Southern Cross University
ePublications@SCU

School of Education

2001

Aboriginal Health Promotion Self Determination Project: background paper

Anthony Franks

Donna Smith-Lloyd
Northern Rivers Area Health Service

Sallie Newell
Southern Cross University

Uta C. Dietrich
Northern Rivers Area Health Service

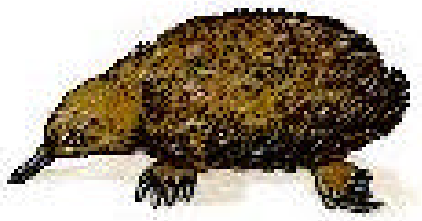
Publication details

Franks, A, Smith-Lloyd, D, Newell, S & Dietrich, UC 2001, *Aboriginal Health Promotion Self Determination Project: background paper*, prepared for Health Promotion Unit, Northern Rivers Area Health Service, Lismore, NSW.

ePublications@SCU is an electronic repository administered by Southern Cross University Library. Its goal is to capture and preserve the intellectual output of Southern Cross University authors and researchers, and to increase visibility and impact through open access to researchers around the world. For further information please contact epubs@scu.edu.au.

Self-Determination Background Paper

Aboriginal Health Promotion Project



Anthony Franks
Aboriginal Health Promotion Officer
Health Promotion Unit
Division of Population Health
Northern Rivers Area Health Service

NSW HEALTH DEPARTMENT

This work is copyright. It may be reproduced in whole or in part for study training purposes subject to the inclusion of an acknowledgement of the source and no commercial usage or sale.

Copyright NSW Health Department 2001.

State Health Publication No: (NRAHS) 010193
ISBN: 0 7347 3361 5

For further information please contact:

Health Promotion Unit
Division of Population Health
Northern Rivers Area Health Service
PO Box 498
Lismore NSW 2480
AUSTRALIA

Phone: (02) 66 207500
Fax: (02) 66 222151
Email: anthonyf@nrhs.health.nsw.gov.au

November, 2001

Glossary of Abbreviations

ACPDW	Aboriginal Child Protection Development Worker
AHC	Aboriginal Health Council
AHEO	Aboriginal Health Education Officers
AHMRC	Aboriginal Health and Medical Research Council of NSW
ALO	Aboriginal Liaison Officers
AMHW	Aboriginal Mental Health Workers
AMS	Aboriginal Medical Services
ASAW	Aboriginal Sexual Assault Worker
ASHW	Aboriginal Sexual Health Worker
Aboriginal	Aboriginal & Torres Strait Islander
ATSIC	Aboriginal & Torres Strait Islander Commission
CDEP	Community Development Employment Program
DoCS	NSW Department of Community Services
DoPH	Division of Population Health
DPECS	Directorate of Primary and Extended Care Services
FaCS	Department of Family and Community Services
HPU	Health Promotion Unit
NRA	Northern Rivers Area
NRAHS	Northern Rivers Area Health Service
NR	Northern Rivers
OATSIH	Office for Aboriginal & Torres Strait Islander Health
SAC	State Advisory Committee
THAHOC	Tweed Heads Aboriginal Health Outcomes Council

When reading the word Aboriginal in this document it refers to both Aboriginal and Torres Strait Islanders.

Acknowledgments

This review eventuated with the valuable assistance, support, ideas and expertise of the following individuals, departments and communities for whom I wish to thank and express my gratitude
.

- Aboriginal Education Council Consultants;
- Aboriginal Communities within the NRAHS;
- Aboriginal Pre-school Coordinators within the NRAHS;
- Kimberlii Baker – Transition program – Box Ridge/Coraki;
- Teena Binge – Senior Aboriginal Health Educator, Western Cluster;
- Bundjalung Aboriginal Elders Council, with special thanks to Uncle Roy Gordon;
- Commonwealth Department of Health and Aged Care, Canberra;
- Carl Daley – Acting Senior Aboriginal Health Educator, Southern Cluster;
- Uta Dietrich – Manager, Health Promotion Unit, NRAHS;
- Therese Dunn – Data Coordinator, Division of Population Health, NRAHS;
- Debbie Faulkner – Coordinator of Intensive Family Base Services, Casino;
- Warwick Fisher – Senior Lecturer, College of Indigenous Australian Peoples, SCU;
- Auntie Sue Follent – Senior Aboriginal Health Educator, Northern Cluster;
- Mavis Golds – Aboriginal Health Coordinator, NRAHS;
- Denise Hughes – Research Librarian, Division of Population Health, NRAHS;
- Leonie Jefferson - Senior Aboriginal Health Educator, Southern Cluster;
- Warren Jones – Project Officer for Parents As Teachers Tweed Heads;
- Jacquie Laurie-Welsh – Mental Health, Lismore NRAHS;
- Rossi Lyons – North Coast Coordinator, Families First;
- Lyndy McPhee – Resource Development, Health Promotion Unit, NRAHS;
- Sallie Newell – Research and Evaluation Coordinator, Health Promotion Unit, NRAHS;
- Ian Raymond – Health Promotion Strategy Unit, North Sydney;
- Evelyn Robinson – Aboriginal Sexual Health, Western and Eastern Clusters;
- Darren Rogers – Mental Health, Lismore NRAHS;
- Graham Skinner – Senior Aboriginal Health Educator, Eastern Cluster;
- Donna Smith Lloyd – Coordinator – Health Inequalities, Health Promotion Unit, NRAHS;
- Greg Telford – Coordinator, Rekindling The Spirit program;
- Dana Williams – Aboriginal Health Education/Child Health, Northern Cluster;
- Tina Williams – Ngulingah Land Council;
- Warren Williams – Community Development Officer for Box Ridge/Coraki;

Contents

SECTION 1 ..... **1**

Executive Summary 1

Introduction 2

Summary of Review Process 4
- Background 5
- The Big Picture 5
- Socio-economic Status of Aboriginal People 5
- Health Status of Aboriginal People 5
- Health Status of Aboriginal Children 6

The Local Picture 8
- Bundjalung Communities 8
- Demographic Profile of Aboriginal People Residing Within the NRAHS 9
- Health Status of Aboriginal People Within the Many Rivers ATSIC Region 11
- Hospitalisation Data - Aboriginal People Residing Within the NRA in 1997/1998 11
- Mortality Data - Aboriginal People Residing Within the NRA in 1994/1998 11

Diagramatic Overview of National Organisations for Aboriginal People 12

SECTION 2 ..... **13**

National Organisations for Aboriginal People 13
- Aboriginal Affairs 13
- Commonwealth Department of Health and Aged Care 13
- Office for Aboriginal and Torres Strait Islander Health (OATSIH) 14
- Aboriginal and Torres Strait Islander Commission (ATSIC) 15
- The Department of Family and Community Services (FaCS) 16
- Australian Indigenous Health Promotion Network 16

State Organisations for Aboriginal People 18
- NSW Health 18
- NSW Aboriginal Health Partnerships 18
- NSW Aboriginal Health Strategic Plan 18
- Aboriginal Health Promotion 19
- Department of Aboriginal Affairs 20
- ATSIC State Offices 20
- NSW Department of Community Services (DoCS) 20

Local Services Which Support Aboriginal People....20
The Northern Rivers Area Service....20
Aboriginal Health Council (AHC)....20
Health Promotion Unit (HPU)....21
Department of Primary and Extended Care....21
Aboriginal Health Education Officers (AHEO)....22
Aboriginal Mental Health Workers (AMHW)....22
Aboriginal Sexual Health Worker (ASHW)....22
Aboriginal Sexual Assault Worker (ASAW)....22
Aboriginal Child Protection Development Worker (ACPDW)....22
Aboriginal Liaison Officers (ALO)....23
The Bugalwena Service....23
The Tweed Heads Aboriginal Health Outcomes Council (THAHOC)....23
Families First....23
Area Mental Health Service....24
Aboriginal Medical Services (AMS)....24
ATSIC Many Rivers Regional Council....24

Programs Conducted Within the Northern Rivers Area for Aboriginal People....25
Rekindling the Spirit....25
Wula Wula Nga (Shared Vision)....25
Malanee Bugilmah (Healing People)....25
Community Development Employment Program (CDEP) – ATSIC Many Rivers....26
DPECS Health Promotion/Education Programs Developed and Implemented for Aboriginal People within NRA from 1990 to 2000....26

SECTION 3....29

Review of the Literature....29
History, Culture and the Effects of Colonisation....29
The Importance of Family, Self Value and the Loss of Social Cohesion....31
Education and its Impact on Aboriginal Communities....33
The Effects of Substance Abuse in Aboriginal Communities....35
Alcohol....36
Tobacco....37
Family Violence and Aboriginal Communities....37
Mental Illness and Aboriginal Communities....40
Dietary and Physical Behaviours Affecting Aboriginal Communities....41
Overcoming Health Inequalities in Aboriginal Communities....42
Early Childhood Interventions....43
Fathering Programs....45
Self Determination and Aboriginal Communities....48

SECTION 4 ..... **50**

Review of Self-determination Programs 50
Nunkuwarrin Yunti 50
We-Al-Li 50
Resourceful Adolescent Parent (RAP-P) Program 50
Aboriginal WAVES Project 51
Nutrition Program in a Remote Aboriginal Community 51
Bibbulung Gnarneeep Project (Solid Kid project) 52
Ngumytju TjiTji Pirni (NTP) 52
Beststart 52
Family Well Being Empowerment Course 53
"Ngama-ngamalinya Kampi-Kampilinya" Mother and Child : Father and Child 53
Social Cognitive Theory (SCT) and Problem Solving Skills (PSS) Program 54

SECTION 5 ..... **55**

Summary 55

SECTION 6 ..... **58**

References 58

Appendices 62
Appendix 1: List of Contacts 62
Appendix 2: Parent/Early Childhood Interventions 70
Appendix 3: Parenting & Early Childhood Programs 71

Tables

Table 1: Aboriginal population estimates by NRAHS Clusters 9
Table 2: Age distribution of Aboriginal people 9
Table 3: Percentage of births to Aboriginal mothers 10
Table 4: Percentage of Aboriginal single parent families 10
Table 5: DPEC Programs for Aboriginal People within the NRA 26

Figures

Figure 1: Flowchart Highlighting the Review Process 4
Figure 2: Aboriginal Communities Within the Bundjalung Country 8
Figure 3: Aboriginal Organisations - Commonwealth 12
Figure 4: Diagrammatic Overview of State Organisations for Aboriginal People 17
Figure 5: Interaction Between Commonwealth, State and Northern Rivers Departments/Organisations 28
Figure 6: Historical Impacts of White Society on Aboriginal Culture 31

SECTION 1

Executive Summary

In 1999, the NRAHS committed funding to Aboriginal Health Promotion. The Health Promotion Unit employed an Aboriginal Health Promotion Officer to develop, pilot, implement, evaluate and coordinate, in partnership with other service providers, a Health Promotion Self-Determination project.

Early on in the project it became evident that before future planning could take place at a local level, it was necessary to review the overall complex organisational context of Aboriginal health; the many organisations that make up Aboriginal health, their structure, role and how they inter/intra relate with each other. Therefore, an exploration into existing frameworks and structures was necessary at a National, State, and Local level to review existing strategies, partnerships, policies and programs.

A comprehensive literature review was also undertaken. Focusing on the concept of Self Determination, this search covered a plethora of topics exploring physical, mental, social and spiritual issues facing indigenous communities with particular attention directed at evidence based practice and outcomes.

This review details the process undertaken and summarises information collected during the first twelve months of the project. This information includes: -

- social, demographic and health status data of Aboriginal people;
- a map of Aboriginal communities within the NRAHS;
- demographic and health status data of Aboriginal people residing in the NRAHS;
- national and state Aboriginal Government and non-Government organizations;
- local Aboriginal Government and non-Government organizations;
- a summary of health programs for Aboriginal people conducted within the NRAHS 1990-2000;
- a literature review supporting the need for self-determination of Aboriginal people;
- a summary of information collected on Aboriginal programs conducted across Australia;
- a list of people contacted and information received (Appendix 1);
- outcomes associated with parent /early childhood interventions (Appendix 2);
- a summary of early intervention programs conducted at the local, state and national (Appendix 3).

Introduction

To understand Aboriginal health it is paramount that service providers develop an understanding of Aboriginal culture and acknowledge the many factors that have impacted on Aboriginal communities (*1-3*).

Colonisation has had a significant influence on the Aboriginal population and has contributed to the long-term health issues which continue to greatly impact on the poor health status of Aboriginal communities today.

Prior to European arrival, Aboriginal people lived an active lifestyle as hunters and gatherers, which promoted good health. There is little evidence to suggest widespread illness or disease amongst Aboriginal people until colonisation (*4*).

Colonisation oppressed Aboriginal people by excluding them from their traditional spiritual base, the land. With dispossession from the land came alienation of Aboriginal communities, loss of cultural identity, reduced social cohesion, low self-esteem and the disintegration of traditional social controls resulting in a loss of control over their own lives and destiny.

The historical effects of colonisation on traditional Aboriginal culture has led to poor dietary patterns, increased diseases, tobacco and other substance abuse. Since the breakdown of traditional restrictions regarding substance use, alcohol and other drugs abuse has impacted greatly on the holistic health status of Aboriginal people, resulting in family violence and many other social and health problems connected to these substances (*1, 2, 5, 6*).

Evidence shows the mortality and morbidity rates of Aboriginal people are unjustly imbalanced with greater physical and mental illness and early death compared to non-Aboriginal people (*2, 7*). The morbidity and mortality rate of Aboriginal people is far greater in comparison to the mainstream Australian population (*8*). The lower health standard is related to social inequality characterized by powerlessness and socio-economic deprivation attributed historically to colonisation (*8, 9*).

If powerlessness is a determinant of poor health status then empowerment, self determination or control of one's destiny are concepts which should be explored when developing programs aimed at improving the health of Aboriginal people (*10*).

Therefore, Aboriginal health needs to be viewed holistically. Health for Aboriginal people means the physical well-being of the individual, as well as the social, emotional and cultural well-being of the whole community (*11*).

WHO defines health equity as reducing differences between people's health by providing equal opportunity for all people to enjoy health to their fullest potential. Health improvement should thereby aim to accomplish the status to which each individual can achieve their full capacity as a person, positively influencing their community well-being as a whole (*11*).

Summary of Review Process

Figure 1: Flowchart Highlighting the Review Process

Specific Issue Identified = SELF DETERMINATION

Mapped out the functions of Government and Non-Government organisations at National, State and Local levels

Collected national, state and local demographic, mortality and morbidity data on Aboriginal people

Conducted Literature Review of Aboriginal issues/projects/programs

- History and Culture
- Self determination
- Mental Illness
- Health status
- Education
- Self-esteem issues
- Family Violence
- Drugs & Alcohol, Violence
- Social and community support
- Dietary and physical activity behaviours

Review of Indigenous projects/programs at international, national, state and local level

Conducted ongoing consultations to determine issues of concern with:

- Community members,
- Health-workers
- Government Departments
- Local Aboriginal Preschools - made observations during preschool visits for program suitability within particular environments. Eg: supportive staff, evidence of a supportive community etc.

Issues identified from consultations

- Family Violence.
- Literacy and numeracy.
- Drugs and Alcohol.
- Need for parents to value education.
- Support for young children - transition from home, Playgroup, Preschool, Primary, wider mainstream Community.
- Support and intervention programs for parents.

Background

Health and socio economic status differ greatly for Aboriginal communities compared to mainstream Australia. Census data reveals that Aboriginal people have higher morbidity and mortality rates then non Aboriginal people. (4,11,12) The following provides a brief overview of health and socio economic patterns associated with Aboriginal communities in general. The section concludes with a summary of the social demograhpics and health status of Aboriginal communities residing in the Northern Rivers area.

The Big Picture

In 1996, Aboriginal people represented approximately 2.1% of the Australian population (18,310,700) with New South Wales having the largest Aboriginal population (109,900), followed by Queensland (104,800), Western Australia (56,200) and Northern Territory (51,900) (*2*). Aboriginal populations tend to be younger (average 20.1 years) compared to the mainstream Australian population (average 34.0 years) (*1, 2*).

Socio-economic Status of Aboriginal People

As a group, Aboriginal people are socioeconomically disadvantaged compared to other Australians. These disadvantages place them at greater risk of ill health and reduced wellbeing. For example, in 1996:

- Aboriginal adults were less likely than non-Aboriginal adults to have a post-school educational qualification (11% versus 31%) (*1*);
- The unemployment rate at the time of the 1996 Census was higher for Aboriginal adults (23%) than for non-Aboriginal adults (9%), and the median weekly income was lower for Aboriginal males ($189) and females ($190) than for their non-Aboriginal counterparts ($415 for males and $224 for females) (*1*);
- Aboriginal people were also much less likely than other Australians to own their home. Only 31% of Aboriginal households lived in homes that were owned or being purchased by their occupants, compared with 71% of other Australian households (*1*).

Health Status of Aboriginal People

Aboriginal people continue to suffer the affliction of ill health at a greater magnitude than non-Aboriginal people (*2*). The unfavourable health status of Aboriginal people starts early in life and continues throughout the life cycle. Some of the variance between the health of Aboriginal people and non-Aboriginal people can be attributed to health risks associated with second-rate living conditions,

violence exposure, poor nutrition, smoking, alcohol consumption at harmful levels and the use of other harmful substances and prohibited drugs (*1, 2*).

In 1991 to 1996, life expectancy was estimated at 56.9 years for Aboriginal males and 61.7 years for Aboriginal females compared with 75.2 years for non-Aboriginal males and 81.1 years for non-Aboriginal females. The age specific death rates for Aboriginal males and females exceeded non-Aboriginal males and females in all age groups with the greatest variance among the 35 – 54 year age group (6-8 times higher) (*1, 2*). In 1996, life expectancy was estimated at 18 years less for Aboriginal males compared to non-Aboriginal males and 19 years less for Aboriginal females compared to non-Aboriginal females (*1, 2, 12*).

According to the Australian Bureau of Statistics in 1996, smoking and obesity were more prevalent among Aboriginal people than non-Aboriginal people (*1*). Alcohol consumption by Aboriginal people was less than non-Aboriginal people, however, Aboriginal people who did drink were more likely to do so at a harmful level (*13*). Aboriginal people were at a greater risk than non-Aboriginal people of being victims of violence resulting in hospitalisation (*1, 13*).

In 1996 to 1997, circulatory (cardiovascular) disease, respiratory disease and injury were among the main causes of hospitalisation for both Aboriginal males and females (*1, 2*). Aboriginal people, in comparison to non-Aboriginal people, were more likely to be hospitalized for, or die from mental health conditions such as self-harm, substance abuse and suicide (*1, 2*). The threat of diminished mental, spiritual and emotional status is more likely to result from factors such as violence, removal from family and land, low socio-economic status and racism (*1, 2*).

Health Status of Aboriginal Children

The combination of past injustices, low socio-economic status, inadequate education, unemployment, together with remoteness of some communities, means the health risks Aboriginal children face are high (*1, 2*). Aboriginal children are disadvantaged as compared to mainstream children. Throughout Australia, Aboriginal children are at a greater risk than non-Aboriginal children of being victims of abuse and neglect (2-8 times greater in most jurisdictions in 1997-98) under welfare protection (approximately 4 times higher in 1998) and on fostering placements (approximately 6 times higher in 1998) (*1, 2*). In the 1996 Census, approximately 40% of children in corrective institutions were identified as Aboriginal (*1, 2*).

The 1996 NSW School Health survey revealed 24% of Aboriginal school students used cannabis weekly compared to 10% of their non-Aboriginal peers (*14*). Aboriginal students were 1.6 times more likely to have used cannabis, 2.0 times more likely to have used ecstasy, 1.9 times more likely to have used cocaine, 1.7 times more likely to have used narcotics (*14*). These statistics represent a vulnerable population of Aboriginal students at increased risk of developing drug related problems (*14*).

The same survey revealed 53% of Aboriginal school aged children reported hazardous drinking compared with 34% of non-Aboriginal students (*14*). In addition, 40% of Aboriginal year 7 students, in comparison to 18% of their non-Aboriginal peers, drank at hazardous levels (*14*).

