

Strengths-Based Approaches to Providing an Aboriginal Community Child Health Service

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Article Info

Keywords

Aboriginal
Australia
Child
Health
Well-Being
Urban
Strengths-Based

Abstract

Adopting strength-based approaches reinstates power and control to Aboriginal communities, while nurturing decision making in the design and delivery of culturally contextualised approaches to addressing Aboriginal health and well-being. Aboriginal health policy and practice continues to address Aboriginal child health and well-being from a whole-of-population deficit discourse, exacerbating disadvantage for Aboriginal children and young people. Furthermore, population health-level data provides an opportunity to understand the complexities of health and well-being for urban Aboriginal children and young people, yet such information is rarely documented due to the size of the population of interest or the incapacity of services to undertake additional internal data analysis. This paper discusses the development of multi-disciplinary community-based Aboriginal child health services in an urban community using strengths-based principles. We highlight the opportunities and challenges in addressing Aboriginal child health over a 10-year period and demonstrate that access to culturally safe, resilience-building services can produce measurable improvements in health-seeking behaviour, maternal health, and early intervention. We draw on holistic frameworks to demonstrate that optimal outcomes can be achieved through integrated interdisciplinary models of care that are responsive to the needs of the local community, understand the social determinants of health and build resilience—all critically important to addressing Aboriginal child health and well-being.

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10.32799/ijih.v19i1.41292

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Glossary

Aboriginal: Within this article, Aboriginal respectfully includes Aboriginal and Torres Strait Islander peoples.

Children: In Australia, a child is defined as being aged 0–9 years.

Young person: In Australia, a young person is defined as being aged 10–24 years.

The gap: An Australian term referring to the Australian Government’s strategy to address the ongoing health and life expectancy “gaps” between Indigenous and non-Indigenous people.

Introduction

Partnerships with Aboriginal families, workers and communities are crucial to the success of outreach services aimed at optimising children’s health, well-being, and development (Harding, et al., 2021). The resurgence of self-determination, true collaboration and co-design has seen many Aboriginal communities co-deliver local solutions to address health inequity for Aboriginal children

and young people. The impacts of colonisation, historical and ongoing disempowerment and disadvantage are well described in health outcomes and health service usage for Aboriginal people (Gardner, et al., 2015). The health of our Aboriginal children and young people is fundamental to the prosperity and survival of Aboriginal culture, language, and communities (Brown, 2020).

Aboriginal children comprise 5.9% of children aged 0–14 years across Australia, but experience 18% of the total burden of disease (Australian Institute of Health and Welfare, 2016). These inequities are structurally perpetuated in the social determinants of health, such as employment, education and housing, and the concept of health must be understood in the entirety of an individual's context (Dudgeon et al., 2014; Miller et al., 2020). Recent data shows that positive outcomes and resilience in the face of adversity are associated with supportive family environments, social support, encouragement of school attendance and regular exercise (Young et al., 2017; Young et al., 2019; Chando et al., 2020). This contrasts with the deficit discourse that is often prevalent across Aboriginal health policy and practice. Deficit discourse perpetuates a culture of blame and frames Aboriginal identity in a negative narrative of failure and inferiority whereby those experiencing disadvantage are seen to be responsible for their problems without consideration for the broader socio-economic circumstances of individuals or communities (Fogarty et al., 2018). Language such as “high likelihood of incarceration”, “poor child development”, “low rates of school completion”, “failure to attend” and “poor compliance” in health service delivery denotes a deficiency, results in barriers to improving health outcomes and inhibits opportunities for Aboriginal children to thrive (Fogarty et al., 2018).

