Chapter 8

IMPROVING THE SOCIAL AND EMOTIONAL WELLBEING OF ABORIGINAL CHILDREN AND YOUNG PEOPLE

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This chapter begins with a clear message for agencies, policy makers and service providers – attempts to formulate effective policies for the arrangement of human services and their delivery to individual Aboriginal children and their families will fail without an understanding of the basic characteristics and processes shaping the Australian Aboriginal population.

This is explained with reference to the key findings in this volume along with results from Volume One.[1] In guiding suitable responses on the part of governments, agencies and communities to improve circumstances for Aboriginal Australians, four important areas of existing and emergent knowledge are discussed:

- ***the prevalence and burden of social and emotional difficulties in Aboriginal children and young people***
- ***mechanisms that prompt, facilitate and constrain the development of social and emotional wellbeing in children and adults***
- ***the current policy context***
- ***drivers of developmental change.***

INTRODUCTION

The median age of Australian Aboriginal people is 20.5 years, compared with 36.1 years for the total Australian population.[2] In Western Australia, life expectancy of Aboriginal people is estimated at 59 years for males and 67 years for females, compared with 78 years for males and 83 years for females in the total WA population.[3] Nationally, death rates for Aboriginal people were higher than for non-Aboriginal people in all age groups, with the largest difference occurring in the age range 35–54 years, where death rates in Aboriginal people are five times higher than those of the total population.[4]

In WA, 27.8 per cent (CI: 26.3%–29.4%) of Aboriginal children were born to mothers aged under 20 years compared with only 6.3 per cent in the total WA population. Some 6.0 per cent (CI: 4.2%–8.3%) of Aboriginal children aged 0–3 years were not cared for by either biological parent, compared with 19.6 per cent (CI: 16.9%–22.6%) of Aboriginal children aged 12–17 years.[1] In terms of day to day care, about 46.7 per cent (CI: 44.5%–48.9%) of Aboriginal children were cared for by both original parents (40.6 per cent; CI: 38.3%–42.9%, exclusively so) while 30.9 per cent (CI: 28.8%–33.2%) were cared for by a sole mother (24.1 per cent; CI: 22.0%–26.3%, exclusively so).[1]

Compared to the general population, carers of Aboriginal children have lower levels of education. About one third of carers of Aboriginal children left school prior to the completion of ten years of compulsory education. Carers are more likely to have serious chronic illnesses and conditions that compromise their capacity to care. Amid a significantly higher rate of unemployment, employment that is available and undertaken is generally at a lower level of occupational skill and qualification.[1]

This combination of circumstances not only creates impoverishment of the financial wherewithal to raise children, but also compromises the very basis of human, psychological and social capital which forms the wider pool of resources essential for child growth and development, including their social and emotional wellbeing. The impoverishment across all of these resource domains is accompanied by a reduction in the choice, capacity and flexibility of carers, families and communities to meet the demands and challenges of daily living. This is a recipe for cumulative stress.

Given the scale of these population processes, fundamental changes in developmental outcomes that lead to the greater social, civic, and economic participation of Aboriginal people will need to be judged across two to three Aboriginal generations. In order to produce effective change, political leaders, bureaucrats, policy makers and service providers will have to act in concert over the long term (up to three generations), with determination and persistence, and resist the temptation to abandon, re-brand, or water down effective strategies known to produce change in populations and individuals over time. There will be little or no progress without a common understanding leading to coordinated and sustained action among the many players seeking to change the circumstances of Aboriginal people. This requires leadership at the highest levels within the Aboriginal community and from governments of the day.

In this chapter, findings of the current volume are drawn together with those of Volume One[1] to develop a broader understanding of their context and meaning. To guide suitable responses on the part of governments, agencies and communities four important areas are discussed:

- The prevalence and burden of social and emotional difficulties in Aboriginal children and young people
- Prompts, facilitators and constraints of social and emotional wellbeing
- The current policy context for action
- The drivers of developmental change.

THE PREVALENCE AND BURDEN OF EMOTIONAL OR BEHAVIOURAL DIFFICULTIES

Based on carer reports, an estimated 24.0 per cent (CI: 21.9%–26.1%) of Aboriginal children aged 4–17 years were at high risk of clinically significant emotional or behavioural difficulties. This equates to an estimated 5,490 (CI: 5,020–5,980) Western Australian Aboriginal children who are likely to benefit from services providing them and their families with thorough and appropriate assessment and treatment.

The burden associated with these emotional or behavioural difficulties may be judged from three perspectives: the individual children, their carers or families, and the community or population. These burdens can also be assessed from moral, social, historical and economic perspectives.

THE CHILD'S PERSPECTIVE

With respect to the experiences of Aboriginal children, the burden of an emotional or behavioural difficulty is significant. Aboriginal children and young people are more likely than their non-Aboriginal counterparts to be at high risk of clinically significant conduct problems or hyperactivity. Not discounting the burden of suffering associated with emotional symptoms, particularly confronting outcomes were observed with

conduct problems and hyperactivity. Children with hyperactivity are known to sustain poorer academic and social outcomes across the life course.[5,6] Children with conduct problems, particularly boys, have even more problematic outcomes: These include early school leaving, antisocial behaviour, unemployment, and involvement with the justice system.[7-9] Conduct disorders, when they occur early in life, are particularly resistant to treatment.

Independent of their carers, self-reports from Aboriginal young people aged 12–17 years indicate that an estimated 11.1 per cent (CI: 9.0%–13.4%) of young people (an estimated 1,010; CI: 820–1,220) were at high risk of clinically significant emotional or behavioural difficulties. Of this group, one in three reported that these problems either distressed them personally, or caused significant problems with their family members, friends, learning or leisure. These young people were more likely to have thought about ending their own life or of having made an attempt to take their life in the 12 months prior to the survey.

THE CARER'S PERSPECTIVE

About one third of children at high risk of clinically significant emotional or behavioural difficulties were reported by their carers to have problems affecting their home life, friendships, learning and leisure. Carers who rated their children as being at high risk of clinically significant emotional or behavioural difficulties also reported that higher proportions of these children had eating and sleeping problems (including nightmares), bed wetting, running away from home, alcohol and drug use and suicidal thoughts.

THE COMMUNITY AND POPULATION PERSPECTIVE

In studies of emotional or behavioural difficulties in children in the general population significant community burden has been demonstrated. In the general population, children with these difficulties are significantly more likely to use a range of health, mental health, education, and family services relative to children without such difficulties.[10-12] A similar profile emerges in the findings on Aboriginal children and young people. Those at high risk of clinically significant emotional or behavioural difficulties were significantly more likely to have been seen by Mental Health Services than children at low risk. However the burden of these problems to communities is only partially evaluated in this volume. Further data on the burden of emotional or behavioural difficulties in Aboriginal children will be featured in subsequent volumes, where themes such as education, and family and community will be explored.

At the population level several observations can be made about this burden.

About 66,100 Aboriginal and Torres Strait Islander people were living in Western Australia at the time of the survey, of whom 36,300 were adults aged 18 years and over. These adults have a principal responsibility for the care of an estimated 5,490 Aboriginal children (CI: 5,020–5,980) who were at high risk of clinically significant emotional or behavioural difficulties. The non-Aboriginal population has about 1.4 million adults aged 18 years and over, and an estimated 54,300 (CI: 46,900–61,700) non-Aboriginal children were at high risk of clinically significant emotional or behavioural difficulties. Thus, at a population level, emotional or behavioural difficulties in children impose a burden on the adult Aboriginal population that is 3.9 times (CI: 3.2–4.6) greater than that imposed on the non-Aboriginal population. This burden is exacerbated in the Aboriginal population by a shorter life expectancy,

greater family disruption, and impoverishment of human, psychological and social capital.[1]

Aboriginal people comprise a very small proportion of the Western Australian population. Just over three in every one hundred Western Australians identify as being of Aboriginal or Torres Strait Islander descent, and six in every one hundred Western Australian children are of Aboriginal or Torres Strait Islander descent. These proportions, and the estimated numbers of children they represent, are a very small fraction of the total Western Australian population of around 2 million people. Whatever the challenges and difficulties may be in addressing the causes of health and mental health burdens in the Aboriginal population, the scale of this problem in human terms needs to be appreciated. These health burdens are disproportionately very large within the Aboriginal population, despite representing small numbers of individuals relative to the size of the Western Australia population and its services and resources. While the complexities of achieving better health and wellbeing in the Aboriginal population are substantial, they can be defined, and entail a small identifiable population. This perspective should foster hope and determination in those with a responsibility in areas of promotion, prevention and treatment.

