Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the development of an Early Years Strategy

May 2023

Vision

The Strategy's vision should include improving early childhood outcomes, as well as closing the gap in early childhood outcomes between the least and most vulnerable.

Specific areas / policy priorities

Improving the outcomes for Aboriginal and Torres Strait Islander children, and closing the gap between their outcomes and those of non-Indigenous Australia should be a priority for the Strategy.

The Strategy should include a focus on prevention, including:

- Addressing poverty and inequality as drivers of poor early childhood outcomes
- Parental – and especially maternal – education and adult literacy as key pathways to preventing poor early childhood outcomes
- a national, evidence-based policy on reducing alcohol-related harm at a whole-of-population level, including action on price and availability

Improving Outcomes for Aboriginal and Torres Strait Islander children

Support universal access to evidence-based early childhood development programs

Recommend the establishment of multidisciplinary child and youth assessment and therapy teams in Aboriginal community controlled health service demonstration sites

Include a case study of Congress' integrated model of child and family services to illustrate the value an integrated, multidisciplinary model to meet the needs of Aboriginal children and families within a comprehensive model of primary health care.

The Strategy should recognise that the NDIS does not work well to support the health and wellbeing of Aboriginal children in remote areas; and recommend trialling alterative mechanisms with a focus on services for Aboriginal children

Improving coordination and collaboration

Implementation Action Plans should be developed through established, agreed and functioning collaborative mechanisms.

The Strategy's Outcomes and Evaluation Framework should be developed and overseen by a panel of experts, including Aboriginal and Torres Strait Islander leaders with experience in early childhood

Principles

Aboriginal peoples' right to self-determination as recognised under international agreements should underpin addressing early childhood outcomes for First Nations.

Aboriginal community controlled health services should be recognised in the Strategy as preferred providers for any early childhood services for Aboriginal communities.

Central Australian Aboriginal Congress Aboriginal Corporation
ABN 76 210 591 710 | ICN 7823
PO Box 1604, Alice Springs NT 0871
(08) 8951 4400 | www.caac.org.au

About us

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal* health, a national leader in primary health care, and a strong advocate for the health of our people. Since the 1970s, we have developed a comprehensive model of primary health care that includes: multidisciplinary clinical care; health promotion and disease prevention programs; and action on the social, cultural, economic and political determinants of health and wellbeing.

2. Congress delivers services to more than 17,000 Aboriginal people living in Alice Springs and remote communities across Central Australia.

3. In recent years, the community-elected Congress Board of Directors has focused on improving the developmental outcomes of Aboriginal children. This has led to the creation of an innovative model for the delivery of child and family services, based on the belief that the best way to "close the gap" is to make sure it is not created in the first place.

Our response to the Discussion Paper

Question 1: Do you have any comments on the proposed structure of the Strategy?

4. The structure if the Strategy described in the Discussion Paper is appropriate.

Question 2: What vision should our nation have for Australia's youngest children?

5. The Strategy's vision should include:

   - improving outcomes for Australia's children as a whole;
   - improving early childhood outcomes for children of vulnerable groups (First Nations; those in poverty etc); and
   - closing the gap in early childhood outcomes between the least and most vulnerable. This is critically important for Aboriginal and Torres Strait Islander children, and aligns with the *National Agreement on Closing the Gap* [1].

The Strategy's vision should include improving early childhood outcomes, as well as closing the gap in early childhood outcomes between the least and most vulnerable.

Question 3: What mix of outcomes are the most important to include in the Strategy?

The main outcome that needs to be measured are the outcomes from the Australian Early Development Census. For Aboriginal communities it is vital that equity is achieved and the gap in outcomes for all children is closed in the first year of school. The national CTG indicator is really important but this only looks at the proportion of children that are vulnerable on one or more domains. Given the sensitivity of the measure there is a risk that at only one domain in a cross cultural context it may not represent a true developmental vulnerability. Congress therefore thinks it is also important to consider the

proportion of children who are developmentally vulnerable on two or more domains as this is much more likely to reflect a true and more global developmental concern. It is also at this level that the real inequity between Aboriginal and non-Aboriginal children becomes more apparent, especially in remote areas. In order for this measure to be properly used however the data needs to be available broken down by Aboriginal / non-Aboriginal children in all regions throughout Australia at least for the purposes of planning and funding allocation. This data needs to be available at the locality level.

