LEGISLATIVE ASSEMBLY FOR
THE AUSTRALIAN CAPITAL TERRITORY

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH IN THE ACT

Report No. 10 of the
Standing Committee on Health
and Community Care

August 2001

Resolution of Appointment

The following general purpose standing committees be established to inquire into and report on matters referred to it by the Assembly or, after the Assembly's endorsement, matters that are considered by the committee to be of concern to the community.

> ... a Standing Committee on Health and Community Care to examine matters related to health and community care policy, planning and purchasing acute, community health and population health services, hospitals, housing and housing assistance and any other matter under the responsibility of the portfolio minister.

Legislative Assembly for the ACT, *Minutes of Proceedings*, (1998), No. 2, 28 April 1998, pp 15 and 16.

Amended on 7 December 2000, *Minutes of Proceedings* (2000), No. 110, p 1129

Terms of Reference

That the Standing Committee on Health and Community Care examine the state of Aboriginal and Torres Strait Islander health in the ACT and report on strategies for improvement.

ACT Legislative Assembly *Minutes of Proceedings* No. 76, 17 February 2000, p 728.

Committee Membership

Mr Bill Wood, MLA (Chairman)

Mr Dave Rugendyke, MLA (Deputy Chair)

Mrs Jacqui Burke, MLA (February 2001 onwards)

Mr Harold Hird, MLA (Deputy Chair, 1998 - February 2001)

Secretary: Mr David Skinner

Administrative Officer: Mrs Judy Moutia

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SUMMARY OF RECOMMENDATIONS

Recommendation 1

The committee recommends that the ACT Government work with the Commonwealth to prioritise data collection efforts in relation to Aboriginal and Torres Strait Islander health.

Recommendation 2

The committee recommends that:

a) the Government consult with the ACT Aboriginal and Torres Strait Islander community to assess the value of establishing a community and cultural centre for Indigenous people; and

b) should this consultation find a sufficient level of support for such a centre, funding arrangements be developed to progress the proposal.

Recommendation 3

The committee recommends that the Government develop housing policies that reflect the special circumstances of the Indigenous population, ie a comprehensive Aboriginal Housing Policy which is informed by the Indigenous communities of the ACT and the housing sector.

Recommendation 4

The committee recommends that the Government design and develop public and community housing aimed directly at Indigenous families, particularly where women and children are escaping domestic violence.

Recommendation 5

The committee recommends that the Government provide advice, support and resources to facilitate the establishment of partnerships between the Indigenous Business Chamber, local Indigenous groups and individuals, the business community and the Government sector (both local and federal) that identify and help nurture entrepreneurial and employment opportunities for Aboriginal and Torres Strait Islander people.

Recommendation 6

The committee recommends that the Government examine the *Violence in Indigenous Communities* report to ensure that it has an appropriate range of programs and services in place for dealing with violence in the ACT Indigenous community.

Recommendation 7

The committee recommends that the Government:

a) provide post custodial accommodation which aims to keep families safe and to work towards healthy reintegration into the community;

b) develop early intervention programs with known populations whose needs are not being met within the current system e.g refuges;

c) provide outreach workers who maintain close links with a family in crisis, who can be a point of early intervention and work as advocates across the spectrum of health and welfare services that are required; and

d) develop a written, public domestic violence policy within ACT Housing.

Recommendation 8

The committee recommends that the Government consult with the Commonwealth and ATSIC to identify additional recurrent funding to improve the Canberra Rape Crisis Centre's capacity to provide effective services for Aboriginal and Torres Strait Islander people.

Recommendation 9

The committee recommends that the Government report to the Assembly on a regular basis about its performance in relation to the actions and outcomes outlined in the ACT Aboriginal and Torres Strait Islander Regional Health Plan.

Recommendation 10

The committee recommends that the ACT Government continue to support the principle of community control and that close consultation and negotiation takes place with the ACT Aboriginal community not only with regard to funding decisions but also in planning programs' timeframes, performance measures and outcomes.

Recommendation 11

The committee recommends that the Government advocate the broadest notion of community control in negotiations with state and federal counterparts regarding framework agreements and other Indigenous related policies.

Recommendation 12

The committee recommends that the ACT Government negotiate with NSW and the Commonwealth government to develop a funding package to create a practice manager position in Winnunga Nimmityjah.

Recommendation 13

The committee recommends that the ACT Government increase its financial support to Winnunga Nimmityjah to allow for the expansion of services.

Recommendation 14

The committee recommends that the ACT Government, in consultation with Winnunga Nimmityjah, make representations to the Commonwealth and NSW governments to identify joint funding for the development of a purpose built facility for Winnunga.

Recommendation 15

The committee recommends that:

a) the Government in consultation and negotiation with Gugan Gulwan review the appropriateness of its new premises in Erindale over the next year to ensure that the location opens up access to the fullest extent possible for the Corporation's client group; and

b) should this review find Civic to be a more appropriate location the Government shall make provisions for relocating Gugan Gulwan.

Recommendation 16

The committee recommends that the Government provide additional funding to Aboriginal-specific health and related services and make representations to the Commonwealth for increased ACT funding in this area.

Recommendation 17

The committee recommends that the Government consult with the ACT Aboriginal and Torres Strait Islander community to begin a systematised review of operating policies for all mainstream health services to ensure they are tailored to be culturally appropriate.

Recommendation 18

The committee recommends that the Government review all the processes at Canberra's hospitals in consultation with the ACT Aboriginal and Torres Strait Islander community to ensure that there is sufficient flexibility in their application and that operating processes and policies are culturally appropriate.

Recommendation 19

The committee recommends that the Government undertake vigorous efforts (and intensify existing programs) to expand the knowledge of cross cultural awareness and sensitivity across the entire health portfolio, particularly at the Canberra Hospital, this effort should be ongoing and reviewed periodically to determine where gaps exist.

Recommendation 20

The committee recommends that the Government consult with the various peak groups responsible for overseeing medical specialties to instigate Indigenous and

other cross-cultural awareness training for health professionals across all specialties.

Recommendation 21

The committee recommends that the Government fund further designated ALO positions in mainstream health services in the ACT.

Recommendation 22

The committee recommends that the ACT Government consult with the Commonwealth and the local Aboriginal and Torres Strait Islander community to begin refining and implementing the strategies identified in the 1996 Winnunga report to the Commonwealth Department of Human Services and Health.

Recommendation 23

The committee recommends that the Government consult with Aboriginal community groups, the ACT Division of General Practice and the AMA to develop strategies to minimise the extent of 'doctor shopping' and to identify GPs that are misprescribing benzodiazapines and other potentially dangerous drugs.

Recommendation 24

The committee recommends that the Government, in consultation with the ACT Aboriginal and Torres Strait Islander community, instigate a review of admission policies for detoxification services and other processes to identify current barriers to Indigenous people and following the review, implement measures to remove the barriers.

Recommendation 25

The committee recommends that the Government allocate funds to consult with the ACT Aboriginal and Torres Strait Islander community to assess the different approaches for providing rehabilitation and detoxification services for Indigenous people and that this assessment should be auspiced by an Aboriginal Controlled organisation such as Winnunga Nimmityjah or Gugan Gulwan and should consider:

- **how services can be better provided to support Aboriginal and Torres Strait Islander people who have had a drug addiction in the past and are released from prison;**

- **the value to the community of extending Gugan Gulwan's bush retreat program; and**

- **the capacity for family members of people seeking rehabilitation and detoxification to be involved in the treatment options and the capacity for a facility to offer support for family members as well as addicted persons.**

Recommendation 26

The committee recommends that following the assessment of Indigenous needs in relation to rehabilitation and detoxification services, the Government give funding priority to the proposals that arise out of the consultation.

Recommendation 27

The committee recommends that the Government consult with the ACT Aboriginal and Torres Strait Islander community to begin implementing Winnunga Nimmityjah's recommendations in relation to the Drug and Alcohol Program set out in the 1998 report, *Understanding Indigenous Needs: How can the Alcohol and Drug Program better meet the needs of Indigenous people in the ACT region.*

Recommendation 28

The committee recommends that the ACT Government through the Aboriginal and Torres Strait Islander Consultative Council develop proposals for sport, music, art and dance to provide activity for young Indigenous people and provide funds necessary to develop proposals and subsequent activity.

Chair's Statement to Assembly

The following is the text of a statement made by Chairman, Mr Bill Wood MLA, to the Assembly on at the commencement of this inquiry, which outlined the areas that the committee would concentrate on.

I'm advising the Assembly about the manner in which the Health and Community Care Committee will attend to the reference that you gave it, to consider and report on the health of indigenous residents of the ACT.

I indicated at the time that very likely a pre-requisite of any effective action would be to consider the spirit of a people and to see where society may need to change, if that is possible, to lift that spirit.

Members, the primary tasks the committee is undertaking are these: first, to consider those underlying societal, cultural and identity factors which may predetermine the approach a person takes to maintain a healthy outlook and high morale; second, to consider the relationship between Aboriginal and Torres Strait Islander people, the Assembly, the Government and the general community as community attitudes impact on a person's sense of belonging and worth. If we can attend to those two tasks it may in turn lead to a greater concern for a healthy body.

As a long-time political activist I am much aware of the strong claims over many years from different governments, especially the national government, that they will attend to problems around indigenous health.

There was no more genuine, dedicated and knowledgeable minister than Gordon Bryant, Whitlam's Aboriginal Affairs minister, who set out with determination to improve the health of Aborigines and Torres Strait Islanders. It didn't happen. A succession of mostly competent and interested ministers including Mr "Fixit or heads will roll" Graham Richardson have since had no more success.

Richardson's comment was particularly inane, failing to recognise that the answer does not entail simply providing programs, resources and facilities, important as they are. Though gaps no doubt exist, if it was simply a matter of providing services and facilities, the health of Aborigines and Islanders in the well resourced ACT would be very much better than the statistics indicate.

We know that the Aboriginal and Torres Strait Islander members of the ACT community are over-represented in very many areas associated with poor health and lower life expectancies, and we know that we must work with them to turn this around.

Still, we do not have the rough camps, the remote settlements with few facilities and many more health problems. But Canberra, the Aboriginal word for meeting place, is truly that. The indigenous population here is formed by people from many areas of Australia, many different backgrounds even within the Community. This adds to the complexity of the problem.

The committee will attend to the reference you have given us by considering those fundamental issues I have indicated. As a natural extension of that we will also focus on the circumstances of the youngest of that community and the means by which interventions may successfully occur as early as possible.

A detailed account of providing actual services to meet specific health needs is underway. The Assembly knew this when it gave the committee the reference. The strategy for improving indigenous health is being developed through the work of the ACT Department of Health and Community Care, the Aboriginal and Torres Strait Islander Commission, the Commonwealth and the ACT indigenous community. The work of the Assembly committee will complement that task. After meeting with the Minister and his officers there is agreement that there should be no unnecessary duplication of work. The committee expects the departmental strategy to deal with measures to improve the services and facilities that are needed over the foreseeable future.

If appropriate, we will join with departmental officers in meetings with local groups. We will be briefed on progress. We ask the Minister to allow the committee to make comments on a draft strategy and where appropriate will recommend changes based on our work.

While it is no easy task, the committee hopes we can return with a meaningful report.

ACT Legislative Assembly Minutes of Proceedings, 29 February 2000, p 1163.

CHAPTER 1. BACKGROUND AND SCOPE OF INQUIRY

1.1. On 17 February 2000, the Assembly referred this inquiry to the committee. The inquiry was born of many concerns that had been raised by Indigenous[1] groups, MLAs, and community groups about the adequacy of health policy and health services for Aboriginal and Torres Strait Islander people in the ACT. Of course, the large disparity between health outcomes for Indigenous and non-indigenous people across Australia is widely acknowledged and the situation is no different in the ACT. Indeed the recent Commonwealth Parliamentary Inquiry into Indigenous Health noted that the health of Aboriginal and Torres Strait Islander people is just as poor in urban areas as in rural and remote areas.[2]

1.2. As the Australian Institute of Health and Welfare (AIHW) noted in its report, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People*:

> Indigenous Australians suffer a higher burden of illness and die at a younger age than non-indigenous Australians, and this is true for almost every type of disease or condition for which information is available…
>
> The health disadvantage of Indigenous Australians begins early in life and continues throughout the life cycle… Indigenous Australians are about 2-3 times more likely to be hospitalised… as Australians overall… [and] suffer higher rates of infectious diseases…[3]

1.3. The committee sees that there is a broad range of factors which impact on health outcomes for Indigenous people. In addition to a wide range of specific health risk factors such as smoking or diet, poor health is tied to other types of social disadvantage including poverty, high rates of incarceration, day-to-day experiences of racism, high rates of substance abuse, low self esteem, loss of culture and the disintegration of family ties to name a few. In this vein, the committee notes the comments made in the submission from Winnunga Nimmityjah:

> Current health problems are… multifactorial and related to past experiences as well as to present conditions. The Commonwealth Inquiry into Indigenous Health recognised that the health of Aboriginal and Torres Strait Islander people is affected by an interplay of socioeconomic status, social and cultural factors including past dispossession and dislocation, environmental factors and specific risk factors such as poor nutrition, alcohol misuse and high levels of tobacco consumption. Health is also linked to the provision of good quality health care with lack of cultural awareness, location, workforce limitations and financial circumstances acting as barriers to access by Aboriginal and Torres Strait Islander people.[4]

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[1] NB The committee has used the terms Indigenous, Aboriginal and Aboriginal and Torres Strait Islander interchangeably in this report to refer to Aboriginal and Torres Strait Islander people.

[2] House of Representatives Standing Committee on Family and Community Affairs, (2000) 'Health is Life, Report on the Inquiry into Indigenous Health' cited in submission 5, p 2.

[3] Australian Institute of Health and Welfare and Australian Bureau of Statistics (1997) 'The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People' cited in submission 8, p 2.

[4] Submission 5, p 2.

1.4. For these reasons the committee believes that an holistic approach must be adopted if we are to make inroads in improving the health status of the ACT Aboriginal and Torres Strait Islander community. This is not a new notion but the committee has attempted to take on board and express many of the messages that the local community have stated about their health needs and the way that these other social issues are intertwined. The committee is aware that innumerable inquiries have been undertaken over the last thirty years to ascertain what can be done about the poor health of Indigenous Australians. The problems have been identified and prescriptions for improvement articulated time and time again. However, it appears that little progress has been made. The committee notes the comments of Philip Ruddock made in 1979 when he was Chair of the House of Representatives Standing Committee on Aboriginal Affairs. Mr Ruddock noted that:

> When innumerable reports on the poor state of Aboriginal health are released there are expressions of shock or surprise and outraged cries for immediate action. However, the report appears to have no real impact and the appalling state of Aboriginal health is soon forgotten until another report is released.[5]

1.5. It appears that little has changed.

1.6. The committee does not pretend to have any panaceas for these complex problems but has tried to put forward achievable and realistic recommendations aimed at creating a more robust and effective health infrastructure for Indigenous people in the ACT, leading to services which Indigenous people *want* to use and which deliver better health outcomes. The committee has included large sections of submissions and other documents and reports that it believes have already traversed the issues in some depth.

1.7. The committee is aware that there are significant problems in the manner that mainstream health agencies deliver their services to Indigenous people and that a better understanding of cultural issues in the health sector should be developed with service providers as a matter of priority. The committee also heard that specific health services for Aboriginal and Torres Strait Islanders are warranted in some areas.

1.8. Beyond the service delivery side of the equation, the committee also learned about the great spiritual crisis that appears to pervade many sections of the Aboriginal community. Causes of ill-health were said to be the result of poor self-image and poor self-esteem that has arisen in large sections of the Aboriginal community as a result of the loss of culture, dispossession of their land and over 210 years of subjugation and discrimination.

1.9. The committee has attempted to reflect on this notion of a spiritual malaise as being one of the chief antecedents of ill-health, especially in terms of mental health. A submission to Commonwealth Inquiry on Indigenous Health from the Royal

[5] The Hon. P Ruddock, MP. Chairman, House of Representatives Standing Committee on Aboriginal Affairs. 1979 cited in Standing Committee on Family and Community Affairs op cit, p 7.

Australian and New Zealand College of Psychiatrists noted that mental health and emotional well-being were impacted by:

> …the loss of loved ones, childhood trauma, alcohol and drug related misery, violence, ongoing racism, stereotyping and discrimination, and the accumulated loss of two hundred and eleven years of cultural destruction and dispossession.[6]

1.10. The committee's attention was brought to the escalating drug problem in the local community, especially in relation to heroin addiction. The committee spoke with alcohol and drug workers, loved ones of users, general health practitioners and community elders about the extent of the problem. The committee concluded that very few people were unaffected by the devastating effects that drug abuse is having on the local community. The committee has included a separate chapter on this pressing problem in its report.

1.11. The committee relied heavily on the views of the local Aboriginal and Torres Strait Islander community for ideas about what can be done to improve the current situation and has also sought the views of Indigenous people in other parts of Australia to see what advances are happening across the board. The committee would like to see this report as a report for and to the ACT Indigenous community as much as it is a parliamentary report. Where possible, the committee has used material provided by Indigenous witnesses and from submissions made by Indigenous groups and individuals.

1.12. The committee has also taken the unusual step of reproducing, in full, the submission made by Winnunga Nimmityjah. This submission eloquently outlines many of the problems confronting Aboriginal and Torres Strait Islander people in terms of receiving appropriate health care as well as the larger social and cultural issues which impact on poor health outcomes. The committee drew heavily on this submission and wishes to give special thanks to Winnunga Nimmityjah for taking the time out of its busy schedule to make such a detailed submission.

1.13. The committee also saw value in drawing on parts of the recent report from the Commonwealth Parliamentary Committee report on Indigenous health, *Health is Life*, which synthesises many of the contemporary issues surrounding Indigenous health policy and service delivery across Australia.

1.14. The committee also reviewed the ACT Aboriginal and Torres Strait Islander Regional Health Plan produced in collaboration by Winnunga Nimmityjah, ACT Department of Health and Community Care, ATSIC, Department of Health and Aged Care and Commonwealth Department of Family and Community Services. The committee welcomes the document as a step towards ensuring more Indigenous involvement in decision-making. The actions proposed are all most sensible and the committee looks forward to seeing the parties to the plan realise some of the key goals

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[6] The. Submission No 88, p 1038 . cited in Standing Committee on Family and Community Affairs op. cit. p 5.

outlined therein. The committee has referred to elements of the plan throughout its report.

1.15. The committee conducted two public hearings in the course of the inquiry, one on 22 November 2000 and the other on 26 February 2001. The committee also travelled to Perth, Adelaide, Sydney and Narooma and met with Aboriginal health workers and officials.

1.16. The committee wishes to thank all those who participated in the inquiry for making valuable contributions to this important area, especially the local Indigenous community who were able to greatly assist the committee in understanding the on-the-ground problems confronting them.

1.17. The committee is acutely aware that it is comprised of three middleclass 'whiteys' with limited experience in Aboriginal and Torres Strait Islander matters and it may seem presumptuous of us to give advice in this area. We have, however, been attentive to what has been said to us and hope that this report will play some part in bringing about real improvements to the health status of Aboriginal and Torres Strait Islander people and hopes that it does not become a document to be filed away for another day. As noted above, reports on this issue are so numerous yet so few improvements have been made. The actions suggested in this report are all most urgently required and the committee implores the Government to realise this urgency and act accordingly.

Structure of the report

1.18. Chapter 2 outlines the demographic composition of the ACT Aboriginal and Torres Strait Islander population along with recent data about morbidity and mortality rates. The committee has also outlined the key causes of Indigenous ill-health ranging from asthma and cancer, through to diabetes, injury and mental illness. This is a cursory examination and the committee does not propose specific policy remedies to overcome these health problems but merely wishes to highlight the extent of disadvantage in terms of health outcomes within the Indigenous community.

1.19. As noted above, the committee was advised that the antecedents of ill-health in the Aboriginal and Torres Strait Islander community are multi-factorial. In Chapter 3 of the report, the committee has attempted to synthesise the comments made by submitters about what types of social disadvantage can bring about poor health outcomes. The committee has also looked at barriers which may exist to bringing about improvements to health outcomes. Variously, the committee discusses unemployment, housing, violence, racism, limited self-determination and poor self-esteem. The committee also examines the relationship between reconciliation and health in this chapter.

