The Australian paradox of Aboriginal Health

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Summary

Acknowledgements 4

Introduction 5

Terminology 6

Part 1: The context 7

The Australian Model

Political System 7

Health System 9

Being an Aboriginal in the Australian Society

Historical Elements 10

Impact on the Current Aboriginal Society 16

Key Elements about Aboriginal Health

Demography 17

Physical Well-Being 20

Mental Well-Being 30

Social Well-Being 32

The "Alcohol Problem" Clarification 34

Part 2: Barriers & Solutions 37

The Beginning of a Change

A Multiple-Scale Solution

The Closing the Gap Initiative 39

The Aboriginal Health & Medical Research Council 40

Aboriginal Community Controlled Health Services 42

Some Concrete Interventions

Socio-Economic Issues 45
Appropriate Medical Caring 46
Changing Behaviours 54
Break The Cycle 61

Part 3: Feedback 68

How to Improve the System ?

Doing Better with the Same 68
The Resources Issue 71
Quality Improvement Processes 72

How to Solve the Problem ?

Closing the Gap ... ? 73
A Society Problem 74

Conclusion 77
Activities 79
About the artwork 81
Bibliography 82

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We acknowledge the traditional custodians of the different lands we have visited during our placement and would like to pay our respect to their Elders past, present and future and more broadly to all the Aboriginal nations of this beautiful country. We also wish to advise people of Aboriginal descent that this document may contain images of persons now deceased.

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In particular, we would like to thank two individuals for their important contribution. First, **Sarah Cumberland** (WHO, *Communications Officer*), an incredible human being who joined this adventure on 12th November 2012 and never lost hope even though we were plagued by doubts and questions, back in Geneva. She was always available and of great assistance. Secondly, **James Porter** (AH&MRC, *Workforce Initiatives Project Officer*) who reached out to us from Sydney on 11th December 2012. He organised a big majority of our activities onsite and was involved in most aspect of this project.

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Flag at half mast at the protest gathering area installed in front of the Old Parliament House (Canberra)

Introduction

In the context of our Bachelor's thesis, the Faculty of Medicine of the University of Geneva asked us to conduct a project in public health in order to study the concept of "community medicine". Although not compulsory, it was possible for us to carry out this placement abroad and we both thought it would be interesting to come to Australia. The idea came from the two previous travels of one of the co-authors, in 2005 and 2009, that made him aware of the problem of health access due to the huge distances in this country. Indeed, part of the population lives hundreds of kilometres away from any medical structure, and in case of an emergency, flying doctors have to come to rescue by plane.

However, when doing some research, we soon realised that another community far more important, but much more discrete, suffered as well from barriers to health access, ones that were actually much more subtle. We probably could have tried to find a placement in Northern Territory because it is the region of Australia that is known for having the most Aboriginal health issues, but we decided to go to New South Wales (NSW) instead. The difference is significant and has to be considered all through the report. NSW being indeed a "model pupil" when it comes to those matters. This implies that any generalisation should be considered with great care.

Mosaic inspired by an Aboriginal painting at the entrance of the Parliament House (Canberra)

The first thing we would like to acknowledge is the fact that we arrived in Australia with preconceptions that everyone we met during our six weeks placement helped us tackle. The first, and probably most important one, is that there is no such thing as "Aboriginals". Traditionally there were indeed at least (historians and anthropologists are currently still debating on this) more than 250 Aboriginal nations. As we are going to explain, we arrived with the same conviction as the British did, when invading Australia 243 years ago. Imagining that all these people share the same language, culture and traditions, over the almost 7'700'000 km^2 of this country (just to give you an idea, it equals 185 times the size of Switzerland) was very naïve of us. It must be understood that the term "Aboriginal" is a creation of the successive Australian governments and defines, according to their criteria, a person that has Aboriginal ancestors, identifies as being an Aboriginal and is recognised by his community.

We would also like to emphasise that this report contains facts supported by data from literature, but also points of view expressed by some of the people we met as well as our own opinions. We did our best to clearly distinguish the different types of information and would like to point out that our conclusions are not coming from a randomised or systematic study, but from a general and subjective impression.

If you want to discuss or comment on our work, you are most welcome to do so and can contact us by email: Adrien.Duran@etu.unige.ch and Laura.Meijers@etu.unige.ch.

Terminology

The term "Aboriginal(s)" will be used throughout this report in preference to "Aboriginal(s) and Torres Strait Islander(s)" because we focused on the Aboriginal health issues in New South Wales whose original inhabitants and traditional custodians are the Aboriginal peoples. When considering more broadly the situation at the national level, despite not mentioning the Torres Strait Islander peoples we do acknowledge them as well.

We also decided to rather use the term "Aboriginal(s)" instead of "indigenous". The latter is indeed a broader term, which could define «*any person originating or characterising a particular region or country*»[1] and therefore could have caused ambiguities, especially since Australia has an important immigrant population.

There are two key concepts that will guide this report:

- **Community Control**, which is the process that allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures that are determined by the Community.
- **Holistic Approach** [2], which is an all inclusive, integrated health care that addresses all aspects arising from social, emotional and physical factors. Besides providing medical care, it also includes services as environmental health, pharmaceuticals, counselling, preventive medicine, health education and promotion, rehabilitative services, antenatal and postnatal care, maternal and child care, programs and necessary support services to address the effects of socio-somatic illness.

We chose to use the term "patient" above "client" because of the business connotation potentially associated with the latter, especially in french.

"Public health", as defined by C.E.A Winslow in 1920, is the «*science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort»*. Whereas "population health" is the body of scientific disciplines interested in the study of the distribution and determinants of health and disease states in the population.[3]

Australia is part of the Commonwealth of nations, being a former territory of the British Empire. When we use the term "Commonwealth", we are referring to the Commonwealth of Australia and all its associated federal institutions.

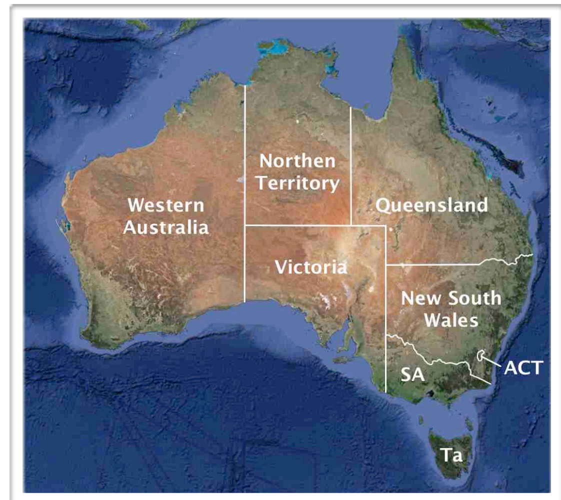
Abbreviations used throughout the report

NACCHO: National Aboriginal Community Controlled Health Organisation
AH&MRC: Aboriginal Health & Medical Research Council
ACCHS(s): Aboriginal Community Controlled Health Service(s)
AMS(s): Aboriginal Medical Service(s)

Finally, the "*Closing the Gap* initiative" will refer to the "National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes"

Part 1: The context

To understand in-depth the stakes that come with Aboriginal health issues, the problematic must be placed in a wider spatial and temporal frame. We will start by giving you a few indispensable elements to understand the political and medical systems in Australia, as well as the socio-historical context in which they take place. Then, we will give you our review of the available literature that is essential to understand to what extent Aboriginal health is concerning.



Different states and territories of Australia

I. The Australian Model

Like Switzerland, Australia is a federation composed of six states and two territories. In the following section, we will discuss Australia's general organisation and will focus on the political system as well as on the health system.

A. Political System

✦ Parliamentary Democracy

Australia is a federal constitutional parliamentary democracy as well as a constitutional monarchy. There is a parliament at the federal level as well as a parliament for each state and territory.

House of representatives of the Federal Parliament

Every parliament is composed of two chambers:
- the **house of representatives**, whose members are directly elected by the citizens through instant-runoff voting
- the **senate**, is constituted of representatives of the different states and territories, who are chosen by their respective inhabitants

As in the Anglo-Saxon model, there are two main parties:
- the reformative **labor party** (formally, *Australian Labor Party*)
- the conservative **liberal party** (formally, *Coalition of the Liberal & National Party*)

Currently the *labor party* governs Australia, this has been the case since the last federal elections in 2007. But with the upcoming elections in September 2013, this might change, the labour party having been quite unstable over the past years. Kevin Rudd was indeed Prime Minister from 2007 to 2010. With the growing dissatisfaction in his leadership, he was forced to resign and was succeeded by **Julia Gillard**. After a leadership spill in June 2013, she was forced to leave and **Kevin Rudd** became Prime Minister again. Six parliamentarians[4] announced their resignation from the cabinet that day, showing their discontentment. Concerning the Aboriginal issues, the labor party seems more prone to undertake reforms to improve their situation and is responsible for the official apology towards the Stolen Generations and their families.

Parliament House, Canberra

✦ Constitution

In 1901, the six former colonies who used to be independent formed a federal state with a constitution. The Australian constitution does not contain a “bill of rights”, in other words a listing of the rights guaranteed to every citizen. This is sometimes criticised for the potential risks arising from this insufficient legal protection of the fundamental rights and freedoms of the Australian individuals.

The only four rights & freedoms mentioned in the constitution are the following:

- Right to just compensation [section 51xxxi]
- Right to trial by jury [section 80]
- Right against discrimination on the basis of out-of-state residence [section 117]
- Freedom of religion [section 116]

For the constitution to change, amendments have to be proposed and approved by the two chambers of Parliament. The Australian Federal Parliament cannot change the constitution by itself; the Australian citizens have to approve it. A referendum is then proposed, and to pass there has to be: a majority of ‘yes’ at a national level, as well as a majority of states having a majority of ‘yes’ votes. Therefore, it appears to be quite complicated to change the constitution.

✦ Power Structure

The power structure between the federal state and the states is quite complex and polemic. Concerning our fields of interest (i.e. health, education and Aboriginal policies), they are all taken care of by both the Commonwealth and the states. This can lead to some issues concerning laws, funding and responsibility. According to [section 109] of the constitution, the federal law systematically prevails on a state law if there is an inconsistency. This is usually called the “federal supremacy rule”.

B. Health System

✦ Available Services

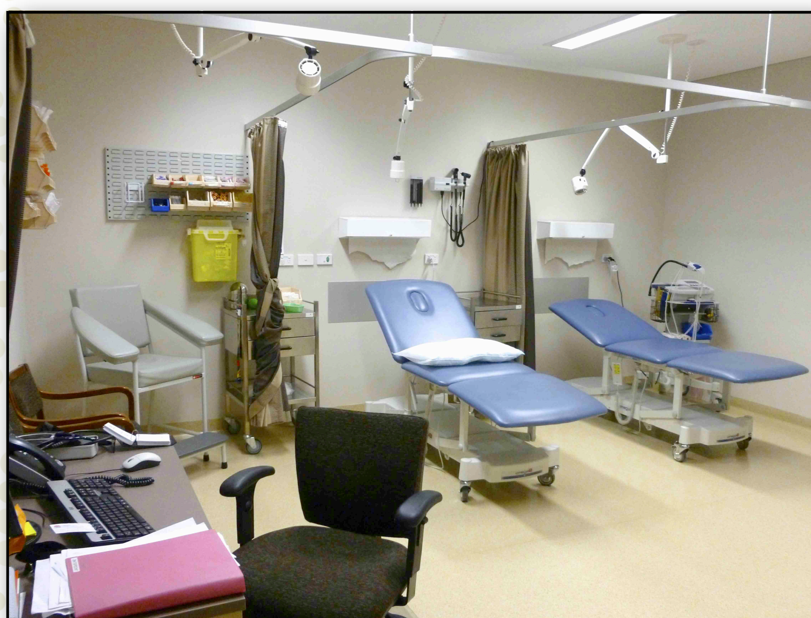
A health system is composed of four actors: the users, the providers, the insurance companies and the state. Among the providers there are different medical structures. Apart from the AMS network, we define the "mainstream" as being the traditional occidental health field. It includes every clinic, hospital (private or public), general practitioner and specialist practice as far as the Medicare locals or organisations run by religious groups that can provide health (e.g. Anglicare).

✦ Funding

The public health sector, which includes the AMSs, is partly financed by Medicare Australia, a government structure funded by State taxes. Medicare Australia is quite similar to the *TARMED Suisse* system we use in Geneva and has a pricing system that depends on the service provided. Nevertheless, most GPs charge an extra payment of $30-60 and thus do not practice what we call “bulk billing”.

On the other hand, when a patient goes to an AMS, he does not have to pay anything at all: he just needs to show his Medicare card. The AMS will declare the care provided to its patients and Medicare will reimburse the practice according to a well-established pricing scheme. For example, a consultation is worth (at least) $36 and a complete health check is worth $204. The latter costing actually less than that in practice, there is here an opportunity to do some benefit and fund other health programs for which there is no grant available. At the Orange AMS for example, this money is used to provide free dental care to their Aboriginal patients who are, therefore, systematically asked to do a health check.

An important issue in the public health sector is that the waiting list for some types of care can be really long, encouraging some people to subscribe to an additional insurance that would also cover the private health sector.



Clinical room at the Orange AMS

II. Being an Aboriginal in the Australian Society

«Without a knowledge of history we cannot hope to understand Aboriginal/Non-Aboriginal relations today, for they are deeply moulded by that history.» [Commissioner Hal Wotton]

A. Historical Elements

✦ Traditional Aboriginal Society[5]

The Aboriginal society is one with an extremely complex organisation, both as regards to the relationships between the individuals as to the connection to the land. The affiliation system is very intricate and the family model is very different from the occidental one (father/mother/children): it involves the whole extended family, which means also the uncles, aunts, cousins, grandparents, brothers and sisters (among other relatives) who all have their share of responsibility towards the child's upbringing.

A way to assess how wealthy a society is, is to use the time spent to fulfil the five basic requirements (i.e. food, water, shelter, clothing and love) as an indicator. In the traditional Aboriginal society, it was about four hours a day, making them a very wealthy community and leaving them plenty of time for their cultural pursuits. Contrary to common belief, the Aboriginals were far from having a primitive 'hunter and gatherer' lifestyle; they had agriculture and exploited mines and quarries. Far from being isolated, the different tribes interacted a lot between each other and even with south-east Asia. Big trade routes for food, minerals, plants and manufactured goods have indeed been identified by anthropologists.

This market also led to cultural and linguistic exchanges between the different tribes and overseas that would not have been possible without a thorough knowledge of different languages. The education system was extremely structured with different stages similar to what we would observe in our western system (with primary, secondary and tertiary education) corresponding to the different stages of life ('pre-puberty', 'between puberty and adulthood', 'the rest of one's life'). Every stage adds an extra layer of knowledge in different fields as varied as the kinship system, the learning of languages, the territorial borders, the laws, the exploitation of natural resources and the ecological consciousness. The extent of their knowledge was not restricted to their own tribe, but spread to all the surrounding ones. This list would not be complete without an intense initiation to culture and spirituality that both are learning aims as well as, when mastered, tools to broaden their knowledge even more.

Every stage of the education process is marked by a ritual ceremony that, in some tribes, included scarification. For those who could read the number and types of marks on the body, it provided information on the degree of knowledge of that person. It is important to be aware that Aboriginal tradition was mainly oral, everything being transmitted through songs, dance and culture, justifying the artistic wealth of these people and the lack of writing.

The Aboriginal societies had an understanding and a detailed knowledge of the different natural and climatic cycles that they described in a precise manner in their legends. This was compulsory to master agriculture in such a hostile environment as the Australian desert. The Aboriginals lived in harmony with their environment by managing their natural resources sustainably. For instance, after eating seafood tribes on the coast used to leave some empty shells near the water so that the people who followed knew what species had to be avoided to maintain a certain balance.

Totems were assigned to most Aboriginals. A totem is an emblematic animal or plant that a person would observe and study in detail, to be aware of its reproductive cycle, habits, natural habitat and the potential uses of it (e.g. food, cure, etc). By becoming a specialist of that living being, the individual became custodian of a knowledge useful for the entire tribe.

People that were essential to traditional (as well as current) Aboriginal communities were elders. They are the oldest members of the tribe and thus the wisest and more experienced. Because of their wide knowledge, they are really important teachers and used to be very respected. They represent their community and are the reference persons both in case of conflict between members of the community and, when needed to establish a link with outsiders.

✦ British Settlement

The colonisation of Australia by Britain took place in the context of the fight for supremacy between the different European countries.

Around 1770: Arrival of James Cook

After a long expedition to the south Pacific ocean, James Cook arrived in Australia. He declared the land to be the property of the British King, George III. Australia was then defined as “**terra nullius**” despite the presence of Aboriginal inhabitants. The reflection of the philosopher John Locke, who said that if there was no sign of agriculture, then the ‘natives’ must still have been living in a ‘state of nature’ and therefore could not be considered the owners of the land, was used to justify this act. Despite their belief, Australian natives had however engaged in agriculture, manufacture, construction and trade (as we mentioned previously).

In 1788: Arrival of Governor Phillip

The Founding of Australia, painting by Algernon Talmage (1937)

On 26th January 1788, Governor Philip landed with his First Fleet in Sydney Cove to establish a penal colony. At that time there was a huge loss of the Aboriginal population for different reasons. First of all, Aboriginals had no resistance to European diseases and a smallpox epidemic in 1789 wiped out half of the Sydney tribes. This was a serious problem: such epidemics affecting more severely the fragile age groups, this led to a loss of the elders and the young ones, thus interrupting the cycle of knowledge transmission.

With the arrival of the Europeans, Aboriginals were chased off their known lands and could no longer sustain themselves. Finally, in many parts of Australia there was fierce resistance by Aboriginals, leading to reprisal by the white. They were then seen as 'violent savages', which led to massacres and mass murders of Aboriginals, like at Myall Creek in 1838. The vast majority of settlers saw Aboriginals as an impediment to taking up land: «*they were considered as part of the flora and fauna -like dingoes and emus- something to be cleared from the land to allow farming and grazing to develop in a safe, tidy and profitable environment*»[6].

Around 1800: Arrival of Governor Macquarie

Governor Macquarie was sent to Australia to solve the problem of the relation between Aboriginal and white people by 'civilising the Aboriginals' and set up a school called the Native Institution. It was Government policy to 'teach' Aboriginals the habits of clothes, prayer, work and industry, thus making them Christian, 'civilised' and useful at the same time. It was in that spirit that the first mission was established in Wellington Vally in 1825. Children were also kidnapped and placed away from the influence of their families. From 1838, protectorates were established where Aboriginal languages were taught and rations were given out. Aboriginals rejecting this lifestyle, this failed and all the protectorates were closed down by 1857.

From 1860, with political power progressively passing from London to the settlers in Australia, a second wave of dispossession came, where Aboriginals were put off their farms and endured terrible working conditions.

Protection Era

In the 1850s and '60s, it was concluded that Aboriginals were 'so inferior' that no success was likely and that only complete segregation onto closed reserves could minimise their suffering. It was also assumed that they were a dying race, their extinction being considered as being inevitable and beneficial. This led to a period of segregation, protection and separation as Aboriginals were subjected to ever increasing laws denying their rights and freedoms. Like most legislations designed to 'assist' or 'protect' an oppressed or disadvantaged group, they served more to institutionalise their oppression than to encourage their liberation.

By the end of the 19th century, Australian states were introducing far more comprehensive 'protection' legislation, which enabled more extensive regulation of the lives of Aboriginals.

In **1901**, the federal state was formed and the **Australian Constitution** was written. Here are the two sections mentioning the Aboriginals:

- "*The parliament shall have power to make laws for the peace, order and good government of the Commonwealth with respect to: the people of any race, **other than the Aboriginal race**, in any state, for whom it is deemed necessary to make special laws.*" [section 51]
- "*In reckoning the numbers of people of the Commonwealth or of a state or other part of the Commonwealth **Aboriginal natives shall not be counted**.*" [section 127]

In **1909**, the **Aborigines Protection Act** was introduced. It embodied the legislative power to exert massive control over the movement and lives of Aboriginals. To enforce this legislation the **Aborigines Protection Board** relied heavily on the police, becoming the group of non-Aboriginals with whom Aboriginals had the most contact. The Aboriginal Protection Board, was later renamed Aboriginal Welfare Board.

In NSW, between approximately 1883 and 1969, thousands of Aboriginal children were taken away from their parents and placed in white training institutions where they were taught to be domestic servants and labourers. Government policy was designed to break up Aboriginal families so the next generation would not grow up identifying as Aboriginal. This was especially the case for “Part-Aboriginal” children (the children of mixed Aboriginal and European descent). They were forcibly removed by the Aborigines Protection Board, from their parents and the reserves, to be placed in orphanages, foster care or training homes to be merged into the white population.

Reserves

The segregated reserves (also known as ‘missions’ or ‘stations’) were the chief instrument of Aboriginal administration during the protection era and led to the wholesale institutionalisation of many Aboriginal families that effectively kept them away from the community and society at large. Aboriginal traditions were undermined by fierce efforts to impose European ways, by removal from traditional lands and often by mixing with Aboriginals from other areas.

In 1883, there were 25 Aboriginal reserves (and 122 by 1900) in which the conditions were really bad: they were forced to be self-sufficient, but for the most part farming the land could not support the whole community. Rations were supplied to the aged, sick and children, but were substandard. The manager of the reserve defined, organised and controlled all aspects of the lives of Aboriginals: he could search them at any time, confiscate their property, expel them to other reserves breaking up families, etc. Restrictions imposed on Aboriginals on and off the reserves were similar to those used for criminals and the insane. Part-Aboriginals could receive exemption certificates if they displayed exemplary behaviour in European terms and ceased all contact with non-exempted Aboriginals.

Entrance of the ancient mission of Murrin Bridge

Stolen Generations

The term 'Stolen Generation' refers to the victims of the practice of the Aborigines Protection (or Welfare) Board and church authorities who took Aboriginal children away from their families and fostered them or put them in homes or mission dormitories. The estimates vary widely because it is almost impossible to trace their origins, but between the 1920s and '60s, between 20'000 and 100'000 children were removed from their families. To put it another way, this means that between 1910 and 1970, 10-30% of Aboriginal children were forcibly removed from their families and communities. These removals were justified as being "for their own good" or as part of the assimilation policies.

These removals were official government policy from 1909 to 1969, in the regard of the Aborigines Protection Act. In reality, similar events started in the earliest days of European settlement and might still be happening today. It is important to acknowledge that taking children from their families was one of the most devastating practices since white settlement and has profound repercussions for all Aboriginals today.

Assimilation

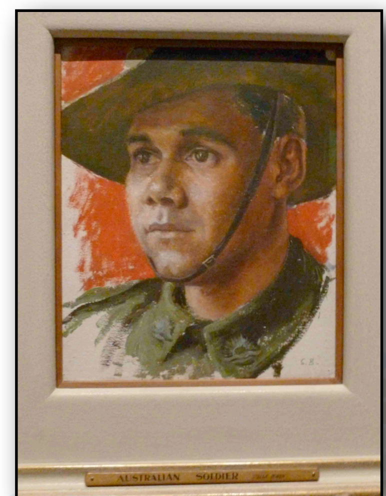
In 1961, the Native Welfare Conference defined 'assimilation' as following: «*All Aborigines and part-Aborigines are expected to attain the same manner of living as other Australians and to live as members of a single Australian community enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and influenced by the same beliefs, as other Australians*».

The move towards an assimilationist policy began in the late '30s, but was delayed due to World War II (WWII). By 1951, all Australian governments claimed that they were acting in accordance with such a policy. It was considered a new and progressive policy, but in fact missions and protection boards had always aimed at the assimilation of Aboriginal children. A new form of surveillance, the District Officers, appeared in the late 1940s and aimed to 'assist and supervise' Aboriginals moving from the reserves and into the towns.

According to the magazine *Dawn* published by the NSW Aborigines Welfare Board in 1953, «*the greatest barriers to the attainment of assimilation [lay] in the apathy and lack of initiative on the part of the great majority of Aborigines and the prejudice of the white community and its reluctance to fully accept them*». There was indeed an important resistance to assimilation and integration among the non-Aboriginal community: there was still a lot of segregation in schools, theatres, hotels, hospitals, public swimming pools, shops, etc.

Change

In the 1920s, after the ignored participation of Aboriginals in the First World war, demands for political rights and equity began. Associations and petitions were set up by activists, such as **Fred Maynard** or **William Cooper**. But with WWII, Aboriginal affairs were put aside. In the late 1950s, there was a new wave of protest and the Aboriginal Advancement leagues were established, but many of these were led by non-Aboriginals, which did not really solve the problem since the approach was still quite paternalistic.



Painting of an Aboriginal soldier, War Memorial of Canberra

The 1960s saw the birth of Aboriginal militancy and the beginning of a major struggle for basic rights, in particular for land rights. Fights also began against segregation and denial of civil rights by Aboriginals. For instance, the Freedom Ride of February 1965 consisted in a group of students that undertook a bus trip to a number of towns in New South Wales to investigate race relations in country towns and living conditions for Aboriginals on reserves and in the towns and to protest against discrimination[7]. Around that time, the idea of an Aboriginal flag was born as a rallying symbol for Aboriginals and their goal.

In 1963, amendments were made to the Aborigines Protection Act, repealing a range of prohibitions that used to apply to Aboriginals, mainly concerning alcohol access and vagrancy offences. In 1967, the major referendum for changing the Australian Constitution included an amendment of [section 51] to give the Commonwealth the power to make laws relating to Aboriginals and the deletion of [section 127], making it law that Aboriginals would be counted in the national census. From that time, the Commonwealth has gained more importance in the legislation concerning Aboriginals. Almost 90.8% of Australian citizens voted 'yes' at this referendum and for the first time, a majority of 'yes' votes was obtained in every state for an amendment to the constitution.

Students involved in the demonstration against discrimination of Aboriginals in Walgett (NSW, 1967)

Aboriginal flag

This brought hope and strength to the continued fight for equal rights for Aboriginals and provided the basis for future legislative enactments. Unfortunately, rather than simplifying Aboriginal issues to permit needed initiatives, the referendum led to a further duplication of authority with the establishment of a federal office of Aboriginal Affairs within the Prime Minister's Department to co-ordinate and fund state programs. Not much changed until the investiture of the new government in 1972. The Department of Aboriginal Affairs (DAA) was then established and the policy of self-determination could start. In **1969**, the Aborigines Protection Act was repealed and the associated board dissolved. The Aborigines Act was created and an Advisory Council set up.

The National Days

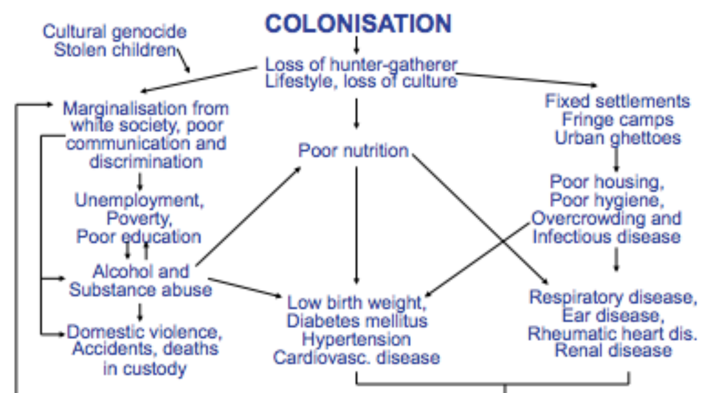
The Australian National Day is on 26th of January, in remembrance of the foundation of Australia. But to most Aboriginals, it is remembered as "Invasion Day" or "Survival Day". There is an unofficial day of remembrance, apology and reconciliation that arose out of the report into the Stolen Generations. It was celebrated for the first time on 26th May 1998 and is still celebrated every year, but mainly in Aboriginal communities. This National Sorry Day is followed by the "Reconciliation week".