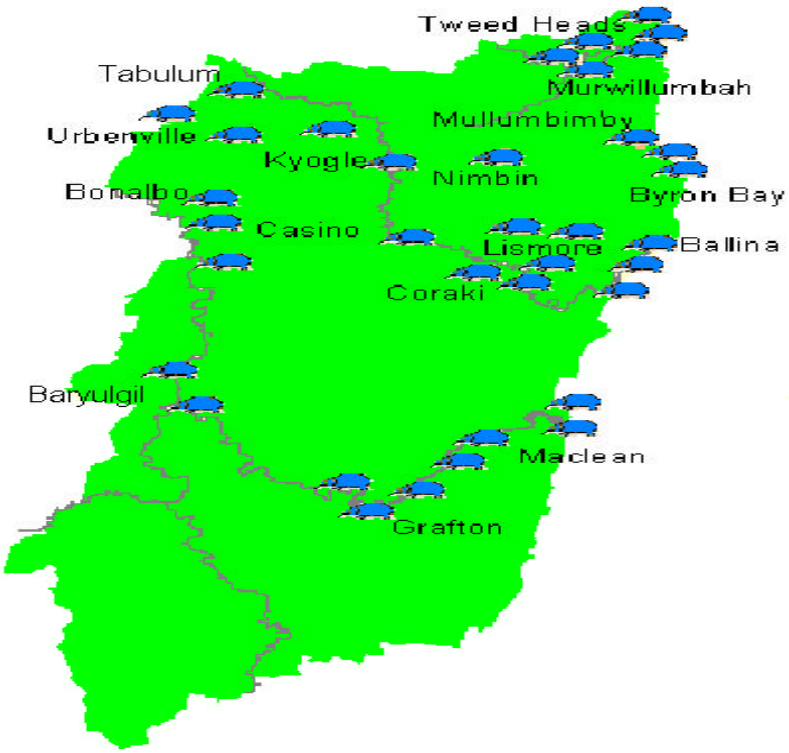
The 1996 New South Wales (NSW) School Health Survey revealed the prevalence of weekly smoking among Aboriginal school children was 30% compared to 20% of non-Aboriginal school children (*14*). Smoking was greater among females (33%) than males (27%) compared to non-Aboriginal females (21%) and males (19%) (*14*).

The Local Picture

Bundjalung Communities

The Far North Coast of NSW is known as Bundjalung Country and is home to 13 different tribes. Each tribe is represented through Elders on the Bundjalung Elders' Council.

Figure 2: Aboriginal Communities Within the Bundjalung Country, Northern Rivers Area



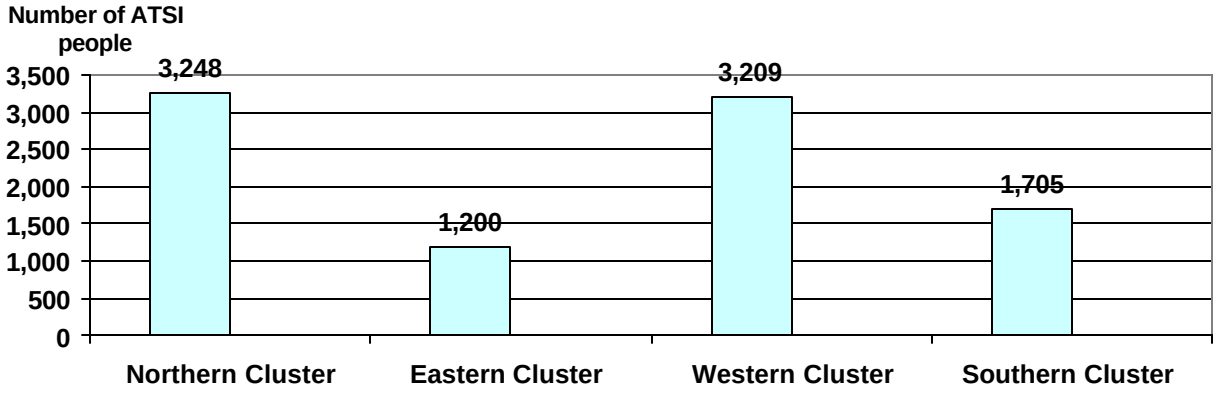
Bundjalung country falls within the boundaries of the Northern Rivers Health Area. The following list shows Aboriginal communities by NRAHS clusters:

- Northern Cluster: Tweed Heads, Pottsville, Murwillumbah and surrounding areas;
- Eastern Cluster: Ballina, Cabbage Tree Island, Byron Bay, Ocean Shores, Mullumbimby and surrounding areas;
- Western Cluster: Coraki, Casino, Tabulam, Muli Muli, Urbenville, Kyogle, Nimbin, Lismore, Goonellabah and surrounding areas;
- Southern Cluster: Yamba, Maclean, Grafton, Baryulgil and surrounding areas.

Demographic Profile of Aboriginal People Residing Within the NRAHS

According to the 1996 Census, the Aboriginal population in the Northern Rivers Area was 6,152. However, according to a profile collected in 1997 by NRAHS Aboriginal Health Workers, the Aboriginal population was estimated at more than 9,000 (*11*). Table 1 shows Aboriginal population estimates per NRAHS Clusters in 1997 (*11*).

Table 1: Aboriginal population estimates by NRAHS Clusters



Source: (*11*).

Table 2 shows the age distribution of Aboriginal people within the NRA in 1996. More than 50% of Aboriginal people living in the Northern Rivers Area are under 20 years of age (*11*).

Table 2: Age distribution of Aboriginal people

Age Grouping	% of Total Aboriginal Population
0 – 12 years	36.0%
13 – 19 years	14.1%
20 – 24 years	9.4%
25 – 29 years	8.2%
30 – 34 years	7.3%
35 – 39 years	6.7%
40 – 44 years	5.7%
45 – 49 years	3.7%
50 – 54 years	2.6%
55 – 59 years	2.0%
60 – 64 years	1.8%
65 years and over	2.6%

Source: (*11*)

Table 3 shows the percentage of births to Aboriginal mothers less than 20 years of age as per Cluster area for the NRA in 1997

Table 3: Percentage of births to Aboriginal mothers

Local Government Area	% of Births to Aboriginal Mothers Less Than 20 Years of Age
Eastern Cluster	
Ballina	22%
Byron	0%
Northern Cluster	
Tweed	27%
Western Cluster	
Lismore	15%
Casino	13%
Kyogle	33%
Richmond River	33%
Southern Cluster	
Grafton	20%

Source: ***(15)***

Table 4 shows percentage of Aboriginal Single Parent Families within the NRA in 1997

Table 4: Percentage of Aboriginal single parent families

Local Government Area	Aboriginal Single Parent Families
Eastern Cluster	
Ballina	36.5%
Byron	24.0%
Northern Cluster	
Tweed	25.9%
Western Cluster	
Lismore	37.8%
Casino	33.5%
Kyogle	29.8%
Richmond River	27.6%
Southern Cluster	
Copmanhurst	27.6%
Grafton	30.3%
Maclean	30.1%
Nymboida	18.6%
Ulmarra	18.6%

Source: ***(15)***

Health Status of Aboriginal People Within the Many Rivers ATSIC Region

According to the 1998 Indigenous Data Profile of the Many Rivers ATSIC Region (which encompasses the Northern Rivers area) :

- 41% of the Aboriginal population were aged less than 15 years, 22% for non-Aboriginal populations.
- 3% of the Aboriginal population was aged 65 years and over, 16% for non-Aboriginal populations.
- Unemployment rate for Aboriginal people, aged 15 years and over, was 35.1% (36.5% Aboriginal males, 33.1% Aboriginal females) which is more than double the unemployment rate of 14.9% for non-Aboriginal persons (16.2% non-Aboriginal males, 13.1% non-Aboriginal females)
- Family weekly income was considerably lower for Aboriginal families ($464) than for non-Aboriginal families ($541). Also, more male 51% and less female 47% Aboriginal people reported a weekly individual income of less than $200 a week compared to male 38% and female 49% non-Aboriginal people.
- 31% of Aboriginal homes were owned or being purchased by their occupants compared with 71% for non-Aboriginal occupants. The 1996 Census also reported, 68% of Aboriginal people reported living in rented accommodation, in contrast to only 26% of non-Aboriginal people.
- 13% of Aboriginal adults had a post school educational qualification compared to 28% of non-Aboriginal people. Less than 31% of Aboriginal students compared with 72% of non-Aboriginal students completed year 12 (*16*).

Hospitalisation Data - Aboriginal People Residing Within the NRA in 1997/1998

According to the statistics, health status of Aboriginal people appears to be worse in comparison to non-Aboriginal people. In 1997/1998, the most common causes of hospitalisation of Aboriginal male residents were respiratory disease 20.3%, injury 16.1%, digestive disease 10.3% and circulatory disease 9.5%. For Aboriginal female residents, the major causes of hospital admissions were pregnancy 24.2%, respiratory disease 13.0%, injury 8.4% and digestive disease 10.3% (*1, 2, 16*).

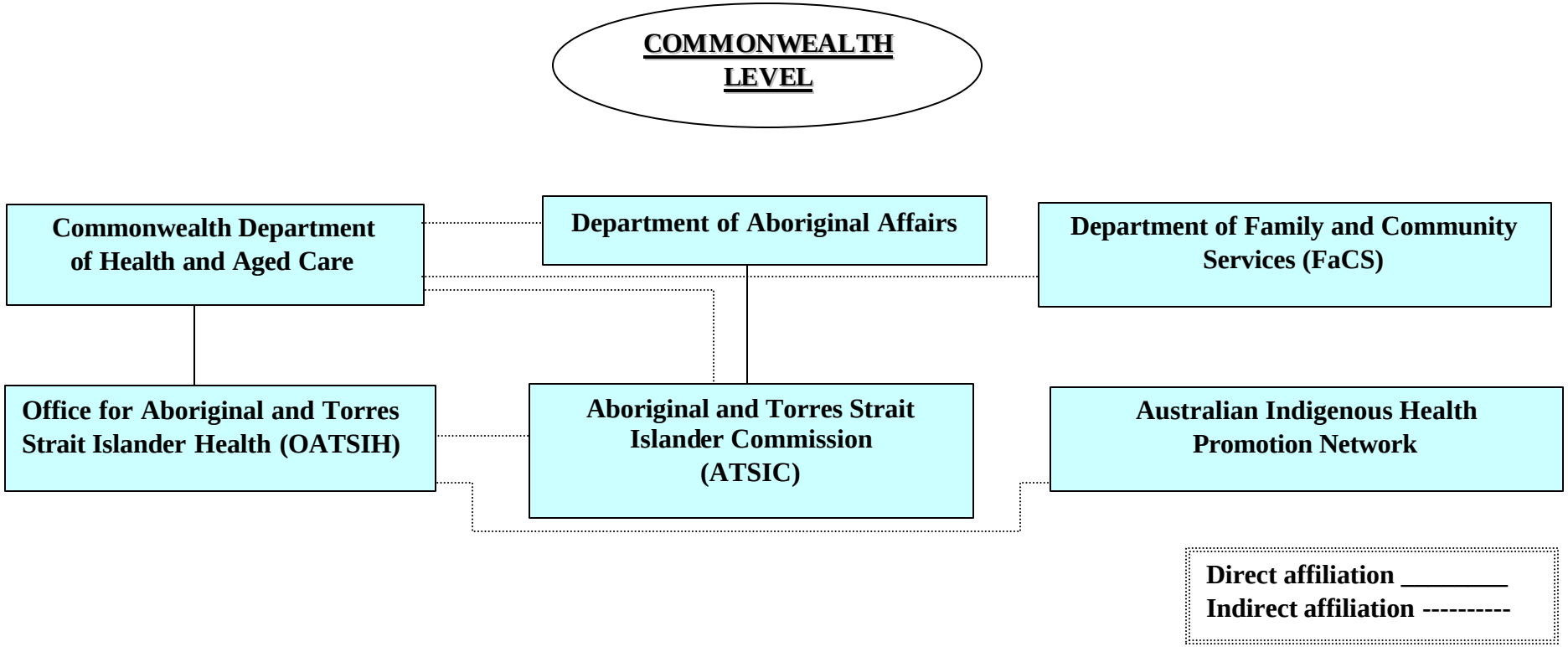
Mortality Data - Aboriginal People Residing Within the NRA in 1994/1998

During 1994/1998, the most common cause of mortality for Aboriginal male residents was circulatory disease 36.7%, followed by injury 22.4%, cancer 10.2% and respiratory disease 10.2%. For Aboriginal female residents, circulatory disease 45.9% were also the leading cause of death in 1994 - 1998, followed by cancer 16.2% and respiratory disease 8.1% (*1, 2, 16*).

Diagramatic Overview of National Organisations for Aboriginal People

This map illustrates the different Commonwealth Departments and National organisations involved in Aboriginal health/issues and how they interact. Each play an important role in the improvement of lifestyles for Aboriginal People.

Figure 3: Aboriginal Organisations - Commonwealth



SECTION 2

There are a substantial number of organisations established to assist and represent Aboriginal people at a National, State and local level.

National Organisations for Aboriginal People

Aboriginal Affairs

Key objectives of the Government are to ensure that all the resources allocated to Aboriginal affairs are spent in a way that will provide maximum benefit to Aboriginal people and communities, with full accountability for outcomes achieved. Many people are unaware of the stringent accountability requirements in the area of Aboriginal affairs (*12*).

Responsibilities and powers include:

- Appointing the CEO and the Director of Evaluation and Audit of Aboriginal Affairs, after consultation with the Board;
- Representing Aboriginal interests in Parliament, before Cabinet and in Federal Budget processes (*12*).

Commonwealth Department of Health and Aged Care

The Department's responsibilities include promoting good health and ensuring all Australians have access to key health services. The Health and Aged Care Portfolio includes:

- medicare benefits;
- hospitals;
- private health insurance and medical workforce issues;
- public health including issues concerning AIDS and other communicable diseases;
- immunisation;
- specific women's and men's health issues;
- environmental health issues and drug abuse reduction;
- health research, strategic policy analysis and evaluation;
- corporate leadership and resource management;
- Health Insurance Commission;
- Aboriginal health issues (Office for Aboriginal and Torres Strait Islander Health, known as OATSIH).

Office for Aboriginal and Torres Strait Islander Health (OATSIH)

In 1994 the Commonwealth Department of Health and Aged Care established the Office for Aboriginal and Torres Strait Islander Health (OATSIH) to give greater focus to Aboriginal health needs in mainstream health programs. OATSIH is responsible for:

- administering funding for primary health care, mental health and substance–abuse prevention, mainly through community based Aboriginal Medical Services (AMSs);
- updating the National Aboriginal Health Strategy.

The organisation aims to improve access of Aboriginal people to comprehensive primary health care services by providing coordinated clinical care, population health and health promotion activities to facilitate illness prevention, early intervention and effective disease management.

OATSIH strategies are firmly based on the principles of working in partnership with the Aboriginal community controlled health sector, the Aboriginal and Torres Strait Islander Commission and State/Territory governments.

Four broad components to OATSIH strategy:

1. Develop the health infrastructure and resources necessary to achieve comprehensive and effective health care for Aboriginal people. Development of the primary health care infrastructure requires reforms in the financing of Aboriginal health, improvements in workforce training and availability, coordinated regional planning, data systems and the accountability of services.

2. Address particular health issues and risk factors such as the major causes of high mortality. Also expanding on strategies to address particular health issues with mental health, sexual health, diabetes and renal disease as well as specific risk factors affecting poor health such as substance misuse and injury.

3. Improve the evidence base that underpins these interventions. This component focuses on a more strategic approach to research particularly research funded by the National Health and Medical Research Council (NHMRC) and to improving health data and performance measures.

4. Improve communication between primary health services, Aboriginal people and the general population. The aim of this component is to inform stakeholders, the public, politicians, and the media of Aboriginal health initiatives, programs and policies being progressed by the Department and by Aboriginal communities (*17*).

Aboriginal and Torres Strait Islander Commission (ATSIC)

- ATSIC is the principal Commonwealth agency operating in the field of Aboriginal affairs;
- It is the premier policy-making body and is responsible for administering a diverse range of Commonwealth programs for Aboriginal people;
- It was established by the *Aboriginal and Torres Strait Islander Commission Act 1989* (the ATSIC Act) and began operations on 5 March 1990, amalgamating the previous Department of Aboriginal Affairs (established 1972) and Aboriginal Development Commission (established 1980);
- ATSIC was designed to put into effect the principle of self-determination for Aboriginal people. Through ATSIC's representative arm, Aboriginal people may participate in the processes of government. Elected representatives are able to make decisions about the programs and policies that affect their communities, at both the regional level and the national level (*12*).

ATSIC's Regional Councils' Structure

- In 1998-99 ATSIC's representative arm consisted of 35 Regional Councils around Australia. Elections are held every three years;
- Though established under the ATSIC Act, the Regional Councils are independent bodies. They consult with their local communities and represent their interests;
- The ATSIC Act sets out the functions of Regional Councils. These include formulating a regional plan to improve the social, economic and cultural life of local Aboriginal people, and making decisions on ATSIC expenditure in their regions;
- Regional Councilors elect 16 Commissioners, one for each ATSIC zone. One Commissioner is elected from the Torres Strait, and two Commissioners are appointed by the Minister for Aboriginal and Torres Strait Islander Affairs (*12*).

ATSIC Central Office

Central Office is responsible for the main co-ordination and policy-development functions within ATSIC, and administers funds for certain National programs excluding from Regional Council budgets. These include:

- housing loans and loans and grants for enterprises;
- funding for the activities of other portfolio organisations;
- funding for programs to be conducted by a State/Territory government;
- funding for programs most appropriately managed at the national level; and
- administrative expenses (*12*).

Central Office Divisions

1. Social and Cultural Division.
    - Housing, Health, Infrastructure & Heritage;
    - Culture, Legal & Family Policy;
    - Native Title & Land Rights;

2. Economic Division;
    - Commercial;
    - CDEP & Employment Policy;
    - Office of Torres Strait Islander Affairs;

3. Corporate Services Division;
    - Information Technology & Client Services;
    - Finance;
    - Human Resources & Corporate Administration;

4. Strategic Development & Support Division;
    - Strategic Planning &Policy;
    - Legal;
    - Strategic Support;
    - Office of Public Affairs (*12*).