PROMPTS, FACILITATORS AND CONSTRAINTS OF SOCIAL AND EMOTIONAL WELLBEING

INTRODUCTION

Human potential far exceeds what individuals actually manage to do, and it is this contrast that characterises the human predicament.[13] For many people, life and life's potential remain highly circumscribed, constrained by lack of capacity, lack of choice, social exclusion, and inequality. The gulf between human potential and the present circumstance of the Australian Aboriginal population highlights this predicament most vividly.

This section discusses the nature of human development with specific reference to the findings in this volume on the social and emotional wellbeing of Aboriginal children. Our emphasis here is on the circumstances that alter social, civic and economic participation across the life span. This is not to deny the importance of children as beings and becomings and the critical experience of being a child and having a childhood. There are, however, less romantic realities that operate to constrain and significantly alter child developmental trajectories leading to optimal outcomes. For significant numbers of children, particularly Aboriginal children, these outcomes are unnecessarily lost.

FACTORS ASSOCIATED WITH HIGH RISK OF CLINICALLY SIGNIFICANT EMOTIONAL OR BEHAVIOURAL DIFFICULTIES

The findings from the WAACHS show that the factors most strongly associated with high risk of clinically significant emotional or behavioural difficulties in Aboriginal children were:

- poor physical and mental health of carers
- poor physical health of the child (particularly hearing, speech and vision impairment)

- multiple family life stress events
- high residential mobility
- poor quality of parenting
- poor family functioning
- exposure to racism
- use of tobacco and alcohol
- sole parent care or non-original parent care
- the primary carer having been forcibly separated from their natural family.

On the surface, this list of associations is similar to findings about children and their development from a range of surveys in Australia and around the world. Some encouragement should be taken from the fact that children, regardless of nation or creed, are affected by similar adversities. This should give hope that the types of preventive and treatment interventions that work well for children, if adapted for local Aboriginal culture and circumstance, may bring significant benefits to Aboriginal children and their families. However, there are some profound differences that are hidden from view in this list that may pose threats to progress in the betterment of circumstances for Aboriginal children and their families.

FACTORS THAT WERE NOT ASSOCIATED WITH HIGH RISK OF CLINICALLY SIGNIFICANT EMOTIONAL OR BEHAVIOURAL DIFFICULTIES

The survey findings are critically important for what is ***not*** significant.

Neither the level of the primary carer's income nor the level of their education was significantly associated with risk of clinically significant emotional or behavioural difficulties. The lack of this association was also observed in relation to the physical health outcomes of Aboriginal children.[1] These observations are in stark contrast to what appears in the non-Aboriginal population where increases in carer income and education are associated with improvements in the health and mental health of their children.

Education and income are critical levers of change for individuals, families and their communities – Aboriginal and non-Aboriginal alike. This does not mean that improvement of education and income for Aboriginal Australians is inconsequential or unimportant. Far from it. What these data suggest, however, is that increases in carer income and education are not being effectively translated across the Aboriginal population into better overall child health. This includes outcomes for both physical health and social and emotional wellbeing.

This is likely to occur because the effects of multiple life stress events, poor family functioning and carer health weaken or cancel the effects of improvements in carer income and education. This pattern of results suggests that these stresses are, for many, overwhelming the benefits that may accrue merely through improving education and income for individuals. This is a population problem, and it is a measure of how much work lies ahead for agencies involved in offering education, training and employment opportunities for Aboriginal Australians. Efforts to improve participation and retention in education, training and employment for Aboriginal people will need to substantially increase beyond their present levels if this is to appreciably affect changes in population outcomes in Aboriginal health and social and emotional wellbeing.

Moreover the context in which these increases occur will have to fundamentally change. In the meantime, and along with these improvements, other initiatives are urgently needed to support Aboriginal capability expansion to break the vicious cycle that commits substantial numbers of children and families to sub-optimal development and a diminution in life prospects.

DEVELOPING KEY CAPACITIES AND TALENTS FOR LIFE

DEVELOPING KEY CAPACITIES AND TALENTS FOR LIFE – SOME ESSENTIAL CONCEPTS

Key capacities

There are four key capacities essential for good social and emotional development:[14]

- the capacity to form meaningful attachments to significant others
- a capacity for personal identity and autonomy
- the capacity to regulate emotions
- the capacity to understand societal norms and discriminate right from wrong.

When mastered, these capacities are built upon and developed for the rest of one's life. When one or more of these are damaged or fail, it is widely accepted that a person's development is sub-optimal or, for some, fundamentally compromised. Creating environments that increase the likelihood that these capacities will develop in optimal ways, and decrease the risks that they will not, has been the focus of intense scientific and social scrutiny over the past 75 years.

Proximal processes – the engines of child development:[15]

Some settings and situations make them particularly powerful in the way they influence these developmental capacities. Settings and situations that are close to the developing child, fairly regular in their occurrence, present over extended periods of time, and involve 'progressively more complex reciprocal interactions with persons, objects, and symbols in the child's immediate environment'[15] are called proximal processes.

Talents for life

Proximal processes are particularly important because they change a child's development through individual and joint action on six principal developmental talents:

- exploratory behaviour
- emotional regulation
- self-direction (initiative)
- intellectual flexibility
- introspection
- self-efficacy.

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DEVELOPING KEY CAPACITIES AND TALENTS FOR LIFE – SOME ESSENTIAL CONCEPTS
(continued)

These individual developmental talents in turn influence socialisation and how children (and later, adults) come to use their social and physical environment for their own development and that of others. In other words, as humans develop these specific talents they then use them instrumentally for the development of themselves and others.

The development of key capacities and talents (see commentary box *Developing key capacities and talents for life – some essential concepts*) that occurs from childhood to adulthood is neither once and for all nor does it occur in a vacuum. Most of the principles that apply to children apply equally well across an entire human life span. The development of these capacities and talents can be prompted, facilitated and constrained by several key mechanisms. The term *prompts* is used to signify those mechanisms that require or cause development to occur at particular times or in response to specific circumstances. *Facilitators* of development are those mechanisms that assist, or make easier, the growth, establishment, elaboration and maintenance of developmental capacities and talents. *Constraints*, not surprisingly, inhibit, delay or prevent the development of these key capacities and talents. Much is known about these prompts, facilitators and constrains of developmental capacities and talents that is of direct relevance to the findings in this and the previous volume of results from the WAACHS.

DEVELOPMENTAL PROMPTS

There are three major prompts of optimal social and emotional wellbeing in children and young people:

- biology
- expectations
- opportunities.

Biology

Social and emotional development is prompted by biology. At the opening of the 21st century the time honoured tradition of contrasting the roles of nature and nurture in affecting child development has been substantially repositioned to reflect the dynamic interplay that biology has in mediating gene-environment responses. Almost all gene expression is dependent on stimulation from the environment, the presence or absence of which, switches the gene either on or off.[16] Even when severe stress, malnutrition or lack of stimulation slows the growth of brain structures, the order of gene expression is conserved. Each stage of brain growth follows its predecessor, and the genetic plan still unfolds. However, it does this more slowly and less perfectly. Biology prompts development in the form of milestones – crawling, walking and talking – and it prompts physical development and sexual maturation during early adolescence.

The survey data in both the first and this volume of results clearly document the significant association between biology, in the form of the physical health of children,

and their social and emotional outcomes. These analyses also show the extensive association between the physical health of their carers and both the physical and social and emotional wellbeing of Aboriginal children. Children are entitled to good health. Poor health at birth and onward predisposes children to poor health and illness in adulthood. Illness diminishes life's prospects by diminishing human capability. This impairs social, economic and civic participation and is abundantly clear in the extensive literature on Aboriginal adult health. In this way, physical health is central to the development of human capital. The very capacity to benefit from educational, social, and vocational opportunities is compromised by ill health.

Expectations

Social and emotional development is prompted by expectations. Carers have expectations about the development of their children. Some of these are explicitly acknowledged and others are not. Social and emotional capacities in children are prompted by carer expectations about the capacities of their children. These expectations in the form of carer values, attitudes and beliefs are part of a carer's psychological and human capital. Some of these expectations are revealed in the excitement when parents respond to a child's first steps or words – or alternately express concern in the late appearance of these milestones. Many more of these expectations are revealed in requests, demands and rules that govern such things as picking up, cleaning your room, making your bed, doing chores, doing your homework, reporting in, being home on time, and being polite.