1.20. The committee was informed time and time again about the advantages that Aboriginal community controlled health services offer in delivering primary health care services. The committee was also advised that there are serious impediments to

achieving good health care and effective service delivery in many mainstream services. These issues are discussed in Chapter 4.

1.21. The committee has included a separate chapter (Chapter 5) on the issues raised in relation to Indigenous drug abuse in the ACT.

CHAPTER 2. HEALTH STATUS AND DEMOGRAPHICS

The make up of the ACT Indigenous population

2.1. Australian Bureau of Statistics (ABS) figures indicate that as at 1996 there were 3058 Indigenous people living in the ACT[7]. However, many believe that this figure underestimates the population. Julie Tongs, Chief Executive, Winnunga Nimmityjah Aboriginal Health Service put the figure at closer to 5,000.[8]

2.2. Whatever the exact figure, the committee is aware that the Indigenous population in the ACT is a relatively mobile group, with people coming in and out of the territory all the time.

2.3. The ACT Government submission noted that that this high level of mobility has implications for how health programs and services can be developed. The Government noted that:

> The population is not static. There is continual movement of Indigenous people not only within the ACT itself but also within the wider region. The mobile population and contrasting urban and rural communities create difficulties for seamless service provision. Indigenous people living in Canberra as the Urban hub of the region have very different needs and access to services than those living in more rural communities…
>
> The cultural spread of the Indigenous population in and around the ACT, combined with its mobility create another important issue that adds to the complexity for the Government in achieving desired outcomes for Indigenous health. There are proportionately fewer ACT Indigenous families and residents having easy access to their extended families and elders for general support, particularly in times of crisis.
>
> [Another]… demographic factor of significance, based on the 1996 census is that the Indigenous population in the ACT is rapidly increasing. The population is gender balanced but has a younger profile than the broader ACT population.[9]

2.4. In relation to population growth, the ACT Government cites research from the University of New England as well as 1996 census figures which show that between 1991-1996, the average annual rate of increase in the ACT's Indigenous population was 11.8 per cent. The was attributed to, 'natural increase, internal migration within Australia and an increasing identification by individuals as Indigenous.[10]

2.5. A feature of the Indigenous community in the ACT is its diversity. The following statistics indicate its general poor health in comparison with the broad population. But a large number of the community is in good health; the problem the committee discusses are not problems for all the Indigenous community.

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[7] ABS cited in Dance, Brown and Bammer (2000) '"They'll just read about us in story books": estimations of the number of young Indigenous people using illegal drugs in the ACT and region' p 2.
[8] Ibid, p 3.
[9] Submission 7, p 4.
[10] Submission 7, p 4.

Unequal health status

2.6. The ACTCOSS submission to the inquiry included a number of statistics demonstrating the disparity in health and other social outcomes between Indigenous and non-indigenous people in the ACT. The following table is drawn from the ACTCOSS submission.

	Indigenous	**Total ACT Population**
% population aged 49 and under	95	80
% population aged over 60	1	10
Fertility rate	2.6	1.8
Mortality rate (per 1000 persons) Male	17.2	8.4
Mortality rate (per 1000 persons) Female	43.6	5.4
Average age death (years)	56.5	68.4 [11]

2.7. In commenting on these figures, ACTCOSS noted that:

> Mortality rates for Aboriginal and Torres Strait Islander people are significantly above those of the total ACT population [ACTCOSS note, however, that these figures should be treated with caution 'given the small number of Aboriginal and Torres Strait Islander deaths in the ACT']. The mortality rates for Indigenous women are particularly disturbing. The age-standardised death rate for Aboriginal and Torres Strati Islander men and women is 17.2 and 43.6 per 1000 persons respectively, compared to 8.4 and 5.4 per 1000 persons respectively. The average age of death for Indigenous people in the ACT in 1997 was 56.5 years, compared to 68.4 for all ACT deaths in that year.
>
> Over the last 20 years, the causes of the higher mortality rate among Aboriginal and Torres Strait Islander people compared to the total population have changed. Where previously they were predominantly caused by acute infections, they are now caused largely by chronic non-communicable diseases and deaths resulting from accident or injury. There have been increased rates of hypertension, heart disease and diabetes in particular over the past two decades. Three quarters of all Aboriginal and Torres Strait Islander deaths now result from: heart attacks and strokes; road accidents, suicide and murder; respiratory diseases; cancers; or diabetes.[12]

[11] 1996 Census of Population and Housing, Aboriginal and Torres Strait Islander People, ACT cited in Submission 8, p 3.

[12] Submission 8, p 4.

2.8. The Government submission, too, made mention of the unequal health status of the Indigenous population in the ACT when compared to the non-indigenous population. The Government noted that:

> The National Centre for Aboriginal and Torres Strait Islander Statistics incorporates the Aboriginal and Torres Strait Islander Health and Welfare Information Unit and is the primary source of statistical information on the health status of Indigenous Australians. Under the auspices of the Australian Bureau of Statistics only data from Western Australia, South Australia and the Northern Territory is considered valid for general publication. It is suggested that data available from other jurisdictions does follow the trend data of WA, SA and the NT. From this position the following information is available and can be applied in general terms to the ACT.
>
> Age at Death
>
> Indigenous people are more likely to die at a younger age than other people, compared with the total Australian population. Using the trend data of WA, SA and NT (1995-97) about one in two Indigenous males who died in this period was under 50 years of age. For other Australians males, deaths of under 50 year olds made up just over one in ten deaths. There were similar results for females.
>
> Causes of Death
>
> In the period 1995-97 the most common causes of indigenous death were: circulatory diseases, injury, cancer, respiratory diseases and endocrine diseases (eg diabetes). Together, these causes were responsible for three out of every four Indigenous deaths. Although the causes of death are similar to other Australians in general, Indigenous people died at higher rates from these causes.
>
> Hospital Statistics
>
> In general terms and using Australia as a whole hospital separation rates between 1997-98 were higher for Indigenous people than for other Australians in all age groups.
>
> Dialysis treatment, pregnancy and childbirth, respiratory diseases and injury were the most common reasons for admission to hospitals by Aboriginal and Torres Strait Islander people during 1997-98.
>
> Australian Bureau of Statistics Research indicates that there were more than the expected number of hospital separations for Indigenous people for: dialysis treatment, pregnancy and child birth, respiratory diseases, injury, mental disorders, circulatory diseases, skin diseases, infectious and parasitic diseases, endocrine, nutritional and metabolic disorders and diseases of the nervous system.[13]

2.9. The evidence cited above clearly demonstrates the extent of Indigenous disadvantage in terms of health. The committee wonders that if any other section of the Australian community was experiencing such appalling health outcomes, whether more would have been done to date to address the problems. The measures for success in improving Indigenous health should be based on outcomes, on statistics

[13] Submission 7, p 7.

showing higher rates of life expectancy, on reduced morbidity rates for disease and illness, not based on processes and attempts to solve these problems.

Need for better data

2.10. The committee is aware that the quality of data is not adequate for appropriately informing policy decisions on Aboriginal and Torres Strait Islander health.

2.11. As the Government noted in its submission:

> Previously released epidemiology data was not robust and is indicative of similar problems concerning data on indigenous health in other jurisdictions…
>
> There are few available mechanisms to influence the evolutionary process of identifying as being of Indigenous origin. It is likely data will continue to show an under representation of the indigenous population. More particularly effective analysis of disaggregated data to pin point need, access and measure the effectiveness of programs is impeded.[14]

2.12. The ACT Aboriginal and Torres Strait Islander Health Plan emphasises the importance of improving health data. The Plan states:

> As with all other States and Territories, the issue of Indigenous health data collection, management and utilisation is compounded by the lack of an agreed system. The currently available hospital data is not reliable due to the small numbers and the lack of consistency of Indigenous identification. Adequate and appropriate data collection should commence as a priority.[15]

2.13. The committee considers that the lack of reliable data on the state of Indigenous health in the ACT is a major barrier in developing effective Indigenous health programs. The committee is aware that efforts are being undertaken at both the federal and local levels to develop better data.

Recommendation 1

The committee recommends that the ACT Government work with the Commonwealth to prioritise data collection efforts in relation to Aboriginal and Torres Strait Islander health.

The international experience

2.14. The poor state of Indigenous health in this country is an aberration in the developed world. Indigenous people in countries such as New Zealand, the USA and Canada have far better health outcomes than do Australia's Aboriginal and Torres Strait Islander people.

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[14] Submission 7, p 5.

[15] ACT Department of Health and Community Care, Department of Health and Aged Care, Department of Family and Community Services, Winnunga Nimmityjah, ATSIC, (2000) *'ACT Aboriginal and Torres Strait Islander Regional Health Plan'*, p 9.

2.15. Often people speak of the state of Aboriginal and Torres Strait Islander health as if it is a lost cause and there is nothing that can be done to improve it. Why then do Indigenous people in other countries have comparatively better health? Are there inherent differences between Aboriginal and Torres Strait Islanders and other Indigenous peoples? What was life like for Aboriginal and Torres Strait Islander people before contact with European settlers?

2.16. An article appearing in the Medical Journal of Australia by Lisa Jackson and Jeanette Ward notes that the pre-colonial lifestyle of Aboriginal peoples lead to good health. The authors note that:

> Before the arrival of Europeans, the Aboriginal peoples of Australia were a strong and healthy race of hunters and gatherers whose active lifestyle promoted good health. Little evidence has been found of widespread illness or disease in Aboriginal people, making it unlikely that they suffered from obesity, hypertension, diabetes, renal failure, coronary heart disease, cancer, arthritis or other diseases endemic in Aboriginal people today.
>
> It is possible that, in 1770, when Cook charted the east coast of Australia, Aboriginal people were healthier than the average person in Britain or other parts of Europe. Further, Aboriginal people had a strong oral pharmacopoeia which was passed down from generation to generation. The early European colonists, without a means of replenishing their medical supplies, were taught by Aboriginals to use "medicinal plants growing in the new country".[16]

2.17. In a submission to the Commonwealth inquiry, the Australian Medical Association and Public Health Association commented that:

> The failure to make significant improvement in the health of Australia's Indigenous population is unique in the developed world and yet there is nothing that is unique in the experience, disease pattern, or circumstances of Aboriginal and Torres Strait Islander people which could reasonably explain the failure to make satisfactory progress.[17]

2.18. The Association went on to say that:

> The all causes mortality for the Aboriginal and Torres Strait Islander population is twice as high as the Maori rate, 2.3 times the United States Indigenous rate and 3.1 times the total Australian rate. The Maori death rate declined by 44% in the period between 1974 and 1994 and the United States Indigenous rate by 30% in the same period.[18]

2.19. The following table indicates the significant differences in life expectancy between Australian Aboriginals, New Zealand Maoris, Canadian Indians and American Indians for 1981-1986.

Population	**Male**	**Female**

[16] Jackson, Lisa R et al(1999) Medical Journal of Australia <www.mja.com.au> – '*Aboriginal Health: why reconciliation is necessary?'* 170:437-440.

[17] Australian Medical Association and Public Health Association of Australia, Submission No 32. P 50 cited in Standing Committee on Family and Community Services op cit, p 6.

[18] Ibid, Appendix E.

Australian Aborigine	55.7	63.9
New Zealand Maori	65.6	70.9
Canadian Registered Indian	64.4	73.6
American Indians and Alaskan natives	73.1	81.0 [19]

2.20. The committee asks why it is the case that Australia's Indigenous peoples are unique in their health disadvantage. What policies have these other countries pursued to improve Indigenous health that we have not? Later in the report, the committee reflects on one advancement that Australia has yet to make which these other countries have and that is the development of a treaty, which appears to have had a significant impact on health outcomes in these countries.

Major health issues

2.21. In this section of the report the committee has attempted to outline the most pressing health issues in the ACT Indigenous community. The committee has drawn on an ACT Department of Health and Community Care monograph on Aboriginal Health, which is based on data collected via the National Aboriginal and Torres Strait Islander Survey and the National Health Survey. The committee does not examine these various illnesses in any great depth but merely wishes to highlight the large rate of morbidity and mortality arising from a range of preventable diseases.

Mental Health

2.22. In the course of the committee's inquiry, the committee became aware of the significant mental health problems facing many Aboriginal and Torres Strait Islander people in the ACT community.

2.23. Winnunga Nimmityjah noted in its submission that:

> Mental health, particularly mental and emotional wellbeing, is a major problem for Aboriginal and Torres Strait Islander people. In the ACT, Aboriginal and Torres Strait Islander people had a significantly higher hospital separations rate due to mental and emotional conditions of 29.5 per 1,000 separations, compared with the non-Aboriginal rate of 20.6 per 1,000 people hospitalised in the ACT. While Aboriginal and Torres Strait Islander females had a lower rate of separations than non-indigenous females, 15.3 and

[19] Hogg RS. '*Indigenous Mortality: Placing Australian Aboriginal mortality within a broader context*' Soc Sci Med 1992; 35:335-346. Cited in submission 21 to the Standing Committee on Family and Community Affairs, p 509.

> 20.1 respectively, Aboriginal and Torres Strait Islander males had twice the number of separations, 44.8 compared to 21.3 per 1,000.[20]

2.24. A 1996 report, *The Mental Health Needs of Aboriginals and Torres Strait Islanders Living in the ACT* found that 8.5 per cent of the ACT Indigenous community used the ACT Mental Health Services while only 1.5 per cent of the 'general community' accessed the services.[21]

2.25. Between 1994 and 1995 ACT Mental Health Services recorded 27 suicide attempts by Aboriginal people living in the ACT.

2.26. The 1996 Winnunga Nimmityjah report made a raft of recommendations (28) aimed at improving the state of Indigenous mental health. The committee would like feedback from the Government as to how many of these recommendations have been implemented.

2.27. In relation to the antecedents of mental illness in the Indigenous community, the Winnunga submission cites a passage from the recent House of Representatives Committee report on Indigenous health, which the committee believes summarises the main issues. That committee's report noted that:

> The poor mental health status of Aboriginal and Torres Strait Islander people has been linked to:
>
> "…the loss of loved ones, childhood trauma, alcohol and drug related misery, violence, ongoing racism, stereotyping and discrimination, and the accumulated loss of two hundred and eleven years of cultural destruction and dispossession".[22]

2.28. The committee examines the antecedents of mental ill-health and poor self esteem as well as proposals for improvement later in the report.

Diabetes

2.29. Diabetes is a major health issue in the ACT Indigenous community. Diabetes mellitus is described as, 'a complex group of syndromes that all have in common a disturbance in the oxidation and utilisation of glucose. It occurs when the pancreas is unable to produce sufficient insulin, or the insulin produced in unable to work effectively. Insulin is required to make glucose available for basic cell and organ function'.[23]

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[20] Submission 5, p 2.

[21] O'Neil 1996, cited in Briscoe et al, (1997) *'Health Series Number 12:The health of Aboriginal and Torres Strait Islander people in the ACT'* ACT Government publication, p 41.

[22] Standing Committee on Family and Community Affairs cited in submission 5, p 2.

[23] Briscoe et al, op cit, p 38.

2.30.There are a range of poor health outcomes associated with diabetes such as blindness, kidney failure, heart disease, stroke, peripheral vascular disease, amputations and impotence.[24]

2.31. The committee notes that medical literature on the subject has identified that genetic risk factors can predispose a person to mature-age onset diabetes. There are also a range of preventable risk factors such as consumption of fats, alcohol and sugar as well as obesity. It has been argued that these risk factors contribute to the high incidence of diabetes in the Aboriginal community.[25]

2.32. The 1995 National Health Survey found that 15.1 of every 1000 Aboriginal people in the ACT suffered from diabetes mellitus. The National Aboriginal and Torres Strait Islander Survey found that 11.7 per 1000 persons suffered from the condition in the Queanbeyan region.

2.33. Between 1991/92 and 1994/1995, there was a diabetes-related hospital separation rate of 51.9 per 1000 in the ACT Aboriginal community, significantly higher than for non-aboriginal people.[26] Diabetes is particularly a problem for Aboriginal men as noted in the 1997 ACT Department of Health and Community Care Monograph on Aboriginal health (Briscoe et al):

> Aboriginal males in particular were over represented in the hospital population with a diabetes separation rate of 66.4 compared to the non-Aboriginal male rate of 27.5 per 1000. Although Aboriginal female diabetes rates were much lower at 38.5 per 1000, they were still twice that of the non-Aboriginal female hospital separations (19.4).[27]

Cardiovascular disease

2.34. Briscoe et al outline the following description of cardiovascular disease:

> Cardiovascular means pertaining to the heart and blood vessels. Cardiovascular disease includes cerebrovascular disease (stroke, hypertension, coronary heart disease (ischaemic heart disease), peripheral vascular disease and other diseases of arteries and veins and other circulatory conditions'.[28]

2.35. Briscoe et al note that in the National Aboriginal and Torres Strait Islander Survey, chest and heart problems were reported as being in the 'top five most common self reported long term illnesses and conditions'.[29]

2.36. Between 1991/1992 to 1994/1995 there was a hospital separation rate of 73.4 per 1000 persons for Aboriginal people versus 68.5 per 1000 people for non-Indigenous persons. While hospital separations due to cardiovascular disease between

[24] Ibid, p 38.
[25] Ibid, p 38.
[26] Ibid, p 38.
[27] Ibid, p 38.
[28] Ibid, p 35.
[29] Ibid, p 36.

Aboriginal and non-aboriginal populations in the ACT was not significantly different, coronary heart disease was found to be more pervasive in the ACT Aboriginal community.

2.37. Briscoe et al note that:

> The rate per 1000 hospital population for a primary diagnosis of coronary heart disease was slightly higher for Aboriginal than non-Aboriginal females, 21.5 and 14.4 per 1000 females respectively. However, there was a significant difference between Aboriginal and non-Aboriginal males for coronary heart disease, 54.8 and 36.1 respectively…[30]

Asthma

2.38. Asthma is a significant health problem in the ACT Indigenous community. Asthma is described in Briscoe et al as being, 'a condition distinguished by severe attacks or laboured breathing, wheezing, feeling of constriction in the chest and coughing'.[31]

2.39. The National Aboriginal and Torres Strait Survey found that asthma was reported by Aboriginal people in the Queanbeyan region as the most common long term illness or condition. Briscoe et al note that:

> The rate of self-reported asthma was 186.6 per 1000 population, compared to 114.6 per 1000 for the ACT population as reported in the first results from the National Health Survey, which is itself high compared to the rest of Australia.[32]

2.40. Between 1991/92 and 1994/95 Aboriginal hospital separations for asthma amounted to 28.7 per 1000 compared to 17 per 1000 for non-aboriginals. There was a far higher incidence of hospital separations for Aboriginal males than for non-aboriginal males with 38.2 per 1000 and 18.9 per 1000 respectively.[33]

Cancer

2.41. The committee notes that cancer is, in the main, a disease which affects older people. Given that the Aboriginal and Torres Strait Islander community has a low life expectancy and therefore fewer older people than the community at large, cancer may not be seen as such a significant problem as it might other wise be if more Aboriginal and Torres Strait Islander people reached old age.

2.42. Briscoe et al note that:

> Apart from lung cancer, cancers were not mentioned in the National Aboriginal Health Strategy. This probably reflects the fact that while cancer can and does occur at all ages, it is predominantly a disease of the elderly… and it is well documented that the

[30] Ibid, p 36.
[31] Ibid, p 36.
[32] Ibid, p 33.
[33] Ibid, p 33.

> Aboriginal community has a relatively young age structure… and hence less likely to exhibit diseases associated with old age.[34]

2.43. However, cancers such as lung cancer, liver cancer, pancreas cancer and cervical cancer do concern epidemiologists and medical practitioners, 'because of their association with known risk factors such as smoking, hepatitis and alcohol consumption'.[35]

2.44. Briscoe et al cite a study which showed that late detection of cervical cancer in Aboriginal women had resulted in a mortality rate of 51.9 per 100,000 versus only 10.8 for non-indigenous women.[36]

2.45. On the whole, however, Aboriginal and Torres Strait Islander people do have a lower incidence of hospital separations for cancer.

