Overcoming Indigenous Disadvantage

Overcoming Indigenous Disadvantage

Key Indicators 2007

REPORT

Steering Committee
for the Review
of Government
Service Provision

2007

ISSN 1448 9805

The Productivity Commission acts as the Secretariat for the Steering Committee.

Secretariat
Steering Committee for the Review of Government Service Provision
Productivity Commission
LB 2 Collins Street East Post Office
Melbourne VIC 8003

Level 28, 35 Collins Street
Melbourne VIC 3000
Tel: (03) 9653 2100
or Freecall: 1800 020 083
Fax: (03) 9653 2359
Email: gsp@pc.gov.au
www.pc.gov.au/gsp

Suggestions:

The Steering Committee welcomes suggestions on the information contained in this Report. Please direct your suggestions to the Productivity Commission Secretariat at the above address.

An appropriate citation for this Report is:

SCRGSP (Steering Committee for the Review of Government Service Provision) 2007, *Overcoming Indigenous Disadvantage: Key Indicators 2007*, Productivity Commission, Canberra.

The Steering Committee thanks Reconciliation Australia for providing the photographs reproduced on the Report cover. No inference is intended that the people or communities shown are the subject of any issue raised in the report.

Cover photos (top to bottom):

Photo taken by students of Woree High School, Cairns, for Reconciliation Australia's All About Us project in 2006. Photo courtesy of Reconciliation Australia.

Indigenous Governance Awards Finalists 2006, photos courtesy of Wayne Quilliam and Reconciliation Australia:

– Wunan Foundation, WA. Charmaine Johnson, trainee tour guide with Wunan Foundation partner Kimberley Wilderness Adventures.

– Yirra Yaakin Aboriginal Corporation, WA. Board members Lynette Narkle, Frederick Spring and Gningala Yarran-Clanton.
– WuChopperen Health Service, Qld. Health Service health worker Virginia Coutts, Noah Noble and Tiana Yeatman.

Foreword

In 2003, when heads of Australian governments commissioned 'a regular report against key indicators of Indigenous disadvantage', they made a commitment to be held accountable for improving outcomes for Indigenous Australians. In April this year, the Council of Australian Governments reaffirmed its commitment to 'closing the outcomes gap between Indigenous people and other Australians over a generation'. Against these objectives, *Overcoming Indigenous Disadvantage: Key Indicators* is like a report card, showing how much progress has been made, and how much further we need to go.

The Report focuses on the disadvantage experienced by many Indigenous people, arising from historical, social and economic causes. However, most Indigenous Australians live constructive and rewarding lives, contributing to their families and wider communities. This Report aims to help governments address the disadvantage that limits the opportunities and choices of some Indigenous people.

This third Report in the series reveals that many Indigenous people have shared in Australia's recent economic prosperity, recording improved employment outcomes and higher incomes. There have also been welcome improvements in some educational and health outcomes for Indigenous children. Yet, even where improvements have occurred, Indigenous people continue to do worse than other Australians. And many indicators have shown little or no movement. Indeed, in some areas, particularly criminal justice, outcomes for Indigenous people have been deteriorating.

Such results should challenge all Australians to do whatever is necessary to remedy the causes of Indigenous disadvantage. Australia is not the only country confronting this challenge, and overseas experience shows that concerted action can make a difference. For example, taking what is perhaps the most important single indicator of disadvantage, the difference in life expectancy between Indigenous people and other citizens has been reduced to around seven years in North America and New Zealand. In Australia, the gap is almost two and a half times as great.

This Report contains further improvements in its scope and content. Nevertheless, and despite COAG's endorsement of the indicator framework, data in some critical areas remain poor. For example, we still do not have meaningful comparative data on school attendance, or on learning outcomes for Indigenous children according to

the degree of regional remoteness. Hospitalisation data for Indigenous people in NSW and Victoria, the two largest states, are considered to be of insufficient quality to be published. Nevertheless, some laudable efforts at data improvement are underway. These are strongly supported, but more is needed.

On behalf of the Steering Committee, my heartfelt thanks to all those who have contributed to this report, either by providing data or through their advice and feedback on earlier reports and proposals for change. I record our particular appreciation for the contribution over the past five years of Dan Black, who recently retired as Director of the ABS's National Centre for Aboriginal and Torres Strait Islander Statistics. Special thanks are also due to all those in the Working Group overseeing the development of the Report, including in particular its Convenor, Robert Fitzgerald, who also played a key role in consultations. Finally, thank you to all those who organised and participated in the consultations, which have contributed greatly to the advances evident in this latest Report.

