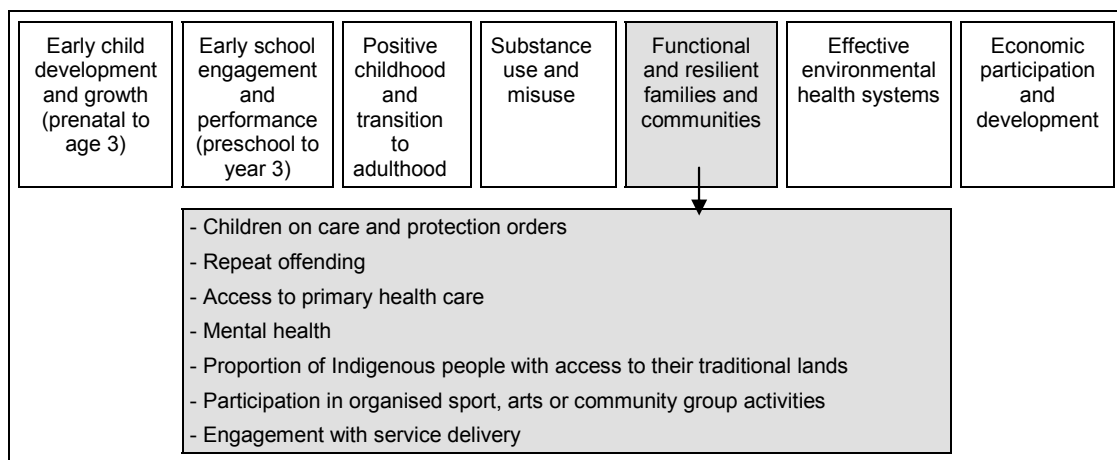

9 Functional and resilient families and communities

Strategic areas for action



Functional and resilient families and communities are generally seen as being fundamental to the physical and mental wellbeing of adults and children. Characteristics of functional and resilient families and communities may include: a caring, protective and supportive environment; positive health outcomes and cultural awareness.

Ideally, a functioning family and community will provide a supportive and caring environment that acts as a conduit for positive outcomes in (among other things) life expectancy, education, employment and income. Problems in families and communities can lead to breaks in schooling and education, disrupted social relationships and social alienation, with implications for unemployment, alcohol abuse, criminal activity, violence and suicide.

There are links between outcomes in functional and resilient families and communities and several of the headline indicators:

- disability and chronic disease
- year 10 and 12 retention and attainment
- labour force participation and unemployment

-
- income
 - suicide and self-harm
 - substantiated child abuse and neglect
 - family and community violence
 - imprisonment and juvenile detention rates.

Outcomes in this area are also related to outcomes in other strategic areas for action, particularly:

- early child development and growth (injury and preventable diseases, birthweight, hearing impediments, children with tooth decay) — chapter 5
- positive childhood and transition to adulthood (juvenile diversions, transition from school to work) — chapter 7
- substance use and misuse — chapter 8
- effective environmental health systems (overcrowding in housing) — chapter 10
- economic participation and development (Indigenous owned or controlled land, governance capacity and skills, governance arrangements) — chapter 11

The Australian Government Attorney-General's Department's report, *Violence in Indigenous Communities*, noted that violence towards children was having major adverse effects on the future of Indigenous families and communities (AGD 2001). The inability of child abusers or neglecters to deal with their problems has been identified as a contributing factor in the perpetuation of a cycle of abuse. The witnessing and experiencing of violence from a young age has been shown to manifest later in life as being strongly associated with both a desensitisation towards violence, and a predisposition towards violence in one's own relationships (AGD 2001).

As explored in more detail in section 3.11:

- family and community violence and child abuse problems are complex, and are interrelated with other health issues, as well as socioeconomic and environmental conditions
- alcohol and substance use have been identified as common contributing factors to violence in Indigenous communities
- the presence of family violence is a strong predictor of child abuse.

(See sections 3.9, 3.10 and 3.11 for more information on substantiated child abuse and neglect, and family and community violence.)

Section 9.1 contains data on Indigenous children who have been placed on care and protection orders. Care and protection orders are a legal intervention to provide protection for children who may have been abused or neglected. The extent of care and protection orders may indicate the social and cultural stress occurring in Indigenous communities and the breakdown of social networks that would normally protect children. Section 9.4 provides more information on the high levels of stress and distress experienced by many Indigenous people.

As intervention by the State in the welfare of a child is indicative of a family that is not functioning well, the same can be said of families and communities where the State intervenes as a result of continued criminal behaviour. There are many factors that may influence the extent of re-offending, including: the justice system providing appropriate sanctions and rehabilitative options for the initial offence; the socioeconomic circumstances of the offender (including education and employment); and the ability of families and the community to assist the offender to re-integrate back into society. Repeat offending is not only an indicator of families and communities that are not functioning, it also can mean (through imprisonment and detention) that the individual is separated from family and community for potentially long periods. The negative impacts of interaction with the criminal justice system include such things as stigma, alienation and effects on future employment and family relationships (ANCD 2003). Repeat offending is reported in section 9.2.

Indigenous people suffer a variety of physical and mental illnesses. Indigenous health outcomes can be related to various factors — one of which is access to health care. Since the 2005 Report, the previous indicator on ‘access to the nearest health professional’ has been renamed ‘access to primary health care’ to broaden the indicator and reflect the importance of primary health care in health outcomes for Indigenous people.

Primary health care is the first point of contact between the individual and the health system and enables early intervention, case management and ongoing care for individuals. Primary health care can be critical in terms of early prevention. It can help address and modify health risk behaviours such as dietary behaviour, physical activity, smoking, alcohol and substance use, and assist in improving health outcomes such as heart disease, injury, cancer and diabetes, which are the leading causes of death for Indigenous people. Health services can also assist in providing maternal and child health services, and community education programs (SHRG 2003). A functional family and community, based around appropriate access to health care, can lead to significant benefits in terms of Indigenous wellbeing. Information on access to primary health care is included in section 9.3.

Following consultations in 2006, a new indicator on mental health has been included in this strategic area for action to recognise the importance of mental health and social and emotional wellbeing for Indigenous people. Mental health has been designated a national health priority area for Australia and is the subject of a national strategy and action plan. Mental health and wellbeing are linked to headline outcomes of life expectancy, disability and chronic disease, labour force participation and unemployment, suicide and self-harm, family and community violence and imprisonment rates. Information on mental health is in section 9.4.

Many people recognise the cultural significance of land and the sense of ‘connectedness’ that it brings to Indigenous people. The 1991 Royal Commission on Aboriginal Deaths in Custody noted that:

Whilst the particular priorities with respect to land differ between Aboriginal people, they are united in their view that land, whether under the banner of land rights or not, is the key to their cultural and economic survival as people.....It was the dispossession and removal of Aboriginal people from their land which has had the most profound impact on Aboriginal society and continues to determine the economic and cultural wellbeing of Aboriginal people to such a significant degree as to directly relate to the rate of arrest and detention of Aboriginal people (paragraph 19.1.1).

A feeling of spiritual and cultural belonging will strengthen the family and community. More discussion on ‘culture’ and its links to the headline indicators is contained in chapter 2. Survey data on Indigenous people’s access to their homelands and traditional country can be found in section 9.5. (Economic aspects of Indigenous people’s ownership and control of land are explored separately in section 11.3.)

Australian and international research suggests that participation in sport can contribute to physical and mental health, confidence and self-esteem, improved academic performance and reduced crime, smoking and illicit drug use. Indigenous people’s participation in artistic and cultural activities helps to reinforce and preserve their culture, while also providing a profitable source of employment. Section 9.5 provides some information and case studies on the participation of Indigenous people in sport, arts and community activities.

Following consultations in 2006, a new indicator ‘engagement with service delivery’ has been added to the strategic area for action ‘functional and resilient families and communities’ to focus attention on service accessibility for Indigenous people, for both mainstream and Indigenous specific services. Appropriate access to services is crucial in reducing Indigenous disadvantage. Appropriate access to services affects outcomes in a wide range of indicators covering health, education, employment and justice. Section 9.7 presents information on engagement with service delivery.

Box 9.1 'Things that work' — functional and resilient families and communities

Lake Tyers Community Renewal Program (Victoria)

The Lake Tyers Aboriginal community in East Gippsland is recognised across Victoria's Koori community and by both State and Federal Governments, as the most disadvantaged Indigenous community in Victoria. Following incidents of community instability in late 2003, which led several government agencies to withdraw services from Lake Tyers, the Department of Justice (DOJ) and Victoria Police convened several cross-agency meetings with the Lake Tyers community. The community identified concerns such as the need to improve community safety, education and employment outcomes, governance structures within the Lake Tyers Aboriginal Trust, health outcomes, and housing and sewerage conditions. These meetings acted as a catalyst for the development of the Lake Tyers Community Renewal Project (the Renewal Project), a partnership in progress between the Lake Tyers Aboriginal community and the Victorian Government.

Since the Renewal Project commenced, there have been consistently low police call-out rates to the Lake Tyers community, a significant drop in reported incidents of family violence and a significant improvement in feelings of personal and community safety.

The Renewal Project has delivered a range of other positive outcomes including:

- improved community infrastructure, including housing upgrades and the construction of new houses, maintenance of an on-site sewerage system as well as plans for a long-term sewerage system, the building of a new community hall and a multi-purpose court and upgrades to roads on Trust property
- improved levels of educational participation and performance through the Lake Tyers School Breakfast Program which commenced in August 2005 and currently serves breakfast to an average of 22 children at Lake Tyers during the school year
- improved training opportunities for residents provided at the Lake Tyers Training Centre (located on-site) which currently has 18 students enrolled in a General Certificate in Adult Education, Hospitality and Business Studies course.

Strategies under the Renewal Project have not only focussed on improving community infrastructure, but on creating opportunities for positive engagement for residents in order to strengthen the community fabric within Lake Tyers. For example, the Lake Tyers Gym has created a space in which the community can participate in healthy activities, while school holiday activities have created opportunities for increased involvement by adults in the community, leading to an increase in positive community interaction.

To date, the whole of government partnership approach has greatly strengthened the quality of engagement, enabling the Victorian Government to work meaningfully with the Lake Tyers community to determine the scope, direction and pace of the Renewal Project.

Source: Victorian Government (unpublished).

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 9A.2.3). A list of attachment tables is in section 9.9. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

9.1 Children on care and protection orders

Box 9.1.1 Key messages

- Almost 30 out of every 1000 Indigenous children aged 0–17 years were on care and protection orders at 30 June 2006, compared to 4.5 per 1000 non-Indigenous children (table 9.1.1).
- From 1999-2000 to 2005-06 the rate of children on care and protection orders increased for both Indigenous and non-Indigenous children in all states and territories (table 9A.1.1).

Data on Indigenous children under care and protection orders show the extent to which the State or Territory has made some form of legal intervention for protective reasons. This intervention may be indicative of the social and cultural stress under which many Indigenous communities live. In such conditions, the extended networks that could normally intervene in favour of the child may no longer exist. This indicator also includes data on placement of Indigenous children in out-of-home care in accordance with the Aboriginal Child Placement Principle.

The headline indicator 'substantiated child abuse and neglect' shows those instances where authorities were notified, and subsequently decided, that a child was or could be at risk (see section 3.9). Once a matter has been substantiated, the authorities have a number of options available to them that do not require a care and protection order:

- working with the family to address protective issues
- developing networks of support for the child
- monitoring and reviewing the safety of the child
- monitoring and reviewing family progress against case planning goals
- case conferences with agencies providing services to the child
- specialist child-focused therapeutic support (SCRCSSP 2003).

These options are intended to address the specific issue(s) causing the child protection concern. Various services could be provided without a court order being granted. Not all substantiations, therefore, will lead to a care and protection order.

A care and protection order is a legal intervention for protective reasons. Court orders may be used to enable the relevant agency to undertake activities necessary to resolve the protection issue. The use of court orders could be associated with:

- the speed of response required (that is, an emergency response)
- the family not engaging with the relevant agency over a period of time
- a change of circumstances that increases the risk to the child or young person (SCRCSSP 2003).

Some children are on care and protection orders for reasons other than abuse or neglect; for instance, where there is an irretrievable breakdown in the relationships in the family or where the parents are unwilling or unable to care for the child. Notwithstanding this, given that legal intervention is usually a last resort after other options have failed or are considered infeasible — care and protection orders may provide some insight into the most serious or long-term instances of child abuse and neglect. These instances could, potentially, reflect the most serious harm and damage to the child and the ability of the family to function.

The types of orders that are classified as ‘care and protection’ include:

- *Guardianship or custody orders*: which have the impact of transferring custody or guardianship
- *Supervision orders*: and other finalised orders which give the State or Territory some responsibility for the child’s welfare
- *Interim and temporary orders*: which include orders that are not finalised, and care applications.

Care should be taken in interpreting the care and protection data. It is a proxy indicator because no credible data exist on actual levels of child abuse or neglect. The data collected by community service departments may under-estimate the true extent of abuse or neglect occurring within both the Indigenous and non-Indigenous communities.

In some instances, increases in notifications (and subsequent substantiations) may be a result of reduced tolerance in Indigenous families and the broader Indigenous community of abuse or neglect of children. An increased rate in these instances will signify increased awareness and identification of the problem — which is more desirable than abuse and neglect occurring but not being reported.

An increased rate may also be due to improvements in the identification of Indigenous status. The practices used to identify and record the Indigenous status of children in the child protection system vary across states and territories. Over the last few years, several jurisdictions have introduced measures to improve the identification of Indigenous clients. In some jurisdictions, however, there is a significant proportion of children whose Indigenous status is unknown and this impacts on the quality of data for Indigenous children (AIHW 2006).

Finally, an increased rate may be due to an increase in resources in the protection and support area, allowing more notifications to be investigated more thoroughly.

Table 9.1.1 Children (0–17 years) on care and protection orders, 30 June 2006^a

	<i>Number of children</i>			<i>Rate per 1000 children</i>			<i>Ratio Indigenous to Non-Indigenous</i>
	<i>Indigenous</i>	<i>Non-Indigenous</i>	<i>Total</i>	<i>Indigenous</i>	<i>Non-Indigenous</i>	<i>Total</i>	
NSW	2 409	6 804	9 213	37.2	4.5	5.8	8.3
Victoria	740	5 244	5 984	56.4	4.6	5.1	12.4
Queensland	1 667	4 779	6 446	26.7	5.2	6.5	5.2
WA	798	1 248	2 046	25.8	2.7	4.2	9.5
SA	378	1 293	1 671	31.8	3.9	4.8	8.2
Tasmania	125	708	833	15.2	6.5	7.1	2.3
ACT	100	458	558	53.3	6.2	7.4	8.6
NT	303	134	437	12.2	3.8	7.3	3.2
Australia	6 520	20 668	27 188	29.9	4.5	5.6	6.7

^a Non-Indigenous includes Indigenous status not stated.

Source: AIHW *Children on Care and Protection Orders, Australia* data collection (unpublished); table 9A.1.2.

- The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 29.9 for Indigenous children and 4.5 for non-Indigenous children at 30 June 2006 (table 9.1.1).

-
- From 1999-2000 to 2005-06 the rate of children on care and protection orders per 1000 children in the population aged 0–17 years increased in all jurisdictions for both Indigenous and non-Indigenous children (table 9A.1.1).

Placement in accordance with the Aboriginal Child Placement Principle

The Aboriginal Child Placement Principle outlines a preference for placement when Indigenous children need to be placed in out-of-home care. Children who are in out-of-home care may or may not be subject to a care and protection order.

The objective of the principle is to ensure the safety and welfare of Indigenous children and, where possible, maintain cultural ties by placing Indigenous children with other Indigenous people. According to the Aboriginal Child Placement Principle (NLRC 1997), the following hierarchy or placement preference should be pursued in protecting the safety and welfare of Indigenous children:

- placement with the child’s extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child’s Indigenous community
- placement with other Indigenous people.

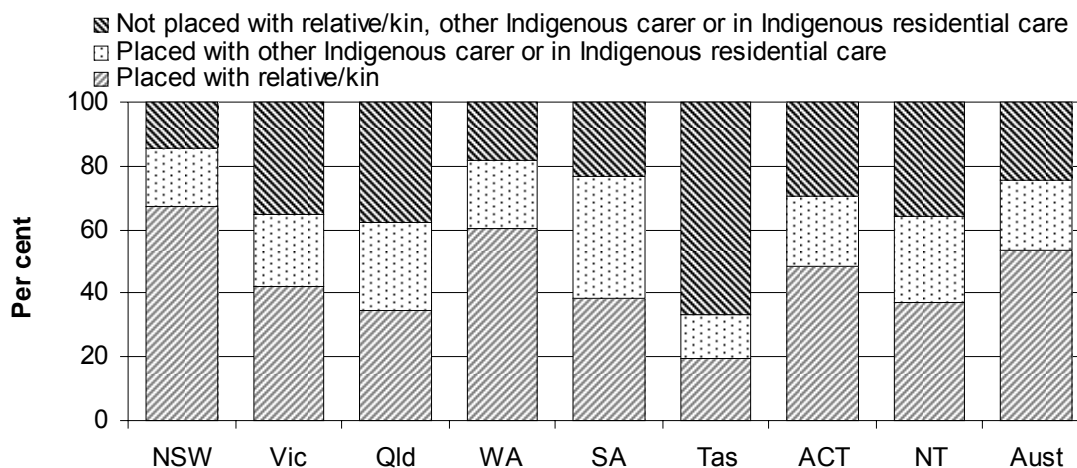
All jurisdictions have adopted this principle, either in legislation or policy.

Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is generally considered to be in their best interests. While it is desirable that children be placed in accordance with the principle, this is one factor among many that must be considered in the placement decision.

Consultations with Indigenous people have highlighted that the safety of the child needs to be paramount in applying this principle. This may mean that on occasions, placement with a non-Indigenous carer is warranted.

Data are reported separately for children placed (i) with relative/kin, (ii) with other Indigenous carer or in Indigenous residential care, and (iii) not placed with relative/kin, other Indigenous carer or in Indigenous residential care.

Figure 9.1.1 Placement of Indigenous children in out-of-home care, 30 June 2006^{a, b}



^a Excludes Indigenous children living independently and those whose living arrangements were unknown.
^b Data for Tasmania and the ACT relate to a small number of Indigenous children (98 and 82 respectively) in care at 30 June 2006.

Source: AIHW *Children in Out-of-Home Care, Australia* data collection (unpublished); table 9A.1.5.

The proportion of Indigenous children in out-of-home care at 30 June 2006 who were placed with Indigenous or non-Indigenous relatives or kin or with another Indigenous carer or in Indigenous residential care varies across jurisdictions (figure 9.1.1).

9.2 Repeat offending

Box 9.2.1 Key messages

- In 2006, a greater proportion of Indigenous prisoners (74.4 per cent) than non-Indigenous prisoners (52.0 per cent) had prior adult imprisonment (figure 9.2.1).
- From 2000 to 2006, there was no significant change at the national level in the proportion of Indigenous prisoners with prior adult imprisonment (table 9A.2.3).
- In studies on juvenile offenders carried out in NSW, Queensland, WA and SA, Indigenous juveniles experienced a higher number of court reappearances and higher rates of repeat offending than non-Indigenous juveniles (table 9A.2.6 and figures 9.2.4, 9.2.6 and 9.2.7).

Recidivism of Indigenous offenders and its impact on their families and communities is a significant issue. The NSW Standing Committee on Law and

Justice (1999) found that incarceration of one generation impacts on later generations through the break down of family structures, and has ramifications for the rehabilitation and employment prospects of individuals, and the socioeconomic capacity of families to function.

Indigenous children are more likely to have a parent imprisoned at some point in their lives than non-Indigenous children (NSW Standing Committee on Law and Justice 1999). Research has shown that children of prisoners often commit offences that result in their own imprisonment, particularly for Indigenous families (NSW Standing Committee on Law and Justice 1999, 2000; Woodward 2003). Given the extent of Indigenous imprisonment, it is important that people who have contact with the criminal justice system have the ability and opportunity to integrate back into the community and lead positive and productive lives, which may also break the intergenerational offending cycle. However, Borzycki and Baldry (2003) highlighted that there are only a small number of programs in Australia to help Indigenous and non-Indigenous people make the transition back into the community after prison.

Initiatives that have been successfully put in place to reduce recidivism among Indigenous people in NSW and Victoria are described in boxes 9.2.2 and 9.2.3, respectively.

Box 9.2.2 ‘Things that work’ — Circle Sentencing Courts in NSW

Circle Sentencing, introduced in Nowra, NSW, in February 2002, is an alternative sentencing court for adult Indigenous offenders. In 2005, The Australian Institute of Criminology awarded Nowra’s Circle Sentencing program with the Australian Crime and Violence Prevention Award for reducing recidivism among Indigenous offenders and making a positive contribution to the Indigenous community. Due to the success of this program, Circle Sentencing Courts have been established in eight locations in NSW, including Nowra, Dubbo, Walgett, Brewarrina, Bourke, Lismore, Armidale and Kempsey (Attorney General’s Department of NSW 2005).

Circle sentencing is used for offences that can be dealt with summarily. Serious offences are excluded, such as, malicious wounding, drug related offences and sexual offences. Circle Sentencing Courts in NSW allow greater Indigenous involvement in the criminal justice process by reducing barriers between Indigenous offenders, the Indigenous community and the courts. They provide more appropriate sentencing options for Indigenous offenders and support to Indigenous victims of crime. Circle Sentencing Courts empower Indigenous people to address criminal behaviour within

(Continued next page)

Box 9.2.2 (continued)

their local community and to take an active role in reducing recidivism by raising awareness of the consequences of offences on the offenders, the victims and their families.

In a typical Circle Sentencing Court, the magistrate, members of the community and in some cases the victim sit in a circle to discuss the offence and the offender. The Circle also talks about the background and effects of the offence and develops a sentence that is tailored to that offender. Aboriginal Project Officers are responsible for organising each Circle Sentencing Court appearance by liaising between the magistrate, the court and the community, and providing follow-up on each offender to ensure they are complying with the agreed sentence outcome plan (Attorney General's Department of NSW 2005).

Early evidence shows that many offenders who participate in Circle Sentencing make dramatic changes to their life and their offending behaviour is reduced considerably (Drabsch 2006; Potas et al. 2003). A comprehensive evaluation of Circle Sentencing in NSW was conducted between 2005 and 2006 to measure the program's impacts and outcomes. The results are yet to be released to the public.

Culturally appropriate justice practices for Indigenous people have also been implemented in magistrates courts in Victoria (Koori Courts), SA (Nunga Courts) and Queensland (Murri Courts), and like Circle Sentencing in NSW have had a positive effect on offenders and the broader Indigenous community in these states (see boxes 3.12.2, 3.12.3 and 3.12.4, respectively).

Box 9.2.3 'Things that work' – Rumbalara Women's Mentoring Program

The Rumbalara Women's Mentoring Program was established in 2002 as a pilot initiative to intervene in the cycle of reoffending among Indigenous women. The program provides Indigenous women undertaking community-based orders, including parole, with mentoring and support by Indigenous Elders and Respected Persons. The program also assists women to access a range of other social support services. The program's dual aims are to improve community-based order completion rates and reduce reoffending.

As at April 2005, 27 women had accessed the pilot Women's Mentoring Program at Rumbalara, of whom 19 had successfully completed the program and a further five women were still completing community-based orders with the assistance of the program. These outcomes contrast to a normal community-based order breach rate of nearly 29 per cent.

Based on the success of the Rumbalara pilot, the mentoring program, now known as the 'Koori Offender Support and Mentoring Program' has been expanded and will soon be delivered in five locations throughout Victoria for both Indigenous men and women.

Source: Victorian Government (unpublished).

This section examines data on both adult and juvenile repeat offending. For the adult population, data on prior imprisonment under sentence are from the ABS *Prisoners in Australia* publication (ABS 2006) and provided for each State and Territory. Data on juvenile repeat offending are limited to only four jurisdictions, NSW, Queensland, WA and SA, based on four cohort studies published by the Bureau of Crime Statistics and Research in NSW, Griffith University School of Criminology and Criminal Justice, University of Western Australia Crime Research Centre, and the Office of Crime Statistics and Research in SA, respectively. Sections 3.12 and 7.4 of the Report present data on juvenile detention and juvenile diversions, respectively, and cover a greater number of jurisdictions than the data available on juvenile repeat offending.