Injury

2.46. In the ACT between 1991/1992 and 1994/1995 the hospital separation rate attributed to injury was 80.6 per 1000 for Aboriginal people and 60.9 per 1000 for non-Aboriginal people.[37]

Drug Use

2.47. Giving the pressing drug problems in the ACT Aboriginal and Torres Strait Islander community, the committee has included a separate chapter on this issue later in the report.

[34] Ibid, p 35.
[35] Ibid, p 35.
[36] Ibid, p 35.
[37] Ibid, p 40.

CHAPTER 3. UNDERLYING ISSUES

> *Next to shooting Indigenous peoples, the surest way to kill us is to separate us from our part of the Earth. Once separated, we will either perish in body or our minds and spirits will be altered so that we end up mimicking foreign ways, adopt foreign languages, accept foreign thoughts and build a foreign prison which suffocates rather than nourishes as our traditional territories of the Earth do. Over time, we lose our identity and eventually die or are crippled as we are stuffed under the name of "assimilation" into another society.*
>
> *A senior official of the World Council of Indigenous People*[38]

3.1. The committee became aware of the many underlying factors which contribute to poor morbidity and mortality rates in the Aboriginal and Torres Strait Islander community. The idea of a spiritual crisis was raised many times as being a cause of ill-health. The troubles of the spirit and poor self-esteem were seen as emanating from the loss of land, the loss of family members and the loss of cultural practices over the last 210 years of European settlement. The committee believes it is important to discuss these issues as well as how the process of reconciliation may help heal some of the wounds arising from this sense of loss.

3.2. The committee also became aware that poor health outcomes are closely tied-in with social and economic disadvantage in the ACT Aboriginal and Torres Strait Islander community. The fact that Aboriginal people in the ACT fare poorly in just about every type of social indicator when compared to the community as a whole is cause for great concern.

3.3. This chapter reflects on some of the barriers and antecedents of ill-health in the ACT Aboriginal community such as low self-esteem, experiences of racism, poverty, violence and low rates of employment.

Social indicators

3.4. The ACTCOSS submission to the Inquiry outlined the stark discrepancies between the social outcomes for Indigenous ACT residents compared to the ACT community as a whole. The following table was compiled by ACTCOSS using ABS data from 1996.

	Indigenous	**Total ACT**

[38] International Commission on Humanitarian Issues. Proceedings of Conference, 1987: In: The health of Aboriginal Australia. Reid J, Trompf P, editors. Sydney: Harcourt Brace Jovanovich, 1991: xi. Cited in Jackson et al op cit (1999).

		Population
Median weekly family income	$306	$432
Home ownership (% population)	8	31
% population renting	62	30
% population renting through Government agency	28	10.5
% students left school at 15	39.3	29.4
% students leaving school at 17 or over	37.3	53
% population with post secondary qualification	26.9	45.9
% population with bachelor degrees	8.2	15.6 [39]

3.5. In commenting on many the disparity between these social indicators for the two different populations, Winnunga Nimmityjah noted in its submission that:

> The relationship between the poor health status of Aboriginal and Torres Strait Islander people and a range of socioeconomic factors and experiences has been discussed at length by The National Aboriginal Health Strategy (1989), the report of the Royal Commission into Aboriginal Deaths in Custody (1991), and the Bringing Them Home Report. In comparison to Aboriginal and Torres Strait Islander people in other parts of Australia, those in the ACT are more likely to be better educated, have a higher income and standard of housing, and to be employed. However, when compared with other ACT residents, these rates are low (ACT Department of Health and Community Care Monograph Series). The 1999 Social Health Atlas of Australia clearly points out the existence in the ACT of an association at the Statistical Local Area level between high proportions of Aboriginal and Torres Strait Islander people and socioeconomic disadvantage. Meaningful correlations exist between Aboriginal and Torres Strait Islander people resident in the ACT and the variables for low income families and single parent families (both 0.51). There are also associations with the variables for public rental housing (0.46), early school leavers (0.42), unskilled and semiskilled workers (0.42) and unemployed people (0.38). The 1996 Census found unemployment rates in the ACT of 22.9% for Aboriginal and Torres Strait Islander men and 11.0% for Aboriginal and Torres Strait Islander women in comparison with non-indigenous rates of 8.0% and 6.4% respectively. Since education, housing, employment and income are social determinants of health, there is a pressing need to combine strategies and resources across government agencies.[40]

[39] 1996 Census of Population and Housing, Aboriginal and Torres Strait Islander People, ACT cited in Submission 8, p 3.

[40] Submission 5, p 3.

The breakdown of traditional social structures

3.6. The committee wishes to make some comment on how previous government policies have had the effect of weakening and in some cases, have destroyed, traditional cultural, family and social structures within the Aboriginal and Torres Strait Islander community. A 2001 report by the Commonwealth National Crime Prevention program examined three particular areas of relevance. Although the examples given pertain to Queensland, the polices in question were similar right around Australia.

3.7. The report notes that:

> Researchers and lawyers participating in the Queensland RCIADIC [Royal Commission into Aboriginal Deaths in Custody] team argued that from the 1890s until the 1960s, Aboriginal social structures were broken down by three mechanisms:
>
> 1. State policies of removing Aboriginal people to reserves or missions, and the allied policy of removing people of mixed descent from their families. Regarding the policy of Aboriginal removals, Commissioner Hal Wootten… stated:
>
>   *It would be difficult to find an Aboriginal person above the age of thirty who had not had some experience of State intervention in Aboriginal families.*
>
> 2. The dormitory system: in Queensland from the turn of the century until as late as the 1970s in some places, the dormitory system was instituted in many Aboriginal communities. Neill describes her experiences living in the Cherbourg dormitories in the early and mid 1960s:
>
>   *The mothers' dormitories housed women, who had babies in most instances from rape whilst working away on stations and properties in south-east Queensland. When the children reached the age of three they were either placed in the boys' or girls' dormitories. When they became of working age as deemed by the managers of the missions, they were in turn farmed out as cheap labour. This maintained the production of cheap and/or slave labour as many of our folks' wages were paid into an account controlled by the manager…*
>
> 3. The political and disciplinary disempowerment of elders by mission and reserve managers: on the erosion of power of Aboriginal elder and community leaders, Memmott… argues that the practice of undermining the authority of such elders was an outcome of the work of the mission managers whose duty it was to effect on Indigenous communities social changes. This disempowerment was achieved through mechanisms such as banning ceremonies, banning traditional marriages and polygymy, banning Indigenous languages as well as punishment for those who would not conform, and the undermining of Indigenous religions and cultural values.
>
>   *Contributing factors such as those above have occurred over the last 100 years or more, and are responsible for the loss of 'social [and family] control stemming from the erosion of values concerning traditional social structures, their underpinning ideologies, leadership qualities and desirability of social control (Memmott 1990)*[41]

[41] National Crime Prevention Committee (2001) '*Violence in Indigenous Communities*' pp 11-12.

3.8. This is the background against which Indigenous health should be considered. The committee sees that the effect of these policies has had devastating effects for Aboriginal and Torres Strait Islander people. The policies have diminished cultural practices, kinship ties and spiritual identity and have, in many ways, taken away the capacity for Indigenous people to be a self-determined proud people with high hopes for what the future will bring. This must have a bearing on the prospect for improving health outcomes.

Reconciliation, self-esteem and spirituality

3.9. The committee heard over and over again that poor self-esteem and the spiritual crisis pervading many sections of the Aboriginal and Torres Strait Islander community are major factors tied in with poor health outcomes for Indigenous people. Poor self esteem and the loss of spirit was seen as being brought about by loss of self-determination, dispossession from the land, the removal of children from families and the subsequent breakdown of those families as well as day-to-day experiences of racism. The committee sees that an unhealthy spirit, a crushed spirit, will inevitably lead to physical and mental deterioration. Health is construed in very broad terms by Aboriginal and Torres Strait Islander people, not only is good health a sound mind and body, it is a healthy family, a strong community, a nourishing land and above all, a sense of spiritual interconnection between these things.

The Aboriginal concept of health

3.10. An article in the Medical Journal of Australia by Jackson et al, *Aboriginal Health: why is reconciliation necessary?*, talks about the Aboriginal concept of health. Jackson et al note that:

> To Aboriginal people, ill-health is more than physical illness; it is a manifestation of other factors, including spiritual and emotional alienation from land, family and culture. Aboriginal people have a spiritual link with the land which provides a sense of identity, and which lies at the centre of their spiritual beliefs. Land is the crux of Aboriginal health and well-being[42].

3.11. In a similar vein, the National Aboriginal Health Strategy defined health as perceived by Aboriginal in the following way:

> Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life.[43]

3.12. This understanding of health is markedly different to the traditional approach of much western medicine. It is important for health professionals and policy makers to gain an appreciation of the Aboriginal concept of health, especially regarding the

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[42] Jackson et al op cit (1999)

[43] National Health and Medical Research Council. Promoting the health of Indigenous Australians. A review of infrastructure support for Aboriginal and Torres Strait Islander heath advancement. Final report and recommendations. Canberra: NHMRC, 1996: part 2:4. Cited in Jackson et al.

spiritual dimension. The committee speaks later in the report about how many mainstream services rely on a 'body parts' approach to health care and medicine and this approach is in many ways incongruous with Aboriginal expectations of health care.

The Federal Government

3.13. Following on from this quite different concept of health, the committee was particularly interested in comments made at a meeting with Winnunga Nimmityjah workers, patients and elders[44] about the effects that the Federal Government's approach to Aboriginal and Torres Strait Islander affairs has had on self esteem and more directly on health outcomes.

3.14. It was noted at this meeting that every time there was the perception of an attack on Indigenous people by the Government whether it was expressed in terms of denying the existence of the stolen generation or populist rhetoric about 'Sorry' or land rights, Winnunga was said to experience a significant increase in the number of patients coming through its doors. The argument was put that comments made by Federal Government Ministers and the Prime Minister, in particular, was directly correlated to a rise in the number of people seeking medical attention[45]. It seemed that Indigenous people were deeply affected by Federal Government proclamations of this nature.

3.15. Following on from this, the committee noted comments of Dr Tom Gavranic, a General Practitioner who has worked with Aboriginal communities for some time. Dr Gavranic noted that:

> Lack of respect breeds no end of "problems of the heart" with a multitude of psychic problems leading on to physical and emotional ill-health, violence, drug addiction and counter-productive behaviour by all concerned…
>
> So much healing and improvement in Aboriginal health could have been done by our Prime Minister if he had only had a better understanding of our history. Until we as a nation make a healing compact with the Aboriginal population in our midst and so let go of the deep fear of Aborigines in our hearts, Aboriginal[s] will continue to suffer deep hurts, resentment and fear, which all lead to ill-health. I have experienced this fear in white people wherever I have worked in Australia. It is palpable real fear that soaks into the Australian psyche. Instead of diminishing it, Mr Howard has magnified it. His stated aim is to improve Aboriginal health, but the result of his actions will be to worsen it, including here in the ACT.[46]

3.16. Similar comments to this were made to the committee during the course of its inquiry and it is true to say that committee sensed a deep level of distrust by Indigenous people regarding the commitment of governments all around Australia to their plight - with good reason.

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[44] Meeting took place on 5 October 2000 at the Winnunga Nimmityjah premises in Ainslie.

[45] Meeting with Winnunga Nimmityjah elders, staff and patients.

[46] Submission 6, p 3.

3.17. In recent times, relations between Indigenous Australians and the Federal Government (as an institution) have been experiencing some difficulties. The comments of Dr Gavranic highlight the spiritual and emotional issues that can have both physical and mental health repercussions. While the notion of practical reconciliation has been extolled by the current Federal Government, it is obvious that more is required to heal the wounds of over two centuries of neglect, subjugation and discrimination. There is a need for gestures of kindness and symbols of friendship between Indigenous and non-indigenous Australians. The process of reconciliation must go beyond mere service delivery issues, beyond spending allocations and government interventions per se but must be concerted towards nurturing a mindset of goodwill and building trust across the divide which currently exists.

3.18. It seems that on one level the poor health of Indigenous people is rooted in a crisis of self-identity, poor self image and feelings of alienation from participating in Australian life. The committee does not pretend to have answers to these problems. In fact, the answers are unlikely to come from parliamentary committees but more from the community at large. However, the committee does wish to express the view that more has to be done in terms of building bridges of goodwill between Indigenous and non-indigenous Australians based on mutual respect and an acknowledgment of the past. The committee notes comments in the Commonwealth Parliamentary report on Indigenous health, *Health is Life*, that, 'Concluding a meaningful reconciliation with Indigenous Australians is likely to contribute to a longer term improvement in their health and welfare'.[47] While much of this focus is at the Commonwealth level, the ACT Government and community also needs to build strong relationships and partnerships at the local level.

3.19. A doctor at Winnunga Nimmityjah was even more emphatic saying that, 'Health must be seen as a holistic thing and, while there is a failure of reconciliation, health is not going to improve.'[48]

3.20. Jackson et al outline some of the basic tenets of reconciliation and identify the process of reconciliation as being an integral part of improving Aboriginal and Torres Strait Islander health. Jackson et al note that:

> There is no agreed definition of reconciliation. It is agreed, however, that reconciliation encompasses reparation, as recommended by the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children From Their Families. In the report, Bringing Them Home, five components of reparation have been recommended. These have been taken from the van Boven Principles, drawn up by the United Nations Commission on Human Rights as guidelines for reparation of victims of gross violation of human rights:
>
> - Acknowledgment and apology
> - Guarantees against repetition

[47] Standing Committee on Family and Community Affairs op cit, p 7.
[48] Transcript, 26 February 2001, p 57, Dr Sharp.

- Measures of restitution
- Measures of rehabilitation
- Monetary compensation

> Reconciliation always begins with acknowledgment or, more colloquially, "truth telling". Alexander Boraine, Vice Chair of the Truth and Reconciliation Commission of South Africa, has spoken of the capacity for forgiveness by those who suffered most under apartheid. In Australia, there is a need to acknowledge that the benefits now enjoyed by some have been at the expense of incalculable suffering to others. "Truth telling" is unresolved "sorry business" for our nation.
>
> If contemporary Aboriginal health is accepted to be a manifestation of a population dying of despair, anger and disillusionment, then reconciliation is fundamental. It has been compellingly argued that "The diseases of anger and despair which wrack Aboriginal communities in Australia clearly have many of their roots in childhood." Acknowledgment of the causes of this anger and despair must occur as the first step in the process of reconciliation. Reconciliation is necessary but is not, in and of itself, sufficient to guaranteed improved Aboriginal health.
>
> Reconciliation becomes the foundation for health services development. The Australian Medical Association has stated that "The process of reconciliation would be incomplete without the provision of substantial additional resources for Indigenous health."[49]

3.21. The committee sees immense value in the process of reconciliation, not only in terms of bridging the gap between Indigenous and non-indigenous Australians but also in bringing about real improvements in health outcomes. In particular, the people's movement of reconciliation like the country saw with the walk across the Sydney Harbour Bridge will play no small part in healing the wounds of the past.

3.22. Reconciliation is not an either/or proposition – practical versus symbolic – it is about pursuing both in tandem. There is no need to separate the two as though they have no bearing on each other. Improving the quality of community controlled health care facilities, developing cultural appropriateness in mainstream services and allocating appropriate funding all rests on better understanding of Indigenous culture, acknowledging Australia's past and building the goodwill to move forward. This is reconciliation in its fullest sense and the committee believes that reconciliation must be pursued in these terms.

A Treaty

3.23. As noted above the indigenous people of the United States, Canada and New Zealand have significantly better health outcomes compared to Indigenous Australians. The committee was interested in the perspective that treaties may not only be useful in reconciling the past but also in improving Indigenous health. The *Health is Life* report noted that:

[49] Jackson (1999) et al op cit.

> Treaties, no matter how loosely worded, have appeared to play a significant and useful role in the development of health services, and in social and economic issues, for the Indigenous people of New Zealand, the United States and Canada.[50]

3.24. An ATSIC background briefing paper also makes the case that treaties have played an important role in improving the health status of Indigenous people in other countries. ATSIC notes that:

> Part of the reason for the lack of improvement is inequality of services and lack of infrastructure. No treaty or agreement guarantees our civil rights to these, including access to health care and essential services. Recent reports – to the federal parliament and the Medical Journal of Australia, amongst others – have found that treaties have played a significant role in improving Indigenous health in comparable countries.
>
> During the past 20 years the USA, NZ and Canada have extended formal recognition to their first peoples. As part of that process, there has been a sustained commitment to addressing social and cultural needs and ensuring that indigenous people exercise greater control over their lives. However, in Australia – without a rights-based approach to services – the health statistics are steadily worsening.[51]

3.25. The idea of a treaty is obviously a contentious issue in the current political climate, however, the committee believes that the debate about whether we should establish a treaty with Indigenous Australians is a constructive one. The committee believes that there may well be benefits in devising some form of treaty between the Commonwealth Government of Australia and Indigenous Australians.

Racism

3.26. The extent of racism towards Indigenous Australians cannot be underestimated, even in Canberra which is widely regarded as a tolerant and to some extent 'enlightened' community. The committee heard that experiencing racism and discrimination is a day-to-day part of life for many Indigenous people living in the ACT. Much is made of the ACT population's relatively high levels of education, income and quality of life. However, Indigenous people in the ACT are far less likely to be beneficiaries of these accoutrements of socio-economic advantage. In fact they are likely to be discriminated against by many sections of the community on the basis of their race, particularly on the basis of skin colour. This in the committee's view only serves to highlight the great disparity between the non-indigenous 'haves' and the Indigenous 'have nots'.

3.27. In one of the committee's public hearings, the National Aboriginal Community Controlled Health Organisation (NACCHO) outlined how many Indigenous people's historical experiences with racism are related to poor self image in today's communities. NACCHO noted that:

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[50] Ring, Ian T. and Firman, David. '*Reducing indigenous mortality in Australia: lessons from other countries.*' Cited in Standing Committee on Family and Community Affairs op cit. p 7.
[51] ATSIC (2001) '*ATSIC Health Policy, National Policy Office Canberra*' p 7.

> … I can remember buying a history textook… that had examples of soap ads from the early part of this century. One of the soap ads has a picture of an Aboriginal woman being donged on the head with a wooden spoon, and the caption read "Knock dirt on the head" [interested readers can see an enlarged version of this ad and others of a similar ilk at the Australian National Museum]. And that was an advertisement for soap.
>
> If that were just an isolated example we might be able to say, "Well, you know, this is an isolated example". But the reality is there has been a fundamental lack of recognition of Aboriginal communities that, in my view, has built something into the psyche of Aboriginal communities over time something of poor self-image, of whether we fit, of feeling alienated and feeling marginalised - and, in fact, being alienated and, in fact, being marginalised and not just feeling it - that leads to what might be termed a "depression"…[52]

3.28. Even though the advertisement in question is fairly old, it was indicative of the view held by many non-indigenous Australians that Aboriginal people were somehow inferior. Although such blatant racism has receded to some extent in present day Australia, there is still a 'hangover' from this past that remains today. The committee was interested in the comment of one witness in relation to racism and skin colour in a more contemporary context. In appearing before the committee, Mr Len Barratt, an Aboriginal man living in the ACT, noted that:

> Well, my kids range from very dark, which I don't mind being called black, to lily white. There is a whole spectrum there and they have been treated according to the colour of their skin.[53]

3.29. When the committee met with elders, staff and patients of Winnunga Nimmityjah, the committee was told that experiences of racism occurred on a daily basis. The committee was told that often Aboriginal people, particularly young Aboriginal people are reluctant to go into shops for fear of being accused of shop lifting. One woman relayed a story about going to the bank with two non-indigenous work colleagues to cash a pay cheque from work. She told the committee that while her two white colleagues were able to cash their cheque, she was told that it wasn't possible in the case of her cheque despite the fact that the cheques were from the same company under the same terms in all three instances.

