

The First 1000 Days Policy and Implementers' Symposium Report

Kerry Arabena, Stacey Panozzo and Rebecca Ritte



Goal of the First 1000 Days

To provide a coordinated, comprehensive intervention to address the needs of Aboriginal and Torres Strait Islander children from (pre)conception to two years of age, thereby laying the foundation for their future health and wellbeing.



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Onemda VicHealth Group

Indigenous Health Equity Unit
Centre for Health Equity
Melbourne School of Population and Global Health
Level 4, 207 Bouverie Street
The University of Melbourne, Vic. 3010 AUSTRALIA

T: +61 3 8344 0813

F: +61 3 8344 0824

E: onemda-info@unimelb.edu.au

W: www.onemda.unimelb.edu.au

Authors: Professor Kerry Arabena, Dr Stacey Panozzo and Dr Rebecca Ritte

Managing Editor: Jane Yule @ Brevity Comms

Artwork: Shawana Andrews

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Note on Terminology: In this report the terms 'Aboriginal' and/or 'Torres Strait Islander people' or 'First Peoples' are used to identify the First Peoples of Australia and to refer to and recognise the two unique Indigenous populations in Australia. The term 'Indigenous' refers collectively to the First Peoples of Australia, New Zealand, North America, and other countries around the globe. 'Non-Indigenous' is used to refer to those who do not identify as a member of the community of First Peoples of their respective countries.

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Other publications in this series of First 1000 Days Symposia

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K. Arabena, S. Panozzo & R. Ritte 2015, *The First 1000 Days Researchers' Forum Report*, Onemda VicHealth Group, The University of Melbourne, Melbourne.

K. Arabena, S. Panozzo, R. Ritte, L. Johnston & J. Lyons 2015, *Strengthening Families through the First 1000 Days Community Governance Symposium Report*, Onemda VicHealth Group, The University of Melbourne, Melbourne.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisations
COAG	Council of Australian Governments
DHHS	Department of Health and Human Services (State Government of Victoria)
GUNZ	Growing up in New Zealand [Study]
LSAC	Longitudinal Study of Australian Children
LSIC	Longitudinal Study of Indigenous Children
NDIS	National Disability Insurance Scheme
SIBs	social impact bonds
SNAICC	Secretariat of National Aboriginal and Islander Child Care
VACCA	Victorian Aboriginal Child Care Agency
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Victorian Aboriginal Health Service
VALS	Victorian Aboriginal Legal Service

Terminology

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Executive Summary

This report details the program, proceedings and outcomes of the First 1000 Days Policy and Implementers' Symposium, the fourth and final symposium to be held at, and led by, the University of Melbourne. The aim of the Symposium was to enable policy makers and implementers to identify ways in which policy processes can respond to the evidence generated from the planned First 1000 Days sites in the future, and replicate these findings into other areas of activity across Victoria and nationally.

The focus on the First 1000 Days is important because while the family life of Aboriginal and Torres Strait Islander people is predominantly centred around complex kinship systems and clan structures, with clear lines of rights and obligations to others, an increasing number of our children are vulnerable and at risk. We recognise that, until recently, the education and socialisation of young children took place within the rhythms of family life, the extended family and their Country. We also recognise the intrinsic value of children within our communities.

However, we also acknowledge that these ideals have been radically disrupted for some families, particularly those who have suffered the separation of their children, the destruction of extended family networks, and decades of living in oppressive circumstances – as evidenced by poor health and early deaths, sub-standard housing, poor educational outcomes, high unemployment and large numbers of Aboriginal and Torres Strait Islander people in custody. Despite these hardships, family remains the primary and preferred site for developing and protecting culture and identity in our children.

We also acknowledge, then, the importance of family-strengthening initiatives, the crucial role played by men in raising children and the importance of the First 1000 Days to the future prosperity of Aboriginal and Torres Strait Islander societies. By initiating an early and continued investment in the next generation, we can mitigate connections between adverse early experiences and a wide range of costly problems, such as lower educational achievement and higher rates of criminal behaviour and chronic disease. The First 1000 Days focuses on reducing the burdens of significant adversity on families with young children.

About the Policy and Implementers' Symposium

The First 1000 Days Policy and Implementers' Symposium was held at Graduate House on the University of Melbourne's Parkville campus on Thursday 5 November 2015. More than 100 participants representing over 50 different institutions across seven States and Territories of Australia were present at the Symposium, which was chaired by Professor Kerry Arabena (Chair of Indigenous Health and Director of the Indigenous Health Equity Unit in the Melbourne School of Population and Global Health at the University of Melbourne).

At this fourth and final Symposium, participants heard from researchers, policy makers and implementers working in the area of child health. They provided a continuation of discussions from previous Symposiums concerning the development of a clear, evidence-based strategy to support vulnerable parents and their children in Australia through the First 1000 Days, with a focus on Aboriginal and Torres Strait Islander communities. Participants also considered policy drivers and barriers to sustainable approaches in this area.

The presenters, all of whose presentations are included herein (with audio-visual and full transcripts available on the First 1000 Days website), provided key insights from their experience in local, State and Commonwealth governments, in research and in implementation. Dr Sana Nakata and Professor Leonie Segal brought political and health sciences perspectives concerning early life and giving voice to the voiceless. Representatives from three levels of government – Ms Mary Agostino (City of Whittlesea), Mr Mark Stracey (State Government of Victoria) and Mr Neil Harwood (Australian Government) – gave their respective perspectives concerning investing in the early years and empowering families in early life. Professor Jan Nicholson provided an overview of contemporary longitudinal cohort studies in New Zealand and Australia, presenting clear grounds for a much-needed cohort interventional study of Aboriginal and Torres Strait Islander families and children in early life. Finally, Mr Lyndon Ormond-Parker and Ms Jo Southwell shared their learnings from rural/remote and urban case studies, respectively.

Perverse incentives and policy dilemmas: Reversing policy drivers that entrench disadvantage

The Symposium also provided the opportunity for participant discussions concerning perverse incentives and policy drivers that entrench disadvantage, and, where possible, to consider ways in which to reverse these. In considering perverse incentives and policy dilemmas, participants were asked to consider policy drivers that result in unintended and undesirable consequences, which are summarised here.

Silos and the 'cooperation gap'

The current dilemma of the silos, also referred to as 'cooperation gaps' (Forrest 2014), that exist within and between Commonwealth, State/Territory and local governments and departments. Each of these silos have varying goals as to funding and program ownership, and diverse roles across jurisdictions, thereby adding to the complexity.

Funding cycles and issues of sustainability

Participants also reflected on the policy dilemma of short- to mid-term government funding (i.e. 2–4 years) models, which limit the sustainability and continuity of programs and services within communities. The impact of short-term funding and de-funding of successful services/programs was viewed by participants as further entrenching disadvantage, and providing a disincentive for trust and engagement by Aboriginal and Torres Strait Islander communities. In addition, discussions highlighted that policy is largely informed and driven by a rural and remote perspective of Aboriginal and Torres Strait Islander community needs, over and above those of urban communities.

Issues involving service provision, integration and access

For example, policy drivers that seek to remove children from their families without adequately providing ongoing support for families – in coping with the absence of their children, cultural healing, addressing trauma, etc. – and where possible addressing needs/issues of concern that led to the children's removal, with the long-term goal of re-engaging families with their children.

Participants reflected on the need for a range of service options with a more integrated care approach, which would provide opportunities for consumer choice and engagement with services at any point in time. Culturally appropriate services and interventions that are led by the community, and respond to community needs with culturally responsive and competent delivery of services, are also needed. So too are policy and funding models that value culture and ensure capacity building of both Aboriginal and Torres Strait Islander and non-Indigenous staff in order to enable broader community access to culturally appropriate services.

Such policy dilemmas can be overcome by ensuring engagement with communities to develop an understanding of what community members perceive to be the existing issues or problems, and how these can be best addressed within their community. Establishing and developing the leadership of a local community governance committee was seen by participants as having an essential role in helping to address such policy dilemmas and guide collaboration.

Overall recommendations for reversing policy drivers that entrench disadvantage include the following.

Service integration

- Coordinated and proactive approaches within and across government departments and all levels of government with service providers/ organisations to breakdown existing silos
- Link data across services and governments, and other organisations
- Whole-of-government approaches, similar to that established by the Council of Australian Governments (COAG), be replicated at regional State levels with multiple partner organisations working with Aboriginal and Torres Strait Islander peoples (e.g. VALS, VAHS, VACCHO, and others)
- Tri-level government support for the First 1000 Days initiatives in areas where they will occur
- Integration of services and programs to reflect community needs rather than being just a 'generic' program
- 'Co-design' services with families within communities.

Centralised support

- Assess the feasibility of a centralised reporting mechanism given the current patchwork of funding arrangements for projects/programs and their reporting requirements
- Policy to recognise and incorporate a strengths-based approach
- Bipartisan support to enable long-term continuity and sustainability of funding across all levels of government
- A sustained approach that does not let 'hot-off-the-press' issues result in railroading policy priorities or distracting from current priorities as informed and identified by communities and evidence-based research
- Sustainable funding models to address continuity, cultural responsiveness and competent staff
- Philanthropic investment in projects.

Research and knowledge translation

- Research used to inform policy to be multidisciplinary, holistic and engaged with community
- Policy to recognise and acknowledge the diversity of Aboriginal and Torres Strait Islander communities
- Policy and funding models to include both Aboriginal and Torres Strait Islander and non-Indigenous staff in order to enable broader community access for individuals and families
- Government policy to actively encourages guidance by community
- Relationships to be established with Aboriginal and Torres Strait Islander communities before attempting to help with developing new policy.

Investments in innovations and enablers

- Begin with start-up seed funding from government and, through additional philanthropic investments, develop into an independent entity (see p. 29 for further enablers).

Policy: Sustainable approaches to the First 1000 Days to ensure resilient families

Symposium participants discussed what policy makers can do within both a rural/remote and urban context to build sustainable approaches to the First 1000 Days and what policy frameworks can provide to ensure resilient families. Key factors include:

- sustainability of funding
- bipartisan commitment
- a place-based and strengths-based approach recognising community context.

Enablers and possible interventions for sustainable approaches and ensuring resilient families in rural/remote and urban communities include:

- Business initiatives, such as start-up seed funding from government, that with additional philanthropic investments can develop into an independent entity
- Family-based social entrepreneurialism facilitated by the National Disability Insurance Scheme
- Household-based social entrepreneurialism initiatives, for example, in-home family day care, or nutrition cooperatives for food supply, or Tupperware
- Driving policy change at a local community level, rather than at a government level
- Supporting free Sexual Health Clinics and Youth Clinics as an effective and sustainable approach to ensuring support for families at the preconception stage of the First 1000 days
- Improving the infrastructure, such as telecommunications and satellite services, needed in rural/remote communities
- Within urban communities, implementing technologies that enable the engagement of people with multiple services at one time
- Policy and government funding to allow time for engagement, establishing community governance, collaborations between organisations and setting up a family partnership model to enable future success.

Where to from here?

In December 2015, the Australian Human Rights Commission's Children's Rights Report 2015 recommended that the Australian Government support the First 1000 Days program, stating that:

Recommendation 14: The Australian Government Department of Social Services support the work of Professor Arabena and the Indigenous Health Equity Unit at the University of Melbourne to progress the early intervention research agenda under the First 1000 Days initiative. (AHRC 2015)

As the Australian Model of the First 1000 Days continues to gain momentum, both in partnerships and development, it is paving the way for a longitudinal intervention cohort program. Such a program would include holistic early childhood interventions focusing on (pre)conception to the age of two so as to improve health and wellbeing outcomes for Aboriginal and Torres Strait Islander children through the family environment, and by increasing antenatal and early years engagement as well as service use and provision.

The First 1000 Days team will continue to meet and further develop partnerships with various institutions – including the State Government of Victoria's Department of Health and Human Services (DHHS) – and potential sites, with a range of large non-government community development organisations and also with individuals interested in becoming involved. As partnerships are confirmed, further research and other grant applications will be submitted and work will commence on the First 1000 Days Foundation Project – soon to be formalised by an agreement with a West Melbourne site for the recruitment of parents, their babies and families. The Foundation Project is a proof-of-concept strategy that will be followed by the roll-out of a larger First 1000 Days program of activity in the future.