In addition to this, as the ASQ-Trak become a more widespread tool used to assess developmental progress in Aboriginal children then it will be possible to collate data at a community level of the proportion of Aboriginal children below cut-off on two or more domains. It is proposed that this become a KPI in the NT Aboriginal Health KPIs but this has not occurred as yet. The importance of this data is that it will show developmental concerns earlier than the AEDC data.

Question 4: What specific areas/policy priorities should be included in the Strategy and why?

Closing the gap in early childhood outcomes for Aboriginal children

6. The nurture and care of children is at the heart of Aboriginal culture. For tens of thousands of years, our diverse peoples raised healthy, resilient and creative children. Today, many of our families still do.

7. However, contemporary Aboriginal families have been deeply affected by the processes of colonisation including dispossession and impoverishment; the forcible removal of children and its intergenerational effects; the suppression of culture and language; and the experience of racism and discrimination. Aboriginal families continue to live with these effects of colonisation which challenge their capacity to care for their children.

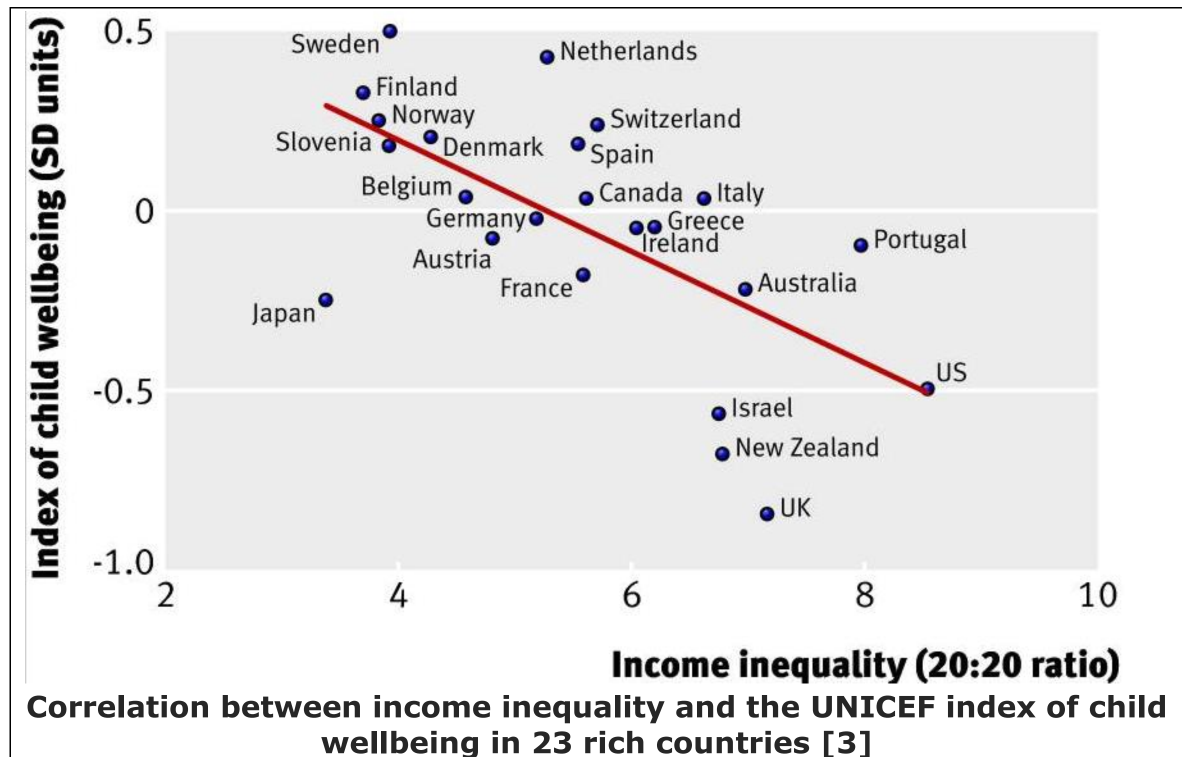
8. The Discussion paper documents the national disparity between early childhood outcomes for Aboriginal and Torres Strait Islander and non-Indigenous children, but the inequity is much greater in remote areas: in Alice Springs in 2015, 43% of Aboriginal children were developmentally vulnerable on two or more domains compared with 7% of non- Aboriginal children [2]. The latest AEDC data from 2021 suggests that this six-fold disparity is not improving.

