



SUMMARY BOOKLET

**The Social and Emotional
Wellbeing of Aboriginal Children
and Young People**

How to obtain a copy of the main report

A copy of the report *The Social and Emotional Wellbeing of Aboriginal Children and Young People* can be purchased for \$80 through:

Telethon Institute for Child Health Research
PO Box 855
WEST PERTH WA 6872

Telephone: (08) 9489 7777
Fax: (08) 9489 7700

A PDF version of the main publication, as well as a PDF version of this summary booklet, can be downloaded from our web site:

www.ichr.uwa.edu.au

Further information

Other WAACHS publications, including Volume One — *The Health of Aboriginal Children and Young People*, can be obtained by contacting the Institute, or from our web site.

If you would like more information about the WAACHS, please email us at:

waachs@ichr.uwa.edu.au

Photographs: Tony McDonough

**Drawing design by Charles, from Carnarvon, as part of the
Western Australian Aboriginal Child Health Survey Schools Art Competition**

About the survey

This booklet summarises the second volume from the Western Australian Aboriginal Child Health Survey (WAACHS) — *The Social and Emotional Wellbeing of Aboriginal Children and Young People*.

This large-scale investigation into the health of 5,289 Western Australian Aboriginal and Torres Strait Islander children aged 0 to 17 years was undertaken by the Telethon Institute for Child Health Research (the Institute) in conjunction with the Kulunga Research Network. The survey was designed to build the knowledge to develop preventative strategies that promote and maintain the healthy development and the social, emotional, academic, and vocational wellbeing of Aboriginal and Torres Strait Islander children. Volume Two concentrates on the 3,993 children aged 4 to 17 years for whom data were collected on their social and emotional wellbeing.

The Institute has previously surveyed the health of all Western Australian children in 1993. Recognising that this survey did not have a focus on Aboriginal and Torres Strait Islander children, the Institute met with several key Aboriginal leaders and representatives from across the state to seek support and endorsement to conduct a survey of Aboriginal and Torres Strait Islander children aged 0 to 17 years. The survey was subsequently endorsed and has been the first to gather comprehensive health, developmental and educational information on a population-based sample of Aboriginal and Torres Strait Islander children in their families and communities.

All phases of the survey, including its development, design and implementation, were under the direction of the WAACHS Steering Committee. The Steering Committee comprises senior Aboriginal people from a cross section of agencies and settings.



About the information in this booklet

Terms used

Aboriginal: refers to Aboriginal and Torres Strait Islander peoples.

Children: refers to persons under the age of 18 years at the time of the survey.

Young people: refers to persons aged 12 to 17 years at the time of the survey.

Age groups: Children are generally grouped in the analysis as follows:

- ▶ 4 to 11 years
- ▶ 12 to 17 years.

Note: Carers of children aged 0 to 3 years were not asked about the social and emotional wellbeing of these very young children. Information on children aged 0 to 3 years is available in Volume One — *The Health of Aboriginal Children and Young People*.

Primary carer: the person spending most time with the child and considered to know most about the child. The child's primary carer was usually, but not always, the mother of the child.

Level of Relative Isolation (LORI): a new classification of remoteness (see page 4).

Accuracy of the estimates

All data presented in this booklet have been subject to rigorous statistical analysis. Estimates from the survey have been calculated at a 95% level of confidence, displayed on graphs by means of vertical confidence interval bars ($\bar{\square}$). There is a 95% chance that the true value for a data item lies between the upper and lower limits indicated by the confidence bars for that item. A full explanation of the survey methodology can be obtained from the Volume Two main report — *The Social and Emotional Wellbeing of Aboriginal Children and Young People*.

Understanding WAACHS data

This report is based either on data collected during the survey or on statutory data for which permission for linkage was obtained. Survey data are composed of responses to questionnaires by carers of Aboriginal children, and also from young people aged 12 to 17 years themselves. These responses were accepted without further validation.

Analysis methods

In this booklet, findings are presented in two main ways:

- ▶ proportions, based on weighted estimates
- ▶ odds ratios, based on logistic regression modelling.

Many of the findings in this booklet are inter-related. There are many factors that were found to be associated with the social and emotional wellbeing of Aboriginal children and young people. For example, age, sex, LORI and physical health of the carer and the child, and number of life stress events in the past 12 months were all found to be associated with emotional and behavioural difficulties. However, these factors are related to each other. Number of life stress events varies by LORI. While percentages show the number of children affected by each factor, they are unable to fully explain the relationships between all the multiple factors that affect a child's social and emotional wellbeing. There is a mathematical technique called logistic regression modelling which can help us understand the relationships between multiple factors. Logistic regression modelling has been used to determine the effect of each factor, separately from the effect of each other factor. Results of the modelling are presented as odds ratios.

For example, 39% of children living in households that had experienced 7 or more life stress events were at high risk of clinically significant emotional or behavioural difficulties compared with only 14% of children living in households that had experienced 0 to 2 life stress events. These are examples of percentages based on weighted estimates.

However, after accounting for other factors affecting emotional or behavioural difficulties using modelling, children living in households that had experienced 7 or more life stress events were five and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties. This is an example of an odds ratio based on logistic regression modelling.

Modelling has revealed that there is a stronger relationship between life stress events and the risk of clinically significant emotional or behavioural difficulties than was suggested by the estimates of percentages.

Level of Relative Isolation

Measuring access to services

For this survey, a new classification of remoteness – the Level of Relative Isolation (LORI) – has been designed. The LORI is based on the ARIA++ product from the National Key Centre for Social Application of Geographic Information Systems at Adelaide University (GISCA). ARIA++ is an extension of ARIA (the Accessibility/Remoteness Index of Australia), which has been widely adopted as the standard classification of remoteness in Australia. Because ARIA is based on describing the entire population of Australia, it has not been specifically designed to describe the circumstances of Aboriginal people living in remote areas. The ARIA++ gives a more detailed description of more remote areas by including more service centres, of smaller sizes, in calculating its remoteness scores.

ARIA++ : better definition of remote areas

Under the original ARIA, over two-thirds of the land mass of WA, and over one quarter of Aboriginal people in WA live in areas classified as ‘very remote’. However, WAACHS data showed that, within this group, there were marked differences in access to basic services, cultures, lifestyles and health outcomes. The greater detail of ARIA++ enables these differences to be more adequately described in the Aboriginal population.