In other developments, the First 1000 Days team recently met with health economists from the University of Melbourne to discuss the economic benefits and potential impacts of the First 1000 Days program and interventions. Time will now be taken to consolidate membership of both the First 1000 Days Community Governance and Scientific Committees. In March 2016, the Walter and Eliza

Hall Institute of Medical Research is facilitating a workshop on behalf of the Scientific Committee to develop a protocol for a cohort study, such as that being proposed, as part of its Reconciliation Action Plan commitments.

With an international focus, the First 1000 Days team will be hosting the Sami Parliament in February 2016 to discuss the potential of conducting the program in partnership with them in Finland. The team has also secured support from the Australian Indonesia Council to develop a white paper on issues relating to early life, health and development across Australian Aboriginal and Torres Strait Islander communities and Indigenous communities in Indonesia.

As the agenda for the First 1000 Days continues to move forward, the team will seek to further develop its capacity to be the best academic partners for these initiatives on the ground. Two-day First 1000 Days short courses will be commencing in February 2016 for interested individuals, institutions and organisations desiring to be a part of the First 1000 Days program. Additional publications will follow concerning the work of the First 1000 Days and we invite you to check our website regularly for updates and further information.

The Evidence

The First 1000 Days between a woman's pregnancy and her child's second birthday offers a unique window of opportunity to shape healthier and more prosperous futures (1,000 Days 2014). In recent years the perceived importance of the First 1000 Days has gained traction as new evidence emerges as to the impact of maternal nutrition on brain development, the neuroscience of infants, the long-term impacts of early childhood experiences such as stress permanently affecting characteristics usually considered genetic ('epigenetics'), and the capacity of infants to begin structured learning earlier than previously supposed (Arabena 2014).

The evidence shows that:

- Ensuring that the brain achieves its optimum development and nurturing during this peak period of growth is vitally important, as it enables babies to achieve the best start in life (Leadsom et al. 2014).
- From birth to 18 months, connections in the brain are created at a rate of 1,000,000 per second. In the initial years of life, as the brain's nerve cells are developing and growing, the baby's earliest environmental experiences and influences shape its brain development and can have a lifelong impact on the baby's cognitive, language, and social and emotional health and development (Emerson, Fox & Smith 2015; O'Connell, Boat & Warner 2009; RACP 2006).
- A baby or foetus exposed to toxic stress can have their responses to stress distorted in later life. Such early stress can come from the mother suffering from symptoms of depression or anxiety, having a bad relationship with her partner or from an external trauma such as bereavement (CDCHU 2011).
- When a baby's development falls behind the norm during the first years of life, it is then much more likely to fall behind even further in subsequent years than to catch up with those who have had a better start in life (AMA 2010).

- The quality of interactions and attachment – that is, the bond between a baby and its caregivers – strongly affects a child's perceptual, cognitive and linguistic abilities, physical, social and emotional development, physical and mental health, activity, skills and behaviour in adult life (Malekpour 2007; MCEECDYA 2010).
- Babies are disproportionately vulnerable to abuse and neglect, which can impair a child's early brain development (Filetti et al. 1998; Anda et al. 2006). A number of our children are living in complex family situations, or at heightened risk in households with problems such as substance misuse, mental illness or domestic violence. Many of the statistics show that serious case reviews involve children under the age of 12 months (Morgan & Chadwick 2009).

When children have opportunities to develop executive function and self-regulation skills – which are crucial for learning and development – both individuals and society as a whole benefit. In vulnerable families, we need to build the capabilities of adult caregivers in order to achieve good outcomes for the children in their care. By supporting the development of children's and caregiver's self-regulation skills, mental health and executive functioning, we can improve the economic and social stability of the family, thereby maximising the health benefits that will positively impact on young children across their life-course (CDCHU 2015).

The First 1000 Days

A radical change is required in how we think about and enhance the early outcomes for Aboriginal and Torres Strait Islander children in Australia (SNAICC 2013). Too many children and young people do not have the start in life they need. As our understanding of developmental science improves, it becomes clearer and clearer that adverse events in a child's life lead to structural changes in brain development that have life-long and societal ramifications (TLRP [n.d.]). We now also know these ramifications are intergenerational (Lee & Macvarish 2014). Not intervening will affect not only this generation of children, but also the next. Those who suffer adverse childhood events achieve less educationally, earn less and have worse health outcomes – all of which makes it more likely that the cycle of harm is perpetuated in the following generation (Leadsom et al. [n.d.]).

The First 1000 Days Scientific Symposium was a call to consider the implementation of new interventions founded in rigorous science, and to consider the opportunities inherent in the 'critical window of opportunity' from conception to the age of two. International research shows that early intervention programs during pregnancy and in the early months and years of a child's life have tremendous positive impacts on health later in life. The physiological, educational and emotional environment of the child in this 'First 1000 Days' has been shown to exert a profound impact on long-term developmental and life trajectories (Illig 1998; The Lancet 2013; The Save the Children Fund 2013).

In our communities, pregnancy, birth and the first 24 months can be tough for every mother and father. Some parents find it difficult to provide the care and attention their baby needs (Arabena et al. 2015). This same time period can also be a chance to affect great change as parents are usually receptive to offers of advice and support, and agencies are able to provide seamless services emphasising community leadership, workforce development, and coordination of effort, partnerships and collaboration.

In the Australian context, early intervention support for mother and baby is not always available to Aboriginal and Torres Strait Islander children. As

a result, they can be subject to poorer health and cognitive development than non-Indigenous infants. This has life-long health and wellbeing implications that impact at the individual, family, community and societal level (McHugh & Hornbuckle 2010).

Thus, the Australian Model of the First 1000 Days is being developed as an approach to improving health outcomes for Aboriginal and Torres Strait Islander children and to maximise the potential of all children. Coordinated by Professor Kerry Arabena, the First 1000 Days will focus attention on preconception, maternal antenatal and postpartum nutrition and healthy lifestyle strategies, and nutritional, social, environmental, educational and family supports for the developing infant and child (The University of Melbourne 2015).

Recent evidence demonstrates there are many areas that could be used to guide the development of targeted interventions for the Australian Model including:

- impact of maternal nutrition on brain development
- neuroscience of infants
- long-term impacts of early childhood experiences such as stress, which may permanently affect characteristics usually considered genetic ('epigenetics')
- capacity of infants to begin structured learning earlier than previously supposed
- building the capabilities of adult caregivers in vulnerable families
- developing executive function and self-regulation skills in the child.

This approach will also involve health care workers, community organisations and all levels of government to address local and systemic-level issues contributing to the growing gap in infant and parental health between Aboriginal and Torres Strait Islander and non-Indigenous Australians. These issues include preconception, maternal and child health, parental support, early childhood education, housing availability and quality, and poverty reduction.

The impact of capacity building in these areas can be global and enduring. For example, when children have opportunities to develop executive function

and skills in self-regulation – crucial for learning and development – the positive outcomes and health benefits to the child extend to improvements in the economic and social stability of the family, and to society as a whole (Vimpani, Patton & Hayes 2004).

Furthermore, interventions in the First 1000 Days have already shown demonstrable and far-reaching outcomes (1,000 Days 2014), such as:

- saving lives
- significantly reducing the human and economic burden of communicable diseases such as tuberculosis, malaria and HIV/AIDS
- reducing the long-term risk of developing some non-communicable and chronic diseases including diabetes
- improving educational achievement and earning potential
- improving a nation's gross domestic product.

Figure 1 (page 8) provides a summary of the intervention points across the life-course and the possible areas of focus for the Australian Model of the First 1000 Days.

By giving children the best start in the First 1000 Days of life we are enabling them to develop to their full potential as psychologically and physically healthy, socially engaged, well-educated and productive adults. By contrast, adverse experiences for the child in this period can derail healthy development, and create learning, behavioural and health challenges that place a heavy burden at the individual, family, community, and national level.

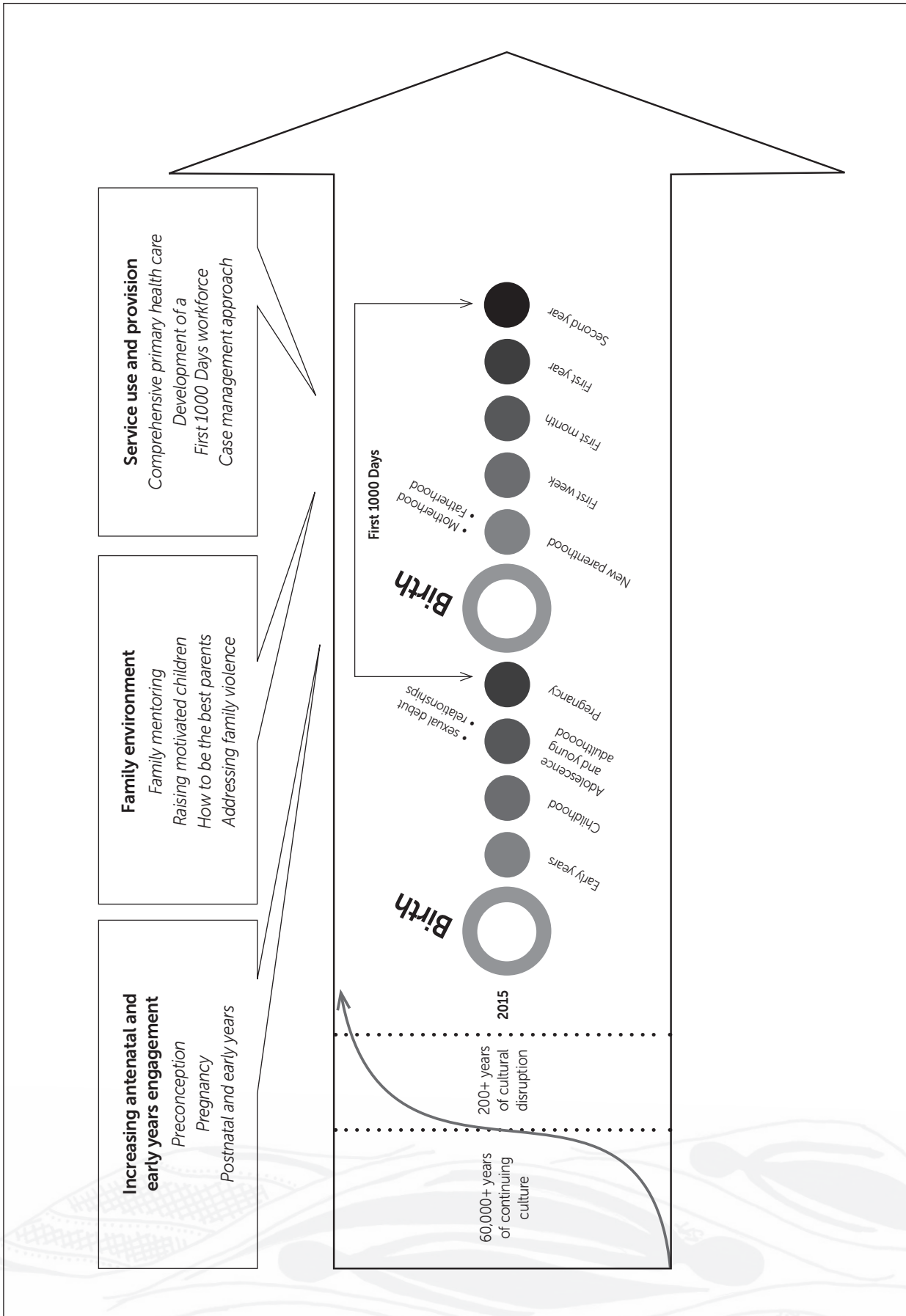


Figure 1: Intervention points across the life-course and possible areas of focus

Overview of Presentations at the Policy and Implementers' Symposium

The following section provides a brief overview and summary of the presentations given at the First 1000 Days Policy and Implementers' Symposium. These are grouped under the following headings:

- Why give a voice to the voiceless?
- Nested policy responses: Empowering families through early life
- Policies, environments and preparation for contemporary parenthood.

Audio-visual clips of the presentations in their entirety are available on the Indigenous Health Equity Unit's website.

Why give a voice to the voiceless?