Data from the survey provide an important observation on the relationship between carer expectations in the form of their parenting styles and practices and the social and emotional wellbeing of their children. As with many other studies in Australia and abroad, the WAACHS data show that positive parenting practices are associated with better social and emotional outcomes for children. Parenting practices comprise the expectations that parents have about their children and their child's feelings and behaviours. While these carer expectations certainly include what are commonly known as values and attitudes about desirable and undesirable behaviour, they also comprise expectations about a child's feelings about their whereabouts and about the legitimacy of appeals.

Teachers too have expectations. These include sitting still, paying attention, taking turns, and following directions. At school and outside of school, rules in the form of playing sport, obtaining work or entry to vocational and tertiary experiences may prompt the development of social and emotional capacities in children and young people as well as modulate their expression.

It should not be forgotten that governments prompt social and emotional development in the form of laws that mandate children to attend school, young people and adults to obtain licenses to operate vehicles, and populations to conform with the basic rules and regulations of society.

Opportunities

Social and emotional development is prompted by opportunities. The opportunities children have to engage in stimulating activities also prompt cognitive development and improve their social and emotional wellbeing. Providing opportunities to talk, play, interact and read, particularly to very young children improves their cognitive outcomes that have significant onward developmental benefits to the child, both in

the form of improved academic achievement but also in the form of improved social and emotional capacities.[17, 18] Mentoring in cognitive skills (i.e. labelling, sorting, sequencing, comparing and noting means-ends relationships) provides efficacious opportunities that change key capacities in children.[19] This is seen again in the form of bidirectional interactions between parents and their adolescent children. Explaining facts, talking about expectations, encouraging skills, and soliciting information about daily activities outside the home produces improved social and emotional capacities in older children and young people.[20,21] All of these opportunities entail social interactions that produce change in children and young people.

The relationship between opportunity and health and social and emotional wellbeing in Aboriginal children and young people will be particularly explored in the third volume of results which will focus on education.

DEVELOPMENTAL FACILITATORS

There are three major facilitators of optimal social and emotional wellbeing in children and young people:

- intellectual flexibility coupled with an outgoing, easy temperament
- good language development
- emotional support, especially in the face of challenge.

Intellectual flexibility

Social and emotional development is facilitated by intellectual flexibility and an outgoing easy temperament. An easy-going, outward personality, and tolerance of new situations substantially facilitate social functioning.[22] The resilience imparted by these temperamental assets has also been shown to have substantial gene-environment contributions.[23] So the developmental resources of the child in the form of their genes as well as their human, psychological and social capital impart their own facilitation to emergent social capacities.

Good language development

Social and emotional development is facilitated by good language development. Findings from the survey are consistent in pointing to the association of both physical health and social and emotional wellbeing with good speech and language functioning. Children with poor speech are at high risk of clinically significant emotional or behavioural difficulties relative to those children who do not have problems with speech. There is an obvious association of hearing with speech,[1] however the analysis in this Volume also shows that speech problems make an independent contribution to increasing the risk of clinically significant emotional or behavioural difficulties. The survey did not afford a direct assessment of the language development of children (as distinct from their speech), however, the measure used in the survey can be taken as a good indicator of speech and language development more generally. Enriched language environments certainly prompt the development of language (see above). Just as importantly, better language acquisition, in the form of increasing complexity and sophistication, facilitates and extends social development. It is a tool to establish and maintain friendships, negotiate needs, and resolve conflicts.

Emotional support

Emotional support, especially in the face of challenge, facilitates good social and emotional wellbeing. Most parents want their children to succeed and generally protect them from excessively adverse experiences. For many children, parental encouragement in the face of difficulty, support in failure, and celebration of success are critical facilitators of their social and emotional wellbeing.

Some examples of emotional support include the encouragement of exploration, celebration of developmental milestones, guided rehearsal and extension of new skills, and protection from inappropriate disapproval, teasing or punishment.[19] These actions allow the extension and elaboration of social responses, validation of the developing child, and once achieved, allow their practice and maintenance. African-American eleven year-olds have better outcomes where parents are taught to provide more regulated communication, racial socialisation about the realities of oppression and the need to overcome this, as well as clear expectations about sex and alcohol use.[21] In the WAACHS there are clear associations between experiences of bullying and higher risks of clinically significant emotional or behavioural difficulties.

DEVELOPMENTAL CONSTRAINTS

There are four constraints on optimal social and emotional wellbeing in children and young people:

- stress that accumulates and overwhelms
- chaos
- social exclusion
- social inequality.

Stress

Social and emotional development in children is constrained by stress that accumulates and overwhelms adaptive abilities.

Stress is defined as 'environmental circumstances or conditions that threaten, challenge, exceed or harm the psychological or biological capacities of the individual'[24] and in experiencing challenge, some level of stress is always present and normal. When present in a context of encouragement and emotional support, and when it does not exceed an individual's coping capacity, stress triggers adaptive biological arousal that increases motivation and the potential for development through task mastery and increased self-efficacy. When these adaptive systems are efficiently and not too frequently turned on and turned off again, the body is able to cope effectively and is in homeostatic balance. In circumstances where these homeostatic systems are either overstimulated or not able to perform normally, this condition has been termed *allostatic load*, or the price of adaptation. Allostatic load may thus initiate biologically dysregulated responses to stress which disrupt development and may lead to disease over long periods due to its effects on autonomic, central nervous system, neuroendocrine, and immune system activity.[16] The activation of these allostatic processes under exposure to stress varies with the physical maturation of the brain. Constant or recurrent exposure to stressful circumstances is associated with chronically elevated cortisol which has potentially deleterious effects on developing competent cognitive and emotional functioning.[25,26] Chronic stress exposures of this

nature have also been shown to be associated with increases in cardiovascular disease risk factors in children, such as heart rate variability and blood pressure reactivity and it has been suggested that family transmission of essential hypertension is mediated, in part, by recurrent exposure to stress.[27]

Studies on the effects of environmental stressors during infancy indicate there are clear and enduring negative effects of maternal separation, abuse and neglect in infants and these negative effects presumably occur independently of the child's cognitive appraisal.[28,29] With older children and adolescents, stress has tended to be viewed in more transactional terms as a relationship between environmental events or conditions and the individual's cognitive appraisal of the degree and type of challenge, threat, harm or loss.[24] While major family life stress events occur in all income groups they occur significantly more often for children raised in lower income families and this differential stress exposure has been suggested as possibly the central mechanism accounting for social gradients observed in health and other developmental outcomes.[30]

In the WAACHS, interviews with carers revealed excessive levels of stress as measured by a selection of life stress events (see Chapter 3). These included events such as death within the family, serious illness of family members, arrest and incarceration, family violence, and financial incapacity. On average, carers reported 4.20 (CI: 4.07–4.33) life stress events having occurred within the past year, out of a possible 14 events. Higher numbers of carer-reported life stress events were associated with an increased proportion of children at high risk of clinically significant emotional or behavioural difficulties.

Chaos

Social and emotional development is constrained by chaos. In 1996 Bronfenbrenner and colleagues reviewed what they termed 'growing chaos' in families, schools, unsupervised peer groups and other settings in which children and young people spend extended periods of time. They noted the damaging and disorganising effects of frenetic activity, lack of structure, unpredictability in everyday activities and high levels of ambient stimulation on the development of social and emotional capacities in children.[15] Not only do such contexts disrupt social development, they have the potential to establish alternate developmental processes that lead to poor outcomes.[31,32] Chaotic systems are effective in disrupting attachment, emotional regulation, and autonomy.[33]

Violence is a prime example of a disorganising influence on human development. In its extreme (e.g. war) violence totally undermines human development, reducing it to a matter of survival. However, less extreme forms of violence (abuse, physical punishment, harsh parenting, bullying and other forms of harassment) are also deleterious to human development and may be particularly harmful for individuals who are genetically or otherwise vulnerable to such harm.[34]

WAACHS data showed that Aboriginal children were more likely to be at high risk of clinically significant emotional or behavioural difficulties where they were subject to higher levels of residential mobility, experienced poor quality of parenting, had exposure to racism and bullying, and for those aged 12–17 years, were no longer being cared for by either of their original parents. This is in addition to the impact of multiple life stress events discussed above.