Another important date was the 13th of February 2008, when the then new Prime Minister, Kevin Rudd, issued an official apology to the Stolen Generations on behalf of the government. He then also reconfirmed the Government's commitment to focus on closing the gap. This apology was welcomed by a majority of Australians and celebrations were held across the country.

«Those who cannot remember the past are condemned to repeat it.»
[George Santayana, spanish philosopher and writer of the 19th century]

B. Impact on the Current Aboriginal Society

The current Aboriginal society is a society that has been deeply hurt and that is just starting to heal. The Aboriginal policies of successive governments have removed the landmarks and stability of generations and we find today too many Aboriginals who have completely lost hope in the future. This is a true barrier to improvement because there no longer is a conviction of that society that things can improve.



Schematic representation of the impact of colonisation

The assimilation policies manifested themselves across history through cultural prohibitions, the impossibility for Aboriginals to speak their mother tongue, transmit knowledge to their younger generations and practice their spirituality. As a consequence, almost the entire traditional knowledge of Aboriginal society is lost. Many languages are extinguished and a lot of expertise about resource management (botanic, zoology, ecology) has been lost. Many programs aim to reintroduce languages in their home areas. This is a long and difficult process because you first have to gather all the linguistic knowledge scattered around the country, before being able to teach it. It therefore makes sense that it has only been a few years since certain schools offer classes in local traditional languages.

Furthermore, the policies that consisted in moving populations erased the feeling of connection to the land, which has always been a major cornerstone of community identity for Aboriginals. Finally, the policies of child removal tore families apart and the actual generations have to face the problem of loss of cultural identity as well as the loss of the link to the original community.

III. Key Elements about Aboriginal Health

«Our single most spectacular failure as a nation has been in the area of Aboriginal and Torres Strait Islander Health». [Dr. Michael Wooldridge]

This confession made by the Commonwealth Minister for Health and Aged Care himself in 2000 shows how recent the awareness by the government is.

The mortality profile of the Australian indigenous population is distinct from that of most national populations in the eight regions of the world and, according to the United Nations, some Aboriginals have health and living conditions that are worse than in some Third World countries[8]. One striking similarity that can be highlighted is with recent Russian mortality patterns, particularly for males. In Russia, in the early '90s, we noticed an increase in the middle-aged group as well as a high mortality among them. It was linked to rising economic and social instability, high unemployment, loss of income, high rates of alcohol and tobacco use and deterioration of the health system. These are characteristic features of the Aboriginal 'health profile' and, unfortunately, the parallels do not stop there.

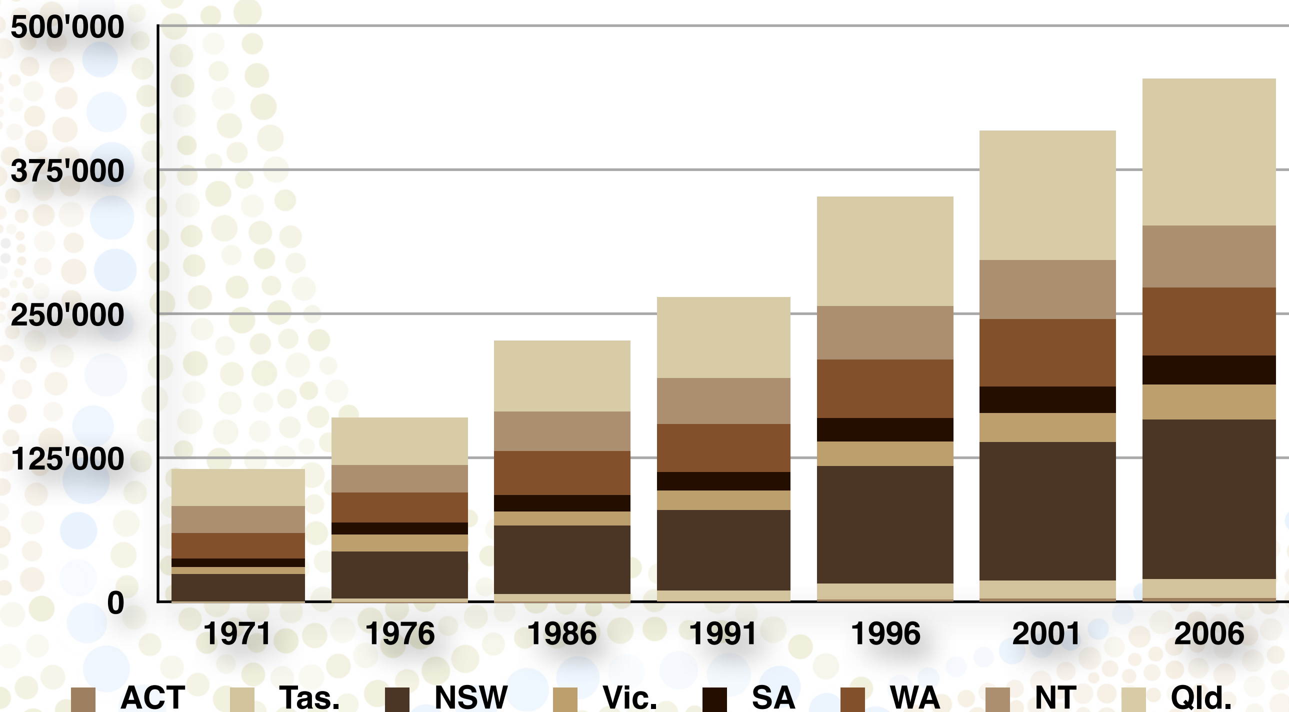
According to the WHO, health is defined as «*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*». Interestingly, the health definition given by the National Aboriginal Health Strategy (NAHS) in 1989 includes another concept that is not often found in western societies, the health of the community: «*Aboriginal health means not just the physical well-being of an individual, but refers to the social, emotional and cultural well-being* ***of the whole Community*** *in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.*»

We would like to say that the separation of the different types of health (physical, mental, etc.) comes from the didactic aspect that comes along. Every person working in the field is conscious that the health of an individual is a whole and cannot be categorised in such a way without being simplistic and slightly artificial. Nevertheless, it allows us to present in a clear and organised manner all the elements we would like to mention.

A. Demography

✦ Census

Fig 1. Indigenous census counts between 1971 and 1991



Every five years, there is a census of the Australian population. In 2011, there were 548'370 people identified as being of Aboriginal and/or Torres Strait Islander origin and counted in the census[9]. Thus, they represented 2.5% of the total Australian population. According to the Australian Bureau of Statistics, the Aboriginal population is projected to exceed 700'000 by 2021. This population has already been growing quite a lot over the past decades as it can be understood from **Figure 1**[10]. Before 1967, Aboriginals were not taken into account in the national census so the figures from before that period are much less reliable. However, it is estimated that prior to British arrival, there were between 314'500 (according to Radcliffe-Brown's estimates) and 1'250'000 (according to Butlin's estimates) Aboriginals and that its population was reduced to one-tenth within sixty years. The Aboriginal population hit its lowest point in 1930, when only 100'000 of them were left[11]. Fortunately, the population has reconstructed itself since then.

✦ Geographical Breakdown

The highest proportion of Aboriginals can be found in New South Wales (where 29.2% of all Aboriginals live) whereas the highest proportion of Indigenous Australians among its total population is found in Northern Territory, (where 29.7% of the population is Aboriginal). The majority of Aboriginals live in cities and towns, but this population is much more widely scattered across Australia than the rest of Australians are.

Population distribution and Lifespan by Aboriginality

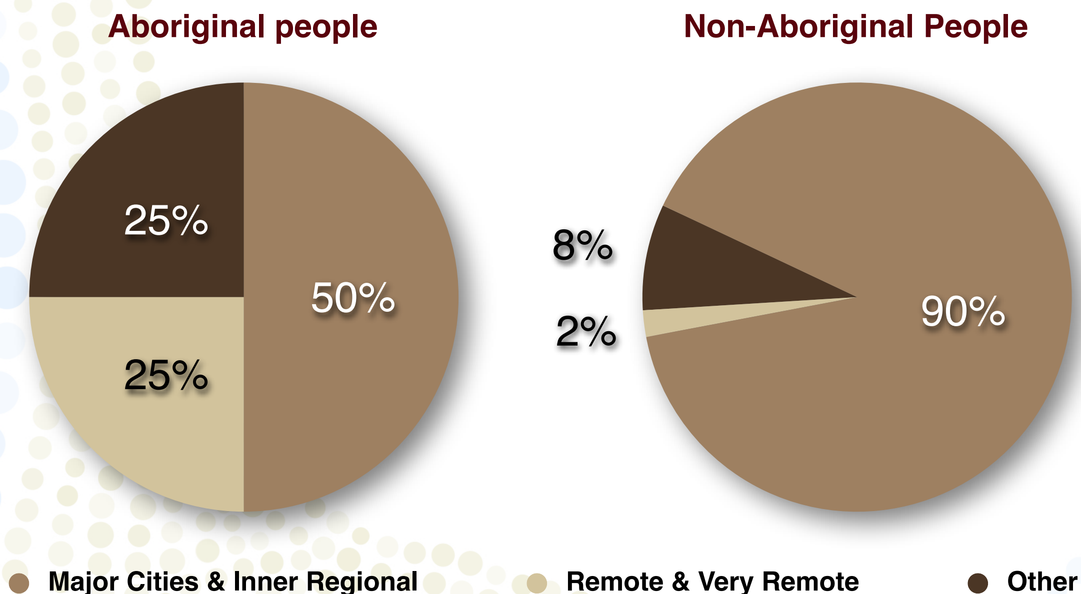


Fig 2. Geographic distribution by Aboriginality

✦ Age Structure

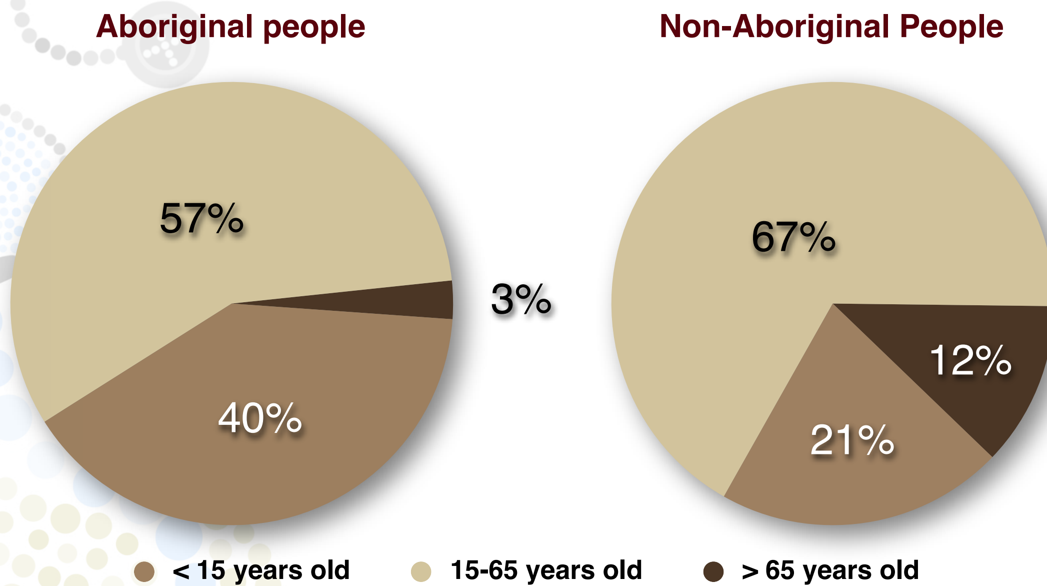


Fig 3. Age structure by Aboriginality

The Aboriginal population is markedly younger than the Non-Aboriginal population: Therefore, it is necessary to adjust figures for differences in age structures, in order for the comparison of both populations to be accurate.

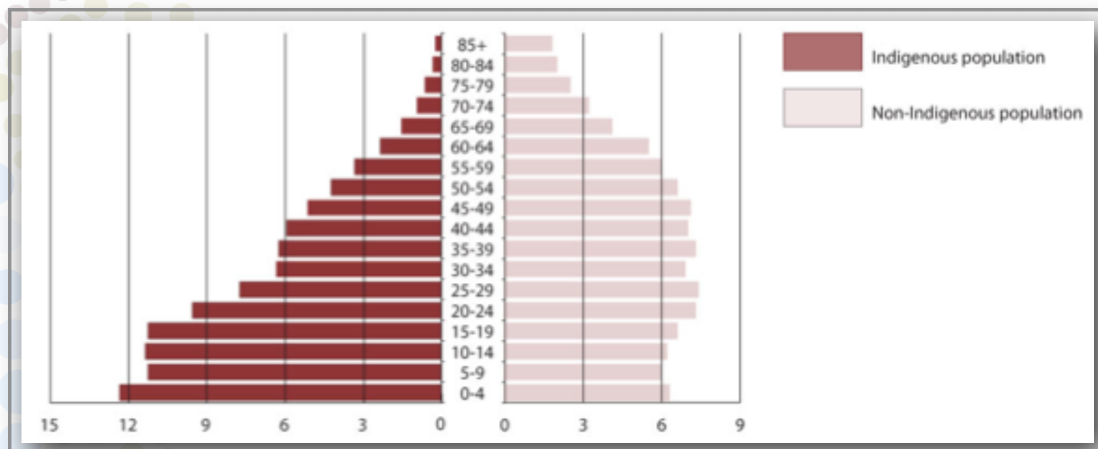
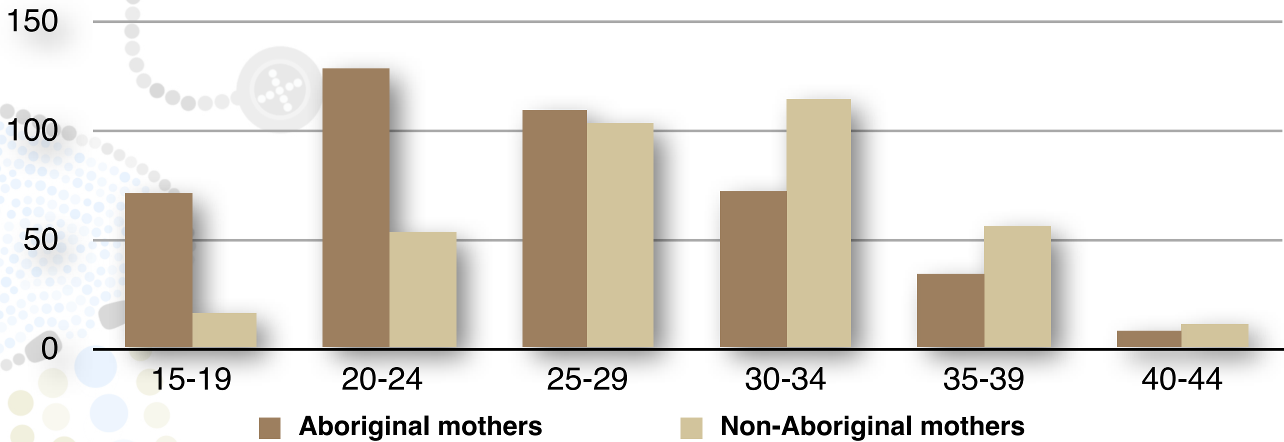


Fig 4. Population pyramid by Aboriginality (2011)

Looking at **Figure 4** we can notice that there are much younger people than older people in the Aboriginal society. This can be explained by both that older people die younger (life expectancy is indeed lower, see below) and that Aboriginal women tend to have more babies (almost 5% of all births registered are from Aboriginal parents (at least one of them) and to have them at younger ages (median age is 24 versus 30 and there are four times more teenage mums among the Aboriginal population). This tends to narrow the gap between the different generations; it is indeed not surprising to see a 35 year old Aboriginal grandmother.

Fig 5. Age-specific fertility rates bill aboriginality



B. Physical Well-Being

✦ Life Expectancy

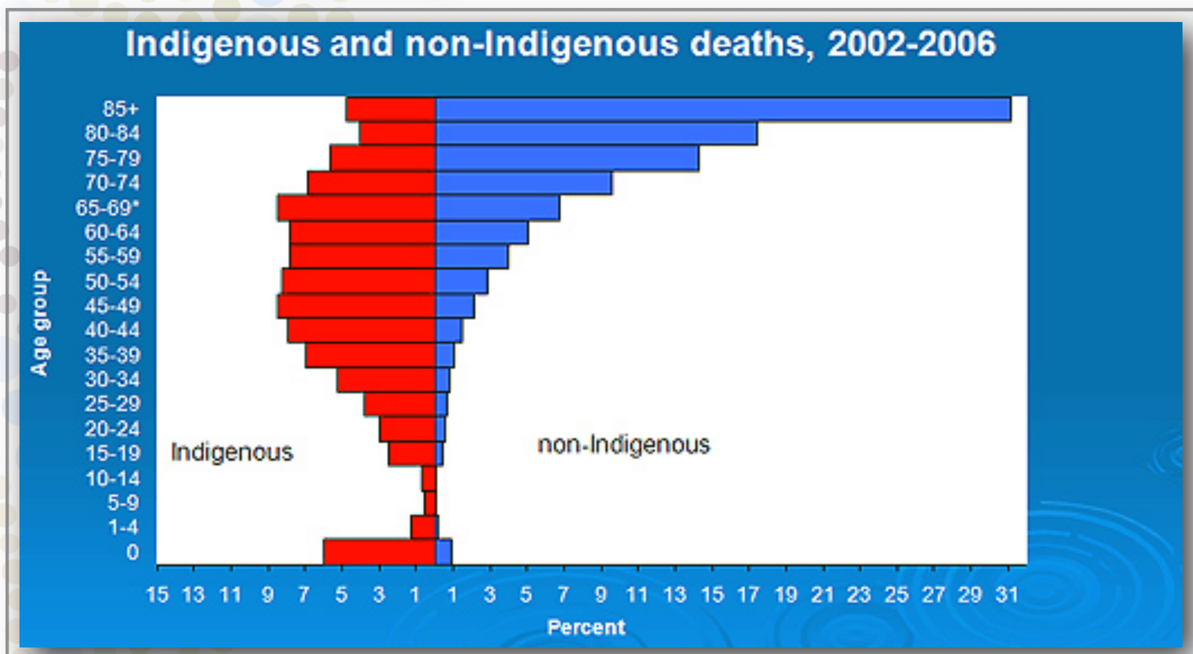


Fig 6. Deaths according by Aboriginality (2002-2006) [12]

Two important things can be understood from **Figure 6**. First of all, the life expectancy of Aboriginals is much lower. It is estimated to be 17 years less than the general population. Furthermore, when adjusting, the age-sex specific death rates of Aboriginals were around four times higher than for the total Australians. Secondly, there are more infant deaths among the Aboriginal population. This is mainly linked to the weight at birth: the average birth weight is 200 grams lower and the Aboriginal newborns are twice more likely to suffer from low birth weight (under 2500 grams). This increases the risk of death in infancy (before the age of one) as well as the risk of developing other health problems. Some infant deaths can be the consequence of infection. This has, however, improved over the past years with the use of immunisations.

✦ Main Causes of Death

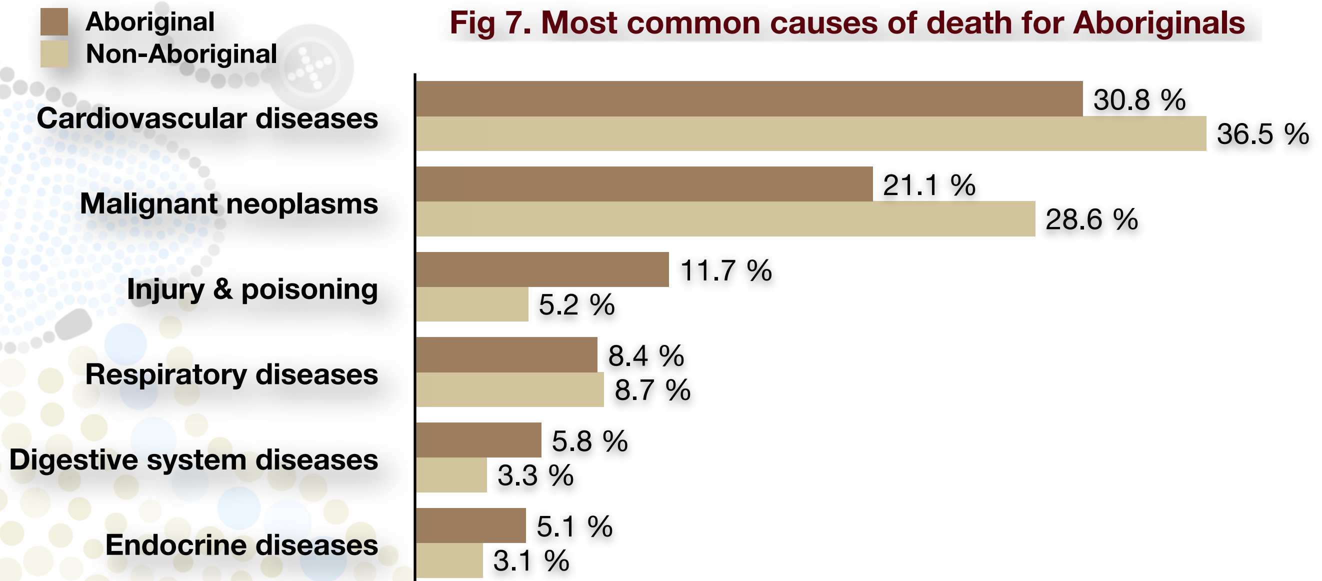


Fig 7. Most common causes of death for Aboriginals

This chart shows the six most common causes of death in Aboriginals. The first two main causes of deaths, cardiovascular disease and cancer, are the same between Aboriginals and non-Aboriginals. However, while the third most common cause of death for Aboriginals is injury & poisoning, it appears to be much less relevant among non-Aboriginals.

✦ Hospitalisations

As shown by **Figure 8**, the main cause of hospitalisation is by far care involving renal dialysis, which is responsible for about 38% of the hospitalisation for Aboriginals.

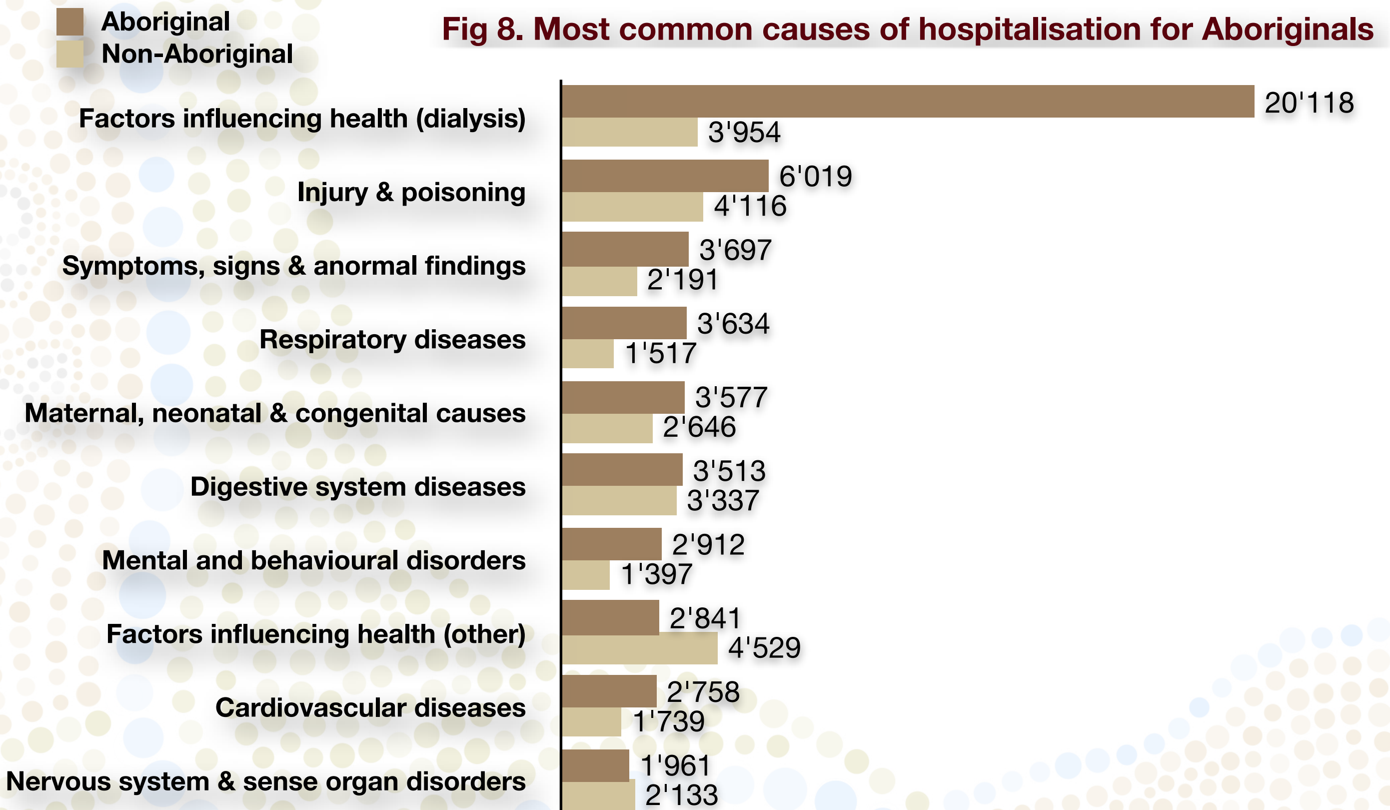


Fig 8. Most common causes of hospitalisation for Aboriginals

For measuring a hospital's activity, separations are used in preference to admissions because diagnoses and procedures can be more accurately recorded at the end of a patient's stay and patients may undergo more than one episode of care from the time of admission. A separation from a health care facility occurs «*anytime a patient leaves because of discharge, transfer, sign-out against medical advice, or death*»[13]. The numbers of separations for Aboriginals all over Australia were higher than the numbers expected from the age-, sex- and cause-specific rates of non-Aboriginals for all main ICD (International Classification of Disease) groups except for digestive disorders. Moreover, the separation rates were higher for Aboriginals than for non-Aboriginals for virtually all age groups.

✦ Selected Health Conditions[14]

Cardiovascular Disease (CVD)

Heart disease and circulatory problems were reported by 12% of the Aboriginal population. After adjusting for the differences in age structure, CVD seems to be 1.3 times more prevalent in their people. Cardiovascular disease is **the leading cause of death** for Aboriginal males and females in NSW, and is estimated to contribute 23% of the excess burden of disease for Aboriginals compared with non-Aboriginals (Vos et al. 2009).

Aboriginals are 1.6 times more likely to be hospitalised for cardiovascular disease than non-Aboriginals. Coronary heart disease and stroke are the main forms of cardiovascular disease, which cause these high rates of hospitalisation and are the main causes of cardiovascular mortality. Acute rheumatic fever and chronic rheumatic heart disease are more frequent among Aboriginals and they are seven times more likely to be hospitalised for these conditions.

High blood pressure is a risk factor for serious diseases of the circulatory system (infarction, stroke…). While there is not a significant difference in rates of high blood pressure between Aboriginal and non-Aboriginals, it is still an important risk factor to work on and it is estimated to account for 6% of the health gap between Aboriginal and non-Aboriginals (Vos et al. 2009).