Democratic representation: Analysing the politics of childhood in 21st century Australia

Dr Sana Nakata, School of Political Science,
University of Melbourne, Victorian Aboriginal
and Islander Child Care, Melbourne

Children figure frequently and significantly in an array of debates that shape contemporary politics. Throughout 2015, images of children drowning and drowned at sea have once again punctuated debates about immigration policies at home and abroad. In Australia, education policy, parental leave, childcare funding, marriage equality, the Royal Commission into institutional responses to child sex abuse and domestic violence agendas all pivot on concerns about children. In September 2015, then Communications Minister Malcolm Turnbull even invoked the 'future of our children's jobs and our grandchildren's jobs' in advocating and negotiating for the China–Australia Free Trade Agreement. Children are often thought of in relation to these and many other political debates and contexts, but it is also important to think of children in highly critical, creative and constructive ways.

Despite the fact that claims to represent children's interests are such a present part of political debate, children's relationship to the political realm remains primarily figured in terms of their apolitical or pre-political status. They are not conceptualised as political beings, with even older children who have some capacity rarely representing themselves in political debates. As a result, the treatment of children in politics is necessarily derivative of the representative claims that adults make about them in political and policy settings, with them appearing either as the subjects of policy and policy-making or as rhetorical devices used for political posturing or claim-making.

Examples that illustrate this debate include:

- Elizabeth Eckford, the African–American teenage student who, in 1957, attempted to enter the newly desegregated Little Rock High School in Arkansas in the United States of America (USA). Eckford's photograph was emblazoned across American newspapers and magazines and raised an intense debate between the philosopher, Hannah Arendt and the African–American author Ralph Ellison. Arendt argued that using Eckford's photo in this way was totally inappropriate, and that children should not be part of politics nor be burdened with these violent and deeply political conflicts. Ellison countered that argument most persuasively, to the point that he did change Arendt's mind, in arguing that you couldn't be an African–American girl in the USA in 1957 and not be political.
- James Bulger, a two-year-old child who was abducted, tortured and murdered on local train tracks by two 10-year-old boys in Liverpool, United Kingdom (UK). The two older boys were found guilty of abduction and murder in 1993. This controversy created a serious debate in the UK regarding the treatment of juveniles in criminal culpability and whether or not children could be held accountable for violent crimes. Some argued for these two boys to be held fully accountable under the weight of adult criminal law, with others even petitioning for the reintroduction of the death penalty. This case immediately juxtaposes two very contrasting conceptualisations of children, and two simultaneous truths – of the innocence

of childhood coexisting with the capacity of very young children for violence and criminal conduct.

- Bill Henson, an Australian photographer, who in 2008 exhibited photographs of a naked girl on the cusp of adolescence, had his photographs withdrawn from exhibition by the New South Wales police after accusation they were pornographic. Henson's works solicited commentary from the then Prime Minister Kevin Rudd, who described the photographs as 'revolting' and without artistic merit. The arts community and Henson's other defenders argued that his works were non-sexual in nature and opposed their censorship.

The intriguing aspects of these briefly illustrated debates emerge from tensions in how we make sense of children in our political landscape. On the one hand, children aren't regarded as political creatures because their capacity for political agency is limited by an emerging rather than a fully formed grasp of reason, maturity and autonomy – the three conditions of political agency. So they're either considered to be apolitical beings, which Arendt tried to suggest in the case of Elizabeth Eckford, who have no political claims of their own to self-articulate and who instead must remain safely in ensconced innocence with a supposedly unproblematic family life in the private realm. Or they are pre-political becomings who need carefully constructed and regulated environments through which they can develop into rational communicative members of the public and political realm.

These accounts of apolitical or pre-political status are rooted in the depths of the history of Western political thought, but they continue to operate in ways that position children in relation to, but always outside of, politics. This compels a range of questions, including:

- Are children excluded from political life because they have no politics of their own? Or because they need time, practice and education to learn how to be political creatures?
- If children aren't political creatures, then why do they keep appearing in these highly political moments, at the heart of debates around education, crime, deviance, of sexuality and of immigration?

- If children aren't political beings, then why do they keep turning up in cases such as these?

It is important to consider what it means to represent children in a democratic society, and what 'democratic representation' means for a population without political status, to better inform our understanding of the lives of children and contemporary politics. It can be argued that democratic representation has dimensions both of reason and knowledge, but also of emotion and imagination, that together determine how the represented child comes to be constituted in these political debates.

In the case of the very young, including those in their First 1000 Days, who have no capacity to represent themselves in political forums, we are obliged democratically to broaden our understanding of the representative claim beyond the boundary of rational knowledge and empirical truth. We are also obliged to recognise that emotion and imagination is a legitimate and a determinant dimension of how these claims come to be discursively contested and operate as a central dynamic in democratic politics and decision making.

Complex and compounding early life adversities in understanding life course health and wellbeing and the desirable policy response

Professor Leonie Segal, School of Health Sciences, University of South Australia, South Australia

The nature of disadvantage is multi-dimensional, and there is accumulating evidence that the layering of adversities increases the likelihood of negative consequences (Fryers & Brugha 2013). A better understanding of how combinations of adversity impact on behavioural, educational and economic outcomes allows the most vulnerable groups to be more clearly identified in the targeting of services.

Australia has a policy commitment to equity and giving the best start in life to all our children. However, this cannot be achieved by a classic population health prevention/universal model focused on a non-exposed group, as many of our children start life at a profound disadvantage so are already 'exposed'. Prevention in this context is best

understood as 'disrupting the intergenerational cycle of disadvantage'. This suggests a focus on the most vulnerable at pre-conception, in young families, and into middle childhood and youth.

The existence of multiple adversities highlights the need for cross-portfolio action to address the complex set of factors responsible for poor health and wellbeing, social and economic outcomes. Effective cross-portfolio action will need to include:

- therapeutic mental health services to address past/current traumas
- strategies to address insecure housing, disengagement from school and work, and harmful approaches to self-medication
- a trauma-informed response by the child protection, criminal justice and social security systems.

Why are parents struggling to be the sort of parents they want to be? Work led by Senior Child Psychiatrist Dr Jackie Amos focuses on mothers and children caught up in highly distressing and aversive relationships to understand in a deep way why mothers maltreat their children. Drawing on ethology, evolutionary biology, attachment theory and trauma theory, the aim of this research is to improve the quality of therapy to ensure better outcomes for this group of severely distressed mothers and their children. What is clear is that mothers and their children can become highly traumatising for each other and any successful therapy will need to employ a classic graded exposure response prevention protocol (Amos et al. 2011; Furber et al. 2013). The underlying findings are highly significant for other disturbed relationships, as found in domestic violence, which often have their genesis in early childhood trauma (Amos et al. 2011; Furber et al. 2013).

Barriers to supporting children and families who are experiencing compounding early life adversities may include, but are not limited to:

- service provider and/or clinician reticence due to challenging client base and impact on key performance indicators
- organisational barriers to develop and deliver holistic interventions.

There is a need to target our most vulnerable families to provide respectful service delivery across health and human services sectors. An increase in resources – including supported outreach services, professional development and capacity building for service providers to deliver a cross-disciplinary family-centred approach, and health promotion and nutrition services in early childhood – is also needed to ensure community child and family mental health services are centres of excellence. As a society we cannot afford to fail in supporting vulnerable families to create a more nurturing environment for their children – the cost of failure in personal and economic terms is simply too high.

Nested policy responses: Empowering families through early life

Local Government: City of Whittlesea and Bubup Wilam for Early Learning: Aboriginal Child and Family Centre

Ms Mary Agostino, Executive Manager Advocacy,
City of Whittlesea, Victoria

The Bubup Wilam for Early Learning Centre or Bubup Wilam, which means 'Children's Place' in the Woi Wurrung Language, was officially opened in 2012 in the City of Whittlesea. Bubup Wilam is an education centre providing programs for Aboriginal and Torres Strait Islander children, families and the local community. The focus of Bubup Wilam is on early childhood development and wellbeing with an



Figure 2: Logo provided by Bubup Wilam for Early Learning: Aboriginal Child and Family Centre

emphasis on cultural education including language development, literacy, maths and science programs. This program is self-determined by the local Aboriginal and Torres Strait Islander community.

Regarding the centre's journey of policy through to delivery, in 2008 the State Government of Victoria met with the local Aboriginal and Torres Strait Islander community in the City of Whittlesea to understand its priorities, which first and foremost were the children of the community. Through a small amount of government funding (\$40,000), the City of Whittlesea then partnered with the local Aboriginal and Torres Strait Islander community in opening an 'interim Bubup Wilam' at a former kindergarten site. Soon after the 'interim Bubup Wilam' opened its doors in 2009, major funding became available from the State and Commonwealth Government's National Partnership of Indigenous Early Childhood Development. This gave the City of Whittlesea an opportunity to partner with the local Aboriginal and Torres Strait Islander community to develop the permanent Bubup Wilam for Early Learning Centre. Bubup Wilam has currently reached its capacity intake of 80 children.

The key to the successful development of Bubup Wilam is the strong community engagement and partnership developed and maintained between the City of Whittlesea and the local Aboriginal and Torres Strait Islander community. This engagement, together with the strong focus, vision and passion of the community itself, enabled the establishment of an education centre that is designed and developed by and for the community. It is a Centre with integrated services that are self-determined and community controlled, and which aim to provide Aboriginal and Torres Strait Islander pre-school children and their families with the best education possible and a smooth transition through to primary school.

The State Government of Victoria's DHHS plays a key role in facilitating and enabling 'the right' policy setting, whereby integrated policy responses can empower Aboriginal and Torres Strait Islander families and communities. Essential to this is community engagement, co-design and conversation about empowering both people and our organisational partners to innovate and collaborate on key reforms aimed at strengthening vulnerable families and creating safe places for children to thrive.

There is a need for the State Government to recognise not only where innovation and partnership can occur in the future, but also to ensure recognition of, and support for, the continued investment in those existing services and programs that are making a positive impact on families and communities.

State Government: Reflections on policy directions and reforms

Mr Mark Stracey, Department of Health and Human Services, State Government of Victoria, Victoria

The State Government of Victoria's Aboriginal Health strategy, Koolin Balit, aims to increase the life expectancy of, and access to health services for, Aboriginal people by 2022. This involves a commitment by the mainstream health system to make a significant and measurable impact on improving the length and quality of Aboriginal Victorians' lives over this 10-year period (Department of Health 2012). The Aboriginal Health Branch together with the Department of Human Services Aboriginal Outcomes Branch are working together with a greater focus on incorporating a holistic definition of health, acknowledging the broader social determinants of health and addressing disadvantage. The following six key priority areas have been identified (see Figure 3).

Almost \$120 million of State Government funding has been dedicated to Aboriginal health over the past six years, with more than half of this contributed in the last two years. This reflects the Government's bi-partisan commitment to Aboriginal and Torres Strait Islander health. The funding is split, with approximately half directed toward supporting State-wide initiatives, including but not limited to:

- increasing and enhancing health sector workforce
- improving access to culturally responsive services
- promoting healthy lifestyles and reducing risks
- a State-wide eye health strategy, and other initiatives that deliver with a State-wide perspective.
- strengthening young Aboriginal people's connection to community, culture, positive social norms and healthy behaviours.

With a commitment to building governance capacity and supporting communities at the local level, the remaining funding has been directed to eight regional Closing the Gap steering committees, which are comprised of Aboriginal health organisations, Local Indigenous Networks, mainstream providers and (sub)regional organisations. These committees are responsible for making localised decisions, based on local community health needs and priorities, and informing implementation strategies (Department of Health 2012). Central themes consistently heard from the Victorian community, Aboriginal people and leaders, the social and health service sectors and key stakeholders provide the State Government of Victoria with a focus on what needs to be built on and what needs to be done differently. These themes include:

- genuine engagement and partnership with Aboriginal people
- that children are part of a family, embedded in community and culture
- a greater focus on prevention and the social determinants of health
- that parts need to work better as a whole service system
- strengthening the cultural competence of all services
- strengths-based and person-focused approaches
- getting policy right so as to better link and leverage efforts
- getting it right for Aboriginal people means getting it right for everyone.

Traditional policy, which has focused on existing client groups or service areas, has had the advantage of enabling effective short-term implementation, but can create policy silos and fragmented approaches. This can be seen in much current policy and service provision where the system focuses on a singular view of the child rather than taking a more systemic focus in which the child is part of a family and the community, connected to culture and to Country. Traditional policy approaches can also create silos across government portfolio areas, resulting in difficulty achieving integration and co-contribution.