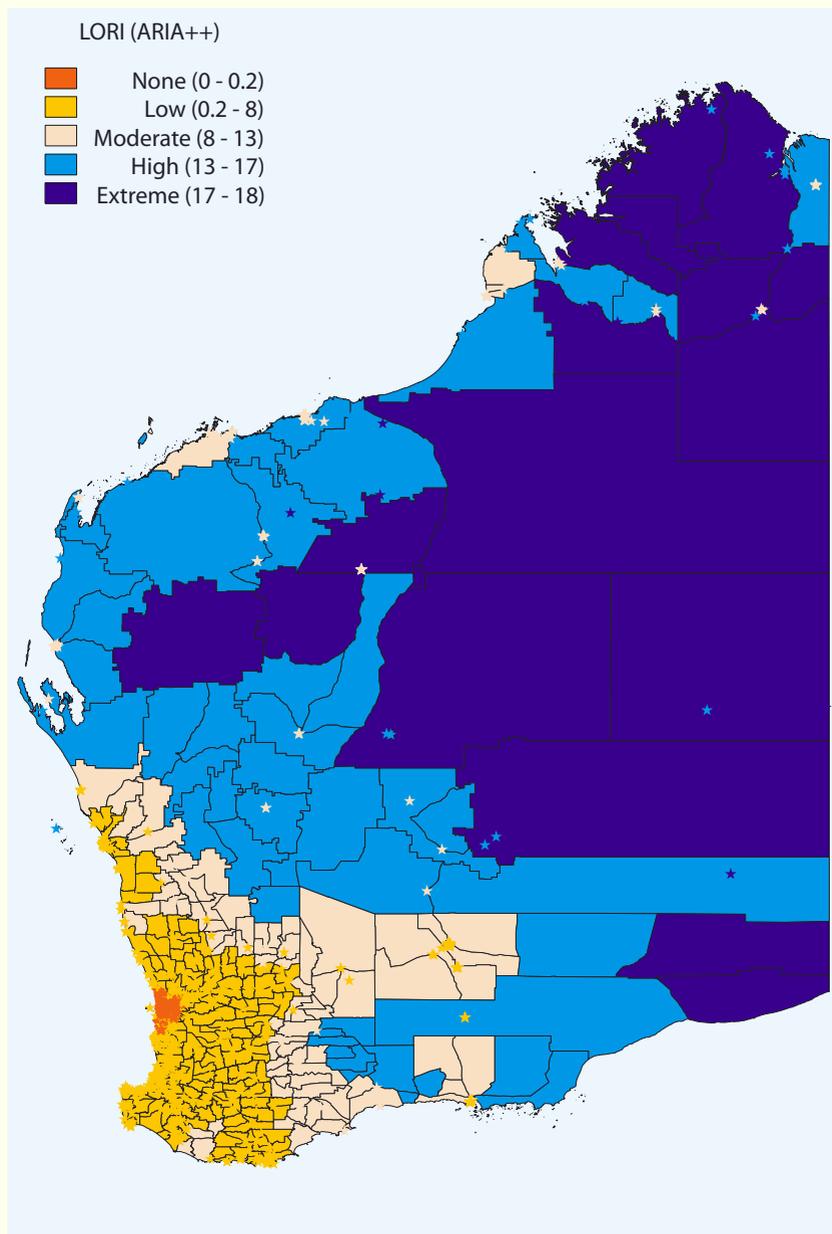
LORI categories

Based on the ARIA++ scores, five categories of isolation have been defined to more appropriately reflect differences in cultures, access to services and health outcomes for Aboriginal children. To avoid confusion with the original ARIA, the five categories are referred to as Levels of Relative Isolation (LORI) and range from None (the Perth Metropolitan area) to Low (e.g. Albany), Moderate (e.g. Broome), High (e.g. Kalumburu) and Extreme (e.g. Yiyili).

The Aboriginal population of WA at 30 June 2001 was estimated at 66,069 or 3.5% of the total WA population. Of this, 29,817 people (45%) were aged under 18 years, representing 6% of the total WA population for this age group. Proportions of Aboriginal children in each LORI category were as follows: None – 34%, Low – 24%, Moderate – 21%, High – 11%, Extreme – 10%.

Level of Relative Isolation (continued)

LEVEL OF RELATIVE ISOLATION (LORI) CATEGORIES BASED ON ARIA++ RANGES



Strengths and Difficulties Questionnaire (SDQ)

Measuring social and emotional wellbeing

Carers were asked for information about difficulties their children might have with emotions, feelings and behaviours, specific episodes of self-harm or attempted suicide, cultural and spiritual engagement and family experiences of grief, loss and trauma. In addition to questions about the overall social and emotional wellbeing of children, interviewers also administered a version of the Strengths and Difficulties Questionnaire (SDQ). This questionnaire, used throughout the world to measure emotional and behavioural difficulties in children and young people, was specifically modified for Aboriginal children in the WAACHS.

To provide a benchmark against which the WAACHS results could be compared, a Computer Assisted Telephone Interviewing (CATI) survey was commissioned to administer the same SDQ to children aged 4 to 17 years in the general population.

Strengths and Difficulties Questionnaire

The SDQ comprises 25 questions looking into five areas of emotional and behavioural difficulties: emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behaviour. The responses from the 20 questions related to the first four of these areas are combined to produce the Strengths and Difficulties Total Score. This score can range from zero to a maximum score of 40. For the WAACHS the maximum score was 38 and the mean was 11.

The Strengths and Difficulties Total Score can be grouped into three ranges to indicate the risk of clinically significant emotional or behavioural difficulties in Aboriginal children and young people:

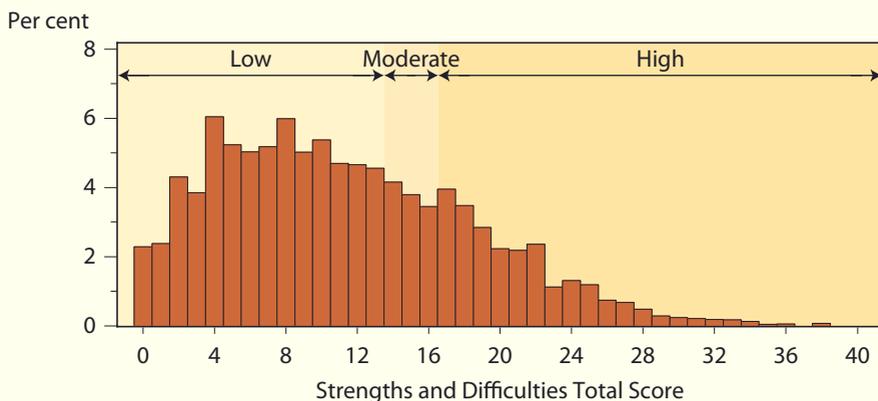
- ▶ low risk (score 0–13)
- ▶ moderate risk (score 14–16)
- ▶ high risk (score 17–40).

Thus, children scoring in the range 17 to 40 are referred to as being at high risk of clinically significant emotional or behavioural difficulties.

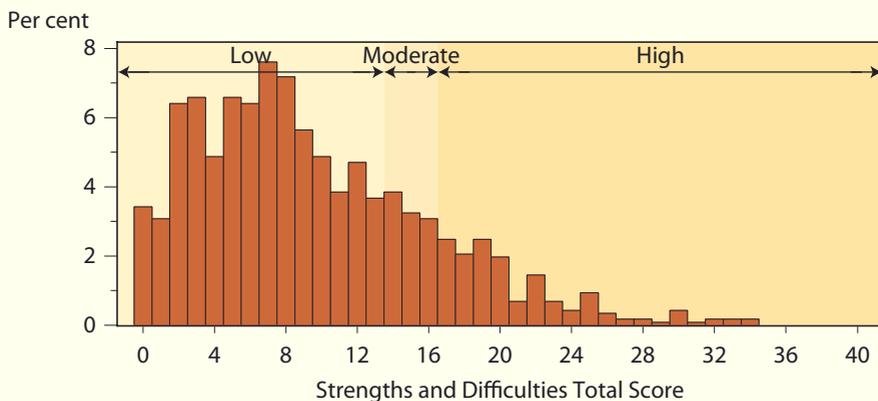
Emotional and behavioural difficulties

There were an estimated 22,900 Aboriginal children aged 4 to 17 years living in WA at the time of the survey. Of these children, 24% were assessed from questionnaires completed by their carers as being at high risk of clinically significant emotional or behavioural difficulties. This compares with 15% of children in the non-Aboriginal population.