If we continue to address Aboriginal health and well-being from a whole-of-population deficit discourse, we will fail to design culturally contextualised approaches. To effect lasting change, government bodies should seek to actively reframe Aboriginal health outcomes to a strengths-based approach rather than using deficit discourse. Current reporting on state and federal funding is deficit focused, requiring descriptions and measuring the size of “the gap” or the extent to which Aboriginal health indicators fall short of non-Indigenous health outcomes. While measuring the magnitude of inequality can be important, it reinforces a negative discourse of blame, hopelessness, and failure. A strengths-based approach moves from a harmful and problem-based paradigm and acknowledges the realities of disadvantage faced by Aboriginal people that exist in the social and economic determinants of health (Fogarty et al., 2018). Strengths-based approaches focus on the resilience and wisdom of Aboriginal communities to find meaningful and positive solutions to overcome issues contextual to socio-economic circumstances (Fogarty et al., 2018). Strengths-based approaches are underpinned by decolonising methodologies, which shift the focus from Western worldviews and ways of doing, to centre Indigenous worldviews (Fogarty et al., 2018). As such, decolonising methodologies engage with Aboriginal multidimensional concepts of health and well-being to meet individual physical, social, emotional, and cultural needs. Strengths-based approaches reinstate power and control to Aboriginal communities, and nurture empowerment and decision making in individuals. Thus, services that aim to promote the health, well-being and development of urban Aboriginal children, young people and their families need to identify factors that promote, support, and shift the focus from a deficit discourse to a holistic strengths-based approach which better reflects Aboriginal community values and principles (Thurber, et al., 2020).

In this paper we discuss the development of multidisciplinary community-based Aboriginal child health services in an urban community using strengths-based principles. We highlight the opportunities and challenges in addressing Aboriginal child health and demonstrate that access to culturally safe, resilience-building services can produce measurable improvements in health seeking behaviour, maternal health and early intervention.

The context of health for urban Aboriginal children

The health of urban Aboriginal children is rarely reported through a cultural lens that understands the intersection of good health as more than merely the absence of disease. Aboriginal people living in urban areas comprise 60% of the health gap between Aboriginal and non-Aboriginal people and represent only 11% of all studies on Aboriginal health (Eades et al., 2010). While particularly heightened experiences of dislocation, racism and disempowerment continue to contribute to the health disadvantage of urban Aboriginal children, considerable gains have been made in achieving good health and reducing Aboriginal child mortality (Eades et al., 2010).

The majority (39%) of Aboriginal children and young people live in major Australian cities (Australian Institute of Health and Welfare, 2018). Additionally, 76% of Aboriginal young people aged 15–24 report being happy most of the time, and 63% self-report their health as “excellent” or “very good” (Australian Institute of Health and Welfare, 2018). The proportion of Aboriginal children in New South Wales recorded as “fully immunised” remains higher than non-Indigenous children at 60 months of age, highlighting the positive impacts of immunisation programs to protect children and whole communities from infectious disease (Ioannides et al., 2019). Moreover, these statistics exemplify effectiveness and positive behaviour changes that often result from promotion of child health and Aboriginal maternal health services.

Among Aboriginal children and young people, 69% are involved in cultural events, such as National Aboriginal and Islanders Day Observance Committee (NAIDOC) celebrations, ceremonies, “sorry business”, and funerals. The majority (60%) recognise their traditional homelands or traditional country (Australian Institute of Health and Welfare, 2018). There is evidence that suggests having the ability to sustain connection to culture and practice language during a critical transitional period for Aboriginal children and young people is linked with their ability to maintain relationships, cope with additional stressors, look positively to the future and feel confident in having a say on important issues in their community (Australian Institute of Health and Welfare, 2018). Having a strong sense of self and connection to culture is integral to future health and well-being for Aboriginal children and young people.

Active participation and meaningful engagement in schooling, post-school qualifications, housing adequacy, income that meets financial needs, and employment that creates a sense of self-worth are key factors in shaping health and well-being. There are many examples of policies and programs that have had positive impacts on social and economic determinants of health, improving positive life experiences and outcomes for Aboriginal children and young people (Australian Institute of Health and Welfare, 2018). While stronger improvements are still needed, considerable gains have been made in reducing the burden of disease and mortality in children under five, partly due to focused policy aimed at early intervention to improve health outcomes across the life course (Australian Institute of Health and Welfare, 2019). Aboriginal children are more likely to be enrolled in a preschool program in the year before school than non-Indigenous children (95% and 90% respectively) (Australian Institute of Health and Welfare, 2019). There are notable increases in the proportion of Aboriginal children in year five (9 years old) at or above the national minimum standards for reading (63% to 77%) and numeracy (69% to 81%) (Australian Institute of Health and Welfare, 2019). There has been a rise in the rate of Aboriginal year 12 completions, from 47% in 2005 up to 65% in 2016. Of the wider Aboriginal population, the majority of which live in urban areas, more than one in three (34%) Aboriginal young people lived in a home that was owned outright or with a mortgage (Australian Institute of Health and Welfare, 2018).