Thus, there is a need to generate opportunities for conversations on collective leadership and co-design by government and community leaders, and to create greater alignment across portfolios, particularly in social and economic policy.

The State Government is experiencing many key changes in social policy and reforms that have been implemented or are in the process of consultation, which require increased engagement with community and the sector in their development. This includes the DHHS, in collaboration with other government departments, leading the 'Roadmap for Reform: Strong Families, Safe Children' – an important and ambitious project to reshape the way Victoria protects and supports vulnerable children and families from the ground up. It aims to create a children and families services system that makes it more likely to have more children:

- living safely at home with their families
- reunited with their families
- in home-based rather than residential care.

Further to this, the 'Education State: Early Childhood Development Reform' led by the Department of Education and Training, with DHHS a co-contributor to the conversations, focuses on the early childhood years so that the success already available to many within our community is available for all. Its focal areas are:

- improving Maternal and Child Health services
- supporting parents and children
- enhancing early childhood education and care services.

The recently convened Aboriginal Children's Summit, led by the Hon. Jenny Mikakos, Victorian Minister for Families and Children and for Youth Affairs, represents a new way of listening more deeply to the Aboriginal and Torres Strait Islander community on specific issues and working together:

- to achieve a reduction in the over-representation of Aboriginal children in out-of-home-care
- to progress work on providing support for vulnerable Aboriginal children and young people
- to promote strong Aboriginal families so children can thrive.

The DHHS's Sector and Community Engagement Branch and Aboriginal Health and Wellbeing Branch seek to enable the Department to develop, design and deliver culturally responsive policies, service delivery models and programs through meaningful and effective engagement with sector partners and Aboriginal and Torres Strait Islander communities to achieve the Victorian Government's objectives for closing the health gaps between Aboriginal and the wider community. This enables a platform for engagement for the Aboriginal community and DHHS to come together as equal partners to create a new, inclusive and enduring dialogue to achieve the shared goal of Aboriginal people living well and

prospering within the Victorian community. The Sector and Community Engagement Branch's new approach sits across a large number of complex services systems that can often be fragmented or silos.

Aboriginal communities continue to be among the State's most vulnerable and disadvantaged communities. Getting it right for Aboriginal and Torres Strait Islander people and communities offers us the opportunity to learn from them about resilience, social cohesion, self-determination, as well as working effectively with communities to empower themselves to move out of disadvantage.

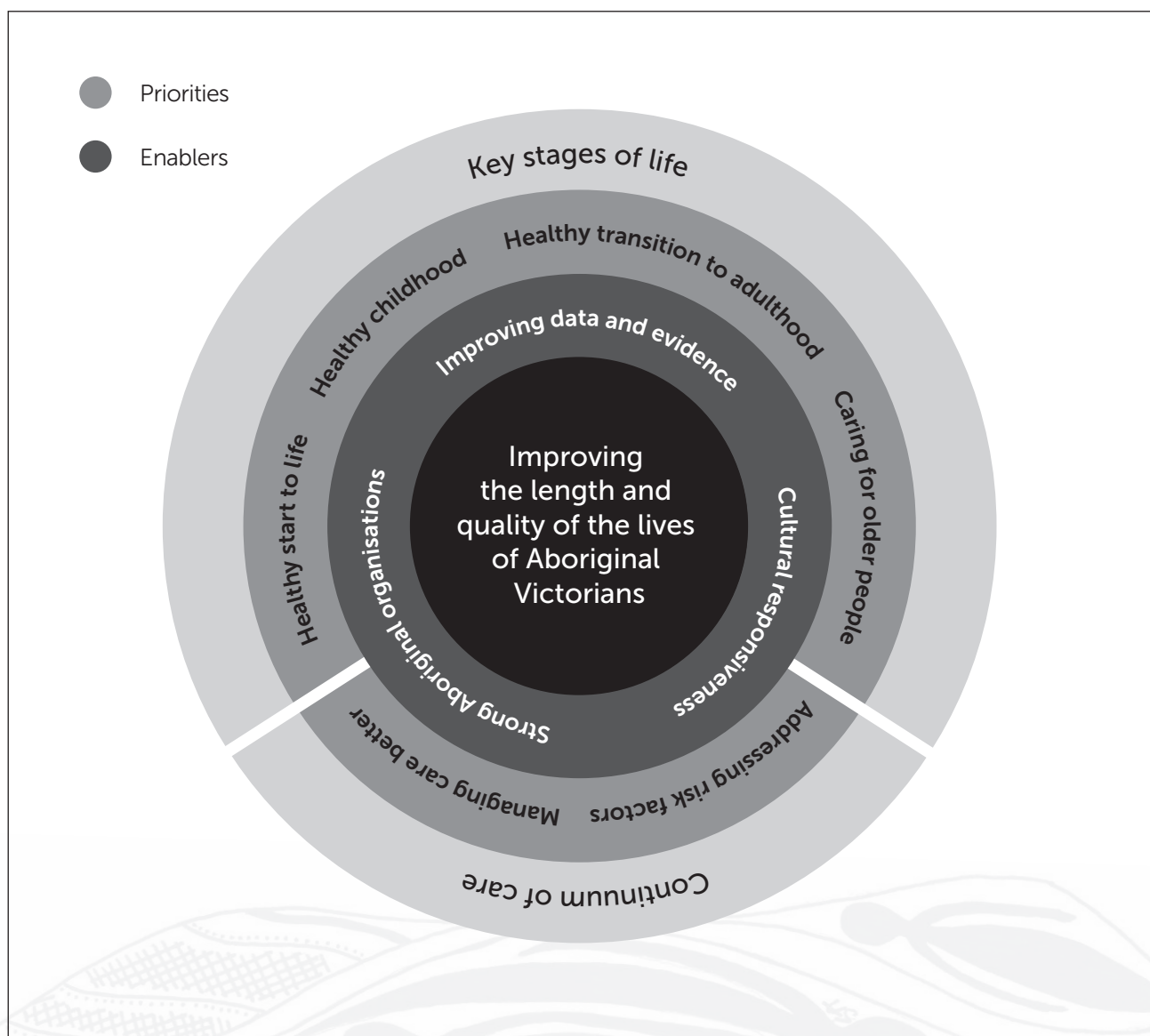


Figure 3: Koolin Balit's 6 key priorities and 3 foundational key enablers to support achieving priorities
(Dept of Health 2012)

Australian Government: Investing in the early years

Mr Neil Harwood, Early Childhood and Higher Education Branch, Department of the Prime Minister and Cabinet, Australian Government, Australian Capital Territory

Working nationally, the Australian Government plays a key role in influencing the national agenda and working with State and Territory governments through mechanisms such as the Council of Australian Governments. The First Ministers of the COAG have agreed that a national effort is required to improve early childhood education, early years and maternal health outcomes for Aboriginal and Torres Strait Islander children.

Working nationally

- Council of Australian Governments
- Closing the Gap in Indigenous Disadvantage – Early Childhood Targets
- Investing in the Early Years – A National Early Childhood Development Strategy
- National Aboriginal and Torres Strait Islander Health Plan (2013–2023)

Working with States and Territories

- The National Aboriginal and Torres Strait Islander Education Strategy
- The National Partnership Agreement on Universal Access to Early Childhood Education
- Working bilaterally to improve access and integrated services delivery

Working with service providers

- Regional Network.

Ongoing Commonwealth collaborations investing in the early years include, but are not limited to, the following areas..

Working nationally

Previously, COAG agreed to Closing the Gap in Aboriginal and Torres Strait Islander disadvantage and set two major early childhood targets. The first target was halving the gap in mortality rates for Aboriginal and Torres Strait Islander children under five years of age by 2018. There has been significant progress on narrowing this gap – between 1998 and 2013 it has dropped by 31 per cent – but there is still a way to go (Commonwealth of Australia 2014). Collectively, governments continue to be hopeful that this target will be met by 2018 (Commonwealth of Australia 2013). The second target was to ensure access to early childhood education for all Aboriginal and Torres Strait Islander four-year-olds in remote settings by 2013. Although this target was not achieved, governments are nevertheless still working on ways to improve these children's access to education.

Further national strategies in the early childhood space are spread across a number of Commonwealth agencies to improve outcomes on the ground, and include 'Investing in the Early Years – A National Early Childhood Development Strategy', which is led by the Department for Education and Training (COAG 2009). In addition, the implementation strategy for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 was launched in October 2015 (Department of Health 2015). This outlines the actions to be taken by the Australian Government, the Aboriginal community controlled health sector and other key stakeholders to give effect to the Plan's vision, principles, priorities and strategies. Led by the Department of Health, the Plan has 20 practical actions to improve the health of Indigenous children and adults, including:

- increasing the percentage of Indigenous children from birth to four years of age who have at least one health check a year from 23 per cent to 69 per cent by 2023
- increasing the percentage of Aboriginal and Torres Strait Islander children who are fully immunised by the age of 1 from 85 per cent to 88 per cent by 2023 (Department of Health 2015).

Working with State and Territory governments

The National Aboriginal and Torres Strait Islander Education Strategy was agreed upon by Education Ministers in September 2015 (Education Council 2015). An extension has also been provided to the National Partnership Agreement on Universal Access to Early Childhood Education. Following agreement by the First Ministers of the COAG in 2015 concerning national efforts to improve early childhood education, early years and maternal health outcomes for Aboriginal and Torres Strait Islander children, the Australian Government is now working bilaterally with State and Territory governments to identify opportunities for collaborative work and to improve access and integrated services delivery.

Working with service providers

Since 2013, there have been recent changes in the Australian Government, with the Indigenous Affairs Group now working within the Department of the Prime Minister and Cabinet, and the development of a Regional Network spread across 12 regions, with 630 staff in 100 locations across Australia. The Regional Network staff are positioned and available to work directly with communities and service providers in developing regional strategies that will articulate the challenges and opportunities of each region. This approach ensures that regional issues and priorities are clearly understood at the Federal level, provide a rationale for future funding and inform policies and programs going forward.

Finally, there are a number of initiatives or strategies in place across agencies at the national level, which are designed to fund those programs or projects at the grass-roots level focused on improving health, development and education outcomes for Aboriginal and Torres Strait Islander children and their families.

These include the following national, place-based and universal strategies:

- Indigenous Advancement Strategy with a focus on children and schooling
- Australian Nurse Family Partnership Programme
- New Directions: Mothers and Babies Services
- Home Interaction Program for Parents and Youngsters (HIPPY) (DSS 2015)
- Stronger Communities for Children
- Child Care Safety Net (Community Child Care Fund and Integrated Early Childhood Service Delivery).

The Australian Government is focused on investing early in a child's development, and aims to:

- improve Aboriginal and Torres Strait Islander children and families access to universal services
- improve the flexibility and responsiveness of government-funded programs and projects
- continue its focus on Closing the Gap
- look for opportunities to share data and reduce red tape in this process
- work with service providers to build their capacity to build evidence-based programs to maximise quality
- work with a focus on engaging and supporting Aboriginal and Torres Strait Islander parents and families so they can give their children the best start in life.

Policies, environments and preparation for contemporary parenthood

Influences on the health development of Aboriginal and Torres Strait Islander children

Professor Jan Nicholson, Judith Lumley Centre, La Trobe University, Victoria

Across Australia and New Zealand there have been a number of cohort studies undertaken to further our understanding of early childhood, education and health (see Table 1). These include, though are not limited to, such examples as the:

- Growing up in Australia: The Longitudinal Study of Australian Children (LSAC)
- Footprints in Time: The Longitudinal Study of Indigenous Children (LSIC)
- Growing up in New Zealand (GUNZ) study.

These and other types of early childhood longitudinal studies have each sought to learn from, and consider, further aspects of early childhood, education and health that have not yet been fully explored in earlier research.

Growing up in Australia: The Longitudinal Study of Australian Children

The LSAC began in 2004 as part of the Australian Government's Stronger Families and Communities Strategy, conducted in partnership between the Department of Social Services, the Australian Institute of Family Studies and the Australian Bureau of Statistics. This multidisciplinary study commenced with two cohorts – including 5000 children aged 0–1 years and 5000 children aged 4–5 years – and data collected every two years. By studying the impact of Australia's unique social and cultural environment on the next generation, the LSAC seeks to address a range of research questions by understanding aspects of:

- parenting (from both mothers and fathers)
- family relationships
- children's physical health and social, cognitive and emotional development

- childhood education
- children's experiences of non-parental child care (Growing up in Australia 2012).