9. A focus on remote and regional areas is appropriate, but with the explicit recognition that a significant part of the gap in outcomes between these places and urban areas is due to the higher proportion of Aboriginal and Torres Strait Islander children in remote and regional areas.

Improving the outcomes for Aboriginal and Torres Strait Islander children, and closing the gap between their outcomes and those of non-Indigenous Australia should therefore be a priority for the Strategy.

A focus on prevention through reducing poverty and inequality

10. The Discussion Paper notes the effect of low socioeconomic status on early childhood outcomes. However, both absolute deprivation (poverty) and relative deprivation (inequality) are strongly correlated with poor child wellbeing (see graph).



Correlation between income inequality and the UNICEF index of child wellbeing in 23 rich countries [3]

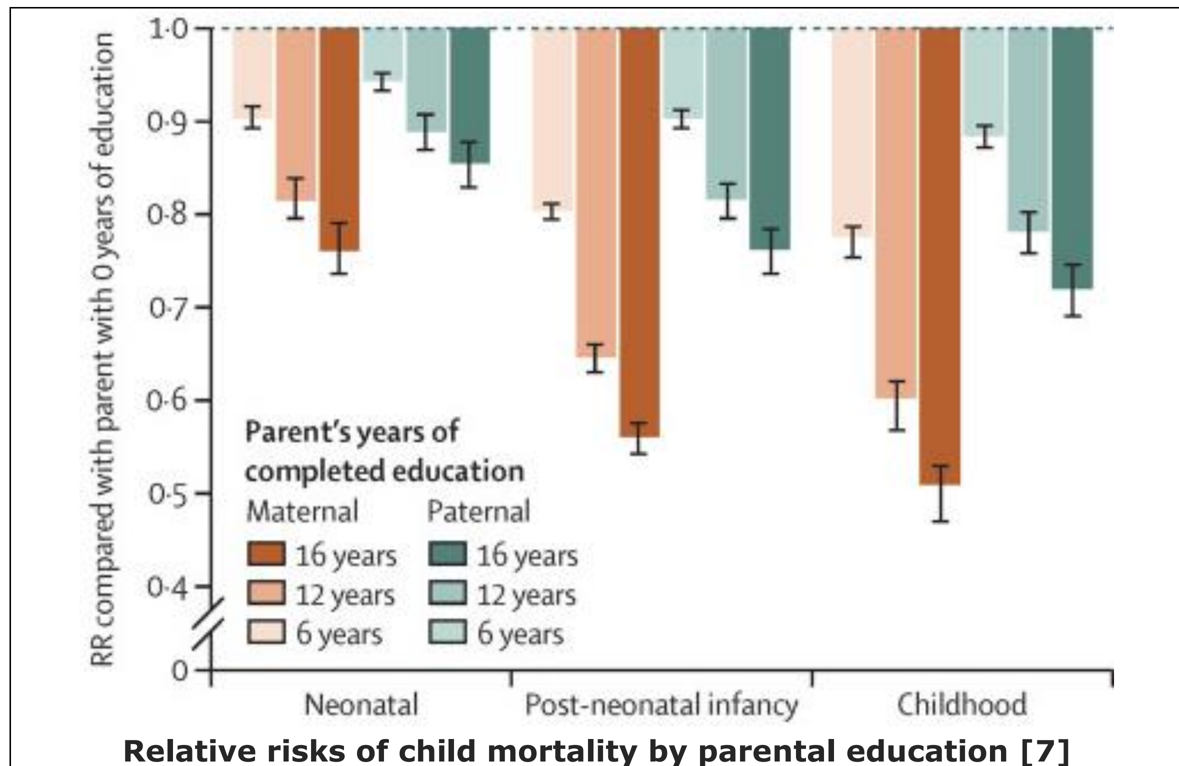
11. Australia is a wealthy country but on average, Aboriginal and Torres Strait Islander people receive a personal income that is only two-thirds that of the non-Indigenous population [4]. The situation is considerably worse in Central Australia where the median weekly personal income for Aboriginal people is $281: barely more than a quarter of that for non-Indigenous people in the region ($1,080) [5].