Cancer

Cancer is the **second leading cause of death** for Aboriginal and non-Aboriginals in NSW, after cardiovascular disease.

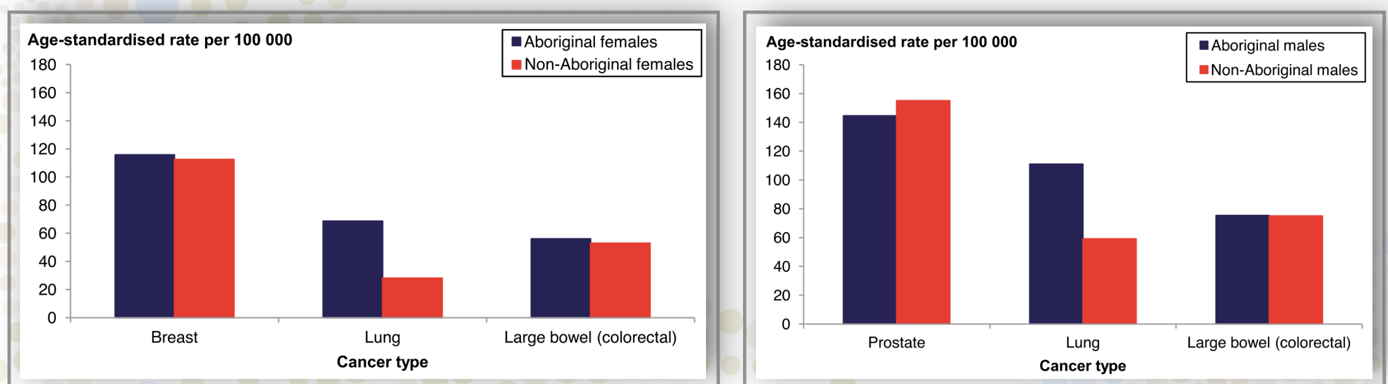


Fig 9. Common cancers by sex and Aboriginality (NSW, 1999 to 2007)

Compared with non-Aboriginals, Aboriginals in NSW have a higher incidence of cancer, higher mortality rates due to cancer and significantly lower rates of cancer survival (Morrell et al. 2012 | Cancer Institute NSW 2012). Between 1999 and 2007, Aboriginals were diagnosed with cancer at a 10% higher rate. The most common cancers among Aboriginals are preventable for example, by reducing smoking (lung cancer) or increasing Pap test coverage (cervical cancer).

Injury

Injury is a significant burden of ill-health among the Aboriginal population, but it is difficult to assess its total impact since the vast majority of injuries do not lead to hospitalisation or death. One fourth of the Aboriginal population reported being a victim of physical or threatened violence in the past year. After adjusting for differences in age structures, the level of victimisation is more than twice the level it is for non-Aboriginals.

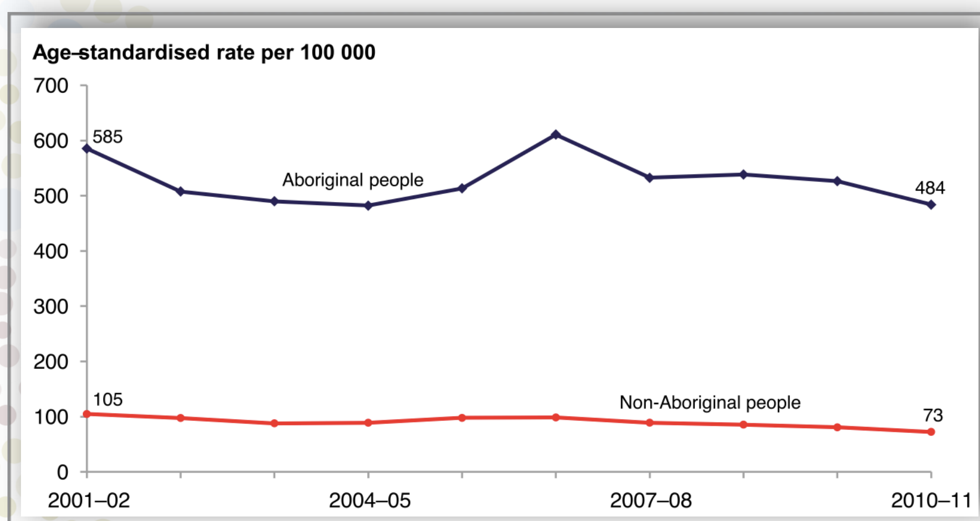


Fig 10. Interpersonal violence hospitalisations by Aboriginality (NSW, 2001 to 2011)

Injury and poisoning is the **third leading cause of death** for Aboriginals in NSW. Burden of disease data attribute 15% of the difference in health between Aboriginal and non-Aboriginals to injury; in particular road traffic accidents, suicide, homicide and violence (Vos et al. 2009). This difference is significant, with Aboriginals being 1.5 times more likely to be hospitalised for injury and poisoning. The leading causes of hospitalisations for injury and poisoning in Aboriginals in NSW are falls, interpersonal violence and transport accidents. Falls are the leading cause of hospitalisations for injury for Aboriginals in NSW. The greatest disparity in injury hospitalisation rates by cause between Aboriginal and non-Aboriginals are for interpersonal violence. Aboriginals were indeed 6.7 times more likely to be hospitalised for interpersonal violence.

Respiratory Disease

About 27% of Aboriginals suffer from respiratory disease. The most commonly reported condition is asthma with a prevalence of 15%. In 2010. Aboriginals of NSW were 1.6 times more likely to self-report having current asthma than non-Aboriginals. Also, they are 3.9 times more likely to be hospitalised for COPD and four times more likely to die from a respiratory disease.

Diabetes

Diabetes (especially Type 2 diabetes) is a major contributor to excess burden of disease among Aboriginals and to the health gap with non-Aboriginals. The onset of diabetes occurs earlier among Aboriginals, which leads to a greater burden of illness associated with the complications of diabetes, including kidney damage, loss of vision, peripheral nerve damage and peripheral vascular diseases (NSW Health 2008).

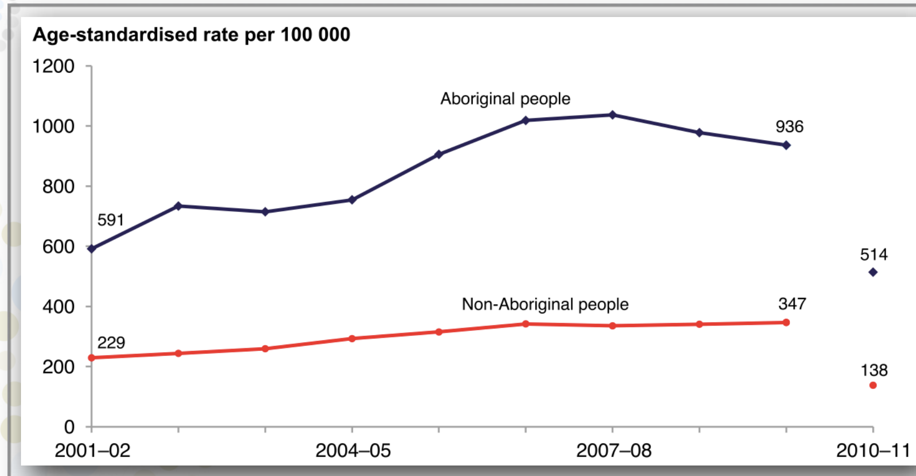


Fig 11. Diabetes hospitalisations by Aboriginality (NSW, 2001 to 2011)

In 2009–10, Aboriginals were 2.7 times more likely to be hospitalised for diabetes than non-Aboriginals. In 2010, the NSW Adult Population Health Survey estimated that Aboriginals were 1.2 times more likely to have diabetes or high levels of blood glucose than non-Aboriginals.

Chronic Kidney Disease

The higher prevalence of diabetes among Aboriginals contributes to higher rates of renal disease. In 2010–11 there was a significant difference between Aboriginal and non-Aboriginals, with Aboriginals being five times more likely to be hospitalised for chronic kidney disease.

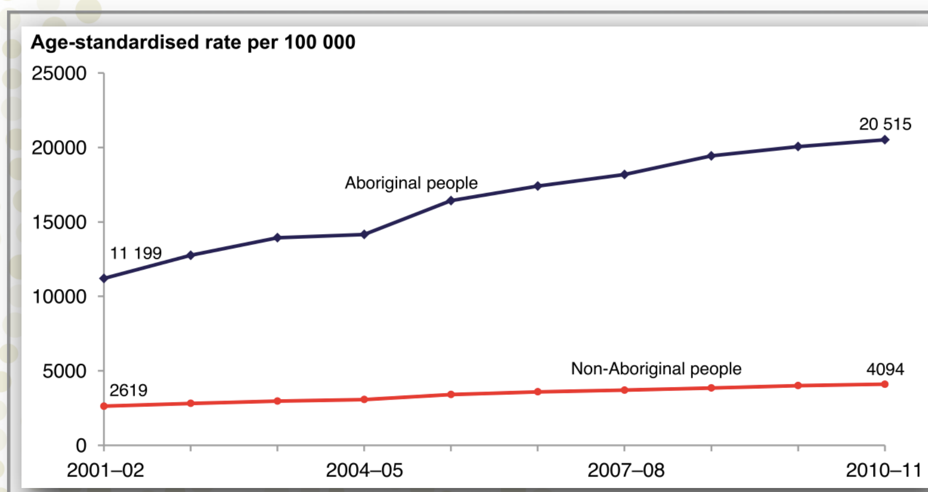
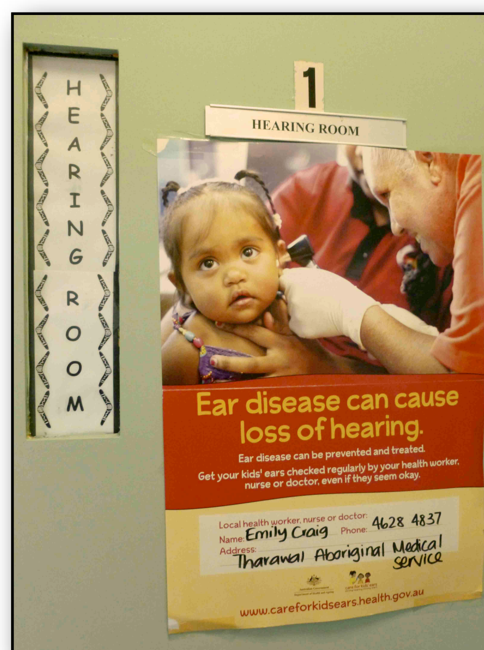


Fig 12. Chronic kidney disease hospitalisations: dialysis, diabetic nephropathy and chronic renal disease (NSW, 2001 to 2011)

The most severe form of chronic kidney condition is end-stage renal disease, which requires dialysis or kidney transplantation. Kidney failure has a number of causes, the most common being Type 2 diabetes, glomerulonephritis and high blood pressure. Too many Aboriginals have dialysis three times a week, which affects their quality of life and social and emotional wellbeing. However, fewer Aboriginals than non-Aboriginals receive kidney transplants (Australian Government 2011). Care involving dialysis is indeed the most common reason for hospitalisation for Aboriginals. They are indeed 1.9 times more likely to be receiving dialysis for end-stage renal disease.

Ear Disease

Hearing loss is more common in Aboriginal children than non-Aboriginal children. The main causes of hearing loss are disorders of the middle ear, including otitis media. Middle ear infection is common in children following an upper respiratory infection. Repetitive unresolved episodes of otitis media can lead to perforations of the eardrum, hearing loss and, particularly in younger children, delayed speech development, reduced learning ability and reduced social interaction (Australian Government 2011). Aboriginal children are twice more likely to be admitted to hospital for tympanoplasty (surgical intervention often needed to treat a perforated eardrum associated with chronic otitis media), reflecting the higher prevalence of persistent otitis media in Aboriginal children. Furthermore, of the 18% of Aboriginal children who have recurring ear infections, 28% have abnormal hearing.



Hearing room at the Tharawal AMS

The WHO (World Health Organization) has identified a prevalence of Chronic Suppurative Otitis Media (CSOM) of greater than 4% as being a «*massive public health problem*» requiring «*urgent attention*». In some communities there is a prevalence of CSOM up to ten times higher than this. Level of ear disease and hearing loss among Aboriginals are higher than that of the general population, particularly among children and young adults. Complete or partial deafness is higher for Aboriginals for all age groups until 55 years and over, where the rates are similar.

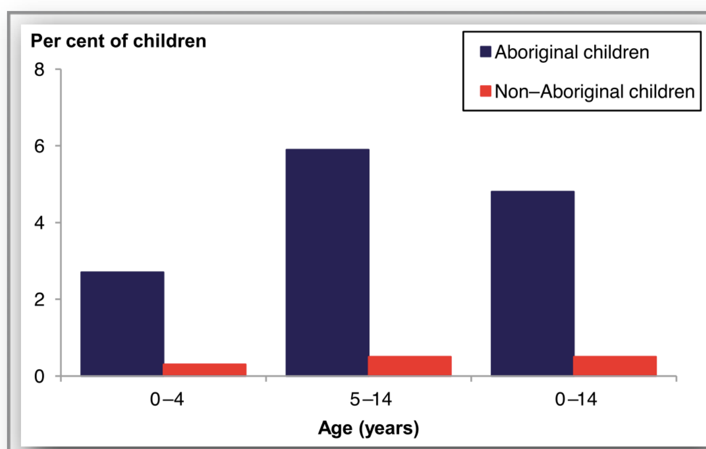


Fig 13. Complete or partial deafness or hearing loss before 14 years by Aboriginality (NSW, 2004-2005)

Oral Health

The term "oral health" refers to the health of the mouth and related tissues which enables an individual to eat, speak and socialise. Oral health issues share common risk factors with other diseases and poor oral health occurs alongside a range of conditions such as cardiovascular disease, cerebrovascular disease, diabetes, preterm and low birth-weight babies, aspiration pneumonia, blood-borne disease, infective endocarditis and otitis media (Australian Government 2011). Oral health in Aboriginal communities (particularly in rural and remote locations) is affected by factors that operate from infancy through to old age, including water quality and fluoridation, diet, smoking, alcohol consumption, stress, infection, the cost and availability of dental services and transport issues (NACOH 2004).

Early childhood caries are defined as at least one decayed lesion affecting a deciduous or permanent tooth. It is a common dental decay disease with a large health burden, despite being mostly preventable (through changed bottle feeding practices, dietary modification, fluoride delivery and good oral hygiene). It can adversely affect growth, cognitive development, speech, communication, self-image and social functioning (Douglass et al. 2004), and children who experience dental caries are more likely to experience other dental problems as they grow older (Li and Wang 2002). The *NSW Child Dental Health Survey (2007)* showed Aboriginal children experience a higher burden of dental disease than non-Aboriginal children (Centre for Oral Health Strategy NSW 2009).

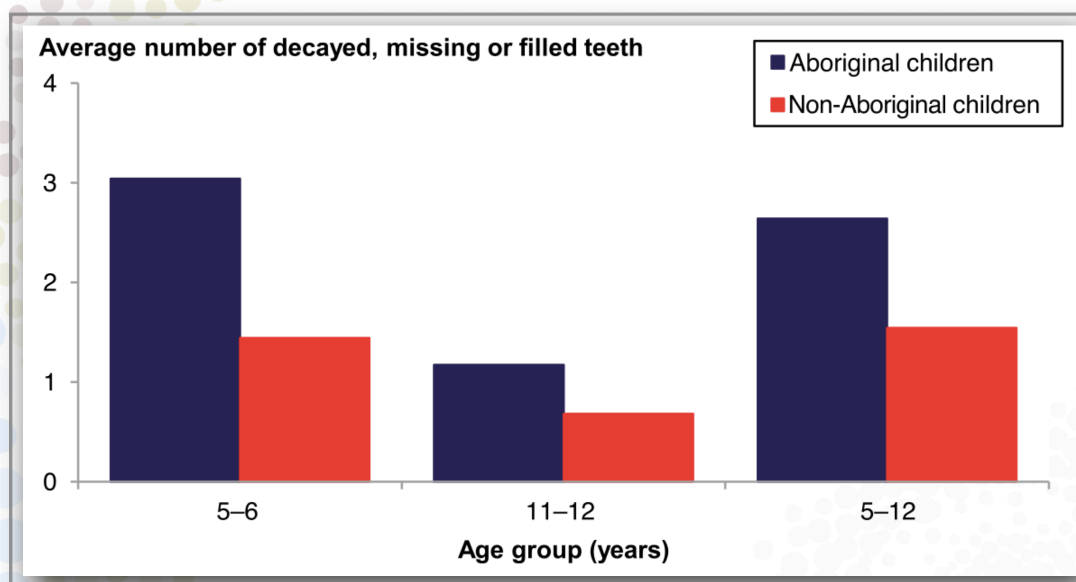


Fig 14. Decayed, missing and filled teeth between 5 and 12 years by Aboriginality (NSW, 2007)

Concerning the older ones, the *National Oral Health Survey (2004–06)* identified that untreated decay was more than twice as high among Aboriginals compared with non-Aboriginals (AIHW 2007a). From 2004–05 national survey data, 11% of Aboriginals aged 15 years and over reported they had never visited a dentist or other health professional for their teeth (ABS 2006). In 2010–11, the hospitalisation rate for removal and restoration of teeth in adults was nearly 2.5 times higher for non-Aboriginals. The difference is due to difficulties in accessing preventive dental services. Aboriginals have dental caries at a rate 30% higher and suffer from injury at a rate 41% higher.

Communicable Diseases

Communicable diseases are illnesses transmitted through direct contact with an infected individual or indirectly through a vector. Aboriginals of NSW experience disadvantage in regard to all social determinants of health, in particular, poverty, disempowerment and social disadvantage; these factors are compounded by poor access to relevant health information and health services. This disadvantage increases the risk of communicable diseases in Aboriginal communities.

	Pathogen	Prevalence
Blood-borne virus & Sexually Transmitted Infections	Hepatitis C	5x higher
	Gonorrhoea	50x higher
	HIV	similar
Vaccine-preventable diseases	Measles virus	more cases (last outbreak)
	Meningococcal diseases	4x higher
	Haemophilus Influenzae B	9x higher
Tuberculosis	Mycobacterium tuberculosis	10x higher

Table 1. Prevalence of different communicable diseases among Aboriginal compared to non-Aboriginal populations

The hospitalisations rate for Aboriginals has been consistently higher than for non-Aboriginals for **influenza and pneumonia** over the past 10 years. Aboriginals experience higher levels of mortality and morbidity from pneumonia and invasive pneumococcal disease. These high rates of pneumonia are associated with higher rates of common risk factors including infectious and chronic conditions, such as respiratory diseases, poor living conditions, malnutrition, smoking and alcohol misuse. Aboriginals are 2.5 times more likely to be hospitalised for pneumonia and influenza.

✦ Potentially avoidable morbidities

Deaths

Premature deaths are deaths that occur before the age of 75 years. Premature deaths can be classified as "potentially avoidable" and "unavoidable". Potentially avoidable deaths are those that could potentially have been avoided given our current understanding of the causes of disease, the availability of disease prevention and effective health care (ABS 2010a). The leading causes of potentially avoidable deaths are cancers, cardiovascular disease and injury and poisoning (NSW Health 2008a).

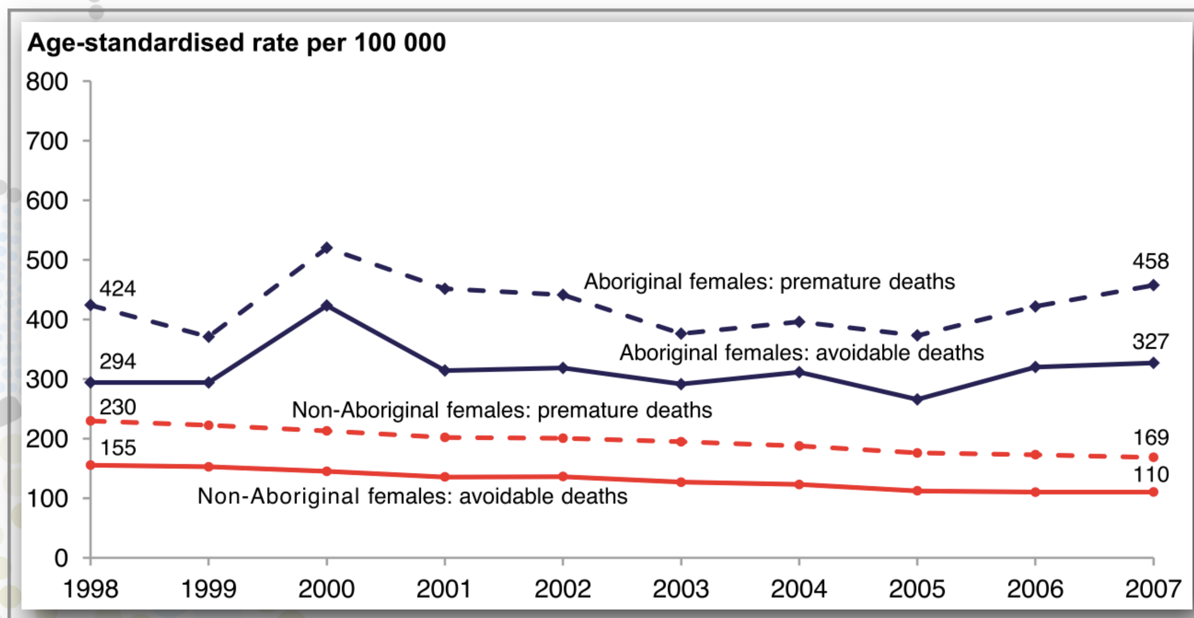


Fig 15. Potentially avoidable and premature deaths of females under 75 years by Aboriginality (NSW, 1998 to 2007)

Hospitalisations

Potentially preventable hospitalisations are hospital admissions that could have been avoided by providing accessible, timely and effective preventive care or early medical treatment delivered through primary health care (Australian Government 2011 | Porter et al. 2007). In NSW in 2010–11, admission rates for potentially preventable hospitalisations were 2.5 times higher for Aboriginals and they were 3.2 times more likely to be admitted for potentially preventable hospitalisations due to chronic conditions and two times more likely to be admitted for potentially preventable hospitalisations due to acute conditions.

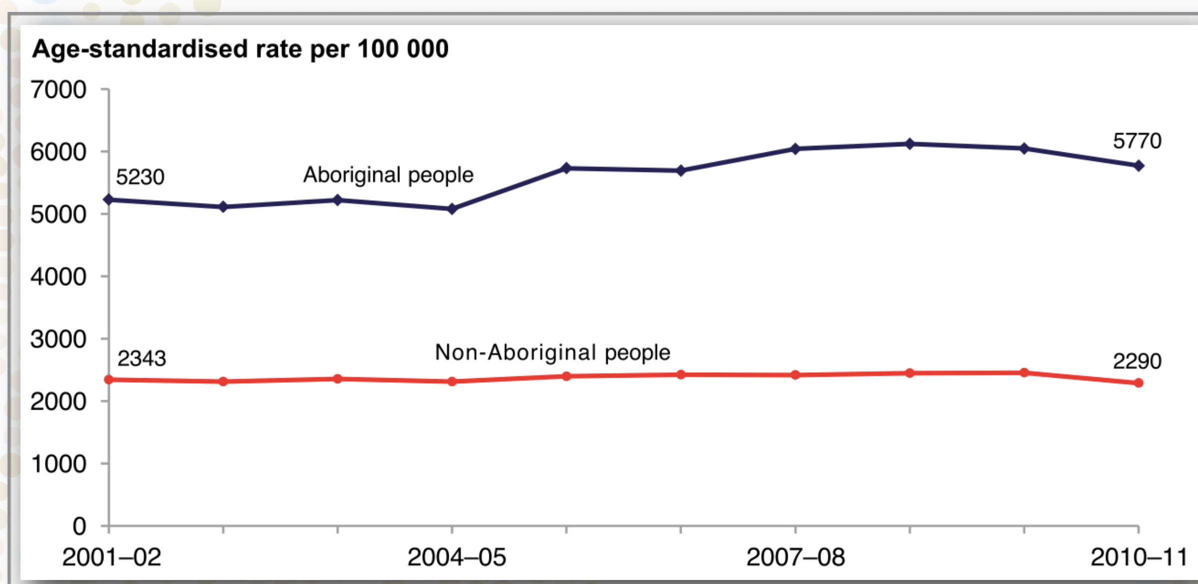


Fig 16. Potentially preventable hospitalisations by Aboriginality (NSW, 2001 to 2011)

✦ Access to Health Services

Providing equitable access to hospital-based services is a critical responsibility of the health system (Australian Government 2011). Aboriginals often do not have equal access to medical services. For many health conditions, Aboriginals experience a higher prevalence and incidence of disease and injury creating a greater need for procedures. Although, despite this higher burden of disease, the Aboriginal population does generally not benefit from the amount of procedures it should.

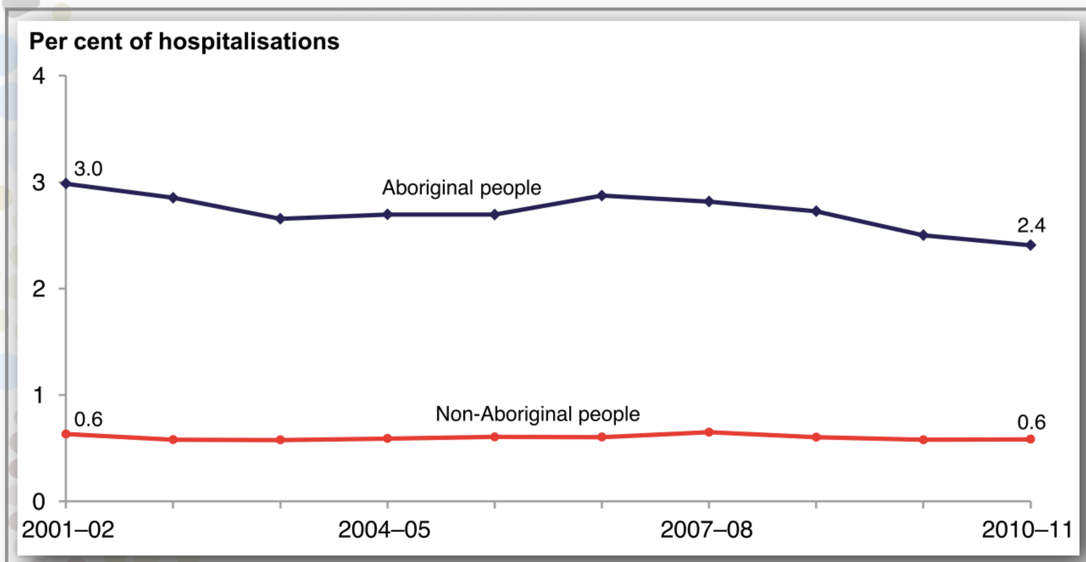


Fig 17. Hospitalisations ending with discharge against medical advice by Aboriginality (NSW, 2001 to 2011)

For example, in 2010, Aboriginals of NSW were 20% less likely to access high volume surgical procedures and almost 30% less likely to receive revascularisation procedures. They also have lower rates of access to cataract procedures, to total knee and hip replacements and to inpatient rehabilitation services. These differences not being explained by differences in health service needs (on the contrary), it may be an indication of the cultural incompetency and lack of accessibility of services being delivered to Aboriginals in NSW.