Although LSAC sought population parity in the recruitment of Aboriginal and Torres Strait Islander children to the study, final numbers were undersubscribed. Thus, Footprints in Time: LSIC was established to provide further understanding of what happens to Aboriginal and Torres Strait Islander children in early childhood and how it affects their later life. Funded and managed by the Australian Government, this study looks at different development pathways in early childhood and the contributing factors to improved social, emotional, educational and developmental outcomes (Bennetts Kneebone et al. 2012). The study commenced in 2008 with a total of 1680 families forming two cohorts, including one aged six months to two years and one aged three years and six months to five years. Strengths of the study include the level of community engagement in its development, the protection of contributors' privacy, and the geographical and socioeconomic diversity of participants (Thurber et al. 2014). Data collection 'waves' occurred every two years.

The GUNZ longitudinal study follows the development of approximately 7000 New Zealand children from before birth to young adulthood. Themes informing the GUNZ study can be seen in Figure 3. Data collection commenced with the recruitment of pregnant mothers and their partners, who lived in Auckland, Manukau County or Waikato County and had an estimated delivery date between April 2009 and March 2010 (Morton et al. 2010). The study then collected information about development during pregnancy (before birth) and over the first two years of life, with multiple data collections during this time. In addition to considering the antenatal influences on child development, GUNZ also has:

- four data collection points during the first two years of life
- included fathers and partners
- focused on recruiting an ethnically diverse cohort representing births in New Zealand
- focused on an interdisciplinary and life-course approach to child development

Table 1: Australian and New Zealand birth cohort studies commencing since 1970 (Nicholson & Rempel 2004)

Study Name	Year Began	Location	Sample Size	Sample Characteristics	Recruitment Period	Age at recruitment	Number of follow-ups	Age at follow-ups	Status
Aboriginal Birth Cohort (Aboriginal)	1987	Darwin, Australia	686	Aboriginal, birth cohort	4 years	Birth	1 plus continuous	10–13 years, plus continuous health data collection	Ongoing, subject to funding
Australian Temperament Project (Temperament Project)	1983	Victoria, Australia	2433	Representative	2 weeks	4–8 months	12	Approx. 20, 34 months, 4, 6, 8, 10, 12, 13, 14, 16, 18, [20] years	Ongoing
Brunswick Family Study (Brunswick)	1978	Brunswick, Victoria, Australia	304	Representative of poor, multiethnic urban community	6 months	Birth	15	8 times up to 44 weeks, 4 times at 4 years, 3 times at 11 years	Ceased
Christchurch Health & Development Study (Christchurch)	1977	Christchurch, New Zealand	1265	Birth cohort representative	4 months	Birth	20	4 months, annually from 1 to 16, 18, 21 years, [25 years]	Ongoing
Dunedin Multidisciplinary Health & Development Study (Dunedin)	1972	Dunedin, New Zealand	1037	Birth cohort, representative	12 months	Birth	10	Every two years from 3 to 15, 18, 21, 26 years [32 years in 2004]	Ongoing
Life Chances of Children Study (Life Chances)	1990	Inner city Melbourne, Australia	167	Birth cohort, multiethnic, diverse socioeconomic status, urban area	1 year	4–6 months	5	1.5, 3, 5, 6 years	Ongoing, subject to funding
Mater–University of Queensland Study of Pregnancy (Mater)	1981	Brisbane, Australia	8556	Pre-birth cohort, one hospital, all pregnancies to public patients	Approx. 5 years	Pregnancy	5	Birth, 6 months, 5, 14 years [21 years]	Ongoing
Pacific Islands Families Study (Pacific Islands)	2000	Auckland, New Zealand	1376	Birth cohort, at least one parent of Pacific Island ethnicity	9 months	Birth	2	1 years [2 years]	Ongoing
Plunket National Child Health Study (Plunket)	1990	National, New Zealand	4286	Stratified by Maori/non-Maori status	1 year	Pregnancy	9	6 weeks, 3, 6, 9, 12, 18 months, 2, 3, 4 years	Ceased
Port Pirie Cohort Study (Port Pirie)	1979	Port Pirie, South Australia	723	Pre-birth cohort	3 years	Pregnancy	10	Birth, 6, 15 months, annually 2–7, 12 years	Ceased
Sydney Family Development Project (Sydney)	1988	Sydney metropolitan area, Australia	157	Stratified by maternal defence style	3 years	16–20 weeks of pregnancy	6	6 weeks, 4, 12, 30 months, 5, 6 years	Ongoing, subject to funding
Tasmanian Infant Health Study (Tasmanian)	1988	Tasmania, Australia	10 562	Recruited for high risk of sudden infant death	8 years	Birth	3	4, 10 weeks, 8 years. Other follow-ups with partial samples	Ongoing
Western Australia Pregnancy Cohort Study (Raine)	1989	Perth, Australia	2860	Pre-birth cohort, one maternity hospital, trial of ultrasound	3 years	16–18 weeks of pregnancy	11	Five times during pregnancy, 1, 2, 3, 5.5, 8, 10 years	Ongoing

- developed relationships with key stakeholders, including policy makers, proactively seeking to ensure translation of research findings (Morton et al. 2010).

In the development of the Australian Model of the First 1000 Days, it is important to consider some points of learning from these longitudinal studies. For instance, although the LSAC study does provide a large and nationally representative sample, further intensive studies of small subgroups of the population will require separate studies (Soloff et al. 2005).

Further to this, neither LSAC nor LSIC examines the influences on healthy development from preconception, through conception (antenatal) and across multiple points during the first two years of life. Another key point from the GUNZ study is the research team’s active approach to relationship development with policy makers, and their consistent policy input through the proactive reporting of research data with a multidisciplinary outcomes focus.

When considering if the Australian Model of the First 1000 Days cohort and interventions study is needed, there are several key points to consider, including:

- We need to move beyond replicating yet another observational study, and the notion of just taking time to observe populations, to evaluate results, and then try to react with informed action based upon those results.
- We have an ethical responsibility to do the best for populations experiencing vulnerability and to build that into the study design – i.e. through linking a cohort study with holistic interventions and monitoring the impact on children (and families) across the course of young people’s lives (Key point raised by Emeritus Professor David M. Fergusson, University of Otago, New Zealand).
- If there is a continued focus at the clinical, treatment and tertiary end of the spectrum, improvements may be made in the lives of those people, but this will not actually close the gap for the overall population. Geoffrey Rose argues that in order to see a whole of population approach, there is a need to move the whole population a little bit (Rose 1985).

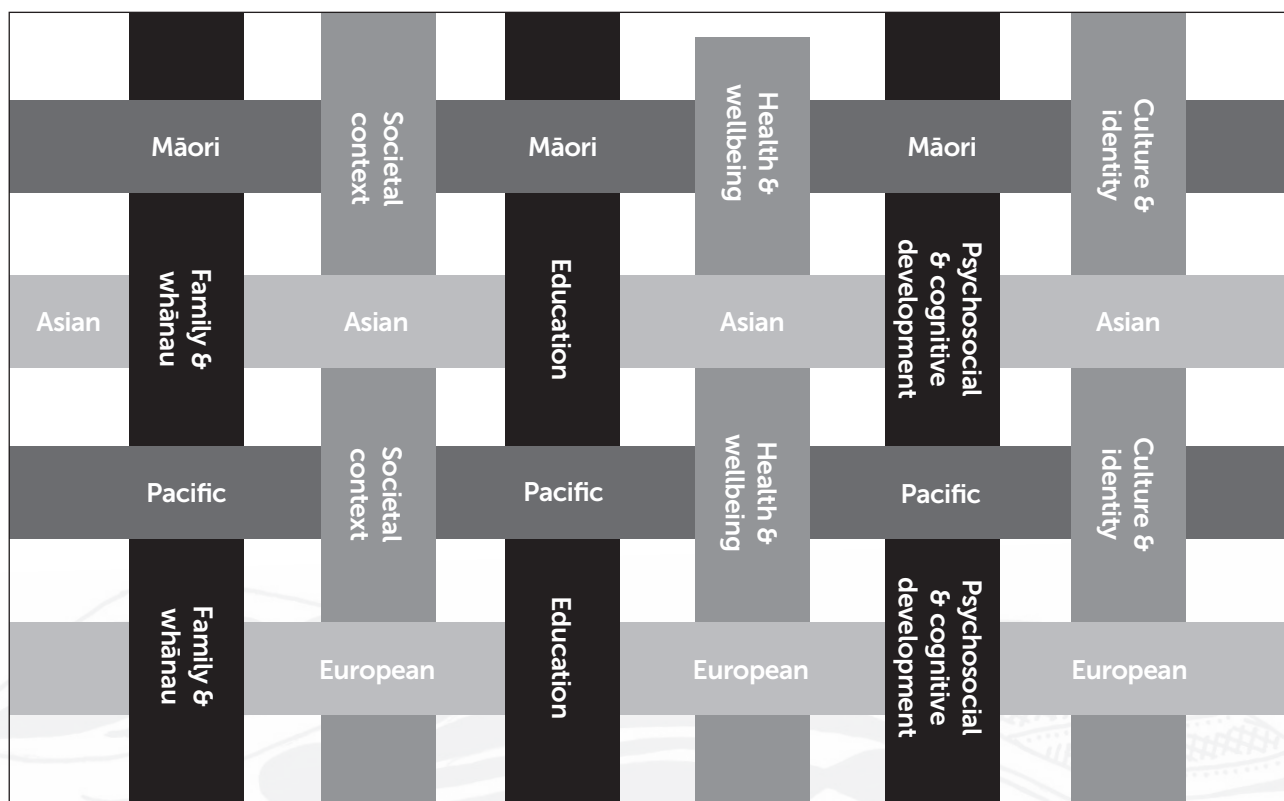


Figure 4: Domain and themes informing Growing up in New Zealand study

- We need a new cohort study in Australia, particularly a cohort and intervention study focusing on Aboriginal and Torres Strait Islander children and families that:
 - focuses on what can be done to make a difference
 - has multiple data collection points across preconception, conception and early years
 - focuses on understanding engagement of parents and families in services
 - looks at the important role of contemporary sources of support and learning (i.e. social media networks, android phones, etc.)
 - collects cost data and provides a health economic evaluation
 - involves the collection of meaningful data through engagement with Aboriginal and Torres Strait Islander communities, health and family support workers and others in the design of research and intervention tools and approaches.

Perverse Incentives and Policy Dilemmas: Reversing Policy Drivers that Entrench Disadvantage

Symposium participants were invited to consider perverse incentives and policy drivers that entrench disadvantage and, where possible, ways in which to reverse these. With regard to perverse incentives, participants were asked to consider policy drivers that result in unintended and undesirable consequences. The following section provides a summary of discussions that reflected on examples of perverse incentives and policy dilemmas and recommendations for reversing policy drivers that entrench disadvantage.

Silos and the ‘cooperation gap’

Participant discussions reflected on the current dilemma of the silos, also referred to as ‘cooperation gaps’ (Forrest 2014) that exist within and between Commonwealth, State/Territory and local governments and departments. Each of these silos has varying goals as to funding and program ownership, and diverse roles across jurisdictions thereby adding to the complexity. In particular, discussions noted that the early childhood space is split between the government departments of health, education and others. This poses a challenge

for organisations and institutions seeking to work beyond boundaries and undertake interventions and research with these different departments/systems. The need for a more coordinated, integrated and proactive approach within and between Commonwealth, State and local governments and service providers was considered a priority to breakdown the current silo approach to dealing with issues and policy development. Investing in existing leadership and relationship structures was also seen as a priority by participants, as was ensuring local community needs and knowledge.

This coordinated approach within and between various levels of government and service providers was considered as vital for genuine long-term collaboration and connection between government policy makers, service providers, academics/researchers and Aboriginal and Torres Strait Islander organisations and communities. Participants noted that such improved engagement across government and services would create challenges, such as resistance to change from traditional ways of doing things and the differing nature of organisational cultures within and between government and service providers/organisations.

A coordinated and proactive approach to data availability and linkage between service providers/organisations was considered crucial by participants. Discussions highlighted a need to address issues of data protection and linkage across services that may currently serve to impede a coordinated approach to service provision and access in the First 1000 Days for families and communities.