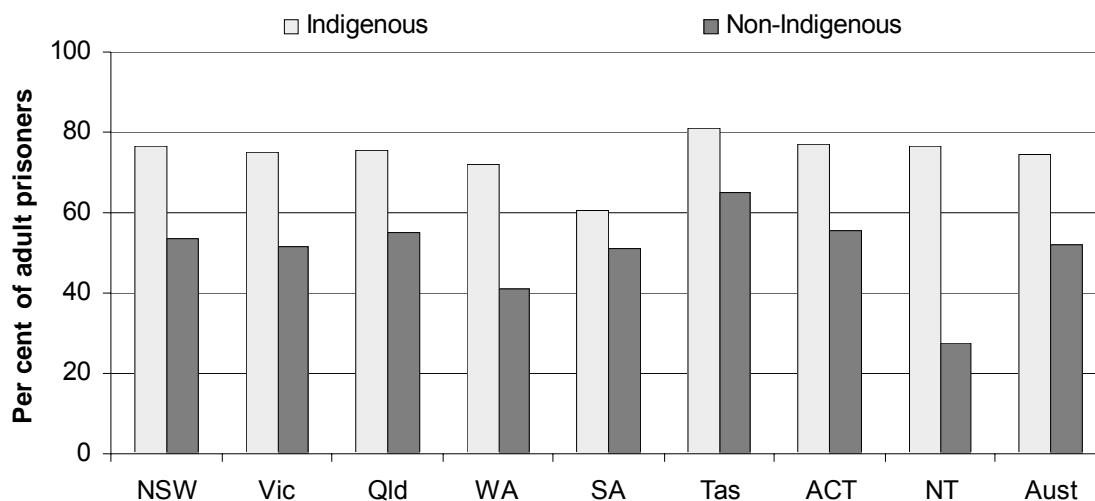
Data on the prior imprisonment of adults sourced from the ABS *Prisoners in Australia* series need to be interpreted with caution. The data are subject to the following caveats:

- some states and territories include episodes on remand as prior imprisonment
- a prior sentence of periodic detention is included as prior imprisonment
- prisoners who have had previous adult imprisonment in another State or Territory may not be counted as having prior imprisonment
- the data do not include arrests that do not proceed to court (for example, as a result of diversion or restitution)
- the data do not include convictions for re-offending that lead to outcomes that are not administered by prisons (for example, community service orders or fines)
- the data only deal with prior imprisonment in an adult prison (juvenile detention is not included).

As a consequence, the true level of repeat offending is under-represented. Furthermore, not all offences come to the attention of police, or are recorded by police, or are dealt with within the criminal justice system.

Adult repeat offending

Figure 9.2.1 Proportion of prisoners with known prior adult imprisonment under sentence, 30 June 2006^a



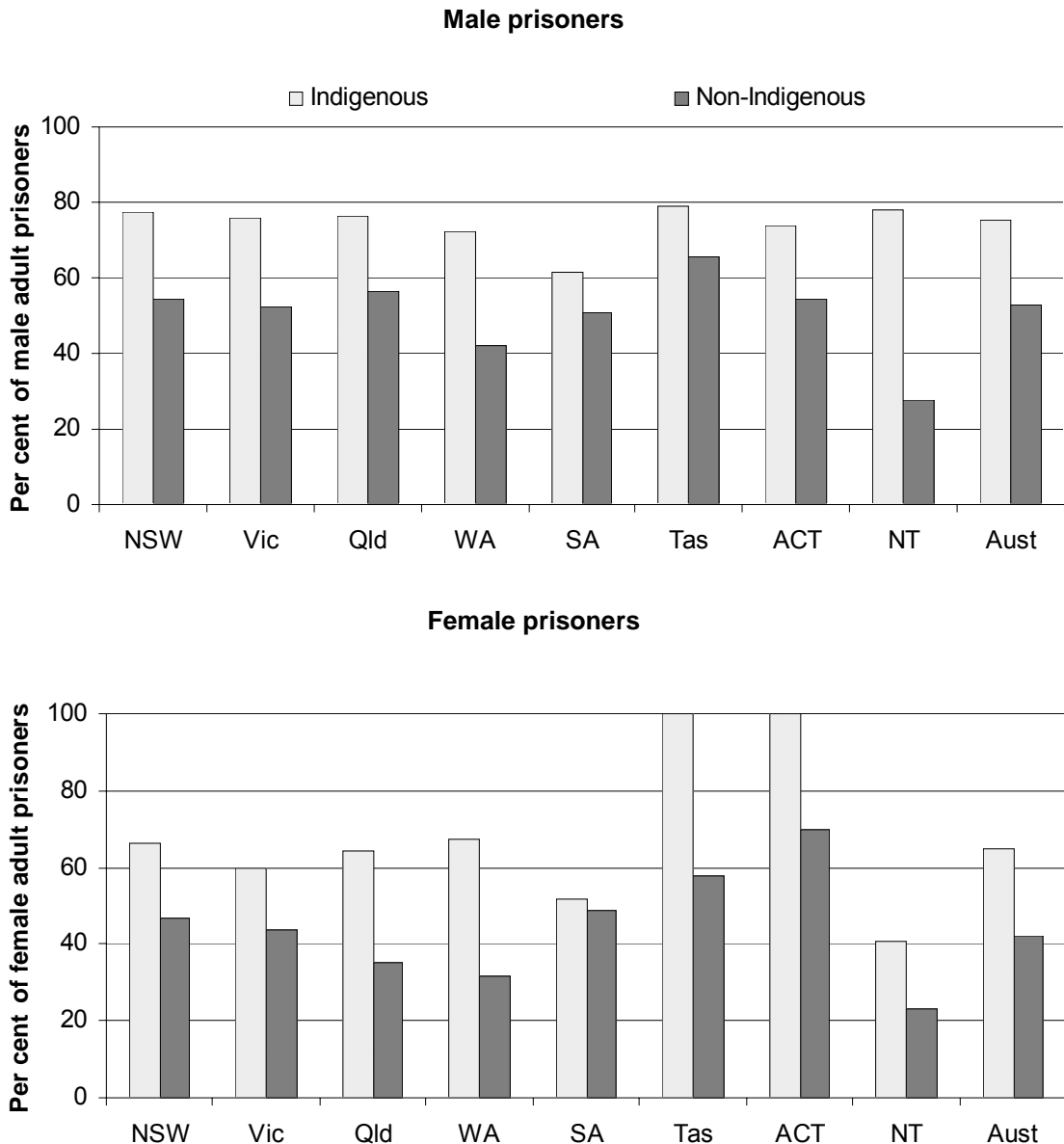
^a Persons known to have had prior imprisonment under sentence in a gazetted adult prison. A prior sentence of periodic detention is included as prior imprisonment. Some states and territories may also include episodes on remand as prior imprisonment. Prisoners who have had previous adult imprisonment in another State or Territory may not be counted as having prior imprisonment.

Source: ABS (2006); table 9A.2.2.

- At 30 June 2006, the proportion of prisoners who had prior adult imprisonment under sentence was higher for Indigenous prisoners than non-Indigenous prisoners in all states and territories (figure 9.2.1).
- Nationally, the proportion of prisoners who had prior adult imprisonment was 74.4 per cent for Indigenous prisoners and 52.0 per cent for non-Indigenous prisoners at 30 June 2006 (figure 9.2.1).
- The NT had the greatest difference between the proportion of Indigenous and non-Indigenous prisoners who had prior adult imprisonment under sentence at 30 June 2006 (76.7 per cent of Indigenous prisoners had prior adult imprisonment under sentence compared to 27.3 per cent for non-Indigenous prisoners) (table 9A.2.2).
- From 2005 to 2006, the proportion of Indigenous prisoners who had prior adult imprisonment under sentence decreased in NSW, Queensland, WA, SA and Tasmania and increased in Victoria and the NT (tables 9A.2.1 and 9A.2.2). There were no data available from the ACT on the proportion of Indigenous and non-Indigenous prisoners who had prior adult imprisonment under sentence at 30 June 2005 (table 9A.2.1).

To complement data on the proportions of prisoners with known prior adult imprisonment under sentence, tables 9A.2.1 and 9A.2.2 also present the actual numbers of Indigenous and non-Indigenous prisoners who have and have not been imprisoned before their current sentence, by State and Territory.

Figure 9.2.2 Proportion of prisoners with known prior adult imprisonment under sentence, by sex, 30 June 2006^a



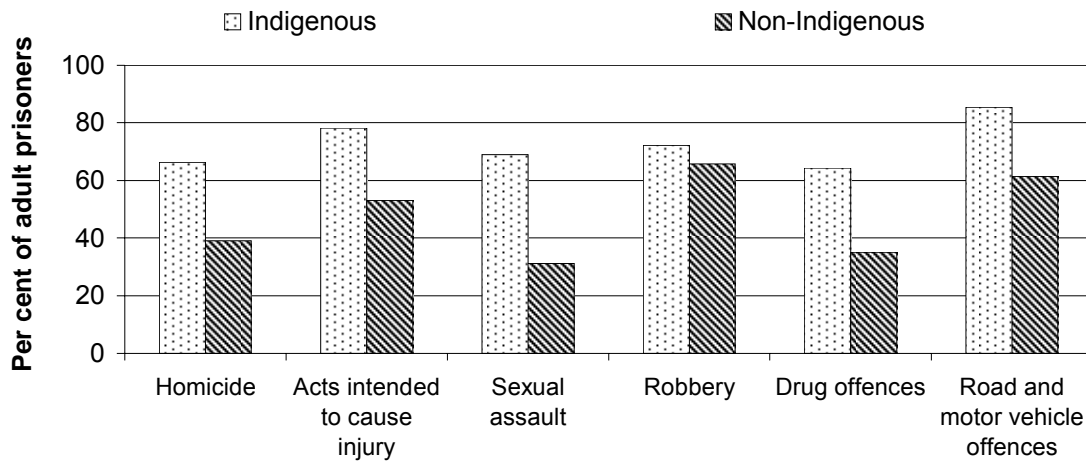
^a Persons known to have had prior imprisonment under sentence in a gazetted adult prison. A prior sentence of periodic detention is included as prior imprisonment. Some states and territories may also include episodes on remand as prior imprisonment. Prisoners who have had previous adult imprisonment in another State or Territory may not be counted as having prior imprisonment.

Source: ABS (2006); table 9A.2.2.

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- Nationally in 2006, 75.3 per cent of Indigenous male prisoners had prior adult imprisonment, compared with 64.6 per cent of Indigenous female prisoners (figure 9.2.2).
 - At 30 June 2006, the proportion of prisoners who had prior adult imprisonment under sentence was higher for Indigenous male and female prisoners than non-Indigenous male and female prisoners in all states and territories (figure 9.2.2).
 - In Tasmania and the ACT, 100.0 per cent of the Indigenous female prisoner population had prior adult imprisonment under sentence at 30 June 2006 (figure 9.2.2). The proportion of Indigenous female prisoners who had prior adult imprisonment under sentence decreased in NSW, Queensland, WA and the NT and increased in Victoria and SA from 2005 to 2006 (tables 9A.2.1 and 9A.2.2).
 - From 2005 to 2006, the proportion of Indigenous male prisoners who had prior adult imprisonment under sentence decreased in NSW, Queensland, WA, SA and Tasmania and increased in Victoria and the NT (tables 9A.2.1 and 9A.2.2).

Table 9A.2.3 shows the trends in the proportions of Indigenous and non-Indigenous prisoners with prior adult imprisonment from 2000 to 2006. Nationally, the proportion of Indigenous prisoners with prior adult imprisonment changed little over that period, from 76.2 in 2000 to 74.4 in 2006. The difference between the proportions of Indigenous and non-Indigenous prisoners with prior adult imprisonment remained constant from 2000 to 2006, with around a 23 percentage point difference between the two rates on a national basis (table 9A.2.3). Among the states and territories, the most noticeable improvement in the proportion of Indigenous prisoners with prior adult imprisonment was observed in SA, dropping from 89.3 per cent in 2000 to 60.7 per cent in 2006 (table 9A.2.3).

Figure 9.2.3 Proportion of prisoners with known prior adult imprisonment under sentence, by most serious offence/charge, 30 June 2006^a



^a Persons known to have had prior imprisonment under sentence in a gazetted adult prison. A prior sentence of periodic detention is included as prior imprisonment. Some states and territories may also include episodes on remand as prior imprisonment. Prisoners who have had previous adult imprisonment in another State or Territory may not be counted as having prior imprisonment.

Source: ABS (2006); table 9A.2.5.

- Figure 9.2.3 shows the proportion of Indigenous and non-Indigenous prisoners with known prior imprisonment disaggregated by the current most serious offence/charge for which the person has been imprisoned. Note, the most serious offence/charge for which the prisoner is serving their current sentence is not necessarily related to any offence/charge for which they may have previously been imprisoned.
- Of those prisoners who were currently in prison for homicide (at 30 June 2006), 66.3 per cent of Indigenous prisoners had been in prison previously and 39.0 per cent of non-Indigenous prisoners had been in prison previously (figure 9.2.3).
- In each offence category shown in figure 9.2.3, the proportion of Indigenous prisoners who had been in prison previously was higher than the proportion of non-Indigenous prisoners at 30 June 2006.
- Indigenous prisoners serving a sentence for ‘road and motor vehicle offences’ at 30 June 2006 were more likely to have been in prison previously compared to the other offence categories (figure 9.2.3).
- The difference between the proportion of Indigenous and non-Indigenous prisoners with prior adult imprisonment was highest for sexual assault offences. Of those Indigenous prisoners who were in prison for sexual assault,

69.0 per cent had been in prison previously, compared with 31.2 per cent of non-Indigenous prisoners (figure 9.2.3).

Data on the number and proportion of sentenced and unsentenced prisoners with prior imprisonment, disaggregated by a greater number of offence categories than those presented in figure 9.2.3, are shown in tables 9A.2.4 (for 2005) and 9A.2.5 (for 2006). In 2005 and 2006, the proportion of sentenced Indigenous prisoners who had been in prison previously was higher than or equal to the proportion of sentenced non-Indigenous prisoners with prior imprisonment for each offence category (tables 9A.2.4 and 9A.2.5).

Juvenile repeat offending

New South Wales

Table 9A.2.6 presents data from a cohort of 5 476 juveniles aged 10 to 18 years who appeared in the NSW Children's Court for the first time in 1995 (BOCSAR 2005). Of the cohort population, 12.7 per cent were Indigenous. The study counted the number of court and custodial appearances for each juvenile from 1995 to December 2003 to evaluate the re-offending behaviour of the cohort. The average number of court reappearances per person in the follow-up period was nearly three times higher for Indigenous juveniles than non-Indigenous juveniles (8.3 court reappearances per person compared to 2.8). Further, 90.5 per cent of Indigenous juveniles in the cohort had at least one adult court appearance in the follow-up period, compared with 52.6 per cent of non-Indigenous juveniles.

Queensland

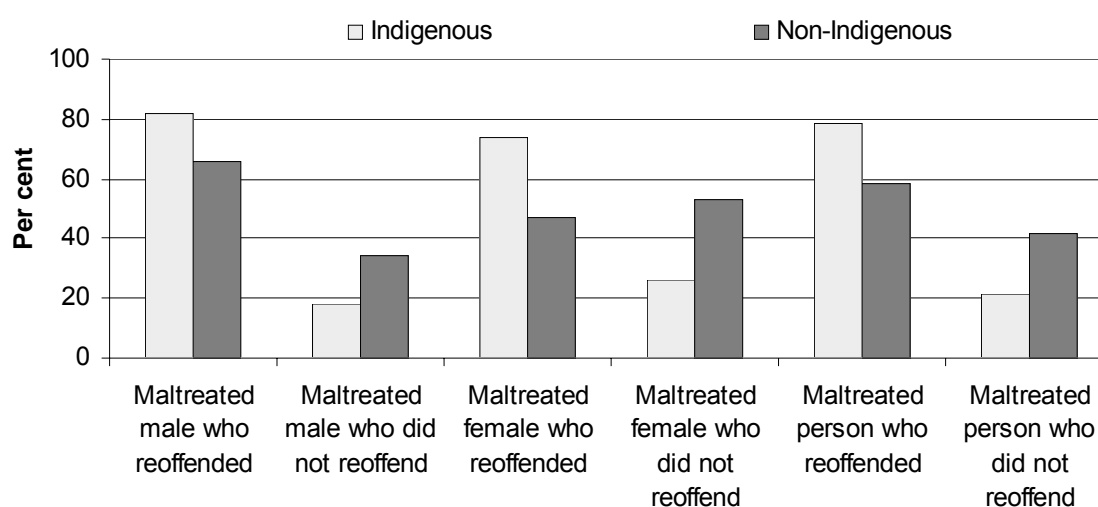
Data from Queensland are sourced from a report published by Griffith University School of Criminology and Criminal Justice (2005) which examines the link between child maltreatment, police cautioning and juvenile repeat offending. The study follows all children born in a 1983 birth cohort through any contact they had with the former Department of Families (regarding a child protection matter) and juvenile justice system up until 2000-01 (that is, until the participants turned 17 years of age and were no longer classified as a juvenile in Queensland). In total, data pertaining to 24 305 children were collected and analysed in this study (Griffith University 2005).

In the population analysed, 14 572 juveniles received a police caution from 1983 to 2000-01. Of those who received a police caution, 993 had been maltreated as a child (Griffith University 2005). Child maltreatment, which can include physical abuse,

neglect or sexual abuse, is considered a specific risk factor for delinquency and juvenile offending (Griffith University 2005).

Figure 9.2.4 presents the rates of Indigenous and non-Indigenous juveniles who were maltreated as children, received a police caution and were/were not repeat offenders in the 1983 birth cohort (48 juveniles had missing data for Indigenous status and were excluded).

Figure 9.2.4 Queensland, repeat offending rates for maltreated juveniles who received a police caution, by sex, 1983 birth cohort^{a, b}



^a Rates were calculated as part of a project examining the link between child maltreatment, police cautioning and juvenile re-offending by following all children born in a 1983 Queensland birth cohort until the age of 17 through any contact they had with the former Department of Families regarding a child protection matter and/or juvenile justice matter that required the child to appear in court or be held in custody. ^b Forty-eight juveniles had missing data for Indigenous status and were excluded.

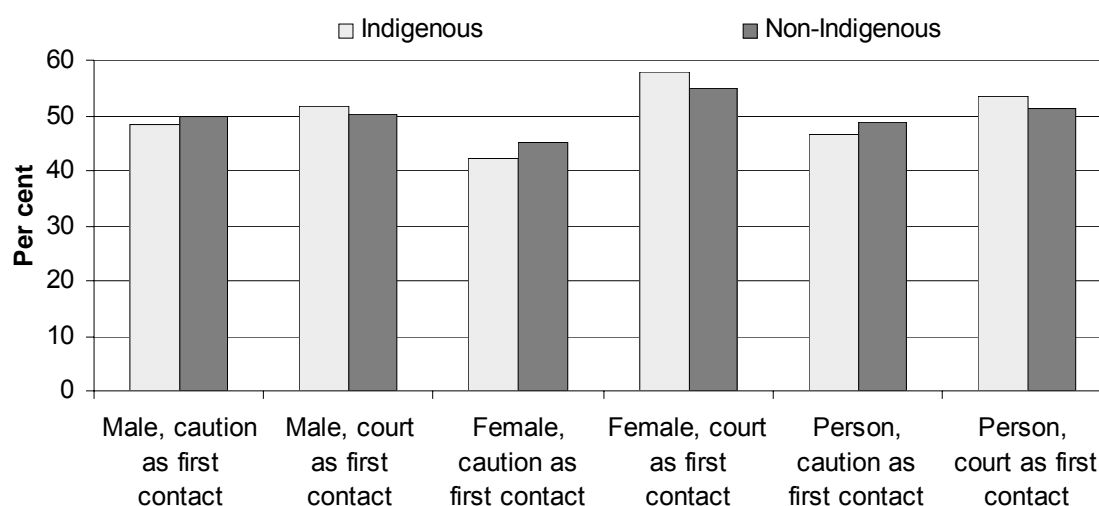
Source: Griffith University (2005); table 9A.2.7.

- Of the juveniles in the 1983 Queensland birth cohort who had been maltreated and received a police caution, a greater proportion of Indigenous males and females re-offended than non-Indigenous males and females. Eighty-two per cent and 74.1 per cent of maltreated Indigenous males and females re-offended, respectively, compared with 66.0 per cent of maltreated non-Indigenous males and 46.7 per cent of maltreated non-Indigenous females (figure 9.2.4).

Figure 9.2.5 examines whether Indigenous and non-Indigenous juveniles who were cautioned for their first offence were more likely to re-offend than Indigenous and non-Indigenous juveniles who appeared in court for their first offence. The rates were calculated based on a population of 4 835 juveniles (1 070 Indigenous and 3 765 non-Indigenous) who may or may not have been maltreated as children. Of the population analysed, 2 339 were issued a caution on first contact with the

juvenile justice system and 2 496 appeared in court on their first contact (Griffith University 2005).

Figure 9.2.5 Queensland, proportion of juvenile repeat offenders who had a finalised court appearance, by nature of first contact with the juvenile justice system and sex, 1983 birth cohort^{a, b}



^a Proportions were calculated as part of a project examining the link between child maltreatment, police cautioning and juvenile re-offending by following all children born in a 1983 Queensland birth cohort until the age of 17 through any contact they had with the former Department of Families regarding a child protection matter and/or juvenile justice matter that required the child to appear in court or be held in custody. ^b Two young people were missing information on the variable sex and were excluded.

Source: Griffith University (2005); table 9A.2.8.

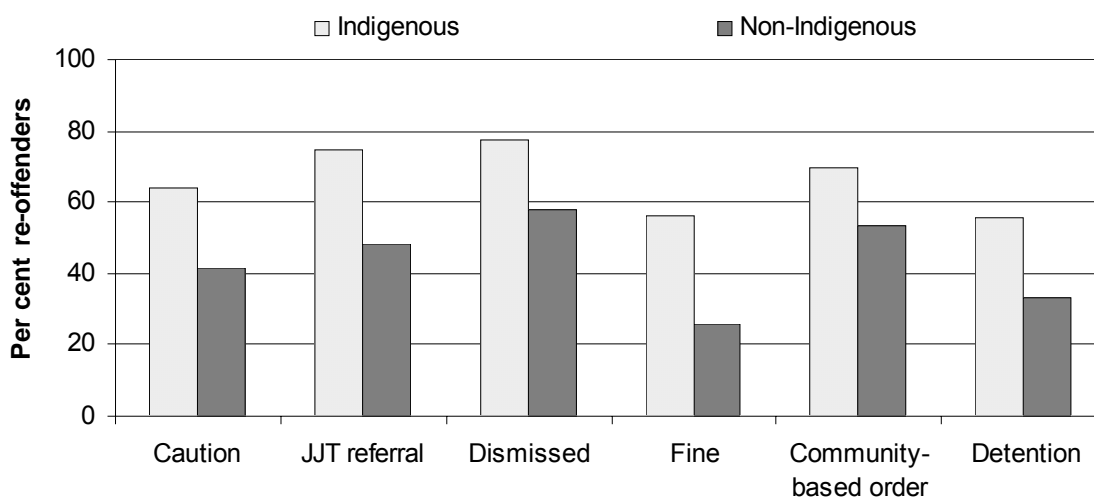
- The proportion of juvenile repeat offenders who had a finalised court appearance after receiving a caution was similar for Indigenous and non-Indigenous males and females in the 1983 Queensland birth cohort (figure 9.2.5). For Indigenous and non-Indigenous males, 48.2 per cent and 49.9 per cent, respectively, had a finalised court appearance after receiving a caution. The difference between the rates for Indigenous and non-Indigenous females was slightly greater (42.1 per cent of Indigenous females had a finalised court appearance after receiving a caution compared to 45.0 per cent of non-Indigenous females) (figure 9.2.5).
- The proportion of repeat offenders who had a finalised court appearance after their first contact with the juvenile justice system led to a court appearance was similar for males and females, although rates for Indigenous males and females were slightly greater than non-Indigenous males and females (figure 9.2.5).
- For both Indigenous and non-Indigenous juveniles, greater proportions re-offended if their first contact with the juvenile justice system was court rather than a caution (46.6 per cent of Indigenous juveniles re-offended after receiving

a caution compared to 53.4 per cent who re-offended after having had contact with court) (figure 9.2.5).

Western Australia

Figure 9.2.6 shows the proportions of Indigenous and non-Indigenous juveniles who re-offended after being dismissed, referred to a juvenile justice team, issued a formal caution, fine or community-based order, or sentenced to juvenile detention on their first contact with the WA juvenile justice system. Data are based on two cohorts of juveniles first entering the WA justice system in either 1995 or 2000. The follow-up times for the 1995 and 2000 cohorts were 7.5 and 2.5 years, respectively. Re-offending was measured by the proportion of the group who re-offended before the end of the study or follow-up period. The 2000 cohort was slightly larger in size than the 1995 cohort (7811 and 7271 offenders, respectively).

Figure 9.2.6 WA, proportion of juveniles re-offending, by type of first contact with the juvenile justice system, 1995 and 2000 cohorts^{a, b, c}



JJT Juvenile justice team.

Source: University of Western Australia (2004); table 9A.2.9.

- For each type of contact with the juvenile justice system, a greater proportion of Indigenous juveniles re-offended than non-Indigenous juveniles in the WA cohort (figure 9.2.6).
- Among Indigenous juveniles, the greatest proportion re-offended after their first contact with the juvenile justice system was dismissed (77.4 per cent) or there was a referral to a juvenile justice team (74.7 per cent). For non-Indigenous juveniles, the greatest proportion re-offended after their first contact with the

juvenile justice system was dismissed (57.6 per cent) or there was a community-based order (53.5 per cent) (figure 9.2.6).