Another major issue worsening the situation is that Aboriginals are 4.3 times more likely to discharge themselves from hospital against medical advice. Patients who discharge against medical advice have higher readmission rates, higher levels of multiple admissions and a higher in-hospital mortality (Choi et al. 2011 | Glasgow et al. 2010).

This measure provides indirect evidence of the cultural competence of hospital services and the extent of patient satisfaction with the quality of care provided (Australian Government 2011). Fortunately over the past 10 years, the proportion of Aboriginals discharging against medical advice has decreased. Furthermore, Aboriginals are 1.3 times more likely to have an unplanned readmission. The latter is defined as a readmission which was not planned within 28 days of discharge from the first admission and to the same facility. It is an indicator of the quality and continuity of care provided to patients while in hospital and in the weeks following discharge (van Walvaren et al. 2011). These readmissions could be avoided through appropriate out of hospital care and support.

C. Mental Well-Being

Mental illness contributes to 10% of the disparity in burden of disease between Aboriginal and non-Aboriginals (Vos et al. 2009). Aboriginals experience higher levels of mortality and morbidity from mental illness, and from related injury and suicide than the general population.

✦ Level of Psychological Distress

In 2010, Aboriginals were estimated to be 2.2 times more likely to report high or very high levels of psychological distress than non-Aboriginals. This may be due to the fact that they experience more significant stressors like the death of a family member or friend, alcohol or drug related problem, trouble with authorities, witness violence, etc. The *2008 National Aboriginal and Torres Strait Islander Social Survey* (NATSISS) found that almost eight-out-of-ten Aboriginals experienced one or more significant stressor in the 12 previous months (compared with 6 out of 10 for the total population).

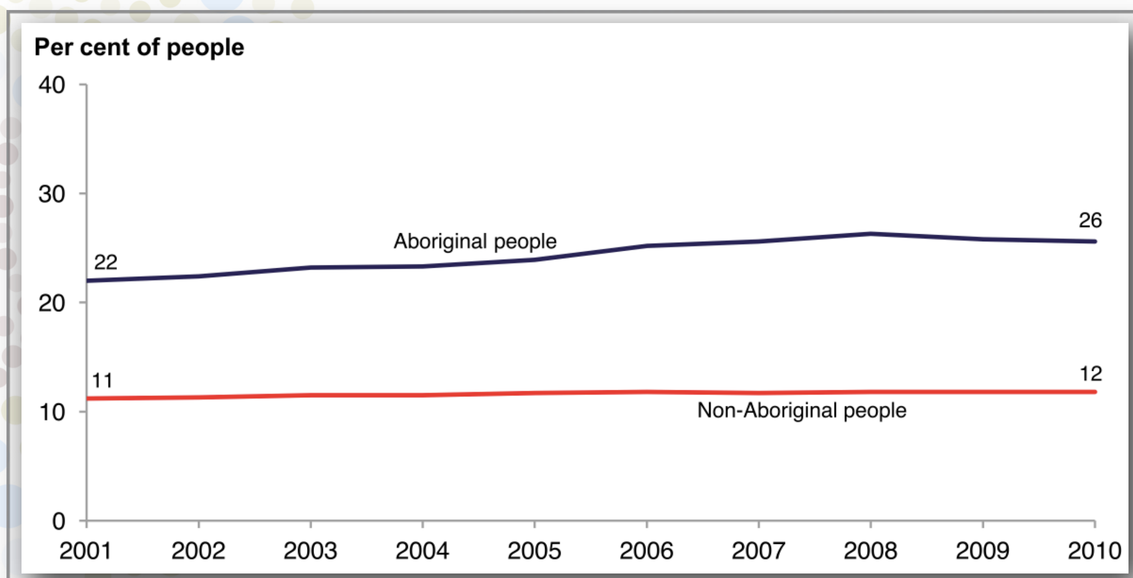


Fig 18. High or very high psychological distress after 16 years by Aboriginality (NSW, 2001 to 2010)

Furthermore, children who had been forcibly taken away from their families were at high risk (twice) of having clinically significant emotional and behavioural difficulties.

✦ Self-Harm

The *NSW Health Suicide Prevention Strategy (2010–15)* reported high rates of self-harm and suicide among Aboriginals, attributing it to a number of factors including poverty, low socioeconomic status, lack of education and poor employment prospects, reduced access to culturally appropriate services, poor overall health, living in rural or remote communities, high rates of incarceration, domestic violence or abuse, and alcohol and other drug misuse. The interrelated nature of these factors can lead to a cycle of despair and depression (NSW Health 2010b). In 2010–11, Aboriginals were 2.9 times more likely to be hospitalised for intentional self-harm than non-Aboriginals.

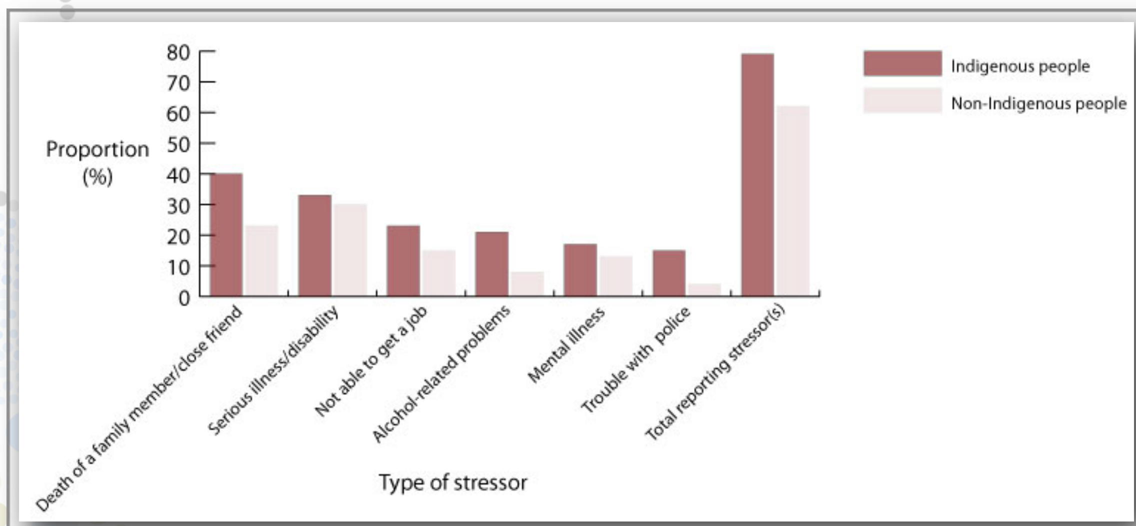


Fig 19. Proportion of people who experienced different stressors by Aboriginality (2008 and 2010)

✦ Depression & Mood Disorders[15]

Depression and other mood disorders are a burden everywhere. But it is even more of a problem for Aboriginals, who already live in a particularly difficult environment.

Depression

Loss and grief promote depression in Aboriginals. Grief is a continual feature of Aboriginal lives and can come from different events, such as frequent illness and early death of loved ones, the massive pressure families are under and their breakdown, the taking of children from their families, the children ending up in the drug culture because of strong peer pressure and lack of alternatives, having family members in jails, etc. There also is an important sense of overburdening and guilt by the responsible caring people because of them being unable to fix all the horrors their families are experiencing. Depression involves destructive feedback cycles, between an initial loss leading to a decline in autonomy and capacity, leading to a further loss.

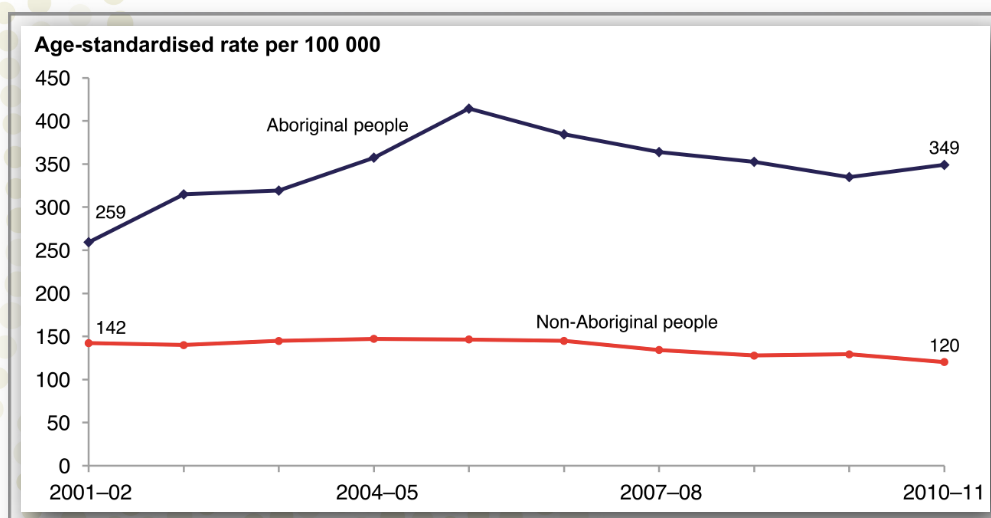


Fig 20. Intentional self-harm hospitalisations by Aboriginality (NSW, 2001 to 2011)

Mood Disorders

The multifactoriality of the Aboriginal Health problem

Mood disorders are common and have a multiplying effect on the many other types of misery that plague the Aboriginal world. A situation of chaotic family life and childhood trauma, including childhood sexual assault leads to permanent brain changes and to what are often regarded as “personality disorders”. Severe and chronic trauma predisposes someone to any of the psychiatric illnesses.

D. Social Well-Being

✦ Socio-Economic Level

Wherever we went, the most frequent answer to the question «*What do you think is the main determinant of the bad health of Aboriginals ?*» was related to their socio-economic level. This aspect is one of the critical elements of the vicious circle in which many Aboriginals of the current society are stuck in. In 2011, the median personal weekly income in NSW for people aged 15 years and over was $375 for Aboriginals and $566 for non-Aboriginals. The median weekly household income was $941 for Aboriginal households compared with $1’247 for non-Aboriginal households.

Poverty brings along housing problems, which in part explains the overcrowded homes and thus the bad health conditions and the higher incidence of infections. In 2008, approximately 15% of Aboriginals in NSW reported living in an overcrowded house, compared with 5% of non-Aboriginals. Furthermore, housing ownership also is important as it is an indicator of housing security and is linked to health status.

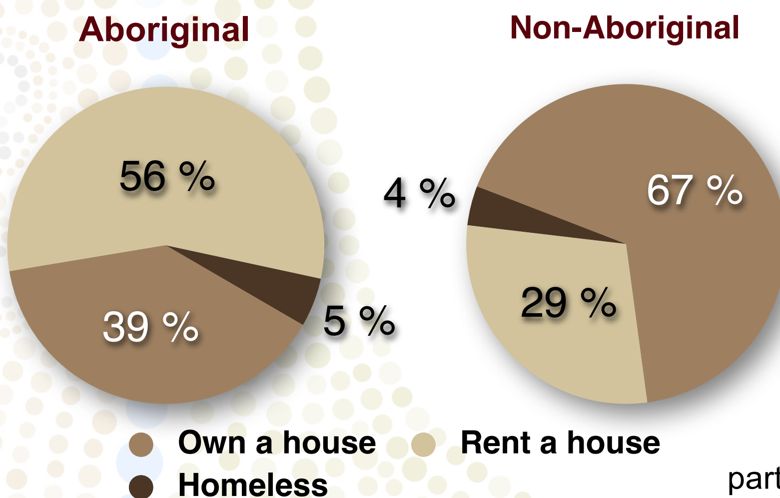


Fig 21. Accommodation by Aboriginality

At the level of the society itself, the Aboriginal population is still highly marginalised. In 2011, the labour force participation rate in NSW was estimated to be 54% for the Aboriginal population aged 15–64 years, with 15% of the Aboriginal labour force unemployed. In comparison, the labour force participation rate for the non-Aboriginal population was 78%, with 5% of non-Aboriginals unemployed.

There thus is an important reliance on government payments, which is about twice more than for non-Aboriginals. Employment is one of the determinants of mental well-being because it provides a setting in which an individual can open up, come out and develop his skills. Aboriginals are overrepresented in jails: in NSW for example, 23.1% of the adult inmates in full-time custody identify as Aboriginal[16]. The situation is even worse in juvenile justice centres, where approximately half of the inmates (168 from a total of 391) identify as Aboriginal. All this contributes to increase stigmatisation and racism (that can be overt, covert or even institutional) towards Aboriginals.

All this stigmatisation has multiple effects. First of all, it lowers self-esteem, leading to sloppiness and a global disinterest in one's health. It also decreases hope in the future and thus diminishing motivation in getting a good education, finding a job and have a better life. Lastly, it increases anger and frustration.

✦ Cultural & Spiritual Well-Being

The health definition of the WHO includes mental and social well-being, but it seems important to consider two other concepts: cultural and spiritual well-being. These two aspects are indeed critical for the understanding of Aboriginal specific health issues and therefore have been included in the definition of Aboriginal health (mentioned previously in Part 1 | chapter 3).

It was difficult for us to find an uniform and consensual definition for these concepts. Most of the people we talked to, understood what they were about until they were asked to formulate their thoughts. Without any surprise, cultural and spiritual well-being can be defined as the accomplishment of the goals fixed by culture and spirituality respectively. The UNESCO[17] (United Nations Educational, Scientific and Cultural Organization) defines culture as "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs."

In Aboriginal tradition, culture and spirituality are intrinsically intertwined. Culture can be understood as what brings people together around a goal and provides them with a common understanding of the world. Whereas spirituality is more specifically the representation system used to answer existential questions (relation to death, reason of existence of this world, purpose of life, etc).

The problem comes from the fact that over the past two centuries, the practice of culture and spirituality was illegal and severely repressed by the succeeding governments. A real fear has thus developed, that still persists nowadays among a number of generations. Some Aboriginals born in the '60s are still afraid to speak their mother tongue in public or to transmit their knowledge to the younger ones, fearing to put them in danger. Another essential component of the Aboriginal spirituality is what they call 'connection to the land'. It is more than just a sense of ownership of the territory, it rather is a sense of belonging to the territory: "*You see, we don't own the land, the land owns us*". Being dispossessed of their lands and moved around, they struggle to establish that connection and thus to feel at home, safe, free from want, at their place, etc.

E. The "Alcohol Problem" Clarification

✦ The Reality of the Problem

Getting Things Straight

We would like to make clear that alcoholism and substance abuse are not the primary issues in Aboriginal communities. It is a point we really wanted to make because when we arrived in Australia we had that preconception that actually still is deeply entrenched in the general population.

Aboriginals are much more likely to abstain from drinking: according to the 2008 NATSISS, more than one-third of Aboriginal adults did not drink alcohol (compared with around one-in-eight for non-Aboriginals). Also, during pregnancies, 80% of mothers of Aboriginal children abstained drinking and 16% drank less alcohol. This shows a certain level of awareness of the risk related to alcohol use. There are also 'self-determined' dry communities that can be found, which means that the community itself decided not to consume any alcohol.

However, Aboriginals who drink alcohol are more likely to drink it at high-risk levels. The prevalence of harmful alcohol use in the Aboriginal population is indeed about twice as great as that in the non-Aboriginal population. Aboriginals are even more than six times more likely to die from an alcohol-related reason than non-Aboriginals. Therefore, alcohol consumption is definitely a problem in Aboriginal communities, but it should be seen as a consequence of other issues and not as a cause that should be worked on as a priority.

	Aboriginal	Non-Aboriginal
Low-risk levels	48%	51%
Risky levels	11%	7%
High-risk levels	6%	8%

Table 2. People reporting having drank at different risk levels in the past 12 months

Proposed Explanation for this Drinking Stereotype

One of the reasons for this misunderstanding is probably historical. Aboriginals used to not be allowed to drink, but (with the changes brought by the '60s) this prohibition was repealed, which gave the impression of a sudden rise in alcohol consumption among this population. It is important to remember that alcohol abuse is a general problem in Australia with 20.4% of Australians drinking at risky or high risk levels (according to the NDSHS). At the same time, there was a lot of international movement around indigenous rights as well as a lot of self-empowerment (think about the "proud to be black" campaigns). Therefore, using the 'drunk stereotype' came in quite handy to justify why Australia should not give their Aboriginals too many rights, thinking they would not be able to handle them responsively.

✦ The Causes of the Drug & Alcohol Consumption

All the observations made concerning the different well-beings (physical, mental and social) translate in risky behaviours, like for instance an excessive alcohol consumption as well as the use of other active substances. The loss of hope, the feeling of powerlessness to one's own self-determination, the loss of cultural identity and the connection to the family of origin are all factors that can lead towards alcoholism that then becomes nothing more, but an expression of a very deep lack of well-being and a sense of abandon.

Another element contributing to the use of substances, mainly among the younger ones, is the total lack of activity for those who have neither education, nor work. In Orange, for instance, the youth centre closed down and the minors who left the school system were left to themselves, with not much to do besides exploring the effects of recreational substances.

Despite that we often find an important consumption of alcohol and cannabis among the different communities, the diversity of the drugs used depends essentially on the community and the geographic location. In more urban communities (or close to big cities) for example, there is an important use of recreational drugs (e.g. heroin, ecstasy, cocaine, speed, etc.) whereas in more rural communities, there is an important use of prescribed drugs (e.g. amphetamines, benzodiazepines and opioids: morphine, oxycontin, methadone, etc). Finally, in more remote areas, the difficult access to recreational drugs leads to a switch towards more dangerous behaviours (sniffing of petrol, glue, detergent, etc).

✦ Consequences of Drug & Alcohol Consumption[18]

		Alcohol	Speed	Cannabis
Short term risks		ethyl coma	• overdose • cardiac arrest	ø
		increase of risky behaviours (with eventually: STI, injuries, etc.)		
LONG TERM RISKS	Physical	• cirrhosis • hepatic cancer • hypertension • vitamin B1 deficiency • impairment of the heart, the nervous system (peripheral and central)	• neurotoxicity • immuno-suppression • malnutrition	• respiratory illness: lung cancer, bronchitis, asthma
	Mental	• increase personal and social problems • leads to violence • increases the vicious cycle of “depression/substance consumption”	• depression • psychosis • violence	• psychosis • other psychiatric symptoms: depression, anxiety.
	Withdrawal syndrome	Important: • sweating • tachycardia (possibly: convulsions, delusions and hallucinations)	Important: • dysphoria • drowsiness • irritability	Discrete & short duration: • agitation, • irritability • insomnia Being often associated with tobacco, a nicotine dependance can also be present.
	Tolerance	yes	yes	moderate
Addiction (relative risk)		3/5	5/5	2/5

Table 3. Health risks associated with the consumption of different substances

- **Dependance** is defined by the presence of a withdrawal syndrome after abrupt termination of drug exposure.
- **Tolerance** is the fact that there is a decrease in susceptibility to the effects of a drug and that one needs to increase the dosage to get the same effect.
- **Addiction** is defined as the compulsive use of a substance, despite the negative consequences. The relative risk of addiction is measured on a scale from 1 (non-addictive) to 5 (highly addictive).

Part 2: Barriers & Solutions

The current state of Aboriginal health as we described it, is the result of many factors and especially of the barriers to health care access. We have identified quite a few and it is by lowering those barriers that the people working in this field can improve the situation. Following the increased awareness of both the Australian society and government, several events led to what appeared as a new era of Aboriginal health, mainly on a legislative level. Nowadays, the solutions that are used are networks of both actors and services on different levels, going from federal to local. One thing that we take to heart is to highlight the amazing work that has been done by the teams on the ground by presenting their challenges and solutions.

I. The Beginning of a Change

Given the situation, the need to find a solution seemed to have become extremely urgent. A couple of events contributed to accelerate that process over the past decades. The first and most important was quite likely the referendum of 27th May 1967. It really was the collective awareness of the entire Australian society that allowed the acceptance of that modification of the constitution. There were indeed 90.77% of the citizens that answered 'yes' to the question: «*Do you approve the proposed law for the alteration of the Constitution entitled* 'An Act to alter the Constitution so as to omit certain words relating to the people of the Aboriginal Race in any state and so that Aboriginals are to be counted in reckoning the Population*' ?*» Besides there being an overall majority, there also was a majority in each of the states, which was quite spectacular. [19]

	Votes	For		Against		Informal
New South Wales	2'166'507	1'949'036	**91.46 %**	182'010	8.54 %	35'461
Victoria	1'630'594	1'525'026	**94.68 %**	85'611	5.32 %	19'957
Queensland	848'728	748'612	**89.21 %**	90'587	10.79 %	9'529
South Australia	560'844	473'440	**86.26 %**	75'383	13.74 %	12'021
Western Australia	405'666	319'823	**80.95 %**	75'282	19.05 %	10'561
Tasmania	189'245	167'176	**90.21 %**	18'134	9.79 %	3'935
Total	5'801'584	5'183'113	**90.77 %**	527'007	9.23 %	91'464

Table 4. Results to the question addressed to the Australian people on 27th May 1967 regarding the deletion of part (xxvi) of the section 51 and the repeal of section 127.

With the acceptance of this referendum, there has been a real fight for self-determination. Concretely, this can be seen as the right to be involved in health service delivery and decision making according to protocols or procedures determined by Aboriginal communities based on the Aboriginal definition of health (defined in Part 1 | chapter III-D).

«Please, before you go running off with all good intentions, talk to our mob around the country. [...] If you are going to do Aboriginal health, do it with us, don't do it without us»
[Dr Puggy Hunter]

The creation of AMSs (Aboriginal Medical Services) came from the need to provide a culturally appropriate medical service for Aboriginals. The first AMS was established in 1971 in Redfern (a suburb of Sydney with a high Aboriginal population). From this time on, there has been an expansion of AMSs throughout Australia. This made it necessary for a structure to be set up that would, on one hand, guarantee the community controlled system and, on the other hand, make the link between the different AMSs. The *Aboriginal Health Research Co-operative* was thus established in 1985. It has since then changed names and is now known (since 1999) as the AH&MRC.

These past years have known quite a few changes. In 2008, the Prime Minister, Kevin Rudd, on behalf of the current federal government, gave, for the first time, official apologies to the members of the Stolen Generations for the actions of the different past Australian governments. The speech given soon after his investiture in front of the house of representatives had been requested for a very long time and definitely made its mark on the history of Australian politics. Here is a transcription of the recording:

"I move - that today we honour the indigenous peoples of this land, the oldest continuing cultures in human history. We reflect on their past mistreatment. We reflect in particular on the mistreatment of those who were **Stolen Generations** - this blemished chapter in our nation's history. The time has now come for the nation to turn a new page. A new page in Australia's history, by righting the wrongs of the past and so moving forward with confidence to the future.

We apologise for the laws and policies of successive parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians. We apologise especially for the removal of Aboriginal and Torres Strait Islander children from their families, their communities and their country. For the pain, suffering and hurt of these Stolen Generations, their descendants and for their families left behind, **we say sorry**. To the mothers and the fathers, the brothers and the sisters, for the breaking up of families and communities, **we say sorry**. And for the indignity and degradation thus inflicted on a proud people and a proud culture, **we say sorry**.

We -the parliament of Australia- respectfully request that this apology be received in the spirit in which it is offered: as part of the healing of the nation. For the future we take heart, resolving that this new page in the history of our great continent can now be written. We today take this first step by acknowledging the past and laying claim to a future that embraces all Australians. A future where this parliament resolves that the injustices of the past must never, never happen again. A future where we harness the determination of all Australians, indigenous and non-indigenous, **to close the gap** that lies between us in life expectancy, educational achievement and economic opportunity. A future where we embrace the possibility of new solutions to enduring problems where old approaches have failed. A future based on mutual respect, mutual resolve and mutual responsibility. A future where all Australians, whatever their origins, are truly equal partners, with equal opportunities and with an equal stake in shaping the next chapter in the history of this great country, Australia."

In his speech, Kevin Rudd mentions the importance of "closing the gap" and outlines the main concepts of the program that will be set up soon after and that involves actions that target not only health directly, but also education, housing and employment.

II. A Multiple-Scale Solution

A. The *Closing the Gap* Initiative

The concept behind the *Closing the Gap* initiative is in reality not an original idea from the Australian government. This type of awareness first arose in a neighbouring country with a similar problem and that has always served as a model concerning indigenous issues: New-Zealand. At the end of the '90s, the government of New Zealand started putting in place policies in order to improve the health of the Māori and Pacific Islander populations.

The various aspects of *Closing the Gap*

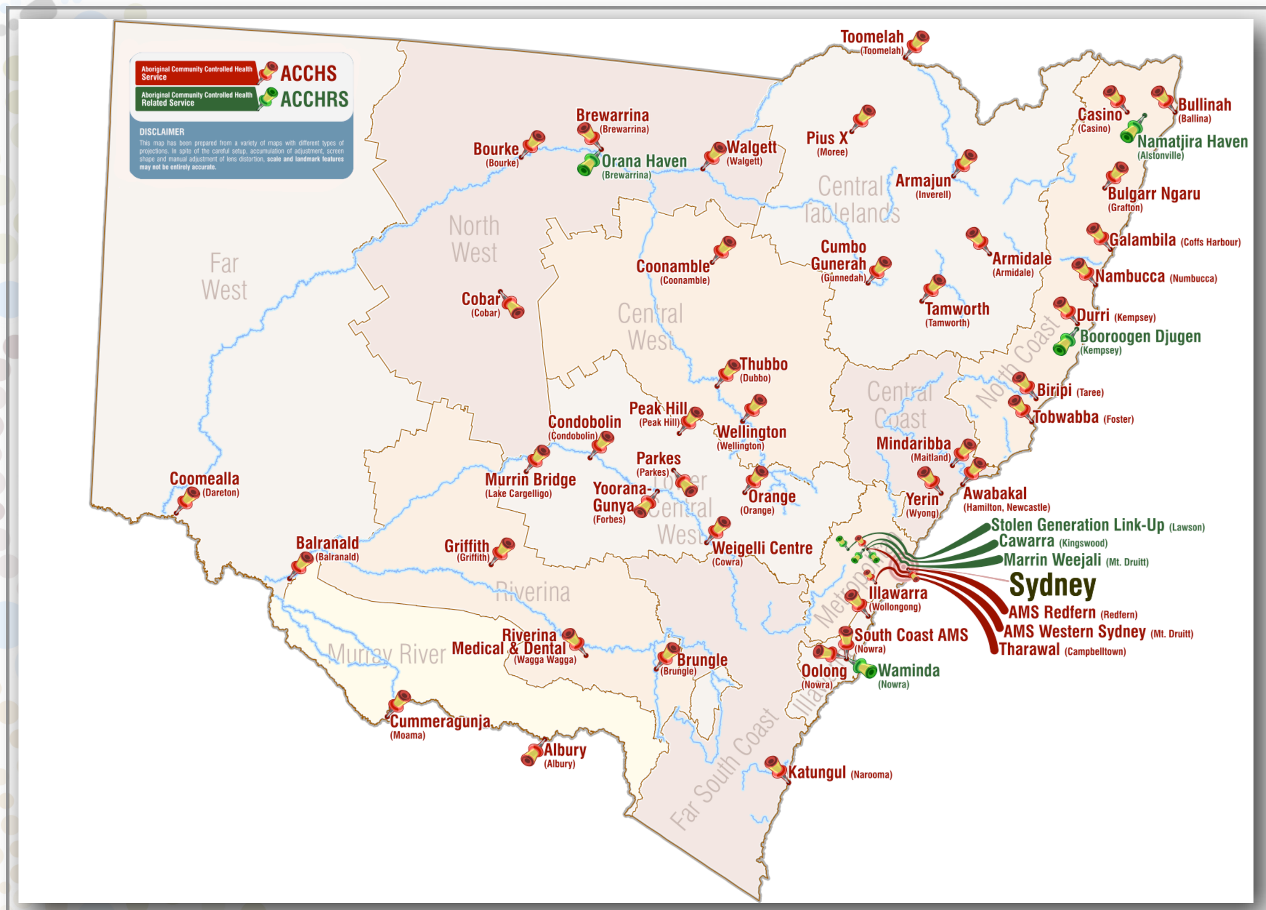
On 2nd April 2005, NACCHO and Oxfam Australia (a charitable organisation that fights against injustice and poverty) published *Close the Gap*, a report that pointed out the huge differences in health statistics between the Aboriginal and non-Aboriginal Australians. This report also calls upon the Australian governments (federal as well as of the different states) to take measures to achieve health equality within the next 25 years, in 2030. Through Oxfam, many Australians have been given the opportunity to express their request for action to the federal government. In response, the federal government, most states as well as the opposition, signed in March 2008 the *Close the Gap Statement of Intent*, a declaration of intention indicating they were ready to get involved and fight against those inequities. The government also engaged itself to publish an annual report of the achieved progress: the *Prime Minister's Report* of which the last edition was published in February 2013. For its part, the Close the Gap Campaign Steering Committee also publishes its *Shadow Report* to give its own opinion of the situation.