Perverse incentive – Case study 1

Policy drivers that seek to remove children from families without adequately providing ongoing support for those families – in coping with the absence of their children, cultural healing, addressing trauma etc. – and where possible addressing needs/issues of concern that led to the children’s removal, with the long-term goal of re-engaging families with their children. A good example of this is the Northern Territory National Emergency Response Act 2007, a legislative response from the Australian Government to the NT Government’s Inquiry into the Protection of Aboriginal Children from Sexual Abuse.

If children and their families do not receive support to deal with the issues that led to children being removed, and instead are given benchmarks which they’re unable to meet without such support, the numbers of children in out-of-home care will continue to rise. While removal was intended to keep children safe, there remains a lack of evidence-based early intervention services for vulnerable families across the country. Thus, children entering the child protection system are growing up in institutional care and the cycle of intergenerational disadvantage continuing (AHRC 2015).

Perverse incentive – Case study 2

The Australian 'baby bonus' maternity payment was an example of a policy-led welfare payment that entrenched disadvantage through the provision of financial incentives to individuals and families to have a child(ren). As observed in the Victorian Aboriginal Child Mortality Study (Freemantle et al. 2013), there was a distinct increase (41.3%) in the absolute number of Aboriginal and Torres Strait Islander births in Victoria between 2003 and 2008, coinciding with the beginning of the baby bonus (commencing 2004). Whether the increase was attributable to the baby bonus, the propensity for mothers and/or fathers to identify as Aboriginal and Torres Strait Islander, or other contributing factors is unclear. However, the magnitude of Aboriginal and Torres Strait Islander births observed between 2003 and 2008 was more pronounced than that of non-Indigenous births in Victoria during the same period.

For example, a story was shared at the Symposium concerning a 16-year-old girl and her 17-year-old boyfriend who had received an unregistered vehicle with a blown motor. In a consultation with a health professional regarding sexual and reproductive health, the young girl indicated that she had become pregnant for several reasons, including:

- She and her boyfriend were ineligible for credit or a bank loan, but if they could wait the gestation period of nine months, have a child and receive the 'baby bonus', they could afford to repair and register their vehicle.
- Becoming pregnant would enable her and her boyfriend to be prioritised for public housing, making them eligible for a two-bedroom flat rather than a bed-sit.
- Her mother was no longer eligible for a family support payment; therefore, by becoming pregnant she could give the child to her mother after birth, reinstating her mother's eligibility for family payments.

Participants indicated that the Development Pathways Project in Western Australia was a good example of a working model of data linkage involving collaboration across multiple institutions and government departments, providing valuable cross-agency data for analyses of important topics concerning children and youth (Data Linkage WA 2015). The project involves collaboration between four agencies - Telethon Institute for Child Health, Crime Research Centre at the University of Western Australia, Curtin University, and the Western Australian Government. The jurisdictions involved include the WA Police, Disability Services Commission, and School Curriculum and Standards Authority, the Departments of Health WA, the Attorney General, Education, Corrective Services, Child Protection and Family Services, Communities, and Housing (Data Linkage WA 2015).

Funding cycles and issues of sustainability

Participants reflected on the policy dilemma of short- to mid-term government funding (i.e. 2–4 years) models, which limit the sustainability and continuity of programs and services within communities. Geographic barriers and differing key performance indicators included in funding requirements were also considered a challenge. The focus on short- to mid-term funding was said to centre on the evaluation of outputs and the direct impact of project deliverables, rather than on the evaluation of broader outcome(s) of services/ programs on a community level and the impact of continued service provision longer term.

Discussions thus highlighted the need for a longer term funding strategy for supporting community services/programs, rather than short-term funding cycles based on predetermined regions of political focus. Bipartisan commitment was also considered critical for project continuity and sustainability, as were champions from government, local council and academia to advocate for this commitment. A bipartisan long-term approach for Closing the Gap

has been called for in earlier consultations focused on creating parity (Forrest 2014).

Short-term funding and the impact of de-funding of successful services/programs were viewed by participants as further entrenching disadvantage, and providing a disincentive for trust and engagement by Aboriginal and Torres Strait Islander communities. However, it was noted that when faced with defunding, services and organisations may engage in innovative partnerships and the pooling of resources to sustain successful programs. Short-term funding was also seen as having the potential to encourage competition rather than collaboration between service/program providers. Discussions suggested that funding opportunities should be weighed against the effort required to comply with reporting requirements while also providing successful delivery of services, an argument further expounded in the forthcoming report *Engaging First Peoples: A Review of Government Engagement Methods for Developing Health Policy* (Thorpe et al.). It was recognised by participants that too many policies had a disadvantage focus, rather than a strengths-based focus with policies to empower and enable individuals and families.

Discussions highlighted that policy is largely informed and driven by a rural/remote perspective of Aboriginal and Torres Strait Islander community needs, over and above those of urban communities. This may, in part, be perpetuated by research focus

and findings. However, participants also discussed how multiple factors determine health outcomes and vulnerability within rural, remote and urban settings and that these factors can vary across settings. For example, geography may actually be considered a protective factor in determining some health outcomes in a rural setting (e.g. prevalence of ICE drug use is lower in the country than the city).

Discussions indicated that research through university institutions was considered expensive, which at times may act as a barrier to funding. To overcome this perceived barrier, participants emphasised the importance of establishing health economic business cases and return on investment is a critical basis for the sustainability of funding.

Funding models also need to include a provision for participation in inter-organisational networking and professional development for service providers and other institutions, as this was seen as lacking and at times prevented much-needed collaboration.

In relation to policy decisions that can lead to further entrenching disadvantage, discussions raised the possibility of a future increase in the Goods and Services Tax to 15 per cent inevitably resulting in a further widening of the gap in inequalities and as potentially leading to greater disadvantage.

Further discussions related to a controversial new funding concept known as 'social impact bonds' (SIBs), which involve government funding and

Participants indicated agreement with The Forrest Review (Forrest 2014), and its reporting of current policy dilemmas and perverse incentives that further entrench disadvantage and result in a failure to create parity. These include:

- A reliance by governments on more public servants and service providers to make the necessary changes rather than empowering Aboriginal and Torres Strait Islander individuals and communities themselves
- A lack of coordination and collaboration between Commonwealth and State and Territory policies and programs and how they are implemented
- An almost exclusive focus by governments on treating the symptoms of entrenched disadvantage, rather than preventing it, so success is limited and very expensive
- Drawn-out approaches, such as targets to only halve employment disparity, therefore extending the trajectory of cost, lost opportunity and misery both to individuals and to the country
- A lack of accountability for results, with service delivery and welfare systems that entrench passive income lifestyles for providers and recipients.

Sourced from *The Forrest Review: Creating Parity* (Forrest 2014)

private investment arrangements structured around a 'payment for results' model for social services. SIBs include the funded organisation receiving a payment of return based on the achievement of program deliverables – so strongly linked to the success of the program. As SIBs are very much in the trial stage here in Australia, it will be some time before clear and definitive evidence is available concerning their impact in this area (SACOSS 2013).

Issues involving service provision, integration and access

Participants highlighted the importance of policy makers recognising the diversity of Aboriginal and Torres Strait Islander people, particularly in relation to needs and service access. Discussions indicated that programs targeted specifically for Aboriginal and Torres Strait Islander individuals and families, and programs focused on selective outcomes or 'high-risk' issues, may create barriers and/or stigma for those accessing such services. It was noted that not all Aboriginal and Torres Strait Islander individuals and/or families access Aboriginal Community Controlled Health Organisations (ACCHOs).

Discussions also reflected on the need for a range of service options with a more integrated care approach, which would provide opportunities for consumer choice and engagement with services at any point in time. In addition, participants emphasised the importance of considering how an intervention or program is provided, and of ensuring in the development of policy that universal/proportionate services have a stepped approach for access without stigma. Similarly, integrated services and programs should be reflective of the needs of the community, rather than a generic program or arbitrary pre-packaged services. Thus, what is needed are policy drivers that encourage community-specific program designs with site-specific interventions addressing local need.

Integrated services can be difficult to undertake, with participants highlighting challenges in finding support and building capacity to lead services and develop partnerships, particularly if there is no funding to move beyond service delivery roles. The importance of funding and support to ensure services can reach beyond delivery and focus on building relationships, and ensure sustainability and continuity of care and encouragement for

those accessing services was also discussed. Participants also stressed the need for integrated services and management systems, particularly those encompassing risk management and a holistic approach, to monitor and assess possible unintended policy consequences.

Discussions emphasised the need for culturally appropriate services and interventions that are led by the community and responsive to community needs. Culturally competent delivery of services was considered important, with policy and funding models that value culture and ensure the inclusion of capacity building for both Aboriginal and Torres Strait Islander and non-Indigenous staff so as to enable broader community access to culturally appropriate services.

Although workforce development was considered important, participants noted an overemphasis on models and approaches rather than on the need to empower communities to help themselves. Within workforce development approaches the inclusion of cultural and trauma-informed work was considered to be under-resourced and frameworks lacking. This situation often results in a champion-based approach by one or two people within an organisation, which creates a challenge when they leave the organisation. Participant discussions highlighted the need for training in cultural responsiveness and trauma-informed practice to be broadly offered across professions, including with general practitioners, nurses, health workers and others. It was considered helpful to have training in cultural competency and a practice framework applied across an organisation, but caution was noted against a one-size-fits all approach. As trauma-informed training is expensive, funding is, therefore, critical to support its provision.

During the Symposium, several presenters reiterated that the First 1000 Days approach addresses vulnerability in a manner that transcends race and class. This means that if we can get it right for Aboriginal and Torres Strait Islander peoples, we can make it work more broadly for other community groups, a point that has been highlighted in previous reports (Forrest 2014).

Participants also questioned whether parents or prospective parents are always able to access an Aboriginal and Torres Strait Islander-specific service or are they having to access other non-Indigenous

services? What about women who are pregnant with Aboriginal and Torres Strait Islander child(ren) but who do not themselves identify as Aboriginal and Torres Strait Islander? How do they become engaged in culturally appropriate services for themselves and/or their child(ren) in early life?

Participant discussions raised the question of how policy makers engage with communities and stakeholders and in what order this engagement occurs in the policy development cycle. It was considered that at times policies could be defined based on the 'knowledge' of policy makers and professionals as to what is needed within communities, rather than as a response to community concerns, suggesting a lack of engagement.

A perverse incentive identified by participants within the area of service provision included policies that, when structured and implemented, can often result in the disruption of service continuity for individuals and families. This can mean services ending prematurely or access being disrupted due to geographic or other changes. For example, participants indicated that policy drivers exist with the aim of rehousing/relocating and segregating public housing populations to avoid ghettoising in a suburb or area. This is often referred to as a 'salt and pepper policy' approach to dispersing ghettoised populations.

For informing the development of the Australian First 1000 Days program, participants suggested consideration be given to the model of the National Disability Insurance Scheme (NDIS) and how it championed change (NDIS 2015). The NDIS works to support people with permanent and significant disability and their families and/or carers to identify the supports they need to live their lives. It does this while ensuring both individuals and families have choice and control over how, when and where services are provided, and by enabling their goals in education, employment and health and wellbeing to be achieved independently (NDIS 2015). People with disability, their families, carers and services providers united with a grassroots campaign to ensure that the necessary supports and services were available to all Australians with a permanent and significant disability.

Positive incentives and creative solutions

Participant discussions highlighted the need for policy and funding models that allow services/ programs the capacity to provide continuity, cultural responsiveness and strong competent staff. It was also noted that service providers are predominantly funded for direct service delivery, rather than preventative services addressing conditions that lead to or sustain problems. Policy and funding models that include a prevention and health promotion foci, in addition to service delivery, were recommended, with these services informed through a community governance structure at a local level.

The 'Preventive Health and Health Services Block Grant' offered in the USA was highlighted by participants as an example of a positive incentive to encourage and support organisations and service providers to address health needs and gaps within the community. This grant offers funding to address unique public health needs and challenges with innovative and local/community methods (CDCP 2015).