Gary Banks

Chairman
May 2007

Contents

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACDP	Aboriginal Communities Development Program
ACT	Australian Capital Territory
AHW	Aboriginal health worker
AIC	Australian Institute of Criminology
AIEW	Aboriginal and Islander Education Worker
AIHW	Australian Institute of Health and Welfare
AHMAC	Australian Health Ministers' Advisory Council
ANAO	Australian National Audit Office
APY Lands	Anangu Pitjantjatjara Yankunytjatjara Lands
ARIA	Accessibility and Remoteness Index of Australia
ARCPOH	Australian Research Centre for Population Oral Health
ASCO	Australian Standard Classification of Occupations
ASGC	Australian Standard Geographical Classification
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIS	Aboriginal and Torres Strait Islander Services
Aust	Australia
BOCSAR	Bureau of Crime Statistics and Research
CAEPR	Centre for Aboriginal Economic Policy Research
CAR	Council for Aboriginal Reconciliation
CDEP	Community Development Employment Projects
CHINS	Community Housing and Infrastructure Needs Survey
COAG	Council of Australian Governments
DEST	Department of Education, Science and Training
DEWR	Department of Employment and Workplace Relations

DFACS	Department of Family and Community Services (now FACSIA)
DHAC	Department of Health and Aged Care
DHFS	Department of Health and Family Services
DMFT	Number of decayed, missing and filled permanent teeth
dmft	Number of decayed, missing and filled infant teeth
DUMA	Drug Use Monitoring in Australia
FACSIA	Department of Family and Community Services and Indigenous Affairs
GP	general practitioner
GSS	General Social Survey
GWEH	Gross weekly equivalised household
HREOC	Human Rights and Equal Opportunity Commission
IBA	Indigenous Business Australia
ICD	International Statistical Classification of Diseases and Related Health Problems
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th edition, Australian modification
ICGP	Indigenous Community Governance Project
IESIP	Indigenous Education Strategic Initiatives Programme
IGA	Reconciliation Australia/ BHP Billiton Indigenous Governance Awards
IHO	Indigenous Housing Organisation
ILC	Indigenous Land Corporation
ILUA	Indigenous Land Use Agreements
IPP	Indigenous Pastoral Program
IVAWS	International Violence Against Women Survey
JJT	Juvenile Justice Team
K10	Kessler Psychological Distress Scale (10 questions)
K5	Kessler Psychological Distress Scale (5 questions)
LDC	Larrakia Development Corporation

LSAY	Longitudinal Surveys of Australian Youth
LSIC	Longitudinal Study of Indigenous Children
MCATSIA	Ministerial Council for Aboriginal and Torres Strait Islander Affairs
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MOU	Memorandum of Understanding
NATSIS	National Aboriginal and Torres Strait Islander Survey
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDICP	National Deaths in Custody Program
NHC	Nganampa Health Council
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NILS	National Indigenous Land Strategy
NIPC	National Indigenous Preschool Census
NNDSS	National Notifiable Diseases Surveillance System
NNTT	National Native Title Tribunal
NSSC	National Schools Statistics Collection
NSW	New South Wales
NT	Northern Territory
NTDE	Northern Territory Department of Education
OCSAR	Office of Crime Statistics and Research
OECD	Organisation for Economic Cooperation and Development
OID	Overcoming Indigenous Disadvantage
OIPC	Office of Indigenous Policy Coordination
ORAC	Office of the Registrar of Aboriginal Corporations
PISA	Program for International Student Assessment
POI	Persons of interest
Qld	Queensland

RA	Reconciliation Australia
Review	Review of Government Service Provision
RSE	Relative standard error
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDQ	Strengths and Difficulties Questionnaire
SEIFA	Socio-Economic Indexes for Areas
SF–36	Medical Outcome Short Form
SIDS	Sudden Infant Death Syndrome
STEP	Structured Training and Employment Project
STI	sexually transmitted infections
TAFE	technical and further education
Tas	Tasmania
TIMSS	Trends in International Mathematics and Science Study
Top End	northern part of the NT
UAI	universities admission index
UEWI	unlawful entry with intent
UNICEF	United Nations Children's Fund
US	United States of America
VET	vocational education and training
Vic	Victoria
WA	Western Australia
WA CHS	Western Australian Child Health Survey
WAACHS	Western Australian Aboriginal Child Health Survey
WHO	World Health Organisation
YPiCHS	Young People in Custody Health Survey

Glossary

Aboriginal — A person who identifies as being of Aboriginal origin. May also include people who identify as being of both Aboriginal and Torres Strait Islander origin.

Age standardised rates — Age standardised rates enable comparisons to be made between populations that have different age structures. Age standardisation is often used when comparing the Indigenous and non-Indigenous populations because the Indigenous population is younger than the non-Indigenous population. Outcomes for some indicators are influenced by age, therefore, it is appropriate to age standardise the data when comparing the results. When comparisons are not being made between two populations, the data are not age standardised.

CDEP — Community Development Employment Projects (CDEP) is an Australian Government funded initiative that provides activities for unemployed Indigenous people to develop work skills and move into employment. For statistical purposes the ABS classifies participants in CDEP as employed rather than as unemployed or not in the labour force. Some CDEP activities are similar to those undertaken by participants in Work for the Dole, while other activities are essential roles in municipal services, health care, community services, education and other sectors that would be considered employment in mainstream communities and organisations (see section 3.5).