3.30. Other reports of racism to the committee were more blatant with some people indicating that they were called names like 'boong, 'abo' and 'coon' to name a few.

3.31. It is hard to imagine what these day-to-day experiences of racism would do to a person's sense of self worth and sense of wellbeing without having had first-hand experiences. However, it is not difficult to see how a person confronting both overt as well as the more insidious forms of racism could come to develop a poor image of themselves, perhaps feeling that they are less important than other people, less likely to be given a fair go, more likely to be derided and suspected of wrong doing.

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[52] Transcript, 26 February 2001, p 85, Mr Ritchie

[53] Transcript, 26 February 2001, p 80, Mr Barratt.

Following on from this sense of being 'less than others', it is not surprising that mental and physical ill-health also become part of the problem.

Education

3.32. The committee is aware that the ACT Legislative Assembly Standing Committee on Education and Community Services is currently conducting an inquiry into Adolescents and Young Adults at Risk of Not Achieving Satisfactory Education and Training Outcomes. In the conduct of the inquiry that committee's attention was brought to the serious problems confronting young Indigenous people in pursuing an education. Education is one of the key determinants of socioeconomic status later in life, leading to better rates of employment, participation in society and improved health outcomes. In keeping with the idea that Indigenous health should be tackled in an holistic fashion, the committee considers it is worth traversing some of the issues surrounding Indigenous education.

3.33. In a submission to Standing Committee on Education and Community Services inquiry, Galilee starkly outlined some of the major barriers that young people, in particular, experience in attempting to undertake an education. Galilee noted that:

> The Gugan Gulwan community parents are consistently providing support and encouragement to their children to maintain their school attendance. The support and encouragement is achieved despite the many difficulties surrounding their lifestyle.
>
> This includes low self esteem, high unemployment rates, non-attendance at school, and the dependency on welfare. Many Aboriginal youths are experiencing being social outcasts. Aboriginal families within the community often exist in a state of trauma. The Aboriginal families' determination to escape this depressive lifestyle has often been destroyed or thwarted by the bureaucratic barriers and the white society's prejudices. Some parents may have poor levels of education that stifle their employment opportunities and impede the parents' desire to assist their children in their homework studies. The children may find it difficult to receive home and family support and the encouragement that is vital to maintain and improve their education standards at school. This lack of family support causes some children to loose interest in their educational development at a time when the schooling system becomes increasingly demanding.
>
> Education for the older generation of the Aboriginal population is viewed as an institution of forced assimilation where they were humiliated and their culture denied (Groome and Hamilton, 1995, 26). The Gugan Gulwan community maintain a strong desire to have their children achieve academic success despite their own lack of academic achievements. They remain sceptical and are very hesitant in having their children face today the many obstacles in achieving their goals.
>
> The Aboriginal students today still face difficulties within the non-Aboriginal schooling system such as:
>
> - Racial abuse and vilification
> - Negative comments about their families and their behaviours on the basis of race;
> - Prejudicial treatment; being treated as a child at school (when they are treated as adults at homes);

- Being spoken to in a domineering manner ('strong talk'); and

- Being made to feel personally guilty for getting extra money and special benefits (Groome and Hamilton, 1995, 37).[54]

3.34. An Aboriginal witness before the inquiry noted that his children had not achieved basic learning outcomes at school despite completing high school. He noted that:

> I've got two children, born in the ACT, who have come through high school and who, for all intents and purposes, cannot read or write. they were born in the ACT and they can't read and write, for all intents and purposes. They have to go and see how to tick the right boxes in a dole form to get their dole – that is how they exist….
>
> After 13 years of education. The reports I got home from school were saying that they were in the bottom part of the learning section, but there was no indication that they were totally hopeless…
>
> And it seems to be the blacker my kids are, the more they get ignored or get patted on the back for mediocrity, so they're actually be taught to be very mediocre in their schooling.[55]

3.35. As noted earlier, there are major disparities between educational outcomes for Indigenous people versus non-indigenous people. 39.3 per cent of Indigenous people in the ACT leave school by the age of 15, while the figure is only 29.4 for the non-indigenous population. Only 26.9 per cent of the Indigenous population have attained a post secondary qualification, while 45.9 per cent of the non-indigenous population have gone on to achieve this level of education[56].

3.36. The committee considers that one of the keys to improving the educational levels of Indigenous people is to offer culturally appropriate curricula and support services. One of the best ways to develop this approach is with the aid of Aboriginal education workers who can provide a safe cultural interface between Indigenous students and the education system.

3.37. In this regard, Galilee noted that:

> …attempts to make school more culturally relevant (for example, indigenous support staff and teaching staff) must be pursued. Groome and Hamilton (1995, 55) state that several schools are starting to address these problems by focussing on the following issues:
>
> - To fully inform all involved members of the staff about the backgrounds and needs of each new student;
>
> - To familiarise new students with geography and routines of the school;

[54] Submission 6, to the Standing Committee on Education and Community Services, Appendix 3, p 12.
[55] Transcript, 26 February 2001, pp 79-80, Mr Barratt.
[56] 1996 Census of Population and Housing, Aboriginal and Torres Strait Islander People, ACT cited in Submission 8, p 3.

- To assist students to relate to a number of teachers; and
- To provide assistance for students with inadequate literacy and numeracy skills.[57]

3.38. Because there is still a 'live' inquiry into this issue, the committee does not make any recommendations about this aspect of improving education in the Indigenous community. The committee looks forward to the Standing Committee on Education and Community Services' report on these issues. With heavy emphasis, the committee states that much improved education outcomes are an essential prerequisite to improved health outcomes.

Community and cultural facility

3.39.The committee received evidence from one witness talking about the need for a cultural and community centre for Indigenous people in the ACT. Mr Len Barratt told the committee that a *meeting place* type facility would have many benefits for all members of the Aboriginal community. Mr Barratt noted that a centre of this type may have advantages in terms of offering a range of holistic services. Mr Barratt noted that:

> … if you made… [the proposed centre] a medical centre which catered for even a birthing centre and mental health and dentistry, you could then see that all these things can be compatible, with entrances for specific functions, including… display areas… they would be room for cottage industries, there would be room for a learning centre, and there is also a creche on site.[58]

3.40. A facility of this type could also deliver services aimed at improving 'life skills' for local Aboriginal and Torres Strait Islander people. As Winnunga Nimmityjah noted in a public hearting, 'A lot of our people, they just need really basic skills, and it's about parenting, budgeting and living skills. The three most important things in a person's life'[59]. The committee wondered whether the facility at Winnunga Nimmityjah could have additional funding applied to expand its sphere of activity in this regard. Ultimately, however, such a decision to develop a facility of this type should rest with the ACT Aboriginal and Torres Strait Islander community.

Recommendation 2

The committee recommends that:

a) the Government consult with the ACT Aboriginal and Torres Strait Islander community to assess the value of establishing a community and cultural centre for Indigenous people; and

[57] Submission 6, to the Standing Committee on Education and Community Services, Appendix 3, p 14
[58] Transcript, 26 February 2001, p 80, Mr Barratt.
[59] Transcript, 26 February 2001, p 98, Ms Tongs.

b) should this consultation find a sufficient level of support for such a centre, funding arrangements be developed to progress the proposal.

Housing

3.41. The committee was informed that there are a large number of Indigenous people living in public housing properties and that overcrowding in small houses can be one cause of ill-health. Gugan Gulwan, a community controlled organisation catering for young people noted that:

> It [poor health] starts from overcrowding in houses, which we see as a major health issue. What is happening is that if they [clients of Gugan Gulwan] are living with their families or extended families – they will go from one house to the other – these young people are not sleeping well. They have bases with their families, but the overcrowding in the house is an issue. People are reluctant to really talk about that, because sometimes they might be in Housing Trust houses, or have a couple of relatives staying with them too.
>
> When the young people are moving into their flats, it is not uncommon to have about 10 of them in a bed-sitter over at Burnie Court, for instance. And that poses a real health risk.[60]

3.42. Beryl Women's Refuge made a submission to the committee relating to the needs of its client group – women and children escaping domestic violence – many of whom are Aboriginal. The refuge expressed deep concerns about the ability of public housing to cater for this client group and in particular Aboriginal and Torres Strait Islander people. The group noted that:

> Domestic violence leads to homelessness which brings with it a whole gamut of problems. Indigenous peoples' capacity to escape from cycles of homelessness and abuse is inevitably hampered by continuing racism and discrimination. The ACT public housing system is not geared to appropriately house our indigenous population and the tales we hear on a daily basis about discrimination faced when applying for housing are enough to make us weary of recommending this avenue to our client group. ACT Housing stands alone in the country as the sole public housing provider with no Aboriginal housing policy.[61]

3.43. The committee has made two recommendations in relation to housing drawn from the Beryl's Women's Refuge submission. The committee discusses domestic violence in more detail below.

Recommendation 3

The committee recommends that the Government develop housing policies that reflect the special circumstances of the Indigenous population, ie a comprehensive Aboriginal Housing Policy which is informed by the Indigenous communities of the ACT and the housing sector.

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[60] Transcript, 22 November 2000, p 2, Ms Davidson.

[61] Submission 3, p 2.

Recommendation 4

The committee recommends that the Government design and develop public and community housing aimed directly at Indigenous families, particularly where women and children are escaping domestic violence.

Employment and welfare dependency

3.44. Economic prosperity is one of the keys to improving Aboriginal and Torres Strait Islander health in the ACT community. The committee is aware of recent comments made by prominent Aboriginal activist, Noel Pearson, about the need for the Aboriginal community to move beyond welfare dependency by developing business and employment opportunities within Aboriginal communities. In an address to the Brisbane Institute in 2000, Mr Pearson made the point that Aboriginal and Torres Strait Islander people need to find ways of including themselves in workforce participation because self esteem and empowerment flow from this basic activity. Mr Pearson noted that:

> The problem with the welfare economy is that it is not a real economy. It is a completely artificial means of living. Our traditional economy was and is a real economy. Central to the traditional economy was the imperative for able-bodied people to work. If you did not hunt and gather, you starved. Life in a traditional economy was extremely hard and involved struggle and work. And the bottom line, namely nature, came bearing down on people, demanding work. This is the same with all kinds of subsistence economies.
>
> The white fella market economy is also a real economy. Central to the market economy is the imperative for able-bodied people to work. If you do not work you starve. The bottom line, namely the market, comes bearing down on people demanding work.
>
> Common to the real economy of traditional society and the real economy of the market is the demand for economic and social reciprocity. This reciprocity is expressed through work, initiative, struggle, enterprise, contribution, effort…
>
> At this point we need to distinguish between positive and negative welfare. I am attacking negative welfare - that is, the provision of income support to able bodied, working age people without reciprocity. It is this that is poisonous and socially corruptive.
>
> In order to understand the social dysfunction of aboriginal society in Cape York, it is my view that its primary cause is negative welfare. I believe that the provision of income support to able-bodied working aged adults without reciprocity is the source of our social problems and the starting place for any solutions.[62]

3.45. The committee sees that there are some fundamental problems with passive welfare dependency, problems that are not, of course, unique to Aboriginal and Torres Strait Islander people. Noel Pearson stressed, however, that the change of policy direction away from negative welfare should not be construed as a call for reduced resources in the Indigenous sector. Mr Pearson conceived that partnerships between

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[62] Address given by Noel Pearson to the Brisbane Institute on Monday July 26 2000.

the private sector, all levels of government and Indigenous communities will revitalise the creativity and initiative of Aboriginal and Torres Strait Islander people. Mr Pearson noted that:

> …the process of social and economic recovery will require significant increases in access to resources by indigenous communities. By inserting real economy principles into the resources that flow into our community, we will not only arrest and eventually reverse the social disintegration that it is presently causing. We will develop the necessary initiative, capability, responsibility and esteem that will orient individuals to re-engage in the real economy - and that must be the objective of our strategies, to use the resources provided by the State to develop our people, through the promotion of education, through tackling grog, through positive engagement in our own health and of those around us, through the development of an economic base, so that we can eventually take our fair share of the country.
>
> In the future in Cape York there is no reason why our people cannot live within and move successfully between two real economies and societies. We can maintain our traditional society and economy and we can engage in the outside market economy and society and our children can move with great facility between the two, provided that we ensure that the resources that the State provides us, and indeed the resources we generate ourselves, and which we distribute within our own communities, is no longer in the form of negative welfare.
>
> Leaders in disadvantaged locations like Cape York have to develop a conscious and long-term strategy for their home regions and communities. They must be involved in the front line of working with the State in reforming welfare resources that come to their people into sources of personal empowerment. They must understand the central importance of education and the encouragement of enterprise, achievement and success amongst our people. They must understand the fact that our social responsibility is not just individual, it is collective.
>
> If the State is prepared to adopt an enabling approach to its role, and the community leaders of the Cape York are prepared to take responsibility, I believe that we can recover our society from our egregious social and economic predicament and eventually take our fair share and our fair place in the country.[63]

3.46. Echoing the notion that past policies towards Aboriginal and Torres Strait Islander people have increased dependence and passivity, Craig Ritchie, Chief Executive Office of the National Aboriginal Community Controlled Health Organisation noted in evidence that:

> … you arrive at a situation now where you have people who have a particular political slant on things, who like to talk about people needing to pull themselves up by their bootstraps and take responsibility, while for the last 200 years we've actually been in a process of removing the capacity of the community to take responsibility[64].

3.47. Another submitter to the inquiry and a member of the Aboriginal and Torres Strait Islander Consultative Council, Mr Len Barratt, also pointed towards the

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[63] Ibid

[64] Transcript, 26 February 2001, p 84, Mr Ritchie.

importance of employment and limiting the extent to which Aboriginal and Torres Strait Islander people rely on welfare.

> I feel that the panacea to getting off welfare is employment. That is the overall strategy that gets people better esteem, empowers people and gets off the welfare system.[65]

3.48. The committee also notes comments of Julie Tongs, CEO, Winnunga Nimmityjah, that young Aboriginal men find it particularly difficult to find work after being incarcerated for a period. Many businesses are reluctant to take on a young person who has spent time in jail, but more so, it was argued, if that person is black.

3.49. The committee agrees that achieving higher rates of employment in the ACT Aboriginal population will have an extremely positive impact for individuals and their community. Employment is a key part of self-determination. Economic independence brought by work, coupled with the sense of esteem engendered by work plays no small part in giving people, all people, the ability to make important decisions about their lives. Employment gives people a sense that the future is something that can be shaped and with this sense comes hope.

3.50. The committee believes that there is a role for the ACT Government to play in encouraging private sector initiatives as well as implementing public programs that provide employment opportunities for Indigenous people. The committee is aware that an Indigenous Business Chamber has been established with one goal being to enhance the linkages between the business community and the Indigenous community to open employment and business prospects for Indigenous people in the ACT. Noting the support already given to Aboriginal employment initiatives, the committee wholeheartedly supports this approach as being a proactive and constructive one. The committee believes that the ACT Government should be willing to help strengthen the role of the Chamber in its dealings with the business and government sectors.

Recommendation 5

The committee recommends that the Government provide advice, support and resources to facilitate the establishment of partnerships between the Indigenous Business Chamber, local Indigenous groups and individuals, the business community and the Government sector (both local and federal) that identify and help nurture entrepreneurial and employment opportunities for Aboriginal and Torres Strait Islander people.

Violence

3.51. A recent report by the Commonwealth's National Crime Prevention Program entitled, *Violence in Indigenous Communities*, examined many of the problems confronting Aboriginal communities in relation to violence. Indigenous people are

[65] Transcript, 26 February 2001, p 75, Mr Barratt.

over represented as being both victims and perpetrators of violence[66]. In assessing the available literature the report notes:

1. that violence is perceived by many people, both Indigenous and non-indigenous, as a major problem in Indigenous communities

2. that the incidence of violence in Indigenous communities and among Indigenous people is disproportionately high in comparison to the rates of the same types of violence in the Australian population as a whole

3. it is apparent that rates of violence are increasing, and the types of violence are worsening in some Indigenous communities and regions.[67]

3.52. A 1998 Australian Bureau of Statistics occasional paper points out that, '45 percent of Aboriginal and Torres Strait Islander people aged 13 years and over felt that family violence was a common problem in their area.'[68]

3.53. The committee understands that there are range of underlying factors that have contributed to the high incidence of violence in Indigenous communities. In this regard, it is noted in the *Violence in Indigenous Communities* report that:

> A strong and commonly presented view is that the incidence of violence in Indigenous communities and among Indigenous people cannot be separated from the history of European and Indigenous relations. The literature argues that patterns of contemporary violence among Aboriginal people have their origins in the violent dispossession of land by Europeans in the early contact period. Ongoing cultural dispossession and its consequences, taking different forms over the past 200 years, have impacted on Indigenous people socially, economically, physically, psychologically and emotionally, to the point that, today, violence in some Aboriginal communities has reached epidemic proportions.[69]

3.54. The *Violence in Indigenous Communities* report outlined a range of proposed programs and initiatives aimed at reducing the incidence of violence within the Aboriginal and Torres Strait Islander population. The report identifies nine types of program required to address the problems. They are:

1. support programs (counselling, advocacy)

2. strengthening identity programs (sport, education, arts, cultural activities, group therapy)

3. behavioural reform programs (men's and women's groups)

4. policing programs (night patrols, wardens)

5. shelter/protection programs (refuges, sobering-up shelters)

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[66] National Crime Prevention Committee (2001) op cit, p iii.
[67] Ibid, p 6.
[68] ABS (1998) '*Occasional Paper: National Aboriginal and Torres Strait Islander Survey – Law and Justice Issue'* publication No. 4189.0, p 2.
[69] National Crime Prevention Committee (2001) op cit, p 11.

6. justice programs (community justice groups)
7. mediation programs (dispute resolution)
8. education programs (tertiary courses, miscellaneous courses, media awareness)
9. composite programs (comprising elements from all programs)[70]

3.55. The comprehensiveness of this multi-pronged approach makes good sense to the committee and the committee would like to see the Government ensure that it has the right mix of programs, drawing on the range above, in place for dealing with the issues of violence.

Recommendation 6

The committee recommends that the Government examine the *Violence in Indigenous Communities* report to ensure that it has an appropriate range of programs and services in place for dealing with violence in the ACT Indigenous community.

Domestic and family violence

3.56. The committee received a submission from the Beryl Women's Refuge outlining some of problems with violence in the ACT Aboriginal and Torres Strait Islander community. Beryl has been operating for 25 years and provides a service for women and children escaping domestic violence. Aboriginal people were identified as being one of the service's key client groups. The committee was therefore pleased to learn that 50 percent of the refuge's employees are Aboriginal.[71]

3.57. In its submission, the refuge noted that:

> Our clients come to the service to escape violence, however they bring with them a range of problems, concerns, and needs that are linked to their current crisis situation. Domestic violence itself is a serious health concern. Domestic violence breeds domestic violence breeds domestic violence. Being 25 years old, we are beginning to see numbers of women and their children coming to us for help who were here with their mothers some years back. We have one Aboriginal family where three generations have been through the service.
>
> Two hundred years of oppression, racism, inequality, and living in fear brings with it a legacy that a brief spell in a refuge cannot remove. Our clients come with ingrained distrust of the community services sector, and overwhelming volumes of shame. They are often incapable of revealing the full nature of their needs for fear of judgement and harsh self-criticism. They believe that if they reveal the extent of their crisis they will be judged, condemned, and rebuffed.[72]

[70] Ibid, p 3.
[71] Submission 3, p 1.
[72] Ibid, p 1.