The origin of such developmental chaos in the lives of children is not merely to be found in families and communities. Governments are also imparting chaos in the

lives of children. Policy development for children has become a political fashion with governments of the day formulating policies and branding, re-branding and repackaging children's services and programs for the life of government rather than for the lives of children.

Governments have a responsibility to formulate, implement and evaluate coherent, sustained policies that assist and support in the development of children. This is predicated on understanding the principles of human development and the expansion of human capability. This means more than just seeking advice, and formulating policy, based upon child development. Previously, children's early development was the sole concern of families. It is now profoundly influenced by practices associated with work, child care, school and community practices, all of which have substantial government inputs. Having well articulated policies regarding the health, safety and development of children that intermesh across departmental jurisdictions is a useful and critical first step. But it is only a first step. Across-government policies need to be translated into coordinated, and jointly developed actions and planning time-frames that require sustaining mechanisms which span State and Commonwealth jurisdictions and the lives of children, rather than just the life of a given government. This requires political and scientific leadership to ensure that parents, the broader community and governments recognise the extent to which the sustainability of society and the economy is dependent on such a strategic vision. It requires bipartisan agreement about what is important in this focus and a commitment to change programs affecting children where evidence shows them to be ineffective or sub-optimal and to implement programs where evidence shows them to be efficacious and effective.

Social exclusion

Social and emotional development is constrained by social exclusion. Social exclusion is a powerful disrupter of the development of social capacities in children and adults alike. At the broadest level, governments have a duty, through legislation and regulatory frameworks, to minimise or prevent actions that result in the unjust exclusion of individuals or groups within the Australian population from participation in social, economic and civic life and to support mechanisms that promote access and equity.

Thus, at the most fundamental level it is the responsibility of governments to address issues of social exclusion. Relative to the period of initial colonization, Aboriginal Australians have had only recent legal recourse to address the fundamental aspects of social exclusion affecting them. Examples include the 1967 constitutional referendum granting the Commonwealth concurrent power to make laws for Aboriginal people wherever they lived, as well as to allow Aboriginal people to be included in the national census; the 1976 Aboriginal Land Rights (Northern Territory) Act establishing the basis upon which Aboriginal people in the Northern Territory could, for the first time, claim rights to land based on their traditional occupation; the Mabo judgement (1992) in which the High Court held that Australia was not *terra nullius* (i.e. land belonging to no one) when settled by the British in 1788, but occupied by Aboriginal and Torres Strait Islander people who had their own laws and customs and whose 'native title' to land survived the Crown's annexation of Australia; and the Wik case (1996) which determined that the granting of a pastoral lease, whether or not the lease has now expired (or has otherwise been terminated), did not necessarily extinguish all native title rights and interests that might otherwise exist.[35] These laws and judgements have

played a central role in recognising not only the existence of Aboriginal people prior to colonization, but in asserting their rights of participation and of ownership.

Social exclusion constrains child and adult development because it restricts access to opportunities and choices to participate socially, economically and civically. Exclusion can take many forms ranging from frank racism and vilification, to bullying and subtler experiences that entail refusals of friendship and non-recognition. These actions also span multiple settings and occur at home, at school, in the work place, and in the day-to-day experiences involving social exchanges and transactions. Experiences such as these alter access to developmental resources and have the potential of establishing reciprocal patterns of socialisation that weaken individual capacities, disrupt social cohesion and alienate groups. Racial discrimination has a major impact on affective function resulting in depression and anxiety and has been shown to prospectively link with drug use in family members.[36]

SOCIAL EXCLUSION AND THE INTERGENERATIONAL EFFECTS OF THE PAST POLICIES OF FORCED SEPARATION OF CHILDREN FROM THEIR NATURAL PARENTS

The WAACHS findings on the intergenerational effects of the past policies of forced separation of children from their natural parents are noteworthy in several respects.

- These are the first data of their kind to establish both the current proportion of WA Aboriginal children and their families affected by forced separations and document some of the associated outcomes
- The survey sample is sufficient to report the current proportion of Aboriginal children living in families where a carer or the carer's parent had been forcibly separated from their natural family with a level of precision not previously available. This shows that over one-third (35.3 per cent; CI: 32.8%–37.8%) of Western Australian children aged 0–17 years are currently living in such households.[1]
- The large sample of almost one-in-six eligible Western Australian Aboriginal families has also enabled the use of multivariate statistical modelling methods which adjust for a range of other possible confounding factors such as age, sex and level of relative isolation. When these adjustments are made, the independent contribution of past experience of forced separation is more clearly apparent.
- The effects of forced separation appear to be transmitted between carers and their own children rather than between children and their grandparents. Outcomes for children whose carers were not separated, but whose grandparents were separated, do not show poorer outcomes relative to children in families not affected by separation policies.
- The WAACHS findings on the longer term effects of forced separation include independently recorded corroborative data on health, and mental health outcomes established from consensual record linkage of the survey findings with Western Australian hospital and Mental Health Service records.

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SOCIAL EXCLUSION AND THE INTERGENERATIONAL EFFECTS OF THE PAST POLICIES OF FORCED SEPARATION OF CHILDREN FROM THEIR NATURAL PARENTS *(continued)*

- The question on forced separation used in the WAACHS survey was identical to that used in the 2002 ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS). While there are some differences in the methodology of these two surveys, the NATSISS and the WAACHS both demonstrate the links between adverse health and social outcomes and prior forced separation of Aboriginal people from their natural families.

While the survey findings are confined to the effects of past child removal policies on the Western Australian Aboriginal population, they help to inform aspects of the national discussion which has followed the release of Human Rights and Equal Opportunity Commission's *Bringing Them Home* report in 1997.

Much of this discussion has centred on the report's summary finding that 'somewhere between one-in-three and one-in-ten Aboriginal children had been separated from their families between 1910 and 1970.' The 'one-in-three' estimate has been widely criticised on the grounds that it over-generalised the finding from a number of local studies in Melbourne, the Kimberley region of Western Australia and the Bourke region of New South Wales.[37] The lower estimate of 'one-in-ten' was based on the 1994 ABS National Aboriginal and Torres Strait Islander Survey which reported that 10.1 per cent of those aged 25–44 years, and 10.6 per cent of those older than 44 years had been separated from their natural family by missions or government or welfare.[38] The findings from the WAACHS are consistent with the NATSISS data in showing that a much higher proportion of child separation occurred within Western Australia than occurred nationally.

Given the differences in removal policies which existed between the States and the ways in which these changed in their application over time, it seems unlikely that the number of Aboriginal and Torres Strait Islander people who were removed will ever be precisely ascertained from historical sources. This suggests that the current lived experience of Aboriginal people as reported in representative population surveys such as the WAACHS, NATSIS (1994) and the NATSISS (2002) will have to be relied upon for the best estimate of the minimum number of people and families so affected (see Chapter 7).

The intense debates about the actual numbers of children and families involved have displaced and excluded from the national discussion the reality that these experiences occurred at all and that they have profound significance for Aboriginal people and the nation. These findings should enable a more nuanced and sympathetic discussion of the enduring impact of past forced separations and point to why this remains an unresolved issue of such pressing concern for so many individuals and families. It is our hope that the WAACHS data will enable the national discussion to move beyond disputation of the precise numbers of children and families involved towards a true understanding of the extent of the suffering and disadvantage that past policies of separation have inflicted on Aboriginal Western Australians.

Social inequality

Finally, social and emotional development in children is constrained by social inequality. Evidence now shows that within and between nations there are sharp social gradients linked to health outcomes and that result in their unequal distribution within populations. The mechanisms that are theorised to link these observed social gradients to unequal population health include:

- Inadequacies in material circumstances that arise from the absolute income of individuals and their ability to influence their immediate and wider environment to the benefit of their health[39,40]
- A hereditary predisposition to the effects of stress that arises from perceptions of relative income inequality can cause poorer health[41,42]
- Unequal accumulation of exposures and experiences that have their source in the material world and that produce an unequal distribution of health and illness.[43]

Social inequality results in the unequal distribution of, and access to, resources for the development of adults and children. These resources certainly include income and wealth, however they extend to include human, psychological and social capital. This inequality may arise from inadequacies in the laws and regulations for the redistribution of wealth and social benefit, differences in the use and accumulation of wealth by individuals and groups, and lack of access to the means for generating these resources by some groups relative to others.