12. Critically, in remote areas both absolute poverty and relative inequality is worsening with Aboriginal and Torres Strait Islander incomes falling in real terms, and the income gap widening [6].

Addressing poverty and inequality as drivers of poor early childhood outcomes must be included in the Strategy.

A focus on prevention: parental education and literacy

13. Parental – and particularly maternal – educational attainment and literacy is an important protective factor for strengthening families and improving outcomes for children. Recent work has been able to quantify the effect, with a single additional year of schooling associated with a reduction in under-5 mortality of 3% for maternal education and about half that for paternal education [7].



Relative risks of child mortality by parental education [7]

14. Educational attainment rates for Aboriginal people, particularly in remote Australia, are low: only 39% of Aboriginal people over 15 in Alice Springs gave completed year 11/12; for remote Central Australia it is half that (21%). The reasons are complex, but a poorly funded and under skilled remote area education system need to be addressed.

15. Aboriginal and Torres Strait Islander people have, in general, much lower English literacy than those in the non-Aboriginal population: nationally it is estimated that at least a third have minimal English language literacy [8]. The figure is much higher in the Northern Territory, where it is estimated that 80% to 90% of Aboriginal people do not have a level of English literacy sufficient to operate independently on literacy and numeracy tasks in education and the workforce [9].

16. Improving adult literacy in English is critical to empowering people to take control of their lives and is fundamental to developing intergenerational 'literacy practices' within families, which then support children to engage and perform well at school [10].

Parental – and especially maternal – education and adult literacy should be included as a key focus for preventing early childhood disadvantage.

A focus on prevention: population level alcohol reforms

17. Parental alcohol dependence is a major cause of child neglect and the need for out-of-home care. The harm caused by alcohol to children is recognised in tools for the assessment of the needs of children and families such as the Family Strengths and Needs Assessment tool (FSNA). In addition, FASD is estimated to be between 3 and 7 times as common in the Aboriginal community as it is in the non-Aboriginal population [11] with one study concluding that 15.6% of avoidable intellectual

disability in Aboriginal children is attributable to maternal alcohol use – twelve times the rate for non-Aboriginal children [12].

18. Although there are significant social determinants of alcohol dependence, a large and immediate impact on the primary prevention of child developmental vulnerabilities (including but not only FASD) can be achieved by reducing the consumption of alcohol amongst all women of child-bearing age and their partners. This is because:

    - the developing child is most vulnerable to exposure to alcohol in the weeks after conception before many women are aware that they are pregnant [13];
    - a relatively high proportion of women continue to drink at risky levels during pregnancy [14];
    - the risk factors for having a child with FASD includes a woman having a male partner who drinks [15] along with emerging evidence that fathers' alcohol consumption can affect the development of the unborn child [16], adding to the likely exposure of the effects of alcohol consumption;
    - parental alcohol misuse is frequently associated with domestic violence and neglect of children during their critical early years [17].

19. For these reasons, and in line with key studies [18], reducing the prevalence of child developmental vulnerability must include broad-based public health measures to reduce alcohol consumption amongst the whole population, including women of child-bearing age. There is a very strong international evidence-base that:

    - increasing the price of alcohol, and particularly that of cheap alcohol, is a 'best buy' for reducing consumption and hence alcohol related harm at a population level; it is also a highly cost effective intervention [19]; and
    - physical availability is the next most important determinant of alcohol harm, in particular through reducing trading hours and license density [19, 20].