3.58. As noted above, the committee was advised that domestic violence can often lead to homelessness for women and children who are unable to live with an abusive male in the family home. Beryl was critical of ACT Housing's lack of understanding and planning for its Aboriginal client group. Beryl also examined how the negative health effects of homelessness and domestic violence are exacerbated by many Aboriginal people's deep suspicions of the police and the public housing sector. Often Beryl was the last resort for many Aboriginal people. The refuge also argued how a range of other health risks come into play when people become homeless. Beryl outlined the story of one women who took her family into a cold winter night to escape from an abusive situation. The refuge noted that:

> Homelessness results in weakening health across the entire health spectrum. It leads to a loss of self-esteem and self worth, which coupled with the issues of dealing with racism and discrimination on a daily basis, lead to serious mental health concerns (depression, suicide, self harming behaviours, misuse of alcohol and drugs which can exacerbate the major psychotic illnesses, and eating disorders).
>
> Sleeping rough, particularly, in Canberra winters, has dire consequences for the immune system and the overall physical health of a person. Last winter, on the morning after the second coldest night of the year, an Aboriginal woman and her five children knocked on our door looking for a bed and a meal. They came down from the mountain nearby after a night in the open. Three of the children were barefoot, not one member of the family had a coat. They were all coughing and they became progressively sicker whilst they were with us. They had a domestic violence situation in the middle of the night and walked to safety, which, in this case, was the bush. They did not consider it safe to contact the police, the inherent mistrust of the police made it impossible for them to seek aid from this avenue. The woman feared that the police would either:
>
> a) ignore her plea for help, which would leave her in a more dangerous situation when her partner realised she had called police, or,
>
> b) beat up the partner and leave him helpless somewhere, or,
>
> c) take the partner into custody where she believed he would take his life or where he would become another statistic in the black deaths in custody saga.
>
> These options scared her so much that she took her children and walked for several hours until she believed herself safe and settled down for the remainder of the night until she knew that we would be open for the morning. She reached out to where she knew that there would be support from people who understood her, she needed other Aboriginal people to speak with. She left home with no money, no clothes, no hopes.
>
> Unfortunately, this woman is not an isolated case. Aboriginal families arrive on our doorstep searching for indigenous workers in the hope that they can access help without damaging their communities and without being further marginalised by racism.[73]

3.59. Beryl Women's Refuge underlined the importance of providing opportunities for early intervention in cases where domestic violence has the potential to render people homeless. In its submission, the Refuge notes that:

[73] Submission 3, p 2.

> Early intervention is the key to the alleviation of homelessness related to domestic violence. At Beryl we regularly see second generation clients of out service – women who come with their children who were at the service when they were children with their mothers. The patterns were repeated and there can be no expectation that it would be otherwise. Provision of a bed, food, transport to appointments and a bit of advocacy cannot possibly undo a lifetime of trauma and abuse. We need to reach the children early, with an outreach program that is staffed by Aboriginal people that goes to homes rather than a system that sits back and waits until the situation has exploded and the family is in tatters.[74]

3.60. The committee supports the establishment of early intervention programs in the area of domestic violence as one way of improving the options available to people experiencing family and domestic violence. The committee learnt that 50 percent of Aboriginal people who flee from domestic violence situations return to be with their partner, the offender.[75] Beryl made the point that currently there are no mechanisms by which the return of the victim to the perpetrator can be monitored and managed. Beryl noted that:

> We wave them goodbye and wait until next time they come back then go through all the same steps again. We need to go *with* them. If we had access to a case worker who could help resolve problems in the home we would be providing less effort at a time when advice can be heeded at a reduced cost. A case worker could check that medications are being taken, provide advice about the payment of rent and utilities, intervene upon low grade health problems such as lice, and a thousand other tasks that would make life more manageable for a stressed and desperate family…
>
> It is time we learnt a lesson from the Aboriginal people of this country. Meeting them on their own turf is one small step towards honest reconciliation and towards showing that there is sincerity in trying to meet the needs of this group. To wait until the crisis is full blown is to wait too long. To respond with measures that fit other parts of the community is like asking me to wear Ian Thorpe's shows, no matter how much newspaper I shovel into them they still won't fit – they may provide a bit of respite from the cold, but a women's size 6 would really do the trick.[76]

3.61. This is a well made point and one that has been made in relation to many areas of Indigenous health – the importance of customising services and policy frameworks to meet the specific needs of Aboriginal and Torres Strait Islander people is the best way forward. What works for other populations may not always work in the Indigenous community.

3.62. In its submission to the committee, Beryl Women's Refuge proposed a several key policy areas which need to be addressed in relation to violence. They are included below as recommendations of the committee.

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[74] Submission 3, p 3.

[75] National Data Collection cited in Submission 3, p 5.

[76] Submission 3, p 5.

Recommendation 7

The committee recommends that the Government:

a) provide post custodial accommodation which aims to keep families safe and to work towards healthy reintegration into the community;

b) develop early intervention programs with known populations whose needs are not being met within the current system e.g refuges;

c) provide outreach workers who maintain close links with a family in crisis, who can be a point of early intervention and work as advocates across the spectrum of health and welfare services that are required; and

d) develop a written, public domestic violence policy within ACT Housing.

Sexual violence

3.63. A submission from the Canberra Rape Crisis Centre places the importance of sexual violence in the context of the committee's inquiry. The Centre notes that:

- The experience of sexual violence is a major factor in 'the approach a person takes to maintain a healthy outlook and high morale' (Statement by Chair).

- We also agree strongly that community attitudes 'impact on a person's sense of belonging and worth'. This has been the experience of survivors of sexual violence generally so the impact for Aboriginal survivors of sexual violence will be even greater than for non-indigenous survivors.

- Early interventions and support for young people is imperative if we are serious about raising the status of Aboriginal health and well-being.[77]

3.64. The committee is aware that one major problem with sexual assault and violence against women is that many of these crimes are not reported to police. This is particularly problematic in the Indigenous community. A report to the Queensland Office of Aboriginal Women in 1990 noted that:

> I have found that the majority of sexual/physical assaults against Aboriginal women are not reported. Most women are terrified of the police 'interrogation' where anything from a woman's sexual history to whether she is a fit mother or not is brought out into the open. Reporting a sexual assault sometimes seems to be just as traumatic as the actual assault.[78]

[77] Submission 4, p 2.

[78] Atkinson, J (1990) '*Violence Against Aboriginal Women: Reconstitution of Community Law – the Way Forward'*, Aboriginal Law Bulletin, Vol 12, No. 46, October, pp 6-9. Cited in National Crime Prevention Committee (2001) op cit, p 7.

3.65. In its submission, the Canberra Rape Crisis Centre noted its endeavours to support Aboriginal people who have been victims of sexual violence as well as some of the gaps in current service provision. The Centre noted that:

> The Canberra Rape Crisis Centre has long had a commitment to providing appropriate services and support to Aboriginal survivors of sexual violence. At different times over the past ten years we have consulted with the Aboriginal community about their need for sexual assault service provision and what sort of services that should include. The feedback we have received, both through questionnaire style interviews and anecdotal, is the need for service provision in this area, and also for that service provision to be available through a service such as the Rape Crisis Centre rather than located solely within an Aboriginal health service. This has been identified as an important issue for confidentiality purposes.
>
> The Rape Crisis Centre has endeavoured to always employ at least one Aboriginal worker. (As a matter of principle we believe there should always be two Aboriginal workers employed to ensure that there is support and a better opportunity for service provision).[79]

3.66. The committee learned that one-off funding has variously been provided by ATSIC and the ACT Government to employ Aboriginal workers in the Centre. However, the Centre advocates recurrent and adequate funding to enable the special needs of Aboriginal people to be addressed in the area of sexual assault. The Centre noted that:

> It takes time for programs and support services to build and time for communities to develop trust in them and in their workers. One-off programs don't provide any opportunity for the Aboriginal community to develop trust or to make full use of the service. One-off funding also means employment insecurity for Aboriginal workers and this perpetuates racism and its accompanying quality of life issues. It is imperative that the Government's commitment to improving the health and life chances of Aboriginal people is translated into recurrent service provision. The community will then be able to have confidence that the service and Aboriginal workers available to support them are not tokenistic but committed to ongoing and long-term relationships with that community.[80]

3.67. In its submission, the Canberra Rape Crisis Centre articulated several principles which it argued should be followed when making decisions to allocate resources in this area. The Centre noted that:

> While the Rape Crisis Centre and The CRCC Aboriginal Support and Education Program are grateful for the funding received there are some important principles which must be applied to any funding for Aboriginal service provision in order to distinguish it from historical token historical attempts at assimilation. These principles include:
>
> - Recurrent funding.
> - Adequate funding.
> - Recognition of specific needs.

[79] Submission 4, p 2.
[80] Submission 4, p 3.

3.68. The committee supports the idea that Aboriginal people have special needs in relation to their health. There seems to be a strong case that these special needs for specialised services are nowhere more apparent that in the area of sexual violence. The committee supports additional resourcing for the Canberra Rape Crisis Centre to extend and improve its services for the Aboriginal community.

Recommendation 8

The committee recommends that the Government consult with the Commonwealth and ATSIC to identify additional recurrent funding to improve the Canberra Rape Crisis Centre's capacity to provide effective services for Aboriginal and Torres Strait Islander people.

CHAPTER 4. POLICY AND SERVICES

4.1. One of the prevailing themes to emerge in the course of the inquiry was the claim that mainstream services are often inappropriate and ineffective in dealing with the health needs of Indigenous people. The argument was put that the uniqueness of Aboriginal and Torres Strait Islander cultures coupled with the lack of cultural awareness in mainstream services has the effect of discouraging Indigenous people from accessing non-indigenous services. The claim was also made that when Aboriginal and Torres Strait Islander people *did* choose to access mainstream services that they often had negative experiences arising from poor understanding of their cultural and health needs. There was a perception, if not a reality, that many mainstream services are 'culturally unsafe' – unable to recognise the unique needs of Indigenous Australians.

4.2. While those venturing this argument did not rule out the fact that mainstream services could and should play a role in providing health care to Aboriginal and Torres Strait Islanders, the general feeling was that Indigenous-specific services were much more useful. In relation to the shortcomings of mainstream services mention was made of institutionalised racism, poor understanding of cultural practices such as the importance of kinship, rigid processes impeding access and too much reliance on a 'body parts' approach to health care.

4.3. The committee examines these issues in this chapter.

The current policy framework

4.4. Indigenous health is a shared responsibility between Federal, State and Territory Governments. As the Government submission to the inquiry notes:

> Responding to the health needs of Aboriginal and Torres Strait Islander people is a joint responsibility where:
>
> a) The Commonwealth has a leading and coordinating role in the development of national health policy while working in partnership with the ACT;
>
> b) The Aboriginal and Torres Strait Islander Commission (ATSIC) has a range of functions under the ATSIC Act (1989) including monitoring the effectiveness of programs for Aboriginal and Torres Strait Islander peoples, including programs conducted by bodies other than the Commission;
>
> c) The ACT has prime responsibility for the provision of, and in conjunction with the Commonwealth, the funding of a range of health services including mainstream and Indigenous services (public hospitals, mental health and other health services).[81]

[81] Submission 7, p 9.

4.5. In August 1996 the ACT Government entered into a tripartite agreement with the Commonwealth and the Aboriginal and Torres Strait Islander Commission. Speaking of this in its submission, the Government noted that:

> The aim of the Agreement is to improve the health outcomes for Aboriginal and Torres Strait Islander peoples through:
>
> a) improving access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs which reflect the level of need.
>
> b) increasing the level of resources allocated to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples, including within mainstream services, and transparent and regular reporting for all services and programs; and
>
> c) joint planning processes which allow for:
>
> - full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities;
> - improved cooperation and coordination of current service delivery, both Aboriginal and Torres Strait Islander specific services and mainstream services, by all spheres of Government; and
> - increased clarity with respect to the roles and responsibilities of the key stakeholders.[82]

4.6. A recent development flowing from the tripartite agreement is the development of the ACT Aboriginal and Torres Strait Islander Regional Health Plan 2000-2004 endorsed by all parties. In relation to the Regional Health Plan, the Government noted that:

> The Plan is the result of extensive consultation with the Indigenous people of the ACT and region. Many representatives of the Aboriginal and Torres Strait Islander communities and community controlled organisations have given their ideas and opinions during the development of the Plan.
>
> Coordination of the effort and agreement amongst the Indigenous community for the Plan has occurred through the ACT Aboriginal and Torres Strait Islander Health Forum.
>
> Successful implementation of the Plan will require coordinated action across the whole-of-government and a continuation of the high level of collaboration between the government and non-government sectors.
>
> Considerable effort on the part of the three partners to the Plan, the ACT and Commonwealth Governments and the Aboriginal and Torres Strait Islander Commission has occurred to ensure that the Indigenous communities in the ACT and surrounding region 'own' the Plan.
>
> The Government is seeking to develop more appropriate ways to work with Indigenous people and the Government believes that the Regional Health Plan is a good product of

[82] Submission 7, p 10.

> such learning. The Action Plan supporting the main document is a grass roots, bottom up approach which our Indigenous Community can understand, accept and work with to improve their overall health standard.[83]

4.7. The ACT Aboriginal and Torres Strait Islander Regional Health Plan identifies many of service delivery issues that need to be addressed in order to make progress. The Plan outlines eight key directions goals for implementation between 2000 and 2004. They are:

1. An across-government approach to Aboriginal and Torres Strait Islander health
2. Indigenous community control of health services through increased Indigenous participation in planning, monitoring and evaluation of services
3. Access to and delivery of culturally appropriate health and health-related services
4. Appropriate and needs based distribution of resources
5. Development of a supported and skilled Indigenous health workforce
6. Improved gathering and analysis of Indigenous health data to enable measurement of performance and evaluation of strategies and health outcomes
7. Improved health outcomes in identified health priority areas
8. Intersectoral issues (including collaborative approaches between agencies; cross-border issues and enhancing role of private sector service providers).[84]

4.8. The committee believes that these key directions sum up most of the areas that need to be pursued in relation to Indigenous health. The actions outlined in the plan present some excellent steps towards improving Indigenous access to services. However, the committee is also interested in whether the key outcomes of the plan are achieved during its four year span and particularly, in how the ACT Government performs. Accordingly, the committee would like the Government to report to the Assembly on how it has managed to implement the actions, for which it is responsible and whether the outcomes identified within the plan are being realised.

Recommendation 9

The committee recommends that the Government report to the Assembly on a regular basis about its performance in relation to the actions and outcomes outlined in the ACT Aboriginal and Torres Strait Islander Regional Health Plan.

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[83] Ibid, pp 10-11.

[84] ACT Department of Health and Community Care et al op cit (2000) pp 8-9.

Inter-government coordination problems

4.9. All these planning documents recognise the need to develop a collaborative approach across agencies and service providers, the various levels of government and the local Indigenous community. However, in the recent Commonwealth Parliamentary Committee Report on Indigenous Health, *Health is Life*, the Standing Committee on Family and Community Affairs identified some basic deficiencies in coordinating Indigenous health programs across the various levels of government. The comments of that committee cast a very poor light on the current state of play. The committee was particularly interested in the comment that the lack of effective coordination and clear demarcation of responsibilities between the levels of government has meant that cost-shifting is commonplace.

4.10. The Commonwealth committee noted that:

> With services and programs being delivered by Commonwealth, State, Territory and Local government agencies, there is no clear delineation, or agreement, about which level of government is ultimately responsible for ensuring there are continuing improvements in the health of Australia's Indigenous population.
>
> There appears to be little, if any, coordination between these diverse Commonwealth/State health programs, other environmental programs or programs provided through other agencies, in areas such as education and employment…
>
> There is only a limited amount of program coordination between the various health service providers:
>
> - the Commonwealth focuses mainly on primary care, through Medicare Benefits Schedule (MBS) payments for services provided by private General Practitioners (GPs) and those working in Aboriginal Medical Services (AMS), as well as direct grants to the AMS; and
>
> - the States and Territories focus on acute care, but also provided primary care through hospital outpatients and community health programs, as well as providing support for more specific population programs through the AMS.
>
> The outcome of these piecemeal funding and coordination arrangements is fragmented policy and programs, across the States, Territories and Commonwealth, which do not result in any consistent approaches, either nationally or even at the local level. [One submitter noted that:]
>
> > …we have to look at simplifying the funding mechanisms and also making them more transparent. This crossover between States and Commonwealth is a nightmare for people sitting out there with minimal resources.
>
> The lack of clear delineation of responsibility for Indigenous health is also an incentive for the parties, particularly the States, to indulge wherever possible in shifting the onus for payment to the other sector.

> The lack of any real efforts to integrate community involvement into the planning and delivery of health and related services has been the biggest barrier to progress.[85]

4.11. One submitter to the Commonwealth inquiry noted that:

> It is unlikely that the health of Indigenous Australians will improve significantly until the fragmentation of services, cost shifting and lack of agreement about responsibility for Indigenous health are fully addressed.
>
> The Committee believes that for this to happen there must be a clear agreement between the States and the Commonwealth, not only about what their respective responsibilities are, but also how these responsibilities will be acted upon and the level of resources to be committed by all parties.
>
> > Effective coordination can only be achieved if there is collaboration between Indigenous communities, community controlled organisations and government institutions. This can only be achieved if the premises on which coordination are built are shared by all parties. Some of the premises include:
> >
> > Definitions of health
> >
> > Equitable sharing of power and decision-making
> >
> > Respect for varying patterns of organisation and planning
> >
> > Collaboration in setting performance indicators and evaluation procedures.[86]

4.12. The submission from Winnunga Nimmityjah more comprehensively outlines some of the problems it perceives in relation to the implementation of the current framework (Attachment A).

Lack of self determination and community control

4.13. The principle of self-determination is central to addressing problems surrounding poor Aboriginal and Torres Strait Islander health. The call for community control of Aboriginal and Torres Strait Islander health services is long standing and has been mentioned in countless government inquiries, the Royal Commission into Aboriginal Deaths in Custody and is a generally accepted principle in the health sector. However, there is still debate about the form which community control should take and whether we do, in fact, have the right policies and practices for ensuring that proper community control is in place. Is there sufficient community control of health services directed at Aboriginal and Torres Strait Islander people in the ACT? Some groups argued before the committee that there is not.

4.14. The Winnunga Nimmityjah submission to the committee notes that:

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[85] House of Representatives Standing Committee on Family and Community Affairs, (2000) 'Health is Life, Report on the Inquiry into Indigenous Health' 5, pp 1- 2.

[86] A/Prof A-K Exkerman, Submission No 11. p 1. Cited in Standing Committee on Family and Community Affairs op. Cit. p 3.

> Health is a fundamental human right. The United Nations Charter, the Universal Declaration on Human Rights, the Royal Commission into Aboriginal Deaths in Custody and the International Covenant on Human Rights express the right of Aboriginal and Torres Strait Islander people to self-determination, to have control over their own health decisions and resource allocation. Self-determination is a very basic proposition. It means that agencies no longer tell Aboriginal and Torres Strait Islander communities what they need. Instead, Aboriginal and Torres Strait Islander communities inform Government Departments and mainstream agencies about their needs and priorities and how these can be best addressed. It is time for policy, program and service delivery responses to be 'built up' by the Aboriginal and Torres Strait Islander communities. If we are really to move forward from the stop, start, band-aid approach of the past, self-determination and community control must be put into practice. They are essential to achieving equitable health outcomes for Aboriginal and Torres Strait Islander people.[87]

4.15. True community control is a 'bottom up' or grass roots approach whereby the Indigenous community are able to achieve a large degree of autonomy with real decision-making powers regarding how health priorities are established, where money will be spent and how other strategic issues will be addressed. Although third-party advice from non-indigenous people may well be welcomed in the context of a community controlled health facility, decision making should rest with the community itself, not bureaucrats, politicians or health professionals.

4.16. However, the Commonwealth *Health is Life* report raised the important point that community control needs to happen in an environment where community capacity building is happening as well. One submitter to the Commonwealth inquiry noted that:

> The important thing about community control is that the community has the capacity to do it. It is no good just suddenly hurling a whole bunch of money into a community and saying 'You have community control now. Off you go and do what you like,' when people do not necessarily have the skills in the community to do that.[88]

4.17. The committee sees that the ideal situation would be where experts in all areas of health policy and service delivery were available to provide advice, training and ongoing support as needed but that grass-roots level decision making within the Aboriginal and Torres Strait Islander community is paramount. As Dr Sharp, a doctor at Winnunga Nimmityjah noted in a public hearing:

> I am not saying there is no role for the whitefellas in the Aboriginal field at all – that is my career – but… it is important that technical skills and advice be provided, but ***not*** decision making [emphasis added]. Now, communities can only make the right decisions if they're given the right knowledge in the first place, and our role is to give advice.[89]

4.18. Reflecting on the 1996 Agreement on Aboriginal and Torres Strait Islander health between the ACT Government, the Commonwealth and ATSIC, Winnunga Nimmityjah argue that while the right noises are being made about self-determination

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[87] Submission 5, p 3.