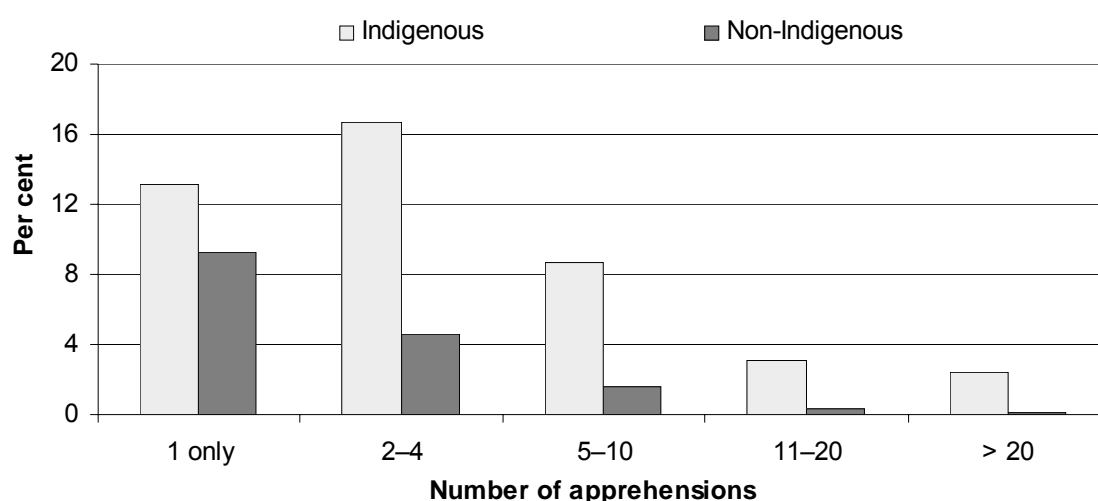
- The greatest difference between the proportion of Indigenous and non-Indigenous re-offenders was for juveniles receiving a fine as their first contact with the justice system (56.0 per cent of Indigenous juveniles re-offended after receiving a fine compared to 25.8 per cent of non-Indigenous juveniles) (figure 9.2.6).

South Australia

Figure 9.2.7 presents data from a cohort study assessing the extent to which juveniles in SA had formal contact with the juvenile justice system. Each juvenile included in the study was born in 1984 and the follow-up period was 18 years. In SA, a juvenile's formal contact with the justice system commences when they are officially apprehended by police, either by way of an arrest or report. The 1984 cohort comprised 540 Indigenous juveniles and 20 362 non-Indigenous juveniles (table 9A.2.10).

Data in figure 9.2.7 must be interpreted with caution as they do not measure the actual levels of offending as not all apprehended youths are subsequently found guilty or admit guilt (although the majority do) (OCSAR 2005).

Figure 9.2.7 SA, proportion of juveniles in the 1984 cohort which were apprehended as juveniles (0–17 years), by the number of apprehensions and Indigenous status^a



^a Excludes 18 year olds.

Source: OCSAR (2005); table 9A.2.11.

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- In the 1984 cohort, Indigenous juveniles were more likely than non-Indigenous juveniles to be in contact with the SA juvenile justice system (figure 9.2.7).
 - Overall, Indigenous juveniles were 2.8 times more likely to be apprehended at least once than non-Indigenous juveniles (44.1 per cent compared with 15.8 per cent) (table 9A.2.11).
 - The proportion of Indigenous juveniles who were apprehended on two to four occasions in the 1984 cohort were 3.6 times as high as the proportion of non-Indigenous juveniles (16.7 per cent compared with 4.6 per cent) (figure 9.2.7).
 - The difference between the proportion of Indigenous and non-Indigenous juveniles who were apprehended in the 1984 cohort increased as the number of apprehensions increased (figure 9.2.7).

9.3 Access to primary health care

Box 9.3.1 Key messages

- In 2001-02, expenditure per Indigenous person on primary health care, including that paid through the Medicare Benefits Scheme, was less than half the expenditure per non-Indigenous person (table 9.3.1).
- In 2004-05, the hospitalisation rate for Indigenous people with potentially preventable chronic conditions was 8.2 times the rate for non-Indigenous people, and the rate for potentially preventable acute conditions was 2.7 times the rate for non-Indigenous people (tables 9.3.2 and 9.3.4). For Type 2 diabetes, the Indigenous hospitalisation rate was 6.5 times the rate for non-Indigenous people (table 9.3.3).
- Hospitalisation rates for influenza decreased for both Indigenous and non-Indigenous people between 2003-04 and 2004-05. However, the reduction was greater for non-Indigenous people (table 9.3.5).
- Hospitalisation rates for Indigenous people for sexually transmitted infections were between 12.7 and 66.6 times the rates for non-Indigenous people (table 9.3.6).

Indigenous people, like other Australians, experience a variety of physical and mental illnesses. Primary health care services (for example, doctors in private practice and Aboriginal and Torres Strait Islander primary health care services) influence the health status of Indigenous people by detecting and treating illness and managing prevention programs associated with long term health conditions. Access to primary health care can affect outcomes in a range of headline indicators and strategic areas for action, including life expectancy, infant mortality, disability and

chronic disease, early child development and growth, substance use and misuse, and functional and resilient families and communities. Poor health can also affect people's educational attainment and ability to work.

In the 2003 Report, access to health care services by Indigenous people was quantified in terms of distance to the nearest health professional and nearest community health centre. This information was sourced from the 2001 Community Housing and Infrastructure Needs Survey (CHINS) (ABS 2002). The CHINS was conducted again in 2006 and data on access to primary health care are presented in this section (ABS 2007).

From consultations with Indigenous people and health policy makers in the preparation of the 2005 Report, there was general agreement that distance is only one aspect influencing access to primary health care and that a more comprehensive measure was required to reflect the barriers faced by Indigenous people. This includes those living in remote and non-remote areas. Indigenous people who live in cities and towns, where clinics, doctors and other health professionals are at close reach, can face cultural, language and racism barriers that reduce their access to primary health services. Cutcliffe (2004) reported examples of racism and cultural insensitivity in mainstream health services and found that these were not uncommon experiences for Indigenous people. These barriers lead to some Indigenous people not being diagnosed and treated for disease in the early stages, when it is often more easily and effectively treated.

In the 2005 Report, the 'access to the nearest health professional' indicator was expanded to include the use of health services more broadly as well as data on hospitalisations for potentially preventable chronic and vaccine-preventable conditions.

To improve reporting on access to primary health care in the 2007 Report, this indicator has been renamed 'Access to primary health care' and expanded once again to include:

- expenditure on health care services for Indigenous people in 2001-02
- 2001-02 to 2004-05 data on hospitalisations for potentially preventable chronic and acute conditions, vaccine-preventable conditions and sexually transmitted infections
- survey data from the ABS 2004-05 NATSIHS and 2006 CHINS on Indigenous people accessing primary health care services in 2001, 2004-05 and 2006.

In addition to providing data on expenditure, hospitalisations and access to health care, this section presents three initiatives which were successfully implemented in NSW, Victoria and WA to improve primary health care services for Indigenous

people (see boxes 9.3.2 to 9.3.4). Other examples of successful primary health care initiatives are included in sections 5.1, 5.2 and 5.3.

Box 9.3.2 ‘Things that work’ — Marrang Aboriginal Child and Family Health Model

The Marrang Aboriginal Child and Family Health Model (MACFHM) was developed to improve access to health care services and health outcomes among Indigenous families living in Orange, NSW. The model is based on a two-person team comprising an Aboriginal Health Worker and a nurse dedicated to servicing Aboriginal families. The model engages Aboriginal families in a culturally appropriate manner.

The model was developed following consultation with Aboriginal families to gain a better understanding of why they were not using child and family health care services. The model advocates community development and building strong partnerships with local communities. Flexibility of service provision and a strong antenatal focus assists in engaging the Aboriginal community. The NSW Health Family Partnership Model and training was used to sustain good relationships with families in this project.

The key to the success of the new service delivery model was that the contact with Aboriginal people recognised socioeconomic factors affecting the Aboriginal community which have often been overlooked. These include low literacy levels and not having a telephone or transport. Improved health access was achieved by using an interpreter, providing transport, encouraging clients to seek additional health services, ensuring health appointments were attended, and providing health education.

The main outcome resulting from the implementation of the MACFHM has been that referrals from within the Aboriginal community or through the more traditional health services/professionals as well as attendances at antenatal clinics have increased. Further, sustained contact by the dedicated team has increased the Aboriginal community’s trust in the health care services available in the region.

Box 9.3.3 'Things that work' — Condom Social Marketing for Indigenous Australia: Mildura Area Pilot Initiative

The Condom Social Marketing for Indigenous Australia project, launched in 2004, aims to help reduce unplanned teenage pregnancies and the spread and incidence of sexually transmitted infections (STIs), including HIV/AIDS, in Indigenous communities. The project was piloted in Mildura, Victoria, and the surrounding area over an 18-month period, culminating with the launch of 'Snake Condoms' – Australia's first ever Indigenous-friendly socially marketed condom brand.

The Mildura pilot was led by Marie Stopes International Australia (MSIA) in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Mildura Aboriginal Health Service (MAHS). The initiative arose from an earlier VACCHO-MSIA project which highlighted the need to improve young Indigenous people's access to condoms to enable them to practise safe sex and reduce unwanted pregnancies and STIs.

Indigenous youth in the Mildura area worked closely with MSIA, VACCHO, MAHS and Cummins & Partners advertising agency to develop 'Snake Condoms', including the product name, logo and packaging material. The condoms and safe sex message were then promoted in the Mildura area through a print, poster, transit and radio advertising campaign. In addition to stocking the condoms at retail outlets, a number of young Indigenous people were trained as peer sellers, enabling the product to be distributed at parties in private homes—a place where many key decisions about sexual behaviour are made.

The evaluation of the Mildura area pilot initiative found that there had been a significant improvement in the rate of condom use among sexually active Indigenous young people and a significant shift in attitudes among young Indigenous people about safe sex practises (Marie Stopes International Australia 2005). As a result of the campaign, Indigenous people aged 16 to 30 years in the Mildura area were more likely to use condoms and were more worried about having unsafe/unprotected sex. The evaluation also found that partnerships with key Indigenous organisations, input from the local community, and working within the principles of Aboriginal self-determination and community control were key to the success of the initiative (Marie Stopes International Australia 2005).

Based on the success of the Mildura pilot, MSIA and VACCHO are currently seeking interest from other Indigenous communities with the aim of expanding the initiative Australia-wide (Marie Stopes International Australia 2005).

Box 9.3.4 'Things that work' — Jirrawun Health

Jirrawun Health, based in Kununnura, WA, is a non-government body established through charitable donations which works with mainstream health care services to improve the health outcomes of the Gija people in the East Kimberley region. Jirrawun Health sits on the District Health Advisory Council and advocates culturally competent health services. The service visits communities in and around Warmun community on a daily basis to respond to chronic hearing problems, eye problems, blood pressure and kidney health, nutrition, diabetes, medication compliance, dental health, smoking, sexual health, alcohol dependence, mental health, maternal health and environmental health. In addition, Jirrawun Health has started to produce DVDs which promote positive health messages that will be distributed to communities in the East Kimberley.

For information on the Jalaris Aboriginal Corporation, a health initiative focusing on Indigenous children in Derby, WA, see section 9.7.

Expenditure on health care services for Indigenous people

Expenditures per person on health services by type of service provide an indication of the relative use of health care services between Indigenous and non-Indigenous people. The most recently published data on health expenditure for Indigenous people are for 2001-02 (AIHW 2005).

It is not always possible to make accurate estimates of health expenditure for Indigenous people and their corresponding service use. For example, Indigenous status is not always clearly stated or recorded. Data on Indigenous status are often unavailable for privately funded services (although they are available for many publicly funded health services). The scope and definition of health expenditures also have some limitations. Other (non-health) agency contributions to health expenditure, such as those incurred within education departments and prisons are not included. There may also be some inconsistencies across data providers resulting from limitations of financial reporting systems and different reporting mechanisms (AIHW 2005).

Table 9.3.1 compares the total expenditure and expenditure per person on health care services for Indigenous and non-Indigenous people. The data include expenditure on primary health care services such as medical, community health and dental services.

Table 9.3.1 Expenditure on health care services for Indigenous and non-Indigenous people, by type of health good or service, current prices, Australia, 2001-02^a

Health good or service type	Total expenditure (\$ million)			Expenditure per person (\$)		
	Indigenous	Non-Indigenous	Indigenous share (%)	Indigenous	Non-Indigenous	Ratio
Hospitals	849.5	21 456.9	3.8	1 852.8	1 132.0	1.6
Admitted patient services	682.5	17 927.4	3.7	1 488.4	945.8	1.6
Private hospital	11.5	5 057.1	0.2	25.1	266.8	0.1
Public hospital	671.0	12 870.2	5.0	1 463.3	679.0	2.2
Non-admitted patient services	142.4	3 116.5	4.4	310.6	164.4	1.9
Emergency departments	34.6	615.7	5.3	75.5	32.5	2.3
Other services	107.8	2 500.8	4.1	235.1	131.9	1.8
Public (psychiatric) hospitals	24.7	413.0	5.6	53.8	21.8	2.5
Medical services	99.6	11 112.5	0.9	217.2	586.3	0.4
Medicare benefit items	75.9	9 185.4	0.8	165.5	484.6	0.3
Other	23.7	1 927.2	1.2	51.7	101.7	0.5
Community health services ^{b, c}	439.9	2 810.5	13.5	959.3	148.3	6.5
Dental services ^b	21.8	3 734.2	0.6	47.6	197.0	0.2
Other professional services	16.9	2 252.4	0.7	36.8	118.8	0.3
Pharmaceuticals	66.2	9 011.6	0.7	144.4	475.4	0.3
Benefit-paid ^d	42.3	5 471.8	0.8	92.2	288.7	0.3
Other pharmaceuticals	23.9	3 539.8	0.7	52.2	186.8	0.3
Aids and appliances	15.8	2 474.0	0.6	34.5	130.5	0.3
Services for older people	49.9	4 591.6	1.1	108.8	242.3	0.4
Patient transport	62.8	892.7	6.6	137.0	47.1	2.9
Public health activities	72.5	1 029.9	6.6	158.2	54.3	2.9
Other health services (nec)	50.6	1 458.9	3.4	110.4	77.0	1.4
Health administration (nec)	43.1	1 883.6	2.2	94.0	99.4	0.9
Total	1 788.6	62 708.9	2.8	3 900.8	3 308.4	1.2

^a Total expenditure by type of health good or service is the same as total funding. ^b Community health services include State and Territory government expenditure on dental services. ^c Includes \$186.3 million in OATSIH expenditure through Indigenous-specific primary health care services. The Indigenous ratio for the non-Indigenous-specific primary health care services component of community health is estimated at 4.06:1 and for the non-Indigenous-specific primary health care services component it is estimated at 1.07:1. ^d Includes estimates of benefits through the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme.

Source: AIHW (2005a).

- In 2001-02, expenditure on primary health care (medical, community health and dental services) for Indigenous people was \$1224 per person compared with \$932 per non-Indigenous person (table 9.3.1).

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- Primary health care expenditure on medical services per Indigenous person was one-third of the expenditure per non-Indigenous person in 2001-02. For dental services, expenditure per Indigenous person was one-quarter of the expenditure per non-Indigenous person (table 9.3.1).
 - Expenditure per person on community health services was 6.5 times greater for Indigenous people than non-Indigenous people (\$959 compared to \$148) (table 9.3.1).
 - Expenditure per person on pharmaceuticals was less for Indigenous people, one-third of that for non-Indigenous people (\$144 compared to \$475) (table 9.3.1).

Hospitalisations for potentially preventable conditions

In many cases, hospital admissions can be prevented if more effective non-hospital care were available, such as primary health care services, either at an earlier stage in the disease progression or as an alternative to hospital care (Australian Health Ministers' Advisory Council 2006). This section explores preventable illness by looking at hospitalisations for potentially preventable chronic (tables 9.3.2 and 9.3.3) and acute conditions (table 9.3.4), vaccine-preventable conditions (table 9.3.5), and infections with a predominantly sexual mode of transmission (table 9.3.6).

The availability of hospitalisation data for Indigenous people is significantly reduced in the 2007 Report compared to previous Reports. AIHW analysis of the quality of Indigenous identification of hospital statistics has shown that while the quality is good in some jurisdictions, in other jurisdictions it is poor (AIHW 2005b). Consequently, Indigenous hospitalisation data are only available for Queensland, WA, SA and the NT.

NSW, Victoria, Tasmania and the ACT are working with the AIHW to improve the quality of their Indigenous hospitalisation data. Hospitalisation data for four jurisdictions should not be assumed to represent the hospitalisation experience in the other jurisdictions.

Non-Indigenous data from the AIHW includes hospitalisations of people identified as non-Indigenous as well as those with a 'not stated' Indigenous status.

Tables 9.3.2 and 9.3.3 show much higher hospitalisation rates for Indigenous people than non-Indigenous people for a range of potentially preventable chronic diseases and for complications associated with diabetes.

Table 9.3.2 Age standardised hospitalisation rates for potentially preventable chronic conditions, per 100 000 people, Queensland, WA, SA and public hospitals in the NT, 2004–05^{a, b}

		<i>Indigenous</i>	<i>Non-Indigenous^c</i>	<i>Total</i>
Asthma	rate	485.6	182.8	190.2
Congestive cardiac failure	rate	777.6	193.0	203.7
Diabetes complications	rate	17 891.2	1 615.3	1 907.0
Chronic obstructive pulmonary diseases	rate	1 402.7	265.0	282.3
Angina	rate	608.7	221.0	229.2
Iron deficiency anaemia	rate	163.7	98.0	99.6
Hypertension	rate	122.9	30.3	32.2
Nutritional deficiencies ^d	rate	2.0	0.6	0.8
Total for potentially preventable chronic conditions^e	rate	20 477.3	2 496.8	2 822.5
Total hospitalisations for all conditions	rate	95 139.9	34 005.8	35 338.8
Hospitalisations for potentially preventable chronic conditions as a proportion of hospitalisations for all conditions	%	16.7	7.4	8.0

^a Hospitalisation rates are directly age standardised to the Australian population at 30 June 2001. ^b Data are based on state of usual residence. ^c Non-Indigenous includes hospitalisations of people identified as not Indigenous as well as those with a 'not stated' Indigenous status. ^d The Indigenous nutritional deficiencies standardised rate is based on only 25 hospitalisations and should be used with caution. ^e The total is not the sum of the individual conditions because diabetes complications overlap other categories.

Source: AIHW National Hospital Morbidity Database (unpublished); table 9A.3.2.

- Hospitalisation rates for Indigenous people with potentially preventable chronic conditions were 8.2 times as high as the rates for non-Indigenous people (20 477.3 hospitalisations per 100 000 Indigenous people compared to 2496.8 hospitalisations per 100 000 non-Indigenous people, respectively) (table 9.3.2).
- Hospitalisation rates for Indigenous people with diabetes complications were 11.1 times as high and for chronic obstructive pulmonary diseases 5.3 times as high as the rates for non-Indigenous people (table 9.3.2).
- Hospitalisations for potentially preventable chronic conditions were more common among Indigenous people (16.7 per cent) than non-Indigenous people (7.4 per cent), which suggests that inadequate use of, or access to, primary health care services is a greater contributor to Indigenous hospitalisation rates.
- From 2001-02 to 2004-05, hospitalisations for potentially preventable chronic conditions increased every year for Indigenous people (tables 9A.3.1 and 9A.3.2). The hospitalisation rate for potentially preventable chronic conditions in 2004-05 was 2.1 times as high as the rate in 2001-02 (20 477.3 hospitalisations per 100 000 people compared to 9683.2 hospitalisations per 100 000 people) (tables 9A.3.1 and 9A.3.2).

Data shown below in table 9.3.3 are different to those relating to diabetes in table 9.3.2. Data in table 9.3.2 show hospitalisation rates for all types of diabetes (Type 1, Type 2 and unspecified) and where diabetes may have been an additional diagnosis and not just the principal diagnosis (that is, it could be associated with other reasons for going to hospital). Data in table 9.3.3, on the other hand, only include Type 2 diabetes as a principal diagnosis. Thus, the data in table 9.3.3 are more narrowly specified and hospitalisation rates are lower.

Table 9.3.3 Age standardised hospitalisation rates for Type 2 diabetes as principal diagnosis by complication, per 100 000 people, Queensland, WA, SA, and public hospitals in the NT, 2004–05^{a, b, c, d, e}

	<i>Indigenous</i>	<i>Non-Indigenous^f</i>	<i>Total</i>
Circulatory	37.1	20.5	20.9
Renal	323.5	16.2	21.5
Ophthalmic	239.5	94.2	96.1
Other specified	530.2	56.0	65.3
Multiple	365.8	41.4	47.9
No complications	24.0	3.8	4.2
Total^g	1519.8	232.2	256.1

^a Hospitalisation rates are directly age standardised to the Australian population at 30 June 2001. ^b Figures are based on the ICD-10-AM classification. The codes used were E11.x, where x=2 (renal complications), x=3 (ophthalmic complications), x=5 (peripheral circulatory complications), x=7 (multiple complications), x=8 (unspecified complications), x=9 (without complications), and x=0, 1, 4, 6 (other specified complications). ^c Results for individual complications may be affected by small numbers, particularly for Indigenous people, and should be interpreted with caution. ^d Although same day admission for dialysis is not normally coded with a principal diagnosis of Type 2 diabetes, the data contain a significant number in several jurisdictions. ^e Data are based on state of usual residence. ^f Non-Indigenous includes hospitalisations identified as not Indigenous as well as those with a 'not stated' Indigenous status. ^g Totals include hospitalisations for unspecified complications.

Source: AIHW National Hospital Morbidity Database (unpublished); table 9A.3.3.

- Hospitalisations for Indigenous people with Type 2 diabetes as a principal diagnosis were 6.5 times as high as the rates for non-Indigenous people in 2004-05 (1519.8 hospitalisations per 100 000 Indigenous people compared to 232.2 hospitalisations per 100 000 non-Indigenous people) (table 9.3.3).
- Hospitalisations for renal (kidney-related) complications of diabetes were 20 times as high for Indigenous people as non-Indigenous people (table 9.3.3).
- For Indigenous people, hospitalisations for complications associated with Type 2 diabetes as a principal diagnosis increased every year from 2001-02 to 2003-04 (from 1338.1 per 100 000 people in 2001-02 to 1594.8 per 100 000 people in 2003-04) (table 9A.3.3). From 2003-04 to 2004-05, this rate fell to 1519.8 hospitalisations per 100 000 people (tables 9A.3.3).

Tables 9.3.2 and 9.3.3 above presented data on hospitalisations for chronic conditions — those which typically persist for at least six months. Table 9.3.4

presents hospitalisation rates for a variety of conditions which cause serious short-term affliction and could possibly be prevented, or their severity minimised, through access to effective primary health care services.

Table 9.3.4 Age standardised hospitalisation rates for potentially preventable acute conditions, per 100 000 people, Queensland, WA, SA, and public hospitals in the NT, 2004-05^{a, b}

		<i>Indigenous</i>	<i>Non-Indigenous^c</i>	<i>Total</i>
Dehydration and gastroenteritis	rate	372.8	215.1	218.0
Pyelonephritis ^d	rate	750.0	198.0	209.9
Perforated/bleeding ulcer	rate	36.0	23.5	23.7
Cellulitis	rate	555.0	134.2	148.3
Pelvic inflammatory disease	rate	83.8	24.9	27.4
Ear, nose and throat infections	rate	401.7	180.4	188.9
Dental conditions	rate	311.6	282.5	285.6
Appendicitis	rate	158.3	140.1	140.9
Convulsions and epilepsy	rate	870.7	135.2	157.0
Gangrene	rate	146.5	19.3	22.1
Total^e	rate	3 684.3	1 352.2	1 420.7

^a Hospitalisation rates are directly age standardised using the 2001 Australian population. ^b Data are based on state of usual residence. ^c Non-Indigenous includes hospitalisations of people identified as not Indigenous as well as those with a 'not stated' Indigenous status. ^d Kidney inflammation caused by bacterial infection. ^e Totals may not equal the sum of the individual conditions due to rounding.

Source: AIHW National Hospital Morbidity Database (unpublished); table 9A.3.5.