20. In October 2019 the Northern Territory Government introduced a package of reforms to deal with the jurisdiction's long-standing issue with high levels of alcohol-related harm [21]. The reforms demonstrated very significant reductions in alcohol-related harm across the Northern Territory [22-24].

The Strategy should recommend a national, evidence-based policy on reducing alcohol-related harm at a whole-of-population level, including action on price and availability similar to the Northern Territory Alcohol Policies and Legislation Reforms.

Question 5: What could the Commonwealth do to improve outcomes for children—particularly those who are born or raised in more vulnerable and/or disadvantaged circumstances?

Universal access to evidence-informed early childhood development programs

21. There is an abundance of strong evidence that well-designed early childhood development programs are a key, cost-effective intervention to address and offset the effects of poor early childhood experience. Examples of such preventative

programs include the Nurse Family Partnership (NFP) Program Home Visitation and the Abecedarian model of Educational Day care.

22. Evidence from overseas, based on decades of study, show incontrovertibly that such early childhood programs can:

- significantly lower prevalence of risk factors for cardiovascular and metabolic diseases in adults (especially men) [25]
- reduce the use of alcohol and other substances by young adults [26];
- more than double school retention rates [27];
- dramatically reduce the youth incarceration rates [28]; and
- dramatically increase (by a factor of four) the likelihood that at age 18 young people will report having an active, healthy lifestyle [27].

Support universal access to evidence-based early childhood development programs as an essential contributor to raising children who are resilient and thus better equipped to meet challenges to their health and wellbeing.

Funding of child and youth assessment teams in ACCHSs demonstration sites

23. Congress' Child and Youth Assessment and Therapy Service (CYATS) is a multidisciplinary team including an Aboriginal Family Support Worker; a Speech Pathologist; an Occupational Therapist; and a neuropsychologist. The team provides a best-practice service for the early detection of neurodevelopmental conditions such as FASD, ADHD and Autism Spectrum Disorder (ASD), and in providing a multidisciplinary approach to diagnostic assessment, early intervention, and support for families to access the NDIS.

24. Early diagnosis and resultant therapeutic support through CYATS allow Aboriginal children greater opportunity to improve developmental outcomes. An important part of CYATS is the level of engagement by the team with the families, many of whom experience severe social and personal turmoil and face language and cultural barriers to accessing specialist services. Often families are disengaged and require enormous support to participate in assessments. Cultural expertise is provided by CYATS' Aboriginal Family Support Worker.

25. There is a high demand for CYATS with over 200 children on the wait list with a wait time of approximately 12-18 months for multidisciplinary neurodevelopmental assessment, and 6-9 months for speech or OT assessment/intervention. Since 2018, over 800 Aboriginal children have been assessed. A significant number of children have been referred to the NDIS, providing critical resources for families to access therapeutic interventions for those who have been accepted into the scheme.

26. The Australian Government should build on the success of the CYATS model by establishing formalised funding processes including demonstration sites in other ACCHSs in a range of settings (urban, rural and remote). Demonstration sites should include a common formal evaluation and research component to measure incidence / prevalence of developmental vulnerability; to maximise service delivery effectiveness including through culturally responsive, trauma informed care; and to translate this knowledge to other settings. Demonstration sites should be provided with 5 year block-funding to allow proper monitoring and evaluation and service refinement over time.

Recommend the establishment of multidisciplinary child and youth assessment and therapy teams in Aboriginal community controlled health service demonstration sites to improve early diagnosis, support and access to NDIS for Aboriginal children with developmental issues.

Case study: the Congress model of integrated child and family services

27. We believe that the Congress integrated model of child and family support may be of interest in addressing early childhood development in Aboriginal communities, and would be happy for it to be included as a case study in the Strategy. The model has been described in the peer-reviewed literature [29, 30].