Methods

How can we enable optimal health outcomes?

Health is commonly referred to by Aboriginal Australians, as “not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole community” (National Aboriginal Health Strategy Working Party, 1989). The diverse social contexts in which Aboriginal people live influences both their health status and their use of health services, and as such, focusing on physical health outcomes alone will continue to provide limited evidence for understanding urban Aboriginal health (Priest et al., 2012). Population health-level data, such as that collected by local Aboriginal health services from a defined geographical location, provides opportunity to understand the complexities of urban Aboriginal children and young people (Brown, 2020; Gardner et al., 2015).

There are examples of self-determination and positive health-seeking behaviours by Aboriginal children and young people. For example, the majority of Aboriginal people aged 15–24 report having strong social support networks that they can count on when navigating challenges, which provides protective factors for mental health and well-being (Australian Institute of Health and Welfare, 2018). Access to safe and secure housing, positive social supports and the capacity to remove oneself from witnessing family violence demonstrate understanding of the social and economic determinants critically important to health and well-being of Aboriginal children and young people (Australian Institute of Health and Welfare, 2018).

A study by Priest and colleagues exploring Aboriginal child health and well-being in an urban setting developed a conceptual, holistic framework comprising four broad themes considered critically important and central to Aboriginal child health and well-being (Priest et al., 2012). “Strong culture” was identified as the core element to supply strength in an individual’s life and provided a basis for “strong child” and “strong environment” (Priest et al., 2012). “Strengths and challenges” recognizes the additional factors faced by Aboriginal children and young people due to social, historical, and political environments (Priest et al., 2012). Actively engaging in community consultation enables participation in the decision-making processes and builds capability in the community, particularly in urban contexts. By developing a greater understanding of the health needs of urban Aboriginal children and young people, organisations can provide increased access to culturally appropriate services (“strong environments”) while facilitating community connectedness (“strong culture”) and early intervention, preventing disease in childhood and negative life course trajectory (“strong child”) (Priest et al., 2012; Eades et al., 2010). To enable optimal outcomes, we need integrated interdisciplinary models of care that are responsive to the needs of the local community, understand the social determinants of health, build resilience, and empower individuals.

