social environment for the developing foetus that can be challenged by the complexity of the health concerns facing many Indigenous Australians. Ensuring that young people are healthy prior to conceiving and during pregnancy has the potential to significantly improve long term health outcomes for Aboriginal and Torres Strait Islander children.

Preparation for pregnancy and advice to young people about sexual and reproductive health through school programs can potentially improve engagement with health services in the antenatal period, and provide opportunities for health promotion and prevention strategies to be implemented.

A number of programs operate across Australia targeting the health of young people, including some that are specifically concerned with preparation for pregnancy such as the Core of Life Program. Often programs for young people are run in conjunction with cultural or sporting activities to improve engagement. However, there have been few programs that have been evaluated and demonstrate improved health outcomes, highlighting the need for greater attention to this stage of development.

### 4.4 Social and Other Service links

An in-depth analysis of the relationship between health, education and welfare is beyond the scope of this review. However, it is important to acknowledge the complex interaction between these three domains, including:

- The relationship between a mother’s level of education, and child health outcomes. Specifically, a mother’s educational attainment has been found to influence breastfeeding practices, care of newborn / infant / toddler (i.e., awareness of ‘normal’ growth and development, nutritional requirements, provision of stimulating environment to support emotional and cognitive development) and self-care behaviours (Griew *et al.*, 2007)
- The relationship between health and education. Health is likely to affect school participation, attendance and learning. This, in turn, may impact on educational outcomes (e.g. levels of literacy and numeracy, educational attainment) which is associated with health in adulthood (Griew *et al.*, 2007). Specifically, higher levels of schooling were positively related with health status (AIHW, 2011b)
- The role educational settings (pre-school and schools) play in supporting child health outcomes (e.g., early detection and treatment of hearing, language, visual and behavioural problems; school-based health and nutrition programs) (Griew *et al.*, 2007; SCRGSP, 2011)
- The role of welfare / social support services in assessing, monitoring and supporting ‘at risk’ Indigenous women, children and families (domestic and family violence, suspected and substantiated child abuse and neglect, housing assistance).

These patterns indicate that health outcomes do not occur in isolation, but are influenced by education and exposure to harm. These ‘social determinants’ of health highlight the importance of creating links among relevant services (http://www.health.gov.au/natsihp). As such, maternal and child health services need to be aware of these relationships, and establish links with educational and social support services.
4.5 Important linkages across the continuum

4.5.1 Health and education

As noted previously, there is a strong correlation between educational attainment and health. Based on the evidence, the following links between health services and educational facilities are considered to be important to the health and wellbeing of Indigenous children and their families:

- Health services and childcare facilities or preschools:
  - Provision of a range of health care services at one location (e.g. Children and Family Centres, childcare facility or preschool), including assessments and screenings (for early detection and intervention), support and advice (parenting programs) and referral to appropriate services
  - Delivery of educational programs and interventions at childcare centres or preschools which promote and support health and wellbeing (e.g. Get Up and Grow: Healthy Eating and Physical Activity for Early Childhood resource)
  - School readiness and transition to school programs (e.g. Home Interaction Program for Parents and Youngsters (HIPPY)).

- Health services and primary schools, high schools, TAFE:
  - Health services can support school engagement, retention and attainment (e.g. health checks to minimise absenteeism, and facilitate learning and educational attainment)
  - Educational facilities can support health outcomes through the delivery of health educational programs and interventions (sexual and reproductive health education, personal safety programs, preparing for parenthood).

4.5.2 Health and welfare

Child abuse and neglect have both direct and indirect health consequences. Direct consequences include malnutrition, failure to thrive, and preventable injuries; and indirect outcomes include the longer term effects such as developmental delays (cognitive, emotional, social), chronic disease, substance abuse, mental health issues.

Child welfare and protection is concerned with the prevention of harm to normal child development. Based on the Little Children are Sacred Report (Northern Territory Government, 2007) recommendations and recent legislative developments, Griew and colleagues (2007) identified a number of ways primary health care can help prevent and/or minimise the effects of harm:

- Provision of maternal and child health visitation services, such as nurse home visiting. International research has found home visiting programs to be effective in the prevention of injury, improving parenting and the quality of the home environment, and reducing child abuse and neglect (Herceg, 2005; JTAI, 2013)
- Compulsory child health checks, screening and monitoring of growth and development (identify signs of abuse or neglect)
- Provision of family support programs, including parenting programs, particularly for young Indigenous people
- Provision of community mental health and alcohol and drug services
- Provision of family welfare or support services in settings that families commonly access (e.g. AMS, multi-purpose child family centres).
5 CONCLUSION

This paper is a companion document to the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families. It is designed to support the Framework by providing background to issues that were considered in its development.

The background evidence summarised in this document identifies some reductions in the health gaps between Indigenous and non-Indigenous people, including life expectancy, child mortality and birthweight. It also identifies a number of ways in which the existing system of child and family health policies and programs are not meeting the broad spectrum of needs of Aboriginal and Torres Strait Islander families.

The document highlights the importance of taking a holistic approach to addressing the health needs of Aboriginal and Torres Strait Islander children and families as well as the need for genuine cross sectoral approaches that respond to child and family health and wellbeing needs, rather than designing and delivering services based on organisational structures and priorities. Given the heterogeneity of Aboriginal and Torres Strait Islander families and communities, regional or place based systems are most likely to provide a sound basis for the delivery of universal and more targeted services, based on thorough understanding of individual and community level needs.
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