Core activity limitation (ABS definition)

Self care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as follows: mild, where a person has no difficulty with self care, mobility or communication, but uses aids or equipment; moderate, where a person does not need assistance, but has difficulty with self care, mobility or communication; severe, where a person sometimes needs assistance with self care, mobility or communication; and profound, where a person is unable to perform self care, mobility and/or communication tasks, or always needs assistance (see section 3.2).

Confidence intervals

Survey data, for example data from the 2004-05 National Health Survey, are subject to sampling error because they are based on samples of the total population. Where survey data are shown in charts in this Report, error bars are included, showing 95 per cent confidence intervals. There is a 95 per cent chance that the true value of the data item lies within the interval shown by the error bars. See 'statistical significance'.

Disability (ABS definition)

A person has a disability if he or she has a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. These activities include: loss of sight (not corrected by glasses or contact lenses); or an aid to assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; blackouts, fits, or loss of consciousness; difficulty learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding things; incomplete use of feet or legs; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long-term effects of head injury, stroke or other brain damage causing restriction; receiving treatment or medication for any other long-term conditions or ailments and still restricted; or any other long-term conditions resulting in a restriction.

ICD

ICD is the International Statistical Classification of Diseases and Related Health Problems, endorsed by the World Health Organization (WHO). It is primarily designed for the classification of diseases and injuries with a formal diagnosis. ICD-10-AM is the Australian modification of the tenth revision and was adopted for Australian use for deaths registered from 1 January 1999 (superseding ICD-9).

Equivalised household income

Equivalised household income adjusts the actual incomes of households to make households of different sizes and composition comparable. It results in a measure of the economic resources available to members of a standardised household (see section 3.6).

Income ranges

See 'quintiles'.

Inner regional

See 'remoteness areas'.

Hospitalisation

Hospitalisations recorded in this Report are called 'hospital separations' in many other publications using hospital statistics. A 'separation' refers to an episode of care, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). It is also defined as the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care. For measuring a hospital's activity, separations are used in preference to admissions because diagnoses and procedures can be more accurately recorded at the end of a patient's stay and patients may undergo more than one separation from the time of admission. Admitted patients who receive same day procedures (for example, renal dialysis) are recorded in hospitalisation statistics.

Indigenous status not stated/ Indigenous status unknown

Where a person's Indigenous origin has either not been asked or not recorded.

Indigenous	A person of Aboriginal and/or Torres Strait Islander origin who identifies as an Aboriginal and/or Torres Strait Islander.
Inner regional	See 'remoteness areas'.
Jurisdiction	The Australian Government or a State or Territory Government and areas that it has legal authority over.
Labour force	The labour force is the most widely used measure of the economically active population or the formal supply of labour. It is a measure of the number of people contributing to, or willing to contribute to, the supply of labour and, as defined by the ABS, comprises two mutually exclusive categories of population: the employed (people who have worked for at least one hour in the reference week, including those who have participated in Community Development Employment Projects (CDEP)), and the unemployed (people who are without work, but are actively looking for work and available to start work within four weeks).
Major cities	See 'remoteness areas'.
Mean and median income measures	A mean income value is the average value of a set of income data. It is calculated by adding up all the values in the set of data and dividing that sum by the number of values in the dataset. Median value is the middle point of a set of income data. Lining up the values in a set of income data from largest to smallest, the one in the centre is the median income value (if the centre point lies between two numbers, the median value is the average value of the two numbers). Median value is a better measure for income than mean as mean income values are more influenced by extreme income values (including the lowest and highest incomes). Therefore, median income value is a more accurate measure of income for an average household or average individual income earner.

	For example, the gross monthly incomes for 9 households are: $10 000, $5000, $2500, $1500, $1500, $1500, $1000, $450, $450. The **mean income value** among the 9 households is ($10 000+$5 000+$2500+$1500+$1500+$1500+$1000+ $450+$450)/9=$2655.6. The **median income value** is the fifth value (the mid point), $1500.
Non-Indigenous	A person who does not identify as Aboriginal and/or Torres Strait Islander.
Non-school qualification	Non-school qualifications include vocational or higher education qualifications.
Non-remote	See 'remoteness areas'.
Outer regional	See 'remoteness areas'.
Quintiles	Income quintiles are groups that result from ranking all people in the population in ascending order (from the lowest to the highest) according to their incomes and then dividing the population into five equal groups, each comprising 20 per cent of the population.
Rate ratio	The rate ratio is the rate for the Indigenous population divided by the rate for the non-Indigenous population. See 'relative Indigenous disadvantage'.
Regional	See 'remoteness areas'.
Relative Indigenous disadvantage	Relative Indigenous disadvantage is measured by comparing the rate of Indigenous disadvantage (for example, the proportion of Indigenous people reporting they do not have a non-school qualification) with the rate for the non-Indigenous population. See 'rate ratio'.