- Hospitalisation rates for Indigenous people with potentially preventable acute conditions were 2.7 times as high as the rates for non-Indigenous people in 2004-05 (3684.3 hospitalisations per 100 000 Indigenous people compared to 1352.2 hospitalisations per 100 000 non-Indigenous people, respectively) (table 9.3.4).
- Hospitalisation rates for Indigenous people with gangrene were 7.6 times as high and for convulsions and epilepsy 6.4 times as high as the rates for non-Indigenous people (table 9.3.4).
- For dental conditions and appendicitis, hospitalisation rates were similar for Indigenous and non-Indigenous people (table 9.3.4).
- Indigenous hospitalisation rates for potentially preventable acute conditions were similar in 2001-02 and 2002-03 (3542.1 and 3543.2 hospitalisations per 100 000 people, respectively) (table 9A.3.4). The Indigenous hospitalisation rate for potentially preventable acute conditions increased in 2003-04 to 3678.2 hospitalisations per 100 000 people and remained at similar levels in 2004-05 at 3684.3 hospitalisations per 100 000 people (table 9A.3.5).

Table 9.3.5 presents the hospitalisation rates for influenza and ‘other vaccine-preventable conditions’ from 2001-02 to 2004-05.

Table 9.3.5 Age standardised hospitalisation rates for vaccine-preventable conditions, per 100 000 people, Queensland, WA, SA, and public hospitals in the NT^{a, b}

		<i>Indigenous</i>	<i>Non-Indigenous^c</i>	<i>Total</i>
2004-05				
Influenza	rate	60.0	15.0	16.2
Other vaccine-preventable conditions	rate	65.2	11.2	13.0
2003-04				
Influenza	rate	65.7	27.5	29.5
Other vaccine-preventable conditions	rate	70.2	9.3	11.0
2002-03				
Influenza	rate	68.2	24.9	26.1
Other vaccine-preventable conditions	rate	57.5	12.2	13.6
2001-02				
Influenza	rate	66.1	24.4	25.5
Other vaccine-preventable conditions	rate	76.7	16.0	18.1

^a Hospitalisation rates are directly age standardised using the 2001 Australian population. ^b Data are based on state of usual residence. ^c Non-Indigenous includes hospitalisations of people identified as not Indigenous as well as those with a ‘not stated’ Indigenous status.

Source: AIHW (unpublished); table 9A.3.6.

- Hospitalisation rates for influenza and other vaccine-preventable conditions were higher for Indigenous people than non-Indigenous people in 2001-02, 2002-03, 2003-04 and 2004-05 (table 9.3.5).
- In 2004-05, hospitalisation rates for influenza and other vaccine-preventable conditions for Indigenous people were around four and six times as high as non-Indigenous hospitalisation rates for the same conditions (table 9.3.5).
- The hospitalisation rates for influenza decreased for both Indigenous and non-Indigenous people between 2003-04 and 2004-05. However, the extent of the reduction in the hospitalisation rate for influenza was greater for non-Indigenous people, reducing from 27.5 per 100 000 people in 2003-04 to 15.0 per 100 000 people in 2004-05 (table 9.3.5).
- For ‘other vaccine-preventable conditions’, the hospitalisation rate for Indigenous people decreased between 2003-04 and 2004-05, whereas the non-Indigenous rate increased over the same period (table 9.3.5).
- From 2001-02 to 2004-05, hospitalisation rates for influenza and other vaccine-preventable conditions fluctuated on a yearly basis for both Indigenous and non-Indigenous people (table 9.3.5). Despite the fluctuations, hospitalisation rates for influenza and other vaccine-preventable conditions in 2004-05 were

lower than those in 2001-02 for both Indigenous and non-Indigenous people (tables 9.3.5).

The data presented in table 9.3.6 focus on infections with a predominantly sexual mode of transmission.

Table 9.3.6 Age standardised hospitalisation rates for infections with a predominantly sexual mode of transmission, per 100 000 people, Queensland, WA, SA, and public hospitals in the NT, 2004-05^{a, b, c}

		<i>Indigenous</i>	<i>Non-Indigenous^d</i>	<i>Total</i>
Syphilis	rate	59.3	2.4	3.9
Gonococcal infection	rate	53.3	0.8	3.3
Chlamydial infection	rate	28.0	2.2	3.5
Other sexually transmitted diseases	rate	68.0	21.6	23.5

^a Hospitalisation rates are directly age standardised using the 2001 Australian population. ^b Data are based on state of usual residence. ^c Includes principal or additional diagnosis based on ICD-10-AM classification.

^d Non-Indigenous includes hospitalisations of people identified as not Indigenous as well as those with a 'not stated' Indigenous status.

Source: AIHW (unpublished); table 9A.3.7.

- Hospitalisation rates for sexually transmitted infections were greater for Indigenous people than non-Indigenous people in 2004-05.
- Hospitalisation rates for Indigenous people with gonococcal infection were 66.6 times as high and for syphilis 24.7 times as high as the rates for non-Indigenous people (table 9.3.6).
- For Indigenous people, the hospitalisation rate for chlamydial infection increased every year from 2001-02 to 2004-05 (from 23.1 hospitalisations per 100 000 people in 2001-02 to 28.0 hospitalisations per 100 000 people in 2004-05 (table 9A.3.7). From 2001-02 to 2004-05, there were no consistent trends in Indigenous hospitalisation rates for syphilis, gonococcal infection and other sexually transmitted diseases (table 9A.3.7).
- Hospitalisation rates for syphilis and other sexually transmitted infections in 2004-05 were lower than those in 2001-02 for both Indigenous and non-Indigenous people (table 9A.3.7).

Indigenous people accessing primary health care services

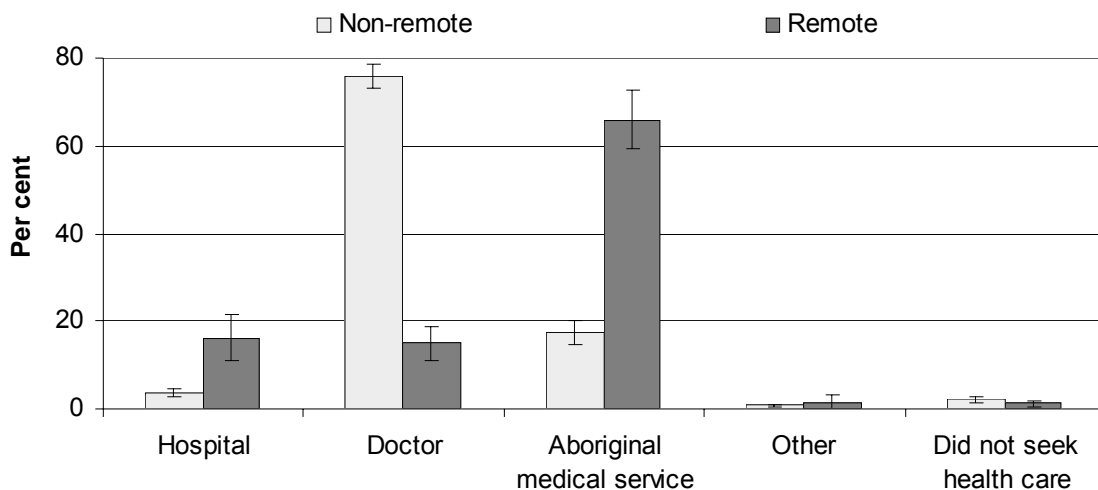
Due to cultural differences, language barriers and racism, some Indigenous people feel more comfortable seeing Indigenous health professionals and accessing Indigenous-controlled medical services. However, Indigenous people represent a small proportion (0.9 per cent) of people working in health-related occupations in

Australia (ABS and AIHW 2003). For some particular occupations (nurses — 0.8 per cent, medical practitioners/doctors — 0.3 per cent, dentists — 0.2 per cent, and pharmacists — 0.1 per cent) the proportion of workers who were Indigenous was lower than the proportion of all health workers who were Indigenous (0.9 per cent) (ABS and AIHW 2003).

Survey data from the ABS 2004-05 NATSIHS

Figure 9.3.1 presents data from the ABS 2004-05 NATSIHS on where Indigenous people usually go when they have a health problem. It compares the use of different primary health care services by Indigenous people in non-remote and remote areas.

Figure 9.3.1 Health care services Indigenous people sought when they had a health problem, 2004-05^{a, b, c}



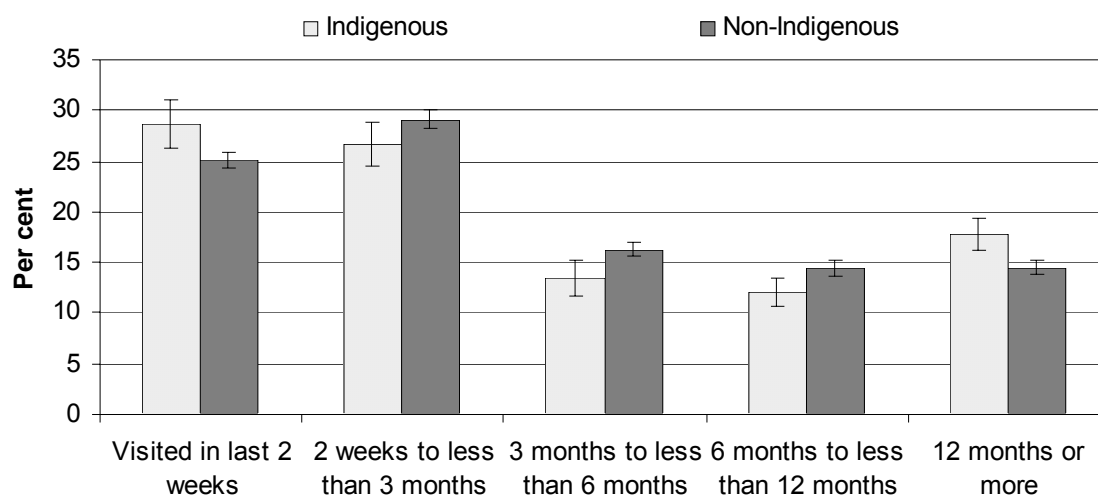
^a Error bars represent 95 per cent confidence intervals around each estimate. ^b 'Other' includes traditional healers. ^c Data presented above is for the whole population.

Source: ABS 2004-05 NATSIHS; table 9A.3.8.

- In 2004-05, Indigenous people living in non-remote areas were around five times as likely to go to a doctor when they had a health problem as Indigenous people living in remote areas (76.0 per cent compared with 14.9 per cent) (figure 9.3.1).
- Indigenous people living in remote areas were around four times as likely as those living in non-remote areas to use Aboriginal medical services (66.0 per cent compared with 17.4 per cent) or to go to hospital (16.1 per cent compared with 3.7 per cent) (figure 9.3.1).
- Around two per cent of Indigenous people living in non-remote areas stated that they did not seek health care when they had a health problem, compared with 1.2 per cent in remote areas (figure 9.3.1).

Figure 9.3.2 compares the length of time since Indigenous and non-Indigenous people last consulted a GP/specialist.

Figure 9.3.2 Time since last consulted GP/specialist, people aged 18 years and over, by Indigenous status, age standardised, 2004-05^a



^a Error bars represent 95 per cent confidence intervals around each estimate.

Source: ABS 2004-05 NATSIHS; table 9A.3.9.

After taking into account the different age structures of the Indigenous and non-Indigenous populations:

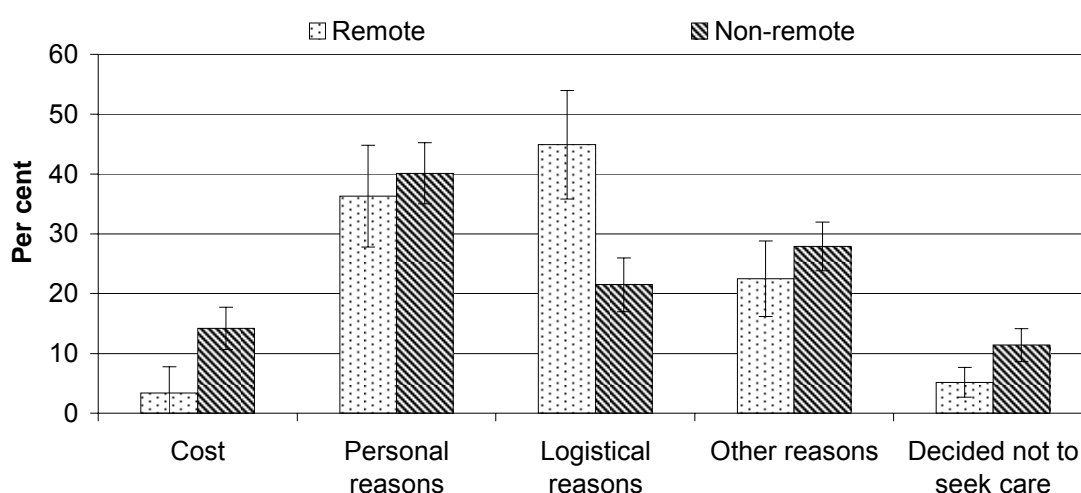
- In 2004-05, the overall pattern of times since Indigenous and non-Indigenous adults had last consulted a GP/specialist was similar (figure 9.3.2).
- A higher proportion of Indigenous than non-Indigenous adults had visited a GP/specialist in the two weeks prior to the survey (28.7 per cent compared with 25.1 per cent) (figure 9.3.2).
- A greater proportion of Indigenous than non-Indigenous adults had not consulted a GP/specialist in the past 12 months in 2004-05 (17.8 per cent and 14.5 per cent, respectively) (figure 9.3.2).
- A higher proportion of Indigenous adults living in remote areas had not consulted a GP/specialist in the past 12 months than Indigenous adults living in non-remote areas, in both 2001 and 2004-05 (table 9A.3.9).

Table 9A.3.10 compares the length of time since Indigenous and non-Indigenous people last consulted a dentist. A lower proportion of Indigenous than non-Indigenous people visited a dentist in the two years prior to the survey being completed in 2001 and 2004-05. Further, a greater proportion of Indigenous than non-Indigenous people had not consulted a dentist for two years or more in 2001 and 2004-05. Indigenous people living in remote areas were more likely to have

never consulted a dentist compared to Indigenous people living in non-remote areas in 2001 and 2004-05 (table 9A.3.10).

Figure 9.3.3 compares the various reasons why Indigenous people in remote and non-remote areas did not go to a GP when they had a health problem.

Figure 9.3.3 Reasons for not going to a GP in the last 12 months, Indigenous people aged 18 years and over, by remoteness, 2004-05^{a, b, c, d}



^a Error bars represent 95 per cent confidence intervals around each estimate. ^b Personal reasons include: too busy (work, personal or family responsibilities), discrimination, service not culturally appropriate, language problems, dislikes service or health professional, afraid, embarrassed, or felt service would be inadequate. ^c Logistical reasons include: transport/distance, service not available in area, waiting time too long, or service not available at the time required. ^d The relative standard error for the percentage of Indigenous people in remote areas who reported 'cost' as a reason for not going to a GP is greater than 50 per cent. The ABS states that estimates with a relative standard error greater than 50 per cent are considered too unreliable for general use.

Source: ABS 2004-05 NATSIHS; table 9A.3.11.

- More than a third of Indigenous adults living in remote and non-remote areas reported 'personal reasons' for not visiting a GP when they had a health problem (figure 9.3.3).
- For Indigenous adults living in remote areas in 2004-05, the most commonly reported reason(s) for not going to a GP were logistical, more than twice as high as Indigenous adults in non-remote areas (figure 9.3.3).

Table 9A.3.12 compares the various reasons why Indigenous adults in remote and non-remote areas did not go to a dentist when they had a dental problem. In 2004-05, Indigenous adults in remote areas were twice as likely as those in non-remote areas to report 'logistical reasons' for not going to a dentist (52.9 per cent compared with 26.6 per cent). Conversely, Indigenous adults in

non-remote areas were twice as likely as those in remote areas to report 'cost' as a reason for not seeking dental treatment (33.7 per cent compared with 16.2 per cent).

Data on reasons for not going to 'other health professionals' and to hospital by remoteness are reported in tables 9A.3.13 and 9A.7.1 (see section 9.7 for the latter).

Survey data from the ABS 2006 CHINS

The ABS 2006 CHINS collected information on the number of Aboriginal primary health care centres and state-funded community health centres located in discrete Indigenous communities¹. Information was also collected on access to medical professionals and whether any Indigenous health workers visited or worked within these communities (ABS 2007). Data were collected from a total of 1187 discrete Indigenous communities with a combined population of approximately 92 960 people.

Number of health care centres for discrete Indigenous communities

Aboriginal primary health care centres are community-controlled health facilities that provide health care services and support to Aboriginal and Torres Strait Islander people. In 2006, 107 communities (41 450 people) reported that an Aboriginal primary health care centre was located in their community (45 per cent of the total population participating in the 2006 CHINS). Seventy-one per cent of Aboriginal primary health care centres were located in very remote communities, 9 per cent in remote communities and 20 per cent in non-remote communities.

Distance to health care centres for discrete Indigenous communities

One-hundred and four discrete Indigenous communities (7743 people) had an Aboriginal primary health care centre located within 10 kilometres of their community (8 per cent of the total population participating in the 2006 CHINS). However, a larger number of Indigenous communities (417), with an aggregate population of 25 486, reported being 100 kilometres or more from the nearest Aboriginal primary health care centre (27 per cent of the total CHINS population).

The NT accounted for almost half the communities located 100 kilometres or more from the nearest Aboriginal primary health care centre, followed by WA, with 35 per cent of the communities.

¹ Discrete Indigenous communities are defined by the ABS as geographic locations inhabited by or intended to be inhabited predominantly (greater than 50 per cent of usual residents) by Aboriginal or Torres Strait Islander peoples, with housing or infrastructure that is managed on a community basis.

Access to Indigenous health workers and medical professionals

Indigenous health workers are trained to certificate level and generally provide a first point of contact for Indigenous people accessing health care services. They provide assistance and information on health issues such as alcohol and mental health, diabetes, ear and eye health, sexual health and hospital education. Indigenous health workers also act as liaison officers with other medical professionals. Table 9.3.7 presents the number and proportion of discrete Indigenous communities that reported having a female or male Indigenous health worker, registered nurse or doctor visit or work within their community in 2006.

Table 9.3.7 Number and proportion of discrete Indigenous communities that reported having Indigenous health workers and medical professionals visit or work within their community, 2006^a

<i>Type of health professional Frequency of visit or work</i>	<i>Discrete Indigenous communities</i>		<i>Population of communities</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Male Indigenous health worker				
Daily	75	6.3	34 300	36.9
Weekly/fortnightly	47	4.0	4 991	5.4
Monthly	10	0.8	1 331	1.4
3 monthly	5	0.4	448	0.5
Less than 3 monthly	11	0.9	1 906	2.1
Female Indigenous health worker				
Daily	121	10.2	45 587	49.0
Weekly/fortnightly	38	3.2	3 256	3.5
Monthly	14	1.2	1 335	1.4
3 monthly	4	0.3	119	0.1
Less than 3 monthly	3	0.3	820	0.9
Registered nurse				
Daily	120	10.1	44 923	48.3
Weekly/fortnightly	64	5.4	8 054	8.7
Monthly	17	1.4	1 663	1.8
3 monthly	2	0.2	150	0.2
Less than 3 monthly	8	0.7	933	1.0
Doctor				
Daily	14	1.2	11 344	12.2
Weekly/fortnightly	104	8.8	25 969	27.9
Monthly	58	4.9	11 478	12.3
3 monthly	6	0.5	2 550	2.7
Less than 3 monthly	10	0.8	1 860	2.0

^a Proportions were calculated by dividing the number of communities (population) in each category by the total number of communities in the ABS 2006 CHINS (total population) and multiplied by 100. Data were collected from a total of 1187 discrete Indigenous communities with a combined population of approximately 92 960 people.

Source: ABS 2006 CHINS.

-
- A greater proportion of discrete Indigenous communities reported having a female Indigenous health worker visit or work within their community on a daily basis than a male Indigenous health worker (10.2 per cent compared with 6.3 per cent) (table 9.3.7).
 - Nearly half of the survey population (49 per cent) reported having a female Indigenous health worker visit or work within their community on a daily basis (table 9.3.7).
 - A greater proportion of discrete Indigenous communities reported having a registered nurse visit or work within their community on a daily basis than a doctor (10.1 per cent compared with 1.2 per cent) (table 9.3.7). Doctors were more likely than registered nurses to visit or work within a discrete Indigenous community on a weekly to monthly basis (table 9.3.7).
 - Only 1.0 per cent of the CHINS population reported that registered nurses did not frequently visit or work in their community and 2.0 per cent reported that doctors did not frequently visit or work in their community (less than 3-monthly) (table 9.3.7).

9.4 Mental health

Box 9.4.1 Key messages

- In 2004-05, psychological distress data showed that 26.6 per cent of Indigenous adults had experienced a high to very high level of distress compared with 13.1 per cent of non-Indigenous adults (figure 9.4.1).
- In 2004-05, 56.4 per cent of Indigenous adults reported feeling calm or peaceful all or most of the time and 71.4 per cent reported being happy all or most of the time (table 9A.4.13)
- From 2001-02 to 2004-05 Indigenous people had higher rates of hospitalisation for mental and behavioural disorders than non-Indigenous people (figure 9.4.3).
- ‘Life stress events’ has been identified as the factor most strongly associated with high risk of clinically significant emotional or behavioural difficulties in Aboriginal children (Zubrick et al. 2005). In WA, in 2001 and 2002, over one in five Aboriginal children aged 0–17 years were living in families where 7 to 14 major life stress events, such as death, incarceration, violence and severe hardship, had occurred in the 12 months prior to the survey (Silburn et al. 2006).
- In WA, Indigenous children in remote communities had better mental health than children living in Perth, suggesting that growing up in very remote communities, where adherence to traditional culture and ways of life are strongest, may be protective against emotional and behavioural difficulties in Aboriginal children (Zubrick et al. 2005).

Consultations following the release of the 2005 Report identified a broad consensus about the need for a mental health indicator to assist in presenting a comprehensive picture of Indigenous health (SCRGSP 2007). This indicator includes data on the:

- prevalence of anxiety, depression and mental disorders
- mental health of prisoners and juveniles in detention
- mental wellbeing of children.

How is mental health defined? The Indigenous view of health, including mental health, is holistic — ‘health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community’ (Swan and Raphael 1995, p. 7). The wellbeing of the community is as important as the individual’s wellbeing. Accordingly, the mental health indicator has been included in the ‘functional and resilient families and communities’ strategic area for action. Data on the mental health or wellbeing of discrete Indigenous communities are not available.

The following definitions of mental health and mental illness are used by health professionals to describe particular symptoms exhibited by individuals. They are also the definitions used throughout this section of the report.

Mental health is defined as an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). Mental health is a broad concept which encompasses:

- mental health and wellbeing (a person may have diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental disorder are met)
- mental illness (a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities (DHA 2002)).

Mental wellbeing problems are distinct from mental illness, although the two interact and influence each other.

Issues of mental health and wellbeing cover a broad range of problems which can be the result of domestic violence, substance misuse, physical health problems, incarceration, family breakdown and social disadvantage (AHMAC 2004). For Indigenous people there are also broader social and historic issues, such as forced separation or forced relocation, which influence mental health and wellbeing (Blair, Zubrick and Cox 2005; Procter 2005).

Mental illness includes anxiety and depression, post traumatic stress, suicide and self-harm behaviour, as well as psychotic disorders, affective disorders, and organic and degenerative disorders (DHA 2002). Suicide and self-harm are explored in more detail in section 3.8. Mental illness clearly impacts upon and can contribute to an individual and family's general wellbeing.

Co-occurrence of depression and anxiety with substance use are risk factors for suicide in all age groups (Harris and Barraclough 1997; Moscicki 1997; Rajkumar and Hoolahan 2004). A number of studies have found that the use of inhalants is a particular mental health concern and that the inhalation of petrol is a significant issue among young Indigenous people (James 2004; Select Committee on Substance Abuse in the Community 2004; Siegel 2003). More information on substance use and misuse is included in chapter 8.

Mental health is designated a national health priority area for Australia and is the subject of a national strategy and action plan, the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003) and the *National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and*

Social and Emotional Wellbeing 2004–2009 (NATSIHC 2004). Box 9.4.2 provides examples of programs that have been successful in improving Indigenous mental health and wellbeing.

Box 9.4.2 ‘Things that work’ — improving mental wellbeing

Apunipima Cape York Health Council Family Wellbeing Empowerment Program

The capacity to take control of the day-to-day challenges of life without feeling overwhelmed, positive feelings of self-esteem and a sense of power over one’s life are considered key determinants of good mental health (Australian Health Ministers 1991).

The need for a school-based mental health promotion program to enhance the life skills and confidence of young Indigenous people prompted the Apunipima Cape York Health Council and researchers at the University of Queensland to adapt the Family Wellbeing Empowerment Program to the needs of remote Indigenous school children.

The School-based Family Wellbeing Program was piloted in two schools in remote Indigenous communities in far north Queensland. The aim of the School-based Family Wellbeing Program was to develop the analytical and problem solving skills of the students to enhance psychosocial development and in particular, to build personal identity and to encourage students to recognise their future potential.