[88] Mr J Gallacher cited in Standing Committee on Family and Community Affairs (2000) op cit, p 44.

[89] Transcript, 26 February 2001, p 57, Dr Sharp.

and community control, there is still much left wanting in terms of achieving a real commitment in this area. Winnunga Nimmityjah note that:

> It is important to emphasise that the Framework Agreements between Commonwealth and State or Territory Governments primarily relate to ways in which mainstream services need to be enhanced. Significantly, they do not really address the role of the Aboriginal community control sector in terms of ensuring meaningful dialogue. Nor do they specify the degree of Aboriginal and Torres Strait Islander community participation in the planning and delivery of health services. So while these agreements reflect an emerging new direction about how things are done in Aboriginal and Torres Strait Islander health, they fall short of guaranteeing the active involvement of Aboriginal community controlled health services in policy, planning and service provision.[90]

4.19. To support this claim Winnunga cite the view of the Australian National Audit Office who, in commenting on the Commonwealth Aboriginal and Torres Strait Islander Health Program, noted that:

> The ANAO consider that the framework Agreements are 'in principle' agreements, without any detail committing the parties to undertake specific action, provide a level of funding or achieve quantifiable outcomes within an agreed timeframe. Furthermore there is no recourse for DHAC [Department of Health and Aged Care] where States and Territories do not comply with the requirements of the Agreements. The ANAO consider the value of these Agreements as being in clarifying expectations of State and Territory Governments.[91]

4.20. In order for the concept of community control to be realised, it is important that governments provide genuine decision making powers to the Aboriginal and Torres Strait Islander community about the 'how, what, when and where' of its health services and strategies for improvement. The ACT Government should construe the notion of community control in its broadest sense.

4.21. A more complete examination of the current Indigenous health policy framework can be found in the Winnunga Nimmityjah submission (Attachment A).

Recommendation 10

The committee recommends that the ACT Government continue to support the principle of community control and that close consultation and negotiation takes place with the ACT Aboriginal community not only with regard to funding decisions but also in planning programs' timeframes, performance measures and outcomes.

Recommendation 11

The committee recommends that the Government advocate the broadest notion of community control in negotiations with state and federal counterparts regarding framework agreements and other Indigenous related policies.

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[90] Submission 5, p 4.

[91] The Auditor-General 1998:96 cited in ibid, p 4.

Aboriginal community controlled services

4.22. The central importance of Aboriginal community controlled health services is beyond question. Community control is part and parcel of self-determination, a fundamental human right, and serves to empower Aboriginal and Torres Strait Islander people with control over their own destiny.

4.23. In the ACT context, community controlled services for primary health care are also seen as being far more effective in reaching, diagnosing, treating and referring Aboriginal and Torres Strait Islander people. Of particular importance is the fact that community controlled services have unique cultural resources and tools at their disposal which mainstream services just can't provide – community control is the basis of cultural appropriateness. A submission from Winnunga Nimmityjah outlines the crucial role which community controlled health services offer:

> A properly resourced Aboriginal community controlled health service is able to provide culturally appropriate educational, preventative and early intervention services that minimise preventable hospitalisation. Access to mainstream services is also facilitated through the provision of transport and support network services. The integrated and holistic programs provided are also cost-effective. The need for high-cost hospital treatment is reduced and services are better targeted because they are based on first-hand knowledge of the needs and priorities of the local Aboriginal community.[92]

4.24. The committee agrees that Aboriginal community controlled health services are the best way of delivering health services to Aboriginal people, especially in terms of primary health care. The committee also believes that if Aboriginal community controlled health services were better funded to meet the range of community need (early intervention activities in particular) there would be significant financial returns by way of reduced hospitalisation.

Winnunga Nimmityjah

4.25. Winnunga Nimmityjah is the ACT's Aboriginal community controlled health service. It is perhaps the most important contact point for Aboriginal people wishing to address their health needs. Because Winnunga is a primary health service it also plays a vital role in assisting the community with accessing mainstream services such as medical specialists.

<u>High demand</u>

4.26. The committee notes that Winnunga is the primary destination for Aboriginal people seeking medical attention. As Winnunga Nimmityjah noted in the public hearing:

> … we are funded to deliver a primary health care service to Aboriginal people. What we are doing now is also delivering a drug and alcohol service to Aboriginal people, and also

[92] Submission 5, p 5.

> mainstream, because it's not being addressed in the mainstream. People aren't accessing the service. They don't go there; they come to Winnunga.[93]

A practice manager at Winnunga Nimmityjah

4.27. The committee received evidence that Winnunga Nimmityjah was in need of a practice manager. The Winnunga Nimmityjah submission noted that:

> Winnunga Nimmityjah is committed to actively advocating for appropriate needs-based planning and funding decisions through collaboration with other community controlled and mainstream agencies. However, joint planning processes require the attendance of the CEO who would be otherwise engaged in staff support and direct administration of the Health Service. The objective of joint planning would therefore be practically enabled by the resourcing of a practice manager at Winnunga Nimmityjah. This position would then ensure that the CEO is free to participate in essential planning processes at national, territory and local levels. This involvement is particularly essential given that full Aboriginal community participation in the determination of priorities remains less than optimal. Priorities are often determined at Departmental or funding-body levels and Winnunga Nimmityjah AHS's input is frequently reduced to negotiating about how to respond to pre-determined priorities.[94]

4.28. Speaking about the on-the-ground problems arising from too much work and not enough resources, Winnunga Nimmityjah's CEO noted in evidence that:

> You have to realise too that I do more than just the CEO of Winnunga. I am also the territory affiliate and the National Director for which Winnunga gets no funding. So I do three jobs. As well, I am in the community working with the elders and the young people and doing what I can. My job is not just an wight hours a day job., My job is an 18 hours a day job. Yet we don't get resourced. I go home and do things like this [write a submission to the committee]. This is when the paperwork starts…
>
> We don't get funded to do that. Like, I am not like your CEO. I don't sit in a department somewhere and just delegate work. I'm it. There's no-one to delegate to.[95]

4.29. The committee understands the difficult conditions that Winnunga operates under in terms of limited resources and it appears that the position of CEO entails so many roles that something has to give somewhere. The committee sees value in having a dedicated practice manager at Winnunga Nimmityjah. By allowing the CEO to have a greater role in planning and negotiating health issues, the spirit of community control may be better realised.

Recommendation 12

The committee recommends that the ACT Government negotiate with NSW and the Commonwealth government to develop a funding package to create a practice manager position in Winnunga Nimmityjah.

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[93] Transcript, 26 February 2001, p 90, Ms Tongs.

[94] Submission 5, p 12.

[95] Transcript, 26 February 2001, p 101, Ms Tongs.

Recommendation 13

The committee recommends that the ACT Government increase its financial support to Winnunga Nimmityjah to allow for the expansion of services.

Premises

4.30. The committee is aware that the estimates committee commented on what it saw as being the inappropriate size and condition of the premises which Winnunga currently occupy in Ainslie. The committee has been to Winnunga Nimmityjah and agrees that the current facility is in need of upgrading at the very least to ensure that privacy for patients and appropriate occupational health and safety requirements are being met. The committee understands that the Winnunga Nimmityjah community would prefer a purpose built facility. The committee was impressed with community controlled health facilities that it visited in Narooma and in Mount Druitt in Sydney. The Mount Druitt Aboriginal Health Service, a purpose built facility, was particularly impressive.

4.31. The committee understands that Winnunga is currently funded by the Commonwealth.

4.32. The committee was informed in the course of the inquiry that the ACT Government had decided to 'hand-over' the land and the building which Winnunga operates out of, to the community. However, the committee was informed that the hand-over process has yet to be completed. The committee urges the Government to finalise these arrangements so that Winnunga has some certainty and the capacity to plan for the future.

4.33. The committee believes that the ACT Government should engage in negotiations with the Commonwealth and NSW governments to identify funding for a purpose-built facility to enable improved services and expansion of services.

Recommendation 14

The committee recommends that the ACT Government, in consultation with Winnunga Nimmityjah, make representations to the Commonwealth and NSW governments to identify joint funding for the development of a purpose built facility for Winnunga.

Cross-border funding

4.34. Due to the degree of mobility in the ACT Aboriginal population it is not surprising that people from other states access ACT services. However, while mainstream services have developed cross-border funding arrangements, there are currently no provisions for Winnunga Nimmityjah to receive funding from NSW, from which 20 per cent of the services clientele come from. In this regard Winnunga Nimmityjah pointed out that:

> Winnunga Nimmityjah AHS has formed a strong partnership with the NSW Southern Area Health Service, Katungal Aboriginal Medical Service, the South-east division of General Practice, and Bateman's Bay Hospital. This represents one of the only four successful partnerships nation-wide.
>
> In this context, joint planning involves issues of cross-border funding. The Canberra Hospital is classified as a regional hospital and receives funding from NSW. Likewise, Goulbourn Jail is classified as a regional jail and consequently, receives funding from the ACT. Approximately 20% of Winnunga Nimmityjah AHS's clients live outside the ACT. However, Winnunga Nimmityjah AHS's constitution and the ACT Government consider Winnunga Nimmityjah AHS's catchment area to be the ACT, whereas the NSW Heath Department and its Southern Area Health Board, as well as OATSIH consider it to include Yass, Queanbeyan and Goulbourn. The Southern Area Health Service allocates funds to the ACT for health and if there is a component dedicated to Aboriginal and Torres Strait Islander people, the extent and use of these funds needs to be clarified[96].

4.35. The committee believes that funding arrangements do require clarification and it may be appropriate for the ACT Government to consult with the NSW government and the Commonwealth to resolve funding issues.

Gugan Gulwan Aboriginal Youth Corporation

4.36. Gugan Gulwan is an ACT Aboriginal community controlled service delivering a broad range of health services to young people as well as other services. More recently the Corporation has been funded to provide drug and alcohol outreach services for young people. Gugan takes a broad ranging approach, dealing with parents and extended families to address problems and provide services to young people.

4.37. The committee was informed that its premises in Red Hill were unsuitable, in terms of accessibility, for much of the Corporation's client group. The committee therefore welcomes the recent ACT Government decision to relocate Gugan Gulwan to premises in Erindale, which the committee understands is a better location. However, the committee understands that Gugan Gulwan's preference was to be located centrally, somewhere in Civic. The committee would like the Government to review the suitability of locating Gugan Gulwan at Erindale over the course of the next year to determine whether it is the best place to locate the Corporation to enable increased accessibility – a big element of improving health outcomes. The committee sees that Gugan Gulwan will play a big role in bringing about improved health outcomes.

Recommendation 15

The committee recommends that:

a) the Government in consultation and negotiation with Gugan Gulwan review the appropriateness of its new premises in Erindale over the next year to

[96] Submission 5, p 12.

ensure that the location opens up access to the fullest extent possible for the Corporation's client group; and

b) should this review find Civic to be a more appropriate location the Government shall make provisions for relocating Gugan Gulwan.

Recommendation 16

The committee recommends that the Government provide additional funding to Aboriginal-specific health and related services and make representations to the Commonwealth for increased ACT funding in this area.

Mainstream services

Limited cultural awareness in mainstream services

4.38. The committee heard that many mainstream services are not Indigenous-friendly due to a lack of knowledge about the Aboriginal and Torres Strait Islander culture. The committee also received the impression that some services, in particular The Canberra Hospital, fail to understand the cultural sensitivities required to deliver effective and holistic health care to Indigenous patients. This has had the effect of making some services places that Aboriginal and Torres Strait Islander people are reluctant to attend, often putting off seeking treatment until it is too late.

4.39. As one Aboriginal witness, Mr Len Barratt, noted, 'Hospital services are only accessed as a last resort. That is why I think so many of the community go into hospital and they never come out - or they do in a pine box. So the hospital seen as a bit of a taboo thing'.[97]

4.40. In speaking about some of the problems Aboriginal people face when they do, in fact, seek medical attention at the hospital, the witness went on the note that:

> The other thing that happens in a hospital is they shove a piece of paper in front of you and tell you to fill in these particulars before they even look at you. I think you will find that about 43 per cent of the overall population of Indigenous people cannot effectively read and write. So it is pretty imposing to even contemplate going there when you know what's going to happen. So you do not go there unless you're really sick. I do not think the triage staff on duty always understand this and I think delays to people being seen are very detrimental in this case, and that's why they need some culturally appropriate training.[98]

4.41. These comments were echoed by NACCHO which saw that a bigger emphasis on primary health care, on preventative health care, could lessen the extent to which Aboriginal and Torres Strait Islander people need to access the hospital. NACCHO stressed that outcomes in mainstream services should be the benchmark for success,

[97] Transcript, 26 February 2001, p 77, Mr Barratt
[98] ibid, p 77, Mr Barratt

not the rigid adherence to processes and procedures. NACCHO noted in the public hearing that:

> I think we need to make a shift – and this is not an easy shift for politicians and health administrators in government systems to make – in the focus of health care from the acute end of the spectrum into the primary care end of the spectrum.
>
> Mr Barratt pointed out – and it is absolutely true – that by the time you wheel an Aboriginal person through the doors of an emergency room it is often too late for them. So what we need to do is we need to have a focus on building strong and effective private care networks in communities to keep people out of the hospitals…
>
> It is about systemic issues. It is about how is it possible for us to make sure that we have got a system in place that is geared towards getting the best outcome. Unfortunately, it is the bureaucracy, and the health bureaucracy as much as anybody else. It is almost like the primacy has been vested in process, not in outcome. So, when it comes to accessing services, the important thing for people has been, "We've got to get the form filled out," or, "We've got to get the process right," rather than the outcome. And so we have had situations in Newcastle where just a very simple thing like the number of visitors that people are allowed to have when they're sick in hospital … [has become a problem]…
>
> To us it seem such a simple thing, but you had directors of nursing going berserk because there was three people and there was only two were allowed. At the end of the day, health services exist primarily, I would have thought, to get people well. So the focus needs to be on what does it take to get people well, and particularly for Aboriginal people. And so there is a need for flexibility in systems and in structures within mainstream. There is a need for an awareness of cultural issues, and I think the whole issue of cultural awareness within mainstream services needs to be seriously addressed – and I mean seriously addressed - and addressed with Aboriginal communities themselves.[99]

4.42. As one example of the primacy of process over outcomes, NACCHO relayed the following story about an Aboriginal man seeking assistance in a Newcastle hospital. NACCHO noted that:

> … one of my health workers in Newcastle was wheeled through the doors of the main hospital up there with an appendix that was about to rupture. He is an Aboriginal person like myself, fair skinned. But everybody knew him, they knew he was [an Aboriginal person]. He is one of the main Aboriginal health workers in the medical service. But they wheeled him in and, of course, he had to do the paperwork. It got to question 6, and question 6 in the Hunter Valley was, "Are you of Aboriginal or Torres Strait Islander descent?" That is a very important issue - the question of identification of Aboriginal people when they are accessing services. He said "Yes" and the very officious person looked at him, and said, "No, you can't be. Shall I write 'part-Aboriginal'?" This was a man whose appendix was about to rupture who had to engage in some cultural awareness training with the person who was admitting him, and we were just astounded.[100]

4.43. NACCHO argued that the emphasis placed on process has two negative bi-products 1) lessening the value of treatment for Aboriginal people who have chosen to

[99] Transcript, 26 February 2001, p 87, Mr Ritchie.
[100] Ibid, p 87, Mr Ritchie.

access the service and 2) impeding access in the first place. NACCHO pointed out that:

> I think that [primacy of process] often mitigates against two things. It mitigates against an effective outcome once a person has accessed the service. But more importantly and more problematically, often an inflexible mainstream health system, be it government provided through hospitals or private practice or specialist, actually works against access. So it is okay if you happen to get an Aboriginal person through the door and you can get them there in this system, but getting them there in the first place can be a problem…[101]

4.44. The committee completely agrees that more emphasis needs to be placed on flexibility so that the best health outcomes can be achieved. In order to attain the flexibility needed, mainstream services and administrators in these services need to consult with the local Indigenous community about process improvements and customised approaches for dealing with Indigenous patients.

4.45. The committee welcomes recent attempts by the Department of Health, Housing and Community Care to provide cross-cultural awareness training in relation to Indigenous culture. However, the committee is concerned that there still appears to be significant problems in some health services, particularly within The Canberra Hospital.

4.46. The committee is also pleased that the ACT Division of General Practice is undertaking cross-cultural awareness programs with its membership. The committee believes that there is also an onus on medical specialists to become more aware of the cultural issues specific to Indigenous people to be better able to meet their health care needs. The committee would like to see cross-cultural awareness programs (and not just in terms of Indigenous culture) become part of continuous improvement programs across all specialties. The committee believes that the Government could play a role in liaising with the various peak groups responsible for the oversight of medical specialties to get results in this area. The committee believes that basic social justice principles and equity of access principles make it incumbent on the medical fraternity to avail itself of information and education about delivering to health care services to Indigenous patients – it is a core responsibility.

Recommendation 17

The committee recommends that the Government consult with the ACT Aboriginal and Torres Strait Islander community to begin a systematised review of operating policies for all mainstream health services to ensure they are tailored to be culturally appropriate.

Recommendation 18

The committee recommends that the Government review all the processes at Canberra's hospitals in consultation with the ACT Aboriginal and Torres Strait

[101] Ibid, p 87, Mr Ritchie.

Islander community to ensure that there is sufficient flexibility in their application and that operating processes and policies are culturally appropriate.

Recommendation 19

The committee recommends that the Government undertake vigorous efforts (and intensify existing programs) to expand the knowledge of cross cultural awareness and sensitivity across the entire health portfolio, particularly at the Canberra Hospital, this effort should be ongoing and reviewed periodically to determine where gaps exist.

Recommendation 20

The committee recommends that the Government consult with the various peak groups responsible for overseeing medical specialties to instigate Indigenous and other cross-cultural awareness training for health professionals across all specialties.

'Body parts' approach

4.47. Witnesses advised the committee that the Western approach to medicine is sometimes not compatible with Indigenous conceptions of their health. The notion of a Western 'body parts' approach was seen as being one problem. In a public hearing, Winnunga Nimmityjah noted that:

> … the mainstream [services] take… a body-parts approach to health. It's about funding, for say, sexual health, or diabetes, or women's health or whatever, but to us they are all joined. You can't separate one from the other. Our doctor's [at Winnunga Nimmityjah] already do that.[102]

4.48. ACTCOSS also spoke about some of the problems associated with using a 'body parts' approach when providing services to Indigenous people. ACTCOSS noted in a public hearing that:

> … we have very much a body parts view of health. You know, there is one part of the body, whether it be the liver or you leg or whatever, that is going wrong and that is what our medical model looks at. There is a problem with that in general, but we find there is a particular problem with that way of looking at health for people from an Indigenous background. There is a wide range of reasons for that.
>
> First of all, it is our understanding from talking to people from the Indigenous community that that is not how Indigenous people think about health. There is also the fact that many Indigenous health issues are a result of broader systemic factors beyond just something that might be particularly wrong with someone's liver or one particular part of their body. It is a broader lifestyle issue because of the high level of poverty amongst Indigenous communities and the low level of education, the housing issues, transport problems.

[102] Transcript, 26 February 2001, p 99, Ms Tongs.