ABORIGINAL CHILDREN AGED 4 TO 17 YEARS – DISTRIBUTION OF STRENGTHS AND DIFFICULTIES TOTAL SCORES



NON-ABORIGINAL CHILDREN AGED 4 TO 17 YEARS – DISTRIBUTION OF STRENGTHS AND DIFFICULTIES TOTAL SCORES



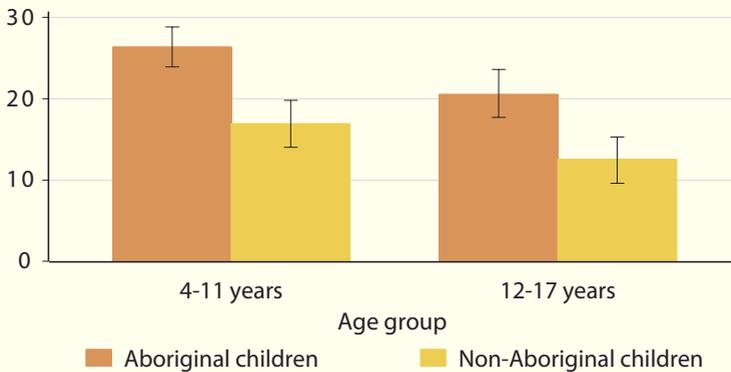
Emotional and behavioural difficulties (continued)

An estimated 26% of Aboriginal children aged 4 to 11 years were at high risk of clinically significant emotional or behavioural difficulties, compared with 17% of children in the non-Aboriginal population from the same age group.

For Aboriginal children aged 12 to 17 years, 21% were at high risk of clinically significant emotional or behavioural difficulties, compared with 13% of children in the non-Aboriginal population from the same age group.

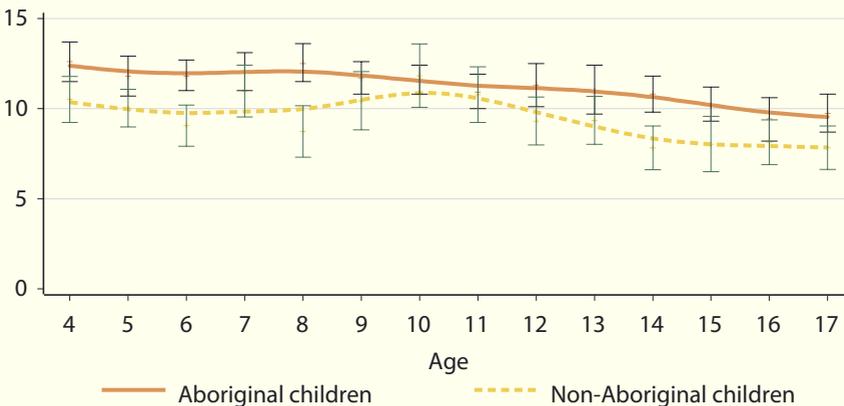
ABORIGINAL AND NON-ABORIGINAL CHILDREN AGED 4 TO 17 YEARS – PROPORTION AT HIGH RISK OF CLINICALLY SIGNIFICANT EMOTIONAL AND BEHAVIOURAL DIFFICULTIES, BY AGE GROUP

Per cent



ABORIGINAL AND NON-ABORIGINAL CHILDREN AGED 4 TO 17 YEARS – MEAN STRENGTHS AND DIFFICULTIES TOTAL SCORE, BY AGE

Mean



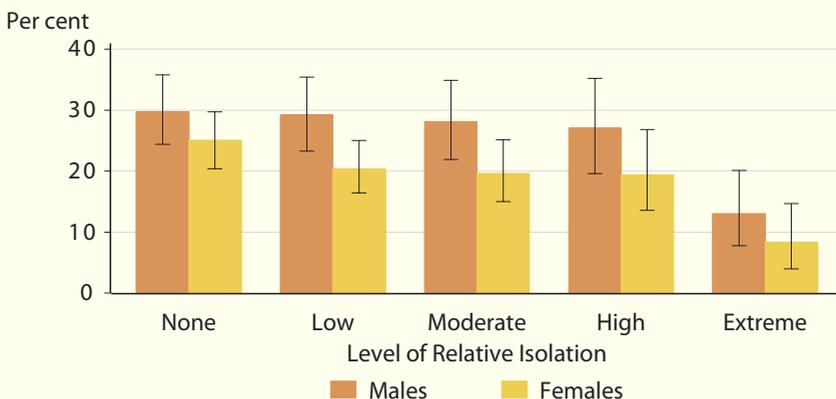
Emotional and behavioural difficulties (continued)

As shown in the two previous figures, the mean SDQ score tends to decrease as children get older for both Aboriginal and non-Aboriginal children. The figure also illustrates that at each age from 4 years to 17 years the mean SDQ score appears higher for Aboriginal children than for non-Aboriginal children.

Level of Relative Isolation

For both male and female children, SDQ scores were lowest in areas of extreme isolation when compared to the rest of the state. This suggests that growing up in areas of extreme isolation, where adherence to traditional culture and ways of life is strongest, may be protective against emotional and behavioural difficulties in Aboriginal children.

PROPORTION OF CHILDREN AGED 4 TO 17 YEARS AT HIGH RISK OF CLINICALLY SIGNIFICANT EMOTIONAL OR BEHAVIOURAL DIFFICULTIES, BY LEVEL OF RELATIVE ISOLATION AND SEX