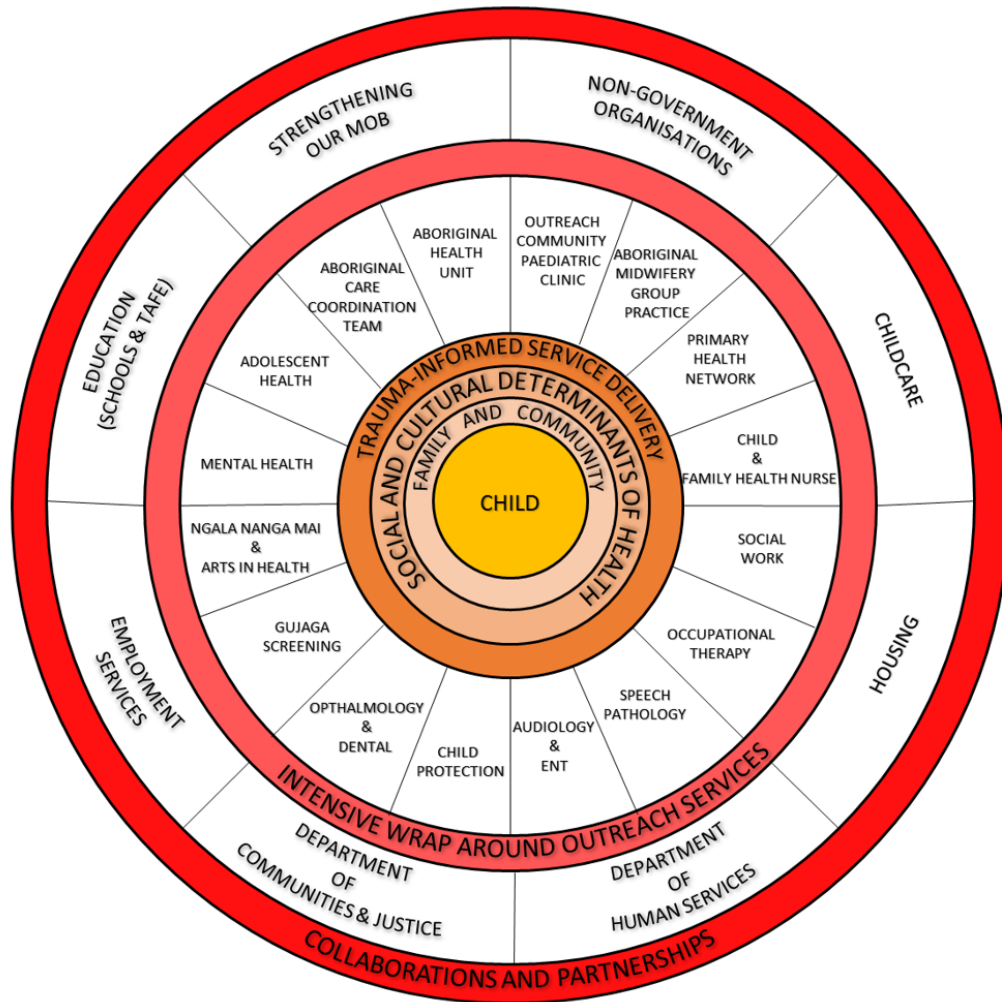
Promoting “strong environments”

La Perouse, a suburb of Randwick City in south-east Sydney on Botany Bay in New South Wales (NSW), is closely linked to the earliest days of European colonisation of Australia. As a former Aborigines’ reserve and with a central role in the land rights struggle in NSW, it has been a mainstay of urban Aboriginal culture for nearly 150 years. Of the La Perouse population, 37% identify as Aboriginal, while children and young people aged 0–14 years comprise 30% of the total Randwick City population (Australian Bureau of Statistics, 2016).

In 2006, La Perouse Aboriginal families and community expressed their concerns to local health service providers for their children’s health and development, including school readiness, psychosocial and behavioural issues, and healthy nutrition. In response, the La Perouse Aboriginal Community Child Health Service Delivery Model was developed (Figure 1). This was based on Bronfenbrenner’s

ecological systems theory, which recognises the complex reciprocal interactions between an individual’s genetic, epigenetic, environmental, and experiential systems (Bronfenbrenner, 1992). The service delivery model has evolved over the past decade and is a formal partnership between the local community and outreach clinical services from Sydney Children’s Hospital, Randwick (SCH) and the Royal Hospital for Women. It is delivered as an intensive wrap-around service for Aboriginal children at the La Perouse Aboriginal Community Health Centre, on the lands owned by the La Perouse Aboriginal Land Council. Intensive outreach services have been offered since November 2006 and aim to provide empowering, family-centred and resilience-building health services; elements that promote “strong environments”. Prevention, treatment, and health promotion strategies are provided in conjunction with educational, housing and employment programs and opportunities, in recognition of the social determinants of health.