> There is a broader view of health that needs to be taken on board when we think of Indigenous health…
>
> We are, time and time again, guilty of looking at a particular health issue and not seeing the broader person, and seeing the fact that this person might need some health outreach work, for example, to assist them in their lifestyle rather than just fixing the particular problem, the particular organ at risk or the particular issue that has been brought to the doctor's attention. I mean some broader health outreach work to consider the person's lifestyle or housing situation or employment situation – to consider the broader human being, rather than the specific issue at hand.[103]

4.49. The committee acknowledges that Western Medicine has quite necessarily compartmentalised the treatment and diagnosis of diseases and illnesses to different parts of the body and to medical practitioners who specialise in particular areas of the human body. Consequently funding programs have sometimes been defined in 'body parts' terms as well. However, as noted above, the emphasis on 'body parts' is, in some ways, incongruous with Aboriginal people's understanding of health and their expectations of health care. There is not necessarily a complete incompatibility between a 'body parts' approach and a holistic approach to health. It is more that when dealing with Aboriginal patients the emphasis should be shifted to encompass a broader notions of what is meant by good health. The committee believes that doctors dealing with Indigenous patients need to be cognisant of Indigenous conceptions of health and equipped with the tools to improve communication with Aboriginal patients about their health. The committee's recommendation 19 about extending cross-cultural training to general practitioners and specialists should be construed as including an examination of Aboriginal conceptions of health.

Aboriginal liaison officers

4.50. The committee heard that there is a critical shortage of Aboriginal Liaison Officers in mainstream health services.

4.51. In its submission ACTCOSS argued that:

> There is a chronic shortage of ALOs [Aboriginal Liaison Officers] in the ACT health system. The National Aboriginal Health Strategy sets a needs-based target for a ratio of Indigenous staff to population of 1:300. With the inclusion of surrounding areas, the ACT health system services an Aboriginal and Torres Strait Islander population of approximately 6000 people.
>
> Under the needs-based ratio established by the National Aboriginal Health Strategy, this means that there should be 20 Indigenous staff in mainstream health services in the ACT. However, ACTCOSS understands that there are only 9 ALOs at present in mainstream health services in the ACT. From its discussions with the community, the Council is concerned that this is clearly insufficient to meet the needs of Aboriginal and Torres Strait Islander people in the ACT and region.[104]

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[103] Transcript, 26 February 2001, p 108, Mr Stubbs.

[104] Submission 8, p 11.

4.52. The committee is also concerned about the apparent shortfalls in ALO positions in mainstream services and received evidence that this shortage is placing an inordinate demand on Indigenous-specific services such as Winnunga who are often called by The Canberra Hospital to help facilitate admission to the hospital. As Julie Tongs, the Chief Executive Office of Winnunga Nimmityjah noted in evidence:

> People aren't being treated properly in the hospital system, you know; people are being sent away and refused treatment. That's not our job to chase after the hospital and get them to do their job. Our job is to run a primary health care service, an Aboriginal community controlled primary health care service.
>
> At the moment we seem to be everything to everyone and we're picking up the responsibility for these places that aren't taking responsibility.[105]

4.53. In its submission, ACTCOSS implored the committee to recommend bringing the number of ALOs up to the ratio outlined in the National Aboriginal Health Strategy, arguing that, '…funding for at least 20 ALO positions in health services needs to be made available immediately to meet this need, and meet the recommended target of the National Aboriginal Health Strategy'.[106]

4.54. The committee believes that there is a strong case to put additional resources into ALO positions and makes a recommendation to this effect below.

Recommendation 21

The committee recommends that the Government fund further designated ALO positions in mainstream health services in the ACT.

Improving access

4.55. The committee believes that it is important to improve the quality of mainstream services delivered to Aboriginal people. The committee was interested to note that Winnunga Nimmityjah has already made representations to the various levels of government about appropriate strategies for opening up access to mainstream services.

4.56. The committee has included these strategies which were outlined in a 1996 report from Winnunga Nimmityjah to the Commonwealth Department of Human Services and Health.

1. Improve awareness of mainstream services including location, nature of services provided, costs involved, subsidies and rebates;

2. Develop a consultative process such as a working party made up of personnel from services, to meet regularly with members of Winnunga Nimmityjah, Gugan Gulwan Aboriginal Youth Corporation and others from the Aboriginal and Torres Strait Islander community;

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[105] Transcript, 26 February 2001, p 89, Ms Tongs.

[106] Submission 8, p 12.

3. Appropriate resourcing of Winnunga Nimmityjah;

4. Cultural training of staff in all services;

5. Establishment of Aboriginal and Torres Strait Islander creches and occasional child care centres;

6. Employment of Aboriginal and Torres Strait Islander outreach workers (either based in single agency or shared by a number of similar small services);

7. Funding for research to ascertain from Aboriginal and Torres Strait Islander communities exactly what their needs are in the health, welfare and childcare areas;

8. Provision of an information service for Aboriginal and Torres Strait Islander people and which is provided by an Aboriginal and Torres Strait Islander organisation.

4.57. The committee supports the thrust of these recommendations and believes that the government should aim to work with the Indigenous community to implement any of the recommendations that have not yet been.

Recommendation 22

The committee recommends that the ACT Government consult with the Commonwealth and the local Aboriginal and Torres Strait Islander community to begin refining and implementing the strategies identified in the 1996 Winnunga report to the Commonwealth Department of Human Services and Health.

CHAPTER 5. DRUG USE

4.58. In the course of the committee's investigations, the committee was informed through several sources that drug use and, in particular, heroin use has become widespread in the ACT Aboriginal community. At the end of last calender year 27 per cent of fatal overdose deaths were Indigenous people, while Indigenous people only make up less than one per cent of the ACT population. This caused great concern for members of the committee who felt that it was appropriate to produce a separate section of the report detailing some of the issues that have been raised in this regard.

4.59. Having visited with elders, patients and staff at Winnunga Nimmityjah and listened to witnesses from a range of backgrounds, the committee felt that it had to make some comment on this pressing problem and urge the Government to take some action.

4.60. This chapter outlines the evidence that the committee has received in relation to Indigenous drug use in the ACT. It is not an exhaustive examination, but attempts to highlight the devastation that is being wrought in the ACT Aboriginal community by heroin addiction.

4.61. A number of recurring themes emerged in the course of the committee's inquiry including: gaps in service provision; inappropriate services for Indigenous people; dual diagnosis in terms of mental health and drug addiction, poly-drug use and issues relating to self esteem in the Aboriginal community. The committee examines these themes throughout the chapter.

4.62. The committee does not pretend to have any magic solutions for stemming drug use in the Indigenous community, but it does see that additional resources for Aboriginal-specific drug and alcohol programs are a priority. There is also a need to improve the way in which mainstream drug services interact with Indigenous patients.

4.63. The issue of Aboriginal heroin use in Canberra has come to public attention more and more over the last 12 months. It has been raised in the media, in the committee estimates process and by numerous local community groups and service providers.

4.64. The committee is aware that drug use in the local Indigenous community has had far reaching effects. Not only are the users and their families negatively impacted by drug use but the committee understands that the ramifications are being felt throughout the entire Aboriginal community across generations.

4.65. Below, the committee outlines some of the evidence that it received through its visit to Winnunga Nimmityjah, the public hearing it conducted on 22 November 2000 and a report produced on the issue by the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University.

4.66. The committee has attempted to report on the extent of the problem, the effects that it is having on health outcomes for Aboriginal people and offers a number of recommendations aimed at addressing this serious issue.

The extent of the problem

4.67. In a submission to the committee, a local doctor working with the Aboriginal community, Dr Tom Gavranic, outlined the severe problems associated with drug use in the Indigenous population. Dr Gavranic noted that:

> We continue to deny the centrality of drug addiction to Aboriginal ill-health. Alcohol is the main destructive drug though smoking is also of obvious importance. However, illegal drugs, especially marijuana and heroin are assuming increasing importance, especially because of their legal consequences. I find this denial to acknowledge the issue almost amounts to taboo. Yet, right from the very early historical records, the problem is quite evident and continues to be high-lighted time and again in official reports and documents. Despite our denials, it remains a major cause of reduced life expectancy, of many medical and psychiatric problems (including diabetes and schizophrenia), domestic violence and family disruption (with attendant schooling and self-esteem problems), and leads to incarceration in gaols and correctional institutions.
>
> Instead of devoting to addressing this problem, we are busy building (private) gaols, and hospitals which serve to create (1) employment opportunities for non-Aboriginals and (2) a present day, on-going "stolen generation", which creates more ill-health! These actions are explained away using much the same rhetoric of previous stolen generation policies. We seem to regard the stolen generations as belonging to another less enlightened time. Yet here we are, repeating the same mistakes![107]

Committee meeting at Winnunga Nimmityjah

4.68. On 5 October 2000, the committee met with elders, staff and patients at Winnunga Nimmityjah Aboriginal Health Service. The members of the community assembled on that day presented the committee with many heart-felt accounts of how drug use had impacted their lives and the lives of their loved ones. The committee discussed a range of issues confronting the ACT Indigenous community but the major theme to emerge on the day related to the increasing problems that many young Aboriginals are having with heroin addiction.

4.69. The committee wishes to sincerely thank all the people that it met with at Winnunga for sharing their often very personal stories. The committee gained a good understanding of the magnitude and seriousness of heroin addiction in the Aboriginal community and the immense damage it is doing.

4.70. To establish some context, the committee considers that it is worth summarising the key points that were made by the community members in this regard. The following points are paraphrased from comments made at the meeting with Winnunga Nimmityjah.

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[107] Submission 6, p 4.

- Heroin use in the local Indigenous community was seen by all participants as being a massive problem, with a number of people's sons having recently died from heroin overdoses.
- A theme to emerge throughout the day was that mainstream services in Canberra are quite inappropriate and ineffective in dealing with the health issues of Aboriginal and Torres Strait Islanders.
- The committee was informed that many young Aboriginal people don't feel that they are able to talk with people at the needle exchange program.
- Dual diagnosis was seen as being a significant issue, with some participants noting that there needs to be greater recognition that mental health, self-esteem, drug use and poor health outcomes are all inextricably intertwined.
- Polydrug use was also seen as being a problem with many kids using benzodiazapines, alcohol, speed and heroin concomitantly.
- There was mention that many of the young kids are going off to jail in increasing numbers as a result of their drug use and associated activities.
- As a result of incarceration many young Aboriginal people found it near impossible to gain employment after receiving a criminal conviction. This was seen as only feeding the despair and the loss of self-esteem, possibly leading to a further opting out from the community and further drug use.
- Some members of the forum noted that there is a perception in the community that Aborigines in the ACT are middleclass or upperclass, which they argued was not really the case. There was talk of severe poverty in many families and the local Aboriginal community generally.
- Some members of the group mentioned that rehabilitation was a much more useful intervention for their children than incarceration.
- The point was made repeatedly that more resources were needed to deal with the problems confronting their community, especially in relation to drug addiction.
- One lady expressed the view that detoxification in mainstream services was generally culturally inappropriate for Aborigines. For instance there was a failure to acknowledge the all-important kinship system which operates in the Indigenous community. The failure of many services to recognise the importance of kinship had resulted in failure to deliver services. For example, the committee was advised that a mother wished to take her daughter to detoxification and check-in with her daughter for support – this was not allowed under the internal policy of the detoxification centre and her request was denied. Subsequently the detoxification service was not rendered and the young person continued to use heroin.
- One person's 16 year old relative was denied treatment from a detoxification service on the basis that she, 'wasn't addicted enough'.
- Many members of the group felt that mainstream services concentrated more on alcohol problems of young Aboriginal people, to the exclusion of heroin and other drug use.

- One person noted that her son was actually given heroin in a detoxification facility by another patient.
- There was also a view that the reporting processes currently in place for measuring the extent of heroin use in the Aboriginal community were inadequate - that they were underreporting the problem.
- Some people's sons had accessed detoxification services in places as far away as Kempsey and Nowra as there was nothing suitable in the ACT.
- Aboriginal-specific detoxification services were seen as being a priority. One person felt that ideally the facility should be just outside Canberra, away from Civic where drugs are readily available.
- Julie Tongs, the Chief Executive of Winnunga, said that as it is often the case that a number of siblings in a family are drug users, it was often important to detoxify and rehabilitate a key member of the family and that the benefits of that one person's success would flow on to the other siblings, 'it's like the Pied Piper,' she said.
- There was mention of the fact that while there is a general trend towards home detoxification, this was not appropriate for many Aboriginal families as there needs to be a degree of stability in the home environment for this type of intervention to be successful and unfortunately this sort of stability was often not present.
- The idea of building partnerships with industry and business was seen as being important, particularly in relation to employment opportunities for Aboriginal people. This was seen as one way of overcoming problems getting employment associated with the stigma of a person having a criminal record.
- It was noted that although there are a range of significant health problems confronting the local Indigenous community such as renal failure, liver problems, heart disease etc, a lot of their time is currently being taken up with looking after young drug dependants.
- It was noted that there needed to be proactive not reactive services and that there was a lot of value in promoting and educating people in basic life skills such as budgeting.
- A comment was made that often ACT Housing makes inappropriate placements for Aboriginal people with substance use problems, putting them in places like Burnie Court where drug use and distribution appear to be widespread.
- A comment was made that 'doctor shopping' for prescription drugs, particularly benzodiazapines, was prevalent.

Young Indigenous population

4.71. ABS statistics indicate that in 1996 there were 1333 young Indigenous people (between the ages of 10 and 30) living in the ACT as the following charts shows.

Age Group	Number of people
10-14	375
15-19	323
20-24	337
25-29	298
Total	**1333**[108]

Drug use estimates

4.72. In the middle of 1999, the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University were commissioned by the ACT Office of the Commonwealth Department of Health and Aged Care to estimate the extent of illicit drug use in the ACT Indigenous community. Following its study, the Centre produced its report, *"They'll Just Read About Us in Storybooks": Estimations of the Number of Young Indigenous People Using Illegal Drugs in the ACT and Region*.

4.73. Through interviews with service providers and members of the local Aboriginal community, the Centre reported on the contacts that services had with Aboriginal illicit drug users. The committee felt that it was worth reproducing the findings that the centre made in this regard and has included to the following table.

Organisation, type & Clientele	**Number of Indigenous clients using drugs**	**Total number of clients in contact with organisation**	**Status of numbers**	**Timeframe for Numbers**	**Drug/s used**
Winnunga Nimmityjah Aboriginal Health Service **Indigenous People with any health problem, including drug use**					
➢ **Julie Tongs**	500 (all ages)	3 700 (this total includes 500 non-Indigenous people)	Estimations	Current: 14.1.2000	Polydrug use, including heroin
➢ **Dr Peter Sharp**	"Hundreds" (all ages)	"	"	Current: 2.2.2000	"
Gugan Gulwan Youth Aboriginal					

[108] ABS figures cited in Dance, Brown and Bammer.

Corporation Indigenous Youth	[a] 29	[b] 832	Precise	[a] Quarterly [b] Annual	"Heroin, marijuana, alcohol and pills"
Aboriginal Legal Service Indigenous People with legal problems ➢ **Paul Brandy & Jim Jeffery** ➢ **Eduardo Laginha**	100-200 60-80	200 "	Estimations "	Current: 20.1.2000 " 9.2.2000	Heroin "

Organisation, type & Clientele	**Number of Indigenous clients using drugs**	**Total number of clients in contact with organisation**	**Status of numbers**	**Timeframe for Numbers**	**Drug/s used**
ADP, ACTCC Mainstream Alcohol & / or other drug users	15	411	Precise	November, 1999-January 2000	Alcohol & / or other drugs
Karralika Therapeutic Community, ADFACT: Mainstream Alcohol & / or other drug users	16	180	Precise	February 1999-February 2000	Alcohol & / or other drugs
Mancare Community, Salvation Army Mainstream Polydrug users	2-3 a year	Circa 157	Estimations	Annual	Polydrug use
ADP, Southern Area Health Service Mainstream Alcohol & / or other drug users	6 30	300 851	Estimations "	20.1.2000 June 1998-June 1999	Alcohol & / or other drugs "
ADDInc Mainstream Polydrug users	[a] 30-50 known, estimates "at least two hundred"	[b] "Thousands"	"Precise and estimations"	[a] Current [b] Annual	Polydrug use, including, for the majority, heroin

Organisation, type & Clientele	**Number of Indigenous clients using drugs**	**Total number of clients in contact with organisation**	**Status of numbers**	**Timeframe for Numbers**	**Drug/s used**

CIN Inc **Mainstream** **IDUs**	30 known, estimates "at least two hundred"	300-350	Estimations	Since opening: August 1999	Heroin
ACT Adult Corrective Services **Mainstream** **People with legal problems**	25	Not obtained	Detainee record count	January - December, 1998	Most commonly, heroin & / or marijuana
ACT Community Based Corrections (Probation and Parole) **Mainstream** **People with legal problems**	3-25	966	Record count	1.12.1999	Illegal drug use
ACT Periodic Detention Centre **Mainstream** **People with legal problems**	0	69	Record count	30.9.1999	Illegal drug use
ACT Youth Justice System **Mainstream** **Young people with legal problems**	33 35	162 160	Census Census	30.9.1999 21.1.2000	Marijuana & heroin "

4.74. As the reader can see the figures vary quite markedly between the services. Quality of data also varies. In addition to interviewing service providers, the NCEPH researchers also interviewed elders in the local Aboriginal community about whether they were concerned about drug use in their families as well as interviewing a number of ex-users.

4.75. The research team concluded that even by conservative estimates, there are at least 100 young Indigenous illicit drugs users in the ACT and region[109]. Given that the most recent ABS figures estimate that there are 1333 Indigenous people in the 10-30 year old age group, this conservative figure represents almost 10 per cent of the youth demographic, far higher that the rates of illicit drug use for the wider non-Indigenous population.

4.76. This is of extreme concern to the committee, who is of the view that should effective strategies not be adopted as a matter of urgency, the problem is only likely to get worse.

4.77. The committee believes that high quality quantitative research is required to track the extent of illicit drug use in the ACT Indigenous community. There is an onus on the ACT Government as well as governments in other jurisdictions to take heed of

[109] Op Cit Dance, Brown and Bammer, p 20.

the problem as it stands and to adopt rapid response measures in consultation with the local community. These responses should be aimed at providing additional support services in relation to drugs as well as developing broader policy measures to assist with improving the social milieu in which the local Indigenous community find themselves. However, better empirical monitoring of the illicit drug use problem must also be adopted to demonstrate whether new and existing policies are adequately addressing the problem. Without such an approach, policymakers are flying blind.

4.78. In the 'proposals' section below the committee makes a number of recommendations designed to enhance the effectiveness of support services. The committee acknowledges that this is a problem needs to be tackled holistically.

Poly-drug use

4.79. The point was raised in the course of the committee's meeting at Winnunga and in its public hearing that poly drug use was one of the main areas of concern. As Gugan Gulwan noted in relation to over doses, 'The heroin is not what's making them drop [overdose]: it is all the poly drug use that is making them drop'.[110]

4.80. The committee was advised that Valium and other benzodiazapines are often the 'legal' drug of choice for many young people and that when mixed with heroin the results can be disastrous. The synergistic effects of using heroin in conjunction with other depressants such as alcohol or benzodiazapines can be fatal in that the mixture can severely depress the central nervous system to the extent that vital cardiovascular functions stop working.

4.81. In order to glean benzodiazapines, many young people were said to be involved in 'doctor shopping' – the practice of going to multiple doctors to seek prescriptions for the drugs. The committee was informed that often these drugs were sometimes 'onsold' by some people to friends and acquaintances.[111]

4.82. The committee was very concerned about the practice of doctor shopping and considers that there is a need to identify strategies to circumvent the practice.

4.83. An imputation was also made in the committee hearing that it is possible that some doctors are aware that the drugs are being used for recreational purposes but prescribe them to young patients nonetheless.

Recommendation 23

The committee recommends that the Government consult with Aboriginal community groups, the ACT Division of General Practice and the AMA to develop strategies to minimise the extent of 'doctor shopping' and to identify GPs that are misprescribing benzodiazapines and other potentially dangerous drugs.

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[110] Transcript, 22 November 2000, p 9, Ms Davidson.

[111] Ibid, p 10, Ms Davidson.

Proposals

Kinship and detoxification centre policies

4.84. The committee received evidence that due to the strict policies of many detoxification programs, which bar the concurrent detoxification of family members and don't allow family members/friends to be present for support, most Aboriginal clients fail to attend the services and therefore miss out on treatment.