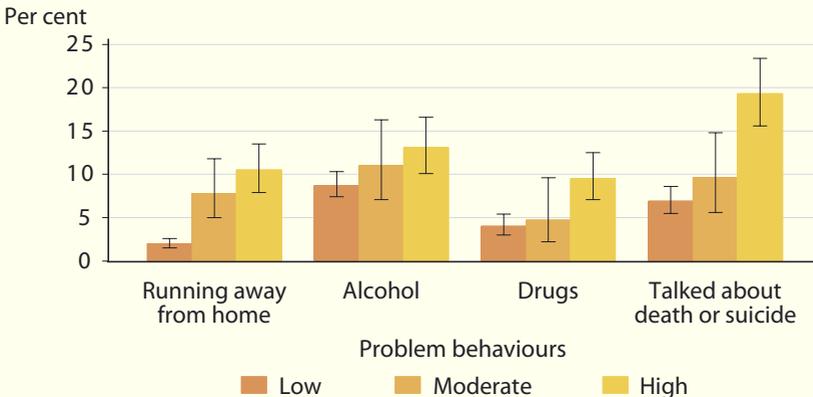
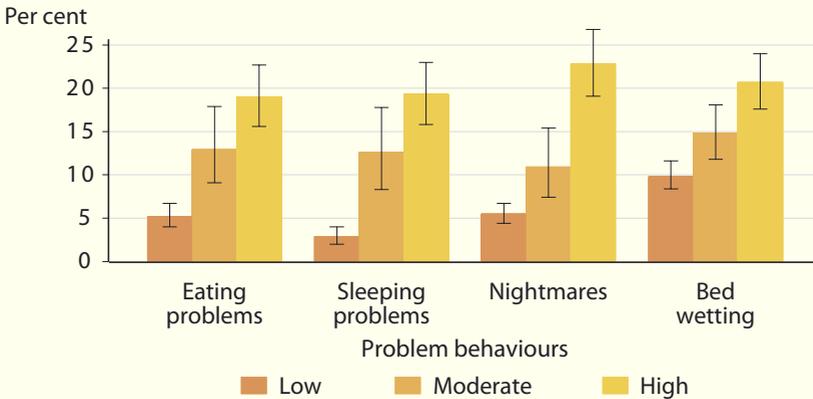


Independently of age and LORI, males aged 4 to 17 years were twice as likely as females to be at high risk of clinically significant emotional or behavioural difficulties.

The SDQ and specific problem behaviours

Carers were asked about a number of specific problem behaviours such as eating and sleeping problems or drinking alcohol or using drugs. Responses to these questions were used to assess how well the SDQ correlated with these behavioural problems. A higher proportion of children at high risk of clinically significant emotional or behavioural difficulties had problem behaviours compared with children who were at low risk of clinically significant emotional or behavioural difficulties.

PROPORTION OF CHILDREN AGED 4 TO 17 YEARS WITH SPECIFIC PROBLEM BEHAVIOURS, BY RISK OF CLINICALLY SIGNIFICANT EMOTIONAL OR BEHAVIOURAL DIFFICULTIES



Factors associated with emotional and behavioural difficulties

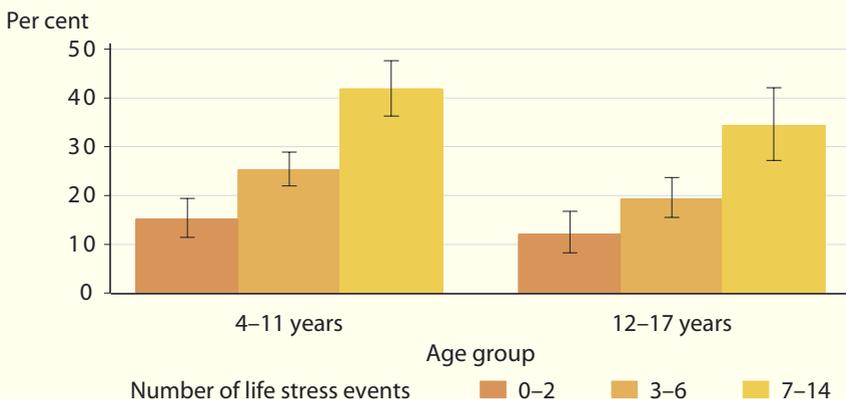
A variety of social circumstances, health conditions and lifestyles experienced by individual children, their carers and families may be associated with emotional or behavioural difficulties in Aboriginal children.

There are clear associations between family and household factors and risk of clinically significant emotional or behavioural difficulties experienced by Aboriginal children and young people.

The factor most strongly associated with high risk of clinically significant emotional or behavioural difficulties in children was the number of major life stress events (e.g. illness, family break-up, arrests or financial difficulties) experienced by the family in the 12 months prior to the survey.

Of children aged 4 to 11 years, 42% were at high risk of clinically significant emotional or behavioural difficulties in families that had experienced 7 or more life stress events compared with 25% of children in families experiencing 3 to 6 life stress events and 15% in families experiencing 0 to 2 life stress events. Similarly for children aged 12 to 17 years, 34% were at high risk of clinically significant emotional or behavioural difficulties in families that had experienced 7 or more life stress events compared with 19% of children in families experiencing 3 to 6 life stress events and 12% in families experiencing 0 to 2 life stress events.

PROPORTION OF CHILDREN AT HIGH RISK OF CLINICALLY SIGNIFICANT EMOTIONAL OR BEHAVIOURAL DIFFICULTIES, BY NUMBER OF LIFE STRESS EVENTS AND AGE GROUP

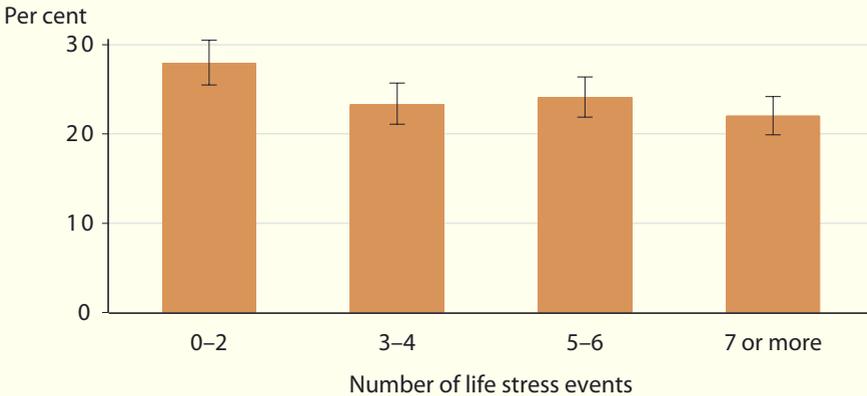


Family and household factors

Life stress events

Just over one in five children (22%) were living in families where 7 or more major life stress events had occurred over the preceding 12 months. These children were five and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children in families where 2 or less life stress events had occurred.

CHILDREN AGED 4 TO 17 YEARS, BY NUMBER OF FAMILY LIFE STRESS EVENTS



Quality of parenting

Around one in four children (25%) were living in families with poor quality of parenting. These children were almost four times as likely to be at high risk of clinically significant emotional or behavioural difficulties than children living in families with very good quality of parenting.

Family functioning

Around one in five children (21%) were living in families that functioned poorly. These children were over twice as likely to be at high risk of clinically significant emotional or behavioural difficulties compared with children living in families with very good family functioning. This likelihood is independent of the effect that life stress events have on family functioning, although the potential links between life stress events and family functioning need to be recognised.

Family and household factors (continued)

A number of other family and household factors were found to be significant in terms of the likelihood of Aboriginal children aged 4 to 17 years being at high risk of clinically significant emotional or behavioural difficulties.

Family care arrangements

Just over one-third of children (34%) were in the care of a sole parent. These children were almost twice as likely to be at high risk of clinically significant emotional or behavioural difficulties than children living with both their original parents.

Children cared for by a person other than an original parent (such as aunts and uncles) were over twice as likely to be at high risk of clinically significant emotional or behavioural difficulties.