Figure 1
La Perouse Community Child Health Service Delivery Model



Promoting “strong culture”

The Ngala Nanga Mai pARenT Group (NNM) Arts in Health program has been running alongside the paediatric outreach services at the La Perouse Aboriginal Community Health Centre since 2009. NNM aims to improve the health of carers and their Aboriginal children by facilitating opportunistic access to health services, promoting parental education, social support, and community connectedness. This is based on the strong evidence base that shows arts in health interventions contribute to the promotion, prevention and management of a range of mental and physical health conditions (Fancourt & Finn, 2019; Stuckey & Nobel, 2010; Davis et al., 2004). The participants are actively assisted to engage with Aboriginal culture, with invited artists running creativity sessions, while the social determinants of health known to improve language and cognitive child development, such as housing, education, and employment, are addressed (Miller et al., 2020). NNM builds on the resilience and assets of the participants to enhance their empowerment and agency, resulting in effective co-designed activities, over a dozen art exhibitions, and commissioned art works. By building on the strengths of the carers, NNM has created a culturally safe space where 93.5% of regular participants engaged their children at least once with paediatric health services (Jersky et al., 2016). Simultaneously, NNM promotes “strong culture” through encouragement of creative expression for healing and sharing knowledge through storytelling, dancing and singing, in spaces intended for discovery and celebration of Aboriginality (Jersky et al., 2016).

Promoting “strong child”

Healthcare includes outreach and drop-in paediatric clinics and community development programs as well as hospital and emergency department follow-up. An Aboriginal midwifery group practice, early childhood nursing, home visiting and parent support groups facilitate engagement with Aboriginal women and mothers to Aboriginal babies throughout pregnancy and into the first 2000 days. The links between midwifery, early childhood and paediatric services enables continuity of care through to 18 years of age for Aboriginal young people and families. Co-located services are delivered by accessible mental health, allied health, audiology, ear, nose and throat, ophthalmology, and dental services. These are supported by Aboriginal reception staff, Aboriginal health workers, and the Aboriginal care coordination team, promoting the “strong child” within a well-supported integrated service system with many positive role models for children and young people.

Responding to strengths and challenges

Each of the services are underpinned by trauma-informed practice principles with enhanced awareness and acknowledgement of the historical experiences that have impacted on the everyday lives of individuals, families and communities attending the services, promoting safety physically, emotionally, and culturally (Atkinson & Australian Institute of Family Studies (AIFS), 2013). The family-centred approach to care, provided in partnership with Aboriginal community, enables healing, fosters positive relationships between services and community and reinstates power and decision making (Atkinson & AIFS, 2013; Thurber et al., 2020).

Results

What has been achieved by this strengths-based approach to service delivery?

Evaluation is the opportunity to understand what a service or program is achieving and provides opportunity to harness and develop community expertise (Kelaheer et al., 2018). The Indigenous Evaluation Strategy calls for a better understanding of programs affecting the health and well-being of Aboriginal and Torres Strait Islander people (Productivity Commission, 2020).

Eight formal mixed methods evaluations have been conducted over the last 10 years of intensive service delivery at the La Perouse Aboriginal Community Health Centre, including observational studies and participant or key informant interviews. These evaluations looked at health promotion, the Arts in Health program, paediatric medical, midwifery and antenatal components collectively. It would be challenging to evaluate any individual components and it is likely that the cumulative impact of multiple services throughout the life course and for different family members adds value. Results demonstrated measurable improvements in health seeking behaviours, maternal health, and intervention in early childhood for developmental-behavioural concerns while also contributing to the limited evidence base on the burden of disease in urban Aboriginal children and young people.