Relative standard error (RSE) The relative standard error (RSE) of a survey data estimate is a measure of the reliability of an estimate and depends on both the number of people giving a particular answer in the survey and the size of the population. The RSE is expressed as a percentage of the estimate. The higher the RSE, the less reliable the estimate. Relative standard errors for survey estimates are included in the attachment tables. See also 'statistical significance'.

Remote See 'remoteness areas'.

Remoteness See 'remoteness areas'.

Remoteness areas Remoteness areas are defined in the Australian Standard Geographical Classification (ASGC) developed by the ABS. The ASGC remoteness classification identifies a place in Australia as having a particular degree of remoteness. The remoteness of each place is determined using the Accessibility/Remoteness Index of Australia (ARIA). The ABS generates an average ARIA score for each location based on its distance from population centres of various sizes. Locations are then added together to form the remoteness areas in each State and Territory. Remoteness areas comprise the following six categories:

- major cities of Australia
- inner regional Australia
- outer regional Australia
- remote Australia
- very remote Australia
- migratory regions (comprising off-shore, shipping and migratory places).

The aim of the ASGC remoteness structure is not to provide a measure of the remoteness of a particular location but to divide Australia into five broad categories (excluding migratory regions) of remoteness for comparative statistical purposes. A map of Australia showing geographic areas according to each of the five remoteness categories is included in section 11.3.

Statistical significance

Statistical significance is a measure of the degree of difference between survey data estimates. The potential for sampling error — that is, the error that occurs by chance because the data are obtained from only a sample and not the entire population — means that reported responses may not indicate the true responses.

Using the relative standard errors (RSE) of survey data estimates, it is possible to use a formula to test whether the difference is statistically significant. If there is an overlap between confidence intervals for different data items, it cannot be stated for certain that there is a statistically significant difference between the results. See 'confidence intervals' and 'relative standard error'.

Torres Strait Islander people

People who identify as being of Torres Strait Islander origin. May also include people who identify as being of both Torres Strait Islander and Aboriginal origin.

Universities Admissions Index (UAI)

Eligibility for admission to a public university in Australia on the basis of merit is determined in each State and Territory through the use of a score — the UAI. Calculating the UAI varies between each State and Territory.

Very remote

See 'remoteness areas'.

Terms of reference

PRIME MINISTER

CANBERRA

3 MAY 2002

Mr Gary Banks
Chairman
Steering Committee for the
Review of Commonwealth/State Service Provision
C/- Productivity Commission
Locked Bag 2
Collins Street East Post Office
MELBOURNE VIC 8003

Dear Mr Banks

I am writing in my capacity as Chairman of the Council of Australian Governments (COAG). As you would be aware, COAG met on 5 April 2002 and agreed to undertake further work to advance reconciliation. A copy of the communiqué from the recent COAG meeting is attached for your information.

COAG agreed to commission the Steering Committee for the Review of Commonwealth/State Service Provision (SCRCSSP) to produce a regular report to COAG against key indicators of indigenous disadvantage. The key task will be to identify indicators that are of relevance to all governments and indigenous stakeholders and that can demonstrate the impact of programme and policy interventions.

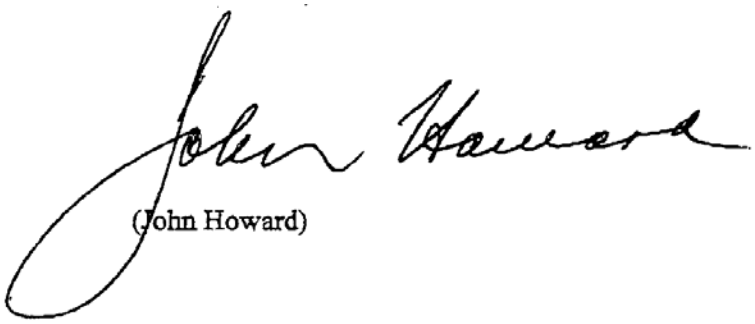
The development of the indicators will be progressed in the first instance through discussions at officials level between COAG, the Ministerial Council for Aboriginal and Torres Strait Islander Affairs (MCATSIA) and the SCRCSSP. I understand that the SCRCSSP proposed at its recent meeting to progress this matter through a working group that will include representatives of the COAG senior officials working group on reconciliation and MCATSIA officials. Such an approach is consistent with the COAG decision.

In May 1997, I wrote to your predecessor, Mr Bill Scales, requesting that the SCRCSSP give particular attention to improving indigenous data. The development of the new COAG reconciliation report should not reduce the emphasis on indigenous data that is now a feature of the annual *Report on Government Services.* This emphasis has helped ensure that indigenous data in mainstream and targeted programmes are as comprehensive and comparable as possible.

I would appreciate further advice from you when the SCRCSSP has completed its work in developing a proposal for the report against indicators of indigenous disadvantage so that COAG members may consider the detail of the proposed approach.

I have copied this letter to the Chairman of MCATSIA and New South Wales Minister for Aboriginal Affairs, the Hon Dr Andrew Refshauge, and to the Minister for Immigration and Multicultural and Indigenous Affairs, the Hon Philip Ruddock MP.