Mobility

Children that had lived in 5 or more different homes since birth were one and a half times as likely to be at high risk of clinically significant emotional or behavioural difficulties than children who had lived in fewer than 5 homes.



Protective factors. Some attributes appear protective against children developing emotional or behavioural difficulties. The likelihood of Aboriginal children being at high risk of clinically significant emotional or behavioural difficulties was found to be lower where the following circumstances existed.

High household occupancy level

Children living in homes with a high household occupancy level were half as likely to be at high risk of clinically significant emotional or behavioural difficulties compared with children living in homes with a low household occupancy level.

Living in extremely isolated locations

Children living in areas of extreme isolation were one-fifth as likely to be at high risk of clinically significant emotional or behavioural difficulties compared with children in the Perth metropolitan area.

Child and carer factors

A number of child physical health and carer health factors were found to be independently associated with an increased likelihood of Aboriginal children being at high risk of clinically significant emotional or behavioural difficulties.

Children with speech impairments

Children with a speech difficulty (having trouble saying certain sounds) were over three times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children without a speech difficulty.

Children with runny ears

Children suffering from runny ears (a more severe form of otitis media) were over one and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children not suffering from runny ears.

Children with vision problems

Children without normal vision in both eyes were over one and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children with normal vision in both eyes.

The physical health of the carer

Children in the primary care of a person with a long term and limiting medical condition were three and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children whose primary carer had no medical condition lasting six months or more.

Carer's use of Mental Health Services

Children in the primary care of a person who had used Mental Health Services in WA were one and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children in the primary care of a person who had not accessed these services.

Associations with emotional and behavioural difficulties

CHILDREN AGED 4 TO 17 YEARS – LIKELIHOOD OF BEING AT HIGH RISK OF CLINICALLY SIGNIFICANT EMOTIONAL OR BEHAVIOURAL DIFFICULTIES, ASSOCIATED WITH CHILD, CARER, FAMILY AND HOUSEHOLD CHARACTERISTICS

Parameter	Odds Ratio
Sex—	
Male	1.97
Female *	1.00
Age group (years)—	
4–7 *	1.00
8–11	0.95
12–14	0.99
15–17	0.38
Level of Relative Isolation—	
None *	1.00
Low	0.79
Moderate	0.89
High	0.86
Extreme	0.20
Whether child has runny ears—	
No *	1.00
Yes	1.66
Whether child has normal vision in both eyes—	
No	1.67
Yes *	1.00
Whether child has difficulty saying certain sounds—	
No *	1.00
Yes	3.04
Whether primary carer has a medical condition lasting six months or more—	
No medical condition *	1.00
Medical condition – not limiting	1.44
Medical condition – limiting	3.52
Not stated	1.47

Parameter	Odds Ratio
Whether primary carer has used Mental Health Services—	
No *	1.00
Yes	1.57
Don't know	1.54
Family care arrangements—	
Both original parents *	1.00
Sole parent	1.79
One parent and new partner	1.03
Other (e.g. Aunts or uncles)	2.09
Household occupancy level—	
Low *	1.00
High	0.48
Not stated	1.47
Number of homes lived in—	
1–4 *	1.00
5 or more	1.54
Family functioning—	
Poor	2.39
Fair	1.29
Good	1.76
Very good *	1.00
Not stated	1.47
Quality of parenting—	
Poor	3.78
Fair	1.88
Good	1.46
Very good *	1.00
Not stated	5.02
Number of life stress events—	
0–2 *	1.00
3–6	1.77
7–14	5.46
Not stated	1.47

* reference category — Odds ratios show risks relative to children in this category.

Health risk factors

Health risk factors – self reports from 12 to 17 year-old young people

When carers were asked to provide information about their children for the WAACHS, they were also asked to give permission for any 12 to 17 year-olds in their care to independently answer a separate questionnaire for young people. This Youth Self Report (YSR) questionnaire asked a range of questions about activities and behaviours, including:

- ▶ physical exercise and participation in organised sport
- ▶ cigarette smoking
- ▶ use of alcohol
- ▶ use of other drugs
- ▶ sexual knowledge and experience.

This section describes experiences of young people with these health risk factors, as reported in their YSR questionnaires. This information is separate to the carer reported data that is presented in previous sections of this summary booklet.

Participation of young people in the WAACHS

Only 75% of eligible 12 to 17 year-olds actually completed a YSR questionnaire. A comparison of the young people who completed a YSR questionnaire with the carer reports for all young people found that a higher proportion of the young people who did not complete a YSR questionnaire were at high risk of clinically significant emotional or behavioural difficulties.

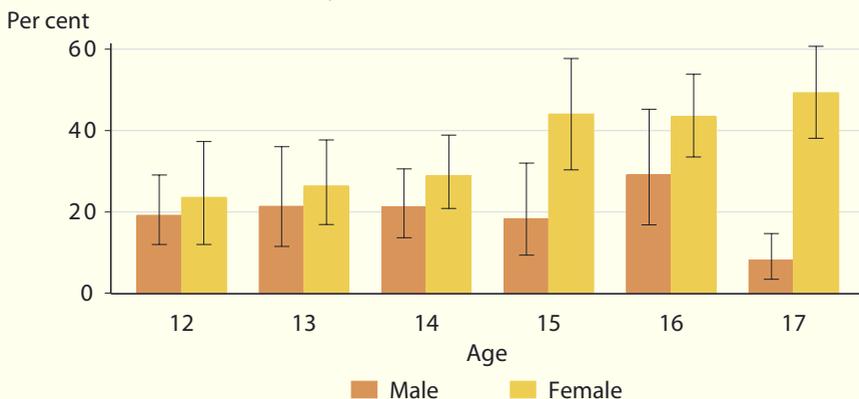
As a result, the estimates based on the self-reports of young people will under-estimate the proportion of young people at high risk of clinically significant emotional or behavioural difficulties. This must be considered when interpreting the results presented here, and when comparing them with results based on carer reports shown elsewhere in this summary booklet.

Physical activity

Young people aged 12 to 17 years were asked how often in the last 7 days had they exercised or played sport or games enough to make themselves sweat or breathe hard. This definition of strenuous exercise has been used in this booklet.

- ▶ More than one quarter of young people (28%) had not done strenuous exercise in the week prior to the survey. One in five males (20%) and more than one in three females (36%) had not done strenuous exercise in the previous week.
- ▶ Of 17 year-old females, half (49%) had not done strenuous exercise in the previous week compared with a much lower 8% of 17 year-old males.
- ▶ Young people no longer attending school were half as likely to have done strenuous exercise in the past 7 days as young people still attending school.
- ▶ Young people who have smoked cigarettes regularly were less likely to have done strenuous exercise in the past 7 days.
- ▶ A higher proportion of young males participated in organised sport in the previous 12 months (70%) compared with young females (56%).
- ▶ Some 51% of young people had both done strenuous exercise in the past 7 days and participated in organised sport in the past 12 months, while 14% had done neither.