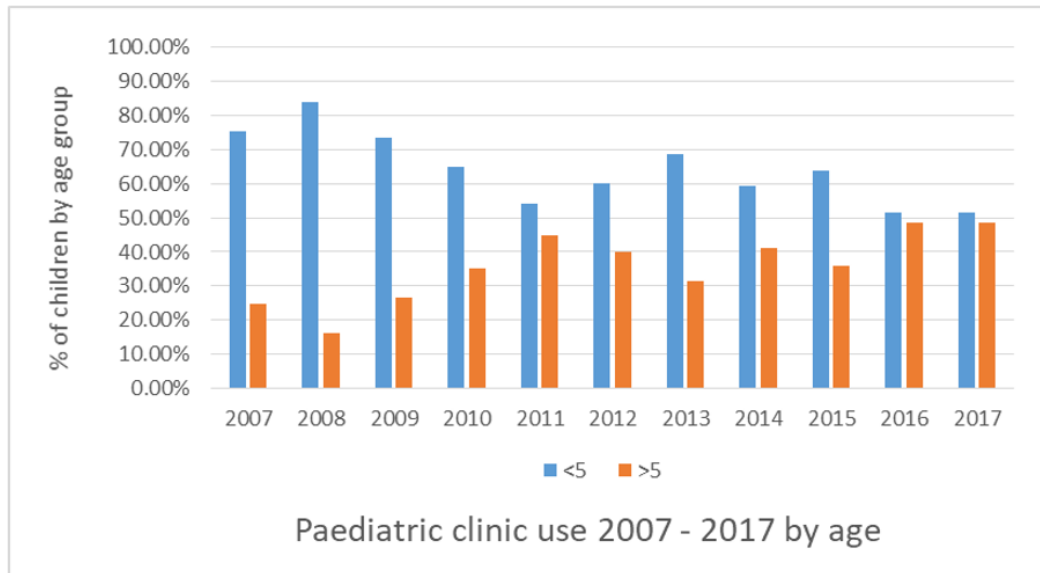
Ethics approval

The Sydney Children's Hospital Network HREC and the Aboriginal Health and Medical Research Council granted approval for this research to be conducted (HREC Reference number: 763/10). This article is based on data previously published

Table 1. Key health outcomes over 10-year period (2007–2017) from the evaluations

Evaluation	Key outcomes 2007–2017
Occasions of service	The occasions of service have increased steadily from 432 during the 2007–2012 period to 609 during the 2013–2017 period, likely reflecting enhanced trust and engagement with the local community (Gardner et al., 2015), (Harding et al., 2021).
Age of children seen	The age of children seen has changed from predominately 0–5 years of age (75%–85% in 2007) to 5 years and over (40–45% in 2011–2012), to equal distribution of both age groups (52%, 48% respectively in 2017). This reflects continuity of care over time (Gardner et al., 2015; Harding et al., 2021).
Caring arrangements	A majority of children were in the care of their parents with 40% of children having a single parent. There was an observed increase in children in kinship care or out-of-home care (2007–2012, 14% and 2013–2017, 26.2%) (Gardner et al., 2015; Harding et al., 2021).
Most frequent diagnosis	The most frequent diagnoses during the periods 2007–2012 and 2013–2017 respectively were developmental delay (39%) and speech and language delay (23.2%) (Gardner et al., 2015; Harding et al., 2021). Mental and behavioural disorders increased and were the most common diagnostic group over the ten-year period (Gardner et al., 2015; Harding et al., 2021). The medical complexity experienced by the children and young people was compounded by a range of psychosocial factors such as poor housing and domestic violence, which are known to be associated with physical and mental health conditions (Henry, 2019).

Diagnosed with a chronic condition	During 2007–2012, 20% of children who attended the clinic had a chronic medical condition (Gardner et al., 2015). From 2013–2017, 73% of children who attended the clinic had ever been diagnosed with a chronic condition (Harding et al., 2021). This study found that the number of diagnoses increased with age and males had significantly higher numbers compared with females.
Most frequent referrals resulting from consultation	From 2007–2012 audiology and ear, nose and throat (ENT) specialists and speech pathology referrals were 49% and 23% respectively (Gardner et al., 2015). From 2013–2017, audiology and ENT decreased to 34.5% while speech pathology referrals increased to 32% (Harding et al., 2021).
Children who required two or more referrals	From 2007–2012, 40% of children required two or more referrals and this increased to 62.56% from 2013–2017 (Gardner et al., 2015; Harding et al., 2021).
Antenatal and perinatal risk factors	From 2007–2014, mothers and babies using the Aboriginal Midwifery Group Practice (Malabar Midwives), saw clinical outcomes of nursery admission, low birth rate and preterm birth rates below that of the NSW Maternal Infant Health Indicators for Aboriginal and Torres Strait Islander mothers (Hartz et al., 2019). Smoking in pregnancy reduced by 25% and breastfeeding at discharge was higher compared to NSW Aboriginal and Torres Strait Islander mothers (Hartz et al., 2019). High levels of psychosocial risk persisted during this period yet the data suggest that the intensive service delivery may have ameliorated the impact on health outcomes (Hartz et al., 2019)
Maternal health	The Growth and Empowerment Measure (GEM) was conducted to assess the impact of NNM on 17 participants in 2012 as compared to 2011. Response scores across 10 empowerment scenarios were significantly higher in 2012 compared to 2011. Most scales showed incremental improvement over time, with significant improvements in feeling happy in oneself, ability to make positive changes in one's life and ability to deal with painful feelings. Levels of psychological distress did not change significantly between 2011 and 2012, however Kessler scores improved in relation to self-motivation and feeling nervous. Overall participants reported decreased feelings of isolation, enhanced connectedness, and keenness to give back to community (Jersky et al., 2016).
Maternal education and employment	From 2009–2012, 27.2% (n = 25) NNM parents enrolled in further education including technical and further education (TAFE), literacy, and business courses. Five gained employment through the assistance of NNM (Jersky et al., 2016). Although we are no longer formally measuring access to education and employment, this continues to be a strong and effective element of NNM and several graduates from NNM have gained employment at our health services.