In November 2008, a 5-year funding program (until June 2013) allowed to make 1.57 billion dollars available, as part of the *Closing the Gap* initiative. The idea is to finance different programs that are competing with each other. It is important to understand that these funds are not reserved for AMSs and that any structure claiming to work in order to improve Aboriginal health can apply for them. The reason for this deadline is quite simple: a government only being elected for five years, the prime minister cannot take decisions that would engage the country further than the potential end of his mandate. It will then be up to the new government to evaluate and decide on the amount of resources to allocate in order to continue the *Closing the gap* initiative.

B. The Aboriginal Health & Medical Research Council

✦ Goals and Organisation

The AH&MRC (Aboriginal Health & Medical Research Council of New South Wales) is the peak representative body and voice of Aboriginal communities on health in NSW. They represent their members, different ACCHSs (Aboriginal Community Controlled Health Services) of the state of NSW that deliver culturally appropriate comprehensive primary health care to their communities.



Regional Map of the Members of the AH&MRC

The AH&MRC is mostly funded by the federal government and by the government of NSW and to a lesser extent by the contributions of individuals or independent organisations. According to its own *Strategic plan 2011-2014*, the purpose of the AH&MRC is to:

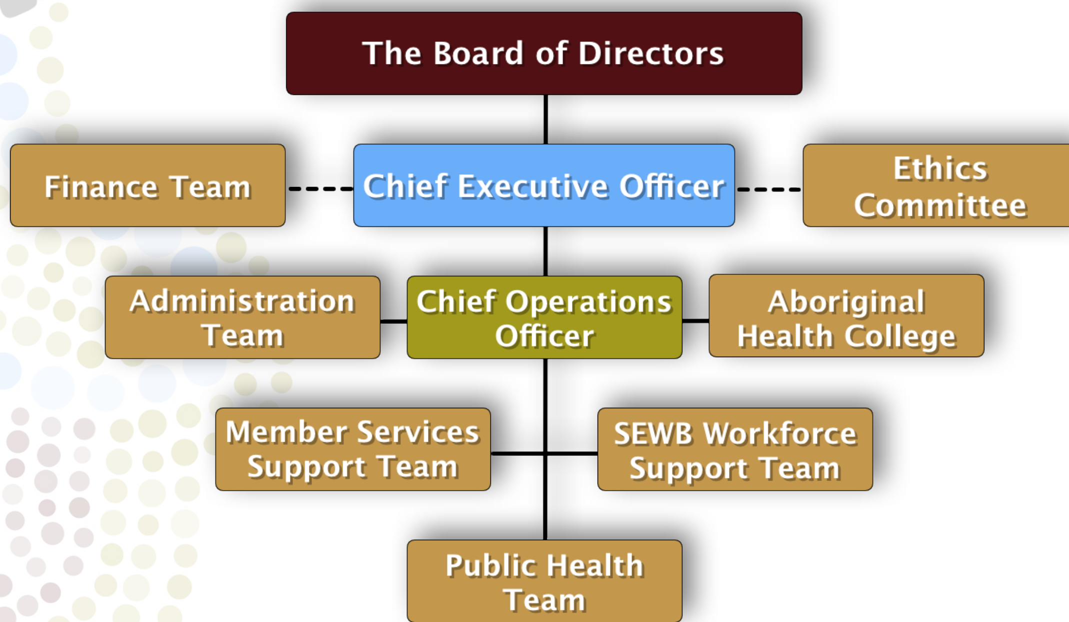
- lead the Aboriginal health agenda for better policies, programs, services and practices
- ensure Aboriginal knowledge informs decision-making processes
- support, strengthen and sustain Aboriginal Community Controlled Health Services

The main goals of the AH&MRC are to:

- improve the health of Aboriginals across the state
- improve Aboriginals' access to culturally appropriate primary health care services
- reinforce the capacity of the NSW's ACCHS to deliver "high quality, comprehensive, holistic primary health care services"

The AH&MRC chose to focus on four priority areas:

- self-determination: increase of the effectiveness of the AH&MRC's active involvement in decision-making at state level
- relationships: improvement of the quality and effectiveness of relationships with all stakeholders
- workforce development: strengthen of the capability and competence of the Aboriginal health workforce
- health services & programs: ensure that they are effective, sustainable and reflect local Aboriginal community needs



Schematic representation of the AH&MRC organisational chart

✦ Examples of Undertaken Actions

With the funding program coming to an end and the possible upcoming change of the federal government, one of the actions that is undertaken consists in making sure that a maximum of ACCHS obtain a double accreditation: clinical and organisational. These accreditations attest to the quality of the medical facility and their efficiency in providing primary health care of quality. For the moment, it is not necessary to be organisationally accredited to receive funds, but that might change in the future. An AMS is accredited clinically against the Royal College of General Practitioners (RAGP) standards and organisationally against Quality Improvement Council (QIC) or International Organisation for Standardisation (ISO) standards. Organisations known as 'License Providers', have the license from the standard holders to review the practices to see if they are adhering to the standards and if so, can grant them accreditation.

Another example of action led by the AH&MRC is the organisation of a GP forum that brings together general practitioners coming from different ACCHS all around NSW. It lasts two days and enables them to update their knowledge, highlight the things that are not working, the challenges they come along and the barriers there are facing. It also gives them the opportunity to ask questions to the people in charge from the AH&MRC and to discuss potential new solutions.

We have ourselves been able to attend the 2013 edition of this forum, in which 29 GPs participated and noticed that many pertinent issues arose, allowing the AH&MRC to get feedback directly from the field. However, such a forum involving only general practitioners does not provide a complete overview. The AH&MRC does run workshops and seminars for other health professionals as well, including Aboriginal health workers, on quite a lot of topics (ranging from tobacco control to social and emotional well-being). They also hold a conference on continuous quality improvement (the *CQI Conference*).

C. Aboriginal Community Controlled Health Services

✦ Definition

An ACCHS is an incorporated Aboriginal organisation, initiated by a local Aboriginal community, based in a local Aboriginal community, governed by an Aboriginal body (which is elected by the local Aboriginal community) and delivering a holistic and culturally appropriate health service to the community which controls it.

It could be seen as a western medical centre that has been ‘aboriginised’. Aboriginal staff acts a front-line: drivers, receptionists, health workers are all Aboriginal and are the first people that patients come across when going to the AMS. You also have culturally trained nurses and doctors, who are rarely Aboriginal because of the lack of staff qualified for these positions. Aboriginal health workers are encouraged to go further up and do longer courses to get more clinical skills, which also gives them more recognition by the community. In Orange AMS for example, one of the drivers was training to become a Drug & Alcohol and mental health worker and one of the Aboriginal health worker was training to become a registered nurse.

✦ Organisation

Each service has its own board, composed exclusively of Aboriginals. This is necessary for this structure to be community controlled. It is important to keep in mind that the people being chosen by the community, they are not necessarily the most competent, which can lead to some organisational problems.

Chief Executive Officer (CEO)

Public Health	Clinical	Administration
• Tobacco Control workers • Aboriginal Health workers • Sexual Health workers • Drug & Alcohol workers • Eye Health Coordinator • SEWB (BTH Counsellors, Link up Counsellors)	• Doctors • Practice Manager • Nurses • Aboriginal Health Practitioners • Allied Health	• Finance Manager • HR Manager • Funding Relationships Managers (reorients/submissions) • Governance and Accreditation Officers • Administration and Receptionist • Cleaners/Drivers/Gardeners

Table 5. Typical structure of an AMS

✦ Purpose

Contrary to what one may think, Aboriginal Medical Services do not only provide medical service to Aboriginals. Some AMSs indeed are also open to non-Aboriginals, but they do not always benefit from all the programs run by the AMS. Nevertheless, there are important differences between mainstream structures and AMSs.

Primary Health Care

One of the main elements is that AMSs were created as services that provide primary health care above all, as opposed to acute care. Primary health care was defined as follows, during the WHO conference in Alma-Ata in 1978: «*Health care that encompassed health promotion strategies, nutritional and environmental interventions for disease control, social supports, and essential drugs in addition to primary medical care.*»

Their main activities should be focused on intervention and prevention. This means that the main purpose of the AMS is not only to treat an ill patient, but also to do a lot of prevention work as well. The latter can be separated into three stages:

- **primary prevention**: complete avoidance of the disease or delay of its onset
- **secondary prevention**: detecting and curing a disease before it causes symptoms
- **tertiary prevention**: minimising the consequences of the disease

This has a lot of impact on the way chronic disease is dealt with for example. The health care providers are really going to try to coach the patients: make sure they understand what is going on, what and how they are supposed to take their medication (and make it clear to them why their compliance is so important) and advise them about their behaviour. Health checks can be done yearly, and allow to do some early screening as well as primary (possibly secondary) prevention.

Team Approach

The patient is taken care of by a whole team of health specialists to make sure he gets all the support he would need. These 'teams' can be composed for instance of a general practitioner, nurses, Aboriginal health workers, chronic care specialists and a dental team, depending on the AMS and the resources available, as well as on the general needs of a specific community.

«The nurses don't work for me, I work for them.»
[Regional GP Educator, Bila Muuji AHS]

This approach came from the need of meeting a certain number of goals:

- taking into account the different needs of a patient
- connecting the patient with the entire service
- providing a support network for the patient
- improving the medical care, by working as a team and thinking together

Both recruitment and retention are important issues across the whole sector. One must know that it is now mandatory for every GP registrar to spend some time in the Aboriginal health sector. Nevertheless, most of them are not interested in the prospect of pursuing a career in this field. Thus, the frequent turn-over of staff is quite a problem in AMSs. To solve this, various actions are undertaken in view to increase the attractiveness of those services. For example, medical students are offered short placements to discover the reality of working in the Aboriginal health field, with both its pros and cons.

In this context, having a whole team looking after the patient ensures that the patient will always have someone he trusts to refer to, even when one of the health care providers decides to leave. This concept of building a relationship with the team and not only with the individuals is important for the patient to feel comfortable in the service at all times.

✦ Funding

AMSs receive an important part of their funding from a specific area of the federal Health Department that has been set up to focus on improving Aboriginal health issues. Besides being funded by the federal state, they also receive funds from New South Wales, but their funding is totally independent from the AH&MRC.

> «Aboriginal Medical Services have to be run like a business.»
> [Jamie Newman, CEO of Orange AMS]

Sometimes when there is no proper governance, some AMSs are closed down. This can either be due to a lack of management skills (e.g. Thubbo AMS in December 2012) or to corruption and embezzlement. However, it is sometimes possible to prevent the closure of the service by setting up an auspice agreement. The AMS will still be independent, but another AMS will hold the funds and look after their expenses. An example of this is Wellington Aboriginal Corporation Health Service (WACHS) that auspices Tamworth AMS[20] or Griffith AMS with Murrin Bridge.

Murrin Bridge Medical Centre

III. Some Concrete Interventions

On the ground, interventions have a dual function of repair and prevention. The health care providers have at heart to work on the long-term as much as on the short-term. According to what people told us, this approach is indeed necessary to establish long-term change and to prevent the cycle from repeating itself generation after generation, as is currently the case.

A. Socio-Economic Issues

During our various interviews, when we asked the question of what was the biggest barrier to improving Aboriginal health, one of the answers that emerged the most was the problem of the socio-economical environment. Many Aboriginals have a low socio-economic lifestyle (poor, high rate of unemployment, overcrowding in homes) as we disused it in Part 1 | chapter III-D. It is known as being an important determinant of health, regardless of the origin. There is indeed evidence demonstrating a relationship between improved living environments and the improved health of populations (NSW Health 2010a). Within the framework of the *Closing the Gap* initiative, many programs have been put in place to address these issues.

✦ Access to Medical Services

The first thing that is important is that a vast majority of medical services provided by the AMSs are free because there are covered either by Medicare Australia or by the funds associated with the programs of Aboriginal health improvement (for further explanation, please consult Part 3 | chapter I-B). In some AMSs, this is mainly the case for dental care that would otherwise be quite expensive. The government also implemented the Pharmaceutical Benefits Program (PBS) that allows Aboriginals to get medicines cheaper or even for free if they have a concession card (students, seniors, veterans, etc). For example. the price of Champix® (a medication used to help people quit smoking) is normally about $35.40, but Aboriginals can buy it for only $5.80 without concession card. Furthermore, the only condition to benefit from this program is to subscribe to it.

Every year, there is a set amount of money allocated to AMSs. In case of budget excess, the government can sometimes finance some extra cares. Thanks to this, in Tharawal Aboriginal Corporation, children of low income families have benefited from an ENT (Ear Nose Throat) surgery as early as possible, thus decreasing the risk of complications. Without this, these children would have been put on waiting lists and by the time they would finally have had their ear drum repaired, they would already have developed learning delays.

✦ Housing

A second element that is important to improve Aboriginal health is to give them access to better housing. Until now, the government's interventions consisted essentially in making social housing available, but their money is now more and more being used to fund private housing for Aboriginals. However, the access to these services can be difficult.

First, because of the administrative load such a procedure represents, but also because of the different criteria that need to be met and that do not necessarily take into account some specific situations. In some cases, it is necessary to present a certificate of Aboriginality that is not easy to obtain administratively, thus limiting the access for some patients.

To support patients, different AMSs have a team or a person designated to take care of housing issues. At Tharawal Aboriginal Corporation for example, Roxanne advises some patients and helps them avoid being evicted from their homes or to find a new housing after finding an arrangement with the former owner if the patient is indebted. At Griffith AMS, a “Homelessness Action Plan” consists of defending all Aboriginals that have been homeless or couch surfing for over two years to get a house as well as helping them get a furniture package (fridge, washing machine), using the funding of housing NSW (state government body responsible of housing issues). According to Kylie Charles (Griffith AMS, Social & Emotional Well-Being worker), the biggest issue that her clients cannot get over is housing in 9 out of 10 cases (followed by getting a driver’s licence and finding a job).

✦ Money Management

At Tharawal Aboriginal Corporation, a third type of support is provided: the ‘Money Management Education Program’. Harry advises his clients (mostly young adults starting out on their own) and helps them manage their budget. The emphasis is mainly put on the economic disadvantage of tobacco consumption. He takes the time to calculate with smokers how much money they spend every year to satisfy their addiction. This can give them a concrete reason to quit. In the same trend, the AH&MRC’s brochure *‘Is gambling affecting your family and mob ?’* enables to open the dialogue on a problem that is not specific to Aboriginals, but concerns them as well (gambling being a common problem in Australia).

B. Appropriate Medical Caring

✦ Person-Centred Approach

During our medical training in Geneva, a lot of emphasis was put on the “person-centred approach”. This concept is something we found in Australia as well, talking to different GPs, even if it was not explicitly designated in these terms. As in all health care provider to patient relationship, the key to engagement is trust. Taking the time to get to know and understand the patient is a way to show him our respect. A patient who feels respected will trust his practitioner and will be more inclined to get involved in the caregiving process and be compliant. One has to be careful because, in some Aboriginal cultures, open contradiction is something very disrespectful and some patients will not hesitate to concur with the health care provider even if they disagree. For others, this obviously might simply be a way to avoid a consultation to drag on if they do not feel comfortable or are not completely engaged in the relationship with the health practitioner. It is essential for the health care provider to open up to the patient and to show his understanding and goodwill. He also has to make sure he has not been too directive, in order to be able to really have a deal with the patient.

As always in the health field, when a patient comes in a health service, he has a certain complaint and his own worries. It is important to take those into account and not to focus only on what we consider as being the priority. For example, feeling bad emotionally could sometimes be considered by Aboriginals as being much more important than physical pain and it should therefore not be put aside during a consultation. Furthermore, we really had this impression that, for a large majority of Aboriginal patients, health itself is not a priority. For health practitioners this can be extremely frustrating: "*There are many no-shows because people just forget or something more important to them came up.*" A part of this explanation is cultural and to understand what we (as health care providers) would consider as a lack of interest in health, we have to remember the importance of family in Aboriginal society. If, for example, a relative passed away, is ill or in need, the patient will not show up for his appointment and will not necessarily take the time to call it off.

As for all patients, it can be quite difficult for a health care provider to convince them that a disease is not always associated with symptoms. This means that patients are not always likely to show up at the AMS and/or to accept to do a check-up. This is particularly a problem among chronic disease patients who need prevention and a regular follow-up. This is why a lot of work has been put into getting that message through. In this prospect, Aboriginal health workers go to the community from time to time to promote the AMS and explain its goals, what services it provides and why they would benefit from coming for an appointment. Furthermore, much effort has been made so that once patients have made the decision to come to an AMS, they do not have to face an access barrier. Drivers go pick up people at their house to drop them off either at the AMS, or at another health centre where they have been referred to.

Moreover, a wide range of health services can be found in the facilities of the AMS. For example, specialists come in on a regular basis. The closest specialist can indeed be quite far from where the patients live, so they might not be able to visit him. Also, going to see a specialist in his practice would be more expensive than going to see him at the AMS (because of the way Medicare Australia bills the different services depending on where they are delivered). Altogether, this helps improve health access for Aboriginals.

Child and Maternal Health Outreach Service

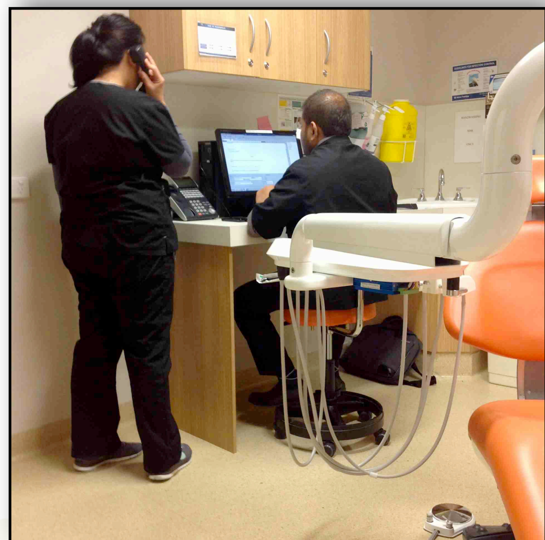
At Griffith AMS, the maternal health team (also knows as 'Mums & Bubs team' by the locals) directly goes inside the community with its motor home, so that parents do not need to get to the medical service for simple interventions like immunisations. This has many advantages and increases the access to health for a great number of patients who, without that, would probably not come at all. Under guise of an immunisation campaign, the health care providers take the opportunity to do some indirect health promotion by dealing out water bottles and toothbrushes to children after their shot (as a gift for their bravery). They also take the time to look after the mother and to discuss with her about problems such as post-natal depression, socio-economic issues and the existing solutions. Also, when possible, they try to convince her to get in for a health check or a consultation with a psychologist at the AMS.

✦ Cultural Adjustment

The first important thing that Aboriginal patients could be looking for when coming to an AMS is an Aboriginal friendly environment (which can be lacking in mainstream services). This environment comes, first of all, from yearly cultural awareness training sessions for staff that makes them more culturally sensitive and respectful towards their patients. They will also be made more aware of the specific factors influencing Aboriginal health. It is always important to adapt to the local community and to take into account the differences in terms of representation of death (linked to the cyclical vision of the world and time) or the differences in terms of expression of pain and lack of well-being. During one of our cultural trainings, we were warned about emotional reserve and were told that it was something that health care providers had to keep in mind when facing an Aboriginal patient.

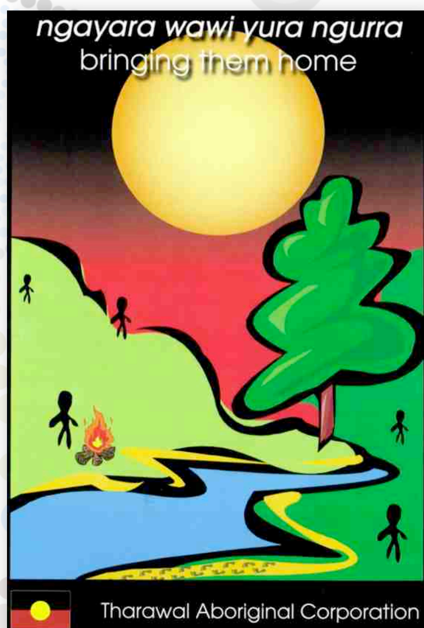
We are really emphasising all this because it changes the priorities of health care (that, as we already mentioned, have to fit with the patient's needs and requests) and also the type of treatment to choose, depending on the compliance of the patient. For making appropriate diagnoses, it can be important to understand that the grief process can be very different: thus, seeing spirits of the deceased and even possibly interacting with them is frequent and must not arbitrarily be considered pathological. The definition of norm in psychiatry is indeed considerably influenced by the cultural and social environment.

Some topics, like the wearing of a white coat, can lead to dilemmas of finding the most appropriate approach. The white coat, besides being an undeniable component of hygiene, is also one of the most representative symbols of the western health care providers. Generally speaking, the white coat we are so used to in Geneva is banned in AMSs because it contributes to creating an important barrier between the health care provider and the patient. Every institution has its own habits, but the most common solution we encountered was the wearing of a uniform by the whole health team. We were astonished during our placement at OAMS to see how the dental team dealt with this issue.



Dental team at the Orange AMS

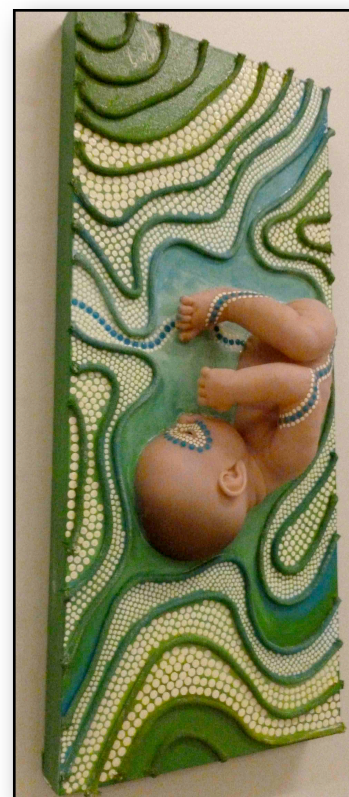
Having to wear lab coasts for the purpose of asepsis, they chose to wear black coats. It is not necessarily linked, but it is interesting to know that in some Aboriginal tribes of Australia's red centre, the white colour is indeed associated with death and grief. This difference in symbolism is another marking example of the cultural disparities.



Intuitively, one might think that it is a good thing to have Aboriginal staff at the front-line because their strong ties with their community reduce the barriers of communication and make the patients feel more at ease. This is true to some extend, but with everyone being acquainted with each other inside the community, Aboriginal workers in the AMSs can sometimes be questioned about their confidentiality, despite their professionalism. It is not possible to predict whether a patient will trust Aboriginal staff more or not and this issue must be addressed individually with the person.

There seems to be a gap between the medical culture where confidentiality is a fundamental principle and the Aboriginal culture, where community and communication are really important. For this reason, Griffith AMS specifies on the back of their brochures that their services are free and confidential.

Another way to show cultural respect is to use words in the local language in brochures, websites, etc. Tharawal Aboriginal Corporation uses for example the term *'Djurali'* (Live well/ healthy) or *'ngayara wawi yura ngurra'* (Bringing them home). On other brochures, alcohol is refereed to as *'grog'*, cannabis as *'yarndi'* and baby as *'boori'*.


Artwork in the waiting room of the Murundhu Dharaa centre

Furthermore, being aware of the cultural differences can help conceiving models of therapeutic interventions that are more adequate. Two elements that lie within Aboriginal culture appeared to us as being at the basis of some programs we will discuss further on. First, community and family are considered being more important than the individual and second, transmission of their culture and knowledge was traditionally oral.

At Tharawal Aboriginal Corporation, Michael Bonning (a young GP trained in Australia) is very conscious of those elements and does not hesitate to do consultations with different members of a family at the same time. The concept is easy, but uncommon in our classic conception of a fifteen minutes consultation. In one hour, he took care at the same time of the problems of the grandfather, the mother and the daughter from a same family. Some patients confessed feeling much more at ease than when on their own with the doctor. Furthermore, this approach has the advantage of getting everyone involved in the healing process. The physician can for example ask the kids and grandkids to look after their (grand)dad and remind him of taking his medication.

Something we often came along at the different places we went to, was the existence of discussion groups and workshops. These groups often target a specific age and/or gender group: teenagers, male adults, female adults, older people, etc. The benefit of such an approach is that you are not just focusing on one person, but on a problem (which makes some people feel much more at ease). It is often easier to talk with people who have the same problem, than to have a face-to-face discussion with your doctor.

One example is the “Building Resilience Campaign”, a youth focused (16 to 30 years old) harm reduction program “aiming to strengthen the resilience of young Aboriginals around drug use and blood borne viruses”[21]. The primary target are the community members, but it also has an effect on the different services (schools, AMSs, etc.), The AH&MRC has even contracted an Aboriginal hip-hop band (the *Last Kinection*) to help implement the campaign. They assisted over this workshop to create songs, record and produce video clips.

Griffith AMS organises men’s groups, called “Aboriginal Men’s Yarn ups” that are quite successful because the organisers use the feeling of isolation of those men. It is the opportunity for them to address problems related to excessive alcohol consumption, domestic violence, parenting and, more broadly, it allows them to feel more concerned about their health. This is a great thing because men in their twenties and forties are less accessible because they are less likely to spontaneously walk into a structure of primary health care like an AMS. Those “yarn-ups” are a good opportunity for them to identify ways in how to manage and work through their different personal issues.

The plan of the organisers, according to their brochure, is *«to make this a safe and comfortable place to be where [they] feel the ability to make a positive contribution and where [their] views are respected»*. According to them *«men tend to have more trouble facing, identifying and exploring their issues and also tend to talk less than women, since their way to deal with personal suffering or incertitude is usually to keep it to themselves»*. Rather than being a refusal to discuss an issue, most of the time it is just a discomfort that comes from direct confrontation and that can thus fairly easily be circumvented by starting a conversation while busy on any unrelated task before slowly bringing up the subject of interest.

Unfortunately, not all the programs created within the framework of the *Closing the Gap* initiative are known about. Yet, informing patients is crucial: if they do not know what they can access, they cannot benefit from it. At Griffith AMS, we talked to Richard Bamblett, an Aboriginal outreach worker. His role is to go to the communities and explain what services are available for them, but also assess what is lacking and where the gaps are, in order for the different programs to fit more accurately the community’s needs. Talking directly to the elders of the community is very important because a big part of the individual information goes through networking.