The program evaluation noted the significant social and emotional growth for the participating students. Other outcomes included greater ability to think for oneself and set goals, less teasing and bullying in the school environment, and enhanced friendships and social relatedness. (Tsey et al. 2005)

(Continued next page)

Box 9.4.2 (continued)

Aboriginal Mental Health Workforce Training Program

Training an Indigenous mental health workforce to deliver culturally sensitive and appropriate services ensures that Indigenous peoples' mental health and wellbeing needs are met. In NSW, the Aboriginal Mental Health Workforce Training Program aims to increase the representation of Aboriginal people in mental health professions.

In 2007, in NSW, over 60 Aboriginal mental health workers are employed in the Area Health Services and over 15 Aboriginal mental health workers in Aboriginal Community Controlled Health Services. These employees are recognised for their expertise and cultural competency.

NSW Health recently established a training program to further develop the Aboriginal mental health workforce and increase the education, retention and representation of Aboriginal people in specialist mental health service delivery. At the end of their training, the graduates are fully qualified Aboriginal mental health professionals in mainstream mental health services. Ten trainee positions were offered in the 2006-07 and another 10 positions will be offered in 2008-09.

An annual Aboriginal Mental Health Workers Forum allows NSW Aboriginal mental health workers to:

- be updated on new developments and initiatives in service delivery
- contribute their ideas and suggestions to the development of Aboriginal mental health in NSW
- network, exchange ideas, build and rekindle friendships (NSW Government unpublished).

Mental health, wellbeing and prevalence of mental disorders

A number of data sources provide some indication of the prevalence of anxiety, depression and mental disorders:

- survey data on mental wellbeing
- hospitalisations for mental and behavioural disorders
- death rates for mental and behavioural disorders.

Survey data

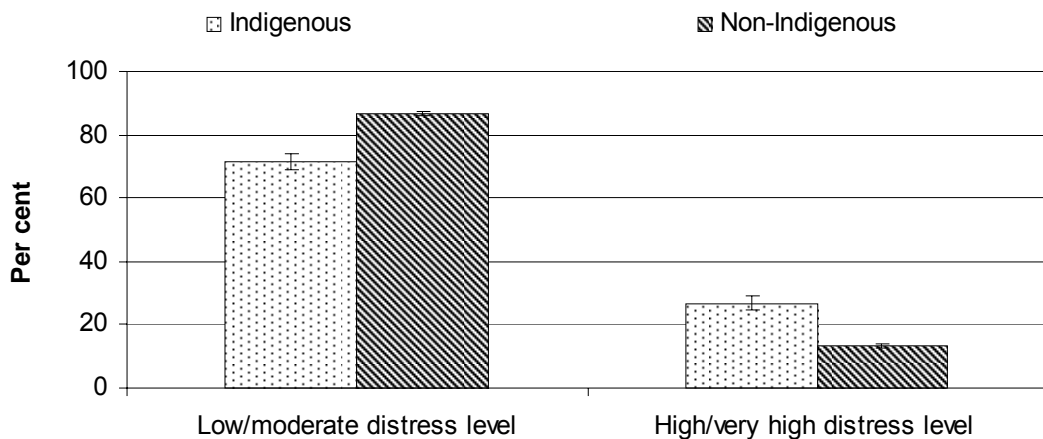
The 2004-05 NATSIHS included for the first time selected questions from two international survey instruments, the Kessler Psychological Distress Scale-10 (K10) and the Medical Outcome Short Form (SF-36) Health Survey.

The K10 questionnaire measures non-specific psychological distress based on questions about negative emotional states experienced in the four weeks prior to interview. For the 2004-05 NATSIHS, the K10 was reduced to five questions (K5) to provide the best set of questions to identify psychological distress (ABS 2006). Indigenous people aged 18 years and over were asked the K5 questions.

The SF-36 Health Survey questions are about positive emotional states experienced in the four weeks prior to interview. The 2004-05 NATSIHS included four SF-36 Health Survey questions on feeling calm and peaceful, happy, full of life, and having a lot of energy (ABS 2006). These questions were not included in the 2004-05 NHS.

Questions about cultural identification and stressors were also included in the survey to provide a context for mental distress (ABS 2006).

Figure 9.4.1 K5 level of psychological distress, people aged 18 years and over, age standardised, 2004-05^{a, b, c}



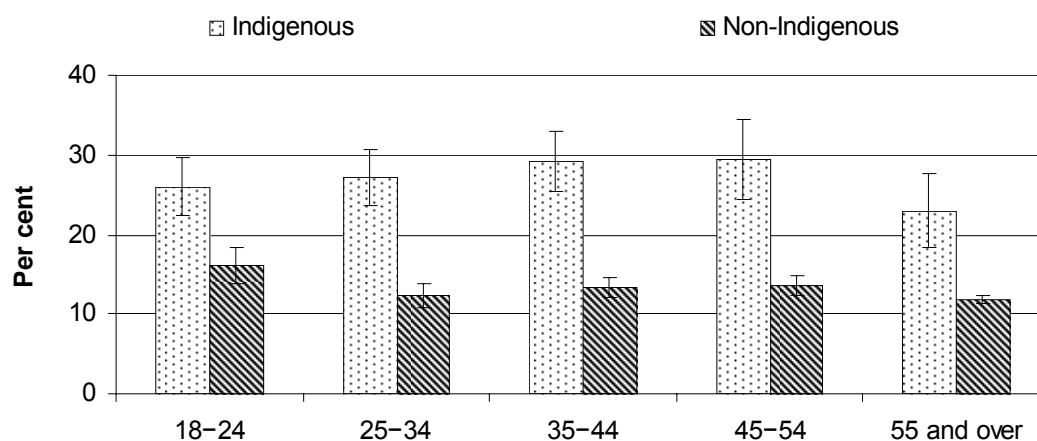
^a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). ^b Low/moderate distress level represents a K5 score of 5–11. ^c High/very high distress level represents a K5 score of 12–25.

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); table 9A.4.5.

- The results of the K5 are grouped into two categories — low to moderate (indicating little or no psychological distress) and high to very high levels of psychological distress. A very high level of psychological distress, may indicate a need for professional help (ABS 2006).
- In 2004-05, after adjusting for age differences between the Indigenous and non-Indigenous populations, 26.6 per cent of Indigenous people had experienced a high to very high level of distress compared with 13.1 per cent of non-Indigenous people (figure 9.4.1).

- In 2004-05, 48.0 per cent of Indigenous people reported that physical health problems were not the main cause of negative feelings (table 9A.4.6) and 63.4 per cent reported that negative feelings did not affect their ability to work or carry out normal activities (table 9A.4.7).

Figure 9.4.2 **High to very high level of psychological distress, by age, Australia, 2004-05^{a, b}**



^a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). ^b High/very high distress level represents a K5 score of 12-25.

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); table 9A.4.2

- In all age groups, except 18-24 years of age, Indigenous people were twice as likely as non-Indigenous people to have experienced high to very high levels of distress in 2004-05 (figure 9.4.2).
- In all age groups, there was a statistically significant difference between the proportions of Indigenous and non-Indigenous people who had experienced a high to very high level of distress (figure 9.4.2; table 9A.4.2).
- In 2004-05, the proportion of Indigenous people who had experienced a high to very high level of distress did not vary significantly between major cities, regional areas and remote areas. There was also no significant difference between remoteness areas for non-Indigenous people (table 9A.4.3).

Data on the proportions of Indigenous people experiencing low to moderate and high to very high stress levels by State and Territory are included in table 9A.4.1.

Table 9.4.1 K5 level of current psychological distress, by reported stressor in the last 12 months, Indigenous people aged 18 years and over, 2004-05^a

	Low/moderate distress level ^b		High/very high distress level ^c		Total ^d	
	Proportion (%)	RSE (%)	Proportion (%)	RSE (%)	Proportion (%)	RSE (%)
Serious illness or disability	63.4	3.1	35.0	5.4	100.0	-
Serious accident	63.0	5.2	33.7	9.0	100.0	-
Death of family member or close friend	66.0	2.4	32.3	4.8	100.0	-
Divorce or separation	61.8	4.7	38.2	7.6	100.0	-
Not able to get a job	63.0	3.6	36.7	6.2	100.0	-
Lost job, made redundant, sacked	64.3	6.3	35.7	11.4	100.0	-
Alcohol related problems	59.1	3.8	39.2	5.7	100.0	-
Drug related problems	59.1	4.2	40.5	6.1	100.0	-
Witness to violence	62.2	4.3	35.6	7.1	100.0	-
Abuse or violent crime	55.8	5.3	42.2	6.9	100.0	-
Trouble with the police	60.3	4.3	38.0	6.6	100.0	-
Gambling problem	59.3	4.4	38.7	6.7	100.0	-
Member of family sent to jail/currently in jail	62.9	3.8	35.1	6.9	100.0	-
Overcrowding at home	58.8	3.9	37.7	5.7	100.0	-
Treated badly because Aboriginal/Torres Strait Islander	61.0	4.5	38.3	7.1	100.0	-

^a Estimates with an RSE of 25 per cent to 50 per cent should be interpreted with caution. Estimates with an RSE greater than 50 per cent are considered too unreliable for general use. ^b Represents a K5 score of 5-11. ^c Represents a K5 score of 12-25. ^d Includes refusals and persons with no K5 score.

Source: ABS 2004-05 NATSIHS (unpublished); table 9A.4.4.

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- Life events or ‘stressors’ that may be possible risk factors for distress are listed in table 9.4.1.
 - Table 9.4.1 shows that levels of high to very high psychological distress were highest among those who had experienced:
 - abuse or violent crime (42.2 per cent)
 - drug related problems (40.5 per cent)
 - alcohol related problems (39.2 per cent).

Although the next section presents the level of psychological distress according to selected health characteristics, such as alcohol consumption, it is not possible to assume a causal relationship.

- In 2004-05, 43 per cent of Indigenous people living in non-remote areas had experienced a high to very high level of distress and reported their health status as fair or poor compared with 31 per cent of Indigenous people in remote areas (table 9A.4.17).
- Eighty-nine per cent of Indigenous people who had experienced high to very high levels of psychological distress had at least one long term health condition and nearly two thirds (64 per cent) had at least three long term health conditions (table 9A.4.17).
- In 2004-05, high to very high levels of psychological distress were most prevalent among Indigenous people with eye/sight problems (53 per cent), back pain/problems (33 per cent) and heart and circulatory problems/diseases (26 per cent) (table 9A.4.17).
- Indigenous people who had experienced high to very high levels of psychological distress were more likely than those who had experienced low to moderate levels of distress to regularly smoke (59 per cent compared with 47 per cent) and to drink alcohol at risky to high risk levels in the long term (19 per cent compared to 16 per cent) (table 9A.4.17).

Some information on positive mental wellbeing for Indigenous people was collected in the 2004-05 NATSIHS (SF-36 questions). Based on the responses to questions about feelings of wellbeing:

- 56.4 per cent of Indigenous people aged 18 years and over reported feeling calm and peaceful all or most of the time (table 9A.4.13)
- 71.4 per cent reported being happy all or most of the time (table 9A.4.13)
- Over half (54.6 per cent) felt full of life all or most of the time (table 9A.4.13)

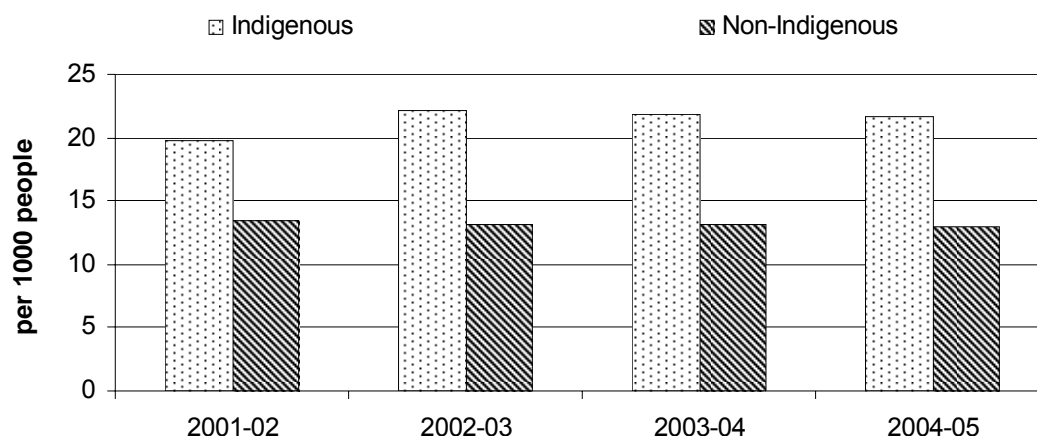
- 47.2 per cent of Indigenous people reported that they had a lot of energy all or most of the time (table 9A.4.13).

Attachment tables 9A.4.9–16 show responses to the K10 and SF–36 Health Survey questions by State and Territory, by sex, by age groups and remoteness areas.

Hospitalisations for mental and behavioural disorders

The availability of hospitalisation data for Indigenous people is significantly reduced in the 2007 Report compared to previous Reports. AIHW analyses into the quality of Indigenous identification of hospital admitted patient statistics has shown that while the quality is good in some jurisdictions, in other jurisdictions it is poor (AIHW 2005). Consequently, Indigenous hospitalisation data are only available for Queensland, WA, SA and the NT. Data from NSW, Victoria, Tasmania and the ACT were considered to be of insufficient quality. Data issues, including hospitalisations are discussed in chapter 2.

Figure 9.4.3 Age standardised hospitalisations for mental and behavioural disorders, Qld, WA, SA, and public hospitals in the NT^{a, b, c, d}



^a Hospitalisation is the discharge, transfer, death or change of episode of care of an admitted patient (see glossary for a detailed definition). ^b Directly age standardised using the 2001 Australian population. ^c These data are based on ICD–10–AM codes F00–F99. ^d Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Vic, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information).

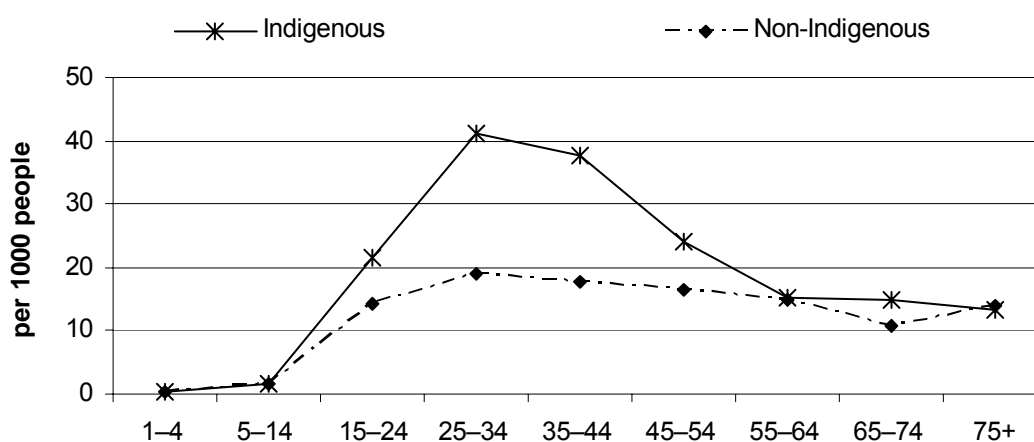
Source: AIHW National Hospital Morbidity Database (unpublished); tables 9A.4.18, 9A.4.24, 9A.4.30 and 9A.4.36.

- From 2001-02 to 2004-05, Indigenous people were hospitalised for mental and behavioural disorders at a higher rate than non-Indigenous people (figure 9.4.3).

- Over the period, the age-standardised hospitalisation rate for Indigenous people increased from 19.8 per 1000 people to 21.7 per 1000 people (table 9A.4.36 and table 9A.4.18 respectively).
- Over the same period, the rate for non-Indigenous people decreased from 13.4 per 1000 people to 12.9 per 1000 people (table 9A.4.36 and table 9A.4.18 respectively).
- In 2004-05, hospitalisations for mental and behavioural disorders represented 3.2 per cent of all hospitalisations of Indigenous people. For non-Indigenous people hospitalisations for mental and behavioural disorders represented 3.8 per cent of all hospitalisations (table 9A.4.23).

More data on age-standardised hospitalisation rates by mental and behavioural disorders for Queensland, WA, SA and the NT for the period 2001-02 to 2004-05 can be found in tables 9A.4.18, 9A.4.24, 9A.4.30 and 9A.4.36.

Figure 9.4.4 Hospitalisations for mental and behavioural disorders, by age groups, Qld, WA, SA, and public hospitals in the NT, 2004-05^{a, b, c}



^a Hospitalisation is the discharge, transfer, death or change of episode of care of an admitted patient (see glossary for a detailed definition). ^b These data are based on ICD-10-AM codes F00-F99. ^c Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Vic, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information).

Source: AIHW National hospital morbidity database (unpublished); table 9A.4.22.

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- Figure 9.4.4 shows that the hospitalisation rate for mental and behavioural disorder was higher for Indigenous people than non-Indigenous people for most age groups, particularly those between 15 and 54 years.
 - For both Indigenous and non-Indigenous people, in 2004-05, hospitalisation rates for mental and behavioural disorders were highest among people aged 25–44 years (table 9A.4.22).
 - The highest hospitalisation rate for both Indigenous and non-Indigenous males was in the 25–34 year age group (44.5 per 1000 Indigenous males and 17.5 per 1000 non-Indigenous males) (table 9A.4.22).
 - The highest hospitalisation rate for both Indigenous and non-Indigenous females was in the 25–34 year age group (37.9 per 1000 Indigenous females and 20.6 per 1000 non-Indigenous females) (table 9A.4.22).

Table 9.4.2 Indigenous standardised hospitalisation ratios for mental and behavioural disorders, 2004-05^{a, b}

		<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>NT</i>	<i>Qld, WA, SA and public hospitals in NT^g</i>
Organic mental disorders (F00–F09) ^c	Number	35	32	18	22	107
	Rate ratio	1.6	2.2	3.7	2.5	2.0
	95% CI	1.0 to 2.5	1.4 to 3.4	2.0 to 6.9	1.2 to 5.4	1.6 to 2.6
Substance use disorder (F10–F19) ^d	Number	630	687	306	242	1 865
	Rate ratio	2.5	6.5	8.7	4.6	3.8
	95% CI	2.3 to 2.8	5.9 to 7.1	7.7 to 9.9	3.7 to 5.7	3.6 to 4.0
Mood and neurotic disorders (F30–F48) ^e	Number	594	528	372	166	1 660
	Rate ratio	0.7	1.0	2.7	1.0	0.9
	95% CI	0.6 to 0.8	0.9 to 1.1	2.5 to 3.1	0.8 to 1.3	0.8 to 0.9
Schizophrenia, schizotypal and delusional disorders (F20–F29)	Number	705	484	270	178	1 637
	Rate ratio	2.2	3.7	3.8	2.0	2.4
	95% CI	2.0 to 2.4	3.4 to 4.1	3.3 to 4.4	1.6 to 2.4	2.3 to 2.6
Other mental disorders ^f	Number	131	58	44	16	249
	Rate ratio	1.0	1.1	2.5	1.1	1.0
	95% CI	0.9 to 1.3	0.8 to 1.5	1.8 to 3.5	0.6 to 1.9	0.9 to 1.2
All mental and behavioural disorders (F00–F99)	Number	2 095	1 789	1 010	624	5 518
	Rate ratio	1.3	2.2	3.9	1.9	1.7
	95% CI	1.3 to 1.4	2.1 to 2.3	3.6 to 4.2	1.7 to 2.2	1.6 to 1.7

Rate ratio = Standardised Hospital Separation Ratio (Indigenous age-standardised rate divided by the non-Indigenous age-standardised rate). CI = confidence interval.

^a Rate ratios were calculated from directly age standardised data using the 2001 Australian population. These data are based on ICD–10–AM codes F00–F99. ^b Data are based on state of usual residence. ^c Includes brain disorders due to brain damage and dysfunction, such as dementia. ^d Includes a variety of disorders due to the use of psychoactive substances, which may or may not have been medically prescribed, such as alcohol, opioids, sedatives, and volatile substances. ^e Includes depressive and anxiety disorders. ^f Includes eating disorders, sleeping disorders, disorders of personality and behaviour, mental retardation, disorders of psychological development, and unspecified mental disorders. ^g Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Vic, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information).

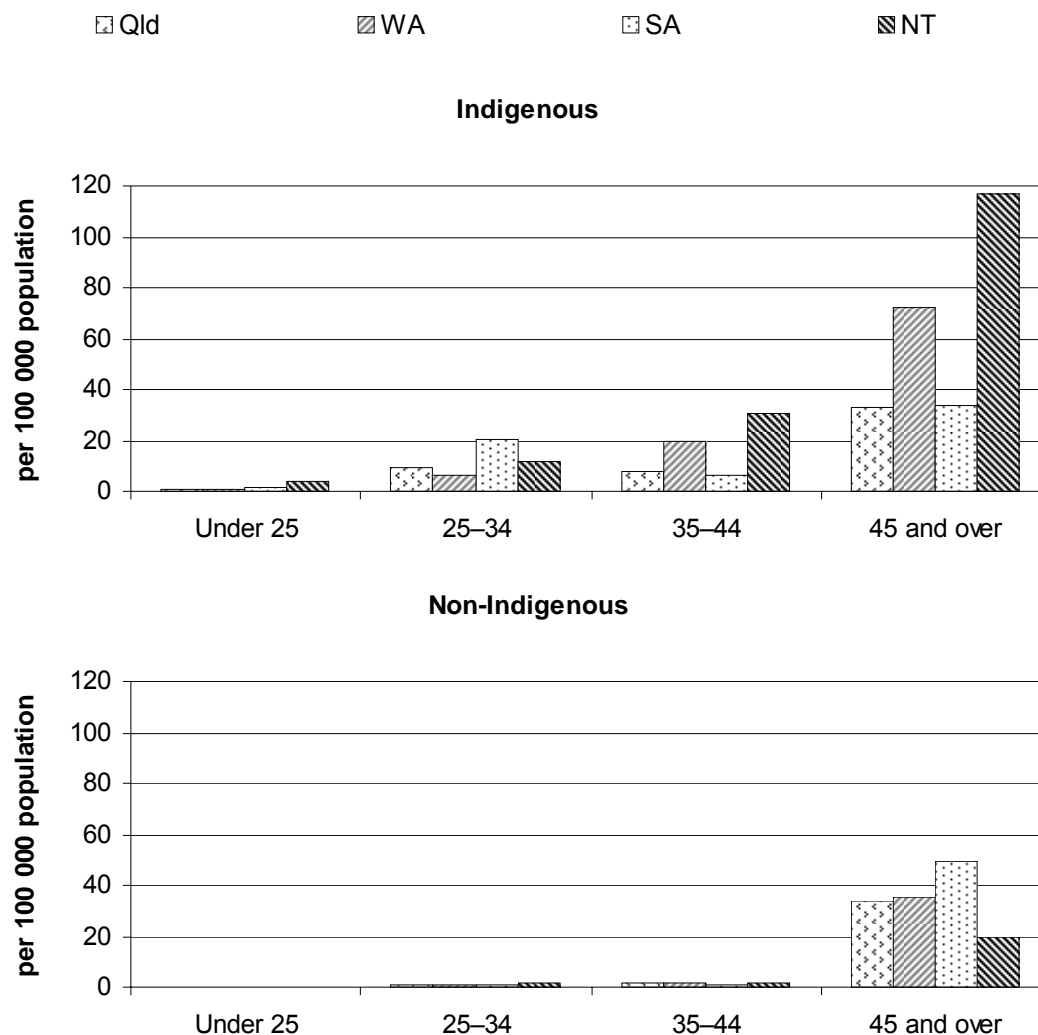
Source: AIHW National hospital morbidity database (unpublished); table 9A.4.21.

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- In 2004-05, Indigenous people were nearly twice as likely to be hospitalised for mental and behavioural disorders as non-Indigenous people (table 9.4.2).
 - Indigenous people were hospitalised for substance use disorders at around four times the rate for non-Indigenous people.
 - Hospitalisations for substance use disorders were the most common Indigenous hospitalisations for mental and behavioural disorders (33.8 per cent of all hospitalisations) (table 9A.4.23).
 - Hospitalisations for mood and neurotic disorders were the most common non-Indigenous hospitalisations for mental and behavioural disorders (56.8 per cent of all hospitalisations) (table 9A.4.23).

More data on standardised hospitalisation ratios for males and females by mental and behavioural disorders (ICD-10-AM codes F00-F99) for Queensland, WA, SA and the NT for the period 2001-02 to 2004-05 can be found in tables 9A.4.18-41.

Death rates for mental and behavioural disorders

Figure 9.4.5 **Death rates for mental and behavioural disorders by age, 2001–2005^{a, b, c}**



^a These data are based on ICD–10–AM codes F00–F99. ^b Care should be taken when using these data as the rates are based on a small number of deaths. ^c Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS Deaths Registration Database (unpublished); table 9A.4.43.

- In 2001–2005, death rates for mental and behavioural disorders were higher for Indigenous people than non-Indigenous people across all age groups (figure 9.4.5).
- In 2001–2005, 228 Indigenous people died as a result of mental and behavioural disorders in Queensland, WA, SA and the NT combined (table 9A.4.45).