PROPORTION OF YOUNG PEOPLE WHO DID NOT DO STRENUOUS EXERCISE IN THE WEEK PRIOR TO THE SURVEY, BY AGE AND SEX

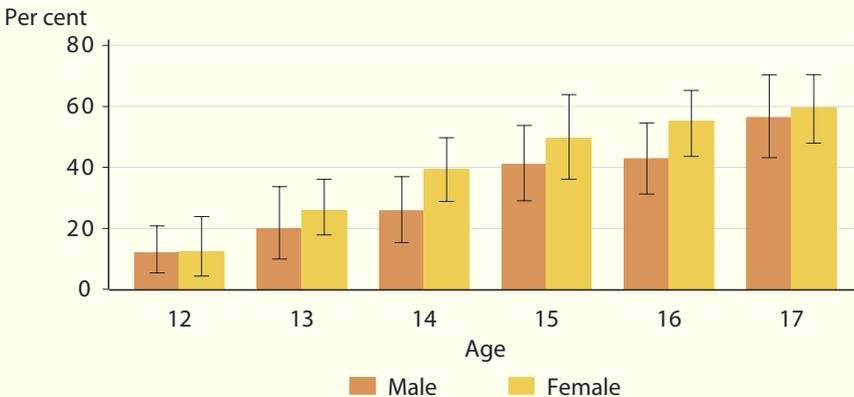


Substance use

Smoking

- ▶ Over one third of young people (35%) have smoked regularly. Over half of those aged 17 years (58%) have smoked regularly.
- ▶ Young people not attending school were over one and a half times as likely to have smoked compared with young people still in school.
- ▶ Young people who have at least one parent who smokes were almost twice as likely to have smoked cigarettes regularly compared with young people whose parents do not smoke.

PROPORTION OF YOUNG PEOPLE WHO HAVE SMOKED, BY AGE AND SEX

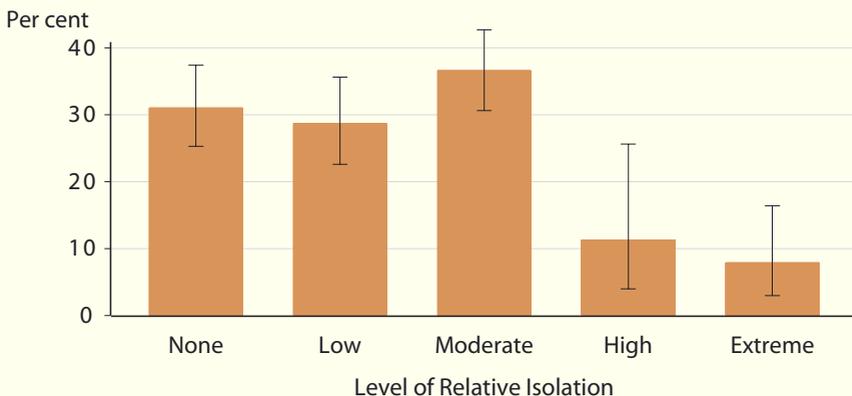


Alcohol

- ▶ Just over one quarter of young people (27%) drink alcohol. At 17 years of age, 61% of males and 43% of females were drinking alcohol.
- ▶ In areas of extreme isolation only 8% of young people drink alcohol compared with 31% of young people living in the Perth metropolitan area.
- ▶ Almost one in five young people (19%) had been in a car with a drunk driver in the six months prior to the survey.

Substance use (continued)

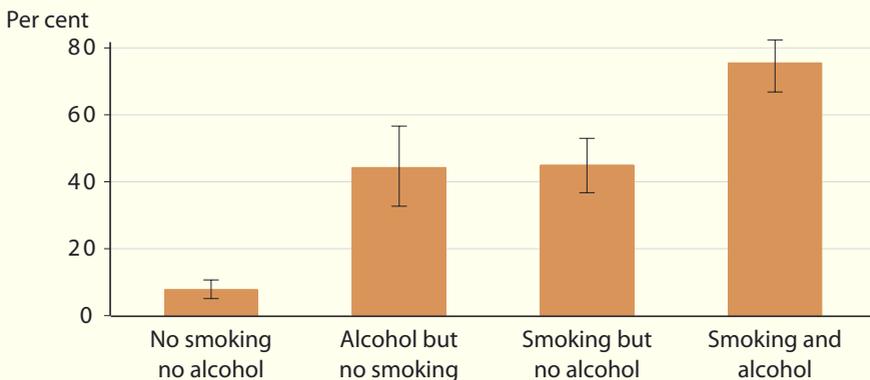
PROPORTION OF YOUNG PEOPLE WHO DRINK ALCOHOL BY LEVEL OF RELATIVE ISOLATION



Marijuana

- ▶ 30% of young people have used marijuana at some time in their lives. Some 45% of 17 year-old males use marijuana at least weekly, compared with 21% of 17 year-old females.
- ▶ Three quarters of young people (75%) who drink alcohol and smoke cigarettes regularly also use marijuana, compared with only 8% of young people who neither drink alcohol or smoke cigarettes.

PROPORTION OF YOUNG PEOPLE WHO USE MARIJUANA, BY WHETHER THEY ALSO SMOKE CIGARETTES REGULARLY OR DRINK ALCOHOL

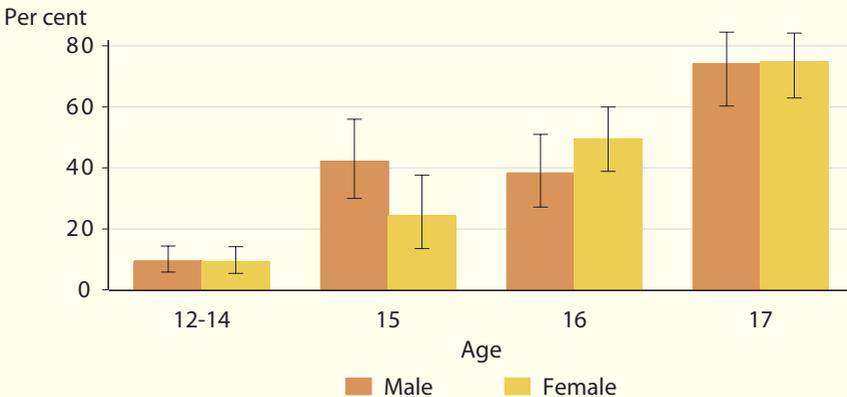


Sexual knowledge and experience

Young people were asked whether they had ever had sex and, if so, at what age they first had sex. They were also asked about contraception methods and whether they had been taught how to avoid sexually transmitted diseases.

- ▶ Some 28% of young people have had sex. Among 17 year-olds, three-quarters (75%) have had sex.
- ▶ Almost half (49%) of 17 year-olds first had sex before the age of 16 years.
- ▶ Young people no longer attending school were six times more likely to have had sex than young people still attending school.
- ▶ Young people who have smoked cigarettes regularly were over four times more likely to have ever had sex than young people who had not smoked.
- ▶ Young people who drink alcohol were over four times more likely to have had sex than young people who do not drink alcohol.
- ▶ Young people who use marijuana weekly or daily were over six times more likely to have had sex than young people who had never used marijuana.
- ▶ One in eight young people (13%) who have had sex had not been taught how to avoid sexually transmitted diseases.