Social inequality constrains access to developmental resources and increases the linkage between developmental resource domains, which include time, income, psychological capital and social capital. Thus, as social inequality increases, the human, psychological and social capital within groups becomes more homogenous. This concentrates risks both within and across contexts for particular groups and sub-populations. For example, as inequality increases it is more likely that within groups of children in their families, or in their neighbourhoods, or in their schools, levels of human, psychological, and social capital are all higher (or lower) – incomes are probably higher too thus enabling more flexibility in purchasing developmental resources from other domains despite lack of time. Several studies have demonstrated the relationship between social inequality and developmental outcomes.[44-46]

Social inequality has been a persistent feature of innumerable reports in which the circumstances of Aboriginal people are compared to those of the majority population. Findings from the WAACHS highlight the extent of social inequality affecting families with Aboriginal children.[1] Along with the other constraints on development, social inequality poses a substantial barrier to effective gains in improving the physical health and social and emotional wellbeing of Aboriginal children and young people.

In summary, this section has detailed the prompts, facilitators and constraints that effect the acquisition of key developmental capacities in children and young people. The application of these principles to children and young people is artificial in the sense that these same mechanisms also apply across the life course to adult development as well. The next section provides policy direction that utilises these developmental principles to suggest actions on the part of governments and agencies seeking to improve the Australian Aboriginal circumstance.

SUSTAINING INTEGRATED ACTION: WHAT IS MOST NEEDED NOW?

THE CURRENT POLICY CONTEXT

Aboriginal mental health is a relative newcomer to the national health agenda. The first national analysis of Aboriginal and Torres Strait Islander mental health was reported by Swan and Raphael in 1995 in their *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*.[47] This seminal report lead to the development, in 1996, of the *Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan*[48] (1996–2000). An independent review of the *Action Plan* in 2001 recommended a more strategic approach building on the work of the *Plan*.[49] In response to these recommendations, Australian Governments in 2003 developed and implemented agreements based upon a National Strategic Framework for Aboriginal and Torres Strait Islander Health. This Framework identifies nine key result areas, one of which is specific to emotional and social wellbeing.[50,51]

The 2003 National Strategic Framework was developed concurrently with initiatives to improve performance reporting across Commonwealth, State and Territory jurisdictions.[52] However, the key result areas are restricted in their capacity to reflect the population mental health morbidity and mental health care of Aboriginal and Torres Strait Islander peoples. In addition to the challenges of data quality and identification of Aboriginal status in many jurisdictions, these performance indicators are largely confined to the measurement of severe mental health outcomes. Rates of hospitalisation for anxiety and depression, self harm and child abuse substantiations are the principal performance indicators for emotional and social wellbeing.

To better balance the need for upstream indicators of social and emotional wellbeing for Aboriginal Australians, nation-wide consultations were undertaken by the Commonwealth during 2003 regarding a draft Social and Emotional Wellbeing Framework. The draft Framework has received State and Territory approval and is now awaiting final Australian Government endorsement to establish this as policy.[53,54] While it recognises the need to engage with other sectors in addressing the many broader issues affecting mental health outcomes, such as employment, education, housing, justice and Aboriginal and Torres Strait Islander Affairs, it particularly highlights the significant responsibility of the health sector in building partnerships between Aboriginal Community Controlled Health Services and other mental health services.

A number of related policy developments in Aboriginal affairs have also shaped the evolution of policy in Aboriginal mental health. In particular, the Council of Australian Governments' Reconciliation Framework[55] in November 2004 affirmed that all governments would continue their efforts to advance reconciliation and address Indigenous disadvantage. In addition to the continuation of support for reconciliation through the promotion of recognition, respect and understanding between Aboriginal and non-Aboriginal Australians, three priority areas for governments were agreed:

- Investing in community leadership and governance issues
- Reviewing and re-engineering programs and services to ensure they deliver practical measure that support families, children and young people; and measures for tackling family violence, drug and alcohol dependency and other symptoms of community dysfunction
- Forging greater links between the business sector and Aboriginal communities to help promote economic independence.

INTERSECTORAL POLICY SIMILARITY AND THE COAG TRIALS

It is difficult to underestimate the importance of the COAG initiative with respect to the establishment of policy similarity across government sectors. Drawing on the work of Freeman in studies of cross-national similarity in health care policy, there are three processes in play that increase policy similarity between sectors: *convergence*, in which policy similarity occurs though similar forces acting on different systems; *diffusion*, through the movement of information and technologies between them; and *intersectoralisation*, (in Freeman's work this is 'internationalisation') through the imposition of a common regulatory framework.[56]

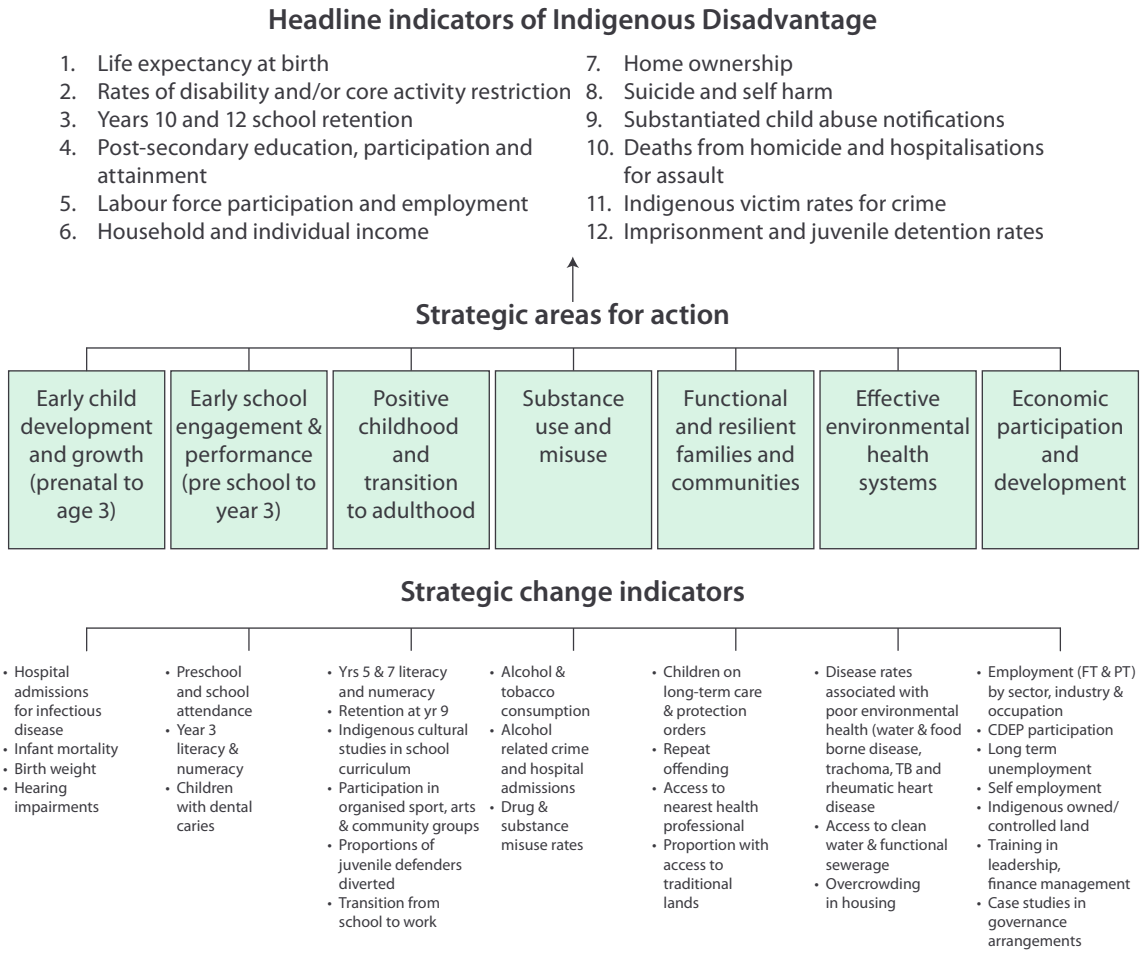
Public sector policy convergence in problems of human development has been most commonly driven (at least tacitly) by outcomes of common interest between departments. These problems are inevitably complex and include drug use, juvenile offending, violence, institutional care, truancy, and early pregnancy, to name a few. Whether these outcomes are regarded politically (as forms of social, economic and civic participation), or as strategic issues for the whole of government (i.e. juvenile offending) or as 'core business' for specific government departments (e.g. in the case of education authorities: school failure, truancy, early school leaving) they have a similar basis. This similar basis is in the form of shared and cumulative risk exposures, life course persistence of many of these problems, causal complexity, their appearance across a variety of service sectors (e.g. mental health, education, judicial) and unequal population distributions substantially linked to social exclusion and inequality. No single agency is in a position to effectively manage these problems and tackle their root causes. This commits departments to managing the pointy end of these problems without recourse to the development and implementation of prevention strategies which entail joint initiatives.