	Primary Prevention Targets children with no current problems but who are at risk of developing problems – identified risk usually based on low SES or maternal education level		**Secondary Prevention** Targets children with current problems identified early in life when most likely to respond to intervention and before gets worse – determined by screening or referral to services	
	Child Focus	**Carer Focus**	**Child Focus**	**Carer Focus**
Centre Based Most work is done at a centre where child or families come in to access service	• Early Childhood Learning Centre • Immunisations • Child health checks • Developmental screening	• Health advice to parents in clinic (e.g. nutrition, brushing teeth, toilet training)	• Child-centred play therapy • Therapeutic day care • Preschool Readiness Program • Antibiotics	• Filial therapy • Circle of security • Parenting advice / programs • Parent support groups
Home Visitation Most work is done in the homes of families where staff outreach to children and families	• Mobile play groups	• Nurse home visitation • Families as first teachers (home visiting learning activities)	• Child Health Outreach Program • Ear mopping	• Targeted Family Support • Intensive Family Support • Case management models for children at risk • Parents under Pressure (PUPS)

Congress' integrated model of child and family services [29]

28. The Congress integrated model of family and child support grew from the community-elected Congress Board's determination to improve the developmental outcomes of Aboriginal children in Central Australia, based on their belief that the best way to "close the gap" is to make sure it is not created in the first place. As a result, over a decade a more Congress has developed a range of evidenced-informed, culturally appropriate early childhood learning programs within our child and family services.

- The Abecedarian Approach Australia (3a) is used as a strategic population health approach with specific interventions to improve the health and developmental trajectory for developmentally vulnerable children. Congress operates:
- two early learning centres for children from both working families and non-working families (this includes support and engagement of parents and carers to participate in the Centre); and
- a Preschool Readiness Program.

29. In addition, our multi-disciplinary team approach within comprehensive primary health care ensures all children have access to a range of integrated, multidisciplinary services including:

- routine and systematic child health checks and developmental screening through all of our clinics (using the ASQ-TRAK assessment tool) for children 0-5 years old, with support provided to parents and carers to attend appointments. This includes following up recalls when appointments are due to ensure children are able to attend;
- further developmental assessments for delay and disability provided through our Child and Youth Assessment Service (CYATS) of allied health professions in collaboration with Alice Springs paediatricians and community health services. This includes the capacity to diagnose Foetal Alcohol Spectrum Disorder (FASD) along with other neurodevelopmental disorders in collaboration with paediatricians from Alice Springs hospital and supported by PATCHES paediatrics and the Telethon Institute in Western Australia;
- close collaboration with education providers to support children to be healthy and developmentally ready for preschool and school, and to gain any additional supports needed for preschool and school; and
- an Intensive Family Support program to support vulnerable families to keep children safe at home and for families involved with the child protection system, in addition to providing support for parents more broadly through the Parenting Under Pressure Program.

We suggest that the Strategy could include a summary of the Congress integrated model of child and family services as a case study to illustrate the value a more integrated, multidisciplinary model of meeting the needs of Aboriginal children and families within a comprehensive model of primary health care.

Making the NDIS work for Aboriginal children in remote areas

30. A fundamental tenet of the National Disability Insurance Scheme (NDIS) is giving people choice and control over the services they receive. This is well intentioned and in some contexts reasonable [31, 32].

31. However, the NDIS does not work unless there are sufficient service providers to meet demand and provide choice [33]. This basic requirement is not met in many regional and remote areas where populations are dispersed and the costs of delivering services are high. Central Australia is one such area.

32. These difficulties are exacerbated when dealing with disadvantaged populations. Populations bearing the burden of multiple, complex overlapping social and health challenges are those least able to navigate the complex bureaucracy of personalised systems such as the NDIS [33]. These differences are multiplied significantly in cross cultural situations such as apply for Aboriginal people in Central Australia where large sections of the population speak English as a second, third or fourth language and where many mainstreams services providers have little experience of delivering culturally-responsive care.

33. Taken together, this means that the NDIS does not work well to support the health and wellbeing of Aboriginal children in remote areas, and may even serve to "widen the gap" between their outcomes and those children in well-serviced mainstream and

urban areas where the NDIS works more as it is intended. We understand that there are around $100 million in approved NDIS plans in Central Australia, but the holders of many of these plans are unable to access services as there are not enough providers with only two currently going into some remote communities.