Figure 2*La Perouse paediatric clinical use 2007–2017 by age*

How has our strengths-based approach responded to the needs identified in the evaluations?

Our evaluations of these services demonstrate the high burden of chronic and complex disease among urban Aboriginal children. Across the reporting periods, we implemented services that were flexible, family-centred, and responsive to the complex needs of the children and families. (Australian Institute of Health and Welfare, 2011). We seem not to have altered the level of psychosocial distress or medical complexity, but have provided a large range of acceptable, accessible, highly utilised services, while building community and individual engagement, empowerment, and agency.

Uptake of paediatric services has doubled since service inception, which likely reflects enhanced trust and engagement with the local community. Community trust was enabled through a “soft entry service” or “drop-in” appointment service; and strengths-based delivery model where a child’s strengths rather than medical diagnoses was highlighted in all patient communication. It is expected, given the increase in paediatric service uptake for chronic disease management, that there would be fewer emergency department presentations however we lack a control group to support this. Building trust and gaining community acceptance is necessary to produce positive health impacts. Interviews and focus groups with mothers and carers at NNM highlighted that the co-located program within the health centre reduced existing barriers to care and effective care-coordination and gave the participants a more holistic appreciation of their child’s health (Jersky et al., 2016).

The age of children seen has remained high in children aged 0–5 years, and over time attendance increased in the proportion of children and young people aged five years and over. This trend may be attributed to ongoing health service engagement, as well as an appreciation that health services can address speech and language delay, psychosocial concerns, school difficulty and developmental-behavioural concerns. The number of diagnoses increased with age and supports

documented negative effects on life course trajectory of complex and chronic conditions in the early years (Henry, 2019).

Mental health and developmental problems dominated across the ten-year period and highlight the complex family lives experienced by the children and young people who attend the service. The community has identified the need for culturally appropriate mental health services that are both rapid and responsive, and that address the social determinants that impact upon health and well-being. Health service delivery improvements include specific outreach child and adolescent mental health services as well as an identified Aboriginal staff to address this. In relation to developmental delay, early intervention is crucial and age of accessing allied health therapies has reduced (Hamill et al., 2022).

The effects of adversity experienced by Aboriginal children begin before conception and extend through childhood and beyond (Henry, 2019). In this study, three important underlying perinatal risk factors – nursery admission, low birth rate and preterm birth rate (Table 1) – were reduced to fall below the NSW average for Aboriginal mothers. The success of reductions of these rates can be attributed, in part, to the model of care, which offers early and repeated opportunities of engagement, enhanced non-judgemental support to enable decision making in a culturally safe and empowering setting. The Aboriginal Midwifery Group Practice (Malabar) service is culturally safe, community-based, community informed and holistic and provides multidisciplinary care and support to women and their families. Evaluation findings report that Aboriginal mothers felt that the Malabar service went “above and beyond” and provided an accessible service that was non-judgemental and culturally sensitive (Hartz et al., 2019). In addition, it has been described as a “significant contributor to women’s social, emotional and physical well-being” (Hartz et al., 2019). This reveals the service is more than a service for pregnancy and antenatal care.