Yours sincerely



(John Howard)

Overview

This is the third Overcoming Indigenous Disadvantage report, prepared at the request of the Council of Australian Governments (COAG). It provides indicators of Indigenous disadvantage, with a focus on areas where governments can make a difference. It contains information on the current level of disadvantage, and where possible, how that disadvantage has changed over time. And importantly, it acts as a driver for positive change by identifying key areas for action.

Across virtually all the indicators in this Report, wide gaps remain in outcomes between Indigenous and non-Indigenous Australians. Despite Australia's world class health system, the life expectancy of Indigenous people is estimated to be around 17 years lower than that for the total Australian population. Despite compulsory education, Indigenous students at all levels experience much worse outcomes than non-Indigenous students. And Indigenous people are significantly over-represented in the criminal justice system, as both victims and offenders.

Although these outcomes are disturbing, the challenge is not impossible. Indigenous people make up just over 2 per cent of the Australian population (although they are widely dispersed across the country). Concerted action by governments, by Indigenous people and by business and the community, can make a difference.

This Report is part of a commitment by all governments in Australia to tackle the problems that lead to Indigenous disadvantage. The Report's framework is like a map — the priority outcomes identify the destination, while the indicators are like staging posts along the way, highlighting key areas for attention, showing how much progress has been made, and how far we still have to go.

The Report has three parts:

- this Overview, which summarises the Report's key messages
- the main Report, which provides more detailed information and the evidence base supporting the Report's framework and choice of indicators
- the attachment tables (published on the Review website), which include all the data used in the Report.

Throughout this Report, the term 'Indigenous' is used to refer to people who have identified themselves as Aboriginal or Torres Strait Islander. Although the

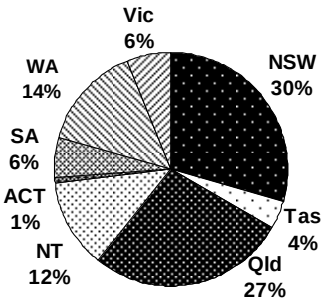
situations of Aboriginal people and Torres Strait Islander people can sometimes be very different, the relatively small numbers of Torres Strait Islander people make it extremely difficult to report separately about their experiences. Available data on Torres Strait Islander people are summarised in the section 'Outcomes for Torres Strait Islander people'.

How many people?

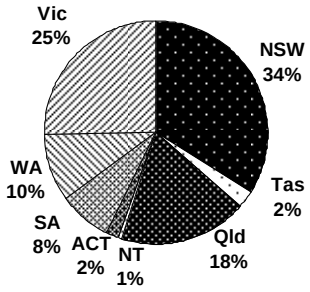
In the 2001 Census (data from the 2006 Census were not available for this Report), 410 000 Australians identified themselves as Indigenous, out of a total population of nearly 19 million people (equating to 2.2 per cent of the Australian population). Of these, 366 000 (89.4 per cent) identified as Aboriginal, 26 000 (6.4 per cent) as Torres Strait Islander and 17 500 (4.3 per cent) as both. A higher proportion of both Indigenous and non-Indigenous populations lived in NSW than other states (30 per cent and 34 per cent respectively). Relatively high proportions of the Indigenous population also lived in Queensland, WA and the NT.

Proportion of the population in each State and Territory, 2001

Indigenous



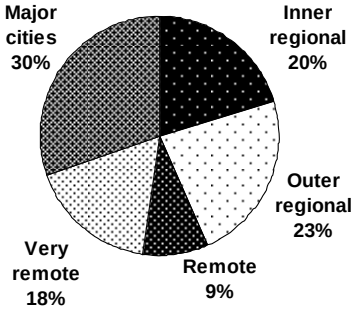
Non-Indigenous



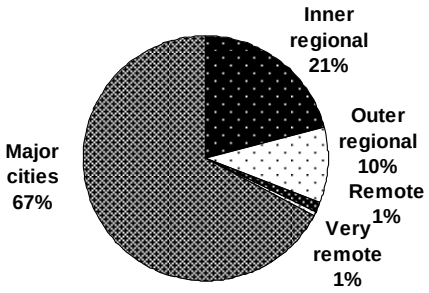
In 2001, 30 per cent of Indigenous people lived in major cities, and 20 and 23 per cent lived in inner and outer regional areas, respectively. Nine per cent lived in remote areas and 18 per cent in very remote areas. Nearly 90 per cent of non-Indigenous people lived in major cities or inner regional areas.

Proportion of the population in each remoteness area, 2001

Indigenous



Non-Indigenous



Source: Figures A3.2 and A3.3. See appendix 3 of the main Report for more information.

Has anything changed?

For this Report, up to ten years data are available for some indicators (although there are no trend data at all for other indicators). The first *Overcoming Indigenous Disadvantage* report was released in November 2003. Given the relatively short time since the first Report, and delays in data collection, data in this Report may not reflect outcomes from more recent government actions. Future editions of this Report will be better placed to measure progress on some indicators — particularly when data from the 2006 Census become available.