PROPORTION OF YOUNG PEOPLE WHO HAVE EVER HAD SEX, BY AGE AND SEX



Self-esteem

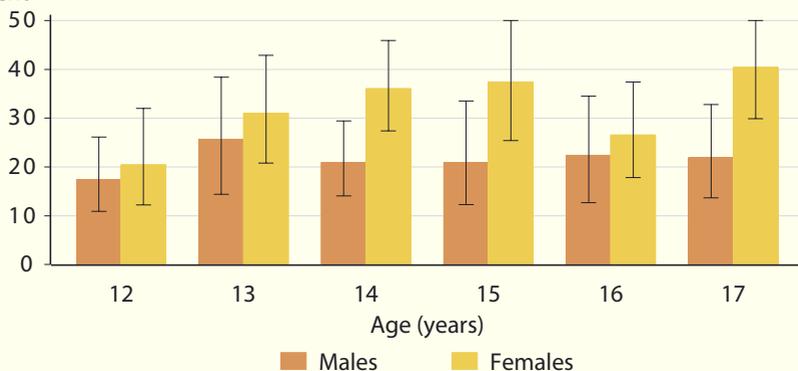
Young people aged 12 to 17 years were asked a series of questions which were used to develop an index of self-esteem.

High self-esteem is an important protective factor and low self-esteem is a risk factor for emotional or behavioural difficulties as well as for health risk behaviours such as smoking.

- ▶ Low self-esteem was significantly more common in females, of whom 32% had low self-esteem, in contrast to 21% of males.
- ▶ The proportion of females with low self-esteem increased with age from 20% at age 12 years to 40% at age 17 years. The proportion of males with low self-esteem remained much the same over the same ages.
- ▶ Physical exercise was associated with high self-esteem. Some 35% of those who had not done any strenuous exercise in the week prior to the survey had low self-esteem compared with 23% who had. Similarly, only 22% of young people who took part in organised sport in the year prior to the survey had low self-esteem in contrast to 35% who did not take part.
- ▶ A higher proportion of young people who have smoked cigarettes regularly had low self-esteem. Some 32% of young people who smoked cigarettes had low self-esteem compared with 24% who did not smoke.

PROPORTION OF YOUNG PEOPLE WITH LOW SELF-ESTEEM, BY AGE AND SEX

Per cent



Self-reported emotional or behavioural difficulties

In addition to the Strengths and Difficulties Questionnaire (SDQ) information obtained from their carers, young people were independently asked to fill in the SDQ.

Based on these reports from young people it was found that:

- ▶ over one in ten young people (11%) were at high risk of clinically significant emotional or behavioural difficulties.
- ▶ a higher proportion of young people cared for by both of their original parents were at low risk of clinically significant emotional or behavioural difficulties (72%) compared with those cared for by a sole parent (61%).
- ▶ a higher proportion of females (15%) were at high risk of clinically significant emotional symptoms than males (6%).
- ▶ around 25% of males were at high risk of clinically significant conduct problems compared with 20% of females.
- ▶ about one in seven young people (15%) were at high risk of clinically significant hyperactivity.
- ▶ only 15% of young people whose carer's parenting style was adequate were at high risk of clinically significant conduct problems compared with 26% of young people whose carer's parenting style was sub-optimal and 40% of young people whose carer's parenting style was poor.



Drawing design by Melissa from Paraburdoo as part of the Western Australian Aboriginal Child Health Survey Schools Art Competition

Associations with health risk behaviours

A number of associations between health risk behaviours and risk of clinically significant emotional or behavioural difficulties were explored. These analyses showed that:

- ▶ some 18% of young people who have smoked cigarettes regularly were at high risk of clinically significant emotional or behavioural difficulties compared with 7% of non-smokers. This association was most pronounced in females with 22% of females who smoked cigarettes regularly being at high risk compared with 7% of females who did not smoke.
- ▶ over one quarter of young people who used marijuana daily (29%) were at high risk of clinically significant emotional or behavioural difficulties compared with 9% of young people who had never used marijuana.
- ▶ of young people who did not participate in organised sport, 16% were at high risk of clinically significant emotional or behavioural difficulties compared with 8% of young people who did.
- ▶ almost one in five young people (19%) who had been subject to racism in the past six months were at high risk of clinically significant emotional or behavioural difficulties, more than twice the proportion of those who had not experienced racism.



Drawing design by Tammy from Paraburdoo as part of the Western Australian Aboriginal Child Health Survey Schools Art Competition

Suicidal behaviour

Recent increases in the official rates of suicide and hospital admissions for attempted suicide by Aboriginal young people has made the prevention, early intervention and clinical management of suicidal behaviour an issue of particular concern to Aboriginal people, communities and health professionals. The survey findings on suicidal behaviour in young people indicated that:

- ▶ over one in six young people aged 12 to 17 years (16%) had seriously thought about ending their own life in the 12 months prior to the survey.
- ▶ a lower proportion of males had seriously thought about ending their own life (12%) compared with females (20%).
- ▶ of the estimated 1,420 Aboriginal young people who had seriously thought about ending their own life in the 12 months prior to the survey, 39% had attempted suicide in the same period. This finding is similar to the rate of suicide attempts in the general population of young people aged 12 to 16 years found in the 1993 WA Child Health Survey.
- ▶ a lower proportion of males had seriously thought about ending their own life if they had high self-esteem (5%) than if they had low self-esteem (21%). While a similar trend was observed in females, it was not statistically significant.
- ▶ a higher proportion of young people at high risk of clinically significant emotional or behavioural difficulties had seriously thought about ending their own life (37%) compared with young people at low risk (10%).
- ▶ a higher proportion of young people who had been exposed to family violence had seriously thought about ending their own life (22%) compared with young people who had not been exposed to family violence (9%).
- ▶ a higher proportion of young people with friends or people known to them who had recently attempted suicide had themselves seriously thought about ending their own life (35%) compared with young people without any acquaintances who had recently attempted suicide (11%).

Effects of forced separation

Forced separation from natural family, forced relocation from traditional country or homeland, and social and emotional wellbeing of Aboriginal children and young people

Until recently there has been little or no empirical data on the nature and extent of intergenerational effects caused by the policies of forced separations of Aboriginal people from their natural family and forced removals from their traditional homeland. The WAACHS sought to obtain information about the association between forced separations and relocations and its effect on the social and emotional wellbeing of subsequent generations.

An estimated 2,760 Aboriginal children (12%) aged 4 to 17 years were being looked after by a primary carer who had been forcibly separated from their natural family by a mission, the government or welfare. For more background information on the number of households affected by forced separations or forced relocations, and the children living in these households, see Volume One — *The Health of Aboriginal Children and Young People*.

The WAACHS found that associations do exist between the social and emotional wellbeing of Aboriginal carers and their children (aged 4 to 17 years) and the past policies and practices of forced separation of Aboriginal people from their natural families.

Effects on carers

Aboriginal carers who were forcibly separated from their natural family by a mission, the government or welfare were:

- ▶ more likely to live in households where there were problems caused by the overuse of alcohol or gambling.
- ▶ almost twice as likely to have been arrested or charged with an offence at some time in their life.
- ▶ less than half as likely to have someone with whom they could discuss their problems.
- ▶ one and a half times more likely to have had contact with Mental Health Services in WA prior to the survey.