The Department of Family and Community Services (FaCS)

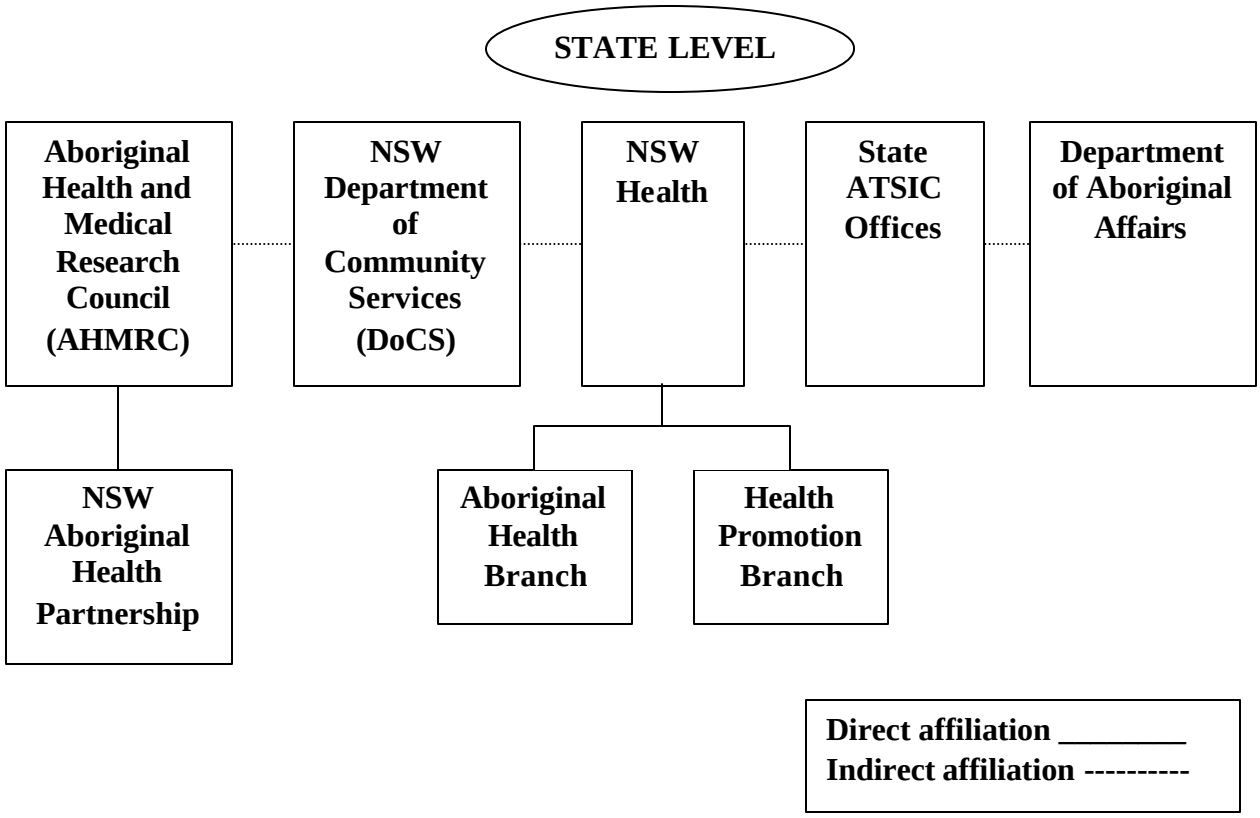
FaCS is the principal policy formulation and advising body. FaCS has responsibility for ensuring the Government's income security policies, services for people with disabilities and families with children, community support services (excluding the Home and Community Care program), family relationship services and welfare housing are implemented as required by the Minister for Family and Community Services. The department also has responsibility for ensuring its programs are implemented in accordance with the relevant legislative frameworks (*18*).

Australian Indigenous Health Promotion Network

The Australian Indigenous Health Promotion Network is a community based and community-controlled network of Aboriginal and Torres Strait Islander Health Workers and Practitioners who are working

towards, or interested in promoting the health of Indigenous communities. Members are employed in Aboriginal Community Controlled Health Organisations, government and non-government organisations (*19*).

Figure 4: Diagrammatic Overview of State Organisations for Aboriginal People



State Organisations for Aboriginal People

NSW Health

The Health Department undertake a number of activities relating to Aboriginal Health: - Health Policies, Aboriginal Health, Centre for Mental Health, Statewide Services Development, Structural Funding Policy, Workforce Planning and Health Promotion.

NSW Aboriginal Health Partnerships

The NSW Aboriginal Health Partnership approved June 1995, is a contract between the NSW Health Department and the then NSW Aboriginal Health Resource Cooperative – Aboriginal Health and Medical Research Council (AHMRC) representing the Aboriginal community controlled health sector. The primary objective of the Partnership is to cooperatively advise the Minister for Health on health policy, strategic planning and broad resource allocation issues to improve the health outcomes of Aboriginal people in NSW (*20*).

"Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System" is an important step in meeting the NSW Government's commitment to restoring the health, social, emotional and cultural harmony and well-being of Aboriginal people in NSW (*21*). It reinforces the NSW Government's commitment to partnership with the Aboriginal community in addressing these issues and was developed in collaboration with the Aboriginal Health and Medical Research Council of NSW (AHMRC) (*21*).

NSW Aboriginal Health Strategic Plan

The main purpose of the NSW Aboriginal Health Strategic Plan is to present strategies to improve health outcomes for Aboriginal people and address the issues raised in the Aboriginal health planning process in NSW. Key priorities 1999/2000 were:

- to improve access to health services;
- to address identified health issues;
- to improve social and emotional wellbeing;
- to increase the effectiveness of health promotion;
- to create an environment supportive of good health (*22*).

Aboriginal Health Promotion

The Aboriginal Health Promotion is a department that addresses the following: -

- policy context;
- past & present funding arrangements;
- strategies for increasing effectiveness;
- steps forward;
- criteria for funding (*23*).

Guiding principles of this unit include:

- a whole of life view of health;
- practical exercise of the principles of Aboriginal self-determination;
- working in partnerships;
- cultural understanding;
- recognition of trauma and loss (*23*).

The NSW Aboriginal Health Promotion Program "Directions Paper" is a NSW Aboriginal Health Partnership endorsed strategic document guiding Aboriginal health promotion practice and investment in NSW. The Paper outlines some key steps in moving Aboriginal heath promotion forward in NSW and they include:

- Comprehensive mapping of current health promotion initiatives to identify and evaluate approaches and gaps;
- Maximising existing, high quality and effective initiatives to establish effective health promotion programs;
- Informing the future development of better practice in Aboriginal health promotion through effective evaluation;
- Supporting programs that target the known causes of morbidity and premature mortality and those that take into account the need to restore social, emotional, economic and cultural well-being;
- Providing strong support for Aboriginal communities to develop, implement and evaluate appropriate health promotion projects;
- Ensuring appropriate linkages to clearinghouses and development of a comprehensive dissemination strategy (*24*).

Department of Aboriginal Affairs

The department of Aboriginal Affairs encourages and supports partnerships with and between Aboriginal people, government and communities, aiding them to respond appropriately to the cultural, social and economic needs of Aboriginal people. The department ensures the needs and aspirations of Aboriginal families and committees are reflected in the development, implementation and evaluation of public policy and government services in NSW (*12*).

ATSIC State Offices

ATSIC's State Offices assist in the administration of programs between Commonwealth, State/Territory and Local government agencies, as well as oversee the State Advisory Committee (SAC) process. This committee meets to consider projects funded under the National program (*12*).

NSW Department of Community Services (DoCS)

DoCS aims to assist people in the community by providing a wide range of services covering the following areas:

- child protection;
- family support;
- support services and accommodation for people with disabilities;
- adoption;
- emergency relief for natural disasters;

The department, also provides funding to community organisations for specialist services to the community.

Local Services Which Support Aboriginal People

The Northern Rivers Area Service

The Northern Rivers Area Health Service provides and supports a comprehensive mix of programs/services to help meet the health needs of Aboriginal people residing in the area.

Aboriginal Health Council (AHC)

The AHC covers the NRAHS catchment area. Representation includes: -

- Department of Community Services;
- Bulgar Ngaru;

- Office of Aboriginal and Torres Strait Islander Health Services;
- NRAHS board member;
- Manager of Aboriginal Health;
- Director of Primary and Extended Care Services;

The role of the AHC is to:

- advise the NRAHS on key issues affecting the health status of Aboriginal communities residing within the NRA;
- provide consumer and community input into the planning and development of health services aimed at meeting the health service needs of Aboriginal communities within the NRA;
- provide advice to the NRAHS regarding accessibility, appropriateness and the health of Aboriginal people;
- provide community and consumer input into the process of monitoring and evaluating the effectiveness of Area wide implementation of major Aboriginal health service programs, plans and policies;

The AHC reports to the NRAHS Board via the Health Services and Quality Committee (51).

Health Promotion Unit (HPU)

The HPU implements various programs promoting health throughout the area by working closely with the local community, other units of the NRAHS and the NSW Health Department. In 1999, the NRAHS committed recurrent funding to Aboriginal Health Promotion. In the same year, the HPU employed an Aboriginal Health Promotion Officer to develop, implement and evaluate a long term project based on Aboriginal Self-Determination.

Department of Primary and Extended Care

DPECS provides a service to Aboriginal communities within the Northern Rivers Area using as a framework, the Northern Rivers Area Health Service's *Aboriginal Health Strategic Plan 1998-2002*. The strategic plan provides both a basis for priority setting utilising resources currently available and a map of what is needed when new resources can be obtained. Through DPECS, the following positions/services are funded:

Aboriginal Health Education Officers (AHEO)

AHEO are responsible for developing and implementing health education/promotion activities in consultation with Aboriginal communities within the cluster areas. They are also responsible for providing information, advice and support to Aboriginal clients of the health service, as well as working with the local community to assist Aboriginal people to access health and welfare services.

Aboriginal Mental Health Workers (AMHW)

AMHW plan and implement services for Aboriginal clients and their families. They provide a service for individuals who experience transient or enduring mental health problems, mental disorders or illness or who are at risk of developing these problems.

Aboriginal Sexual Health Worker (ASHW)

The ASHW is responsible for consulting with AHEO, Aboriginal communities, Aboriginal agencies and Sexual Health Services to develop culturally appropriate Sexual Health Education programs for Aboriginal people within the Western and Eastern Clusters of the NRA. The ASHW operates in accordance with the Commonwealth, State and Local priorities and in accordance with the NSW Health Promotion Strategy. In addition, the ASHW assists with the planning of services involving the Aboriginal Mobile Health Clinic within the Western and Eastern Clusters of the NRA.

Aboriginal Sexual Assault Worker (ASAW)

The ASAW is part of a team which provides services to Aboriginal victims of sexual assault, their families and communities in accordance with the policies of the Department of Health. The initial focus of the position is based on community development activities that assist victims to access the mainstream services. The ASAW is also required to provide counselling, support and advocacy services to victims of sexual assault consistent with their level of training and experience. The ASAW also works with the non-Aboriginal counsellors and doctors of the Sexual Assault Service, to ensure services are culturally appropriate. Additionally, the ASAW liaises with other health services and with government and non-government services around the care of victims of sexual assault.

Aboriginal Child Protection Development Worker (ACPDW)

The ACPDW works collaboratively with Aboriginal families, communities, organisations and with other Government and non-Government organisations, to develop strategies, which enhance the protection of children from abuse and support women in their efforts to address family and domestic violence. The ACPDW provides consultation and acts as a resource regarding child abuse and family violence to other Aboriginal workers in the NRAHS.

Aboriginal Liaison Officers (ALO)

The ALO provides practical help, information and support to Aboriginal clients and their families. This includes assessments, discharge planning, arranging transport, accommodation, family meetings and support counselling. The ALO is responsible for liaising with doctors, nursing staff, allied health professionals and participates in interdisciplinary team meetings for assessment and referral of Aboriginal clients. The ALO also liaise with the appropriate health and welfare services within the local communities such as Aboriginal Medical Services and Community Health.

The Bugalwena Service

The Bugalwena Service is an Aboriginal community based service within the Northern cluster that provides a professional, confidential referral and resource service. The service provides support, educational programs, crisis counselling, health screenings for the Aboriginal community of the Tweed and surrounding areas, in partnership with mainstream health and related services. The Bugalwena Service maintains a cultural model of the "*whole family healing*" by sustaining an approach to social welfare and health care without prejudice.

The Tweed Heads Aboriginal Health Outcomes Council (THAHOC)

The purpose of the THAHOC is to oversee and assist the Bugalwena Service in running Aboriginal programs. Before programs go out to the community for feedback they are presented to this committee. The committee acts as a representative, when needed, on official appointments and performs an advocacy role on behalf of the Aboriginal community (52).

Families First

Families First is a NSW Government initiative to assist families with accessing service networks and to increase community support opportunities. A network of prevention and early intervention services is promoted which:

- support expectant or new parents by making accessibility to antenatal and early childhood health services easier. Home visits are a key strategy;
- support parents with infants and young children, by providing parenting information and connecting parents who are isolated with volunteers who are trained and supervised or with a parent support network;
- facilitate a team approach to assist families in need of extra support or more specialised assistance;

- strengthen the community and family connections, by promoting community projects in high need communities that assist toward building a supportive environment for children and their parents;
- develop specific strategies in consultation with Aboriginal communities and relevant Aboriginal services;
- improve access for Aboriginal families to child and family services by developing strategies at all levels (*15*).

Area Mental Health Service

Through the 2nd National Mental Health Program, funding has been allocated to support a culturally appropriate parenting program for Aboriginal communities situated in the Tweed area.

The project targets parents, grandparents and extended families and aims to:

- Improve access to and awareness of services available for families in crisis;
- Reduce incidence of family conflict;
- Improve parental self esteem and confidence and parent behaviour.

Other organisations within the Northern Rivers Area Health Service supporting Aboriginal communities include:

Aboriginal Medical Services (AMS)

There are the two AMS's within the NRA, Bulgarr Ngaru (Grafton) and Dharah Gibinj (Casino). They are community controlled organisations and aim to provide a culturally appropriate service to the Aboriginal people in their respective regions. A partnership exists between the two AMS's and the NRAHS to address the poor health status of Aboriginal people living in the NRA.

ATSIC Many Rivers Regional Council

ATSIC Many Rivers Regional Council covers the regions between the Hawkesbury and the Tweed rivers. ATSIC is provides all Regional Councils with assistance and oversee projects conducted in their regions (*12*).

Programs Conducted Within the Northern Rivers Area for Aboriginal People

Rekindling the Spirit

Rekindling the Spirit is funded by Probation and Parole, DoCS and NRAHS. This Aboriginal program has a holistic approach to social problems such as family violence, drugs and alcohol abuse. The program assists families in dealing with these problems in a culturally appropriate way. The main aim of the program is to keep families together, making them strong and breaking the cycle of family violence, drugs and alcohol abuse (78).

Wula Wula Nga (Shared Vision)

The Wula Wula Nga information and access centre enables the Aboriginal people within the Richmond Valley of the Bundjalung Nation to gain access to services that are culturally appropriate and which best meet their needs. The access centre is Bundjalung owned and is the first step towards an Aboriginal owned human resource services organization. The role of Wula Wula Nga is to provide information to Aboriginal people on human services in the Western and Eastern Clusters of the NRA and assist with access to these services. The services include: - Health, Community Services, Juvenile Justice, Probation and Parole, Centrelink, Department of Education and Training, Courts, Housing, Police, Ageing and Disability, and Sport and Recreation (*25*).

Malanee Bugilmah (Healing People)

Malanee Bugilmah is an Aboriginal Intensive Family Based Service (IFBS) and provides intensive support and therapeutic assistance to families in which at least one child is at risk of imminent placement (foster care) because of protective concerns. They also provide support in the reunification of the child to the family. This program provides a service to the following Aboriginal communities within the NRAHS: -

- Cabbage Tree Island, Casino, Boxridge/Coraki, Goonellabah, Gundarimbah, Lismore, Muli Muli and Tabulam.

Aims of the service: -

- to prevent the placement of a child/children into substitute care, with regard to the safety of the children;
- to assist in the reunification of families where children are currently in care;
- to protect Aboriginal children from abuse;
- to prevent breakdown in Aboriginal families;

- to empower parents to create a safe environment for their children;
- to reduce the probability of re-notification of child abuse and neglect (79).

Community Development Employment Program (CDEP) – ATSIC Many Rivers

CDEP is a community based employment and development project involving Aboriginal community organisations to assist in community development through work programs for unemployed Aboriginal people. The CDEP assists individuals in acquiring skills, which benefits both the individual and the community. The CDEP participants do not receive unemployment benefits or training allowances but receive a paid wage by CDEP organisations to undertake work and/or training to develop their community. They also assist participants to transfer to the mainstream labour market (*12*).

DPECS Health Promotion/Education Programs Developed and Implemented for Aboriginal People within NRA from 1990 to 2000

According to information collected from each cluster area, between 1990–2000, the following DPEC programs have been conducted within the NRA.

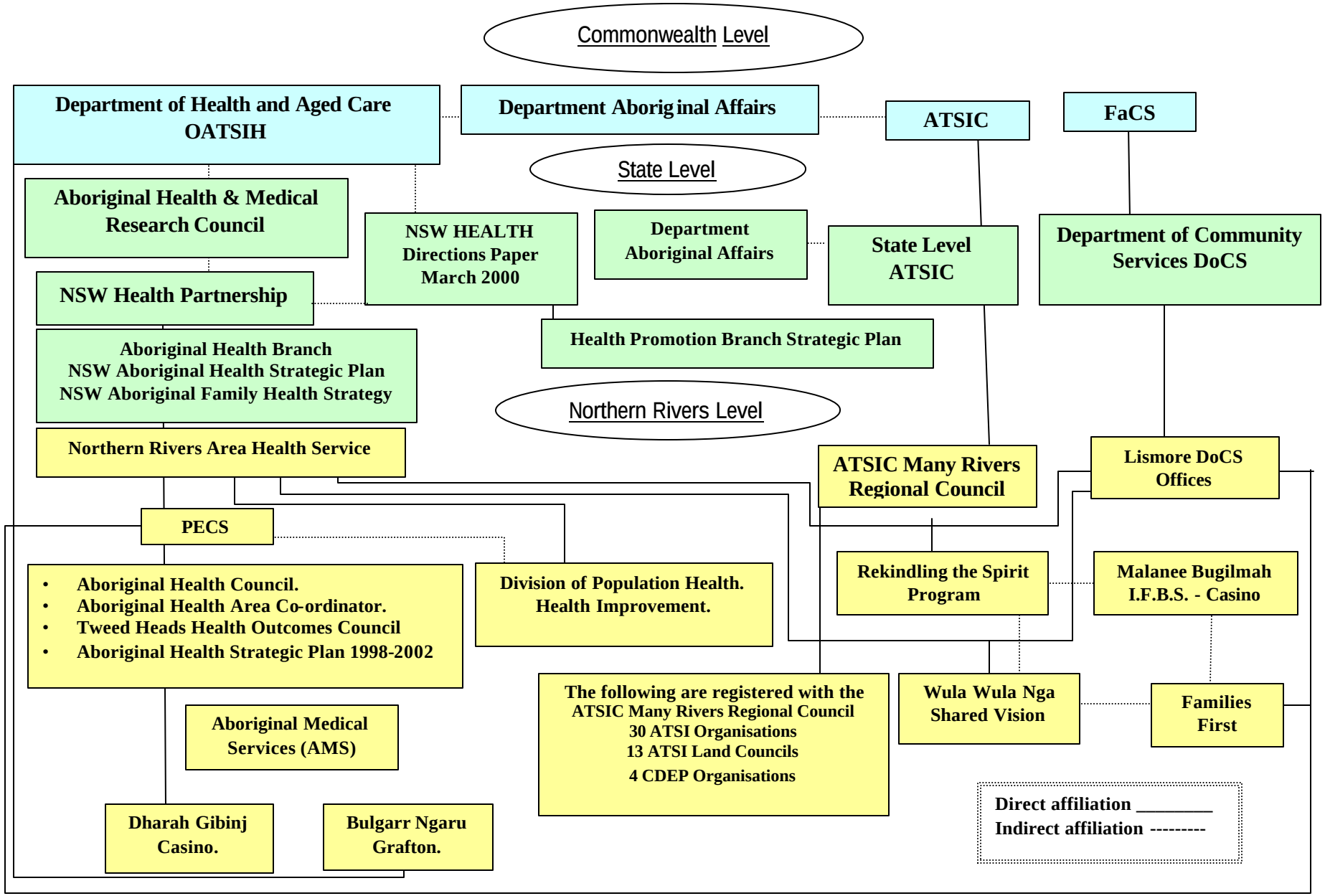
Table 5: DPEC Programs for Aboriginal People within the NRA

Project Name	Years	Northern Cluster	Western Cluster	Eastern Cluster	Southern Cluster
Aboriginal Women's and Children Health	1998 and ongoing				✓
Bugalwena Service	1995 and ongoing	✓			
Breast-Screening for over 40s	2000 and ongoing	✓			
Breast-Screening for under 40s	2000 and ongoing	✓			
Renal disease education	2000 and ongoing	✓			
Playgroup and Support Group	2000 and ongoing	✓			
Goori Women's Group	2000 and ongoing	✓			
Retracing the Steps	1999 and ongoing	✓			
Minyanbugal (low impact exercise groups)	2000 and ongoing	✓			
Aboriginal PANOC	1999 and ongoing		✓		
Antenatal/post/natal appointments, clinics & classes	1999 and ongoing		✓		✓
Aboriginal Parenting Program	2000 and ongoing		✓		
Koori Community Caring for Women Group	1998 and ongoing		✓		
Jali Health Post Clinics	1997 and ongoing			✓	
Children's Clinic with Peadiatrician	2000 and ongoing			✓	
Women's Health Clinics	2000 and ongoing			✓	✓
Early Childhood Nurse Clinics and home visits	1999 and ongoing			✓	✓
Children's Ear Clinics	1999 and ongoing			✓	

Project Name	Years	Northern Cluster	Western Cluster	Eastern Cluster	Southern Cluster
Data research project	1999 and ongoing			✓	
Diabetes Clinics, fortnightly	1999 and ongoing			✓	
Environmental health issues	1999 and ongoing			✓	
Adolescent Girls' group	As needed			✓	
Antenatal Education	As needed			✓	
Stress Management 6 week program	As needed			✓	
Help your Heart day	2000 and ongoing				✓
Footy Project (Drugs & Alcohol)	1999 and ongoing				✓
Diabetes and Nutrition	1999 and ongoing				✓
Market Garden Malabulgilmah	2000 and ongoing				✓
Yamba Community Development Project	1998 and ongoing				✓
Healing Time (D & A)	2000 and ongoing				✓
Aboriginal Women's and Children Health	1998 and ongoing				✓
Bugalwena Service	1995 and ongoing	✓			
Breast-Screening for over 40s	2000 and ongoing	✓			
Breast-Screening for under 40s	2000 and ongoing	✓			
Renal disease education	2000 and ongoing	✓			
Playgroup and Support Group	2000 and ongoing	✓			
Goori Women's Group	2000 and ongoing	✓			
Retracing the Steps	1999 and ongoing	✓			
Minyanbugal (low impact exercise groups)	2000 and ongoing	✓			

NOTE: There is the possibility that more programs have been conducted across the NRA. This table includes all information received from Aboriginal health team leaders/Seniors and Cluster Managers from each of the cluster areas prior to printing.