> «What I may say to you might not be for you,
> but you may know someone who will need it.»
> [Aboriginal outreach worker, Griffith AMS]

This kind of approach, also used by the members of the AH&MRC (who sometime drive for hours just to have a 30 minutes face-to-face conversation), is part of the cultural adjustment necessary when working in this field.

In fact, the most prevalent diseases that Aboriginals suffer from are not really specific to them. In most cases, they have chronic illnesses that have an important prevalence in the general population as well, the biggest difference being that they tend to appear at a much younger age in Aboriginals. This comes from various factors, including a low socio-economic background that can lead to bad lifestyle and the lack of access to health services. For the same reasons, there are also more infectious diseases and third world country illnesses in this population. Typically, living in overcrowded homes increases the risk of otitis media and other communicable diseases. In this context, it seems essential to conceive programs that specifically target those health issues.

Physical Health

Because of the long-term side-effects of medication, when caring for patients with chronic disease, health care providers focus the most on changing their lifestyle. They try to identify patients as soon as possible, through screenings and health checks. Aboriginals are underrepresented in screenings. For type II diabetes, for example, the federal Department of Health and Ageing published a *Risk Assessment Tool* that helps score the risk. This multiple-choice test can be used by the patient willing to do a self-assessment or by any staff member of an AMS to make a quick and easy evaluation. Regarding research, the Cancer Council of NSW set up the Aboriginal Patterns of Cancer Care (APOCC) project to encourage Aboriginal patients to take part in studies, in order to better understand the flaws of the path among the different medical institutions they go through before ending up with a cancer diagnosis.

Many efforts have been made to improve the follow-up of patients. This is the case whether it concerns acute care (for example when a patient is hospitalised he will be linked to an Aboriginal Liaison Officer like in Orange) or chronic care (when a GP management plan is established). The latter comprises a first consultation with a nurse and/or an Aboriginal health worker, followed by one with a doctor. A plan of care is then established that includes the treatment and follow up of the patient, as well as, if needed, appointments with specialists (cardiologist, dietitian, etc). The patient then sees a Chronic care coordinator, like Deon Adamson, who will explain to him everything and become the reference person for any questions related to treatment. She is also responsible for making asymptomatic patients realise how important taking care of themselves is.

Among the younger ones, there is a high incidence of middle ear infections (see Part 1 | chapter III-B). This condition is taken very seriously by everyone who works in the field because recurring otitis media often leads to hearing loss, which impairs language learning and thus leads to learning difficulties at school. The NSW government published a brochure “Healthy Ears, Happy Kids” to raise awareness about the importance of screening and early intervention. On the ground, a lot of effort is done because the issue is well known and can be prevented.

A good hygiene (mainly through hand washing and proper ear cleaning) is promoted and all parents are taught to use the corner of a tissue to slowly remove the wax from their children's ears. This minimises the risk of rubbing the eardrum that can already be weakened by inflammation.

When unfortunately a language delay has developed (very frequent), speech pathologists become essential to compensate it. We have seen them in every AMS we went to and in Dubbo, where the AMS just opened, those issues are dealt with by the Aboriginal Children Therapy Team (ACTT), that takes care of all local Aboriginals until eight years old. At Tharawal Aboriginal Corporation, the work of the speech pathologist is facilitated by the immediate proximity of the preschool for the children of the community. This kind of place, located on the same site as the AMS, allows a privileged access to the young children who, as we already mentioned, face specific medical problems. Besides insuring the medical follow-up, this kind of structure also makes sure that the children find themselves in an intellectually stimulating environment and in which the cultural enrichment integrates traditional Aboriginal elements.

Preschool centre at Tharawal Aboriginal Corporation

Mental Health

A Different Approach

To understand the way mental health services are provided in AMSs, it is important to understand that the approach is very different compared to the one we find in the western world. As we explained previously, Aboriginals suffer from complex trauma issues and complicated grief due to over 200 years of abuse and neglect. If you add to this cultural specificities, it is understandable that the consultation template used in western culture does not fit the needs of Aboriginal communities.

To make a diagnosis, the first step is to put aside the DSM (Diagnostic and Statistical Manual of Mental disorders) that does not take into account a great number of elements specific to Aboriginals. Besides, Aboriginals are already a very pathologised population[22], which means that they tend to be over-diagnosed, leading to an overuse of medication and stigmatisation, while the real cause of their so-called "abnormal behaviour" is being overlooked. From our discussions with mental health workers and psychologists at the AMSs arose that one thing that is essential is to spend a lot of time with the person and his family, if possible outside the setting of the medical practice. Consultations can for example take the form of outdoors strolls. It is recommended spending as much time as possible among the community, at patients' homes or at gathering places. Once again, trust is very important because psychiatrists can be seen as authority figures that the government used in the past to facilitate assimilation. To be able to treat and support a patient, you have to be able to listen to him and one of the best approaches is to put yourself in a "learning mode". If you take the time to build a relationship with them, they will get more explicit on the ways you can help them.

Furthermore, there is an important connection between depression and chronic disease that is often forgotten about. This means that, if a patient with a chronic illness also suffers from depression and that you do not look for the latter, you will not be able to provide him with the best care because you are going past half the problem. Also, patients with mood disorders (whether depression or anxiety) can be more at risk of developing a chronic disease. Treating their mental illness, you can then prevent the arising of a physical illness. It is always important to look for depression when seeing a patient. The *George Institute* is currently testing a new culturally adapted Patient Health Questionnaire (the aPHQ-9) with nine items to see if it accurately identifies depression symptoms among Aboriginals.

Stolen Generations

The Stolen Generations had a major impact on mental health, leading to profound traumas, a sense of abandon and loss, grief, etc. The consequences have been massive because all Aboriginals are either members of the Stolen Generations or are descendants or relatives of someone who is. It was terrible for the taken children who lost a big part of their identity, but also for the parents who experienced a terrible feeling of guilt. You have to remember that children were taken away systematically and not only in case of abuse or neglect. In some families, illiterate parents lost the custody of their children because the authorities made them sign documents they could not understand the content of.

In 1997, the Human Rights and Equal Opportunity Commission (HREOC) undertook the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families. They made 54 recommendations in their *Bringing Them Home Report*. One of which addressed the need to: «*assist Aboriginal and Torres Strait Islander people separated from their families under past laws, practices and policies of Australian governments to undertake family tracing and reunion initiatives.*» The Australian Government responded to this inquiry by providing funding to establish a national network of Family Tracing and Reunion Services (known as the *National Link-Up Program*). The Program would assist Aboriginal and Torres Strait Islander people separated from their families as a result of past governments' policies and practices[23].

In Griffith AMS and Tharawal Aboriginal Corporation, we met the different "Bringing Them Home" teams. Their aim is to redress some of the hurt and assist in the healing process. Besides organising support groups for the victims of the Stolen Generations, they also help them seek information about their family members in the archives to retrace the history of their origins. Knowing "who you are and where you are from" is indeed a key element to mental well-being. Some of the problems they face are that the records are scattered through different institutions (governmental, religious, etc.) and that the information found can be imprecise and sometimes even incorrect. To help with all this, Link Up comes into play, by compiling and indexing the information available on the Aboriginal families of the Stolen Generations.

When family members can be found, the program organises reunions. Different types of get-togethers are possible: "graveside" (if the parents passed away), "back to the country" (when the patient goes back to where he grew up), between siblings, or parents-kids. Most of the time, the siblings are the ones who welcome the person and take the time to teach him culturally appropriate information about his origins. If everything goes well (which is not always the case because of a possible culture shock), a reunion and even a reintegration in the home community can be considered. Despite the fact that this process can be painful for people at first, finding their origins back makes them feel a lot better and even has an incredible impact on health. To make sure everything is alright, a follow-up is organised every month and then progressively less often. Keeping that connection going with the family is the best healing process.

C. Changing Behaviours

✦ Healthy lifestyle

Tobacco

According to the National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 48% of Aboriginals smoke compared to only 22% of non-Aboriginals.

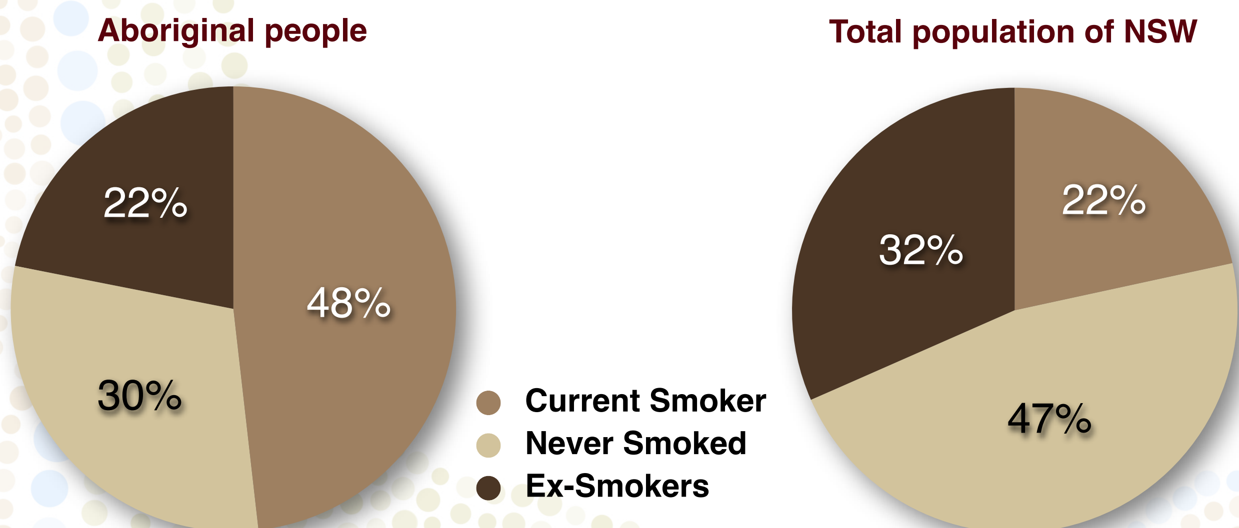


Fig 22. Incidence of tobacco consumption after 15 years by Aboriginality

However, according to what we have been told on the ground, it appears that a few biases in these studies would underestimate the massive smoking problem of Aboriginals. Aboriginals being 2.2 times more likely to smoke than non-Aboriginals, it is not surprising that smoking is estimated as being the first cause of the health disparity between Aboriginal and non-Aboriginal (according to burden of disease data). Indeed, smoking increases the risk of cancer, cardiovascular and chronic long disease, thus leading to many hospitalisations.

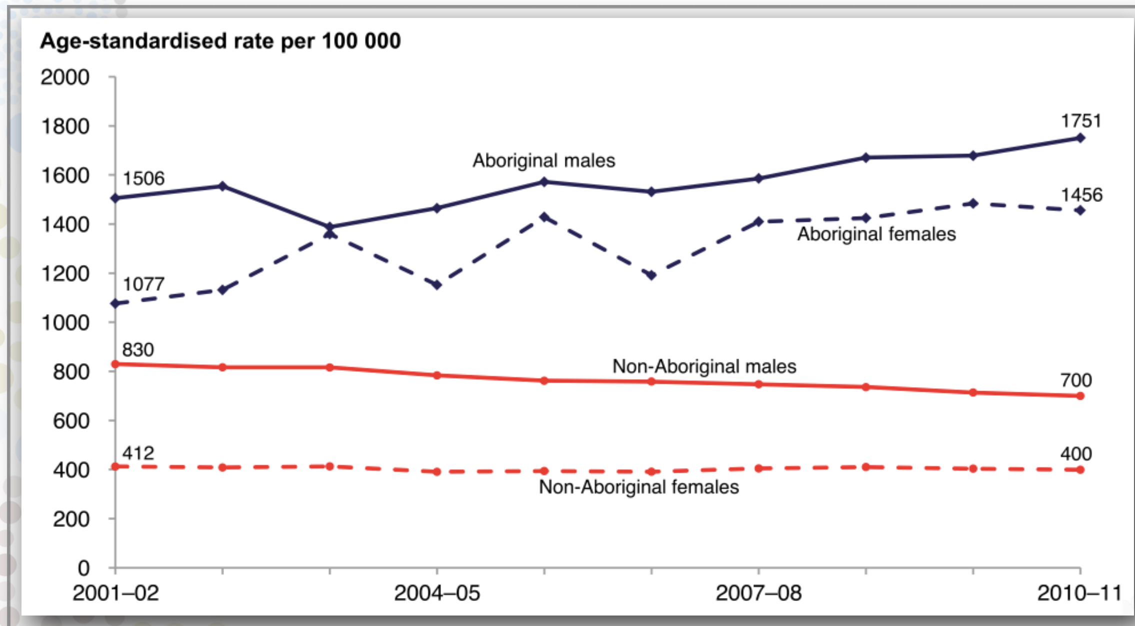


Fig 23. Smoking-attributable hospitalisations by Aboriginality (NSW, 2001 to 2011)

To cope with this problem, the program ATRAC (AH&MRC Tobacco Resistance And Control) was created. Established in 2009-10 with the broad goal to contribute to reduced smoking rates for Aboriginals in NSW, it is funded by the state Ministry of health. Under this program, an *Aboriginal Tobacco Resistance Tool Kit* was developed in consultation with ACCHSs to «*meet the growing need for practical support around tobacco resistance and control by ACCHSs in NSW*».

It is estimated by the current team of the AH&MRC that much progress has already been done in terms of health promotion, the problem on the ground being that there is not necessarily someone to handle the tobacco issue on a clinical level. Its action consists partly in informing and supporting the AMS's staff regarding tobacco control, mainly by organising skill building forums, promoting accredited training packages (e.g. at the Aboriginal Health College) and setting up collaborative structures like the Aboriginal Tobacco Resistance Network (ATRN).

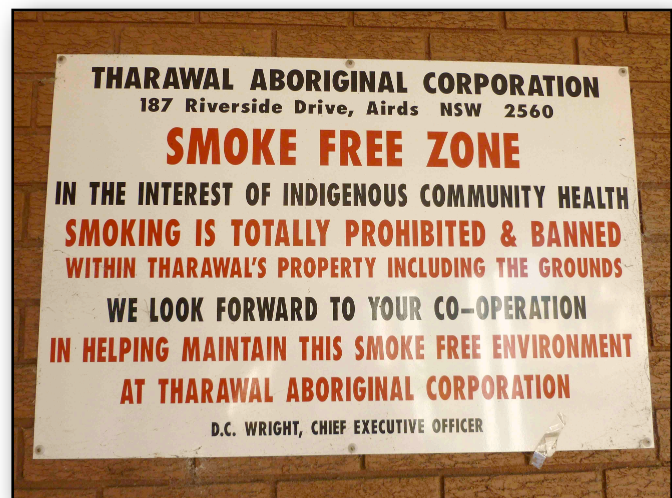
On a local level, several AMSs want to reinforce the skills of every staff member so that the patients can always have someone to talk to. Thereby, anyone can engage the dialogue and see if the patient considers quitting and/or might need some help. However, a potential risk is that each staff member may discharge the responsibility on others and that, ultimately, no one really takes the time to advise the patient properly. Taking this into account, Orange AMS decided it would be more efficient to have a reference person: Jacqueline Watt (a registered nurse) is thus the smoking cessation advisor of the AMS. She is responsible for the smoking cessation consults and is accessible to answer any questions that patients (or other staff members) may have.

The high prevalence of smoking leads to a lot of passive smoking as well, mainly inside homes and cars. Around 16% of Aboriginals reported not living in a smoke-free household, compared to 5% of non-Aboriginals. Yet, passive smoking increases the risk of infectious diseases, especially otitis media in children and respiratory infections in adults, in addition to the obvious cardiovascular and pulmonary impacts.

At Griffith AMS a lot of effort has been put into promoting smoke-free environments. This is done through educating community members and holding events in schools. A drawing competition for the design of a new poster was organised and the young winner won a voucher for some sports equipment. The change in behaviour is particularly difficult for older people that struggle to accept the idea of quitting for two reasons because they do not see the benefit they would get out of it at their age, but also because they come from a generation where the message of the medical profession was completely different.

«The doctor used to tell me to go get a smoke 'cause I was stressed out. And they paid me in sugar, flour and tobacco mate.»
[Patient during a smoking cessation consultation]

Before changing the patients' behaviour, the first step might be to change the behaviour of staff. All ACCHs now encourage their smoking staff to quit and provide them support to do so. The AH&MRC has even imposed a smoke-free policy that is more stringent than the NSW one. This policy prohibits staff members to smoke less than 15 meters from the institution's premises and also prohibits them to smoke when they represent their organisation in the field. The idea is that the denormalization of tobacco consumption, awareness of its dangers and willingness of smokers to change will increase in the future.



Smoke free environment at Tharawal AMS

Physical Activity

Overweight and obesity are real problems in Aboriginal populations. According to *Adult Population Health Survey Data*, 60% of Aboriginals in NSW have a BMI over 25, compared to 54% of non-Aboriginals. This problem is so important that it is estimated to be the second cause of health disparity between Aboriginals and non-Aboriginals (according to burden of disease data). Overweight is a major risk factor for many chronic diseases like diabetes and cardiovascular disease.

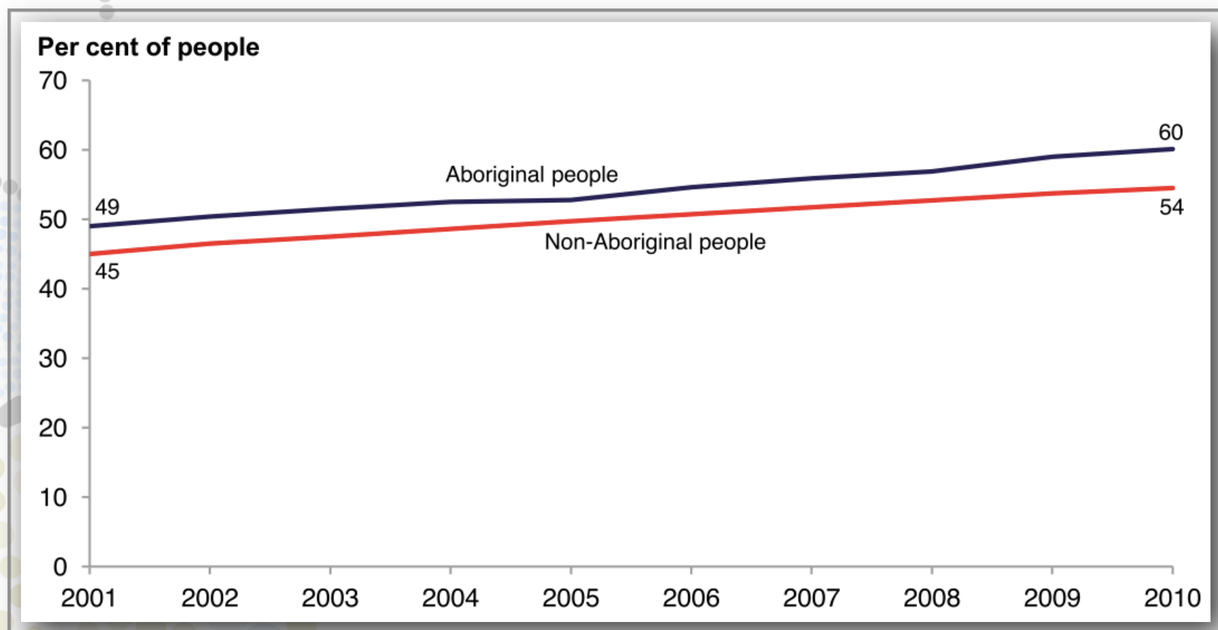


Fig 24. Overweight and obesity after 16 years by Aboriginality (NSW, 2001 to 2010)

This is such a national problem that the government published a brochure *"How to lose your belly without losing out"* that presents the national campaign *"Swap It, Don't Stop It"*[24]. The idea is to introduce in the population behavioural changes like reducing food portions, improving nutritional balance and enhancing physical activity.

One of the reasons for all these weight issues is indeed the lack of physical activity. In 2010, the *NSW Adult Population Health Survey* estimated that only 58% of Aboriginals reported adequate levels of physical activity compared with 57% in the general population. For Aboriginals, physical inactivity contributes 55% to the burden of ischæmic heart disease and 33% of the burden of diabetes.

Extract from the brochure *Swap It, Don't Stop It*

To address those issues and change the image of physical activity, some AMSs (like Griffith AMS) have a complete sport complex with trainers accessible for free. For others who do not have the resources to set up such an infrastructure, physical activity groups have been created. For example in Orange, patients going to the AMS are welcome to join the Aboriginal group that meets up twice a week to train together. More broadly, NITV broadcasts the show *Move it Mob Style*, the «*latest dance-based youth, health and fitness show*» that tries to get people to exercise.

Nutrition

In view to get Aboriginal families to have a balanced diet, cooking classes are organised by different teams in the AMSs (like in Tharawal or Griffith). Participants get taught what they want to learn to cook, but also receive advice from a dietitian who might encourage them to swap some ingredients for some others. Many patients use economical arguments to argue, explaining that eating healthy is too expensive for them. The aim of those teams is also to show that take-away food, besides being of poor quality, can cost more than some homemade dishes. Still in the trend of empowering the community, patients are even taught to read food labels so that they can be aware of what they eat and make informed decisions.

With regard to the daily consumption of fruits and vegetables, it is lower in Aboriginal populations, especially in the ones living in more remote areas because access to that type of food is more difficult and more expensive. In 2010, the *NSW Adult Population Health Survey* estimated that only 40% of Aboriginals were consuming the recommended intake of fruit (two or more serves a day), compared with 56% of non-Aboriginals.
Concerning vegetables, only 9% of Aboriginals were consuming the recommended intake (five or more serves a day), compared with 10% of non-Aboriginals.

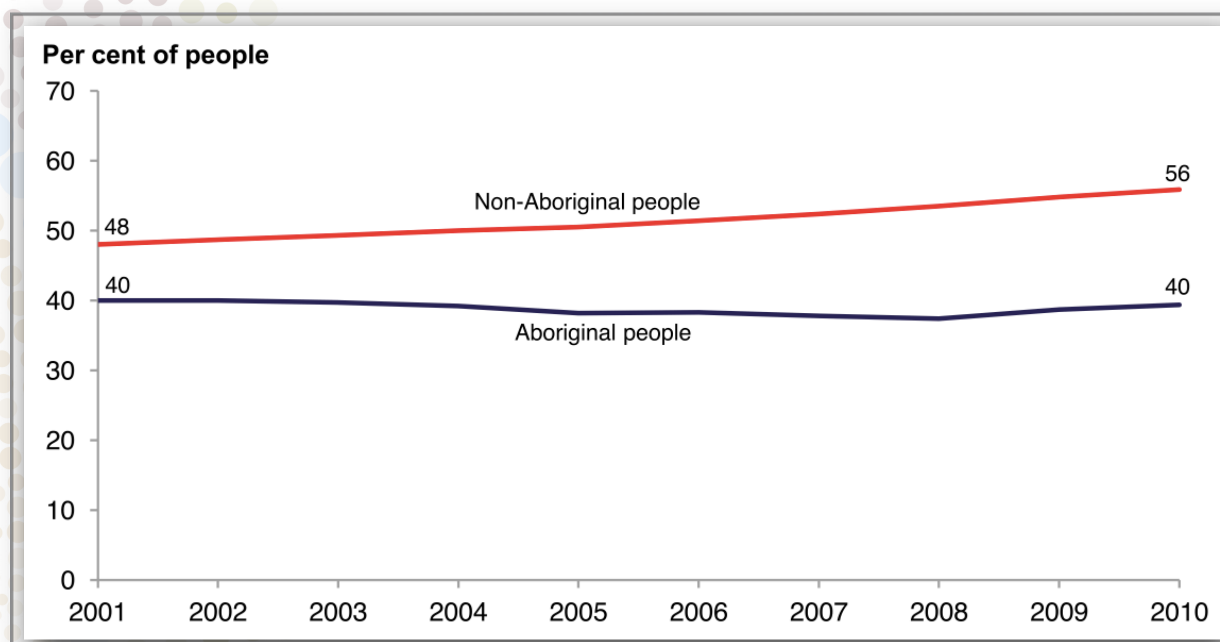


Fig 25. Two or more serves of fruit a day after 16 years by Aboriginality (NSW, 2001 to 2010)

Given the beneficial effects of fruits and vegetables on cardiovascular disease, type II diabetes and renal diseases, many programs aim to encourage their consumption. At Tharawal Aboriginal Corporation, their team delivers boxes of fresh fruit and vegetables for only $15. This bargain comes from purchasing big quantities before distributing it all into small boxes. In other places, the emphasis is put on growing your own vegetables and giving veggie patches to schools.

A lot of prevention is done for the younger ones, mainly in Griffith. The message is then focused on the visual and fun aspects of demonstrations. The Healthy Lifestyle team does for example the following experiment: mixing vegetables and junk food side to side before comparing aspect, smell and taste. For another experiment, they measure the heart rate of kids while they are drinking sodas (the hyperglycaemia stresses the cardiac muscle).

«Here are the facts, now you can make your own choices buddy.»
[Healthy Lifestyle worker]

✦ Drug & Alcohol

Alcohol

Prevention regarding excessive alcohol consumption targeting adult Aboriginals is mainly done through programs that include workshops. One of these are the "yarn ups", Aboriginal men's groups that have been developed by the Department of Family and Community Services of NSW. As mentioned previously (see Part 2 | chapter III-B), the feeling of isolation of some men is used to attract them to attend a men's group in order to be able to discuss different issues later. The men will meet around a meal or any casual activity (even a campfire evening for instance) which will break the ice and allow the discussion of a topic that can be quite difficult to approach, such as excessive drinking.

These workshops are generally organised on a local level by teams designated inside the different AMSs like the Drug & Alcohol Team of Griffith AMS. The latter has also published a specific brochure about alcohol that is part of their series *Just say "NO"*. To help health practitioners in their prevention work, quite a few other resources are available. An example is *"Your guide dealing with grog"*, written by the health department of NSW. It directly targets the Aboriginal youth (between 15 and 25). The emphasis is put on information, choice ("*if you decide to drink…*") and on the connection with the community ("*grog takes away our connection to our culture*").

Other Drugs

Different programs are run all around NSW in the different AMSs «*to help and facilitate personal change, support & encourage personal insight, provide information & education into addiction and its behaviours & to support pre & post detoxification, rehabilitation & recovery*» (Alcohol & Other Drugs Program, Griffith AMS). These programs include both counselling as well as support groups for men and women that aim to identify individual barriers and develop coping methods to face them. A message we frequently came across is the fact that drugs are not part of Aboriginal culture and that their use can cause harm to the community.

Artwork taken from the brochure *Just say "NO"*

To encourage these interventions a great variety of resources is available both for the patients and the D&A workers. You can find brochures written by the Department of Health of NSW like "*Drug Facts*" that gives one fact sheet per drug as well as more local resources like the brochures of the series *Just say "NO" we mentioned previously*. These brochures inform about the method of administration, the effects and the short- and long-term consequences of the use of the different drugs. They also systematically provide a detailed list with all the contacts of information services and cessation programs.

Blood Borne Viruses

In the context of the risk of transmission of blood-born viruses through the use of injectable drugs, comics have been produced by Hepatitis NSW in the form of "*Transmission Magazines*" that can be found in waiting rooms of primary health care services. Other types of resources have been produced by different organisations like the AH&MRC (*Hep C and us mob*) or the Hepatitis C Council of South Australia (*Treat Yourself Right*).