Thus far intersectoralisation as a principal force for policy similarity operating across government departments has been achieved through fiscal and prudential regulatory frameworks that largely have sought to achieve cost containment and efficiency in the competitive allocation of resources and services. This has mandated public contracting of government services with the separation of mechanisms of funding from those of purchasing and providing services. Thus intersectoralisation has been achieved principally in the conduct of government business – that is, the form of it – rather than through any coherence of policy (i.e. the content) aimed at developmental outcomes across government departments – be they health, eduction, welfare or otherwise. Certainly in Australia there has been a recent interest in whole-of-government policy approaches to more complex problems of human development. While the rhetoric of these initiatives suggests intersectoralisation of policy content, in the main such initiatives are linked to short term policy strategies that overarch government departments and that do not regulate joint strategic development of services and, quite particularly, joint accountability for outcomes. Nor have these actions been sustained across the lives of governments (and hence the lives of individuals) in ways to produce policy coherence and efficient progress.

The COAG trials represent an important experiment in which both the form and content of policy are directed at improving Aboriginal circumstances. A key test of this will be the sustainability of this initiative across the lives of governments and hence across the lives of Aboriginal children and families.

A milestone in the implementation of the COAG Reconciliation Framework was the commissioning of a major review of government service provision. Following extensive public consultation on its initial report, the COAG Steering Committee for the Review of Commonwealth/State Service Provision released its *Overcoming Indigenous Disadvantage: Key Indicators 2003* report.[57] The endorsement of the report marked the commitment of Australian governments, to not only to tackle the root causes of Aboriginal disadvantage, but also to monitor the outcomes in a systematic way that crosses jurisdictional and portfolio boundaries. All jurisdictions are now required to report annually against these indicators. While this is an important step towards raising the transparency of government, the indicator framework itself is based on a vision of what life ideally should be like for Aboriginal people and a strategic focus on key areas that need to be targeted if that longer term vision is to be realised.

FIGURE 8.1: COAG INDICATOR FRAMEWORK



SOURCE: Steering Committee for the Review of Government Service Provision, November 2003

The *Overcoming Indigenous Disadvantage Indicator Framework* includes three inter-related priority outcome areas required to sustain human and community development:

- Safe, healthy and supportive family environments with strong communities and cultural identity
- Positive child development and prevention of violence, crime and self-harm

- Improved wealth creation and economic sustainability for individuals, families and communities.

The priority outcomes are under-pinned by further two tiers of indicators. These are first, a set of twelve longer-term headline indicator measures of major social and economic factors that need to improve if the vision is to be achieved (see Figure 8.1). The second tier is a set of seven key areas for action and their associated strategic change indicators. These indicators were selected to be of relevance to all governments and Aboriginal stakeholders and their capacity to demonstrate the impact of programs and policy interventions in the short (18 months) to medium term (5 years).

IMPROVED INFORMATION AND DATA QUALITY

A significant obstacle to progress has been the availability of timely, comprehensive, good quality data specific to the Aboriginal population. In the past decade major steps have been taken to improve this.

The first national survey of Aboriginal and Torres Strait Islander people was conducted in 1994[38,58-60] in response to the 1991 recommendations of the Royal Commission into Aboriginal Deaths in Custody.[61] These data were notable for the inclusion of questions on a diversity of topics, including health. Since this first survey there has been an increasing effort to improve the quantity, timeliness and quality of information on Australia's Aboriginal population.[62-64] These efforts include the Aboriginal and Torres Strait Islander components of the 1995 and 2001 National Health Surveys as well as the biennial reports on the health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples.[2,65-69] At present results of the 2004 Aboriginal and Torres Strait Islander component of the National Health Survey are in preparation. Additionally, the Australian Government has commissioned *Footprints in Time* – the Longitudinal Study of Indigenous Children. This ambitious project will seek to provide the first comprehensive longitudinal data on the development of Australian Aboriginal children.

These surveys, along with the WAACHS, represent significant milestones in the delivery of data to meet information needs for and about Aboriginal Australians. With these data and the evidence that flows from them come expectations of actions and initiatives to address the difficulties that they describe. However, it remains unclear just how the implementation of initiatives such as the COAG trials will measure their progress in meeting their key performance objectives. These objectives call for the collection of adequate quantities of local information targeted specifically to the COAG indicators.

THE ABOLITION OF ATSIC AND THE MAINSTREAMING OF PROGRAMS

In April 2004 the Australian Government moved to abolish the Aboriginal and Torres Strait Islander Commission (ATSIC) and its regional councils and moved to mainstream the administration of the programs for which ATSIC had responsibility. ATSIC Commissioners, elected by the regional councils, were responsible for policy and accountable for program oversight across activities such as community development and employment, legal services, infrastructure, and land issues. The evolution of ATSIC gave it particular strengths in cross-sectoral activities and, through this, the Commission was able to develop a range of policies and programs that entailed the coordination across government portfolios. As Anderson (2004) noted, '(ATSIC) was the only institutional mechanism (with the exception of time limited

interdepartmental committees) that enabled this . . . up until the implementation of the COAG trials' [70]

From 1 July 2004 some thirty-four programs and portfolio agencies that were previously under the aegis of the Aboriginal and Torres Strait Islander Commission (the elected arm) and the Aboriginal and Torres Strait Islander Services (ATSIS – the executive agency) were transferred across twelve Australian Government departments and portfolios. From that date, a new office, the Office of Indigenous Policy Coordination (OIPC), is responsible for:

- Providing the primary source of advice on Aboriginal issues to the Minister for Indigenous Affairs
- Coordinating and driving whole-of-government innovative policy development and service delivery across the Australian Government
- Developing new ways of engaging directly with Aboriginal Australians at the regional and local level
- Brokering relations with State and Territory Governments on Aboriginal issues
- Reporting on the performance of government programs and services for Aboriginal people to inform policy review and development
- Communicating government policy directions to Aboriginal people and the wider community
- Managing a number of Aboriginal programs and transitional services, following the effective closure of ATSIC-ATSIS.[71]

The work of the OIPC is supported by 30 Indigenous Coordination Centres in metropolitan and regional Australia (formerly ATSIC-ATSIS offices) that have become (or are becoming) multi-agency centres for coordination of Aboriginal specific programs in the regions.

At present Australian Government and State and Territory jurisdictions are making a considerable commitment to and investment in whole-of-government strategies.[72] With the abolition of ATSIC, advances in whole of government approaches for large segments of the Aboriginal population are now within the carriage of entirely new mechanisms.

MUTUAL OBLIGATION AND SHARED RESPONSIBILITY AGREEMENTS

One of the more controversial aspects of the Australian Government's July 2004 reforms is the way in which services are to be provided for Aboriginal and Torres Strait Islander people following the abolition of ATSIC. This relates to the way in which Aboriginal interests are to be represented at the local and regional levels and the administrative arrangements supporting coordinated regional planning and accountability.

The regional structures now being established include Regional Partnership Agreements (RPAs) and Shared Responsibility Agreements (SRAs).[71] The concept of RPAs has been generally supported by Aboriginal stakeholders and all levels of government for their potential capacity to bring about more coherent government investment, joint priority setting and coordination of services. However, there has been less universal endorsement of the proposed Shared Responsibility Agreements. Under these arrangements, family or community groups (usually remote) are required to

offer practical commitments in return for Government funding. The SRAs document what the family, community and government are each responsible for contributing to a particular activity, what outcomes are to be achieved, and the agreed milestones to measure progress.