There have been improvements in some indicators, although in some cases outcomes for non-Indigenous people have also improved, meaning a gap in outcomes persists. The clearest improvements have come in some of the economic indicators. From 1994 to 2004-05, there were large falls in the unemployment rate for Indigenous women and men (although these unemployment rates are influenced by participation in the Community Development Employment Projects (CDEP) program). Over the same period, the proportion of Indigenous adults living in homes owned or being purchased by a member of the household increased, and the proportion of Indigenous adults with a qualification of certificate level 3 or above increased from 8 per cent to 21 per cent. From 2002 to 2004-05, median (mid point) incomes for Indigenous people rose 10 per cent.

There have been increases in native title determinations (from almost 5 per cent of the total area of Australia in 2004 to over 8 per cent in 2006) and in land subject to registered Indigenous Land Use Agreements (from 2 per cent of the total area of Australia in 2003 to over 10 per cent in 2006). However, the proportion of Indigenous adults living in non-remote areas who did not recognise an area as their homelands increased between 1994 and 2004-05.

There have been improvements in child health, perhaps reflecting an emphasis on early intervention. Infant mortality rates have improved in recent years (but are still two to three times as high as for the total population of infants), and hospitalisation rates for 0–14 year olds decreased for a range of diseases associated with poor environmental health.

Other outcomes for children have not improved in the period covered by the Report. The proportion of low birthweight babies born to Indigenous mothers did not change between 1998–2000 and 2002–2004, and there was no change in the prevalence of hearing problems among Indigenous children between 2001 and 2004-05. From 1999-2000 to 2005-06, the rates of substantiated notifications for child abuse or neglect and children on care and protection orders increased for both Indigenous and non-Indigenous children.

Other health outcomes deteriorated. From 2001 to 2004-05, there was an increase in the number of long term health conditions for which Indigenous people reported significantly higher rates than non-Indigenous people. The Indigenous rate for kidney disease was 5 times as high as the non-Indigenous rate in 2001 — in 2004-05 it was 10 times as high. Between 2001-02 and 2004-05, older Indigenous people (65 years and over) had increased hospitalisation rates for diseases associated with poor environmental health. Better reporting or improved access to health care may have contributed to these trends, but the negative outcomes are concerning.

Many environmental and behavioural risk factors that contribute to poor health outcomes have not improved. There was no change in the rate of housing overcrowding between 2002 and 2004-05. There was little change in reported 'risky to high risk' alcohol consumption by Indigenous men between 1995 and 2004-05, and the reported rate increased for Indigenous women. Over the same period, the reported rate of smoking among Indigenous women and men remained constant, and the proportion of Indigenous people engaging in moderate or high levels of exercise decreased.

Indigenous people's involvement with the criminal justice system continued to deteriorate. Between 2002 and 2006, the imprisonment rate for Indigenous women increased by 34 per cent and the imprisonment rate for Indigenous men increased by over 20 per cent. The difference between the Indigenous and non-Indigenous juvenile detention rates increased between 2001 and 2005.

Consultations and developments in reporting

The Overcoming Indigenous Disadvantage Report has evolved over time. Each edition has been informed by feedback received during consultations, and by new evidence and data.

Extensive consultations were held in 2006, seeking feedback on the 2005 Report and suggestions for improvements to the framework and indicators. A consultation team visited Indigenous communities and Indigenous organisations across the country, in a range of remote and regional centres, as well as major cities. The team also met with representatives of all governments, and many expert bodies.

Some common themes were evident in the consultations:

- Most fundamentally, there was broad support for the Report — Indigenous people generally considered that the indicators reflected the issues affecting their communities and causing disadvantage.

- The identification of 'things that work' was seen as very useful, and participants supported identification of the 'success factors' behind the 'things that work'.
- Cultural issues were regarded as significant to the wellbeing of Indigenous Australians, but there was general acceptance of the difficulty of developing additional indicators.
- There was a general view that improving governance remains critically important at organisational, community and government levels.

Following the consultations, several improvements were made for this Report:

- Two new indicators have been included in the 'Functional and resilient families and communities' strategic area for action:
  - 'Mental health' — mental health and wellbeing and the prevalence of mental disorders are important factors in Indigenous health
  - 'Engagement with service delivery' — removing barriers to service access is critical to reducing disadvantage for Indigenous families and communities.
- 'Access to the nearest health professional' has been renamed 'Access to primary health care' to provide a broader measure of access to health services.
- 'Things that work' examples have been expanded, and 'success factors' behind the 'things that work' have been identified.
- The governance case studies now include an additional key determinant 'resources' and a discussion of 'government governance'.