Figure 5 Interaction Between Commonwealth, State and Northern Rivers Departments/Organisations



SECTION 3

Review of the Literature

According to the literature there are many issues confronting Aboriginal society. Alcohol, tobacco and other substance abuse, family violence, poor educational attainment, high unemployment, mental illness and poor dietary habits have had a detrimental effect on cultural practises and overall health status for indigenous communities.

To move forward effectively it is important to understand the past. Therefore a literature search was conducted which examined tradition, culture, the effects of colonisation and reviewed the various issues confronting Aboriginal communities today. The concept of self determination, early intervention and parenting as pathways towards improved quality of life for Aboriginal communities were also explored.

History, Culture and the Effects of Colonisation

Prior to colonisation, White and Mulvaney (1987) estimate that the Aboriginal population in Australia was approximately 750,000 (*6*). However, in the 1930s after exposure to white culture, population estimates fell to approximately 70,000 (*6*). It is not certain whether the main cause of decline was the result of massacre or disease but records written by European settlers and explorers have often indicated that upon first encounter the Aboriginal people appeared to be in good health without disease (*4, 6,*).

The environment provided a nutritious diet for the Aboriginal people with both protein and vegetable foods, low in salt, sugar and fat. In addition, regular exercise prevented excess weight gain. Consequently prior to colonisation, it is highly unlikely Aboriginal people suffered from diseases such as hypertension, diabetes, cancer, renal disease, cardiovascular disease, respiratory disease and arthritis diseases which are highly prevalent amongst contemporary Aboriginal people (*6, 7*).

Aboriginal people had a special spiritual connection to the land and its resources, expressed through totemic ancestors that still exists today. As a culture of hunters and gatherers, the Aboriginal people embraced a belief of a very close interdependence between people and the land: *"that the land owns the people"* (*6*). Colonists considered the land to be an economic asset for them to develop for economic profit, but to Aboriginal people it was a part of themselves and was sacred (*6*).

Colonists introduced reserve and settlement herding to prevent hunting and gathering on land used for stock-raising and agriculture (*6*). This led to dramatic changes to the dietary practices of Aboriginal

communities; the traditional healthy diet was substituted for rations of mainly white flour, sugar, tea, rice, tinned meat and salt beef (*6*).

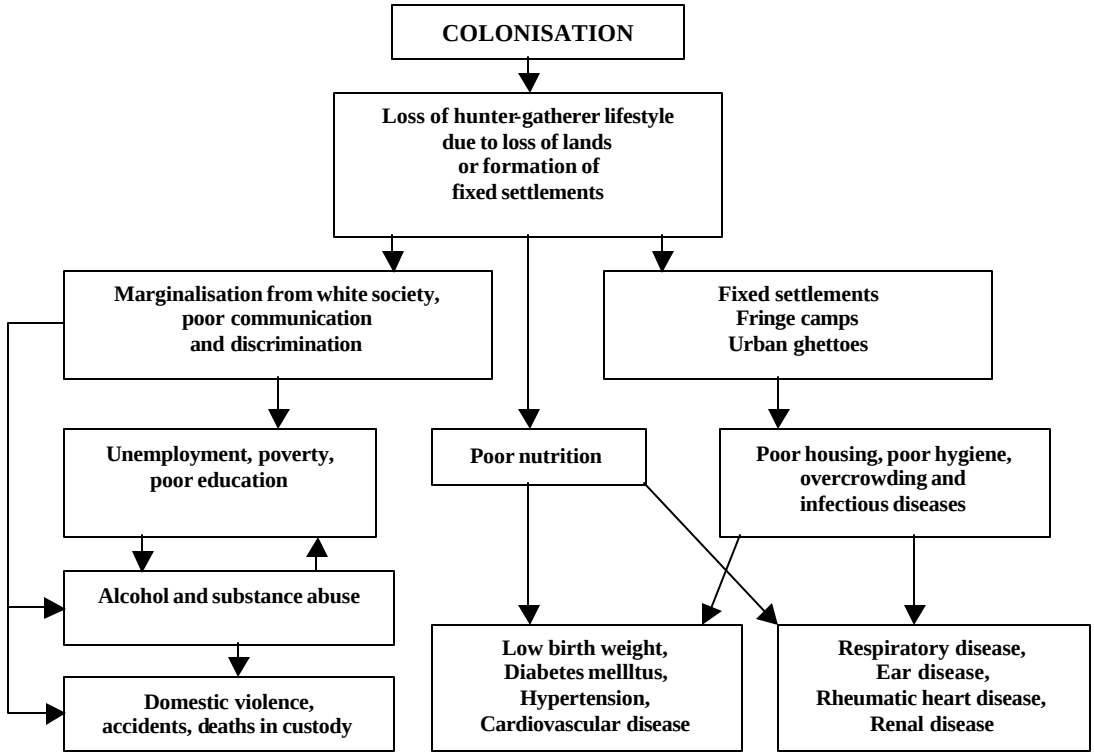
According to Casey, the herding of Aboriginal people onto settlements and reserves was the beginning of Aboriginal cultural degeneration; effecting their means of self-reliant survival, their identity, role, meaning and purpose in life (*13*). This resulted in reduced social cohesion, disintegration of traditional social controls and a loss of control over their own lives and destiny. (3,4,15,17).

A shared history of colonisation and its negative impact on the health status of Aboriginal people is also strongly documented for the minority groups of New Zealand, North America and Canada. The impact on the health and welfare of Aboriginal people from colonisation has resulted in:

- the introduction of new diseases causing immediate (eg. smallpox) and delayed (eg. cardiovascular disease) death;
- psychological illness and spiritual devastation due to the removal from ancestral land;
- social, economic and environmental disadvantage characterized by widespread poverty, unemployment, incarceration, homelessness, inadequate and/or overcrowded housing, low educational attainment, insufficient community infrastructure;
- a lack of control over their own lives and destiny (powerlessness), alienation, forced assimilation, cultural genocide, loss of identity, daily discrimination, lack of social support, loss of social cohesion, minority group status and low self-esteem; a consequence of herding Aboriginal people onto small reserves and settlements (*6, 7, 10, 13, 26-30*).

All of these factors have had a negative impact on the physical and mental health status and life expectancy of Aboriginal communities (*6*).

Figure 6: Historical Impacts of White Society on Aboriginal Culture



Source (*5*)

The Importance of Family, Self Value and the Loss of Social Cohesion

Aboriginal culture is more collective than individualistic compared to non-Aboriginal cultures not only in Australia but also in other Western countries (*13*). The foremost characteristic that presents this collective social responsibility is the kinship system – shared sense of identity, responsibility, care and control (*13*). This feature dominates both family and community life in Aboriginal people. This Kinship was stronger traditionally and, although fragmented, it still remains today (*13*). The most important aspect of the kinship system is the existence of large groups of people identified by an Aboriginal person as his or her aunt, uncle, brother, father, sister, mother, husband, wife or various other classes of blood relations and affinities (*13*). These relationships govern almost all social interactions, including marriage; Aboriginal culture is very integrated and although harmed by dispossession, removal and cultural genocide, it is not as segmented as non-Aboriginal culture (*13*).

There is much evidence in the literature supporting the importance in Aboriginal culture of the extended family network for parenting children: aunties, uncles, grandparents, older brothers and sisters were considered as important and valued members of the parenting and caring system in traditional communities with the childcare and parenting responsibilities shared (*13*).

With colonisation, Aboriginal people were forced to conform to European society and initiative, independence and self-assertion were strongly discouraged through violence. In 1909 the Aboriginal Protection Act was introduced (*6*). This Act was developed on the belief that minimum socialisation of Aboriginal children with their own families would make them more accepting of the influences of European culture. Taken from their extended family, raised by non Aboriginal people, stolen generations lacked the influence of traditional family role models and parenting skills were lost. Excluded from their traditional way of life, they had no legitimate ties to their land or their kin. The forcible removal of Aboriginal children from their families denied the children the experience of identifying with their biological parents as adequate role models and a lack of understanding of cultural practices resulted (*6*).

According to Hunter (1995) the roles of adult Aboriginal people as parents and providers and as transmitters and teachers of culture were systematically undermined (*6*). With colonisation and the breakdown of Aboriginal society, Aboriginal parental roles and adult authority were compromised.

With the loss of land to agriculture and white settlement, enforced mainstream education and restricted government policies, Aboriginal populations became traumatised and families became dysfunctional (*6*).

Clarke et al (1999) states when traumatised individuals become parents and create new families, the trauma responses are transferred down through the generations. The Report of the National Enquiry into the separation of Aboriginal children from their families lists reduced parenting skills as a major outcome of forced separation.

> *"Children survive better when one parent or both can overcome the drama of their partnership sufficient to provide nurturance and support. Children survive better where there is a significant other, an extended family member, a teacher, a doctor or a friend. Children survive better where they have a sense of empowerment, where the child is in control of some aspect of his or her life"*(*31*).

Acknowledgment of the need for individual, family and community support systems and groups is strongly identified in the data (*13, 32, 33*). Studies have indicated that general mortality increases when social support is deficient and social participation is limited (*13*). Additionally, without having support from other people, this can lower the possibility of successfully managing problematic life situations (*13*). People who are socially isolated are often more susceptible toward adopting an unhealthy lifestyle

behaviour, such as smoking, excessive alcohol consumption, poor eating habits and reduced physical activity (*32*).

One population study conducted in Canada concluded that the communities with a greater social cohesion had fewer deaths compared to communities with similar characteristics but lower social cohesion (*34*). Data was used to illustrate how healthier communities, in relation to broad social relationships, produce healthier people (*34*). According to Salisbury a sense of community is essential to a sense of self and that this, in turn, is essential to health.

Universally, many underprivileged people experience a sense of powerlessness, reduced self-confidence and self-esteem where they stop looking for new solutions (*35*). One study conducted with New Zealand Maoris revealed lowered self-value consequently reduces self-care. Unemployment created a very real issue in relation to self-esteem (*34*). The quality of our social relationships represents an essential part of our quality of life and our sense of well-being; the respect, approval, love and care given and received and these behaviours, often defines who we are (*34*).

Education and its Impact on Aboriginal Communities

Traditionally, education of the child was seen as a peer group function (*13*). With the introduction of the European education system, Aboriginal laws, languages and cultures were often devalued as responsibility for education and discipline became the responsibility of the Europeans.

Education was not legally compulsory for Aboriginal children until 1972. Prior to this time, Aboriginal children could be expelled from classrooms at the discretion of the teacher (*6*).

Contributing factors to the current poor employment status for Aboriginal people in Australia include: -
(a) the loss of primary and pastoral industries in which Aboriginal people once strongly participated;
(b) non-Aboriginal employees being reluctant to employ Aboriginal people;
(c) and lower educational levels among Aboriginal people (*8*).

The Aboriginal Deaths in Custody Royal Commission (1996) states that Aboriginal education is often marked by reduced levels of success, reduced levels of achievement, reduced retention rates and inadequate education (*8*). The possible contributing factors to the low attendance levels and retention rates were felt to be a reflection of the common view held by Aboriginal people, that education is not relevant nor appropriate to their needs (*8*).

There have been considerable recent developments in Aboriginal education, such as Aboriginal Student Support and Parent Awareness groups, Indigenous Cultural Studies programs and Aboriginal Training Support Services, where primary school to university level Aboriginal students are provided with tutorial assistance (*36*). In spite of these developments, Tsey (1997) revealed that in the Northern Territory a large percentage of Aboriginal students continue to leave school still unable to read and write and that, in remote communities, many do not even attend school (*36, 37*). In a 1996 Australian Bureau of Statistics survey, only 11% of Aboriginal adults, compared with 31% of non-Aboriginal adults, were likely to have a post-school educational qualification (*1*).

Tsey (1997) has reported that Indigenous people in the United States, Canada and New Zealand are surpassing the Australian Indigenous people in relation to education, employment and income. For example, a greater percentage of employees of the Indian Health Service of the United States are said to be 'Indian' and hold prominent positions within the Health Service as doctors, nurses, dentists and other health workers (*36, 38*).

Tsey (1997) suggests that a lack of educational achievement and lack of formal education is a barrier blocking the Aboriginal effort for self-determination and achieving social and health improvement for Aboriginal people. The Australian Public Health Association (PHA) recognises poor educational outcomes amongst Aboriginal people as a crucial obstruction to their well-being (*39*). Education, as stated by Tsey (1997), generates knowledge, values and skills which are essential for making healthy choices.

One view in relation to education and health is that your earning capacity and societal status is largely governed by your level of skill, knowledge and values. All three influence your health, as higher incomes allow people to afford better food, living conditions and health care (*36*). Hart suggests intellectual training leads to a greater ability to understand, control and act upon the social and economic environment and provides the individual with greater confidence in their intellectual capabilities and belief in their capacity to mould health destiny (*36*).

Tsey (1997) states that to be illiterate is to be powerless and there can never be any significant Aboriginal self-determination or social and health advancements until the literacy level of Aboriginal children is addressed (*36*). Freire (1992), a Brazilian educator who instigated much of the theoretical foundation of empowerment education based on his highly successful literacy programs for Brazilian slum dwellers, has challenged whether education promotes powerlessness with people being treated as objects to be manipulated, or whether education encourages individual empowerment to question and

challenge those forces that keep them powerless (*10*). Over the last three decades, Freire's ideas have been a method for worldwide programs in literacy, health education and community development amongst others. According to Freire, individual liberation should be the aim of education (*10*).

> *"As with community health education and promotion programs, adult learning in Aboriginal communities should aim not only at developing literacy and other skills among adults, but such programs should also aim at working closely with individuals and families to create environments conducive to Aboriginal children to develop their potentials through appropriate education" (36).*

The Effects of Substance Abuse in Aboriginal Communities

According to Reid and Trompf (1991), traditional Aboriginal cultures used mood altering substances which were more often chewed and not smoked. One strong substance was pituri which has been described as a strong stimulant as well as addictive (*6*). A means of social control of such substances was with the processes of preparation, distribution, seasonal factors, restrictions on the knowledge of suitable plant locations, controlled consumption by age and sex status. Collecting grounds with boundaries that were clearly marked, were owned by certain men (*6*).

After white settlement, opium was exchanged to Aboriginal people in exchange for labour on Queensland stations in the 1880's (*6, 13*). Gradually licit drug use, such as analgesics and inhalants (petrol sniffing which is predominantly exercised in the Northern Territory and part of Western Australia), and illicit drug use, such as marijuana, tranquillisers, cocaine and heroin, were introduced and are becoming a major concern (*6*). Suggested contributing factors to drug abuse throughout the general population include:

- intrapersonal factors, such as low self-esteem;
- lack of social values and interpersonal factors, such as family and peer influences;
- psychological depression;
- delinquency;
- non-conformity;
- stressful family status (*6*).

The influential characteristics for Aboriginal drug and alcohol abuse are claimed to be entirely historical, social and political (*6*).

According to Symons (1997), substance abuse affects both the health status and academic achievement of an individual. Additionally, it can have a detrimental affect on adolescent development and endanger their transition into adulthood (*37*). Researchers have found that substance-using

students frequently have less commitment and connection to traditional values and family and school practices, often with a reduced sense of psychological well-being (*37*). The drug-using student usually experiences a poor student/parent relationship, obtains lower grades, manifests negative attitudes toward school and has stronger connections to peers (*37*). Absenteeism, depression, rebellion and frequent risk-taking behaviour in relation to delinquency are all increased (*37*). Additionally, the use of drugs has been linked to truancy along with reduced class participation resulting from a lower attention span (*37*).

The brain's ability to receive, categorise and synthesise information is also obstructed by drug abuse (*37*). The negative effects of drug use can obstruct cognitive functioning, memory, sensation and perception. Tobacco, alcohol, and other drug abuse can inhibit productivity, creativity and ambition (*37*). There has been a connection between drug use and the corrosion of the necessary motivational and self-disciplinary skills necessary for academic success, along with greater risks for intentional and unintentional injury, sexual behaviour risks and legal problems (*37*).

Alcohol

Contrary to some beliefs that all alcohol was introduced to Aboriginal communities by the Europeans, other evidence suggests traditional Aboriginal people made their own mood altering beverages from various bushplants, depending on the area (*6, 13*). As with traditional substance use, social control was exercised with the gathering and processing of beverage contents and other factors, including distribution and consumption and seasonal availability (*6, 13*). However, following colonisation, traditional controls were no longer possible as the alcohol introduced by white settlers was available on a massive scale and the Aboriginal people had never been exposed to the overwhelming intoxicating effects of those substances introduced (*6, 13*).

Casey (1997) states that alcohol abuse was encouraged and became an instrument of oppression as well as a consequence of it. Alcohol misuse assists people to deal with emotional pain in the short-term by creating a numbing effect, although this is impaired as it delays the healing process (*13*).

Alcohol makes a significant contribution to premature morbidity and mortality in Aboriginal communities. Although fewer Aboriginal people drink in comparison to non-Aboriginal people, those who do so are more likely to do so at hazardous levels (*1, 26*).

Failure is often the result of the system rather than the individual. For example, according to Casey (1997), upon discharge from the Alcohol and Drug Rehabilitation Centre in the Kimberleys, Aboriginal

individuals were being set up to fail because when they returned to their communities, the community environment remained unchanged. Without established systems to support these people as individuals and as members of the community and with the availability of alcohol, poor housing, lack of employment opportunities, etc, the sense of powerlessness and despair is once again heightened and the cycle becomes self perpetuating (*13*).

Alcohol abuse must not be looked at as the cause to past and present problems but as a symptom of dispossession, alienation and discrimination (*13*). The real underpinning issues must be acknowledged, with responsibilities and action unanimously undertaken to bring real results rather than blaming the people and involved substances (*13*). Aboriginal problems are shared, as they involve not only the individual, but also the family and community (*13*).

> *The oppressive processes need to be understood, and we need to be made aware of and take social action against our external oppression, as well as break the cycle of internalised oppression as part of addressing the fundamental motives of substance misuse* (*13*).

Tobacco

Tobacco traditionally was obtained from plants of the Nicotiana species and was socially controlled with preparation and distribution restrictions (*6*). Records indicate the traditional tobacco was chewed and in northern coastal people (Queensland) it was also smoked using pipes of Papuan or Malay origin (*6*). With colonisation came an influx of tobacco, which eventually became a regular part of the government rations for many Aboriginal people on settlements and missions (*6*).