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- From the data available in 2001–2005, mental and behavioural disorders accounted for:
 - 2.5 times as many deaths as expected in Queensland
 - 4.4 times as many deaths as expected in WA
 - 3.1 times as many deaths as expected in SA
 - 7.9 times as many deaths as expected in the NT (table 9A.4.46).

More data on death rates for mental and behavioural disorders by age and gender can be found in tables 9A.4.42–46.

Mental health of prisoners and juveniles in detention

Prisoners

Data on the health of prisoners (including mental health) in Australia is sporadic, inconsistent and incomplete (AIHW 2001; AMA 2006). Indigenous prisoners' health data is almost nonexistent.

From the few Australian and international surveys that have been conducted on prisoner health, the common finding is that prisoners have high rates of mental illness and emotional or mental health problems (ABS 1998; Brooke et al. 1996; Butler 1997; Butler and Allnutt 2003; Butler and Milner 2003; Fazel and Danesh 2002; Hockings et al. 2002; Victorian Department of Justice 2003). These surveys do not take into account how the prison environment influences the mental health of prisoners.

The need for more representative data on prisoner health has been one of the main factors influencing the development of a minimum dataset for prisoner health. Minimum dataset development is being undertaken by the Prisoner Health Information Group. Progress by the working group includes a report examining current data sources on prisoner health and identifies data gaps and issues (AIHW 2006). Data from the minimum dataset for prisoner health will not be available for several years.

Another source of data for future reports may be the National Deaths in Custody Program (NDICP) database. Six new variables were added to the NDICP database. Two of these new variables relate to prevalence of mental illness and type of mental illness. These new variables have been added only for deaths that occurred after 1996. The Australian Institute of Criminology may be able to provide these data by Indigenous status for future reports.

A WA study on prisoner health and mental health provides some information on Indigenous prisoners. Hobbs et al. (2006) used data from the Western Australian Data Linkage System to examine the continuing health problems and the use of health services by a cohort of prisoners released in WA between 1995 and 2001 before and after their imprisonment. A key theme emerging from the research was the inter-relationship between social disadvantage, mental health problems and the poor physical health of many prisoners. The high prevalence of mental health problems in prisoners demonstrated in the study by Hobbs et al. (2006) is consistent with studies of prisoners in the United Kingdom (Brooke et al. 1996).

Some of the findings from the WA study include:

- Indigenous prisoners have multiple, long standing health issues, including those linked to alcohol and drug misuse.
- Rates of hospital admissions for mental disorders were approximately twice as high in Indigenous male prisoners and three times as high in Indigenous female prisoners as in the Indigenous population of WA.
- The relative risk of hospitalisation was highest for injury and poisoning and for mental disorders (which includes acute and chronic effects of alcohol and drug addiction).
- In the five years after first release, 31 per cent of released Indigenous female prisoners and 24 per cent of non-Indigenous female prisoners had at least one hospital admission or mental health service contact for mental disorders. For released male prisoners the proportions were 18 per cent for Indigenous and 17 per cent for non-Indigenous prisoners (Hobbs et al. 2006).

Juveniles in detention

There is no systematic collection of data on the health status of juveniles in detention. Research shows that juveniles detainees are at high risk of suffering mental health problems (BMA 2006; Kessler 2002; Vermeiren 2003). Two NSW health surveys provide some information on the mental health of young people in custody and on community orders (Fasher et al 1997; Kenny et al. 2006; NSW Department of Juvenile Justice 2003).

The 2003 NSW Young People in Custody Health Survey (YPiCHS) examined the physical and mental health needs of young people in custody (NSW Department of Juvenile Justice 2003). A total of 319 young people were eligible for inclusion in the survey. Of this group, 242 young people in custody were surveyed, 102 of whom were Indigenous (42 per cent). The YPiCHS found that:

-
- 88 per cent reported mild, moderate or severe symptoms consistent with a clinical disorder
 - 33 per cent reported high or very high psychological distress (implying that they may have a greater than 50 per cent chance of an anxiety or depressive disorder). Population norms suggest that between 11 per cent and 12 per cent of the general population have high to very high scores on the K-10 (NSW Department of Juvenile Justice 2003).

A recent survey of young people on community orders in NSW (Indigenous juveniles comprised 20 per cent of the young people surveyed) found that:

- 25 per cent of young people serving community orders had experienced a high to very high level of psychological distress.
- Young people on community orders reported fewer mental health issues and fewer suicide or self-harm attempts than young people in custody (Kenny et al. 2006).

Mental wellbeing of children

The mental wellbeing of children is intimately connected to the emotional and physical wellbeing of their parents (BMA 2006). Risk factors for vulnerability to both mental and physical illness are often transmitted across generations in the absence of interventions to break the cycles of vulnerability (BMA 2006).

There is a paucity of data to describe the mental health and wellbeing of Indigenous children. The Western Australian Aboriginal Child Health Survey (WAACHS), conducted in 2001 and 2002, used a modified version of the 25 item Strengths and Difficulties Questionnaire (SDQ) to assess risk for clinically significant emotional or behavioural difficulties. The WAACHS found that:

- 24 per cent of Aboriginal children were at high risk of clinically significant emotional or behavioural difficulties compared, with 15 per cent of non-Indigenous children (Zubrick et al. 2005).
- Life stress events was the factor most strongly associated with high risk of clinically significant emotional or behavioural difficulties in Aboriginal children (Zubrick et al. 2005). Families of Aboriginal children report extraordinary levels of stress including, death, incarceration, violence and severe hardship. Over one in five (22 per cent) Aboriginal children aged 0–17 years were living in families where 7–14 major life stress events had occurred in the 12 months prior to the survey (Silburn et al. 2006).

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- The proportion of children at high risk of clinically significant emotional or behavioural problems was lowest in areas of extreme isolation (Silburn 2006). Stronger adherence to traditional culture and ways of life in extremely isolated areas may be a protective factor (Silburn 2006).
 - Approximately one-fifth of Aboriginal children were living in families that functioned poorly. Two key factors were independently associated with poor family functioning: family financial strain and quality of children's diet (Silburn et al. 2006).
 - Of the Aboriginal young people surveyed aged 12–17 years, 9.0 per cent of females and 4.1 per cent of males had attempted suicide in the past 12 months. A high SDQ score; low self-esteem; having friends who had attempted suicide; exposure to family violence and exposure to racism were each independently associated with suicidal thoughts (Blair, Zubrick and Cox 2005).
 - The children of Aboriginal carers who had been forcibly separated from their natural family by a mission, the government or welfare were more than twice as likely to be at high risk of clinically significant emotional or behavioural difficulties (Silburn 2006).

9.5 Proportion of Indigenous people with access to their traditional lands

Box 9.5.1 Key messages

- In 2004-05, there were no data on access to traditional lands for people in remote or very remote areas.
- The proportion of Indigenous adults living in non-remote areas who did not recognise an area as their homelands increased from 28.8 per cent in 1994 to 38.0 per cent in 2004-05 (figure 9.5.3).
- In non-remote areas, the proportion of Indigenous adults who lived on their homelands decreased from 21.9 per cent in 1994, to 15.0 per cent in 2004-05. The proportion who were allowed to visit their homelands remained steady, ranging from 43.6 per cent to 47.5 per cent, between 1994 and 2004-05 (figure 9.5.3).

Indigenous people derive social, cultural and economic benefits from their connection to traditional country. Culturally, access to land and significant sites may allow Indigenous people to practise and maintain their knowledge of ceremonies, rituals and history. Socially, land can be used for recreational, health, welfare and educational purposes. The economic benefits of land are discussed in more detail in section 11.3 of this Report.

Indigenous land rights are recognised in a variety of ways. Land may be owned outright by Indigenous people, or recognised under native title or an Indigenous Land Use Agreement (discussed further in section 11.3). In other cases, Indigenous people may have negotiated access to visit their traditional country with the legal owners of the land. Further, traditional lands may be public land that is accessible to all people.

Data for this indicator come from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS). In this survey, respondents aged 18 years and over were asked:

- whether they recognise an area as their homelands/traditional country
- whether they currently live on their homelands
- whether they are allowed to visit their homelands.

The 2004-05 data reported here are for Indigenous people aged 18 years and over in non-remote areas and are therefore not representative of all Indigenous people. Unlike 2002 data included in the 2005 Report, data for 2004-05 are not available for remote or very remote areas.

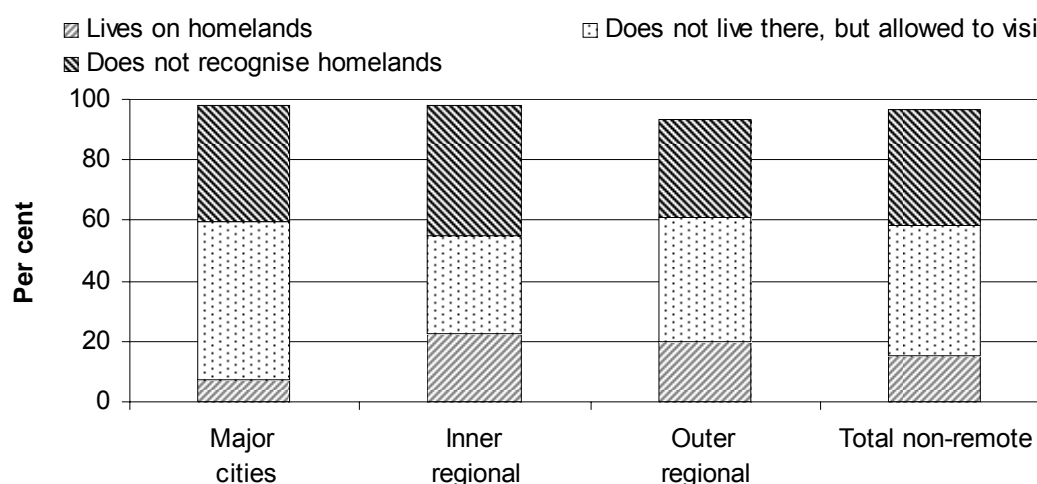
Data for 2002 showed that Indigenous people in remote and very remote areas were more likely to recognise and live on their homelands than Indigenous people in non-remote areas. Indigenous people in very remote areas were the most likely (43.2 per cent) to live on their homelands/traditional country, and the least likely (9.6 per cent) to not recognise an area as their traditional country (SCRGSP 2005).

The data for this indicator show whether Indigenous people live on their homelands/traditional country or have access to their homelands/traditional country. The data do not show the control or ownership that Indigenous people have over their homelands/traditional country, their rights to resources found on their homelands or their ability to access particular sites that may be of special significance.

The data used for this indicator are based on Indigenous people's own understanding of what constitutes their homelands or traditional country, which may vary in different places. Some Indigenous people may live on or visit Indigenous owned or controlled land but they may not consider it to be their homelands or traditional country. Since European colonisation of Australia in 1788, many Indigenous people have moved both voluntarily and involuntarily from their traditional country. Many Indigenous communities comprise a mix of traditional owners and Indigenous people whose traditional country is located elsewhere.

Some Indigenous people living in cities and towns with a majority of non-Indigenous people may say they live on their homelands (see figure 9.5.1), if the place where they live is part of their homelands/traditional country, even though much of it may be owned or occupied by non-Indigenous people.

Figure 9.5.1 Proportion of Indigenous people aged 18 years and over living on, or allowed to visit, their homelands, by remoteness area, 2004-05^{a, b}

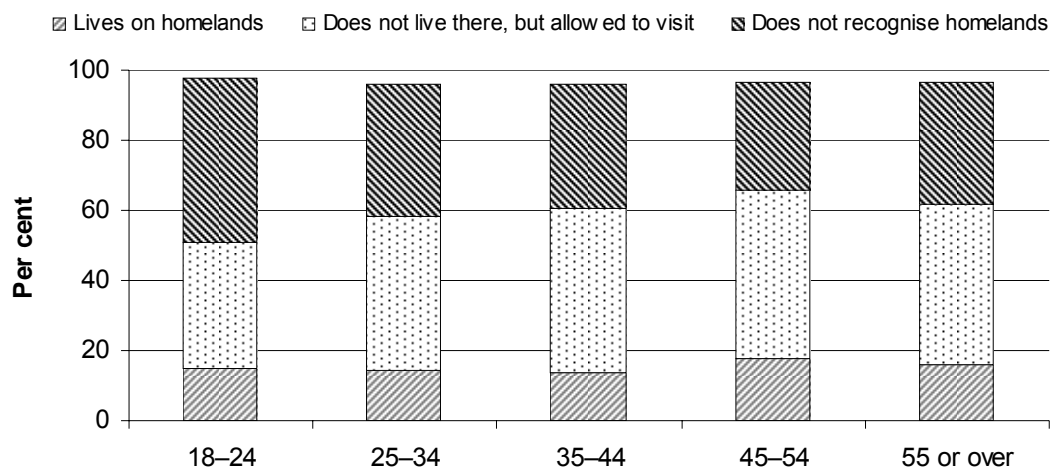


^a The NATSIHS does not provide data for this indicator for remote or very remote areas in Australia. ^b The total does not add up to 100 per cent because the category 'Not allowed to visit homelands' is not shown in the graph (ranged from 0–1.3 per cent). Also excluded are the people who refused to answer, or who provided 'don't know' or 'not stated' responses.

Source: ABS 2004-05 NATSIHS; table 9A.5.1.

- Figure 9.5.1 shows that, in 2004-05, 15.0 per cent of Indigenous adults in non-remote areas lived on their homelands. A further 43.6 per cent were allowed to visit their homelands.
- The majority of Indigenous adults (60.1 per cent) recognised an area as their homeland or traditional country. Of these, only a very few (0.6 per cent) were not allowed to visit their homelands.
- The proportion of Indigenous adults living on their homelands was about three times as high in regional areas (between 19.8 and 22.3 per cent) as in major cities (7.0 per cent).
- 38.0 per cent of Indigenous adults in non-remote areas did not recognise an area as their homelands or traditional country.

Figure 9.5.2 Proportion of Indigenous people living on, or allowed to visit, their homelands, non-remote areas, by age, 2004-05^{a, b}



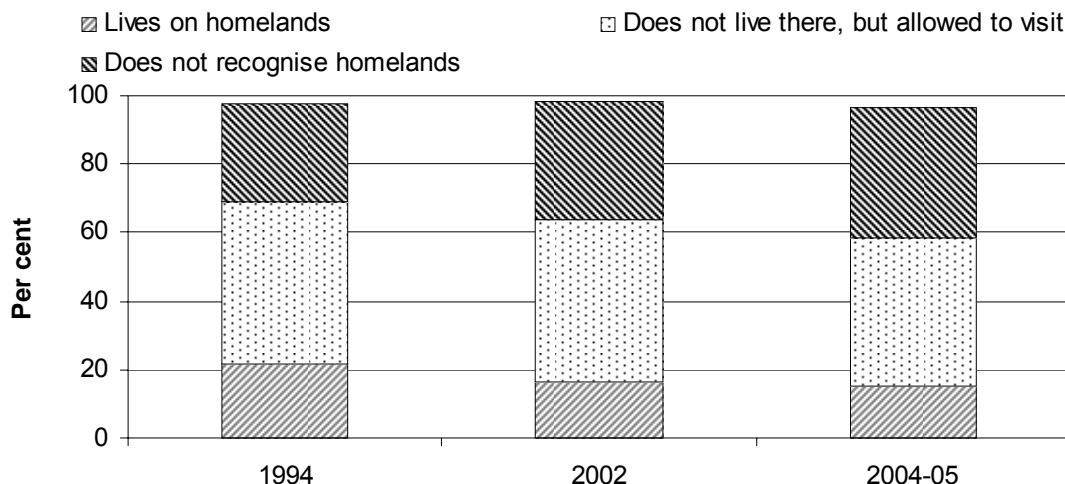
^a The NATSIHS does not provide data for this indicator for remote or very remote areas in Australia. ^b The total does not add up to 100 per cent because the category 'Not allowed to visit homelands' is not shown in the graph (ranged from 0–1.3 per cent). Also excluded are the people who refused to answer, or who provided 'don't know' or 'not stated' responses.

Source: ABS 2004-05 NATSIHS; table 9A.5.2.

- Figure 9.5.2 shows that, in non-remote areas, the proportion of Indigenous adults who lived on their homelands did not vary much according to age.
- Older Indigenous people in non-remote areas were more likely to recognise an area as their homelands. In the 18 to 24 years age group, almost half (47.3 per cent) did not recognise homelands, whereas about one third of older respondents, did not recognise homelands (31.0 per cent of those aged 45 to 54 years, and 35.0 per cent of those aged 55 years and older).

ABS surveys from 1994 and 2002, as well as the 2004-05 NATSIHS, have asked the same questions about Indigenous peoples' access to land. However, comparable data across the three datasets are only available for Indigenous people aged 18 years and over, in non-remote areas, as shown in figure 9.5.3.

Figure 9.5.3 Proportion of Indigenous people aged 18 years and over in non-remote areas, living on, or allowed to visit, their homelands, 1994, 2002, 2004-05^{a, b}



^a Data are estimated from the 'Total non-remote' category for all years, which include major cities, inner regional and outer regional areas. Remote and very remote areas are not included. ^b The total does not add up to 100 per cent because the category 'Not allowed to visit homelands' is not shown in the graph (ranged from 0–1.3 per cent). Also excluded are the people who refused to answer, or who provided 'don't know' or 'not stated' responses.

Source: ABS 1994 NATSIS (unpublished); ABS 2002 NATSISS (unpublished); ABS 2004-05 NATSIHS (unpublished); table 9A.5.3.

- Figure 9.5.3 shows that the proportion of Indigenous adults living in non-remote areas who did not recognise an area as their homelands, increased from 28.8 per cent in 1994, to 38.0 per cent in 2004-05.
- In non-remote areas, the proportion of Indigenous adults who lived on their homelands decreased (from 21.9 per cent in 1994, to 15.0 per cent in 2004-05). The proportion who were allowed to visit their homelands remained steady, ranging from 43.6 per cent to 47.5 per cent, between 1994 and 2004-05.

9.6 Participation in organised sport, arts or community group activities

Box 9.6.1 Key messages

- In 2002, almost one quarter of Indigenous people aged 15 years and over had attended an Aboriginal or Torres Strait Islander ceremony in the previous 12 months (ABS 2004). Indigenous people in remote areas were three times more likely to have attended an Aboriginal or Torres Strait Islander ceremony than those in non-remote areas (ABS 2006).
- The proportion of Indigenous people who were engaged in moderate or high levels of exercise decreased from 30.3 per cent in 1995 to 24.3 per cent in 2004-05 (table 9A.6.2).

Participation in organised sport, arts or community group activities has the potential to lead to improvement in many areas of Indigenous disadvantage, including long-term health and physical and mental wellbeing, as well as improving social cohesion in Indigenous communities.

Participation in organised sport, arts or community group activities can foster (among other things) self-esteem, social interaction, and the development of skills and teamwork. A reduction of boredom and an increased sense of belonging are generally seen as having positive impacts on Indigenous youth.

Participation in sport and recreation activities from an early age has the potential to widely benefit individuals and communities (UNICEF 2004) by:

- strengthening the body and preventing disease — regular physical activity helps to build and maintain healthy bones, muscles and joints and control body weight. Physical activity can also help prevent chronic diseases
- preparing infants for future learning
- reducing the risk of clinically significant emotional or behavioural difficulties — the Western Australian Aboriginal Child Health Survey (WAACHS) found that Indigenous children who did not participate in organised sport were twice as likely to be at high risk of clinically significant emotional or behavioural difficulties than Indigenous children who did (16 per cent and 8 per cent, respectively) (Zubrick et al. 2005)
- reducing symptoms of stress and depression — in a US study, active children were found to be depressed less often than inactive children (ACF 2002)
- improving confidence and self-esteem — a study of seventh-graders found students involved in organised sports reported higher overall self-esteem and

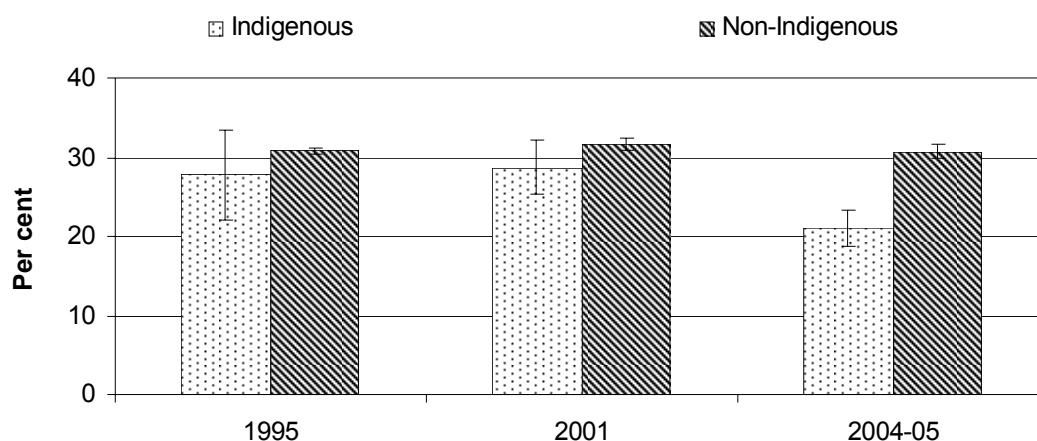
were judged by their teachers to be more socially skilled and less shy than students who did not participate in organised sports (Bush et al. 2001)

- improving learning and academic performance — studies have found that exposure to play and physical activity can improve attention levels and academic performance in primary school students. Similarly, Barber, Eccles and Stone (2001), reported that high school students who participated in organised sports in year 10 completed more years of schooling and experienced lower levels of social isolation than non-participants
- preventing smoking and the use of illicit drugs — Carinduff (2001) suggested that involvement in sport and recreation has the potential to reduce levels of substance abuse and self-harm
- reducing crime — there is strong theoretical support for the proposition that participation in sport and recreational activities can deter young people from delinquent behaviour by reason of improvements in self-worth, relief from boredom and increased social control (Cameron and MacDougall 2000). Mason and Wilson (1988) examined the link between sport and recreation and juvenile crime and concluded that sport and recreation have the ability to play a role in the reduction of offending behaviour, particularly more serious offences.

Data in this section are sourced from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS). The NATSIHS provides information on the frequency, intensity and duration of exercise undertaken by Indigenous Australians living in non-remote areas (figures 9.6.1 and 9.6.2). However, these data do not provide any information about exercise levels for children under the age of 15. The latter part of this section provides some examples of sports and community programs in operation.

Participation in sport, recreation or fitness

Figure 9.6.1 Participation in exercise at moderate/high levels by persons aged 15 years and over in non-remote areas, age standardised^{a, b}

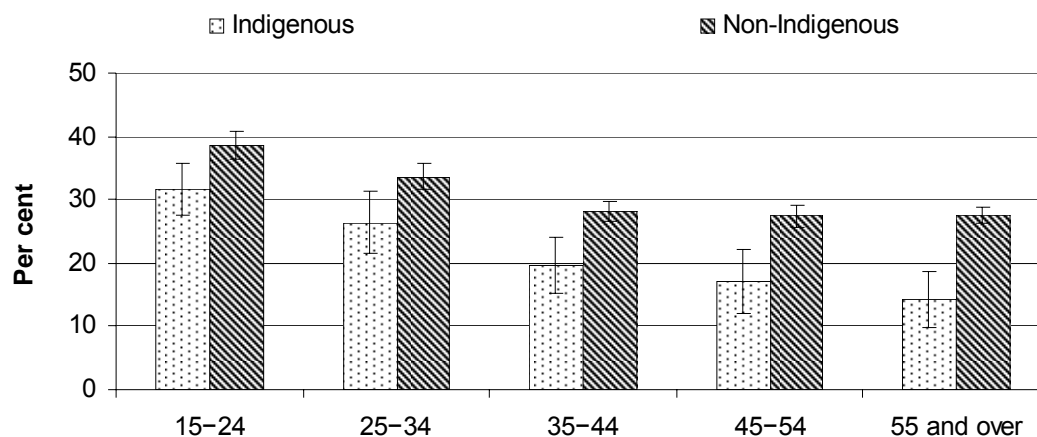


^a Based on frequency, intensity and duration of exercise in the two weeks prior to the interview (moderate and high exercise participation levels). ^b Includes not stated responses.

Source: ABS 1995 and 2001 National Health Surveys (Indigenous component) (unpublished); ABS 2004-05 NHS and NATSIHS (unpublished); table 9A.6.1.

- Between 1995 and 2004-05 there was a statistically significant decrease in the proportion of Indigenous people in non-remote areas who were engaged in moderate or high levels of exercise (from 30.3 per cent to 24.3 per cent) (table 9A.6.2).
- Over the period, the proportion of non-Indigenous people who participated in sport, recreation or fitness did not change (figure 9.6.1).
- The ABS 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) found that for Indigenous people, the level of participation in sport or physical recreation activities increased with income (ABS 2004).