Funding models such as this that allow for place-based approaches were further commended for the development and delivery of community-based interventions that build intensive family support networks, cultural healing and engage parents, grandparents and/or kinship carers and children in a safe and positive manner. Kinship, for example, is important to Aboriginal and Torres Strait Islander families, but sometimes primary care givers (e.g. grandparents) can be left out and not fully recognised and supported by all services. Furthermore, participant discussions reflected on shifting the focus away from such policy-led welfare payments as the baby bonus, and instead introducing a 'stay in school allowance' that promotes positive behaviour.

It is important to note, however, that these policy dilemmas can be overcome by ensuring there is real community engagement – that is, understanding what members of the community perceive as the existing issues or problems and how they can be best addressed within their community. Similarly, ensuring the development and leadership of a local community governance committee was seen as having an essential role in helping to address policy dilemmas and guide collaboration. In addition

to this, participants considered it important to ensure that measurable outcomes from services and interventions are shared with the community to reflect the commitment of funders, partners and government in working together with the community.

Overall recommendations for reversing policy drivers that entrench disadvantage

Service integration

- Need for coordinated and proactive approaches within and across government departments and all levels of government, and with service providers/organisations in order to breakdown existing silos
- Link data across services and governments, and other organisations
- Whole-of-government approaches, similar to that established by COAG, be replicated at regional State levels with multiple partners that work with Aboriginal and Torres Strait Islander peoples (e.g. VALS, VAHS, VACCHO, and others)
- Tri-leveled government support for the First 1000 Days initiatives in areas where they will occur
- The integration of services and programs must reflect community needs and not just be a one-size-fits-all approach
- A need to 'co-design' services with families in Aboriginal and Torres Strait Islander communities.

Centralised support

- Examine the feasibility of a centralised reporting mechanism given the current patchwork of funding arrangements for projects/programs and their reporting requirements
- Policy needs to recognise and incorporate a strengths-based approach
- A need for bipartisan support to enable the long-term continuity and sustainability of funding across all levels of government

- A sustained approach that does not let 'hot-off-the-press' issues distract from the current policy priorities as informed and identified by communities and evidence-based research
- Sustainable funding models must address the need for continuity, cultural responsiveness and competent staff
- Philanthropic investment should be sought for projects.

Research and knowledge translation

- Research that is used to inform policy needs to be multidisciplinary, holistic and engaged with the Aboriginal and Torres Strait Islander community
- Policy needs to recognise and acknowledge the diversity of Aboriginal and Torres Strait Islander communities
- Policy and funding models must include both Aboriginal and Torres Strait Islander and non-Indigenous staff so as to enable broader community access for individuals and families
- Policy should actively encourage guidance by community
- Need to establish a relationship with the Aboriginal and Torres Strait Islander community first before attempting to help with the development of new policy.

Investments in innovations and enablers

- Begin with start-up seed funding from government and, through additional philanthropic investments, develop into an independent entity (see p. 29 for further enablers).

Building Resilient Families and Sustainable Approaches to the First 1000 Days

Rural/remote and urban case studies

Symposium participants were asked to discuss what policy makers can do within both a rural/remote and urban context to build sustainable approaches to the First 1000 Days and what policy frameworks can provide to ensure resilient families. Key factors for project delivery for the First 1000 Days in rural/remote and urban communities discussed by participants included: sustainability; cultural knowledge and safety; and a place-based and strengths-based approach. Other barriers and enablers were also discussed.

Funding and issues of sustainability

Further to earlier discussions, short-term funding (e.g. two years or less) in rural/remote communities was considered wasteful by participants, as it raises issues of sustainability and lack of continuity of care when such funding ceases and programs are shut down. Longer term funding commitments from government were seen as crucial by participants – for example, Children’s Ground, a 25-year place-based program investing in generational change (Children’s Ground 2015) – in addition to bipartisan commitment to ensure sustainable approaches for the First 1000 Days.

Reducing government dependence was also highlighted as critical, with the need for additional non-government support (e.g. non-government organisations, universities, and businesses). Participants noted that three levels of government funding (i.e. local, State and Federal) and multiple departments create difficulty in coordinating services. Ensuring cultural competency for politicians and policy makers was also considered important.

Wadeye rural/remote case study

Mr Lyndon Ormond-Parker, Melbourne School of Population and Global Health, The University of Melbourne, Victoria

Wadeye (pronounced Wad-air), formerly known as Port Keats, is a remote town situated on the western edge of the Daly River approximately 220 km by air south-west of Darwin. Founded by Catholic missionaries in 1935, the current population of Wadeye is approximately 2500, and up to 2800 in the wider regional area. Almost half of the Wadeye population (n=912) is under the age of 20 years, including 320 children aged 0–4 years. A total of 93 per cent of the population are Aboriginal and Torres Strait Islander, and there are five traditional kinship groups – Nangiomeri, Marimanindji, Marithiel, Maringar and Mulluk Mulluk.

Save the Children provides Intensive Family and Children’s Support Services to help parents with complex problems meet the emotional, developmental and physical needs of their children. This service gives support to families with children from birth to the age of 12, and has specialist drug and alcohol, domestic violence and mental health services. In addition, Wadeye has a Children and Family Centre providing a crèche, health checks, meals and pre-school orientation for children. Wadeye also has a new Health Clinic and a Women’s Centre in the community, both of which are great sites for health promotion and education activities.

The Institute for a Broadband-Enabled Society currently partners with the community in a digitisation project of health promotion materials produced in the local language and available at the Health Clinic. Recent funding has also been obtained to set up a local communications system, including community television. Wadeye has a young and growing Aboriginal and Torres Strait Islander population and would make an excellent trial site for the First 1000 Days project.

cohealth urban case study

Towards coordinated, comprehensive, culturally competent policy – The urban setting of Melbourne’s west

Ms Jo Southwell, Child, Family, Aboriginal and Torres Strait Islander Health, cohealth, Victoria

cohealth is a not-for-profit community health organisation delivering a range of local health support services, including: medical, dental, allied health, mental health, counselling and many other specialist health services. cohealth delivers these services across Melbourne’s inner, northern and western suburbs. Those under 25 years of age comprise 58 per cent of the Aboriginal and Torres Strait Islander population in this area, including 453 Aboriginal and Torres Strait Islander children aged 0–4 years.

Aboriginal and Torres Strait Islander individuals and families living within urban settings can often be ‘hidden’ populations with ‘hidden’ issues compared to the more recognised health and wellbeing needs of those in rural/remote settings that government policies seek to address. Yet many of these urban-based individuals and families have experienced similar traumas and intergenerational traumas.

Currently, health policy focuses predominantly on the Aboriginal and Torres Strait Islander population’s chronic health conditions and major risk factors, such as smoking. There is a need for a future-focused policy that enables a family health and wellbeing focus addressing intergenerational trauma. There is also a need to focus on the early years and vulnerable families, to incorporate early interventions, and to work with families on building confidence, skills and cultural connections. Ensuring a multi-sectoral service response, with a strong community governance framework and data linkage across and between sectors, is also crucial.

cohealth has worked to overcome current policy barriers by developing a workforce to respond to the community needs of Aboriginal and Torres Strait Islander families. A total of seven different funding sources from Federal, State and local governments have enabled cohealth to develop a team of 10 staff working across services to provide various programs. cohealth works in partnership with VAHS (Victorian Aboriginal Health Service), VALS (Victorian Aboriginal Legal Service), VACCHO (Victorian Aboriginal Community Controlled Health Organisation Inc.) and VACCA (Victorian Aboriginal Child Care Agency), and more recently with the Onemda VicHealth Group at the University of Melbourne.

Cultural knowledge and safety

Participants called for a human rights perspective to ensure funding is provided in a culturally responsive way that protects people from any unintended consequences of programs. Discussions also highlighted the need for an acknowledgment of existing Aboriginal and Torres Strait Islander individual/community knowledge and historical context, and ensuring that funded programs and interventions are culturally safe.

Furthermore, it was noted that disadvantaged families are already ‘resilient’, and that there should be a reference to ‘families experiencing vulnerability’ rather than labelling families as ‘vulnerable’. In this regard, participant discussions also emphasised the need to more clearly identify urban experiences of vulnerability for individuals and families, as these were thought to be different from the traditional focus on rural/remote.

Place-based and strengths-based approach

Considerations of varying geographic needs and localised, place-based approaches were emphasised as critical by participants. Although commonalities will exist, discussions indicated the need for a focus on the community context, whether rural/remote or urban, to ensure interventions and programs are tailored appropriately to be effective for the local community context. Participants noted that a place-based approach can be achieved through community engagement to determine need(s), to focus interventions, and to build a groundswell of community support. Within an urban context, participants highlighted that services need to be provided in response to what the individual/family identify as their need(s), and that a more child-centred health focus is required.

Discussions also identified the need for flexibility in small communities to enable innovation and continuous quality improvement to increase the efficiency and effectiveness of services and systems. Further to this, participants indicated that the First 1000 Days and other programs or interventions should have a strengths-based focus, moving away from a deficit view. Participants emphasised the importance of building capacity and developing skills of local community, whether urban or rural/remote. Support should be available for successful programs and interventions to be tailored and provided across regions. In discussing urban or regional contexts, participants identified the Rumbalara Aboriginal Co-operative as a positive example of a place-based ACCHO providing health and holistic services for women, men and children.

Barriers to sustainable approaches – Rural/remote communities

Participant discussions raised the issue that competitive funding in rural/remote communities was divisive for collaboration between organisations, and impacted on relationships between local Aboriginal and Torres Strait Islander services. Further to this, school support services (e.g. psychologists, remedial reading, speech pathologists) that are largely available in the mainstream sector to build capacity for families also need to be consistently available across urban and rural/remote communities.

Barriers to sustainable approaches – Urban communities

Barriers to parent engagement in urban community programs discussed by participants included:

- Personal cost in accessing service(s) – e.g. the individual/family might be judged for using the service(s), such as stigma associated with accessing mental health services
- Financial cost in accessing service(s) – need to ensure service is inclusive of the community, rather than assuming that parents can/will engage with a fee-for-service arrangement
- Transport issues in travelling to/from the service(s)
- Personal attitude/motivation.

Further to this, participants considered the impact of silos and a lack of collaboration across organisations and government as a significant barrier to sustainable approaches for families in the First 1000 Days. For many, it was their first time attending a forum in which policy makers and government representatives from local, State and Commonwealth governments were working together with researchers, implementers and service providers to discuss these issues.

Discussions also highlighted the critical role of networking, collaboration and linkages between organisations, and the limited time or financial resources available for many organisations to engage and connect across organisations. Although data linkage can be a particular issue of concern for Aboriginal and Torres Strait Islander communities, particularly based on historical evidence, participants noted that when engagement, direction and governance comes from the community to determine and direct how and if data linkage should occur, concerns and issues may be alleviated.

Enablers and possible interventions for sustainable approaches – Rural/remote and urban communities

Enablers and possible interventions for sustainable approaches and ensuring resilient families in rural/remote and urban communities included the following business initiatives:

- Begin with start-up seed funding from government and, through additional philanthropic investments, develop into an independent entity
- Involve family-based social entrepreneurialism facilitated by the National Disability Insurance Scheme
- Set up household-based social entrepreneurialism initiatives, for example, in-home family day care, or nutrition co-operatives for food supply, or Tupperware
- Make use of the natural resources and local environment, such as bush plums, for setting up a harvesting and selling business, and apply for support through a Community Development Program

- Incorporate peer-mentoring and build on a strengths-based approach
- Apply to organisations such as Pollinators, Sparks Strategy, school entrepreneurs, and/or No Interest Loan or NIL schemes for initial support.

Participant discussions reflected on driving policy change at a local community level, rather than at a government level. This community-driven change, for example through a local football club, may include fund-raising and other community-led activities and initiatives (e.g. healthy canteen policy). Policies that support the initiative of free sexual health clinics and youth clinics were also suggested as an effective and sustainable approach to ensuring support for families at the preconception stage of the First 1000 days.

Improvements in infrastructure, such as telecommunications and satellite services, are needed in rural/remote communities to allow opportunities for program development that embrace technologies. Participant examples included ensuring broadband to enable:

- 'Telehealth' and rural/remote community access to clinic care
- text messaging for follow-up care after leaving hospital and other support programs
- iPads for use as a platform (e.g. group sites, Skype, etc.) to connect and support people with their health, social and/or emotional needs.

Within urban communities, participants called for technologies that enable the engagement of people with multiple services at one time.