Consultation responses on culture

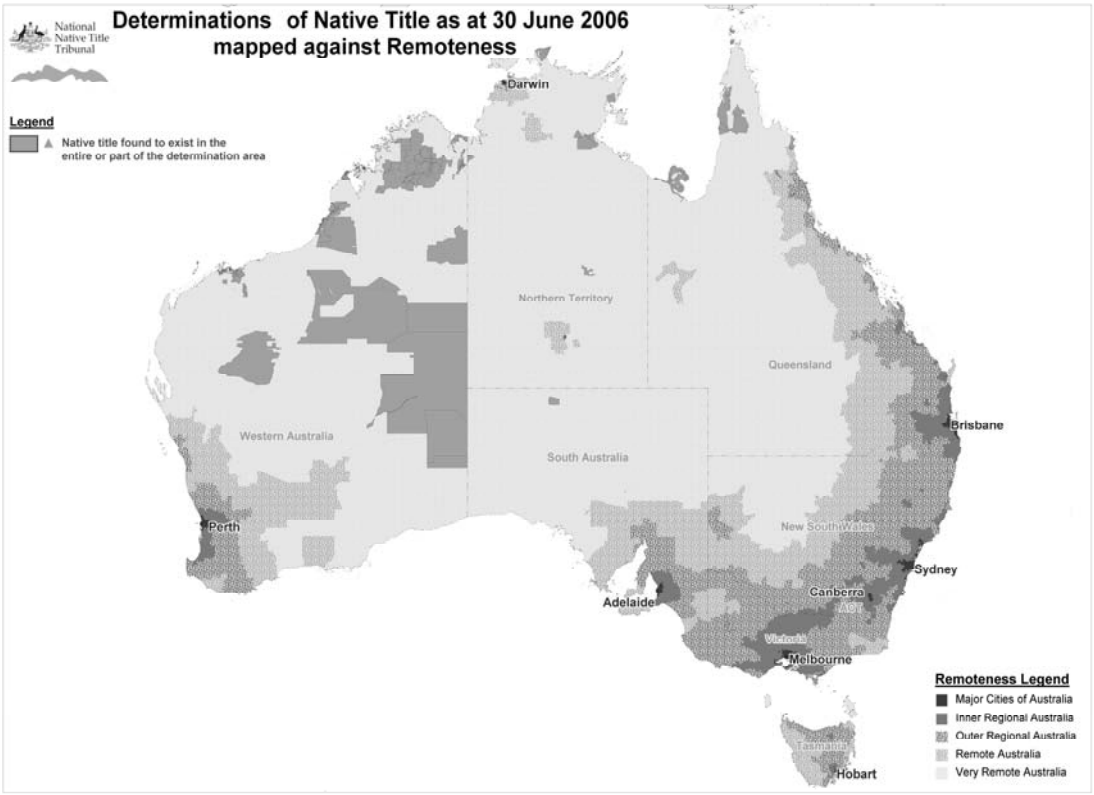
Culture plays a significant role in Indigenous wellbeing, and must be recognised in actions intended to overcome Indigenous disadvantage. This is clearly shown in the 'success factors' identified for the 'things that work' and the key determinants of successful governance arrangements (both discussed below).

Most Indigenous people who took part in the consultations, while encouraging development of additional indicators of 'culture', strongly supported the indicators in the 2005 Report that touched on cultural issues:

- Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies
- Indigenous people with access to their traditional lands (including determinations of native title)
- participation in organised sport, arts or community group activities

- Indigenous owned or controlled land
- case studies in governance arrangements.

Native Title determinations



Source: NNTT (unpublished); table 11A.3.8.

The consultations raised three areas for possible new cultural indicators: language; heritage; and Indigenous culture and law. Each of these areas was regarded as important, but there was no agreement on specific indicators. Some of the 'things that work' in the Report provide examples of these aspects of culture, and continuing research will be undertaken for future reports.