Figure 9.6.2 Participation in exercise at moderate/high levels, by age group in non-remote areas, 2004-05^{a, b, c}



^a Based on frequency, intensity and duration of exercise in the two weeks prior to the interview (moderate and high exercise participation levels). ^b Includes not stated responses.

Source: ABS 2004-05 NHS and NATSIHS (unpublished); table 9A.6.3.

- For both Indigenous and non-Indigenous people in non-remote areas, participation in moderate/high levels of exercise decreased with age (figure 9.6.2).
- In both the Indigenous and non-Indigenous populations, moderate/high exercise levels were highest among people aged 15–24 years (31.7 per cent and 38.7 per cent, respectively) (figure 9.6.2).
- Table 9A.6.4 shows that in both the Indigenous and non-Indigenous populations, the proportion of males engaged in moderate/high levels of exercise was higher than for females.

Data on Indigenous and non-Indigenous people’s participation in sporting and recreational activities from the 2002 NATSISS and General Social Survey (GSS) were included in the 2005 Report.

Participation in arts and cultural activities

Involvement in art and cultural activities may improve social cohesion and contribute to community wellbeing. Participation in Indigenous arts and cultural activities may include:

- arts or cultural activities that are part of contemporary Indigenous people’s lives — this would include evolving and new forms of cultural expression influenced by wider society

-
- more traditional forms of Indigenous arts or cultural involvement.

The production of Indigenous arts is an important economic activity for many Indigenous people. There is further discussion on the economic benefits of self-employment in section 11.2.

Although there are few data on this subject, some findings from the 2002 NATSISS include:

- 35.7 per cent of Indigenous people aged 15 years and over had attended an Aboriginal or Torres Strait Islander festival involving arts, craft, music or dance in the previous 12 months (ABS 2004).
- 23.5 per cent of Indigenous people aged 15 years and over had attended an Aboriginal or Torres Strait Islander ceremony in the previous 12 months (ABS 2004).
- Indigenous people in remote areas were three times as likely to have attended an Aboriginal or Torres Strait Islander ceremony than those in non-remote areas (ABS 2006).

Data on Indigenous people's participation in cultural activities from the 2002 NATSISS and GSS were included in the 2005 Report.

Case studies on sports, arts and community programs

The following case studies describe activities within organisations and Indigenous communities that demonstrate the benefits of participation in sport, arts and community group activities (boxes 9.6.2 to 9.6.8).

Box 9.6.2 Youth disco programs

The Tirrapendi Aboriginal Youth Disco Program in SA involves new police recruits and Aboriginal families working together to plan and supervise Aboriginal youth discos. There has been an increase in Aboriginal youth attending the disco, which provides a safe environment for young Aboriginal people.

The Blue Light NT scheme is a highly successful program, whereby discos are conducted at remote communities such as Milingimbi and Ramingining. There are often over 200 youths at an event. Police members and equipment are transported to the remote locations by aeroplane. Blue Light NT is self sufficient, raising funds through the sale of merchandise at events.

Source: SA Government (unpublished); NT Government (unpublished).

Box 9.6.3 Little Yuin Aboriginal Preschool holiday program

The Little Yuin Aboriginal Preschool established a holiday program at Wallaga Lake in NSW in 2006. The community regarded the school holidays as a time when many of the children were bored. The preschool committee decided to organise a children's festival in the school holidays and work closely with community members to offer a range of activities to suit the childrens' interests and abilities.

Children aged five to 15 years old participated in a range of activities including drawing, painting and sport. Two local artists worked with children to teach drawing and painting skills and to create designs for a mural at the community hall. The mural is permanently on display at the community hall to promote the value and creativity that Indigenous children bring to Wallaga Lake.

The holiday program provided the opportunity for the children to enjoy a range of activities and the opportunity to develop new skills. The children will be able to suggest activities for future holiday programs.

Source: Bega Valley Shire Council (unpublished).

Box 9.6.4 Swan Nyungar Sports Education Program

The Swan Nyungar Sports Education Program commenced at Balga Senior High School in WA in 2002. It started as a football class for Aboriginal boys from the Swan Education District, with girls introduced to the program in 2003. Sport is the attraction for the students but it aims to increase the number of Aboriginal students at school and improve their success, participation in post-school education and employment prospects. Nyungar values are taught as part of the program.

An evaluation of the program's first year showed a doubling of achievement levels in literacy and numeracy and improvements in educational outcomes, attendance, behaviour and attitudes.

The program was evaluated again in 2005. Some of the findings include:

- there was a significant increase in the number of Indigenous males participating in the program
- school attendance increased
- students' cultural knowledge improved
- students' attitude towards school improved.

Source: WA Government (unpublished).

Box 9.6.5 The Rumbalara Football and Netball Club

The Rumbalara Football and Netball Club in Shepparton, Victoria, featured in the 2005 report, has recently celebrated 10 years since it was accepted into the Central Goulburn Football League. The club's vision is still strong and, through its sporting activities and various programs and ventures, is continuing to provide a range of benefits for the Shepparton community.

The Academy of Sport, Health and Education (ASHE), which was developed in association with the University of Melbourne, is not only addressing young people's skills base and furthering education and employment opportunities, but is also providing wider community benefits:

The social and economic benefits of this engagement are already being demonstrated with outcomes in the areas of education, training, employment and reduced juvenile criminal justice interventions in the region (University of Melbourne 2006, p. 1).

The club operates programs that support education, employment and healthy lifestyles. Although the club is not a service provider in these areas, the aim is to:

...build round the footy club an approach to education and an approach to employment and to confronting lifestyle challenges, drugs, alcohol, boredom and also really critically dealing with mental health issues (Australian Prospect 2006 p. 12).

Employment benefits for young people are discernible through many successful job matchings and placements:

- over a two year period 160 young people were placed in jobs through the club's programs
- a large number of potential employers have been enlisted to offer employment, 60 employers were able to offer 100 jobs to young people at the club (Australian Prospect 2006).

Much of the value for members of the club is much less tangible. Playing sport has long been an important community activity and has carried a very special significance to Aboriginal people. It is a way of respecting and sharing Aboriginal identity and a reaffirmation of cultural expression:

The footy club is a place that young people can see pride expressed in their identity. That's the real value of the sporting club and from that we can do all sorts of other things including building pride, esteem, inspiration and aspiration (Australian Prospect 2006, p. 7).

Rumbalara Football and Netball Club, and especially the team building that is involved in sport, is also providing a model for older people and others in the community. It is a positive example for social relationships where young people can show elders how to share and come together for a common purpose. According to Paul Briggs, Club President 'it's a real centre for healing and a place for spiritual revival...' (Australian Prospect 2006, p. 11).

Source: Australian Prospect 2006; University of Melbourne 2006.

Box 9.6.6 Athletics Australia 'Athletics for the Outback' Program

Athletics Australia is the governing body for athletics in Australia. It has made a commitment to providing the opportunity for all Australians to enjoy and participate in athletics and to provide focus for the sport of track and field. Programs range from school based athletics and fun runs to elite development (Athletics Australia 2006).

Athletics Australia's development program has a key focus on Indigenous, remote and rural programs through the Athletics for the Outback Program. It brings athletics to communities by providing resources and assistance, and aims to create a 'whole of life' activity that links education, life skills and responsibilities with sport.

The program encourages participation by women, and all participants are provided with the opportunity to become involved as an athlete, official or coach. There is mentoring available for all areas of athletic development and there is also assistance available for local communities on how to run a carnival or athletic event.

Athletics Australia has conducted many events to assist children from rural or remote areas to be involved in sport during 2006. This included:

- An Indigenous Athletics Camp held in Scotts Head, NSW, which involved 31 athletes from ages 12–17. Participants received training sessions with a variety of coaches as well as education sessions on topics such as alcohol, nutrition and athletic pathways. There were also competitions with a local school and clubs in the area as well as the opportunity to host a dinner with Aboriginal elders and observe some local cultural activities such as Aboriginal singing, dancing and ceremonies (Athletics Australia 2006).
- Travel by several athletics coaches to Normanton in the Gulf of Carpentaria for the second consecutive year. The aim was to identify athletic talent as well as fostering and nurturing talent within the community. At Normanton, a coaching clinic was conducted for athletes from Normanton, Mornington Island and Karumba who ranged in age from 9–15 years (Athletics Australia 2006). In Mt Isa, coaches attended a Little Athletics competition and provided coaching tips as well as identifying a potential coach as part of a strategy to promote and nurture talent in the area. This potential coach will be encouraged and assisted to complete qualification courses.

In 2007, Athletics Australia, in collaboration with the Australian Institute of Sport (AIS) and the Australian Sports Commission (ASC), will embark on a program aimed at talent identification and development.

This is an 18 month pilot of a four year program and is aimed at those already competing at a national or state level. The program is to fast track athletes to high performance levels through training camps, skills sessions, competition and elite coaching. Many athletes have already been identified through the Athletics for the Outback Program (Athletics Australia 2006).

Source: Athletics Australia 2006.

Box 9.6.7 **Yirra Yaakin Noongar Theatre (WA)**

Yirra Yaakin was established in 1993 and has grown to become a world class theatre company and leader in community development. More than an Indigenous theatre company, Yirra Yaakin supports positive self-enhancement through artistic expression.

Yirra Yaakin Noongar Theatre has three main areas of activity:

- A community program — focussing on youth arts, local participation and events that are of major benefit to the Aboriginal Community.
- A development program — ongoing training and mentoring across a wide range of theatre practices. Yirra Yaakin has a core of experienced professional Aboriginal theatre workers as well as a number of trainees and volunteers who receive hands on skills development in a wide range of theatre practices.
- A professional program — supporting new works of emerging and established Aboriginal artists.

Source: WA Government (unpublished).

Box 9.6.8 **National Indigenous Television Service (NITV)**

A Productivity Commission Report into broadcasting (2000) found that broadcasting was important for Indigenous communities, because it provided a primary level of service in remote areas and in local languages. Greater Indigenous access to, and control of, television content and programming has the potential to reduce disadvantage by engaging the Indigenous population and:

- supporting and encouraging a strong cultural identity
- providing an opportunity for Indigenous Australians to see their language and culture reflected back to them, in the same way other Australians see their culture reflected on commercial television
- delivering important health, education and employment messages
- addressing aspects of community isolation as well as support specific community identity
- promoting Indigenous tourism and art (Daly 2001; Silburn et al. 2006).

The Australian Broadcasting Corporation (ABC) and Special Broadcasting Service (SBS) provide some Indigenous programming, and the Australian Government has provided support for independent Indigenous broadcasters since 1987, funding 67 Indigenous broadcasting organisations in 2006-07. However, a 2005 Department of Communications, Information Technology and the Arts (DCITA) review found a strong demand among Indigenous people for increased access to Indigenous television content (DCITA 2005).

(Continued next page)

Box 9.6.8 (continued)

The Australian Government has agreed to provide funding over four years (2006-07 to 2009-10) to establish a National Indigenous Television Service (NITV) (Nelson 2006).

The NITV aims to:

- produce and commission programming including news, children's programs and drama that reflect Australia's diverse Indigenous communities
- provide Indigenous leadership and control over the communication of a broad range of cultural, language, education, documentary, dramatic and current affairs content
- provide vocational and occupational opportunities for Indigenous people associated with broadcasting
- produce programs in Indigenous languages.

The NITV is at the early stages of implementation. There will be opportunity in future reports to explore if these outcomes have been achieved.

Source: Daly 2001; DCITA 2005; Nelson 2006; Productivity Commission 2000; Silburn et al. 2006.

9.7 Engagement with service delivery

Box 9.7.1 Key messages

- In 2002, based on survey data, Indigenous people aged 55 years and over had the most difficulty understanding and being understood by service providers (14.1 per cent) (table 9A.7.7).
- In 2004-05, an estimated 26 500 Indigenous adults needed to go to hospital in the previous 12 months, but did not go because of cost, personal reasons, logistical reasons or other barriers (figure 9.7.1 and table 9A.7.1).
- The Western Australian Aboriginal Child Health Survey (WAACHS) found that even though there was a high proportion of Aboriginal children at high risk of clinically significant emotional and behavioural difficulties, very few children had had contact with Mental Health Services.

One of the outcomes from consultations on the 2005 Report was the inclusion of a new indicator 'Engagement with service delivery' (SCRGSP 2007).

Service engagement is a broad concept that encompasses accessibility (including barriers to access) and appropriate delivery (including Indigenous cultural perspectives in designing and delivering programs). In remote areas, there are

additional barriers to access arising from the lack of services and long distances necessary to access those that do exist.

A Commonwealth Grants Commission (2001) Report found that Indigenous Australians in all regions accessed mainstream services at very much lower rates than non-Indigenous people. Mainstream services are intended to be accessible and meet the needs of all Australians. Indigenous-specific services may influence Indigenous people's access to and use of mainstream services. However, Indigenous-specific programs are often designed to target particular groups or regions or to address particular issues. Generally, Indigenous-specific programs are not funded or designed to substitute for mainstream services.

One of the key issues in the evaluations of the eight Council of Australian Government's (COAG) Indigenous trials was community engagement (Morgan Disney et al. 2007). The trial site evaluation reports emphasised the importance of engagement with Indigenous communities to achieve measurable improvements in economic, health, and social indicators. (Morgan Disney et al. 2007). The level of engagement between the Indigenous community and governments influenced the success of process outcomes (such as improving coordination and collaboration processes, governance capacity building and community development processes) (Morgan Disney et al. 2007). One of the lessons learnt from the COAG trials was that it was essential to take time to engage the Indigenous community and that '...quick wins are not always possible when you are dealing with complex issues' (Morgan Disney et al. 2007, p. 16).

Ineffective service delivery and low levels of access to mainstream programs (because of barriers to access) compound the levels of disadvantage experienced by Indigenous people across a range of outcomes (CGC 2001). For example:

- health — patients with chronic and life-threatening conditions are unable to make informed choices because they do not understand health professionals' explanations of what is making them ill, or how it can be treated (Coulehan et al. 2005; Lowell et al. 2005; Trudgen 2000)
- justice — not understanding legal proceedings affects access to justice (Byrne 2003; Cooke 2002; Eades 1993; Koch 1985; Siegel 2002)
- education — miscommunication in the classroom hinders education (Lowell and Devlin 1998; Malcolm 1982).

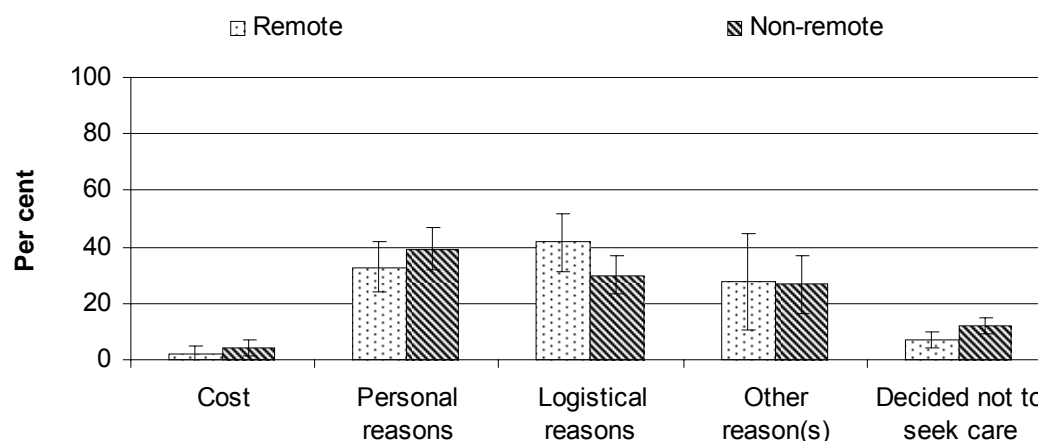
Improving service accessibility and service delivery methods can be expected to lead to better outcomes for Indigenous people. This section includes:

- survey data on barriers to accessing services, perceived treatment when seeking health care, difficulty communicating with service providers, services located in

discrete Aboriginal and Torres Strait Islander communities, the use of mental health services by Aboriginal children and information from primary carers of Aboriginal children on their satisfaction with access to community services and facilities

- hospital data on the rate that Indigenous people discharge themselves from hospital against medical advice
- case studies of effective service engagement. The case studies highlight the importance of monitoring and evaluating the effectiveness of service delivery (and communication) to Indigenous communities.

Figure 9.7.1 Reasons for not going to a hospital in the last 12 months, Indigenous people aged 18 years and over, 2004-05^{a, b, c, d}



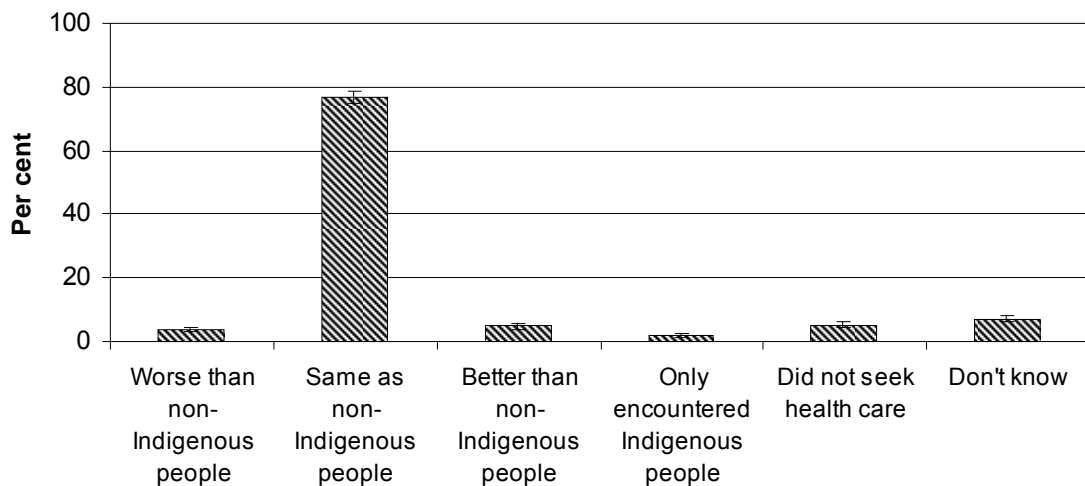
^a Error bars represent 95 per cent confidence intervals around each estimate. ^b Personal reasons include: too busy (work, personal or family responsibilities), discrimination, service not culturally appropriate, language problems, dislikes service or health professional, afraid, embarrassed, or felt service would be inadequate. ^c Logistical reasons include: transport/distance, service not available in area, waiting time too long, or service not available at the time required. ^d The relative standard error for the percentage of Indigenous people in remote areas who reported 'cost' as a reason for not going to a hospital is greater than 50 per cent. The ABS states that estimates with a relative standard error greater than 50 per cent are considered too unreliable for general use.

Source: ABS 2004-05 NATSIHS (unpublished); table 9A.7.1.

- Figure 9.7.1 shows that there was no statistically significant difference between the reasons for not going to a hospital that were reported by Indigenous people living in remote and non-remote areas.
- A 2001 Report (CGC 2001) found that barriers to access to mainstream programs included the way programs were designed, how they were presented and the cost to users. In remote areas, these barriers were exacerbated by the lack of services and difficulties caused by the physical distance to services.

Data on reasons for not going to a GP, dentist or other health professional by remoteness are reported in section 9.3.

Figure 9.7.2 Indigenous people's perceptions of their treatment when seeking health care in the previous 12 months, compared to treatment of non-Indigenous people, 2004-05^{a, b}

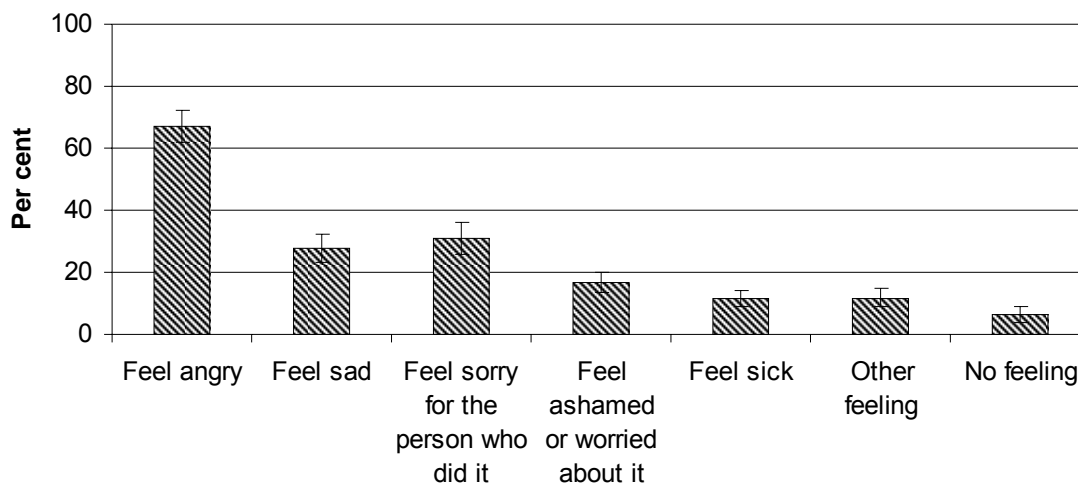


^a Indigenous people aged 18 years and over. ^b Error bars represent 95 per cent confidence intervals around each estimate.

Source: ABS 2004-05 NATSIHS; table 9A.7.2.

- In 2004-05, the majority of Indigenous adults (76.8 per cent) believed that the quality of health care treatment they had received in the last 12 months was the same as that received by non-Indigenous people (figure 9.7.2).
- An estimated 9 500 Indigenous adults (3.7 per cent) believed they had received health care services in the last 12 months that were worse than the health care treatment received by non-Indigenous people (figure 9.7.2).
- Five per cent of Indigenous adults believed that the health care treatment they had received in the last 12 months was better than that received by non-Indigenous people (figure 9.7.2).

Figure 9.7.3 How Indigenous people felt after they had been discriminated against because of their Indigenous status, 2004-05^{a, b, c}

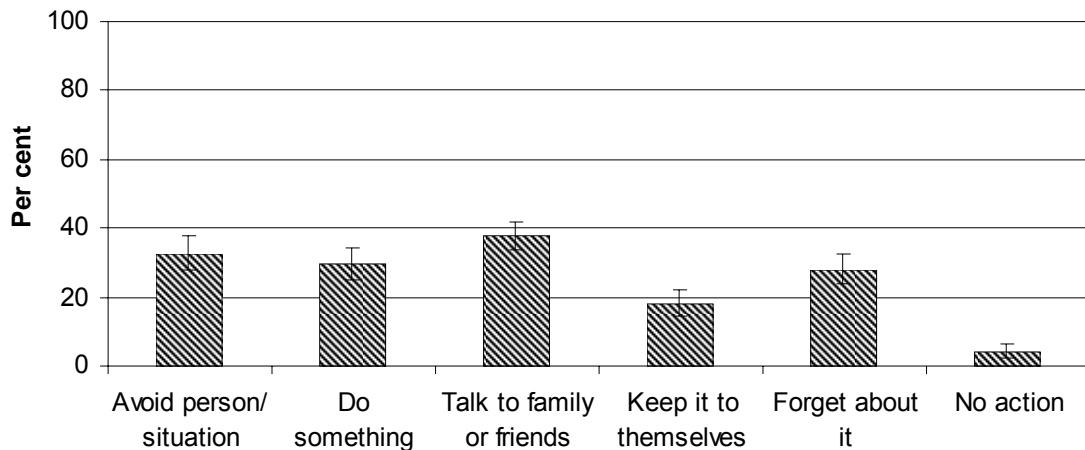


^a Indigenous people aged 18 years and over who felt discriminated against in any situation. ^b Error bars represent 95 per cent confidence intervals around each estimate. ^c Components do not add to 100 per cent because people may have provided more than one response.

Source: ABS 2004-05 NATSIHS; table 9A.7.3.

- Of those Indigenous people who believed that they had been discriminated against, 67.4 per cent felt angry while only 6.3 per cent stated that they had no feelings on the issue (figure 9.7.3).
- Feeling sorry for the person who treated them badly (30.9 per cent), feeling sad (27.8 per cent), feeling ashamed (16.8 per cent), and feeling sick (11.8 per cent), were some of the thoughts and emotions felt by Indigenous people who believed they had been discriminated against in 2004-05 (figure 9.7.3).