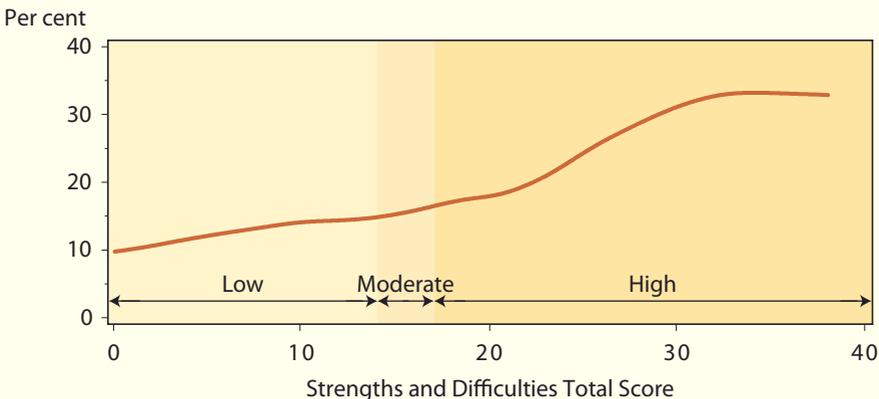
Effects of forced separation (continued)

Effects on children

The children of Aboriginal carers who had been forcibly separated from their natural family by a mission, the government or welfare:

- ▶ were 2.3 times more likely to be at high risk of clinically significant emotional or behavioural difficulties after adjusting for age, sex, LORI and whether the primary carer is the birth mother of the child.
- ▶ were more likely to be at high risk of clinically significant emotional symptoms, conduct problems and hyperactivity.
- ▶ had significantly higher rates of overall emotional or behavioural problems in the 6 months prior to the survey.
- ▶ had levels of both alcohol and other drug use that were approximately twice as high as children whose Aboriginal primary carer had not been forcibly separated from their natural family.

PROPORTION OF CHILDREN WHOSE CARER WAS FORCIBLY SEPARATED FROM HIS OR HER NATURAL FAMILY BY A MISSION, GOVERNMENT OR WELFARE, BY STRENGTHS AND DIFFICULTIES TOTAL SCORE OF THE CHILD



No association was found between risk of clinically significant emotional or behavioural difficulties in children and the forced separation of the carers' parents from their natural family. Also no association was found with forced relocation of carers from their traditional country or homeland, using measures available in the survey.

Discussion

Why was this survey needed?

The WAACHS is the most comprehensive study of its kind to describe the many factors contributing to the social and emotional wellbeing of Aboriginal children and their families. Volume Two builds on the findings on physical health reported in Volume One. It details the extent to which children and young people experience emotional or behavioural difficulties and the many factors which enable some Aboriginal children to grow up to be healthy and emotionally resilient young people.

What is the significance of this publication?

The findings reported in this volume highlight the magnitude and urgency of the emotional and behavioural difficulties faced by many Aboriginal communities and families. Importantly, they also include information on those children and young people who are doing well and living healthy and resilient lives – despite past or current adversity. Understanding how they have achieved these positive outcomes and finding adaptive ways of coping with hard and changing times will guide the development of policies and programs to help more individuals and families to have better outcomes.

The survey provides the first scientific evidence of the long-term effects on the health and wellbeing of children of having a carer who was forcibly separated from their natural family by a mission, the government or welfare.

How can the findings be used?

Reliable population data are essential for the effective planning and delivery of early intervention and culturally appropriate treatment services for Aboriginal children and young people. These data are also important to guide policy and community action to reduce the disadvantage experienced by Aboriginal people.

The findings highlight key areas where action is likely to be effective in bringing about improvements for Aboriginal children and young people. Radically new approaches are needed to address the underlying disadvantage which is compromising the normal processes of child development and the future life prospects of far too many Aboriginal children and young people.

Discussion (continued)

For lasting change to be achieved, three important areas must be addressed:

1 The prevalence and burden of emotional and behavioural difficulties

Compared with the general population, Aboriginal people experience a much higher burden associated with the emotional or behavioural difficulties of their children. This is both because of the higher proportion of children at high risk of clinically significant emotional or behavioural difficulties, and because of the lower adult-to-child ratio in the Aboriginal population which means that there are proportionally fewer adult carers to assist children who have difficulties.

Some 24% of Aboriginal children were at high risk of clinically significant emotional or behavioural difficulties. This means that about 5,500 Aboriginal children could benefit from treatment or support services for these difficulties.

2 Facilitators of social and emotional wellbeing

Key issues which shape children's social and emotional wellbeing include:

- ▶ biological stresses such as low birth weight, chronic infections and poor nutrition which can adversely affect human growth – particularly the way in which the brain and nervous system grow and adapt.
- ▶ the values and beliefs of carers, family rules and expectations play an important role in prompting the child's developing capacity. At school and in the community, expectations of what children and young people should do prompt behaviours and skills at each stage of their development.
- ▶ opportunities to participate, learn and practice new skills and be acknowledged for their accomplishments are vital to children's social development and growing capacity. This includes play, language stimulation, being read to or told stories, being given responsibilities which extend skills and improve their sense of belonging, confidence and self-esteem.

3 Constraints of social and emotional wellbeing

Major disrupters of children's development include:

- ▶ stress that accumulates and overwhelms the individual's ability to cope. This can adversely effect children's cognitive and emotional development.

Discussion (continued)

- ▶ chaotic and unpredictable environments, such as those resulting from multiple family life stresses, high levels of residential mobility and changes to household composition. These can disrupt attachments and childrens' sense of personal continuity.
- ▶ social exclusion which limits development because it restricts access to opportunities and choices.
- ▶ social inequality arising from differences in the accumulation and use of resources and reduced access to the means to generate these resources by Aboriginal people compared with other population groups. This is one of the major drivers of adverse development in Aboriginal children.

What needs to be done now?

Current services targetting the social and emotional wellbeing of Aboriginal children and young people are inadequately provided at all levels. Neither the current *National Mental Health Plan 2003–2008* nor the *Western Australian Mental Health Strategy 2004–2007* afford sufficient attention to the urgent need to address the disproportionate service needs of Aboriginal children and young people. This policy emphasis should be reviewed.

Recent policy initiatives focussing on the multiple causes of Aboriginal disadvantage such as the 2001 *COAG Reconciliation Framework* and the 2003 *COAG Indicator Framework for Overcoming Indigenous Disadvantage* should be supported and sustained over the long term.

The human development implications of WAACHS findings are of particular relevance to policy and service directions now being established at the national, State and regional levels in the post-ATSIC period. These data will assist the joint planning and partnerships between communities and all levels of government to address community identified priorities.

What is needed now is for community leaders, politicians, policy makers and service providers to acknowledge the urgency of the situation, to make commitments to joint action, and to advance this through working in partnerships founded in respect and the mutual desire to bring about a better future for all Aboriginal children.

The Social and Emotional Wellbeing of Aboriginal Children and Young People



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