34. Congress proposes formally investigating the development of increased provider capacity for Central Australia by setting up a disability service organisation to meet the extra demand. The organisation will require grant funding while it establishes itself and recruits clients; after which the number of funded plans in Central Australia should make it financially independent.

The Strategy should recognise that the NDIS does not work well to support the health and wellbeing of Aboriginal children in remote areas; and recommend trialling alterative mechanisms by setting up a non-government disability service organisation with a focus on services for Aboriginal children

Question 6: What areas do you think the Commonwealth could focus on to improve coordination and collaboration in developing policies for children and families?

35. Wherever possible the development of Implementation Action Plans should take place through established, agreed and functioning collaborative mechanisms. In relation to the Northern Territory, these should include the Children and Families Tripartite Forum; and/or the Northern Territory Aboriginal Health Forum; and/or the Northern Territory Executive Council on Closing The Gap / Aboriginal Affairs.

36. The Strategy's Outcomes and Evaluation Framework should be developed and overseen by a panel of experts, including Aboriginal and Torres Strait Islander leaders with experience in early childhood. Regular, public reporting against agreed outcomes and activities should be included.

Implementation Action Plans should be developed through established, agreed and functioning collaborative mechanisms.

The Strategy's Outcomes and Evaluation Framework should be developed and overseen by a panel of experts, including Aboriginal and Torres Strait Islander leaders with experience in early childhood

Question 7: What principles should be included in the Strategy?

The right to self determination

37. Any approach to outcomes for Aboriginal children must recognise the underlying process of colonisation and its effects (see paragraphs above). The Strategy should therefore recognise the rights of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples* [34], which states:

> *Article 23: Indigenous peoples … have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*

Aboriginal peoples' right to self determination as recognised under interal agreements should be a principle underpinning addressing early childhood outcomes for First Nations.

Aboriginal community controlled health services as preferred providers

38. ACCHSs were first established by Aboriginal communities in the 1970s. ACCHSs promote a comprehensive model of primary health care, including culturally safe practice and a multi-disciplinary team approach. While ACCHS model varies from place to place, as well as treatment for sick they seek to provide integrated, culturally safe responses to Aboriginal health needs, through a combination of direct advocacy and the development, implementation and evaluation of evidence-based approaches to what are often seen as intractable health challenges.

39. Congress itself has developed a strong reputation in this area, with a large range of publications in the fields of:

    - early childhood education for disadvantaged children [35, 36]; and
    - integrated models of child and family services [29];
    - multi-disciplinary health promotion in primary health care [37];
    - advocacy for population-level public health approaches to preventing alcohol-related harm [38, 39];
    - SEWB services based on three streams of care (medical; psychological and socio-cultural support) [40];
    - improved funding for, and collaborative planning and implementation of primary health care services in remote and regional Australia [41-43].

40. ACCHSs have contributed significantly to better child and maternal health outcomes including reductions in preterm births and increases in birth weight [44] (see section below for further detail).

Aboriginal community controlled health services should be recognised in the Strategy as preferred providers for any early childhood services for Aboriginal communities.

Question 8: Are there gaps in existing frameworks or other research or evidence that need to be considered for the development of the Strategy?

There needs to be a lot more intervention studies with formal evaluations to assess the impact of different interventions over time in early childhood. In order to do this properly data linkage will need to be used and control groups can then be easily established. It is not acceptable to undertake Randomised Controlled Trials in many cases so the next strongest form of evaluation is a quasi-experimental design that will rely on the use of data linkage and control groups. In Central Australia there is a proposal to establish a longitudinal study of all children all of whom would have data linkage keys in order to have the data infrastructure to properly evaluate all interventions over time. This type of approach will be key to get better evidence in the future about what works and what does not work.

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* In this document we use the term 'Aboriginal' as the most appropriate terms in the Central Australian context to refer to Australia's First Peoples