Tobacco use significantly contributes to the two leading causes of Aboriginal deaths: cardiovascular and respiratory diseases (*26*). Death rates of Aboriginal people from circulatory diseases are 3-4 times higher than that of their non-Aboriginal counterparts (*40*).

Family Violence and Aboriginal Communities

Violence existed in traditional Aboriginal lifestyle prior to European settlement with fights between clan or tribe members (*41*). As well, it was a method of social control in limited, specific forms authorised by Aboriginal Law (*41*). Bennett (1997) stated that in traditional Aboriginal society, violence directed at Aboriginal women and children was not tolerated and could result in death or removal from the community. Degrees of violence previously unknown to Aboriginal people were introduced when white settlers arrived. Aboriginal people were forced off their land, massacred, poisoned, inflicted with diseases, raped, denied traditional culture (language, customs, law and spirituality) and experienced

racism resulting in genocide, assimilation and removal of children (*41, 42*). Over time, drug and alcohol abuse and violence has significantly changed Aboriginal culture (*41, 42*).

Aboriginal people recognise sexism, racism, alcohol and substance abuse brought about by colonisation as being fundamental to family violence (*41, 42*). Lucashenko (1995) states, Aboriginal people believe the abuse of Aboriginal women today, is a direct consequence of the breakdown of Aboriginal Law, and replaced by white norms of sexist behaviour. Family violence is a community issue, not just an individual or family problem (*43*).

Violence is exercised as a form of control over an environment and individuals (*31*). Family violence can manifest itself physically, psychologically, sexually, financially and/or spiritually (*30, 42, 43*). Contributing factors include alcohol, drug use, unemployment, racism, low socioeconomic status, intergenerational abuse and hopelessness (*26, 30, 42, 43*). According to Armstrong (1998), the perpetrator often has low self-esteem and a consistent sense of shame as they cannot live up to the excessive patriarchal values placed upon them by their society and family environment (*31*).

Often a dysfunctional childhood causes a reduced ability to manage psychological or self-image threats and strategies for survival, such as identifying with the aggressor and closing off emotionally in childhood, are often cultivated to help develop a sense of control (*31*). By adolescence, the social learning has developed and patterns are often repeated (*31, 44*).

The strategies employed to overcome family violence depend on varying factors such as age, sex, developmental stage, position and role in the family, the severity and frequency of the violence, the parents' ability to effectively parent and existing economic and social disadvantages (*31, 44*). Purvis and Symons (1995) note the most vulnerable in family violence are adolescents and younger children (infants, toddlers and pre-schoolers) as they have limited cognitive and verbal ability and, therefore, limited resources to understand, cope and adjust to the abusive environment.

Survival strategies of the victims of family violence include:-

- withdrawal which can cause developmental delay especially in language, social skills and lack of concentration;
- identifying with the aggressor/acting out, being aggressive, becoming the school bully, associating with a group with low self-esteem and conduct disorders;
- intervening and directing attention to themselves – often to protect their mother by getting the violence directed their way;

- existence denial and distraction or;
- adopting responsibility with lifelong guilt, shame and frequent depression eg. "It's because I'm too dumb, too fat etc" (*31, 44*).

> *"We must look behind the child's features – this is their strategy, not a biological condition"* (*31*).

Symons (1995) states that any form of violence, whether it occurs in the home, school or community, has a negative impact on a child's ability to learn. Although there appears to be limited information directly linking the effects of violence on academic achievement, emerging evidence indicates exposure to violence has lifelong effects on learning and their developing sense of self (*37, 44*). Children witnessing chronic violence may present with poor concentration and general deterioration in academic performance (*37, 44*).

Academic difficulties related to violence at home have been attributed to environmental disorder and uncertainty resulting in children becoming afraid, cautious, and withdrawn from feelings, reasoning and responses (*37*). Students subjected to violence at home often reveal delayed language development and a total sense of powerlessness (*37*). Physical symptoms are often manifested including sleep disturbances and stress-related sickness such as headaches, abdominal pain and asthma attacks preventing students from benefiting optimally from their educational experiences (*37*).

According to Armstrong (1998), 90% of all violent crime in Australia happens in the family and the family environment. It is estimated that 20% of all Australian homicides are committed by members of the immediate family (*1*). Approximately 90% of male assailants have experienced a violent, patriarchal upbringing, 70% have endured a physically abusive childhood and all have had few close male role models (*1*). Approximately 40% have experienced a similar home-life but have more likely been neglected, emotionally suppressed or sexually abused (*1*). Consequently, the effects of violence are passed onto the next generation of children: 90% of children are present in abusive homes (*1*). The risk of child abuse occurring is 15 times greater for children living in a domestically violent family (*31*). The majority of children are affected directly by abuse not only by the assailant but also by the victim (*31*). A 1998 Australian Bureau of Statistics survey revealed that in most Australian State and Territory jurisdictions, Aboriginal children were 2-8 times more likely to be victims of substantiated cases of abuse and neglect compared to non-Aboriginal children, 4 times more likely to be under care and protection orders and almost 6 times more likely to be on out-of-home placements (*1*).

Mental Illness and Aboriginal Communities

Loss of culture, grief, traumatic and premature mortality, the separation of children from families, racism, unemployment and poverty contribute to high levels of stress in Indigenous communities (*45*).

Salisbury (1998) suggests any discussion of Aboriginal mental illness, as with Aboriginal health generally, is to be viewed in a historical context, including the awareness of the existing differences in lifestyle between Aboriginal and non-Aboriginal people(*28*). Aboriginal people are at a greater risk of mental illness compared to non-Aboriginal people due to factors such as violence, removal from family, poverty, discrimination and racism (*1, 12*).

Reid and Trompf (1991) suggest, that there is a commonly accepted belief that suicide was not a traditional part of Aboriginal culture. Unfortunately Aboriginal mental illness problems, as with the Indigenous people of New Zealand, Canada, and North America, are increasing and although the exact extent is difficult to determine, Aboriginal people are more likely to be hospitalised for and/or die from conditions which suggest mental illness such as self-harm, substance abuse, depression, suicidal behaviour and interpersonal violence (*1, 6, 12, 13, 28, 33*). Aboriginal males and youths are the ones whose social and cultural roles have been most affected and are at a greater risk of self-harm and harm toward others (*6*).

A research investigation of self-harm and suicide conducted in five selected Aboriginal communities in Queensland over an 8 year period, with individuals between ages 15 and 65 years, found that: 72% of interviewed suicide attempters (98% of males and 50% of females) indicated the use of alcohol or drugs at the time of the attempt; 19% of the attempts had taken place in custody (watch houses) with alcohol being involved in all but one of these cases; and 46% of suicide attempters revealed that drinking or drug usage caused their personal problems (*6*). Reid and Trompf (1991) state that mental illness, mostly in the form of depression, affects at least one-third of people who attempt suicide.

In an Adelaide study conducted in 1991, examining stress and self destructive behaviours, heads of households (82% women) were interviewed. Of the 88 respondents those with high levels of anxiety were more likely to have left school early, felt little control over their lives, lacked a supportive friend or confidante and had been frequently assaulted. 31% of respondents had serious thoughts about suicide, 25% had deliberately inflicted harm upon themselves.

Results from a community based study conducted by Swan and Fagan (1991) of people presenting at Aboriginal Medical Services found that a childhood history of separations from biological parents,

neglect and institutionalisation, difficulties in gaining employment and stress predicted mental health problems. In a review by Hunter (1993) of Aboriginal health in remote communities, loss of culture, trauma, grief, poverty, discrimination, racism were strongly associated with heavy substance use and suicide attempts (*45*).

In a study conducted by McKendrick et al (1992) of 114 randomly selected subjects over 14 years of age revealed that respondents who grew up in their own families, learned about their Aboriginal identity early in life and regularly visited their traditional country suffered significantly less mental health problems then those who had been separated from their families and land (*45*).

The National Consultancy Report on Aboriginal Health (1995) implies that mainstream Mental Health Services were viewed by Aboriginal people as failing them in terms of both cultural awareness and response (*28*). The National Aboriginal Health Strategy Working Party (NAHSWP) 1989 states:

> *"Mental illness is a common and crippling problem for many Aboriginal people and appropriate services are a pressing need. Culturally appropriate services for Aboriginal people are virtually non-existent. As a result, mental distress in the Aboriginal community goes unnoticed, undiagnosed, and untreated"*(*6*).

Dietary and Physical Behaviours Affecting Aboriginal Communities

As previously stated, traditionally Aboriginal people lived a healthy lifestyle as seasonal hunters and gatherers (*6*). It appears obesity, diabetes, lactose intolerance, hypertension, infant malnutrition, and circulatory problems were not an issue as they are today (*6*).

With settlement and mission dwellings, meat and vegetable consumption was minimal and a diet of white flour, sugar, tea and salt increased (*5, 6*). As a result of not being permitted a lifestyle of self sufficiency from the land, and with an increase in ration dependence, some of the traditional food skills or practices disappeared and dietary deficiency resulted (*5, 6*). Other contributing factors to the Aboriginal struggle with dietary related illness includes poor economic and educational status and a lack of understanding of basic health and nutritional needs (*5, 6*).

In the National Action Plan for Comprehensive School Health Education (1997), the American Cancer Society and representatives from over 40 health, education and social service organisations declared education and health as interdependent systems (*37*). Participants concluded that healthy children have a greater chance of better learning and cautioned that there is not a curriculum that is great enough to compensate for student health deficiencies.

Evidence from the literature confirms a direct link between student health risk behaviour and educational outcomes, educational behaviours and student attitudes regarding education (*37*). Hungry or undernourished children reveal behaviours including irritability, reduced physical activity and lethargy which have a negative effect on learning (*37*). Because the impact of poor nutrition is community wide in a high percentage of Aboriginal communities, interventions need to be community based rather than individualised (*37*).

According to the European Committee for Health Promotion Development (1999), there is evidence to suggest that poorer socio economic groups tend to have poorer nutrition, less physical activity in leisure time, greater prevalence of smoking and higher damaging patterns of alcohol use due to greater restrictions on their choices of healthier lifestyles due to time, space and financial constraints (*37*).

Connections between increased physical exercise and other positive lifestyle behaviours such as reduced smoking, better dietary practice and effective stress management practices have been confirmed through the literature (*37*). Furthermore, evidence suggests that physical activity is linked with greater academic outcomes, sustainable positive interpersonal relationships and decreased risk of depression, anxiety and fatigue which enhances students' attitudes toward themselves and school (*37*).

Overcoming Health Inequalities in Aboriginal Communities

> *"The health status of Australian Aboriginal people is far inferior to that of non-Aboriginal Australians. The factors underlying this low standard of health are complex but relate to the gross social inequality experienced by Aboriginal people, even today. The social inequality, characterized by extreme socioeconomic deprivation and relative powerlessness, is the end result of the European occupation of Australia, which caused Aboriginal depopulation and dispossession"* (*28*).

There is now a considerable body of evidence from recent Australian and international research linking social inequalities to the health of individuals. People's lifestyles and conditions in which they live and work strongly influence their health and longevity (*46*). Poverty and social disadvantage have a detrimental effect on health at all ages throughout the lifespan. Research has consistently shown that low socio economic groups fare significantly worse in most areas of health. A review of over 200 Australian studies revealed that people in the lower socio economic groups have higher rates of most diseases, higher rates of mental health problems, suffer from higher rates of disease mortality and die younger (*47*).

Communities which experience material deprivation, poor education and economic opportunities, low employment and poor housing conditions are more likely to experience high levels of anxiety, depression, insecurity, low self esteem, social isolation and powerlessness; the perception of having little or no control over work and home situations (*48*). Disempowerment has been associated with reduced physical well being, increased risk behaviours and mortality, reduced mental well being, reduced cognitive functioning and academic achievement and more anti social and criminal behaviour.

Interventions aimed at improving health related knowledge and attitudes, warning against health risk behaviours and encouraging health promoting behaviours have shown some success. However, these interventions appear to have been more successful among higher SES groups, creating an even more uneven distribution of health and disease, with the health differential widening between higher and low socio economic groups. The key is in understanding what makes people sick. Modern health care has less impact on the health of a population then education, housing, nutrition and sanitation (*48*). WHO suggest that health is best where active steps are taken to address the social determinants such as poverty, living conditions, education and employment (*48*).

Healthy social environments that enhance positive self concept improves opportunities for success in life (*49*). Multistrategic, multidisciplinary programs which aim to improve self esteem, confidence and decision making skills have shown favourable long term health, educational and social outcomes for disadvantaged communities (*49*). According to the literature the most effective means of achieving these outcomes is through the implementation of parenting and early childhood intervention programs (*49*).

Early Childhood Interventions

The term *early childhood intervention* encapsulates a variety of programs targeting the child, parent/s and family. Early childhood intervention programs can include services offered in homes and centres aimed at improving educational achievement, health and/or parenting skills (*50*).

Favourable outcomes which have been documented as a result of effective early childhood interventions include:

- Improved physical,mental and overall health outcomes for the child:
- Gains in emotional/cognitive development of the child:
- Improved parent/child relationships:
- Improved parenting and family functioning:
- Improve developmental and educational performance of children:

- Increased economic self sufficiency initially for the parent, later for the child through higher labour force participation, higher income, lower welfare usage:
- Decreased criminal activity level:
- Improvements in health related indicators such maternal reproductive health and maternal substance abuse:
- Reduced levels of child abuse, neglect and criminal behaviour:
- Increased savings for governments in the form of tax revenues, decreased welfare costs:
- Decreased expenditure for education and health and criminal justice system costs.
- Decreased family breakdown and out of home care (*50-53*).

The impact of early development experiences can last a lifetime (*46, 50, 53*). Parenting attitudes and behaviours have a significant impact on the physical, social, mental and emotional well being of children (*46, 50, 53*). Early childhood serves as a foundation for behaviour, well being and success later in life. The failure of the parent to provide competantly for the child's developmental needs will place the child at risk. Insufficient cognitive stimulation, nutritional deprivation, inadequate health care, maladaptive social interaction during early childhood can impede normal development and have long term consequences such as decreased physical, cognitive and emotional functioning in adulthood (*46, 50, 53*).

According to Marmot et al (1997), improving conditions for children would improve the health of future generations of adults (*54, 55*). Investing in young children through improved parenting programs, comprehensive preschool programs, family support and education would have the greatest impact on health gains within a community (*54, 55*). The early years of child development and family functioning present an opportunity for positive interventions that cannot be retrieved at a later stage (*54, 55*).

Given the evidence presented in the literature, early childhood interventions including parenting and support programs are viable strategies for improving overall long term health outcomes within Indigenous communities (*6, 56*). Supporting the evaluation and sustainability of such programs would be an effective Health Promotion strategy. Clarke et al (1999) suggests that effective outcomes will be achieved if Indigenous parenting programs are directed at healing transgenerational trauma, improving parenting practices and enhancing relationships across generations (*56*). Aboriginal parenting programs should be directed at the whole or extended family so that traditional cultural aspects and values are strengthened. Aboriginal parenting programs will be effective if they involve community elders, incorporate Aboriginal principles of community development and acknowledge the importance of the traditional extended family and the role of healing in resolving community disorder (*6, 56*).

The proposed plan of action for the prevention of child abuse and neglect in Aboriginal communities (1996) specifies that parenting programs need to involve local communities in both the development and delivery of such programs (*53*). Programs should be delivered through existing Aboriginal forums, schools, child care centres already utilised by Aboriginal families. Resources to support these programs should include videos, pamphlets and easy to read books tailored for the Aboriginal audience (*53*).

Fathering Programs

Fathers have been identified as a group not easily accommodated within current early intervention and parent support programs and services. Tresillian (1998) has identified fathers as a group requiring further attention when developing parenting programs (*53*).

The role confusion of contemporary men as fathers becomes more apparent from the literature researched (*57*). Issues which have emerged range from, the lack of adequate male role models, the 'distant dad relationship', the change in roles due to feminism, increased participation of women in the workforce and a greater expectation placed on men to be involved in the home and family life (*57*). According to one study involving 350 Australian men in 1994, the patriarch and provider role has almost disappeared (*57*).

The Aboriginal male's role is further confused with the traditional ways being fragmented as a result of colonisation. Traditionally, the man's role was highly esteemed. He performed ceremonial rites and lead the young males through their initiation into manhood. The young men were guided to understand their world, to know their country, to make tools, to dance and paint, to learn Aboriginal stories to understand the spiritual world (*58-60*). Family roles were assigned in accordance with individual tribal position with the responsibilities being shared throughout the family (*58, 59*). According to Howard (2000) *"Traditionally, Aboriginal people existed as tight ecological communities/families where children learnt their place in, and a responsibility to, their community from an early age"* (*61*).

The introduced policies of colonisation had devastating consequences on the Aboriginal population, cultures and lifestyle, especially for men (*6, 62*). With the government settlements and missions came the removal of the men's identity as traditional leaders and land-owners. Additionally, their role as decision makers within the community and as father figures and educators was also taken away (*6, 62*). Aboriginal men have been driven to seek comfort and support through alcohol, substance abuse, self-harm, self-destruction, violence and imprisonment as a result of role confusion where men feel displaced within their communities (*6, 59, 62*).

Amongst Aboriginal people there remain underlying perceptions, attitudes and myths that the work with raising children and the health of a child is women's business and is, therefore, solely the woman's responsibility. These views are compounded by the historical predecessors such as the forced removal of Aboriginal children and the continuance of high Aboriginal imprisonment rates, poor health and socio-economic status and the lack of positive role models. These widespread forces make it difficult for Aboriginal men to accept their rights and responsibilities for parenting children (*63*).

Adams (1997) suggests that the pathway to excessive alcohol and drug abuse is promoted through the alienation process that has displaced Aboriginal men (*63*). Adams states that Aboriginal men are aware of their need to begin claiming back their responsibilities and taking control of their own destiny to enhance obligations as father, educator and decision maker within their family structure and communities (*63*).

Senator Mr Bonner (1997) stated *"As parents, uncles, cousins or brothers, we (Indigenous Men) must take responsibility for the future of our young people … emphasis is placed on sporting personalities, but the best role model a son can have is a patient, caring father. The attitude towards life of the son will mirror that of the father, which is the way things used to be done before white settlement"* (*60*). Factors such as the imprisonment of Aboriginal men, even if transient, and father absence or incapacity form substance abuse, compromise male role models. It is believed that this, along with welfare support for mothers and children, has increased a matriarchal family structure. These factors may have harmful effects for the identity development of young Aboriginal males according to John Hayden (1996) (*60*).
According to the literature researched, there are supportive parenting programs and mainstream fathering programs available. However, there appears to be a large gap in the community support for Aboriginal fathers and culturally appropriate fathering programs (*63*).

In a study conducted by Dye (1998) of 300 fathers to assess men's perceptions of parenting programs, the following factors emerged as barriers for men attending programs:

- Programs are generally conducted during working hours;
- Content style is generally directed at mothers;
- Perception that mothers are the primary care givers and males are the support;
- Failure to focus on the distinctive role of fathering;
- Groups are run by women (*53*).

Strategies to overcome barriers included:

- Establish men only groups;
- Adopt existing programs to include men;
- Target recruitment of fathers;
- Development of father friendly workplaces which recognise family commitments of fathers;
- Provide programs in venues frequented by males;
- Provide services outside working hours (*53*).

The parenting role, which includes caring and nurturance, challenges the traditional construction of men and masculinity. Also, the father role has often included abuse and control (*63*). According to the Australian Institute of Criminology research statistics reveal that natural parents remain the greatest perpetrators of child abuse and neglect (*63*).

Aboriginal fathers face complex issues which include lack of education, lack of employment opportunities, discrimination, low self-esteem, lack of positive role models and a lack of parenting skills and knowledge on issues such as nutrition and child development (*63*). These issues need to be acknowledged and addressed to be able to provide a holistic approach to the well-being of the family and community (*63*). Working with Aboriginal fathers needs to come from the heart and not only be based on theoretical knowledge (*63*).