4.85. The committee was told of the importance of the kinship system that operates in the Aboriginal community and that without an understanding of the importance family relationship ties, interventions tend to be unsuccessful.[112]

4.86. Both elders at Winnunga and the Executive Director at Gugan Gulwan indicated that many Aboriginal people are reluctant to be separated from their friends and family members for the time it takes to detoxify. Gugan Gulwan noted that:

> The thing that keeps cropping up, when we sit down and talk to these young people, is that they cannot do it [detox] without a relative or a friend. When they have got to go into the detox centres, they are isolated from everyone for, I think, a three-day period, and that is something that they just cannot cope with. Four times now we have been through the home detox with clients. That can work really well, because the family is there to help that young person go through detox.
>
> You have to make sure that the families are right to cope with that too, though. It is a very big responsibility. They must cope with the games that the young people play when they are coming off this drug, and of course the mood swings of course are really bad. They need that rehabilitation as something to do once that detox has been achieved.[113]

4.87. The committee also notes comments that while home detox can be a suitable approach for some, it can only take place effectively if there is a stable home environment and that such an environment is not present in many instances. The committee has concerns about the emphasis on home detoxification and questions where homeless people fit into the equation.

4.88. Gugan Gulwan noted that while many young people do seek assistance from detoxification services, they generally can't sustain the isolation for the period required. Gugan Gulwan noted that:

> We are trying to get them into detox centres. When we do get them in, though, they only stay in there for one or two days, or even just half a day, and then they off. At one stage there – it has just started to slow down now - Fred [an outreach worker with Gugan Gulwan] was going to Kempsey, to Binalong, to take the clients up there to an Indigenous-run program. That just takes him completely out of town for a couple of days [taking the resource away from the centre].[114]

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[112] Meeting with Winnunga Nimmityjah

[113] Transcript, 22 November 2001, p 7, Ms Davidson.

[114] Ibid, p 7, Ms Davidson.

4.89. Detoxification services operating in places like Kempsey were extolled as excellent models for Aboriginal-specific detoxification. Gugan Gulwan, indicated that these services place value in kinship and the importance of family relationships. Gugan Gulwan noted that:

> [The difference between current ACT services and services like that in Kempsey are] Very much cultural - understanding and very much understanding of the family unit and the impact that that has, the contact that needs to be made the importance of not letting them go in there with isolation. One of the detox centres [in Canberra] wouldn't let two cousins go in together to detox together. Both of them wanted to detox but, because they were related, they were not allowed to go to the same place, and things like that. It just don't work.[115]

4.90. Ms Davidson spoke of the need for flexibility in the application of these policies and the committee, too, sees value in applying discretion and adaptability in this regard.

4.91. The committee believes that there is definitely a need to review some of the policies under which detoxification services operate. It must be acknowledged that polices which deny people treatment on the basis of a preference to be treated with a family member or be supported by a family member are culturally inappropriate in the context of Indigenous treatment and are having the effect preventing many people seeking help from actually obtaining it.

4.92. The committee heard from Mr Fred Monaghan a drug and alcohol worker with Gugan Gulwan who also spoke about the fact that the rigid processes had made it difficult for some of his clients to gain access. Mr Monaghan noted in evidence that:

> I had a particular case where I walked in with a young person. He wasn't using heroin for a matter of four days but he was using other drugs, speed, all sorts of prescribed tablets, and popping all sorts of pills to counter his craving for the heroin. Because he made the statement that he had not used heroin for the last four days he was denied any access to the services in terms of dealing with his drug problem. I just felt that it was a bit of a kick in the guts for this kid because he was trying. The sad thing about this kid was that he was getting paid the next day. He was getting his dole. He knew he was going to pick up his dole cheque the next day. The reason why wanted definitely to get into the detox service was because he knew once he got money in his pocket he would go and buy heroin. The next day I seen him he was on the heroin.[116]

Recommendation 24

The committee recommends that the Government, in consultation with the ACT Aboriginal and Torres Strait Islander community, instigate a review of admission policies for detoxification services and other processes to identify current barriers to Indigenous people and following the review, implement measures to remove the barriers.

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[115] Ibid, p 8, Ms Davidson.

[116] Transcript, 26 February 2001, p 91, Mr Monaghan.

Away from home to a healing place

4.93. For the reasons cited above, the committee sees some value in developing an Indigenous-specific detoxification and rehabilitation centre. The argument was put that such a facility should be away from Canberra and therefore away from the drug scene. Kim Davidson from Gugan Gulwan noted in evidence that:

> You can have them [young heroin users] in stable accommodation, but they are going to run over to Burnie Court where the heroin is. They are going to go to those places because they need their hits. I really think that we need somewhere where we can take them, once they're detoxed. There should be resources there to take them on to a farm situation or something similar, where they can go into a rehabilitation program and build things or make things, something that will keep them occupied and out of town. That is where it all is [the heroin][117]

4.94. In appearing before the committee, a Ngunnawal elder, Ms Roslyn Brown, argued that such a facility could present a valuable opportunity to teach young people about their culture and help to build a sense of worth and self esteem. Ms Brown noted that:

> I think one of the things is: we are very enthusiastic about getting a camp going in this region for the kids, and I think to teach someone that you don't come from a dumb, stupid, Abo, boong, coon culture that was just like animals all running around, and really teaching them the true culture, a sense of identity, will really help the young kids and parents on the drugs…[118]

4.95. The committee understands that some of the drug and alcohol workers at Gugan Gulwan are already involved in a program which runs along these lines. In commenting on the approach that has been taken by Gugan Gulwan, Mr Fred Monaghan noted that:

> We have connected with Juvenile Justice on a number of occasions to deal with some of their kids that have been released from Quamby. We link with them and select a few of the kids from the community that are on the verge of or probably are in the earlier stages of using heroin. We take them out to the bush and do some cultural stuff with them, fishing, didgeridoos. We get them interested in doing some sort of crafts or painting. I mean, you give an idea of what is out there for the kids and get them to take an interest in what they want to do with themselves.[119]

4.96. The committee considers that it is worth increasing funding to expand the capacity of Gugan Gulwan to provide this service beyond the extent to which people are mandated by court orders. While Mr Monaghan saw value in extending the program for people beyond this select group, he also noted that it isn't suitable for all drug users. Mr Monaghan noted that:

> … the sad thing about it [the program] is that a lot of the kids we deal with are on court orders, and they're required to attend this program and attend that program. I'm thinking

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[117] Ibid, p 10-11, Ms Davidson.

[118] Transcript, 22 November 200, p 15. Ms Brown.

[119] Transcript, 26 February 2001, p 93. Mr Monaghan.

> that should be a way where kids can do it on their own steam instead of being required by the courts to do it. As I said, it's hard to pick on kids that are full blown heroin users. I think we can concentrate on the ones that are really on the verge of probably just smoking or inhaling heroin. When they get to the stage of injecting it turns into a sad state of affairs.[120]

4.97. The committee heard that many young Aboriginal men, in particular, were experiencing great problems in staying away from drugs after they have been released from prison. One witness relayed the story of how her grandson found it difficult to stay clean after getting out of Gaol. The witness noted that:

> … this concerns my grandson… [He's] been in there [Gaol] for a long time, almost a year. Now, he was clean when he came out. He was absolutely clean. I was so proud of him. He was big and strong. As soon as he came out he got on with the same old friends again and he was back on it again. How do we stop that?[121]

4.98. The committee sees that more needs to be done to assist Indigenous people with prior substance abuse problems on their release from prison. The drug subculture is often difficult for a person to escape, especially when a person's peers are also involved. The committee is aware that heroin use, like many types of substance abuse, is a chronic relapsing condition. The urge to use heroin after a period of incarceration is no doubt heightened when that person faces few employment prospects, a poor self-image and doesn't have an adequate support network. The committee believes that a rehabilitation facility away from Canberra, a healing place, which teaches life skills and incorporates Indigenous culture into the program may help to prevent relapse. The committee views the use of drugs to be more a symptom than a cause and that rehabilitation will only be successful if the underlying causes of a person's drug problem are addressed.

4.99. There would also be a need for partnerships to be established between the public and private sectors in terms of opening up employment opportunities for Indigenous people who are released from prison. As noted above, the committee believes that employment is a key to building self esteem and that when people, Indigenous or non-indigenous, come to find meaning and purpose in their lives through employment, the desire to use drugs could be diminished. However, employment is not a panacea and the committee believes that by exploring cultural practices, customs and beliefs, young Indigenous people, in particular, could develop pride in themselves and their cultural heritage.

4.100. Winnunga Nimmityjah noted that addicts are not the only ones in need of support but the families of addicts, often dysfunctional families also, 'need help in coping with things'[122]. The point was also raised that the young people and the families affected by drug problems need to be consulted about the best way forward. Winnunga Nimmityjah noted that:

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[120] Ibid, p 94, Mr Monaghan.

[121] Ibid, p 94, Ms Crawford.

[122] Transcript, 26 February 2001, p 95, Ms Buckskin.

> It [a rehabilitation centre] needs to be family orientated. You can't just pluck one individual out of a family and send them up to rehab up the north coast and expect them to stay there. We have to have something here. I don't know what. I have given it a lot of thought, but we need to have something, a place where we can generate our own income and become self-sufficient and stuff like that. That is not impossible, but it's getting the resources to do that in the first instance, and then to be able to continue it on.[123]

> It is also even getting the resources. You are asking us, and we're probably the wrong people to ask. That is not my area. Fred [From Gugan Gulwan] works with children, but we can't answer for them. It's about giving the resources so that we can go out and ask not only the kids but our community, what is it we can do? What can we do to make a difference to the lives of the children? But it's also not [just] children. Julie can also give you examples of older people in their twenties and thirties that are still having trouble with the drugs. It's a big problem as well. It's about even giving resources so that we can go and find out from them what it is we can develop.[124]

4.101. Commenting on the importance for a farm type environment for young people to access, Special Children's Magistrate, Shane Madden, expressed his view in article appearing the Canberra Times. The article noted that:

> As well as a residential detoxification centre in the ACT, the Government should establish a farm that young offenders could be sent to, like one in the Southern Highlands of NSW. This would require "vision, initiative and expertise in management, with a general will on the part of government and the community to divert young people away from offending behaviour". [125]

4.102. Although Mr Madden's comments were not specifically related to an Indigenous facility, it does underscore the idea that rehabilitation and detoxification centres may have more value located away from the drug scene, perhaps in a rural setting. At any rate, the committee sees that the Government should look at ways of improving access to culturally appropriate detoxification and rehabilitation services for Indigenous drug users. The committee notes that an Aboriginal-specific detoxification service is the ideal service delivery route.

4.103. The argument has been put that the poor economies of scale make such a venture unviable. However, the committee believes that more creative solutions may be able to accommodate the need for culturally appropriate services as well as the fiscal imperatives which the Government operates under.

Recommendation 25

The committee recommends that the Government allocate funds to consult with the ACT Aboriginal and Torres Strait Islander community to assess the different approaches for providing rehabilitation and detoxification services for Indigenous people and that this assessment should be auspiced by an Aboriginal

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[123] Transcript, 26 February 2001, p 95, Ms Tongs.

[124] Transcript, 26 February 2001, p 95, Ms Buckskin.

[125] Roderick Campbell, 'Magistrate hits out at detox 'deficiency'' ***Canberra Times*** 29 November 2000

Controlled organisation such as Winnunga Nimmityjah or Gugan Gulwan and should consider:

- **how services can be better provided to support Aboriginal and Torres Strait Islander people who have had a drug addiction in the past and are released from prison;**
- **the value to the community of extending Gugan Gulwan's bush retreat program; and**
- **the capacity for family members of people seeking rehabilitation and detoxification to be involved in the treatment options and the capacity for a facility to offer support for family members as well as addicted persons.**

Recommendation 26

The committee recommends that following the assessment of Indigenous needs in relation to rehabilitation and detoxification services, the Government give funding priority to the proposals that arise out of the consultation.

Services out of reach

4.104. The committee believes that there is a strong case for the relocation of Gugan Gulwan to somewhere in Civic where much of its client base is located. It is, in the committee's view, common sense that proximity of the service to the clients it serves is of paramount importance.

4.105. Gugan Gulwan noted that:

> We are going to have to use some of that as office space at this stage, because there is just nowhere to put them. We are at crisis point for accommodation. The location is just is just not right. It is right up in the heights of Red Hill. It is a lovely area, and the yard and surrounds are perfect, but is just not ideal for a youth centre.[126]
>
> A lot of our time is spent picking up our clients, and we just do not have the resources for that. If we were placed somewhere central, then it would be much easier on our staff as a whole. We are working under really rough circumstances at the moment, but we'll keep going as long as we have to, because we care what happens to our community and our kids. However, a central location would make it much easier for our staff to cope [if the centre was located more centrally].[127]

4.106. The committee now understands that the Government has provided some resources to allow Gugan Gulwan to move to better suited premises at Erindale in Tuggeranong. As noted earlier in the report, the committee welcomes the move from Red Hill although notes that Gugan indicated it first two preferences were Civic and

[126] Transcript, 22 November 2000, p 3, Ms Davidson.
[127] ibid, p 3, Ms Davidson.

then Woden. The committee hopes that the new location of Gugan Gulwan will increase its accessibility and its reach within the Aboriginal and Torres Strait Islander community.

Winnunga Nimmityjah report on drug use

4.107. Winnunga Nimmityjah made a series of recommendations in 1998 its report, *Understanding Indigenous Needs: How can the Alcohol and Drug Program better meet the needs of Indigenous people in the ACT region.* The committee has included these recommendations below:

1. Formal and informal networking at both managerial and staff levels between mainstream and Aboriginal community controlled organisations;

2. Closer liaison between the ACT Alcohol and Drug Program and Aboriginal community controlled organisations so as to enable the provision of appropriate services;

3. Cross-cultural training courses developed by and presented by Aboriginal and Torres Strait Islander people to mainstream services on a regular basis;

4. Employment of Aboriginal and Torres Strait Liaison Officers to establish links and networks between indigenous and non-indigenous peoples and organisations;

5. Employment of Aboriginal and Torres Strait Islander staff in the Alcohol and Drug Program with appropriate resourcing of formal support mechanisms via Winnunga Nimmityjah.

4.108. The committee considers that these recommendations, if properly implemented, could play an important part in improving the ability of mainstream drug programs to appropriately deliver their services to Aboriginal and Torres Strait Islander people in the ACT.

4.109. The committee supports these recommendations.

Recommendation 27

The committee recommends that the Government consult with the ACT Aboriginal and Torres Strait Islander community to begin implementing Winnunga Nimmityjah's recommendations in relation to the Drug and Alcohol Program set out in the 1998 report, *Understanding Indigenous Needs: How can the Alcohol and Drug Program better meet the needs of Indigenous people in the ACT region.*

Activities for young people

4.110. This section has examined the problems that some young people have with drugs. The committee's comments are highly relevant to the needs of those young people. But they are also relevant to all young indigenous people who may suffer that loss of spirit or morale that has been discussed.

4.111. The committee has sought positive measures to raise that self-esteem, which is so important if young people are to have an enthusiastic approach to life and a concern to maintain good health. Gugan Gulwan points to the beneficial effects of gainful activity.

4.112. Around Australia Indigenous people are achieving remarkable success in sport, music, art and dance. No doubt young people in the ACT dream of emulating their heroes. The committee believes that every opportunity should be given to young people to pursue their interests and talents in any of these fields. The activity, the challenges and the rewards from the outcomes has the potential to bring great benefits.

4.113. Activities of this sort sustain a positive approach to life and self and develop talents that undoubtedly exist.

4.114. In the ACT there are many opportunities for development in these areas. The committee would not wish to see any young person fail to take up the opportunities offered due to a lack of knowledge of what is available, lack of support or lack of money.

4.115. Inevitably most activity is in the mainstream. The committee understands that young indigenous people, especially if insecure or uncertain, would be more comfortable with provisions specifically for them.

4.116. Measures of this nature cannot be suddenly developed and certainly not be imposed. They offer so much in the way of rewarding experiences that the committee is keen to see steady development of specific opportunities in these fields of sport, art, music and dance.

4.117. The committee believes that the Government, with community support, has the responsibility to advance this activity.

4.118. It is a matter that needs much more discussion and planning. It is possible for Gugan Gulwan and other Indigenous groups, or other community bodies to develop programs in the fields identified. There would need to be financial, organisational and community support for establishing those programs and then support for young people to access them.

4.119. The committee is firm in its belief that well organised activities in these areas for Indigenous people from a young age would play a major role in combating the problems outlined in this report.

Recommendation 28

The committee recommends that the ACT Government through the Aboriginal and Torres Strait Islander Consultative Council develop proposals for sport, music, art and dance to provide activity for young Indigenous people and provide funds necessary to develop proposals and subsequent activity.

CHAPTER 5. CONCLUSION

5.1. In the course of this inquiry members of the committee came to learn much about the significant challenges facing Aboriginal and Torres Strait Islander people in the ACT. While health was the focus of the committee's investigations, the committee could not help but see the extent of Indigenous people's disadvantage; disadvantage which runs through all facets of their lives. Health is tied in to homelessness, poor housing, high rates of incarceration, high rates of alcohol and drug abuse, domestic violence and welfare dependency. The committee sees that much of this disadvantage has stemmed from previous mistreatment of Aboriginal people through endemic racism and through past government policies including the dispossession of land, the removal of children from families and the disintegration of traditional cultural practices.

5.2. The committee is convinced that reconciliation between Indigenous and non-Indigenous people is of the utmost importance. Reconciliation should be pursued as a matter of government policy and official involvement but the grassroots people's movement of reconciliation is likely to play an even more important role in developing greater trust, goodwill and friendship between Indigenous and non-indigenous Australians. A rights-based agenda and symbolic gestures are part of this process of reconciliation.

5.3. However, reconciliation must also be pursued in immensely practical ways in terms of adequate funding, improved service delivery, and an increased role for Aboriginal people in the ACT to have control over their destiny, not only with regards to health matters but all aspects of participation in the community.

5.4. The committee believes that community controlled health organisations offer the best chance of improving health in the ACAT Aboriginal and Torres Strait Islander community. They offer culturally appropriate services, services which Aboriginal people *want* to use. The committee believes that a greater emphasis should be placed on the centrality of community controlled health organisations and this should be reflected in funding arrangements.

5.5. Recognising that there will always be a need for mainstream services to provide health care to Aboriginal people, the committee came to the view that much more has to be done to improve the cultural interfaces between Indigenous patients and non-indigenous health workers.

5.6. The committee would again like to extend the greatest thanks to all of those people who participated in this inquiry. The committee trusts that the Government will take on board the recommendations of the committee and continue to consult widely with Aboriginal and Torres Strait Islander people in the ACT about matters affecting their health and general wellbeing.

5.7. The committee looks forward to the Government's response to the committee's report.

Bill Wood
Chairman

6 August 2001

SUBMISSIONS

1. Mr Leonard Barratt
2. Mr Harold Hunt
3. Ms Ara Cresswell, Beryl Women's Refuge
4. MS Dianne Lucas, Canberra Rape Crisis Centre
5. Ms Julie Tongs, Winnunga Nimmityjah
6. Dr Tom Gavranic
7. ACT Government
8. Mr Daniel Stubbs, ACTCOSS

PUBLIC HEARINGS

22 November 2000, Committee Room 1

1. Ms Davidson, Gugan Gulwan Youth Aboriginal Corporation
2. Ms Brown, Ngunnawal Elder
3. Dr Dance, National Centre for Epidemiology and Population Health
4. Mr King and Mrs Summers, ACT Government
5. Mr Brandy, Aboriginal Legal Service
6. Open Family

26 February 2001, Committee Room 2

1. Dr Sharp, Winnunga Nimmityjah
2. Mr and Mrs Bell, Ngunnawal Elders
3. Mr Barratt
4. Mr Ritchie, National Aboriginal Community Controlled Health Organisation
5. Ms Tongs, CEO; Ms Crawford; Ms Buckskin, Chair - Winnunga Nimmityjah
6. Mr Monahan, Gugan Gulwan
7. Mr Stubbs and Mr Johnson, ACTCOSS

ATTACHMENT A