Discussions also highlighted the need for policy and government funding to allow time for engagement, establishing community governance, collaborations between organisations and establishing a family partnership model to enable future success. This strong governance structure and ongoing engagement would provide agency and ownership of the design, development and location of services. This in turn would allow the community to inform and direct what services/programs will look like, and to determine 'working together agreements' that will achieve the most impact as well as effective service provision for individuals, families and the wider community.

Moving the Agenda Forward

In October 2015, the Australian Human Rights Commission's Children's Rights Report 2015 recommended that the Australian Government support the First 1000 Days program, stating that:

Recommendation 14: The Australian Government Department of Social Services support the work of Professor Arabena and the Indigenous Health Equity Unit at the University of Melbourne to progress the early intervention research agenda under the First 1000 Days initiative. (AHRC 2015)

As the Australian Model of the First 1000 Days continues to gain momentum, both in partnerships and development, it is paving the way for a longitudinal intervention cohort program. Such a program would include holistic early childhood interventions focusing on (pre)conception to the age of two so as to improve health and wellbeing outcomes for Aboriginal and Torres Strait Islander children through the family environment, and by increasing antenatal and early years engagement as well as service use and provision.

The First 1000 Days team will continue to meet and further develop partnerships with various institutions (including the Victorian DHHS) and potential sites, with a range of large non-government community development organisations and also with individuals interested in becoming involved. As partnerships are confirmed, further research and other grant applications will be submitted and work will commence on the First 1000 Days Foundation Project – soon to be formalised by an agreement with a West Melbourne site for the recruitment of parents, their babies and families. The Foundation Project is a proof-of-concept strategy that will be followed by the roll-out of a larger First 1000 Days program of activity in the future.

In other developments, the First 1000 Days team recently met with health economists from the University of Melbourne to discuss the economic benefits and potential impacts of the First 1000 Days program and interventions. Time will now be taken to consolidate membership of both the First 1000 Days Community Governance and Scientific

Committees. In March 2016, the Walter and Eliza Hall Institute of Medical Research is facilitating a workshop on behalf of the Scientific Committee to develop a protocol for a cohort study, such as that being proposed, as part of its Reconciliation Action Plan commitments.

With an international focus, the First 1000 Days team will be hosting the Sami Parliament in February 2016 to discuss the potential of conducting the program in partnership with them in Finland. The team has also secured support from the Australian Indonesia Council to develop a white paper on issues relating to early life, health and development across Australian Aboriginal and Torres Strait Islander communities and Indigenous communities in Indonesia.

As the agenda for the First 1000 Days continues to move forward, the team will seek to further develop its capacity to be the best academic partners for these initiatives on the ground. Two-day First 1000 Days short courses will be commencing in February 2016 for interested individuals, institutions and organisations desiring to be a part of the First 1000 Days program. Additional publications will follow concerning the work of the First 1000 Days and we invite you to check our website regularly for updates and further information.

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Appendix 1: Program of the First 1000 Days Policy and Implementers' Symposium

Time	Presentation	Presenter
8:30–9:00am	Coffee and Registration	
9:00–9.20am	Welcome to Country	Aunty Di Kerr Wurundjeri Council Wurundjeri Elder
9:20–9:30am	The First 1000 Days: The journey so far – Where do we stand now?	Professor Kerry Arabena Indigenous Health Equity Unit
9:30–10:30am	<p>Session 1: Why give a voice to the voiceless?</p> <p><i>Presentation 1:</i> Democratic Representation: Analysing the politics of childhood in 21st century Australia</p> <p><i>Presentation 2:</i> Complex and compounding early life adversities in understanding life course health and wellbeing and the desirable policy response</p>	<p>Dr Sana Nakata School of Political Science, The University of Melbourne</p> <p>Professor Leonie Segal School of Health Sciences, University of South Australia</p>
10.30–11.00am	Morning Tea	
11.00–11.30am	<p>Session 2: Nested policy responses: Empowering families through early life</p> <ol style="list-style-type: none"> Local Government perspective State Government perspective Commonwealth Government perspective: Investing in the Early Years 	<p>Ms Mary Agostino Executive Manager Advocacy City of Whittlesea</p> <p>Mr Mark Stracey Department of Health and Human Services, State Government of Victoria</p> <p>Mr Neil Harwood Early Childhood and Higher Education Branch, Department of the Prime Minister and Cabinet</p>
11.30–12.30pm	<p>Group work: Regional profile</p> <ul style="list-style-type: none"> Policy dilemmas Policy solutions Creative solutions and the 'work arounds' 	Group Work
12.30–1.15pm	Lunch	

Time	Presentation	Presenter
1.15–2.00pm	<p>Session 3: Policies, environments and preparation for contemporary parenthood</p> <p>The influence of contemporary family, social and organisational environments on Aboriginal and Torres Strait Islander children’s healthy development</p>	<p>Professor Jan Nicholson Judith Lumley Centre, La Trobe University</p>
2.00–2.30pm	<p>Group work: Perverse incentives – Reversing policy drivers that entrench disadvantage</p>	Group Work
2.30–3.45pm	<p>Session 4: Critical issues facing communities – Case studies and policy questions</p> <p>What can policy frameworks provide so that families can be resilient?</p> <p>What can our policy makers do to build sustainable approaches to the ‘First 1000 Days’?</p>	Group Work
	<p><i>Presentation 1: Wadeye Rural/Remote Case Study</i></p> <p>Group work</p>	<p>Mr Lyndon Ormond-Parker The University of Melbourne</p>
	<p><i>Presentation 2: The Road Less Travelled: Towards coordinated, comprehensive, culturally competent policy – The urban setting of Melbourne’s west</i></p>	<p>Ms Jo Southwell cohealth</p>
3.45–4.00pm	Afternoon Tea	
4.00–4.30pm	<p>Moving the Agenda Forward and Closing Remarks</p>	<p>Professor Kerry Arabena Indigenous Health</p>

Appendix 2: First 1000 Days Policy and Implementers' Symposium Registered Attendees

Title	First Name	Surname	Organisation/Institution
Ms	Mary	Agostino	City of Whittlesea
Ms	Penny	Angus	cohealth
Mrs.	Cassie	Austin	Corangamite Shire Council
Ms	Sakina	Babia	Northeast Health Wangaratta
Ms	Glenda	Bawden	Monash Health
Ms	Vanessa	Beck	Department of the Prime Minister and Cabinet
Ms	Carlina	Black	VACCA
Ms	Kay	Boulden	Montessori Children's Foundation
Professor	Glenn	Bowes	The University of Melbourne
Ms	Isobel	Brooke	
Mr	John	Burton	Secretariat of National Aboriginal and Islander Child Care (SNAICC)
Ms	Leanne	Carlton	Victorian Health Promotion Foundation
Mrs	Renae	Carolin	The University of Melbourne
Ms	Casey	Cassady	Mullum Mullum Indigenous Gathering Place
Dr	Catherine	Chamberlain	Baker IDI/Indigenous Health Equity Unit
Ms	Stella	Conroy	Families Australia
Ms	Dianne	Couch	cohealth
Dr	Amanda	Day	Royal Children's Hospital
Ms	Siv	Eli Kvernmo	The University of Melbourne
Ms	Claire	Emmanuel	Alzheimer's Australia Vic.
Professor	Jane	Fisher	Monash University
Ms	Cassandra	Fletcher	VACCHO
Ms	Kate	Freeman	Royal Women's Hospital
Dr	Jane	Freemantle	The University of Melbourne
Ms	Dianne	Gilmartin	SNAICC
Ms	Kelly	Hammerstein	Monash Health
Mr	Neil	Harwood	Department of the Prime Minister and Cabinet
Ms	Laura	Healy	The Fred Hollows Foundation
Dr	Suzanne	Hood	Australian Research Alliance for Children and Youth
Ms	Vicki	Horrigan	DHHS, State Government of Victoria
Ms	Karen	Ingram	cohealth

Title	First Name	Surname	Organisation/Institution
Ms	Kate	Jarvis	DHHS, State Government of Victoria
Ms	Leah	Johnston	The University of Melbourne
Mrs	Mai	Katona	Mornington Peninsula Shire
Professor	Margaret	Kelاهر	The University of Melbourne
Mrs	Michelle	Kendall	The University of Melbourne
Ms	Alison	Kitten	
Dr	Renata	Kukuruzovic	Royal Children's Hospital
Ms	Robyne	Latham	The Bouverie Centre (LTU)
Ms	Kim	Lee	DHHS, State Government of Victoria
Mrs	Anne	Lewis	Gugan Gulwan Youth Aboriginal Corporation
Mr	Eddie	Longford	Gugan Gulwan Youth Aboriginal Corporation
Mrs	Maria	Luteria	Department of Health, Australian Government
Ms	Jasmine	Lyons	Indigenous Health Equity Unit
Ms	Marianne	Madden	Department of Social Services, Australian Government
Ms	Esmail	Manahan	The Bouverie Centre (LTU)
Dr	Jacinta	Maria Tobin	The University of Melbourne
Ms	Taryn	Marks	The Lowitja Institute
Dr	Willy-John	Martin	Walter and Eliza Hall Institute
Ms	Ascension	Martinez	Save the Children
Dr	Eamonn	Mccarthy	DHHS, State Government of Victoria
Professor	Robyn	McDermott	James Cook University
Ms	Jo	McInerney	DHHS, State Government of Victoria
Professor	Helen	Mclachlan	La Trobe University
Ms	Deborah	Mellett	Mornington Peninsula Shire
Dr	Robyn	Mildon	Save the Children Australia
Ms	Banu	Moloney	The Bouverie Centre (LTU)
Ms	Luella	Monson-Wilbraham	The Lowitja Institute
Miss	Shakara	Montalto	VACCHO
Mr	Eddie	Moore	Peninsula Health
Mr	Tim	Moore	VACCHO
Ms	Alex	Murray	SNAICC
Mr	Nathaniel	Myers	DHHS, State Government of Victoria
Dr	Sana	Nakata	The University of Melbourne

Title	First Name	Surname	Organisation/Institution
Professor	Jan	Nicholson	La Trobe University
Ms	Helen	O'Connor	Northern Bay Family Centre
Ms	Sarah	Ong	DHHS, State Government of Victoria
Mr	Lyndon	Ormond-Parker	The University of Melbourne
Ms	Angela	Papoutsoglou	DHHS, State Government of Victoria
Mrs.	Carmel	Pillinger	Mornington Peninsula Shire
Miss	Dana	Pine	VACCHO
Dr	Megan	Power	Australia Indonesia Centre
Mr	John	Price	Alzheimer's Australia Vic.
Dr	Kerry	Proctor	The Bouverie Centre (LTU)
Ms	Meg	Renfrey	Knox Social & Community Health
Dr	Rebecca	Ritte	Indigenous Health Equity Unit
Dr	Winsome	Roberts	The University of Melbourne
Ms	Janice	Robertson	Department of Education and Training, Australian Government
Ms	Glenda	Ross	Aboriginal community member
Professor	Leonie	Segal	University of South Australia
Professor	Aron	Shlonsky	The University of Melbourne
Mr	Jackob	Siddall	
Ms	Jo	Southwell	cohealth
Ms	Suzy	Stephens	Mornington Peninsula Shire
Ms	Caroline	Stevens	Department of Social Services, Australian Government
Mr	Mark	Stracey	DHHS, State Government of Victoria
Ms	Emma	Sydenham	SNAICC
Ms	Fleur	T Smith	SNAICC
Ms	Lavinia	Tambo	cohealth
Dr	Chris	Tanti	Take Two, Berry Street
Professor	Collette	Taylor	Melbourne Graduate School of Education
Mr	Christian	Thompson	Parenting Research Centre
Miss	Sarah	Thompson	Australian Conservation Foundation
Dr	Jacinta	Tobin	Indigenous Health Equity Unit
Dr	Michael	Tynan	The Lowitja Institute
Ms	Sue	Wilson	Tweddle Child and Family Health Service
Ms	Michelle	Winters	St Vincent's Hospital



Onemda VicHealth Group

Indigenous Health Equity Unit
Centre for Health Equity
Melbourne School of Population and Global Health
Level 4, 207 Bouverie Street
The University of Melbourne
Vic. 3010 Australia

T: +61 3 8344 0813

F: +61 3 8344 0824

E: onemda-info@unimelb.edu.au

W: www.onemda.unimelb.edu.au