The SRAs have been criticised by some as being potentially punitive and discriminatory and because they might breach existing State and Territory Human Rights Acts and some of Australia's international treaty obligations.[73] Other Aboriginal leaders have urged that mutual obligation not be trivialised or misconstrued by 'people who see themselves as advocates of Aboriginal rights'.[74] These leaders argue that such agreements are needed in very disadvantaged communities where there has been a collapse of expectations regarding the provision of basic services that are simply taken as a given by other Australians. Where SRAs are negotiated on a basis of equal responsibility to the achievement of mutual objectives, some Aboriginal leaders have suggested that these could be

> *'…helpful to Aboriginal people and community leaders to ensure the resources needed to sustain culture, language, physical wellbeing and other aspects of their lives for the future of Aboriginal people – but not at the expense of the basic human rights of those they represent.'* [74]

In summary, the findings of the WAACHS emerge at a time of considerable volatility with respect to the current Aboriginal policy setting and the emergent arrangements for regional management of services. Just how these policy settings and service arrangements will affect the uptake and translation of the survey findings into appropriate policy and action is difficult to predict. A potential strength in the current milieu is a focus on the multiple causes of Aboriginal disadvantage and a government imperative for accountable joint action sustained over a longer period of time. Significantly improved data, at least in some jurisdictions, is also of critical value in monitoring progress, although there is now an urgent need to insure timely data collection and delivery to meet need.

THE DRIVERS OF DEVELOPMENTAL CHANGE

In this section the survey findings are assessed with respect to the burden of social and emotional difficulties, the prompts, facilitators and constraints of development, and the policies most likely to foster desired change at the level of populations, communities, families and individuals.

DRIVERS OF DEVELOPMENTAL CHANGE IN POPULATIONS

A major theme in the WAACHS findings is the theme of scale. The scale of burden associated with risk of clinically significant emotional or behavioural difficulties in the Aboriginal population is very high, and the size of the Aboriginal population is very small, relative to the majority population. The evidence suggests that at current levels, gains in education, training and employment are not effectively ameliorating the population burden of physical and mental health morbidity in the Western Australian Aboriginal population. Other factors, notably stress and life circumstances, are overwhelming the benefits that may accrue merely through improving education and income for individuals.

It is in this context that the Australian Government has moved to mainstream programs and services for the Aboriginal population (see above). Whatever the merits

or otherwise of this decision, it needs to be kept in mind that, relative to the majority population, there is not a level playing field with respect to the burden of mortality and morbidity in the Aboriginal population. Numerous reports over several decades continue to document this and, along with the WAACHS results, they confirm striking differences in mortality, morbidity and service access and their regional distributions.[4] It is critical that the intensity (i.e. funding, size, availability and relevance) of programs for prevention, identification and treatment of the burden of Aboriginal disease matches this burden. This will inevitably require management of majority population expectations of what is fair and just and provision of the evidence and rationale for the intensity of service provision to the Aboriginal population.

Equality, sustainability, productivity and empowerment form the basis of human development and the expansion of human capabilities.[75] With this in mind, governments are uniquely placed to influence whole populations or sub-populations through the creation of legal and social frameworks and the implementation of policies. In this way, the Australian Government in concert with State and Territory jurisdictions have a principal responsibility for expanding human capabilities in populations. Thus, at the level of the Aboriginal population the major goal of government is in the expansion of human capabilities by:

- Enforcing legal frameworks that end discrimination, reduce social exclusion and increase economic, social and civic participation
- Promoting and strengthening local institutions that provide opportunities for participation and empowerment in a range of activities and services
- Ensuring a fair distribution of opportunities through a fair distribution of income, wealth and the means of income and wealth generation
- Setting benchmarks for and monitoring three key indicators of human development: income, health and knowledge
- Directing the creation or maintenance of data sources on which to base evidence of progress.

These actions need not be driven from the top-down, nor do they over-ride local or community participation, or the participation of private sector enterprise or initiatives. As Jolly points out,

> *'the principal goal of these actions is to broaden choice and opportunities . . . Nothing should be decided at a higher level than is necessary to ensure that the interests of all stakeholders are taken into account.'*[76]

However, the investment in these actions by government will need to be commensurate with the scale of the task ahead. Changes attributable to advances in income, education and training with the Australian Aboriginal population are presently too weak and require a substantial new focus and an insistence on improvement in order to effect greater population capability. This is why there is a requirement to focus on improvements in fundamental aspects of Aboriginal human capital – health, education and income – as a central, but not exclusive, strategy in improving capability.

DRIVERS OF DEVELOPMENTAL CHANGE AT THE COMMUNITY LEVEL

The effective functioning of communities plays a critical role in supporting the economic and social wellbeing of families and children. Good community leadership and governance is well recognised as a primary driver of human development in

Aboriginal communities.[77] Failures in community governance on the other hand have been associated with catastrophic social dysfunction such as endemic alcohol abuse and family violence.[78] Improving community governance is one of the first objectives of the COAG community trials such as those currently underway in the Tjurabalan region of Western Australia and other States and Territories.[72] These trials are seeking to achieve this by maintaining culturally appropriate community democracy and decision making while developing new regional partnerships between communities and governments at all levels. These arrangements are endeavouring to overcome previous structural impediments such as dispersed and fragmented government funding and accountability. They clearly require significant training investments in community leadership, corporate governance, and community based service provision.[79]

Another important community driver of social functioning and human development in Aboriginal people is the maintenance of Aboriginal self-determination consistent with traditional cultural practices and values. This is evident in a number of studies of Indigenous communities in the USA and Canada. For example Chandler and Lalonde's 1998 study of the variation in rates of youth suicidal behaviour between the various First Nations communities across British Columbia's communities demonstrated that the communities which had taken active steps to preserve and rehabilitate their own cultures, languages and traditional practices were those in which rates of suicidal behaviour were dramatically lower.[80] This highlights the importance for communities of maintaining cultural beliefs and traditional practices which assist young people to maintain their sense of personal continuity and cultural identity in the face of rapid developmental and cultural change.

Recent US studies have demonstrated the importance of self-governance in improving economic viability of Indigenous communities and creating vocational and economic opportunities for families and children. The Harvard Project on American Indian Economic Development has extensively researched its technical assistance projects across Indian communities throughout the USA and identified three key factors which underlie the ability of some Indian Nations to have achieved economic viability in contrast to others.[81] First, these communities have given high priority to asserting Indigenous self direction in decision-making. Second, they have community institutions and processes available to settle disputes fairly, to separate the functions of elected representation and business management, and to successfully implement policies that advance tribal strategic goals. Finally, these communities appear to have established a good match between their governing institutions and Indigenous values and beliefs about how authority should be organised and exercised.

DRIVERS OF DEVELOPMENTAL CHANGE IN FAMILIES

The most substantial drivers of social and emotional wellbeing in children and young people are those directly related to their families. Nowhere is this more evident than in the strength of the association of life stress events, high residential mobility, poor parenting quality and poor family function with the high risk of clinically significant emotional or behavioural difficulties. These exposures are exacerbated where the carer is in poor physical or mental health and where there are fewer, rather than more, family members in the household.

There are three points of intervention that would promote developmental change through families.

The first, and most basic, entails fundamental improvements in Aboriginal family function through improvements in the health and wellbeing of the carers themselves. As previously documented, illness, mental health problems, and a shorter life expectancy impose a primary barrier on the capacity of Aboriginal carers to function well. This diminishes the capacity of a family unit to function well – particularly where early illness and death result in family breakdown and separation.

The second is in improving carers and families to withstand the effects of multiple life stresses. Merely improving a family's capacity to withstand multiple stresses, without addressing the source of these stresses, is both immoral and nonsensical. Families of Aboriginal children report extraordinary levels of stress – death, incarceration, violence, and severe hardship. The source of these stresses is historical, social and personal and is now seen to comprise the Aboriginal circumstance. Much of the root cause is the continued social exclusion and inequality that diminishes opportunity and choice for individuals, families and communities. This is why there is such an emphasis on capability expansion in the Aboriginal population with an emphasis on health, income and knowledge.

However, these actions are not likely to effect rapid capability expansion in carers of Aboriginal children at present. In the meantime, buffering children from the effects of family and carer stresses, building social support for carers, families and communities, improving the capacity of Aboriginal families to function well – that is, to communicate effectively, manage basic decision-making, regulate emotion, and provide practical and emotional support – and providing health, child care and educational services that better recognise and meet the needs of families are critical in improving developmental outcomes for children.