Discussion

Moving forward: considering models of care, lessons learnt and future directions.

Promoting “strong environments”. Building on the strengths of individuals and communities is best practice in supporting chronic and complex needs and has positive impacts on health service access and utilization (Nolan-Isles et al., 2021). Providing parents and families culturally appropriate antenatal and child and youth health services delivered in a child-centred, family focussed, culturally safe environment encourages social connectedness, promotion of child health and well-being and early detection of health concerns. This needs to be sustained over decades to see improved health outcomes in the long-term.

The development of formal and informal partnerships with Aboriginal communities and other services over the ten-year period has resulted in improved access to holistic services, and smoother facilitation of integrated models of care. Additionally, these partnerships have developed the cultural competence of non-Indigenous service providers, enabling them to create positive experiences of cultural safety for Aboriginal children, young people and their families in this and other service provision settings. Relationship building with community and key partners requires ongoing investment.

Promoting “strong culture”. During the ten-year period, NNM achieved and met ten Critical Effectiveness Factors for Youth Well-being as described by Haswell, Blignault, Fitzpatrick and Jackson Pulver (2013). The NNM environment assists the development of protective factors for positive well-being, fosters and nurtures relationships with children and families to feel safe to access services, and promotes confidence and self-esteem. Parents and caregivers can talk through

and learn from life challenges, helping others in decision making processes and developing positive parenting techniques. We plan to expand on the participatory art experiences that provide creative expression for healing, growth and empowerment through discovery and celebration of culture.

Promoting “strong child”. Urban Aboriginal children attending the community child health service have complex and chronic health care needs and can experience similar barriers to care to those experienced by Aboriginal people in regional and remote communities. In this study, we have identified overarching factors that overcome barriers and positively impact on Aboriginal children and young people’s health outcomes (Nolan-Isles et al., 2021). These include flexible referral pathways for patients, families and community, and support from Aboriginal Health Workers to navigate the complex healthcare system and service integration. Our service offering and its evaluations have demonstrated a long-term commitment to enhancing the health and well-being of Aboriginal children, young people, and their families. We need to establish long-term integration across service providers to provide consistency for the community and deepen rapport and trust into the future. Maintaining services that are broad in reach and act synergistically to address adverse experiences in a continuum from conception through to 18 years, and from biomedical health through to the full range of social determinants, is likely to have sustained benefits.

It is possible that this service’s successes could be replicated to inform integrated models of care in other settings for Aboriginal children, young people, and families. This paper’s findings will be presented at conferences and Aboriginal forums to assist other services in replicating such models of care. Using population health data strengthens co-designed services with local Aboriginal children, young people, their families, and the community to create a sustainable model that considers local conditions and demonstrates a long-term commitment to improving Aboriginal child health outcomes.

The data presented here are limited to interventions in one urban community. Service replication and robust evaluation in additional settings, including case studies, may be required for a stronger evidence base to inform policy change. However, this body of work demonstrates long-term commitment set up for sustainability and has prompted local services to continue evaluation and monitoring for culturally enhanced service delivery and design.

Conclusion

Children attending the Aboriginal community child health service have complex and chronic health needs that require early intervention to foster positive health outcomes across the life course. Culturally safe, integrated models of care with interdisciplinary service provision show positive health and well-being outcomes for Aboriginal children and young people. Maintaining engagement and empowering communities to co-design health services that respond to what matters most to the families are needed to reduce the burden of health in urban Aboriginal children and young people. Adequate resourcing and funding will continue to be a challenge, and more work needs to be done in developing culturally appropriate mental health service delivery models of care.

Acknowledgements

We would like to acknowledge the traditional owners of the land upon which we live and work and this research was undertaken; the Bidjigal and Dharawal people. We acknowledge Elders past, present and future, and the First Nations contributing authors on this paper. We would like to thank the La Perouse Aboriginal Community for placing trust in our service delivery and commitment to providing healthcare to nurture the next generation.

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