There is no doubt according to the evidence that children benefit immensely when a father is actively involved with his children from physical and emotional care, to positive discipline as well as creating a positive effect on children's self-esteem (*64*). It has become more recognised in recent years that educating parents offers an opportunity to understand the child's developmental needs, can provide alternative discipline strategies and can increase parenting confidence (*64*). Such programs also promote communication between parents and children which can create a sense of connection. Education regarding behavioural stages and strategies for behavioural management can play an important role in preventing abuse as having unrealistic expectations on children is a key prerequisite to child abuse (*64*). The child development information and parenting advice offered in the majority of parent education and support programs are looked at as critical factors in interventions that aim to prevent child abuse and neglect and to assist parents to provide a firm emotional, social and intellectual start to their children's lives. Prevention programs such as these are seen as preferable to crisis management interventions and to be cost-effective, long-term, for governments in terms of savings in the health, education and criminal justice systems (*65*).

A significant factor in long-term father/child bonds appears to often occur during early care giving. It has been noted that fathers who have had the experience of continued infant care-taking, develop a greater awareness of the child's needs (*60*). To actively care for one's children is not only necessary to the child's development but is also essential to the father's growth and well-being (*60*). Fatherhood should be viewed as a role you grow into as possibilities are explored (*66*). Fathers can promote positive behaviours by setting a proper example for their children, as children tend to copy positive or negative behaviours that they witness on a regular basis (*59*).

Supporting Aboriginal men to build positive relationships with their children offers them and their children a new beginning. Male support, positive role models and relationships are benificial to the children and increase the father's sense of belonging and involvement (*61*). Aboriginal fathers need support in order to develop their fathering skills, learn parenting strategies and nurture their instincts. Aboriginal fathers also need a safe environment to explore their boundaries, their inner self and the importance of being a father. Aboriginal children will benefit from the involvement of their father in sharing the parenting tasks, such as nurturing, role modelling, teaching skills, affection, playing, positive discipline, becoming emotionally involved in the welfare of their children and having fun at their level, and not just imposing adult activities. Being a father means you have to be there and work at being a father.

Self Determination and Aboriginal Communities

> *"The roots of the problems are deep and have a long history. The loss of Aboriginal culture and tradition rendered many Aboriginal people, both men and women, powerless and dependent" (43).*

Self-determination and self-management is vital in order to see an improvement in Aboriginal health status. Empowerment will not come while Aboriginal people have to depend on government bodies for policy making, funding, and instruction. Several studies have indicated that as long as Aboriginal economic independence is absent, self-determination will remain an illusion (*6*).

Powerlessness results when people who have low or no political and economic power also have deficient means in their lives to achieve greater control and resources (*10*). A key element for Aboriginal self-determination is the right to determine and benefit from economic development in one's own area.

> *"Economic independence supports aspirations for self-determination and self-government. Resource management is a concrete step toward self-government*

> *through economic self-sufficiency"* (*67*). *"The way forward lies in supporting the aspirations of Aboriginal people for self-determination"* (*68*).

The process of self-determination needs to be initiated by the community and not imposed upon the community, as it has been over the past 210 years. A project based on self-determination will mean the community will be involved with the decision-making, planning, implementation and evaluation of that project. The aim is for total community control. A greater awareness of the social and political issues influencing the health status of Aboriginal people is necessary to provide sensitive, culturally appropriate health care services (*38*).

> *"A social action process that promotes participation of people, organisations, and communities towards the goals of increased individual and community control, political efficacy, improves quality of community life, and social justice" (7).*

Self-determination enables opportunities for Aboriginal people to prioritize their own decisions in program development and ensures the ongoing services are relevant and appropriate. An awareness of and the ability to flexibly respond to health issues in the community is a requirement of community control (*6*). Therefore, a more holistic view is adopted as health is seen not only at the individual level of disease but also at the wider community level (*6*). Based on self determination principles, the first ever-independent community controlled Aboriginal Medical Service (AMS) began in mid 1971 in Redfern operated by Aboriginal people for Aboriginal communities (*6*). Reid and Trompf (1991) suggest that this ownership of community control in Aboriginal terms signified the revival of community decision-making that was once a part of traditional Aboriginal culture.

The Ottawa Charter suggests that in order for people to have the ability to develop life-styles instrumental to good health, control over their living and working status must be obtained (*69*). Political strength and power supporting their purpose needs to be achieved through people building partnerships (*69*). According to Reid and Trompf (1991) the acknowledgment that local autonomy is crucial to the process of self-determination and self-management needs to be further recognised from the white community and government.

In summary, the literature suggests that long term holistic health outcomes will be achieved if interventions targeting Indigenous communities focus on early childhood interventions that are based on self determination principles. That is, interventions that focus on the parent, child and extended family, that build social cohesion and are wanted by communities, that are planned, developed and implemented by Aboriginal people for Aboriginal people.

SECTION 4

Review of Self-determination Programs

The following section includes outline summaries of documented programs that have been developed focusing on self-determination principles for Aboriginal communities

Nunkuwarrin Yunti

A community project, the Diabetes Educational Project at Nunkuwarrin Yunti, South Australia, focuses on not only the health care needs of the client but also takes into consideration all aspects, such as clients' general health, possible support required by the family, living environment, finances and the effects of diabetes on the family and community (*33*).

We-Al-Li

A program in the development process called We-Al-Li program involves Indigenous therapies assisting Indigenous people to deal with the effects of transgenerational trauma. The healing process, according to the authors, begins when individuals recover their trauma stories of loss, grief and pain as a result of broken relationships with self, others and their community. Sharing experiences with one another in a talking group assists the individual towards the healing process, as the sense of isolation is reduced and being in the company of others with similar experiences provides understanding, support and respect of their experiences. This approach provides an alternative to mainstream services and would more likely be effective if culturally appropriate (*56*).

Resourceful Adolescent Parent (RAP-P) Program

The RAP program for Indigenous Families is a three-part program: -

- *"Parents Are People Too,*
- *Families Are Important, and*
- *Culture and Community"* (*56*).

The RAP resources were developed through a consultation process with Indigenous communities and includes a video and a Group Leader's manual. The knowledge and skill of the Aboriginal people trailing the RAP program is also incorporated. For the first part of the program, community groups, along with a trained facilitator, view each section of the video with a series of exercises and discussions (*56*).

The second part involves the sharing of childhood experiences, told by Aboriginal Elders, who also discuss the vital role of the extended family towards providing a safe environment for children to grow

up in. Discussions involve identifying ways the participants can assist the children to feel good about themselves and increase their confidence and self-esteem (*56*).

Part three of the program provides the opportunity for participants to discuss cultural roles within their own lives. Aboriginal culture, based on strong family values, is an essential element in the process of family and community recovery (*56*).

Aboriginal WAVES Project

In 1995 a WAVES (Water Activities for Vitality in the Eastern Suburbs) program was operating for everyone in the South Eastern Sydney Area (*70*). However; Aboriginal women were often too shy to go along (*70*). After much planning, encouragement and support to the women in the community, Colleen Cawood successfully started the Aboriginal WAVES program in 1997. This program involves exercise classes in the hydrotherapy pool with the aim of reducing the risk of cardiovascular disease and diabetes and to encourage Aboriginal people to take up exercise toward improving their health. This project targets Aboriginal people living in and around the South Eastern Sydney Area and the inner city of Sydney (*70*).

The program is run four terms per year with five classes per week and approximately 10 women attending each class. Aboriginal women joining are asked to supply a health certificate from their General Practitioner. It is requested that necessary medication is brought to the pool at all times, particularly for those with asthma or diabetes. A lack of transport was initially a big issue; however, it is now funded by the Aboriginal Home Care "Alleena" Centre. Poor body image for the women was also an issue, which took the women a few terms before feeling comfortable in swimming costumes. The Aboriginal WAVES Program has received a number of awards, acknowledging its success. With the intention of continuing towards better health, the women suggested starting up an Aboriginal Walking Group which is now in progress (*70*).

Nutrition Program in a Remote Aboriginal Community

Aboriginal people of the Minjulang community on Croker Island (north east of Darwin) initiated a Nutrition Program in 1989 (*71*). An increased intake in nutritionally desirable foods, such as fresh fruit, vegetables and wholegrain bread was encouraged while the consumption of take-away foods and sugar were discouraged. Significant health changes occurred over a year due to a reduction in the dietary intake of sugar and saturated fats and an increase in nutritional foods. These changes revealed lower serum cholesterol levels and reduced blood pressure amongst other positive indicators of nutritional status. Sustaining such improvements has proven to be difficult with external funding and biological

monitoring ceasing in June 1990. However, the Minjilang people have informally continued with the program (*71*).

Evaluation of the program included store turnover of food items as a measure of dietary intake. The turnover of fruit, vegetables, bread (particularly whole-grain) and artificially sweetened beverages was higher after the formal completion of the project than prior to intervention (*71*). Vital to the project's success was that it was community initiated and although there was an effective partnership with those who provided technical support, the community maintained ownership. Community members actively participated in all developmental, implementation and evaluation stages. The applied strategies were specifically targeted to community needs *(71)*.

Bibbulung Gnarneeep Project (Solid Kid project)

Focuses on Indigenous communities and combines a home visiting program with a longitudinal study documenting those characteristics of Indigenous families which enable healthy family functioning. The project aims to evaluate antenatal, perinatal and childhood characteristics of healthy children, document mortality and morbidity and train Aboriginal people to run the program. Baseline data will be used to plan, implement and evaluate Health Promotion programs. Informal evaluations to date indicate that the home visits are providing women with greater social support which in turns supports the development of community networks *(72).*

Ngumytju TjiTji Pirni (NTP)

Antenatal and post natal home visiting program for Aboriginal mothers and children. Western Australian project which aims to improve the health of Aboriginal and Torres Strait Islander people by improving maternal health. Coordinated by Aboriginal Health workers who speak the mothers' language. The visits aim to empower women to make informed choices about their own care, the care of children and reduce the rates of illness and death by the provision of high quality maternal and infant health care. To date, evaluation data not yet published.

Beststart

A West Australian program developed to improve the well being of Aboriginal children form birth – 5 years to better prepare them for preschool and year one. A three year pilot project, Best start provides a range of services including play groups, nutrition program for parents, family centres and immunisation clinics. Ownership and management of each Best start program is maintained by the local community.

Family Well Being Empowerment Course

The Family well being empowerment course - uses empowerment interventions. Predominantly Aboriginal developed, it is based on the premise that all humans have basic needs- physical, emotional, mental, spiritual. Failure to meet these needs results in behavioural problems.

Course aims to empower participants and their families to assume greater control over conditions influencing their lives. Emphasis is on parenting and relationship skills. A nationally accredited course, it assists individuals through personal empowerment to improve their capabilities - increasing awareness, resilence and problem solving ability and improving their overall sense of well being.

"Ngama-ngamalinya Kampi-Kampilinya" Mother and Child : Father and Child

Final Report Wilcannia Parenting Project January 2000. Wilcannia Parent Project was a joint initiative of the Wilcannia Coordinated Care Trial, the Far West Area Health Service and the Wilcannia Social and Emotional Wellbeing Team (Mental Health and Counselling). The project objectives were to:

- Examine all available Australian and New Zealand parenting programs, with an emphasis on Aboriginal programs;
- Recognise programs that may be suitable for implementation in the Wilcannia community;
- Present the conclusion of the research to the Wilcannia Community to enable the Community to choose one or more program(s) for implementation.

The Wilcannia community were surveyed to determine their desires and needs concerning parenting. Those surveyed supported the concept of a parenting project. Survey results clearly indicate that success of a parenting program introduced into Wilcannia is dependent on parents' emotional and social wellbeing issues, as well as parenting issues being addressed.

A literature review was conducted of Indigenous and non-Indigenous parenting programs at both National and International levels. The Wilcannia report documented ten Aboriginal Parenting programs, and of these there were four programs which met the necessary criteria identified by the committee and community. These included:

- RAP-P Parenting Program for Aboriginal Communities
- Best Start
- Aboriginal Adolescent Development Program
- Strong Women, Strong Babies, Strong Culture Program.

The Wilcannia report suggests three general components to a parenting program which include:

- Home visits
- Structured training and peer support for parents; and
- Combination of home visits and structured programs *(73).*

Social Cognitive Theory (SCT) and Problem Solving Skills (PSS) Program

An intervention based on social cognitive theory (SCT) was initiated to develop problem-solving skills (PSS) among sixth graders *(74)*. These skills, when developed in school children, can be considered a basic health capacity as PSS make it possible for children to form educated decisions about their health and to act on the decisions in a social context *(74)*. The ability to learn to recognise and cope competently with emotional stress using PSS can add to general academic success. Furthermore, PSS can assist toward the enhancement of positive mental health, and could also be used as a primary prevention strategy for depression and suicide *(74)*. The acronym SMART is suggested to remember the PSS steps. *"S-Stressor (name it), M-Many ways (think), A-All good points about each way, R- (w) Rong points about each way, and T-Try one way after thinking many ways" (74)*.

SECTION 5

Summary

Many Aboriginal communities are locked into the cycle of poverty and powerlessness. This demoralising sense of hopelessness, constitutes a major health problem *(6)*. Mortality and morbidity documentation from Australia, New Zealand, Canada and America suggests an unjust imbalance of physical and mental illness and early death endured by their Indigenous populations compared to their non-Indigenous populations *(2, 7)*.

The impact of colonisation inflicted on Aboriginal and other oppressed Indigenous people such as the American Indians and New Zealand Maoris includes a wide range of emotional, social and behavioural outcomes. These include; high suicide rates, mental health problems, alcohol misuse, child neglect and violence with families and communities *(7, 38)*. When trauma is suppressed, denied or ignored symptoms often manifest by people self abusing with alcohol or drugs *(13)*. Repressed anger, shame, grief, frustration and hopelessness often erupt in violence toward the self and others *(6, 13, 41)*. Dysfunctional adoptive survival responses such as violence, substance abuse and similar behaviours may occur when the individual has been a victim of family and community violence *(6, 13)*.

Racism, the pain of our history and the denial of the truth by the media, education, welfare and legal systems continues to generate Aboriginal oppression even today *(13)*. Casey states that *"People who are oppressed tend to oppress not only themselves individually, they oppress their own people, especially those closest to them" (13)*. Substance abuse in the form of licit and illicit drugs and family violence amongst Aboriginal people appears to be a response to the deterioration of Aboriginal culture *(13)*. These responses will prevent the individual from reaching long term positive outcomes, including educational achievement and employment *(26, 30, 43, 56)*. Regaining their identity and their own self-image will contribute to their healing *(43)*.

In order to improve the poor health status and socio-economic condition of Aboriginal people we need to recognise and support the goals and aspirations of Aboriginal people towards self-determination and self-management. It is imperative for trust to be established before any positive changes can take place. The need for individual, family and community support systems is essential to health.

OATSIH states that health includes the social, emotional and cultural well-being of the community as a whole and not only the physical health of the individual (*17*). This view is also supported through

literature for Indigenous groups of New Zealand, Canada and America and by the World Health Organisation *(7, 38)*. It is imperative Aboriginal health is approached holistically *(4, 7, 28, 36, 38, 56)*.

> *"Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and thus bring about the total well-being of their community"(28).*

Health improvement should aim to accomplish the physical well-being of the individual, as well as the social, emotional and cultural well-being of the whole community to which each individual can achieve their full capacity as a person, positively influencing their community well-being as a whole *(11)*.

In conclusion, Aboriginal health issues necessitates the acknowledgment that Aboriginal problems are shared issues which include and influence individuals, families and communities. Precedence should be given to promoting interventions built on accessing and strengthening existing Aboriginal contemporary cultural practices at the individual, family and community level. For the provision of sensitive, culturally appropriate health care services to take place a greater awareness of Aboriginal family and Kinship connections, grief and loss, racism and socio-economic disadvantage and political issues influencing the health status of Aboriginal people is imperative. Aboriginal people need to collectively work together with Government and non-Government organisations to address the socio-economic and political causes of the problems in a culturally positive and culturally directed way. In addition, Aboriginal people need greater encouragement and support to become more involve with policy, planning and decision making as well as the development of Aboriginal programs by Aboriginal people.

Culturally relevant programs are required for substance abuse prevention, as well as addressing social issues such as support provided to single parents, reducing school absenteeism and empowering Aboriginal communities to facilitate prevention strategies. Positive environments for Aboriginal children need to be facilitated through individual families and communities to cultivate their potential through education, as they are our adults of tomorrow. Communities need to promote and encourage culturally appropriate substance abuse programs addressing social issues such as depression and hopelessness; parenting programs involving both parents and carers using a holistic model eg: childhood milestones, parenting skills, health issues, financial management and stress management and offer first-aid courses for Aboriginal communities through CEDP and/or parenting programs.

"How would we know when an Aboriginal community was healthy? A simple answer to this very complex question would be: when the environments, cultures, minds and bodies of all members of the community are healthy and conducive to Aboriginal people achieving pride, autonomy, longevity and freedom from disease. This goal can be reached only when communities, individuals and governments work together for real progress by appreciating the extent of the work that must be done in all areas of a paradigm of health that recognises body, land and spirit"(75).

SECTION 6

References

1. Australian Bureau of Statistics: The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, vol. http://www.abs.gov.au/ausstats/ab.../495c8c9d69db4045ca2568a900139402!OpenDocumen. Australian Bureau of Statistics, Canberra, 1999.
2. National Aboriginal & Torres Strait Islander Health Clearinghouse: Summary of Indigenous health status, 1999, vol. http://www.cowan.edu.au/chs/nh/clearinghouse/faq/summary_99/summary99.htm. National Aboriginal and Torres Strait Islander Health Clearinghouse, 1999.
3. Australian Bureau of Statistics: Mortality of Aboriginal and Torres Strait Islander Australians - 1997. Australian Bureau of Statistics, Canberra, 1997.
4. Jackson, L. R., and Ward, J. E.: Aboriginal health: why is reconciliation necessary? Medical Journal of Australia 170: 437-440 (1999).
5. Mathews, J. D.: Historical, social and biological understanding is needed to improve Aboriginal health. Recent Advances in Microbiology 5: 257-334 (1997).
6. Reid, J., and Trompf, P.: The Health of Aboriginal Australia. Harcourt Brace & Company, Marrickville, 1994.
7. Voyle, J. A., and Simmons, D.: Community development through partnership: promoting health in an urban indigenous community in New Zealand. Social Science & Medicine 49: 1035-1050 (1999).
8. National Aboriginal & Torres Strait Islander Health Clearinghouse: National Aboriginal and Torres Strait Islander Health Clearinghouse overviews: selected social indicators, vol. http://www.cowan.edu.au/clearinghouse/health/social_indicators [access date]. National Aboriginal and Torres Strait Islander Health Clearinghouse, 1998.
9. Charlton, I., et al.: Asthma at the interface: bridging the gap between general practice and a district general hospital. Archives of Disease in Childhood 70: 313-318 (1994).
10. Wallerstein, N.: Powerlessness, empowerment, and health: implications for health promotion programs. American Journal of Health Promotion 6: 197-205 (1992).
11. Northern Rivers Health Service: Northern Rivers Health Service Aboriginal Health Strategic Plan 1998 - 2002. Northern Rivers Health Service, Lismore, 1997.
12. Aboriginal & Torres Strait Islander Commission: Aboriginal & Torres Strait Islander Commission 1998-99 Annual Report. Aboriginal & Torres Strait Islander Commission, Canberra, 1999.
13. Casey, W., Garvey, D., and Pickett, H.: Empowering approaches to Aboriginal addictions. Curtin Indigenous Research Centre, Perth, 1997.
14. Forero, R., et al.: Substance use and socio-demographic factors among Aboriginal and Torres Strait Islander school students in New South Wales. Australian & New Zealand Journal of Public Health 23: 295-300 (1999).
15. NSW Government: Families First in NSW - An Initiative of the NSW Government. A Support Network for Families Raising Children - North Coast Area Plan 2000 - 2003. NSW Government, Sydney, 2000.
16. Northern Rivers Area Health Service: Northern Rivers Area Health Profile: Aboriginal and Torres Strait Islander people, vol. http://nrihr1web/HNR2002/profile/abtsi/abtsi_hlth.html. Northern Rivers Area Health Service, 2001.
17. Australian Department of Health and Aged Care: Health and Aged Care Portfolio. Budget Initiatives and Explanations of Appropriations Specified by Outcomes and Outputs. Budget Related Paper No. 1.11. Outcome 7: Aboriginal and Torres Strait Islander Health. Australian Department of Health and Aged Care, Canberra, 1999-2000.
18. Commonwealth Department of Family and Community Services: About FaCS - What FaCS Does, vol. http://www.facs.gov.au/internet/facsinternet.nsf/whatfacsdoes/nav.htm. Commonwealth Department of Family and Community Services, 2000.
19. The Australian Indigenous Health Promotion Network: A Proposal for Investment in Indigenous Health Promotion in Australia. The Australian Indigenous Health Promotion Network, Canberra, 1999.
20. NSW Health Department, and ATSIC: New South Wales Aboriginal Health Strategic Plan. NSW Health Department, Gladesville, 1999.
21. NSW Health, Aboriginal Health, and Medical Research Council of NSW: Ensuring progress in Aboriginal health: A policy for the NSW Health system. NSW Health Department, Gladesville, 1999.