The third point of influence is directly related to the quality of carer-child interactions that seek to directly influence the quality of parenting in Aboriginal families. These programs may take the form of post-natal home visiting, early educational day care, or parenting programs for pre-schoolers or children in early primary years. These are known to be effective in changing child emotional or behavioural outcomes. There is a critical gap in the translation of programs that are effective in the majority population to settings with Aboriginal families in a range of cultural and geographic settings.

DRIVERS OF DEVELOPMENTAL CHANGE IN INDIVIDUALS

Thus far population, community and family drivers of developmental change have been discussed. This is because the principal findings from the WAACHS suggest that these are major drivers of change. So much so, that without addressing them, a focus on services for individuals will result in minimal or ineffective outcomes.

Individual level drivers of children's social and emotional wellbeing are already in effect in the months prior to conception, throughout gestation, birth and in the years of early childhood. These drivers include the quality of maternal and child health, the way in which this is supported by adequate nutrition, child care and supervision, hygienic living conditions and protection from vaccine preventable diseases, as well as family and social environments supportive of child rearing. The critical impact of these basic requirements for health and growth during the early years, is due to the fact that the rate of brain and nervous system growth is greatest during this time than any other period in life. Optimising nutrition, care and stimulation, and protection from exposure to traumatic violence or other forms of abuse during these growing years is now understood to have life-long consequences in terms of children's cognitive,

emotional and social development and in terms of their longer term adult health and wellbeing.[82]

During the pre-school and primary school years, parenting skills assume a greater role in shaping children's later academic, social and behavioural outcomes. The longer term evaluation of programs such as Headstart in the USA have demonstrated the preventive value of such programs for children's transition from the home environment into formal schooling and longer term benefits for their health, education, emotional and social development.[83,84]

In Western Australia, large-scale trials of systematic parenting initiatives targeting parents with pre-schoolers in disadvantaged areas of Perth have demonstrated that improvements in parenting can improve both the behavioural outcomes of the child and the wellbeing outcomes of the carer.[85] National discussions have recently commenced on initiatives to improve the availability of culturally appropriate parenting information and interventions for Aboriginal and Islander families. These highlight the need for:

- Promoting existing products more widely
- Sharing knowledge about existing resources
- Ensuring local relevance through locally produced resources such as posters, videos and books
- Maximising impact through use of local images, language and customs
- Using stories and group discussions to enhance learning and sharing
- Improving education, advice and assistance to mainstream agencies servicing Aboriginal communities.[86]

Carers at home and in settings away from home (day-care, pre-primary and primary school) need to be skilled in providing specific opportunities for cognitive development, language enrichment, and emotional support. There are specific components of these activities that Aboriginal children would benefit from, including:

- Activities that involve labelling, sorting, sequencing, comparing and noting means-ends relationships[19]
- Being read to, drawing and telling stories
- Adult-child exchanges that promote explaining facts, talking about expectations, encouraging skills, and soliciting information about daily activities outside the home as well as racial socialisation about the realities of oppression and the need to overcome this, as well as clear expectations about sex and alcohol use[20,21]
- Emotional support from carers which entails the encouragement of exploration, celebration of developmental milestones, guided rehearsal and extension of new skills, and protection from inappropriate disapproval, teasing or punishment.[19]

Certainly some of this happens for some Aboriginal children, but more of it needs to happen regularly for more Aboriginal children and young people. Programs in health, family and children's services and eduction need to be examined to assess their content with respect to the developmental opportunities and skills needed by carers across settings and the children within them.

Currently, services targeting the mental health of Aboriginal children and young people are inadequately provided at all levels. What now appears to be required is well stated by White-Tenant and Costa (2002):

> *'No matter how mental health services are delivered, the understanding of mental health is the same: prevention first, promotion always and intervention when necessary.'* [84]

While there is general support for prevention and promotion initiatives being more widely available in early childhood, there remain significant bureaucratic and jurisdictional barriers to their effective development and delivery. Health, community development, education and justice systems all have a stake in the outcomes that such programs can bring. However, joint delivery and evaluation of such programs along with an insistence to examine alternate funding and accountability is needed.

With regard to young people, the widespread use of alcohol, tobacco and other drugs and substances is a particularly important driver of their poor health and wellbeing. Apart from the immediate health risks, substance use is a manner of coping that frequently interferes with or precludes the necessary development of other critical skills – particularly when taken up at an early age. Young people who learn to use alcohol or drugs to reduce distress may never learn other more adaptive coping skills. This may truncate, interfere with, or circumvent essential and normative maturation processes. Adolescent gang behaviour and other problems associated with petrol inhalation were first described by Nurcombe et al (1970) in the Mornington Island Aboriginal community in terms a psychiatric framework of individual psychopathology.[87] More recent formulations of alcohol and substance abuse among children and adolescents give greater consideration to the psychological, symbolic and social coping functions which the behaviour may serve.[88] Widespread binge drinking and substance abuse by young people are relatively recent and distressing problems for Aboriginal communities; dealing with them is beyond the experience of many people or the ability of agencies. Nevertheless, among remote and more contained urban communities, there have been some encouraging examples of how Aboriginal initiated, and community focused interventions have successfully dealt with the problem by addressing the social context in which these behaviours develop.[89] It remains the case, however, that prevention is the strategy of choice and it is encouraging that both participation in sport and adequacy of parenting are associated with lower proportions of children at high risk of clinically significant emotional or behavioural difficulties. Both of these factors offer realistic intervention opportunities.

Aboriginal children at high risk of clinically significant emotional or behavioural difficulties have a rate of contact with the WA Mental Health System equivalent to their non-Aboriginal counterparts. This observation, however, is misleading for a few reasons. First, there is no capacity for the existing mental health system to meet the existing population need for services and care. This was observed a decade ago,[10] and despite increases in resources for mental health, the mental health system itself will never have the capacity to meet demand – particularly for children and young people. Second, while some comfort might be taken from the fact that Aboriginal children and young people are receiving mental health services at all, the burden associated with their treatment and care is higher. Thus, achieving a comparable level of service to that of the majority population obscures a higher burden requiring (among other things) greater intensity and duration of treatment. Third, the anecdotal information from hospital and clinical services suggests that mental health care is all too often a case of 'too little too late'. When referrals are made there is frequently a much lower level of

engagement and follow through with treatment than with non-Aborignial children. This may reflect the current paucity of culturally sensitive mental health services for such children and families – particularly in the metropolitan and extremely remote areas of the Western Australia. It could also reflect the practical reality that treatment and support needs cannot be properly met by the child mental health service system alone.

Solutions rest in the development of State policy and local action plans for promoting the social and emotional wellbeing of Aboriginal children and young people across all government sectors. This will require careful community and professional consultation to bring about a better convergence of the human service systems (i.e. health, education, community development, alcohol and drug and justice) having responsibilities for the protection and wellbeing of children and families. It will also require a work force capable of delivering relevant and culturally appropriate services.

MAKING A DIFFERENCE

This chapter commenced with a message to agencies, policy makers and service providers: Without an understanding of the basic characteristics and processes shaping the Australian Aboriginal population, attempts to formulate effective policies for the arrangement of human services and their delivery to individual Aboriginal children and their families will fail. This assertion has been extended by explaining the nature of the burden of emotional or behavioural difficulties, the prompts, facilitators and constraints of social and emotional development, and the drivers of developmental change in populations, communities, families and children.

The findings to date show that the principal resources available to support and promote the development of children include:

- the adequacy of the physical environment (i.e. housing, clean water, sanitation and nutrition) in meeting the basic necessities of living
- levels of family income available to support the development of children
- the levels of human and psychological capital available to support child development
- the social capital available to individuals living in the community and wider society.[1]

This present volume of results provides the first comprehensive analysis of the social and emotional wellbeing of Aboriginal children and young people. The findings illustrate the slow rate of change that is likely to occur unless these drivers of change are understood by leaders — Aboriginal and non-Aboriginal alike — and their communities and agencies.

Aboriginal Australians have, of course, lived these experiences and repeatedly voiced their concerns. These concerns have been met with modernity's requirements for 'evidence'. Will better evidence make a difference to the Australian Aboriginal circumstance through improving social and emotional wellbeing for children and young people? Perhaps. The principles for change are known and the evidence for what will work is available. But it will take political will and commitment to long term policies to remove the barriers and deliver to Aboriginal people equality, sustainability, productivity and empowerment. These are central to social and emotional wellbeing and ultimately to human capability and the expansion of choice.

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