Figure 9.7.4 **Some of the actions taken by Indigenous people after they had been discriminated against because of their Indigenous status, 2004-05^{a, b, c}**

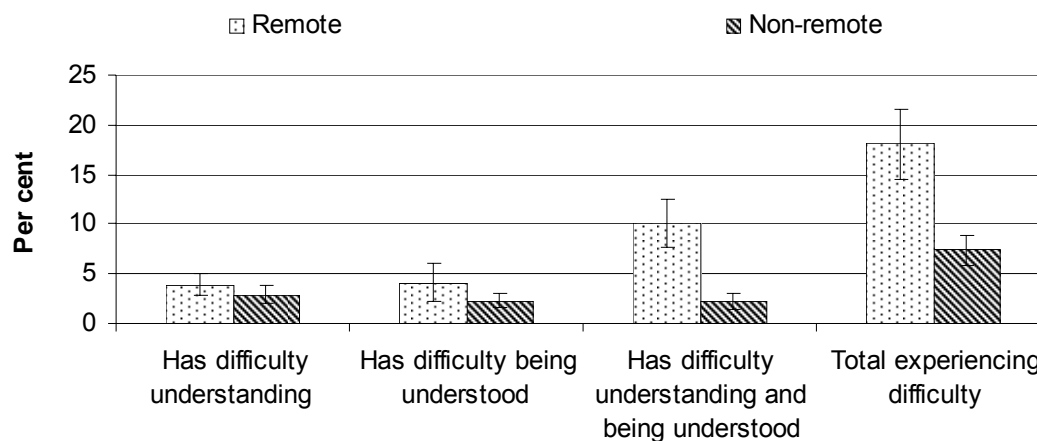


^a Indigenous people aged 18 years and over. ^b Error bars represent 95 per cent confidence intervals around each estimate. ^c Components do not add to 100 per cent because people may have provided more than one response.

Source: ABS 2004-05 NATSIHS; table 9A.7.4.

- The most common responses of Indigenous people who believed that they had been discriminated against because of their Indigenous status were to talk to family or friends about their ordeal (37.7 per cent) and/or do something about the poor treatment they had received (29.8 per cent) (table 9A.7.4).
- More than one quarter (28.0 per cent) of Indigenous people who believed that they had been discriminated against tried to forget about the experience, and 18.2 per cent kept the experience to themselves (table 9A.7.4).

Figure 9.7.5 Communication with service providers, Indigenous people aged 15 years or over, 2002^a



^a Error bars represent 95 per cent confidence intervals around each estimate.

Source: ABS 2002 NATSISS (unpublished); table 9A.7.5.

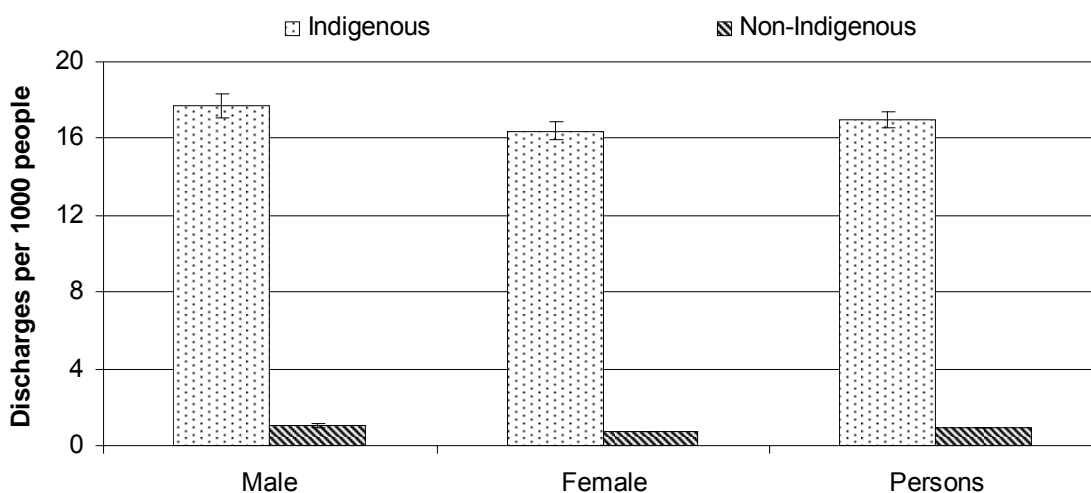
- Indigenous people living in remote areas in 2002 were more likely to report difficulty communicating with service providers (18.1 per cent) than Indigenous people living in non-remote areas (7.4 per cent) (figure 9.7.5).
- In 2002, Indigenous people living in remote areas were approximately five times as likely than Indigenous people in non-remote areas to have difficulty both understanding and being understood by service providers (figure 9.7.5).
- Indigenous people aged 55 years and over had the most difficulty communicating with service providers (14.1 per cent) (table 9A.7.7).
- There was no statistically significant difference in the proportion of Indigenous people having difficulty communicating with service providers in 1994 and 2002 (ABS 2004).

Data on difficulty communicating with service providers by State and Territory are in table 9A.7.6.

The National Hospital Morbidity Database provides information on the rate that Indigenous people discharge themselves from hospital against medical advice. These data do not provide the reasons why some Indigenous and non-Indigenous people choose to discharge themselves against medical advice and if there were differences between Indigenous and non-Indigenous people's reasons. These data do not provide information on the nature of the person's medical condition. In the absence of research to the contrary, it may be possible that the Indigenous and non-Indigenous differences in discharge against medical advice may be a reflection

of socioeconomic differences such as Indigenous people's lower average incomes, employment status, education levels, and greater remoteness. Cost and access to private health insurance and private hospitals may also be a factor.

Figure 9.7.6 Rates of discharge from hospital against medical advice, by sex and Indigenous status, per 1000 people, Queensland, WA, SA and public hospitals in the NT, July 2002 to June 2004^{a, b, c, d, e, f}



^a Rates exclude mental and behavioural disorders. ^b Data are based on State/Territory of usual residence. ^c Data are presented in two-year groupings due to small numbers each year. ^d Rates are directly age standardised using the Australian 2001 Standard population. ^e Rates are presented with their 95 per cent confidence limits. ^f Non-Indigenous includes Indigenous status not stated.

Source: AIHW National Hospital Morbidity Database (unpublished); table 9A.7.8.

- Figure 9.7.6 compares the rates of discharge from hospital for Indigenous and non-Indigenous people for Queensland, WA, SA and public hospitals in the NT. These four states and territories are considered to have the highest level of accuracy of Indigenous identification, although the level of accuracy varies by State/Territory and hospital.
- Rates of discharge from hospital against medical advice for Indigenous people were significantly greater than non-Indigenous rates for both men and women (figure 9.7.6).
- For Indigenous men and women, the rates of discharge from hospital against medical advice were 17.1 and 22.6 times as high as the discharge rates for non-Indigenous men and women, respectively (figure 9.7.6).

The ABS Community Housing and Infrastructure Needs Survey (CHINS) was conducted in 1999, 2001 and again in 2006 (ABS 2007). The CHINS collected information on services (health, education and public transport) available in discrete

Indigenous communities.² The 2006 CHINS collected data concerning 1187 discrete Indigenous communities with a combined reported population of 92 960³ (ABS 2007). Some of the findings from the 2006 CHINS include:

Education

- In 2006, 245 communities (21 per cent of the total number of communities participating in the 2006 CHINS) reported that a primary school was located within the community. Of the 245 communities with primary schools, 212 communities were located in very remote Australia (ABS 2007).
- The number of discrete Indigenous communities that had a secondary school (that provided a year 12 level of education) increased from 17 discrete Indigenous communities in 2001 to 40 communities in 2006 (ABS 2007).

Health

- In 2006, 10 of the 1187 discrete Indigenous communities reported that a hospital was located within the community (ABS 2007).
- 755 discrete Indigenous communities were located 100 kilometres or more from the nearest hospital. On a population basis, 51 992 Indigenous people (55.9 per cent) were living in communities located 100 kilometres or more from the nearest hospital (ABS 2007).
- 663 discrete Indigenous communities reported that they did not have access to medical emergency air services. Of those 663 communities, 487 communities were located 100 kilometres or more from the nearest hospital (ABS 2007). On a population basis, 10 per cent of Indigenous people (9 337 Indigenous people) living in discrete Indigenous communities were 100 kilometres or more from the nearest hospital and did not have access to medical emergency air services (ABS 2007).
- The number of communities without access to medical emergency air services increased from 564 communities in 2001 to 633 communities in 2006 (ABS 2007).

Public transport to nearest town with major services

² Discrete Indigenous communities are defined by the ABS as geographic locations inhabited by or intended to be inhabited predominantly (greater than 50 per cent of usual residents) by Aboriginal or Torres Strait Islander peoples, with housing or infrastructure that is managed on a community basis.

³ CHINS population data include both Indigenous and non-Indigenous people living in discrete Indigenous communities. Populations are not counts and are based on estimates made by informants in each community.

A lack of public transport (government or commercial transport services available for use by the general public, such as regular bus, ferry or air services) can often mean that comparably short distances are an impediment to accessing services. In 2006:

- 63 discrete Indigenous communities with a reported usual population of 10 876 people (11 per cent of the reported population of all discrete Indigenous communities) were located within towns that provided major services (ABS 2007).
- For communities not located within towns, 894 communities reported road as the main mode of transport. These 894 communities represented a combined reported usual population of 63 529 people (63 per cent of the reported population of all discrete Indigenous communities) (ABS 2007).
- 28 discrete Indigenous communities with a reported usual population of 10 699 Indigenous people (11 per cent of the reported population of all discrete Indigenous communities) reported that public transport services were available to and from the community into towns that provide major services (ABS 2007).

Data on access to clean water and functional sewerage in discrete Indigenous communities can be found in section 10.2. Information about Aboriginal primary health care centres and state-funded community health centres located in discrete Indigenous communities and whether any Indigenous health workers had visited or worked within these communities is reported in section 9.3.

Data on the mental health of Aboriginal children in WA collected in the 2001 and 2002 WAACHS was compared with contacts with Mental Health Services in WA (both hospital-based and community-based). Some of the findings include:

- Even though there was a high proportion of Aboriginal children at high risk of clinically significant emotional and behavioural difficulties, very few children had had contact with Mental Health Services (less than one per cent of children under 4 years of age, 3.8 per cent of children aged 4–11 years, and 11.0 per cent of children aged 12–17 years) (Zubrick et al. 2005).
- For the age groups 4–11 years and 12–17 years, the proportion of children who had contact with Mental Health Services decreased with remoteness. This decline reflected the availability of services in extremely isolated areas and the decrease in the proportion of children at high risk of clinically significant emotional or behavioural difficulties with remoteness (Zubrick et al. 2005).

More information on the mental wellbeing of children is reported in section 9.4.

The 2001 and 2002 WAACHS surveyed primary carers of Aboriginal children about access to community services and facilities and these results were compared

with the 1993 Western Australian Child Health Survey (WA CHS). There was a seven to eight year gap between the WA CHS and the WAACHS during which time there may have been changes in overall access to specific services or facilities and this may affect the interpretation of some of the findings.

Some of the findings from the WAACHS and the WA CHS include:

- The proportion of primary carers of Aboriginal children who reported being happy with access to community services and facilities⁴ was, in most cases, significantly below that reported by carers of non-Aboriginal children in the 1993 WA CHS (Silburn et al. 2006).
- For primary carers of Aboriginal children, rates of reported satisfaction for services such as a place where teenagers can get together, after school or vacation care and child care facilities were all at or below 30 per cent (Silburn et al. 2006).
- As the level of relative isolation⁵ increased, the proportion of carers of Aboriginal children who were satisfied with access to a community or child health clinic increased. This pattern was not present among carers of non-Aboriginal children (Silburn et al. 2006).
- The levels of satisfaction with access to Aboriginal Medical Services increased as the level of relative isolation increased (Silburn et al. 2006).

Case studies on service engagement

The following case studies (boxes 9.7.2 to 9.7.8) are examples of initiatives that have been undertaken to improve service engagement. These include acknowledging Indigenous cultural perspectives in designing and delivering programs, and improving communication between Indigenous people and health and legal services.

Information on culturally appropriate justice practices for Indigenous people can be found in chapter 3, section 3.12 (boxes 3.12.2, 3.12.3 and 3.12.4 describe the success of the Koori Courts in Victoria, Nunga Courts in SA and Murri Courts in Queensland, respectively).

⁴ Community services and facilities included schools, police stations or regular patrols, public libraries, community centres, Department for Community Development (Welfare), child care facilities and after school care or vacation care.

⁵ The Level of Relative Isolation (LORI) was used to classify geographic remoteness in the WAACHS. Levels of Relative Isolation ranged from none (Perth metropolitan area) to low (Albany), moderate (Broome), high (Kalumburu) and extreme (Yiyili).

Box 9.7.2 *Sharing the True Stories* — improving communication in Indigenous health care

From 2001 to 2005 the *Sharing the True Stories* (STTS) longitudinal participatory action research project was conducted in renal and hospital services in the NT. The aim of the project was to improve health outcomes for Indigenous people by identifying and addressing barriers to effective communication between Indigenous patients and NT health care workers.

The project was conducted in two stages. Stage 1 identified factors that limited effective communication between Indigenous patients and health care workers in a satellite dialysis unit in Darwin, NT. Stage 2 focused on developing and evaluating strategies and resources to bring about constructive change in health service delivery to Indigenous patients.

Stage 1 was conducted from January to August 2001 and found that miscommunication and lack of shared understanding between health staff and Indigenous renal patients had seriously limited the patients' opportunity and capacity to make informed choices about their health care.

Stage 2 found that the following strategies improved intercultural communication in Indigenous health:

- effective use of Indigenous interpreters, which means, training Indigenous interpreters to prepare them for work with health care workers. As a result of the STTS project participating interpreters gained experience in interpreting in renal and hospital contexts and an education in biomedical concepts.
- effective educational resources for Indigenous patients about the physiological processes and treatment options. Indigenous people involved in the project stated a preference for 'learning in action' (for example role-playing) instead of books or websites. Educational resources for health staff about the cultural, social and economic realities confronting Indigenous patients and their families.
- engaging Indigenous people in the development of strategies and resources to improve intercultural communication and education gives Indigenous people more control of their health care.
- community consultation, training and education of patients and their supporting kin in self-care home haemodialysis.

Source: Cass et al. 2002; Coulehan et al. 2005.

Box 9.7.3 Health Education Unit — Jalaris Aboriginal Corporation

The Jalaris Aboriginal Corporation is a small non-government organisation located in the north west of WA.

A small group of people from the Derby community identified a need for an organisation that could coordinate a holistic approach to addressing the major issues in Derby. The Jalaris Aboriginal Corporation was formed in 1994 and has developed innovative programs to deal with family strength and health with a particular focus on meeting the fundamental needs (such as adequate nutrition) of Indigenous parents and young children.

Jalaris relies on periodic government, non-government and industry partners to deliver services to the Derby community and outlying communities and stations. The Jalaris Aboriginal Corporation firmly believe in philosophy of finding local solutions to local issues.

One example is the Health Education Unit, which provides an effective link between community members and the Derby Aboriginal Health Service. The Health Education Unit is a caravan with medical equipment and educational information that travels to the homes of people in Derby and to the outlying communities and stations.

The caravan enables senior Indigenous women to connect health service professionals to mothers and children who need health care but are uncomfortable about going to the clinic. The service also provides meals on wheels for children and provides a supportive environment for mothers and children to visit and access support.

Source: AIFS 2003.

Box 9.7.4 Improving Care for Aboriginal and Torres Strait Islander Patients program

The Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program is a re-orientation of the long standing Koori Hospital Liaison Officer (KHLO) program which was established in Victoria in 1982. In 2004, the Victorian Department of Human Service (DHS) partnered with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to implement a new approach to improving accurate identification of, and quality care for, Aboriginal and Torres Strait Islander patients in Victorian health services. The former KHLO program was renamed 'Improving Care for Aboriginal and Torres Strait Islander Patients' to symbolise its shift in focus from inputs to outcomes. From 1 July 2004, the previously separate funding streams were amalgamated and increased.

(Continued next page)

Box 9.7.4 (continued)

ICAP encourages:

- an outcomes focus leading to improved identification and health care for Indigenous patients
- responses proportional to the number of Indigenous patients
- whole of health service responsibility where Indigenous patients are everybody's business in a health service, not the sole responsibility of designated Koori liaison staff
- relationships with Indigenous people and organisations.

ICAP guidelines have been developed and disseminated to health services as a condition of receiving increased funding. Four key result areas that form the basis for quality of care reporting in this area are:

- relationships with Indigenous communities
- culturally aware staff
- discharge planning
- primary care referrals.

To support the development of external partnerships and internal cultural change, three ICAP Project Officers have been employed, one in regional and rural Victoria (based at a regional DHS office), one in metropolitan Melbourne (based at St Vincent's Health Service) and one based at VACCHO. The role of the ICAP team is to assist both health services and the Aboriginal community controlled sector with the implementation of the reforms.

A number of results and new initiatives have flowed from ICAP including:

- improved relationships between health services and Indigenous organisations
- an increasing number of formal and informal partnerships between health services and Indigenous organisations
- commitment by health services to improve their cultural sensitivity and create a welcoming environment for Indigenous patients and their families
- the development of an online ICAP Resource Kit to assist health services meet the requirements set out in the ICAP Guidelines
- the creation of new positions that generate new and innovative ways of engaging with Indigenous patients, for example:
 - an Aboriginal Policy and Planning Officer position at St Vincent's Health
 - an Aboriginal mid-wife position at Ballarat Health Services
- increased numbers of Indigenous hospitalisations reported indicating a greater willingness to identify and/or higher numbers of patients using health services.

Source: Victorian Department of Human Services (unpublished).

Box 9.7.5 Interpreter accreditation — Port Augusta

The lack of accredited Indigenous language interpreters prompted the Government to ensure that 15 people in Port Augusta identified with relevant Aboriginal language skills received training to become accredited interpreters. An accredited Aboriginal Language Interpreters Training Program is available through TAFE. The accredited interpreters can be accessed by local justice agencies when required.

Source: South Australian Government (unpublished).

Box 9.7.6 Improvements to Medicare service access

Medicare and the Pharmaceutical Benefits Scheme (PBS) are two key elements of the national health care system. These two key services of the health care system are provided for the benefit of all Australians. Improving Indigenous peoples' access to these fundamental health services provides better health care to Indigenous people.

A 1997 Report on Indigenous access to Medicare and the PBS found that:

- many Indigenous Australians were not enrolled in Medicare (60 per cent to 85 per cent Indigenous enrolments in Medicare in various locations)
- Aboriginal Community Controlled Health Service (ACCHS) claims on Medicare were low
- there were significant barriers to accessing the PBS for Aboriginal and Torres Strait Islander people — the cost of medications was the greatest single barrier.

The 1997 report made 48 recommendations relating to Medicare enrolment, the Medicare claims process, voluntary identification for Indigenous Australians, communications with Indigenous Australians and their health service providers, improved Medicare response to the nature and range of services provided by Aboriginal Community Controlled Health Services and improved access to medications in remote areas.

Some of the initiatives implemented since 1997 include:

- development of a new Indigenous enrolment form for Medicare which allows relevant community members to vouch for an individual's identity
- introduction of a voluntary Indigenous identifier for people enrolling in Medicare
- establishment within Medicare Australia of a network of Medicare Liaison Officers for Indigenous Access (MLOs) with a range of responsibilities including promoting Medicare enrolment, facilitating the processing of Medicare claims, and training and support for health service providers and communities

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Box 9.7.6 (continued)

- introduction of an Aboriginal and Torres Strait Islander access line (1800 number) for Medicare enquiries that is serviced by MLOs and their support staff
- use of s.100 of the *National Health Act 1953 (Cwth)* to enable supply of PBS medicines free, at the time of consultation to clients of eligible and approved Aboriginal and Torres Strait Islander health services in remote areas.

A 2005-06 study was undertaken to examine the effectiveness of the initiatives implemented to improve Indigenous peoples' access to Medicare and the PBS. Some of the key findings included:

- Medicare enrolments for Indigenous people have substantially increased — especially in the NT where more than 95 per cent of the Indigenous population are now enrolled. This is in part due to a group of Medicare Liaison Officers who take Medicare services directly to people living in more remote areas.
- An increase in Medicare billing by ACCHs.
- Section 100 arrangements have had at least two major benefits — increasing access to medications in remote areas and reducing the costs that many health services previously incurred in purchasing medicines for patients. Another positive impact of the s.100 arrangement has been the development of stronger relationships between pharmacists and Aboriginal and Torres Strait Islander Health Services.
- The value in providing Indigenous health content in the formal education and training of doctors, nurses and other health professionals.

The final report from the 2005-06 study made 38 recommendations on Indigenous peoples' access to major health programs (including hearing services, immunisation, point of care diabetes testing and the National Diabetes Services Scheme).

Source: Urbis Keys Young 2006.

Box 9.7.7 'Yarning about Mental Health'

The Menzies School of Health Research has produced a new book which uses pictures and traditional Aboriginal stories to identify and explain some of the causes, symptoms and treatments of mental health problems to people in their communities. The booklet, 'Yarning about Mental Health' was produced to address the need to communicate the complexities of mental health to individuals and Aboriginal communities in a way that they could easily relate back to their lifestyle, culture and environment.

Source: Menzies School of Health Research 2006.

Box 9.7.8 Pre-hospital care in remote Queensland communities

In 1995, several remote Aboriginal and Torres Strait Islander communities and the Queensland Ambulance Service (QAS) were concerned about community access to pre-hospital care services. Initial planning and consultation revealed the specific concerns and challenges to be addressed:

- the relatively high injury rates in Indigenous communities and consequently a high level of need for pre-hospital care services
- the unique needs of remote Indigenous communities, including the need for pre-hospital care services to cover a wider range of roles and functions compared to urban models
- the vulnerability of Indigenous communities in times of emergencies and disasters caused by their geographic isolation, climate, limited community infrastructure and complex cultural issues.

To address these concerns a pre-hospital care model for remote Indigenous communities was developed and has been implemented in the communities of Coen, Horn Island, Cooktown and Kowanyama. This model involves the establishment of a QAS Field Office staffed by a permanent Field Officer (QAS Paramedic). The Field Officer serves the local community, surrounding communities and importantly, the related homelands/outstations.

The role of the Field Officer includes injury prevention and first aid training, developing the emergency response capability of communities, and training primary health care workers in relation to pre-hospital care including the use of emergency equipment such as defibrillators.

The implementation of this model has also resulted in the establishment of permanent ambulance services at Mornington Island, Doomadgee and Palm Island.

Source: Craze and Lucas 1998; Queensland Government (unpublished).

Box 9.7.9 Northern Territory Aboriginal Interpreter Service

The Northern Territory Aboriginal Interpreter Service has been operating for approximately seven years and currently employs 177 interpreters. The Aboriginal Interpreter Service provides a professional service to health and justice agencies and organisations.

In 2000, the Aboriginal Interpreter Service developed a 'roster system' to service some of the Northern Territory hospitals. The roster system means that three interpreters are available five mornings a week to meet the urgent demand of having an interpreter available as soon as possible.

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Box 9.7.9 (continued)

For example, the Tennant Creek Hospital is allocated 20 hours per week for the interpreting roster. Negotiations occur between key staff at Tennant Creek Hospital and the interpreter to ensure that the hours and times allocated are when there is the most need for the service. One hospital clinic in particular that has benefited from having the interpreter available is the regular eye theatre clinic. By having the interpreter, the patient is able to understand the procedure and give informed consent before surgery. As the patient is not under general anaesthetic, the interpreter is able to interpret throughout the surgery. This practice has assisted 65 Indigenous patients who have had surgery and approximately 305 patients who have attended outpatient eye clinics since 2003.

Source: NT Government (unpublished).

9.8 Future directions in data

Mental health

There are few data from which to draw conclusions about the scope, prevalence and burden of mental health problems in Indigenous people (especially for vulnerable groups of the Indigenous population, such as prisoners, juveniles in detention and children). The key challenges are to improve existing collections, such as improving reporting for rural/remote areas, and to expand data collection instruments, such as Indigenous specific surveys and longitudinal studies of Indigenous children, to incorporate mental health modules. One of the potential benefits of the Juvenile Justice National Minimum Data Set is the possible links with other social and health related data (AIHW 2004).

Proportion of Indigenous people with access to their traditional lands

The ABS is likely to ask questions about homelands/traditional country in all remoteness areas as part of the 2008 NATSISS. It would be useful to ask the questions in all remoteness areas in future health surveys also, to create a consistent three-yearly time series.

Participation in organised sport, arts or community group activities

The six-yearly NATSISS provides some data on participation in sport, arts or community group activities. The NATSISS does not provide any information about these activities for children under the age of 15.

The proposed Longitudinal Study of Indigenous Children (LSIC) may collect information on participation in these activities. The LSIC is an Australian Government initiative aimed at improving the understanding of the diverse circumstances faced by Aboriginal and Torres Strait Islander children, their families, and communities.

Engagement with service delivery

There are few data on barriers to accessing services, particularly for Indigenous children and youth. The key challenges are to improve existing collections, such as Indigenous specific surveys and longitudinal studies of Indigenous children to collect information on service engagement for young people. The Australian Survey of Social Attitudes could be expanded to include questions on difficulties experienced by Indigenous people in communicating with police and legal services.

9.9 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 9A.3.2 is table 2 in the attachment tables for section 9.3). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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- Table 9A.3.9** Time since last consulted GP/specialist, people aged 18 years and over, age standardised, by Indigenous status and remoteness, 2001, 2004-05
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- Table 9A.3.11** Reasons for not going to a GP in the last 12 months, Indigenous people aged 18 years and over, by remoteness, 2004-05
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