22. NSW Health: Report on May 2000 Forum Theme: "Aboriginal Health Promotion". Proceedings of the NSW Health Promotion Directors Forum, 2000.
23. NSW Health, Aboriginal Health & Medical Research Council (AHMRC), and NSW Aboriginal Health Partnership: Directions Paper: The NSW Aboriginal Health Promotion Program. NSW Health, 2000.
24. NSW Health: NSW Aboriginal health promotion program, vol. http://www.health.nsw.gov.au. NSW Health,Better Health Good Health Care, 2001.
25. Shared Vision Steering Committee: Wula Wula Nga Business Plan. Wula Wula Nga Information and Access Centre,, Lismore, 2000.
26. Miller, P., and Torzillo, P.: Health, an indigenous right: a review of Aboriginal health in Australia. Australian Journal of Medical Science 17: 3-12 (1996).
27. Syme, S. L.: Individual vs. community interventions in public health practice: some thoughts about a new approach. *In* Health Promotion Matters. Victorian Health Promotion Foundation, Melbourne, 1997.
28. Salisbury, C.: A health service and Aboriginal & Torres Strait Islander partnership to develop and plan mental health services. Australian Journal of Primary Health 4: 18-30 (1998).
29. Hecker, R.: Participatory action research as a strategy for empowering Aboriginal health workers. Australian & New Zealand Journal of Public Health 21: 784-788 (1997).
30. Sumner, M.: Substance abuse and Aboriginal domestic violence. Aboriginal and Islander Health Worker Journal 19: 16-17 (1995).
31. Armstrong, K.: Children living with domestic violence. Aboriginal and Islander Health Worker Journal 22: 4-8 (1998).
32. Dalgard, O. S., and Lund, H. L.: Psychosocial risk factors and mortality: a prospective study with special focus on social support, social participation, and locus of control in Norway. Journal of Epidemiology & Community Health 52: 476-481 (1998).
33. Wilson, K., and King, M.: Diabetes research at Nunkuwarrin Yunti: through the eyes of an Aboriginal health worker. Aboriginal and Islander Health Worker Journal 21: 15-19 (1997).
34. Cox, E.: Building social capital. *In* Health Promotion Matters. Victorian Health Promotion Foundation, Melbourne, 1997.
35. Gillies, P.: Social capital and its contribution to public heatlh, vol. http://www.accmed.net/hpi/documenti/fo834_06.htm. Health Promotion and Investment, 1999.
36. Tsey, K.: Aboriginal self-determination, education and health: towards a radical change in attitudes to education. Australian & New Zealand Journal of Public Health 21: 77-83 (1997).
37. Wolford, C., et al.: Bridging student health risks and academic achievement through comprehensive school health programs. Journal of School Health 67: 220-227 (1997).
38. Tookenay, V. F.: Improving the health status of Aboriginal people in Canada: new directions, new responsibilities. Canadian Medical Association Journal 155: 1581-1583 (1996).
39. Public Health Association: Special Interest Group Aboriginal Health: The continuing consequences of colonisation, vol. http.://www.pha.org.au/sigah.htm. PHA, 1999.
40. Hayman, N.: Cardiovascular disease amongst indigenous Australians. Aboriginal and Islander Health Worker Journal 21: 15-17 (1997).
41. Bennett, B.: Domestic Violence. Aboriginal and Islander Health Worker Journal 21: 11-14 (1997).
42. Lucashenko, M., and Best, O.: Women bashing: an urban Aboriginal perspective. Social Alternatives 14: 19-22 (1995).
43. National Clearinghouse on family violence: Family violence in Aboriginal Communities: an Aboriginal perspective. National Clearinghouse on Family Violence - Family Violence Prevention Division - Health Promotion and Programs Branch, Ontario, 1996.
44. Purvis, R.: Beliefs & realities about family violence - The child's experience. Social Alternatives 14: 39-40 (1995).
45. Raphael, B., and Swan, P.: The mental health of Aboriginal and Torres Strait Islander people. International Journal of Mental Health 26: 9-22 (1997).
46. World Health Organization: The Solid Facts: Social Determinants of Health. World Health Organization, Copenhagen, 1998.
47. Turrell, G., et al.: Socioeconomic Determinants of Health: Towards a National Research Program and a Policy and Intervention Agenda. AusInfo, Canberra, 1999.

48. Auerbach, J. A., Krimgold, B. K., and Lefkowitz, B.: Improving Health: It Doesn't Take a Revolution. National Policy Association, Washington, 2000.
49. Campis, L. K., Lyman, R. D., and Prentice-Dunn, S.: The parental locus of control scale: Development and validation. Journal of Clinical Child Psychology 15: 260-267 (1986).
50. Karoly, L. A., et al.: Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions. RAND, Santa Monica, 1998.
51. Bright, J.: Towards prevention: a framework for local action. *In* Turning the tide: crime, community and prevention. Demos, London, 1997.
52. Tesoriero, F., and Chung, D.: Parenting Network Evaluation: Final Report. Univeristy of South Australia, Adelaide, 2000.
53. Parliament of New South Wales Legislative Council Standing Committee on Social Issues: Working for Children: Communities Supporting Families. Inquiry Into Parent Education and Support Programs. Parliament of New South Wales Legislative Council Standing Committee on Social Issues,, Sydney, 1998.
54. Marmot, M., et al.: Social inequalities in health: Next questions and converging evidence. Social Science & Medicine 44: 901-910 (1997).
55. Marmot, M.: Inequality, deprivation and alcohol use. Addiction 92: S13-S20 (1997).
56. Clarke, C., et al.: Enhancing resilience in Indigenous people: The integration of individual, family and community interventions. Aboriginal and Islander Health Worker Journal 23: 6-10 (1999).
57. Sullivan, R.: Fathering and Children - the Contemporary Context. Proceedings of the Family Futures: Issues in Research and Policy. 7th Australian Institute of Family Studies Conference Sydney, 24-26 July 2000. Sydney, 2000.
58. Walker, Y.: Aboriginal family issues. Family Matters 35: 51-53 (1993).
59. Bernard van Leer Foundation: Fathers matter too. Early Childhood Matters 97 (2001).
60. Wenitong, M.: Aboriginal and Torres Strait Islander Men's Health. Proceedings of the 2nd National Indigenous Men's Health Convention. Sydney, 2001.
61. Howard, S.: Fathering Behind Bars. Proceedings of the Focus on Fathering Symposium at 7th AIDS Conference Sydney 24-26 July 2000. Sydney, 2000.
62. Hazlehurst, K. M.: A Healing Place. Indigenous Visions for Personal Empowerment and Community Recovery. Australian Scholarly Publishing, Kew, Victoria, 1994.
63. Jia, T.: Indigenous young fathers' support group. Aboriginal and Islander Health Worker Journal 24: 18-20 (2000).
64. Mercy Family Centre: Report on Hey, Dad! Project. Mercy Family Centre, Hornsby, 1999.
65. Bowes, J.: Parents' response to parent education and support programs. National Child Protection Clearing House Newsletter 8: 12-21 (2000).
66. Linton, B.: The five myths of fatherhood. *In* Fathers' Forum Online, 1999.
67. Instructional Resources Unit - Curriculum & Instruction Branch - Saskatchewan Education: Native Studies 30: Curriculum Guide Saskatchewan Education June 1997. The Evergreen Curriculum - Saskatchewan Education - Government of Saskatchewan, Regina, Sask, 1991.
68. Sherwood, J.: What is community development? Aboriginal and Islander Health Worker Journal 23: 7-8 (1999).
69. Erben, R., Franzkowiak, P., and Wenzel, E.: People empowerment vs social capital: from health promotion to social marketing. Health Promotion Journal of Australia 9: 179-182 (1999).
70. Cawood, C.: Aboriginal WAVES project. Aboriginal and Islander Health Worker Journal 23: 3-4 (1999).
71. Lee, A. J., et al.: Sustainability of a successful health & nutrition program in a remote Aboriginal community. Medical Journal of Australia 162: 632-635 (1995).
72. Griffiths, R., et al.: Health and Equity: A Targeted Literature Review. South Western Sydney Area Health Service, University of Western Sydney, Liverpool, 2001.
73. Podnieks, M.: Mother and Child, Father and Child: Final Report of the Wilcannia Parenting Project. Wilcannia Coordinated Care Trial, Far West Area Health Service, Wilcannia Social and Emotional Wellbeing Team, Wilcannia, 2000.
74. Sharma, M., Petosa, R., and Heaney, C. A.: Evaluation of a brief intervention based on social cognitive theory to develop problem-solving skills among sixth-grade children. Health Education & Behavior 26: 465-477 (1999).
75. Golds, M., King, R., and Meiklejohn, B.: Healthy Aboriginal Communities. Australian & New Zealand Journal of Public Health 21: 386-390 (1997).

76. Information on Aboriginal Health Council was provided by the Aboriginal Health Area Co-ordinator.
77. Aboriginal Health team leaders/seniors and the Aboriginal Health Area Co-ordinator provided the information on the following position: - AHEO, AMHW, ASHW, ASAW, ACPDW, ALO, The Bugalwena Service and THAHOC.
78. Rekindling the Spirit Advisory Group.
79. Malanee Bugilmah Advisory Group.
80. Northern Rivers Area Health Service Health Promotion Unit "*Echidna Project Proforma 2001*".

Appendices

Appendix 1: List of Contacts

Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
Audrey Trindal Aboriginal Day Care Coordinator Tel: (02) 9827-2222 Fx: (02) 9827-2200	Nov. 1999.	Email			
Marilyn Wise National Centre for Health Promotion Department of Public Health and Community Medicine Building A27. University of Sydney, NSW 2006 Ph: 02 9351 5122 Fax: 02 9351 5205	March 2000	Phone		March 2000	To contact a Preschool in the Redfern area of Sydney. I did, but they had no information that would help us.
Uncle Roy Cordon Chairperson for the Bundjalung Elders Council 29 Campbell Cres Goonellabah NSW 2480	A number of times		Sharon Monagh am		He is supportive and accessible for advice.
Sandy Angus Department Qld Health Government Also a consultant for the National Health and Medical Research Council (NHMRC) Ph: 07 3234 1017	A number of times	Email		A number of times	Richard King's contact number Aboriginal Health Promotion Officer in Northern Territory Department of Health & Community Services.
Ian Raymond Aboriginal Liaison Officer Health Promotion Unit 73 Miller Street North Sydney Locked Mail Bag 961 North Sydney NSW 2059 Ph: 02 9391 9581	A number of times	Phone Email.		A number of times	Direction for Aboriginal Health Promotion
Warwick Fisher College of Indigenous Australian Peoples H Block Southern Cross University Lismore NSW Ph 02 6620 3169	Sept 1999 Feb 2000	Phone In Person		Sept 1999 Feb 2000	Information on Indigenous (books and Readings to read) people self-determination.

Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
Bill Bellew Health Promotion Co-ordinator Physical Activity 73 Miller Street North Sydney Locked Mail Bag 961 North Sydney NSW 2059 Ph: 02 9391 9581	17.03.2000	Email		17.03.2000	Send a copy of the Direction for Aboriginal Health Promotion
Richard King Aboriginal Health Promotion Officer Northern Territory Department of Health and Community Services Ph: 08 8987 0431	15.03.2000	Phone		17.03.2000	To Contact Sue Resburn Aboriginal Education Unit, Education Department NT
Sue Resburn Aboriginal Education Unit Education Department NT Ph 08 8999 5832	17.03.2000 22.03.2000	Phone Email	Richard King	April 2000	Barbara Paterson is on overseas extended leave presently. We are not sure when she will be returning at this stage. I have forwarded your request onto Brad Palmer - Coordinator of the Community Child Health Program here in Darwin. They sent some Pamphlets. (of no use)
Rossi Lyons Families First Far North Coast Project Leader Ph: 02 6620 1673	A number of times	Phone Email In Person		A number of times	Contact Children's Services Advisers from DoCS in Ballina. Also sent information on Families First
Jenny Knight Hunter Centre for Health Advancement Wallsend Health Service NSW Ph: 02 4924 6367	13.04.2000	Phone	Sallie Newell	13.04.2000	Information regarding Health Promotion in Schools in the Hunter Region
Roy Cameron	22.03.2000	Email	Article	22.03.2000	I am forwarding your request to Beth Kawash (her name is on the article). Beth was closer to the implementation process than I was, and I think that she may be in a better position to comment than I am.
Beth Pateman	22.03.2000	Email	Article	23.03.2000	No response from Beth Kawash to date, http://www.cdc.gov/nccdphp/dash/shpps/index.htm
Neil Pearce	23.03.2000	Email	Mihi Ratima	25.03.2000	Sent you a book on implementation process.

Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
Nyanda McBride	22.03.2000	Email	Article	24.03.2000	There are quite a few articles about the WASH Project implementation and I will send you these in the mail. This information received.
Mihi Ratima	22.03.2000	Email	Article	23.03.2000	There is a book we have produced on the implementation process for the project - I wasn't actually involved in the implementation but the last section of the book includes the follow up on which the article is based. Ask Neil Pearce for this book.
Doug Morgan	22.03.2000	Email	Article	23.03.2000	Unable to help
The South and Meso American Indian The South and Meso American Indian Information Center (SAIIC)	10.02.2000	Email	Article	24.02.2000	We are short in personnel; I don't think we can help you at this time; but if we can will be happy to help you. Keep in touch.
James Bradbury Childrens Services Advisers from DoCS. Nell Pickett at Ballina on 66861911	24.03.2000	Phone	Rossi Lyons	31.03.2000	Sent a list of Aboriginal Preschools in the Northern Rivers Area.
Dr. Laura Kann	05.05.2000	Email	Beth Pateman	11.05.2000	Will send a copy of the SHPPS report in the mail.
Dehran Swart National Health Promotion R & D Office Medical Research Council. South Africa.	24.03.2000	Email	Article	18.04.2000	Will send you any documentation that I can find.
Manoj Sharma, MBBS, Ph.D. Assistant Professor, Health Behaviour and Health Promotion School of HPER University of Nebraska at Omaha	24.03.2000	Email	Article	25.03.2000	The first requisite for implementation of such an intervention is to have support from the schools. Then you need to identify which grade levels deserve priority behaviourally and developmentally for your setting. Then you need to pick up a behaviourally robust theory and adapt it to your specific needs. Then develop the intervention, pilot test it and test its efficacy in rather optimal conditions. Finally, you can replicate it in multiple settings through teachers or health educators and test its effectiveness.
Pat Ross	18.04.2000	Email	Web-site	21.04.2000	burnia.dmz.health.nsw.gov.au http://www.patnc.org/page7.htm Parents as Teachers program.
Mavis Golds Aboriginal Health Area Co-ordinator 3rd floor Crawford House Lismore NSW	Number of times.	Phone In Person		A number of times	Supportive and available for consultation

Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
Leonie Jefferson Senior Aboriginal Health Education Officer Community Health Centre Maclean NSW 2463	Number of times.	Phone In person.		A number of times	Information about the communities in Grafton area.
Bundjalung Elders Council	3rd Feb 2000	In Person			Supportive and available for consultation
Dana Williams Aboriginal Health Education Officer/Child	Number of times.	In Person Phone		A number of times	Information about the community in Tweed Heads and the Aboriginal Play-Group about to start.
Marianna Sergki Director, Executive Policy Unit Office of Aboriginal & Torres Strait Islander Health GPO Box 9848 Canberra. Commonwealth Department of Health and Aged Care.	October 1999.	Phone		November 1999	Sent Information on Aboriginal Health
Gail Cordwell New South Wales Department of Aboriginal Affairs	November 1999	Phone		November 1999	Sent information in regards to Aboriginal Health
Sue Reynolds Community Health Murwillumbah and Tweed Heads 6672 0277	March 2000	Phone		March 2000	Information about the Early Defection (ED) Screening.
Rob Monagham Bulgarr Ngaru Aboriginal Medical Service Grafton NSW	Nov 1999 Feb 2000 April 2000	In Persons		Nov 1999 Feb 2000 April 2000	Information about the community in Grafton.
Carl Daley Aboriginal Health Education Officer Grafton Community Health NSW	Number of times.	Phone In person.		Number of times.	Information about the community in Grafton.
Ngulingal Land Council Lismore	Number of times.	In person and Phone		Number of times.	Supportive and available for consultations.
Tim Augus Aboriginal Health Director NSW Health Department	Feb 2000	In Person			Information about Family Health.
Brian Moynihan Manager of Lismore DoCS Office	May 2000	Phone In Person		May 2000	Families First is a State funded program: - DoCS Community, Health-Early Child Nurses, Housing-, Aging Disability Department.
Deb Faulkner Intensive Family Base Service Casino NSW	May 2000	Phone In Person		May 2000	Gorri Preschool in Casino - Byinbin (Louise Smith) Tabulam Family project Person has been employed.