Transmission magazine (Aug. 2011)

These resources mainly highlight the importance of the exclusive usage of sterile syringes. Sharing the same goal, the Department of Health and Ageing of the Australian Government developed a *Needle & Syringe Program* (NSP) that consists of providing fitpacks™ containing four sterile syringes, one integrated recovery device and material useful to the preparation of the injectable solution (e.g. spoon, sterile water, etc). Those packs are available for free in sexual health centres (like in Dubbo) and in injection centres (like in Kings Cross, in Sydney).

That kind of program already in place in many European countries (including Switzerland) and worldwide has been proven to efficiently decrease the risk of transmission of blood borne virus (such as HIV and hepatitis C) as well as reducing the number of contaminated syringes in public places[25].

Australia has also implemented vending machines that provide the same fitpacks™ at a moderate price. This is already the case in some other countries as well (e.g. Switzerland, France, Germany and Austria). The advantage of these machines placed in strategic places is that they allow an easy access to that kind of package on a 24 hours basis, without any need to get close to a structure associated to the medical world.

Methadone Program

During our discussions with different Drug & Alcohol workers, a subject that came up several times was the relevance of setting up a methadone substitution program. This can indeed prevent the use and sharing of any syringes. The lifestyle associated with drug addiction, especially in the context of opioid abuse, can involve criminal activities to sustain the habit. For patients who, despite several attempts, failed to be cured, this program proposes a medically supervised substitution with a legal and less dangerous substance.

Content of a typical fitpacks™

At Griffith AMS for example, a methadone clinic is being set up. In the mainstream, one of the important problems is the lack of methadone prescribers. Indeed, it is mandatory to follow a specific training before being allowed to prescribe to more than a few patients and on a long-term basis. The idea of this type of program is to help those patients to become productive and employed again in view to reintegrate society.

✦ Sexual Health

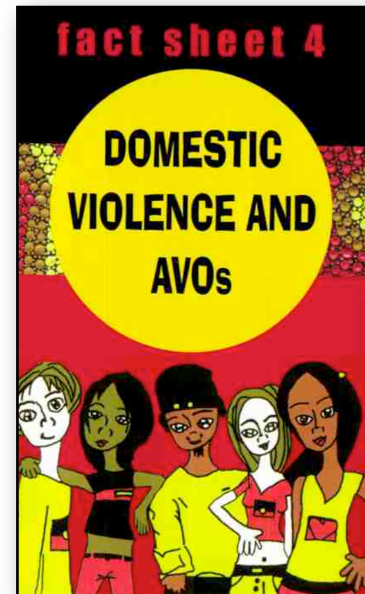
While visiting the different structures on the ground, we noticed that few means were being used to promote sexual health. However, there is a real need in this area and NACCHO and the AH&MRC recognise its importance. The role of sexual health worker slowly starts to rise in various AMSs (e.g. at Tharawal Aboriginal Corporation). Their main goal is to educate young teens about sexual health. This subject being hard to discuss, it is important that these health workers possess some tools and skills to break taboos. NACCHO thus published the resource manual *"Djiyadi, Can We talk ?"* (funded by the Australian Government Department of Health and Ageing) for sexual health workers who work with Aboriginal youth. At Orange AMS, such an identified position (that comes with the free training) was recently created, but has not been filled yet.

The AH&MRC for its part organises the campaign "*It's your choice, have a voice*" for youth in partnership with hip-hop dancers and singers similar to the campaign we mentioned earlier (see Part 2 | chapter III-B). Sallie Cairnduff (AH&MRC, Public Health Manager) explained to us why they turned to Indigenous Hip-Hop Projects (IHHP): it is a team of talented artists in all elements of hip-hop, media, entertainment and performing arts, who have been working extensively in Indigenous communities around Australia since 2005. This campaign aims to empower and educate Aboriginal teenagers to make informed choices about sexual and reproductive health, but also enables them to think about alcohol and other drugs issues. The emphasis is put on respect towards themselves, their partners and their community as well as on the fact that being sexually actives comes with rights and responsibilities.

D. Break The Cycle

One of the problems that people working in the Aboriginal field are facing is the reproduction of generational patterns (e.g. hopelessness, neglect, alcoholism, unemployment, etc). Sometimes, there are even considered the norm, which implies that in order to improve Aboriginal health in general, cycles must be broken. When possible, the problem must be tackled at its roots targeting the younger ones.

✦ Stronger Family Structure



During our placement, we have found that many patients grow up in a familial context that is not conducive to personal development and health; domestic violence, sexual abuse and child neglect are all factors that affect the physical health of our patients and create severe psychological traumas. The repeated exposure to these events drags the patient in a vicious cycle that will lead him, years later, to repeat on his own family the same abuse he has been a victim of. For example, a patient that has been abused sexually during childhood is much more likely to become an abuser in turn as well. It is indeed by the attitude of our parents that we learn ourselves how to approach parenthood. In a similar manner, the long-term exposure to violence decreases tolerance to frustration thus increasing anger and violent behaviours.

Such a familial environment can be a sufficient motivation, although unconscious, to seek imprisonment. We have indeed been able to see with our own eyes that Juvenile Justice Centres (and the same works for adult jails) can be a much safer environment than the family home. At the Orana Juvenile Justice Centre for example, the teenagers are treated with respect and consideration, have five meals a day and have access to a varied education (scholar, artistic, manual, relational, etc). This explains probably why, when you take a closer look at the motives of incarceration of the Aboriginal inmates, the biggest proportion consists of a repetition of relatively minor offences (e.g. theft, substance use, etc.) and much more rarely of severe crimes (e.g. murder, rape, etc). Another problem that Juvenile Justice Centres can cause comes from the fact that, for some of the teenagers whose brothers or mates have the same background, going to prison can be perceived as an initiation rite. Outside in the real world, someone who never experienced incarceration can be left out of the group and considered a child.

To face these critical issues, multiple programs have been developed by governmental organisations as well as by individual AMSs.

Brighter Futures

To prevent the removal from the DoCS (Department of Community Services) responsible for child protection, the program *Brighter Futures* run all around NSW aims at improving the feeling of parental attachment towards their children. It is indeed by reinforcing that relationship that child neglect or even disinterest in the child's health can be prevented most effectively. Besides strengthening that relationship, the "mum team" at Tharawal Aboriginal Corporation provides a whole range of advices about how to look after kids, but also take care of a house and cook properly, the ultimate goal being to provide an ideal environment for the development of the children. These interventions can take many formats from the "one-on-one interventions" (the counsellor directly goes to the mothers' homes to help them out in their own environment) to parenting groups. Despite the fact that the fathers are also welcome to take part in these programs, they are in reality much less represented among the clients.

Australian Nurse Family Partnership Program (ANFPP)

Along the same line of thought, but pushing the intervention to a more intensive level, the ANFPP program consists of following first-time mums who are having an Aboriginal child (i.e. the mother does not have to be Aboriginal herself to attend the program) from early pregnancy (less than 26 weeks) until the second birthday of the baby. The idea is to ensure that a strong relationship is built from the very start and that the woman feels implicated in her role as a mother long before the child's birth, in order to start off on the right foot.

The ANFPP has been introduced in the Wellington and Dubbo area only since October 2011[26]. Therefore, the long-term benefits cannot be seen yet. This program is based on the successful *Nurse Family Partnership home visiting model* developed by Professor David Olds in the USA over the last 30 years[27]. There have been a few randomised, controlled trials that show its efficacy. For example, one study showed that the women benefiting from the program gave birth to babies that were an average of 395 grams heavier than the babies in the comparison group[28]. Another study, shows the long-term effects of prenatal and infancy nurse home visit[29]. Nineteen-year-olds who have a mother that participated in the program at the time of their birth, were less likely to have been arrested and convicted than their comparison group counterparts.

This success is also explained by the fact that an important component of the program targets the mother's education, which ideally allows an improvement of the socio-economic conditions of the entire family. Judy Townsend, a nurse supervisor, presented us this program full of hope when we were in Dubbo and we left her with big smiles on our faces because what she does actually really work and has a positive impact at the time of the intervention as well as on a long-term basis.

✦ Empower People

One of the elements to work on in order to obtain long-term changes is education without which there are less good job opportunities.

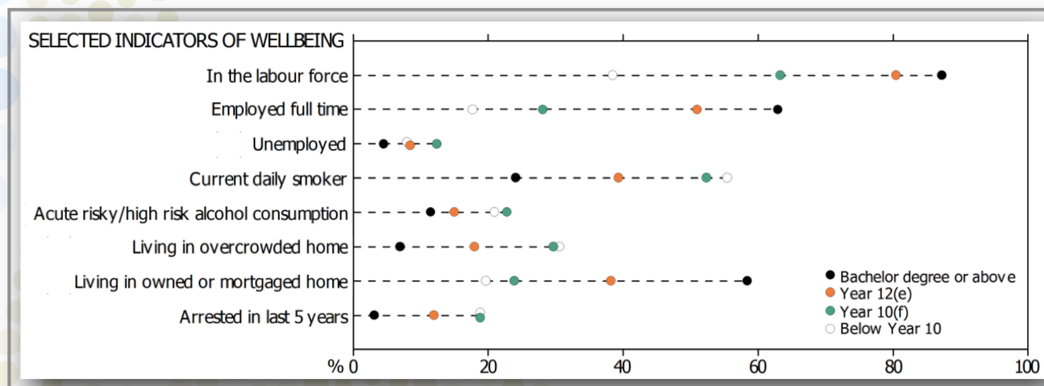


Fig 26. Correlation between the highest educational attainment achieved by indigenous adults and some selected indicators of wellbeing (2008) [30]

One of the problems is the recurrence of parental patterns: if the parents did not have a good experience of the school system, they are less likely to encourage their children to go to school. We should be aware that, not that long ago, discrimination was something normal.

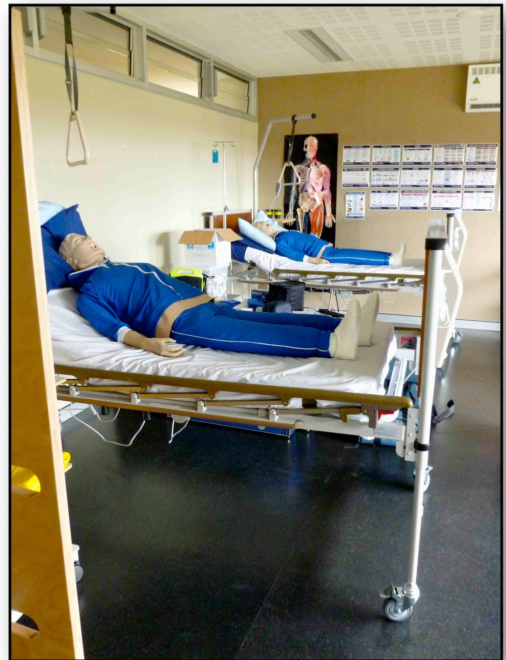
For example, if a parent of a non-Aboriginal child did not want him to study with a young Aboriginal child, the latter could be expelled. This explains why some parents can be quite reluctant to send their children to school. For some parents, however, sending their kids to school has financial advantages as it provides their child with a free meal every day.

Brighter Futures Team in Tharawal AMS

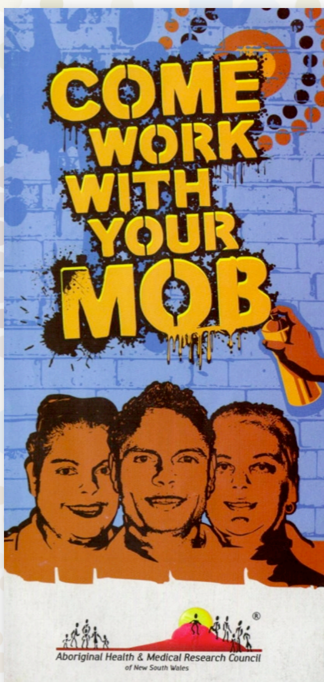
In order to support more directly children throughout their education, the association AIME (Australian Mentoring Indigenous Experience) set up a mentoring system to help Aboriginals finish high school and, if possible, start a university course. They provide moral support as well as educative programs. AIME has proven to dramatically improve the chances of Aboriginal children finishing school. In 2012, the association has 956 mentors for 1417 students. According to their *Annual Report for 2012*, 91.1% (113 out of 124) of 'year 12 students' graduated high school and 31% of them (35 out of 113) went to university. The great success of this organisation comes in part from the young age of the leaders (e.g. the current CEO and founder of AIME, Jack Manning Bancroft, is only 28 years old). The funding of this program is done on a young and innovative manner and involves the *National Hoodie Day* (one day a year when they sell clothes full of colours and logos of the association) and -even more original- the *Budgie Smuggler Parade* to raise funds by walking in swimming costumes in the streets of Sydney.

AIME - Budgie smuggler parade

In parallel of university studies, another way of training that is more anchored in the professional field is continuous training in AMSs. At Griffith AMS for example, 80% of the staff is Aboriginal. This comes from the fact that there are many identified positions that are reserved for Aboriginals and provided with training. Aboriginal health workers are often encouraged to improve their skills even further and when we were at Griffith AMS, almost all of them were preparing to take their certificate 4 (i.e. six months to two years of training). This shows the good level of the staff and thus of the service they want to provide. The various training sessions are paid for by the AMS or by specific programs. It also includes a few yearly workshops across the state.



Class room at the Aboriginal Health College



To encourage Aboriginals to work in the medical field, the *Workforce Initiatives Program* of the AH&MRC published the brochure *"Come Work with your Mob"* that presents all the career opportunities there are in ACCHSs. The Aboriginal Health College of La Perouse (south of Sydney) is part of the AH&MRC and offers a wide range of courses that allow the preparation of about fifty diplomas and certificates that have to do with Aboriginal health and that are recognised all over Australia and not only by AMSs. They allow students to acquire the skills to become an Aboriginal health worker, a Registered Nurse, a Psychologist, a Physiotherapist, a Drug & Alcohol Worker, a mental health & Social and Emotional Well-being worker, a team leader, a practice manager and even a CEO. One of the benefits of this structure is that the training provided for Aboriginals is free and the costs of transport and accommodation can be covered if needed. Everything is organised so that no economical barrier can possibly interfere with raising the number of Aboriginal staff in ACCHSs.

✦ Give Back an Identity

An element that does not necessarily appear as being a government's priority, but that we believe is crucial, is to reestablish an "Aboriginal identity". As an extension of our discussion about cultural and spiritual well-being (see Part 1 | chapter III-D), it is important to understand that the loss of cultural identity does not help take control of one's life, far from that. There are a few elements that complicate the situation even more, like for instance the fact that communities are going through a transition phase where the identification of being an Aboriginal, can be quite difficult. It is indeed not possible to determine whether a person is Aboriginal or not, solely based on his looks (skin colour, facies, etc). Some Aboriginals are blond with blue eyes and can really struggle with that because they do not consider themselves as being part of the "white society", but are nevertheless rejected by the community.

Detail of *The Great Wall of St Kilda* (Melbourne)

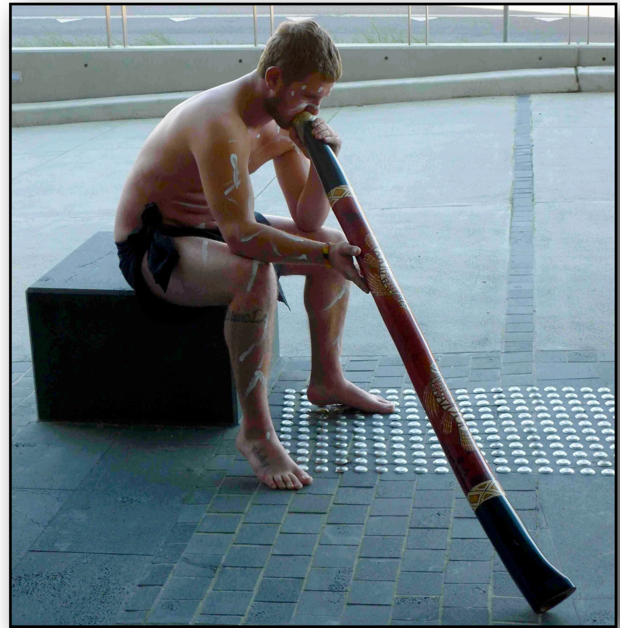
The generation of the parents of the Aboriginals that are in their twenties is facing a very frustrating situation: after decades of fight for recognition of their rights and their traditional cultural identity, they are facing a youth that openly rejects traditions. Furthermore, many Aboriginals confessed to us that young adults do not show any respect anymore to their elders and are thus no longer striving to deserve their knowledge in order to be able to pass it on someday themselves.

One of the important things to do is to link up the children of the younger generations to their culture for it to become an element of strength for them. For this, Aboriginality has to be associated with something positive, to models of success and excellence and one of the critical things is to have role models. With this in mind, the Australian Indigenous Doctor's Association published a brochure entitled *Journeys into medicine* that presents the stories of 20 Aboriginals that are confirmed (or in the making) role models in the medical field. Another example is *ABM: Aboriginal Business Magazine*, a monthly paper that describes successful Aboriginal business owners from across the country and presents Aboriginal business at its best.

ABM cover (Sept. 2012)

A media like NITV (National Indigenous TeleVision, pronounced 'native') is a very interesting resource as well. This channel created in 2007 (but only available freely since December 2012) broadcasts documentaries, series, news and other shows produced essentially by and/or for Aboriginals. Besides highlighting the role models of the community, this channel also shows the situation in other countries that have an indigenous population as well (e.g. New-Zealand, Canada, the United States, etc). It is for instance on this channel that you can watch the news in Māori (with English subtitles) at several times during the day.

We hope that the younger generations, by seeing on TV news about others tribes and cultures and hearing people talking in their own traditional language, will identify with them and want to reconnect with their own culture. It is already possible in some areas, to learn the culture and the language of the local Aboriginal tribe at school. The new generation of children probably is the hope of the communities in their fight to revive the ties with traditions.



Young Aboriginal during a traditional smoking ceremony (22/07/13)

Last but not least, giving back an identity to the Aboriginal populations and having all these different medias available is important to change the opinion of some non-Aboriginal Australians. These resources allow to give another information than mainstream media and, despite being far from objective, it allows nevertheless to raise awareness about Aboriginals and to present role models of these communities to the entire Australian society.

Again, we noticed that there is a lot of racism in this country, that leads to much discrimination. For example, some Aboriginal health practitioners left the mainstream because of the aggressiveness of some of their colleagues towards them. Being in Australia for more than the six weeks period of the placement, one of the co-authors also had the opportunity to spend some time (two months) with non-Aboriginal Australians. A lot of them spontaneously recognise that there is a lot of ignorance and racism. While in Alice Springs (Northern Territory), the same co-author met Australians visiting from the coast and discovering for the first time the traditional Aboriginal Society. They asked rude questions to one of the Aboriginal guides and joked about Aboriginals being savages in a way that did not feel appropriate at all.

Part 3: Feedback

After two months spent in Australia, of which six weeks travelling between the AH&MRC in Sydney and different medical services of NSW, the assessment we made was bitter. Things change, that has to be recognised, but there still is a long way to go and the deadline set by the *Closing the Gap* initiative can seem quite ambitious to some people. Furthermore, as we will explain in detail, the resources are allocated depending on the will of the government to change things. Thus, no warranty is given for the time and energy that will still be invested in the future. More broadly, we noticed with a lot of resignation that the problem went way beyond the government's limits and came from the segmentation of society.

I. How to Improve the System ?

A. Doing Better with the Same

When you start thinking about what could be done better with the same amount of resources available, one thing that comes up and that seems to be improvable is the coordination and collaboration between the multiple actors of this complex network.

✦ With the Different Local Actors

From the discussions we had with the CEOs of the different AMSs, arose the fact that some teams feel very isolated from other local actors. As we explained previously, the AMSs are from far not the only medical structures that provide health services to the Aboriginal community. This makes sense since certain services (such as acute care, dialysis, surgeries, childbirths, etc.) cannot be provided inside AMSs. Thus, it is even a competitive atmosphere that can sometimes be ensued with the mainstream in some areas. This, of course, does not benefit the patient and still very few mainstream structures have qualified staff who take into account the cultural specificities of these patients.

One of the ways to improve the connection between the care delivered by the AMS and by the mainstream is to have, like in Orange, Aboriginal Liaison Officers. Besides making sure of the follow-up of Aboriginal patients during their stay in hospital, it makes them feel more confident and also play a key role in improving the link with their family (which is of great importance in the support of the patient). Another solution that was mentioned to us would be to allow the AMS staff to come along with their patients to the hospital (for the moment, if they do so they would be considered as relatives of the patient and not as qualified medical staff) or to create a culturally appropriate service, specifically destined for the Aboriginal community.

In some places there is a big gap between what is asked for and what is obtained. At the hospital in Orange for example, the Aboriginal staff noticed some logistical problems due to the mass arrival of family members when an Aboriginal patient is hospitalised. They proposed to create a place of gathering and contemplation, away from the hustle of the wards. The hospital board, rather than giving away a room inside the building (a space that actually existed and still remains vacant), simply cleared an assembling point 30 meters from the entrance of the hospital so that the Aboriginals can be 'more in contact with nature'. This gathering place is even frowned upon by the two Aboriginal liaison officers. It is indeed not the most appropriate solution to suit the expressed needs and can be quite inconvenient, especially in winter when temperatures decrease. Furthermore, due to the lack of signs informing on the purpose of this place (despite the request made), it turned into a smoking area for any passer-by.

Gathering place at the Orange Medical Centre

On a different note, Quitline is a hotline to help people quit smoking that is financed mainly by the state government and the cancer institute. Patients can call to benefit from brief intervention counselling over the phone and are called back regularly (after three, six and twelve months) to see where he is at and be supported in case of relapse. The team can also directly call the patient when he is referred to by a doctor if, of course, he has given prior consent. Despite the phone number being present on all cigarette packs as well as in all stores where tobacco is sold, Aboriginals do not appear to be using this service a lot. To address this, the call centre in Sydney recently decided to integrate an Aboriginal worker in the team, in order to have a reference person who can provide counselling in the same manner as it would be done in an AMS.

✦ Between the AMSs[31]

An AMS by itself does not have the possibility to possess the entire resources that are necessary for an exhaustive holistic care of their patients. Typically only few AMSs in New South Wales have benefited from a funding program allowing the setting up of a dental service. However, this would be necessary in all the communities over the state.

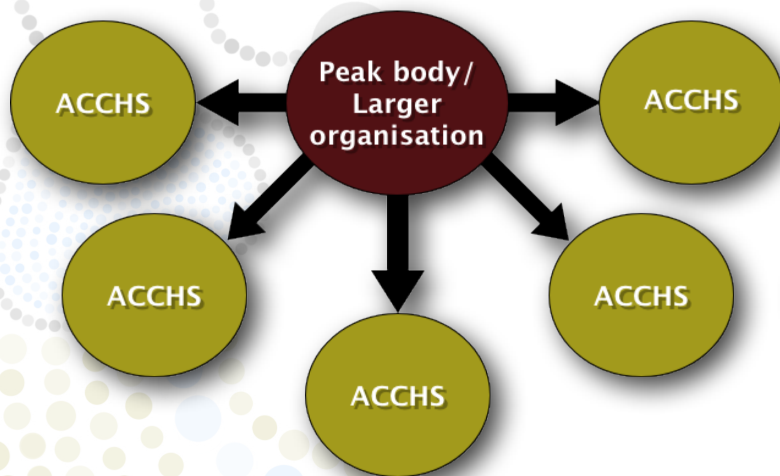
To face that, different models have been proposed by different ACCHS from all over Australia, to deal with the factors impacting on their operational and management functions. An example in New South Wales is the Bila Muuji network composed of the CEOs of every AMS in eastern NSW, especially Bourke, Brewarrina, Coonamble, Coomealla/Dareton, Orana Haven, Orange, Walgett and Wellington. This network is organised according to a "peer support network" model, in which "a group of organisations (or specific staff within organisations such as CEOs or finance workers) form a network to provide support to each other". This collaborative model distinguishes itself from other models, such as the "state-based peak body with a Sector Development Unit" (Queensland A&TSI health council), "regionalised or central support" (Katherine West Health Board) or "auspice arrangements" (Central Australian Aboriginal Congress).

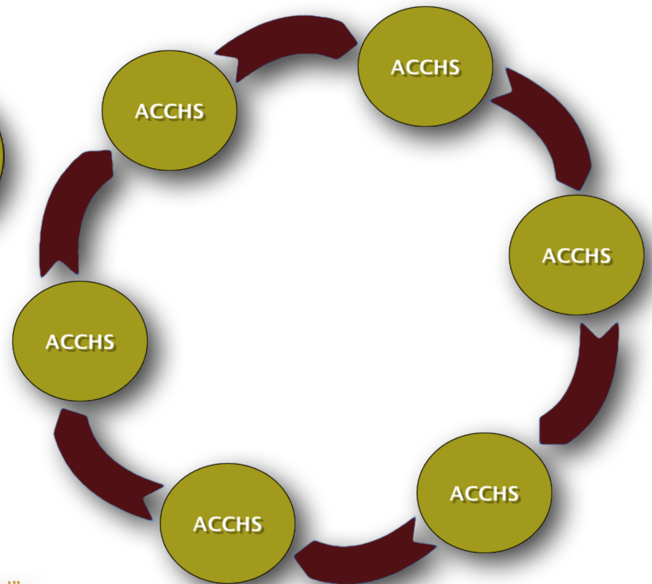
The *Bila Muuji* network was established in 1995 and has always had as goal to improve service delivery in the more remote areas of eastern NSW. Because of the instability of the funding system of the various programs of the *Closing the Gap* initiative, as well as of the changes in state management of the health system, many organisational problems arise in AMSs along with concerns about long-term projects. Hence, the CEOs meet up bi-monthly to identify the issues and find solutions. One of the advantages of this network, is that it eventually facilitates in-service training, by organising workshops that allow the staff of all these AMSs to meet. Another advantage is that, by providing advice to each other, it facilitates the process of obtaining accreditation.

Interestingly enough, the structure of this network is quite similar to the way the Aboriginal society and family is organised, with different family members contributing to the education of the children. Whereas provision of corporate support services by a large or peak organisation is more evocative of a traditional occidental family structure, where the parents provide most of the resources to the children.

✦ With the AH&MRC and NACCHO

During our placement at the AH&MRC, many health promotion programs and resources have been presented to us. When going out in the field we expected to find a lot of these being used. Nevertheless, part of the actions of this peak body seems to be completely unknown to the people on the ground. One solution would be to improve the communication between the AH&MRC and the AMS. According to different team leaders at the AH&MRC, e-mails are often insufficient to convince the people in the field who prefer face-to-face interactions. This is why, for instance, the chronic care program presented its new resources by doing systemic visits of the different services.





"Peak body/Larger organisation" model vs. "Peer support model"

Even when the programs are known, they do not always meet the needs of the AMSs. This could seem quite surprising knowing that all these actions are carried out by "community-controlled" process. This discrepancy, comes from the huge variety between the different communities of NSW: a solution proposed by one community will not necessarily solve the same issue in a different one. This is probably why, in most places we went to, we noticed that AMSs preferred to develop their own programs rather than implementing programs developed by other organisms, whether they were from the AH&MRC or NACCHO.