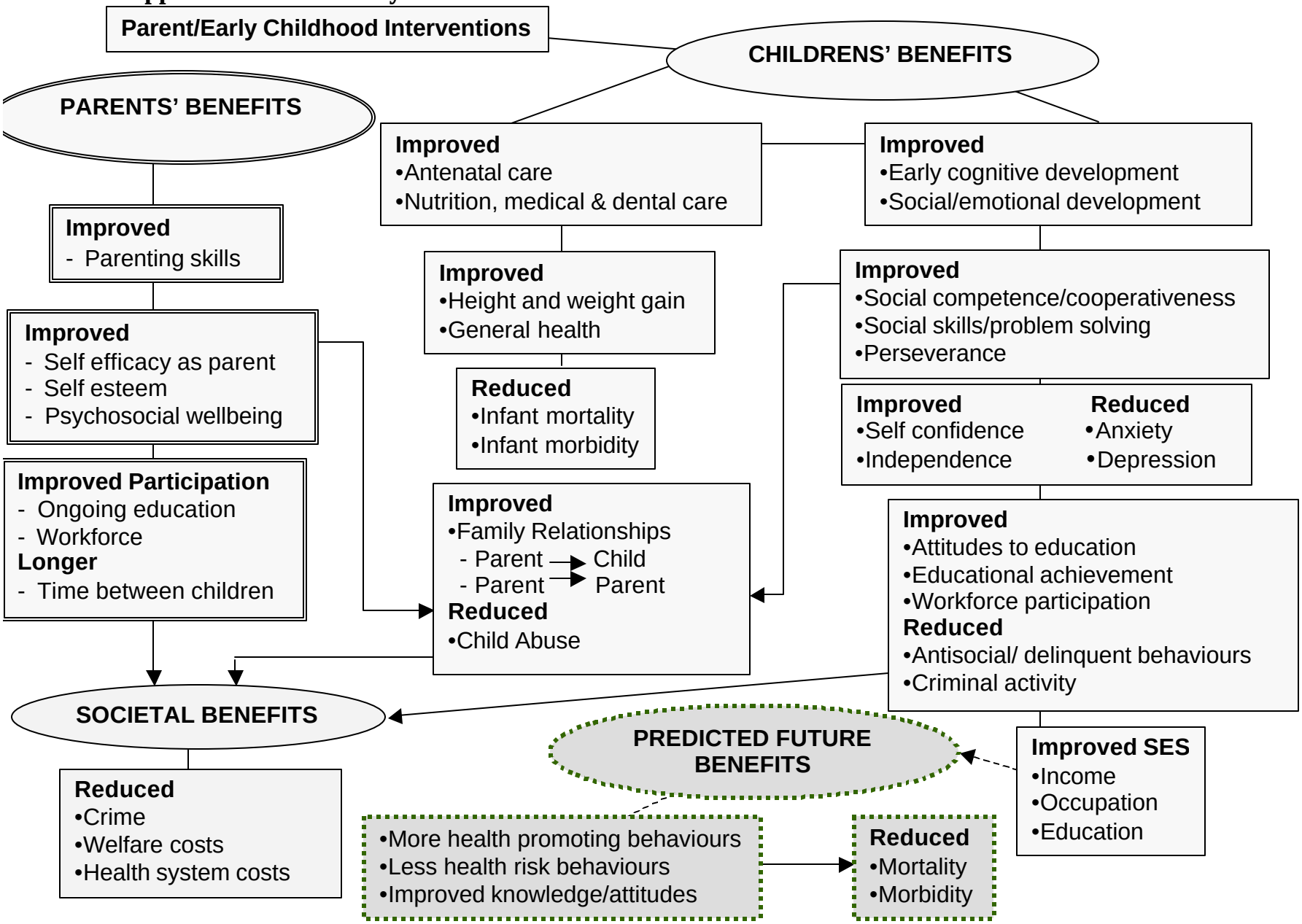
Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
Siandra Webb Gummyaney Aboriginal Preschool Grafton TAFE NSW	17.05.2000	Phone		17.05.2000	Information about Gummyaney Aboriginal Preschool.
Sharon Foran Acting Director Jarjum Preschool Lismore NSW	16.05.2000 17.05.2000	Phone In Person		17.05.2000	Information about Jarjum Preschool
Cheryl Patch Acting Coordinator Casino Aboriginal Preschool	18.05.2000	Phone		18.05.2000	Information about Casino Aboriginal Preschool.
Patricia Randall Yamba Aboriginal Preschool	18.05.2000	Phone		18.05.2000	Information about Yamba Aboriginal Preschool.
Rick Cook and Narelle Parkes Goonellabah Public School	03.10.2000	In person		03.10.2000	Provided information regarding the Transition Program run by Goonellabah Public School for Koori Kids.
Dana Lavelle, Aboriginal Parenting Educator, Child and Family Health, Goonellabah.	25.10.2000 01.11.2000	Phone & in person		01.11.2000	Seeking information about parenting programs. Advised me to contact Helen Binks.
Helen Binks Child and Family Health, Goonellabah.	01.11.2000 17.01.2001	Email Phone In person		17.01.2001	Provided information on a Parenting Program (4 week program) facilitator by herself.
Dana Williams and Warren Jones	07.11.2000	In person		07.11.2000	Parents As Teacher a program facilitator by them at the South Tweed Primary School.
Margie Young Northern Rivers Area Health Services Area Manager for Women's Health	13.11.2000	In person & email		13.11.2000	To contact Kerith Power. M.Ed (Hons) Lecturer in Early Childhood Education School of Education Studies University of New England, NSW 2351. phone (local): 02 6773 2379; email kpower@metz.une.edu.au official departmental web page http://fehps.une.edu.au/f/s/edu/kPower/h.html
Kerith Power. M.Ed (Hons) Lecturer in Early Childhood Education School of Education Studies University of New England, NSW 2351.	06.12.2000	Email		19.12.2000	Dept of health to buy a copy from Batchelor Institute of their book 'Talking early Childhood' full of Aboriginal people's ideas about appropriate ec programs for Aboriginal children and has great pictures.

Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
John Vallely Principle of the Goonellabah Primary school 6624 1444	03.10.2000	Phone		03.10.2000	Paul Johnson Program coordinator 6624 7269. Koori Transition Program facilitated by Ricky Cook each Tuesday and Friday; no health (early childhood nurse) involvement (there used to be). Natalie Lennon facilitator of Transition Program, only Thursday.
Stephen Gibson 6881 2266 040 869 0027 Aboriginal Health Coordinator for the Macquarie Health Services	29.09.2000 03.10.2000 24.10.2000	Phone		24.10.2000	To contact the following Aboriginal Health Workers in the Macquarie Area Health:- ☼ Cheryl (Gilgandra) 6842 6446 ☼ Janne Arrowsmith 6822 1133 ☼ Deb Beehan 6889 1377 ☼ Jane Rabendge 6885 8914
Ann Meagher 6625 0500 Community Services Manager for the Lismore City Council.	03.10.2000	Phone		03.10.2000	Three- (3) childcare centres they have some involvement with. 1. Gingerbread House Occasional Care Centre, operates for children who need care from 1 hour to a whole day, using Preschool program. 2. Koala Childcare Centre, long day care, this is for parents who are working or studying. 3. Lismore Public School (Pound St), An after school program with supervision for children whose Parents are working. Games are the main component of the program, but there is a quiet corner for those children who need to do their homework. Ann also informed me of the instatement of Annett Olive 6625 0432 the new Aboriginal Community Development Officer for LCC.
Debbie Faulkner Coordinator of IFBS Casino 6662 5799	05.10.2000	Met		05.10.2000	Evaluation of Families First Aboriginal projects for the Far North Coast of NSW.
Christine Williams Youth Officer for the Department of Education Training and Youth Affairs Lismore 6626 4348	05.10.2000	Phone		05.10.2000	To contact Rhonda Amatta, Indigenous Education Strategic Initiatives Program (IESIP) 02 9298 7474 Re any information on Transition Program for Aboriginal Children in the Northern Rivers Area.
Jacquie Bealy Department of Education Training and Youth Affairs Sydney 02 9298 7474	05.10.2000	Phone		05.10.2000	Knew nothing about Transition Programs but will ask Rhonda Amatta to return my call.

Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
Rhonda Amatto DETYA Indigenous Education Strategic Initiatives Program (IESIP) 02 9298 7474	06.10.2000 10.10.2000	Phone		10.10.2000	1. Left a message on her answering machine. 2. No connection with any transition program. 3. Sent a list of funded preschools in the Lismore Indigenous Education Unit Area.
Andrew Taylor Acting Aboriginal Community Liaison Officer Department of Education & Training Lismore office 6624 0419	05.10.2000	Phone		05.10.2000	Does not know of any Koori Transition Programs but will find out and return my call.
Doreen Flanders Catholic Education Lismore Office 6622 0422	05.10.2000	Phone		05.10.2000	They have no Transition Programs within the Northern Rivers Area, but provides support to those kids who need some assistance.
Kimberlii Barker 6683 2073 Coraki 6621 6421 Lismore	Number of times.	Phone In person		Number of times.	Matters regarding the Box Ridge/Coraki Transition Program.
Ricky Cook AEA Narelle Parkes Goonellabah Primary school 6624 1444	06.10.2000	Phone		06.10.2000	Arrange to meet with Ricky to find out further information on the Koori Transition Program.
Byron Bay Shire Council 6626 7000 Jane	06.10.2000	Phone		06.10.2000	To contact Fasia the Coordinator of the Sandhills Childcare Centre (a long day care centre 0-5 yrs) 6685 8118. The only one Byron Shire has any involvement with.
Fasia the Coordinator of the Sandhills Childcare Centre 6685 8118 in the Byron Bay Shire Council	06.10.2000	Phone		06.10.2000	To contact Ronda Whealan (Motor Skills) and Evelyn Loucis (Social Skills) Byron Bay Community Health 6685 6254 or 6684 1677.
Casino / Richmond River Shire Council 6662 2622	06.10.2000	Phone		06.10.2000	No Childcare Centre under their control.
Grafton City Council 6643 0214	06.10.2000	Phone		06.10.2000	No Childcare Centre under their control.
Jeff Edward Tweed Heads Council 6672 0400	10.10.2000	Phone		10.10.2000	No Childcare Centre under their control
Katharine Ballina Council 6686 4444	10.10.2000	Phone		10.10.2000	No Childcare Centre under their control
Linda Copmanhurst Council 6642 2855	10.10.2000	Phone		10.10.2000	No Childcare Centre under their control
John Kyogle Council 6632 1611	10.10.2000	Phone		10.10.2000	No Childcare Centre under their control
Tracy Ashley Maclean Council 6645 2266	10.10.2000	Phone		10.10.2000	Before and After School Program conducted in a Primary School in Yamba and Maclean. No Childcare Centre under their control
Phillip Roses Prestige Waters Council 6644 5303	10.10.2000	Phone		10.10.2000	No Childcare Centre under their control

Name - Details	Date of Contact	Contact Method	Refer By	Reply Received	Suggested and Information Provided
Ronda Whealan (Motor Skills) Byron Bay & Murwillumbah Community Health 6685 6254	10.10.2000	Phone		10.10.2000	Will send some information.
Rosemary Laurie Program's Coordinator Grafton AMS 6643 2199	10.10.2000	Phone		10.10.2000	They have a Basic Hearing-Screening Program for children.
Dana Williams 07 5536 0770 Aboriginal Health Education Officer/Child Health. Tweed Heads	23.10.2000 Number of times.	Phone		23.10.2000 Number of times.	Arranged to meet @ South Tweed Heads Primary School Tuesday 7 November 00, Danna, Warren, Donna and myself.
Dana Lavelle 6625 0111 Aboriginal Parenting Educator.	Number of times.	Phone In person		Number of times.	A four-week parenting program conducted by Child & Family Health. Dana & Laurel will be assisting with this program, also leaning the content of the program so they well be able the conduct the programs without any assistance. Danna will pass on information at the end of the four-weeks.
Cheryl (Gilgandra) 6842 6446 Aboriginal Health Worker in the Macquarie Area Health Service.	24.10.2000	Phone			Left a message for Cheryl to call me or send any information she may have on Parenting Program.
Janne Arrowsmith 6822 1133 Aboriginal Health Worker in the Macquarie Area Health Service.	24.10.2000	Phone			Left a message for Janne to call me or send any information she may have on Parenting Program.
Deb Beehan 6889 1377 Aboriginal Health Worker in the Macquarie Area Health Service.	24.10.2000	Phone			Left a message for Deb to call me or send any information she may have on Parenting Program.
Jane Rabendge 6885 8914 Aboriginal Health Worker in the Macquarie Area Health Service.	24.10.2000	Phone			Left a message for Jane to call me or send any information she may have on Parenting Program.
Dianne Harrington 6626 4300 Indigenous Education Unit	24.10.2000	Phone			Left a message for Dianne to call me or send any information she may have on Parenting Program.
Julie Cooper-Mulligan 02 6885 8923 Manager Child Family Health Services Dubbo.	24.10.2000	Phone			Left a message for Julie to call me or send any information she may have on Parenting Program.
Dennis McDermott Senior Research Associate Uni Western Sydney	Number of times.	Phone In person Email		Number of times.	Men's Health and Parenting Program for Aboriginal Men.

Appendix 2: Parent/Early Childhood Interventions



Appendix 3: Parenting & Early Childhood Programs

Aboriginal Parenting & Early Childhood Programs outside the NRAHS

Project Name	Brief Description	Target Group	When Happened	Where Happened	Contact Person/Details	Evaluation
Aboriginal Programs within the NRA Western Cluster						
Aboriginal Parenting Program	Improve self esteem Improve parenting skills Improve relationships	Parents	2000 and ongoing	Lismore	Danna Lavelle 6625 0111	
Aboriginal Transition Program	Operates Monday and Tuesday only Early Childhood Support Service Speech Specialist Sitting and listening program Intensive Family Service Program (IFSP)	Children 4-5 years	1997 and ongoing	Box Ridge Coraki	Kimberlii Baker Ph 6683 2073	
Aboriginal Cooking Program	Cooking Program	Young Mothers		Box Ridge Coraki	Gloria Torrens 6683 2840	
Parenting Play Group		Mothers and Children	1998 and ongoing	Box Ridge Coraki	Kimberlii Baker Ph 6683 2073	
Jarjum Preschool	Early Childhood Support Behavioral Management Culture issues	Children 3 – 5 years	Early 80's and ongoing	Lismore	Sharon Foran acting director 6621 9203	
Jumbunna	Early intervention	Children 3 – 5 years		Casino	Robin Townsend 6662 2866	
Jarjum Playgroup		Mothers and Children		Tabulum		

Project Name	Brief Description	Target Group	When Happened	Where Happened	Contact Person/Details	Evaluation
Aboriginal Antenatal	Aboriginal antenatal programs links in with AMS/Hospital/shared care GP	Aboriginal women		Casino	Dharah Gibinj AMS Casino 6662 3514	
Malanee Bugilmah is an Aboriginal Intensive Family Based Service (IFBS)	provides intensive support and therapeutic assistance to families provide support in the reunification of the child to the family to protect Aboriginal children from abuse; to prevent breakdown in ATSI families; to empower parents to create a safe environment for their children; to reduce the probability of re-notification of child abuse and neglect	Families	1990's and ongoing	Casino	Debbie Faukner PO Box 1005 Casino 6662 5799	
Preschool	Early Childhood Support Behavioral Management Culture issues	Children 3 – 5 years		Casino	Wendy King 6662 1113	
Aboriginal Get Ready Pre-school program	Talking and Listening Reading Social Development	Children 4-5 years		Goonellabah	Narelle Parkes Goonellabah Public School 6624 1444	
Non-Aboriginal within the NRA Western Cluster						
Family Support Services	Improve self esteem Improve parenting skills Reduce family violence Improve family relationships	Family	Ongoing	Lismore Byron Bay Ballina	Lismore office 6621 2489 ifss@nor.com.au Ballina Gail 6686 4109	
Parenting Program	Improve self esteem Improve parenting skills Improve relationships	Parents	2000 and ongoing	Lismore	Helen Binks 6625 0111	
New Mothers	New mothers Group	New Mothers		Kyogle		
Parenting Groups	Weekly parenting groups by ECNs	Parents				

Project Name	Brief Description	Target Group	When Happened	Where Happened	Contact Person/Details	Evaluation
Counseling	C&FH counsellors conduct a 4 week parenting programs	Parents				
Parenting after DV	4 week course	Parents		Goonellabah		
Aboriginal Programs within the NRA Southern Cluster						
Yamba Aboriginal Preschool	Early Childhood Support Behavioral Management Culture issues	Children 3 – 5 years	2000 and ongoing depending on funding.	Yamba	Patricia Randall 6646 2800	
Yamba Aboriginal Playgroup		Children 0 – 2 years	Yet to be implemented	Pippi Beach /Crystal Waters /Yamba	Families First	
Gummyaney Aboriginal Preschool	Literacy and Numeracy programs Early Childhood Support Bundjalung language	Children 3 – 5 years	Early 1990's and ongoing	Grafton TAFE	Sandra Webb or Blanche Biles 6641 4623	
Non-Aboriginal within the NRA Southern Cluster						
Bonding and attachment	Bonding and attachment project Support	Mothers		Grafton		
Home visiting	Home visiting	Mothers		Clarence		
Playgroup	Support playgroup	Mother and young children		Grafton		

Project Name	Brief Description	Target Group	When Happened	Where Happened	Contact Person/Details	Evaluation
Aboriginal Programs within the NRA Eastern Cluster						
Aboriginal Preschool	Individual's Learning program Transition Program Early Childhood Support Health Program Jarjum Early Literacy Program	Children 3 – 5 years	Early 1990's and ongoing	Cabbage Tree Island	Jenny Frost or Glen Cook 6683 4251	
Aboriginal Support group	Aboriginal Mental Health Support group for Mothers	Aboriginal Mothers				
Aboriginal Family	Aboriginal Family Support	Aboriginal Families			Families First	
Aboriginal Childhood Support	Early Childhood support Literacy program	Early Childhood			Families First and Department of Education	
Non-Aboriginal within the NRA Eastern Cluster						
Non-Aboriginal	support for at risk families with infants and young children - embedding appropriate interventions for high risk families with general community based and universally offered parenting programs (Funded AMH)	Parents				
Non-Aboriginal	First time mothers group	Mothers				
Non-Aboriginal	Parenting Resource Centre		2000	Ocean Shores		
Non-Aboriginal	Evaluation and preparation for parenthood classes to include risk ID					
Family Support Services	Improve self esteem Improve parenting skills Reduce family violence Improve family relationships	Family	Ongoing	Lismore Byron Bay Ballina	Lismore office 6621 2489 ifss@nor.com.au Ballina Gail 6686 4109	

Project Name	Brief Description	Target Group	When Happened	Where Happened	Contact Person/Details	Evaluation
Aboriginal Programs within the NRA Northern Cluster						
Aboriginal Play & Support Group	Transition Early childhood Interaction – Parents & Child	Families	2000 and ongoing	South Tweed Heads Primary School	Dana Williams 07 5536 0777	
Parents As Teachers (PAT)	Early learning program for parents with children age 0-3yrs Home visits Group meetings	Families		Tweed Heads South	Dana Williams 07 5536 0777 Warren Jones 07 5523 2648	
Aboriginal Parenting Group	Address needs of Parents	Families			Bugalwena Service Sue Follent 07 5536 0767	
Goori Fathers		Fathers			Bugalwena Service Sue Follent 07 5536 0767	
Family Support	Supporting families	Families	1997 and ongoing		Bugalwena Service Sue Follent 07 5536 0767	
Non-Aboriginal within the NRA Northern Cluster						
Home Visiting	Volunteer home visiting	Families				
Parents As Teachers (PAT)	Early learning program for parents with children age 0-3yrs Home visits Group meetings	Families		Tweed Heads South	Warren Jones 07 5523 2648	
Aboriginal and Non-Aboriginal Programs NOT within the NRA						
Family WellBeing Course	Empowerment program Parenting and relationships skills	Aboriginal Families	March 1998 and April 1999	Alice Springs	Komla Tsey and Anne Every Menzies School of Health Research, Alice Springs	Yes

Project Name	Brief Description	Target Group	When Happened	Where Happened	Contact Person/Details	Evaluation
RAP - P Indigenous Parenting Program RAP - A for adolescents	Parents are people Families are important Culture and community	Parents and Adolescents	Ongoing	Australia	Colleen Clarke Adelaide 08 8373 7522 Griffith University	Incomplete
Good Beginnings National Home Visiting and Parenting Program	Build self-confidence in parents to enable them to raise healthier, happier children Good nutrition in emphasized	Parents	1996 and Ongoing	Lewisham NSW & Katherine NT	Barbara Wellesley National Director Surry Hills NSW 02 9211 6767 goodbegn@magna.co	
Aboriginal Adolescent Family Development Program	Complex community based program for parents of newborn babies Promotes an interdisciplinary and interagency approach	Adolescent Aboriginal Parents		Wollongong University	Natascha McNamara 02 4221 4242 Margaret Valadian 02 4221 4243	In progress
Best Start	Improve the wellbeing of Aboriginal Children from 0-5 yrs Better prepare them for preschool & K1	0-5 years	Ongoing	Piloted in 16 centres W A	Ron Villaflor 08 9350 7220	Tools currently being developed
Home Start	New parenting support service	Young Parents	Mid 2000 and Ongoing	Coffs Harbour	Dinah Eades	
Bibbulung Gnarneep	Longitudinal survey of infant care practices in Aboriginal communities Aims to identify factors associated with good health	Aboriginal mothers of newborn babies	1995 – 1998	WA	SJ Eades TVW telethon institute for child health 08 9489 7777	
Ngunytju Tjitji Pirni	Service of enhanced care for Aboriginal mothers and infants Has become fully community controlled Government funded Awarded PHA community award in 1997	Aboriginal mothers and children	Unclear	WA Eastern Gold-fields	EM Edwards TVW Telethon institute for child health 08 9489 7777	
Identifying HP Opportunities	Longer term flu surveys of longitudinal infant cohort study –2, 3 & 4 yrs old Aims to identify potentially modifiable factors for future HP activities for kids/parents → strategic planing	Parents of children born in WA, 1995 -1997	1995 -2001	WA	SR Zubrick Telethon institute for child health 08 9489 7777	