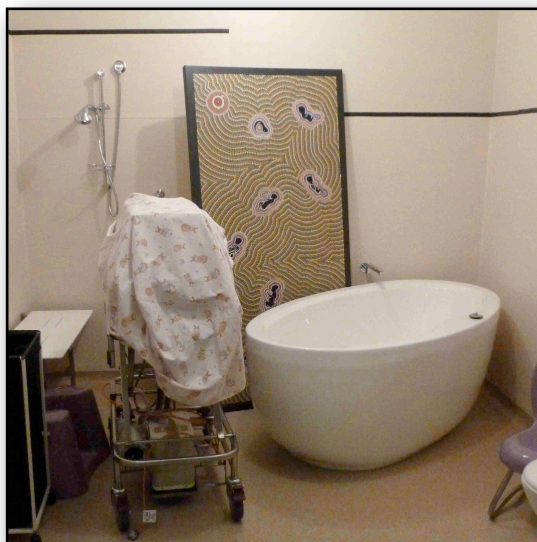
Last but not least, the AMSs do not always have the possibility to implement these programs, mainly if the local community does not want to get involved. For example, Griffith AMS did not manage to convince business managers to establish a smoke free environment in their company. When facing such a situation, even the best cessation program of the AH&MRC would not be efficient.

B. The Resources Issue

Beyond the 'simple' improvement of the usage of the available resources, another issue that often came up during our discussion with the decision-makers of the different AMSs, is the amount of funds available.

For a proper understanding of this problem, it is important to understand how the AMSs are funded. The biggest part of the money comes from the reimbursement of most of the medical procedures by Medicare Australia. Concerning management fees, rather than allocating a set amount of money to the AMSs and thus giving them the autonomy to divide it up as they wish, the government finances programs on a annual basis through grants. Concretely, this means that every structure providing health service to Aboriginals is a potential competitor and that fundings are only available at a certain moment for a certain need (which is not always the important need of the moment of a given AMS).

A good example is Murundhu Dharaa, another medical centre affiliated with the OAMS, but that focuses more on the caring of women, mothers and children (a structure between a maternity ward and a family planning). This name has a particular meaning in Wiradjuri language and a translation of it would be: *"I live, I breathe, house"*.[32] Until recently, women could come to this centre to give birth, but due to the administrative burden that such a project represents, the OAMS' CEO had to reconsider it and shut down the unit.



Equipment from the ancient birthing room in Murundhu Dharaa

Beyond the necessary accreditation, there are indeed quite a lot of insurances that need to be subscribed to. An infrastructure, as important as a public hospital does generally not have trouble to handle these issues, but those smaller structures cannot measure up to them.

Another element is that the funding received often allows to buy the equipment needed for a program, but not to fund the salaries of the staff needed to run it. Furthermore, the government has the ability to withdraw its funds earlier than planned if it considers that the program is not effective or too expensive. At Orange AMS for example, the government announced they would end a program of funding for dentures prematurely. This forced the dental team to accelerate their procedures to be sure that their patients would benefit from a new denture, increasing potentially the risk of complications.

All this probably explains, in part at least, the bitter feeling of some health workers, that the government sets up programs to fail, that are only present to put up a good show and give the impression that the authorities do feel concerned about Aboriginal health.

C. Quality Improvement Processes

To make sure that the resources provided specifically suit the needs of the AMSs and to control afterwards that their use is efficient and has a benefit, a whole process of quality improvement is necessary.

The identification of problems and the development of programs to face them, have to go through a community controlled process. It is important to ensure research of quality, but it is also important that solutions will be proposed to try, and solve these identified problems. The idea is that any research led should have a potential benefit for the community. On the scale of the AH&MRC, the ethics committee analyses the different research projects on Aboriginal communities that are proposed and makes sure they meet the above standards. Aboriginals are indeed the most studied population on earth, and from a historical perspective this research has not always been conducted in their best interest. From the start of colonisation, anthropologists came with the settlers to study this newly discovered indigenous population.

On a more local level, let's take the example of the OAMS where Matthew Day, researcher in population health, runs a program of quality improvement. This program consists in the constant reevaluation of the local community needs, the analysis of the results of the programs put into place and the adjustment of these programs according to these findings. Concretely, besides carrying out surveys and asking patients for their feedback, Matt organises meetings with the entire AMS team to think together and at all levels, about what does not optimally work in the institution, and gives them the opportunity to suggest solutions.

II. How to Solve the Problem ?

The different solutions mentioned previously only allow to optimise a system that clearly has shortcomings. After only six weeks spent in Australia and having interviewed dozens of people, we came to the conclusion that the problem runs deeper than we previously thought.

«What do you think about the *Closing the gap* initiative ?
- That's a good question…»

Asking such a broad question was very interesting for us because the variety of answers we received allowed us to learn much more than expected about the Australian society.

A. Closing the Gap ... ?

✦ "First of All ..."

People answering this question usually started off by recognising it was a good initiative because it acknowledged the fact that there was indeed a gap between the health of Aboriginals and non-Aboriginals and that it needs to be closed. Therefore, the idea of making Aboriginal health a national priority is an excellent thing and justifies that money is allocated for specific programs.

One of the constructive uses of these funds allowed to support a program giving access to a wide range of medication for free (or a much lower cost). This allowed to face one of the major barriers of access to health of this community. Furthermore, people we questioned often emphasised that much progress was actually made in the education field more than in the health field.

✦ "But ..."

Nevertheless, one of the problems of this initiative seems to be that it does not go far enough. Of the 250 proposals originally made by the group of experts gathered in 2008, only 15 have been integrated in the final version of the project. It is obvious that priorities had to be defined, resources not being unlimited. But is some cases, we do have the impression that some projects are not sufficiently thought through. For example, the project that funds the machines measuring the glucose level in the blood for diabetics do not fund the lancing device (and the lancets that come with it) needed to use this machine. The cost of these being too expensive, the people who need them cannot afford it.

One of the big limits of this project is to consider the Aboriginal population as a homogeneous entity; every person working in this field is conscious of the diversity they represent. As we already explained in the introduction, there is no such thing as "Aboriginals", since there were traditionally over 200 Aboriginal nations. The top five national priorities that have been defined are thus not applicable to all the communities when considered individually.

Furthermore, the money is not always well allocated. Typically the Australian Government committed over 50% (805.5 million of australian dollars) of its total budget to an Indigenous Chronic Disease Package to support better access to health care. Even though chronic disease is indeed a main issue among Aboriginal populations, many people think that a more efficient way to solve it would have been to use that money for the development of health promotion programs. In the same trend, mental health is set aside in this project, despite the fact that it is one of the mains issues of Aboriginal health.

Finally, we would like to point out that part of these funds are misused. We have been really disappointed to discover that part of the money of *Closing the Gap* is indeed not necessarily used to benefit Aboriginal patients. For example, some general practitioners advise their patients to present themselves as being Aboriginal to gain free access to some services. This dishonest practice is possible because it is not necessary to show a proof of ones Aboriginality to benefit from the government's money. One of the solutions would be to request a certificate of Aboriginality, which is already obtainable under some conditions and is even necessary to have access to a number of services.

Nevertheless this can be dangerous because it can create a further barrier of access to health and lead to inequalities. Firstly, because it recalls some dark moments in history where Australians, on the contrary, had to prove they were not Aboriginal to access some services. Secondly, the administrative procedures required to get such a certificate are tedious and not within everybody's reach.

B. A Society Problem

Beyond the inherent limits of the *Closing the Gap* initiative, the question of Aboriginal health faces much greater barriers.

✦ Constitution

Protest poster in front of the Old Parliament House (Canberra)

It is not only health, but the general position of Aboriginals in society that would need to be improved. It is important to know that, for the moment, the Australian constitution implemented in 1901 still does not recognise Aboriginals as being the traditional owners of the land. The changes brought in 1967 just gave back some rights to these people, considered until then as being literally part of the fauna and flora. During the following thirty years, many Aboriginals fought for recognition of the past and for the government to take the blame and repair the harm that had been done. For the Aboriginals, the expression of the profound Government's regret has much more impact on the healing process than financial compensation.

The official apologies of 2008 had been clamoured for and were necessary. However, many Aboriginals reckon it was not enough. The actual fight of the activists is for changing the preamble to the Constitution, that would recognise indigenous Australians as the original custodians of the land[33]. The body of the Constitution, should also be reviewed in-depth to recognise the Aboriginality of some Australians (for example by making it possible to add an "Aboriginal and/or Torres Strait Islander" indication on their passport) who, despite being on their land, struggle to identity themselves as citizens of this new nation. These changes would also probably increase cultural awareness of all Australians, which will thus reduce discrimination on the long-term.

Simulated Aboriginal Embassy front of the Old Parliament House (Canberra)

However, because of the democratic organisation of Australia, a change to the Constitution is only possible after referendum, which thus implies having the support of most Australians (see Part 1 | chapter I-A). Aboriginals representing only around 2.5% of the total population, the whole society has to evolve towards recognising their rights to get things moving.

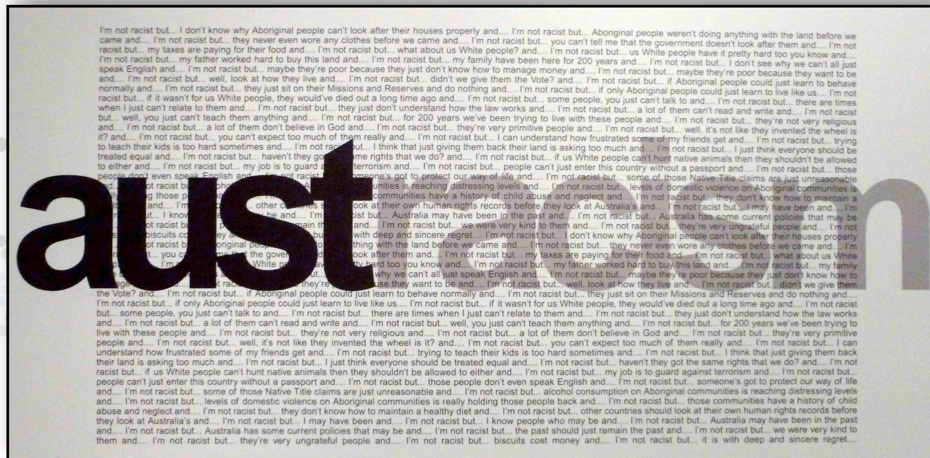
✦ For Non-Aboriginals

Media play a key role in the evolution of public opinion about the different matters of current issues. While media are free and independent, they do not necessarily present news in an objective manner: they talk about what sells. This is a problem in the context of the Aboriginal problematic because their image in society, being already quite bad, is worsened by the media that feeds disinformation in a passive manner by mostly presenting the "bad stories" and not mentioning the "success stories".

Aboriginal street artists at Circular Quay (Sydney)

In the collective unconscious of too many Australians, the typical Aboriginal man seems to be unemployed because uneducated, alcoholic, violent and ungrateful. These preconceived ideas come in part from the media, but also from education. We were really surprised to see how common and widespread racism was. This seemed very paradoxical, because Australia is such a multicultural country that recognises as citizens people that come from all around the world. But for some reason, it fails to accept the cultural wealth of its own indigenous population. Thus, as we discussed earlier (see Part 2 | chapter III-D), the concept of "breaking the cycle" should also apply to non-Aboriginals.

«What you lack in knowledge, you compensate with ignorance.»
[Jamie Newman, OAMS]



Austracism, by Vernon Ah Kee (2003) at the Australian National Gallery (Canberra)

We were very surprised to not have found any cultural centre in the different places we went to. Aboriginal paintings have been booming for less than 40 years now, and fill up art galleries. However, there is not really a place you can go to, to learn more about the local tribe's culture. At Orange, the Local Aboriginal Council set up a project of creating such a centre, but it will still take some time to be put in place. This need is even more important than you'd think, since in some museums we went to (the Australian National Gallery in Canberra and the National Gallery of Victoria in Melbourne), the guides who gave tours were mostly non-Aboriginal volunteers, that sometimes had a very limited (if not incorrect) knowledge of Aboriginal culture. On the other hand, there are a few places you could consider as "models", such as the Koorie Heritage Trust Centre in Melbourne for example, that offers, among other things, cultural awareness trainings and provides a big amount of interactive resources as well as a substantial collection of artwork that comes with detailed description written by the authors themselves.

✦ For Aboriginals

Many Aboriginal health Workers confessed to us that part of their community still victimises themselves without trying to take control of their destiny and improving the situation. For these workers, this is particularly frustrating because they have the impression that opportunities do exist and that many Aboriginals just miss out on them. After the generation born in the Sixties that fought for their rights, the generation that followed was much more passive. Fortunately the newer generation seems more conscious of the goals that represent the concept of closing the gap and is more prone to get involved in the improvement process.

Information panel for Aboriginal students at the University of Melbourne

Another problem not concerning individuals, but more broadly the communities, comes from what people in the field usually call "black politics". Because of the diversity of traditional Aboriginal nations some communities are torn apart by familial rivalries, which slows-down a great number of processes. At the national level this also means that Aboriginals do not always agree on the identification of problems and solutions and are thus unable to speak with one voice.

Conclusion

To be totally honest, out of this placement arose more questions than were solved and we still have mixed feelings at the time of writing this conclusion. Figures speak for themselves, the gap is far from being closed despite all the money that has been injected in this field and the involvement of the people striving to improve Aboriginal health.

As announced from the very start of this work, the situation we described is not confined to the NSW boundaries. When you look at what is going on in other states of Australia, you notice that the situation is not much better. Australia is going through an important societal crisis, which will take decades to get over. The situation in the Northern Territory is even more problematic than in NSW. Because of important issues with violence, child abuse and neglect and unemployment, the government has extended its intervention policy in 2012 for an additional 10 years, despite the protest of communities and the international organisation's criticism[34].

Protest poster in front of the Old Parliament House (Canberra)

It can be surprising to notice such differences with neighbouring countries, such as New Zealand, where the same issues were dealt with way earlier. The explanation is essentially historical and comes from the fact that in 1840, the Treaty of Waitangi was signed by representatives of the British Crown and various Māori chiefs. Again, the unity of the Māori (in contrast with the Aboriginal diversity) had without a doubt a determinant role in their acquisition of rights and recognition.

At the end of the day, we probably arrived too early to see the results of the *Closing the Gap* initiative. The problem is still relevant, but has now been formally identified and acknowledged, and solutions have been proposed. Despite some aspects that clearly could be improved or optimised, it is essentially on the political (if not societal) level that the biggest progress remains to be made. On the ground, teams do whatever they can with the available means and hope that the next changes in governance will have as few consequences as possible on the allocated resources.

We are very curious to follow what is going to happen in the next decades because other steps (like the additional modification of the constitution) will, without a doubt, play an important role in evolving mentalities that, in this context, appears as a pre-requisite to hope for in-depth improvement. The road to reconciliation is long, but bridges have progressively been built between the Aboriginal cultures and the western world. We can for example mention the Smoking Ceremony organised for the inauguration of the new building of the NeuRA (Neuroscience Research Australia) in Sydney. This research institute chose to acknowledge that the traditional owners of the land on which it was built are indeed the Aboriginals. As a consequence, uncle Max (one of the community elders that is present in many similar cultural events) came to purify the site with a traditional ritual to protect researchers from bad spirits.

Peter Schofield (NeuRA, CEO) with Uncle Max during the smoking ceremony

This kind of event should remind us that the healing is a time consuming process that must be undertaken step by step and at every scale.

«Le pardon requiert la mémoire absolument vive de l'ineffaçable, au-delà de tout travail du deuil, de réconciliation, de restauration, au-delà de toute écologie de la mémoire.»
[Jacques Derrida, french philosopher of the 20th century]

Activities

Introduction in Sydney

We spent our first week at the AH&MRC office, in Surry Hills (Sydney). Since we were not familiar with the problematic, the idea was to start off the placement with an overview of the situation. Doing that, we indeed ensured to arrive on the ground with an understanding of the whys and wherefores of Aboriginal health issues. The staff was expecting our arrival and a setup schedule allowed us to interview as many people as possible, including team leaders and their workforce. We adopted a nearly journalistic approach and recorded most of our interviews to make sure that the language barrier did not lead to any misunderstandings. However, these recordings are confidential and will not be made available to people other than those interviewed.

The AH&MRC also gave us the opportunity to attend two forums and to go visit the Aboriginal Health College in Little Bay (southern suburb of Sydney) and the Quitline call centre at Saint Vincent's Hospital. The *Kanyini Vascular Collaboration Annual Meeting* at the National Centre for Indigenous Excellence allowed us to update our medical knowledge on the most recent topics in terms of specific caring for the Aboriginal populations. The *AH&MRC GP Forum and Clinical Update* (spread over two days) enabled us to meet and talk to GPs coming from AMSs scattered all over NSW and see them emphasise, in the presence of AH&MRC team leaders, everything that was not working in their respective services as well as in the entire network.

Visit of the services around NSW

Tharawal Aboriginal Corporation

We only spent three days at Tharawal Aboriginal Corporation, in Campbelltown (a city south of Sydney), but had the opportunity to talk to many people. The interviews we conducted had a similar structure compared to those at the AH&MRC: one asked the questions, while the other took notes. For practical reasons, this approach was maintained throughout our placement, always adapting -of course- the question list. Besides having discussions with almost all the project and program leaders, we also attended a few consultations and went to pick up patients with the drivers.

Orange AMS

We spent three weeks at Orange AMS, which left us plenty of time to do a lot of things. Besides questioning most of the staff (all positions were taken into account), we attended many consultations with nurses, general practitioners or dentists (both at the AMS and on outreach). We also visited the Orange Local Aboriginal Land Council as well as the mainstream hospital. We spent a day there visiting all the departments with the two Aboriginal Liaison Officers who made us follow the typical path of an Aboriginal patient who needs to be hospitalised: emergency room, intensive care, coronary care and stroke unit, dialysis, etc. Finally, as total immersion requested it, we even took part in a physical training with a local Aboriginal sports group.

Dubbo AMS

During our stay in Orange, we went to Dubbo for a few days to have the opportunity to visit an AMS that just opened. Starting off less than a month ago, the team was obviously rather small (half a dozen people) and patients were not pouring in. We took the opportunity to go out and meet the different local public health teams who run programs such as NSP, ACTT and ANFPP. We also took part in the *GP Registrar Indigenous Health Training*, a training module including both conferences about how to do deliver specific medical care to this community and role plays with standardised patients to put this into practice.

Griffith AMS

The last week, we went to spend a few days in Griffith AMS. Due to the little time available, we focused our attention on learning more about the specific programs of this service and on going to the community. Besides our usual talks with the different program leaders, we went to spend a day at the old mission of Murrin Bridge, a two hour drive from Griffith. In its almost abandoned "medicalised unit", we could not help, but notice the situation and the important difficulties that the staff working in these remote areas is facing. We also spent an afternoon with the Child and Maternal Health Outreach Service team, who brought us closer to the local community.

Corrective Services NSW

Visiting these institutions was absolutely unexpected and arranged at the last minute. The authorisations were obtained less than 24 hours in advance and after an induction to ensure our security, we were able to have our first experience in prison.

Orana Juvenile Justice Centre

This centre accommodates about thirty minors between, in average, 12 and 18 years old of whom 80% are Aboriginal. They are all boys, girls just passing by and being put aside the time for them to be transferred to a centre for young girls. We sat in during some consultations with inmates, visited part of the infrastructure as well as the inside of a cell and asked questions about the motives and conditions of detention.

Wellington Correctional Centre

This centre accommodates about 500 inmates of which only 9% are women and approximately half (48.3%) are Aboriginal[35]. Unfortunately, we did not attend any consultation due to lack of time, but we had access to the full medico-legal records of the patients consulting that day. In return, we had a full visit of the prison and have even been inside one of the maximum security units while the inmates were not confined in their cells. The experience was utterly unexpected and allowed us to question them personally about their detention conditions. We also met the leader of the rehabilitation programs and discussed with members of the staff about the emergency medicine protocols in an environment where security remains the absolute priority.

About the artwork

The drawing in dot-painting found on the cover page and as watermark throughout the report was specially designed by Adrien. He took his inspiration from both the artistic approach and the graphic style used in some Aboriginal tribes. The initial idea was to simply create a transparent background to give more relief to the report, but the project took another turn and is now telling a story.

«The stethoscope-headed snake, metaphor of the medical knowledge, blends itself in its natural environment in the form of a river flowing through mountains and valleys. By the river, one can see a man and a woman in the middle of the desert, which evokes their arrival into the unknown. The voluntary use of western symbols to represent them, instead of using Aboriginal ones, refers to the Europeans that we are. The vast white space -that does not stop at the edges of the page- represents the extent of everything that we still have to discover and announces that this is just the beginning of a much more important journey ...»

[Adrien, Co-Author]

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The following resources (i.e. documents, websites, interviews, conferences/workshops) have been used to both find factual informations and draw the 'global picture' presented in this report.

Documents

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Katon K. and Hawke M. **Aboriginal Historical Awareness Workshop.** Indigenous Identities. 2009 | Licensed to NSW Justice Health to 13th February 2012

Silburn K., Thorpe A. and Anderson I. **Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services | Overview Report.** The Lowitja Institute, Melbourne. 2011

NSW Ministry of Health. **The health of Aboriginal people of NSW: Report of the Chief Health Officer.** Centre for Epidemiology and Evidence, Sydney. 2012

Given the amount of work that would have been required to find the data used in their design, we would like to point out that we used the following figures from the previous document (with the agreement of the authors and given the nature of this work):

Figure #2	Potentially preventable hospitalisations by Aboriginality, NSW, 2001–02 to 2010–11
Figure #18	Potentially avoidable and premature deaths by Aboriginality, females aged less than 75 years, NSW, 1998 to 2007
Figure #26	Decayed, missing and filled teeth by Aboriginality, children aged 5–12 years, NSW, 2007
Figure #29	Complete or partial deafness or hearing loss by Aboriginality, children aged 0–14 years, NSW, 2004–2005
Figure #34	Smoking-attributable hospitalisations by Aboriginality, NSW, 2001–02 to 2010–11
Figure #38	Overweight and obesity by Aboriginality, people aged 16 years and over, smoothed estimates, NSW, 2001 to 2010
Figure #40	Two or more serves of fruit a day, people aged 16 years and over, smoothed estimates, NSW, 2001 to 2010
Figure #47	Diabetes hospitalisations by Aboriginality, NSW, 2001–02 to 2010–11
Figure #54	Chronic kidney disease hospitalisations (dialysis, diabetic nephropathy and chronic renal disease), NSW, 2001–02 to 2010–11
Figure #57	High or very high psychological distress by Aboriginality, people aged 16 years and over, smoothed estimates, NSW, 2001 to 2010
Figure #58	Intentional self-harm hospitalisations by Aboriginality, NSW, 2001–02 to 2010–11
Figure #61	Interpersonal violence hospitalisations by Aboriginality, NSW, 2001–02 to 2010–11
Figure #64	Common cancers by Aboriginality, average annual incidence rates, males, NSW, 1999 to 2007
Figure #65	Common cancers by Aboriginality, average annual incidence rates, females, NSW, 1999 to 2007
Figure #71	Hospitalisations ending with discharge against medical advice by Aboriginality, NSW, 2001–02 to 2010–11

Websites

Online version of the Australian Constitution: **www.aph.gov.au**

Australian Bureau of Statistics: **www.abs.gov.au**

Australian Indigenous HealthInfoNet, especially the *Summary of Australian Indigenous Health*: **www.healthinfonet.ecu.edu.au** (last update: 15/05/2012)

Interviews

AH&MRC

- Lucy Abbott (SEWB Workforce Support)
- Shopna Bag (Public Health Medical Registrar)
- Sandra Bailey (CEO)
- Sallie Cairnduff (Public Health Manager)
- Jo Coutts (Chronic Disease, Program Coordinator)
- Elizabeth Dwyer (Quitline, Project Officer)
- Warren Frost (Information Manager Member Support)
- Rebecca Hancock (Ethics Committee, Executive Officer)
- Kerri Lucas (Public health Manager)
- Matt Rogers (Media & Communications Coordinator)
- Ben Thomson (HR Coordinator)
- Hayley Ward (Accreditation, Senior Project Officer)
- Rodger Williams (COO)

Tharawal Aboriginal Corporation

Unfortunately, we could not obtain the list of the staff members of this institution.

Orange AMS

- Deon Adamson (Registered Nurse; Chronic Care Coordinator)
- Amy Burraston (GP Registrar)
- Bronwyn Cooper (Admin Officer)
- Ekala French (AHW Trainee)
- Ann Kable (Clinical Leader)
- Navdeep Kaur (Dentist)
- Ronny Leonard (Transport Officer)
- Yolande Meintjes (Practice Manager)
- Jamie Newman (CEO)
- Diana Peneva Arabadjiyska (GP Registrar)
- Greg Perry (AHW Trainee)
- Prashanth Reddy Tatagari (Dentist)
- Tove Riphagen (GP)
- Johnny Rose (Transport Officer)
- Jacqueline Watt (Registered Nurse; Smoking Cessation Advisor)

Dubbo AMS

- Rick Aitken (GP)
- Patricia Bullen (Practice Manager)
- Michael Ferres (GP)
- Carey Golledge (Registered Nurse)
- Rebecca Suckling (Receptionist)
- Narelle Winters (Receptionist)

Griffith AMS

- Richard Bamblett (Indigenous outreach worker)
- Sid Barone (D&A Coordinator) and his team
- Gary Carey (Mental Health Clinician)
- Kylie Charles (Social & Emotion Wellbeing)
- Stephen Collins (Bringing them Home)
- Sharon Hatley (Tobacco coordinator) and her team
- Candy Kilby (Enhanced Primary Care)
- Larissa Martino (Midwife)
- Stacey Meredith (CEO)
- Lisa O'Hara (Practice Manager)
- Ngiaran Williams (Maternal Health Trainee)
- Health Lifestyle team

Other people of importance

- Chantelle Allan, *Team Leader and Speech Pathologist* (ACTT, Dubbo)
- Graeme Curry, *Registered Nurse and Quitline Advisor* (Saint Vincent's Hospital, Sydney)
- Samia Goudie, *Senior Lecturer in Indigenous Health & Rural and Remote Health* (Australian National University, Canberra)
- Cathy Robbins, *Aboriginal Liaison Officer* (Orange Health Centre)
- Alby Ryan, *Aboriginal Liaison Officer* (Orange Health Centre)
- Terry Smith, *Manager Education and Training* (Aboriginal Health College)
- Annette Steele, *CEO of the Orange Aboriginal Land Council* and new *NAIDOC committee chair*
- Judy Townsend, *Nurse Supervisor* (ANFPP, Dubbo)
- Andrew Walden, *Drug & Alcohol worker* (NSP, Dubbo)
- Lisa O'Brien, *Manager Offender Services & Programs* (Wellington Correctional Centre)

Conferences / Workshops

24th May 2013: **8th Kanyini Vascular Collaboration Annual Meeting**
(organised at the Eora Campus of the National Centre for Indigenous Excellence)
31st May-1st July 2013: **GP Forum and Clinical Update**
(organised by the AH&MRC)
13th July 2013: **GP Registrar Indigenous Health Training**
(organised by *Beyond Medical Education* at the Dubbo Taronga Western Plains Zoo)

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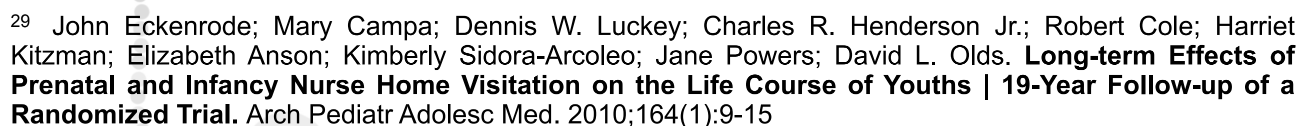

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