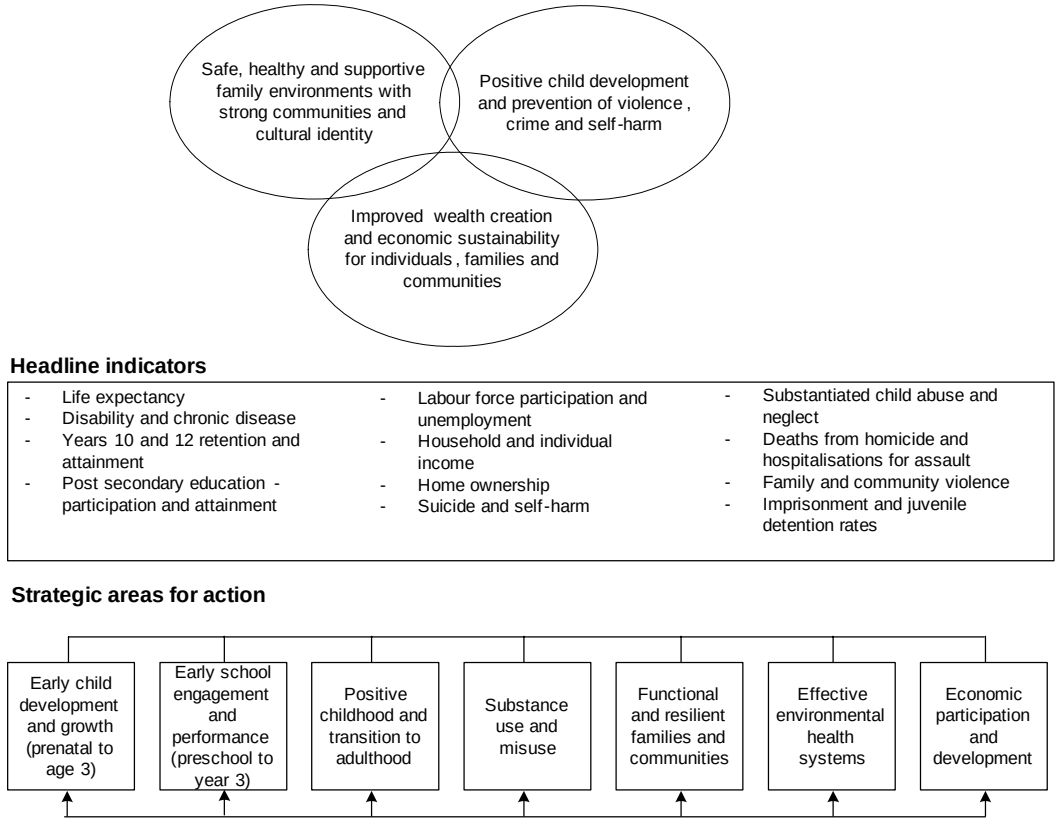
Reporting on 'wellbeing' is related to reporting on culture. Many Indigenous people expressed the view that, although the measures in the Report are important, they do not show the whole picture of Indigenous wellbeing. This partly reflects the terms of reference for this Report — to report on overcoming disadvantage. This requires a different approach to reporting on wellbeing, because wellbeing involves more than just the absence of disadvantage. Although this is not a 'wellbeing' report, it does include some relevant information, including self-reported feelings of happiness, and the stressors experienced by Indigenous people (in the sections on mental health and housing overcrowding). In addition, the section on engagement

with service delivery reports on barriers to accessing services, including cultural barriers. Future Reports may be able to report more 'wellbeing' information, drawing on work by the ABS on measuring Indigenous social and emotional wellbeing.

The reporting framework

The reporting framework is described in detail in the main Report. At the top, three priority outcomes reflect a vision for how life should be for Indigenous people, endorsed by governments and Indigenous people. These outcomes are linked and should not be viewed in isolation — they all need to be pursued in order to overcome Indigenous disadvantage. But how can progress toward achieving such broad outcomes be measured?

The framework



Governments and Indigenous people have endorsed a set of headline indicators that are closely linked to the priority outcomes. Improvements in these indicators would provide strong evidence of progress toward the priority outcomes. However, many of the headline indicators (such as life expectancy) are long term measures that are not expected to change rapidly. This raises the question, how can shorter term progress toward achieving the headline indicators be measured?

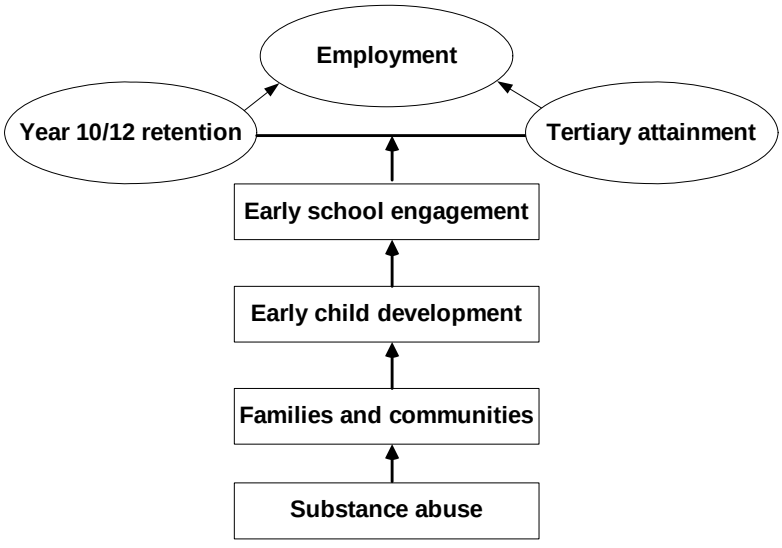
Sitting beneath the priority outcomes and headline indicators are seven 'strategic areas for action'. Research shows that focusing efforts in these areas can make a difference in the shorter term. Each strategic area for action is linked to a set of strategic change indicators. These indicators are designed to show whether actions are making a difference, and to identify areas where more attention is needed.

The logic behind the framework is that improvements in the strategic areas for action (measured by the strategic change indicators) will, in time, lead to improvements in the headline indicators. Improvements in the headline indicators will show progress toward the priority outcomes.

The elements of the framework are highly inter-related. Actions across a range of areas might be required to improve a single indicator. But in other cases, a single, well-targeted action can lead to improvements in many indicators.

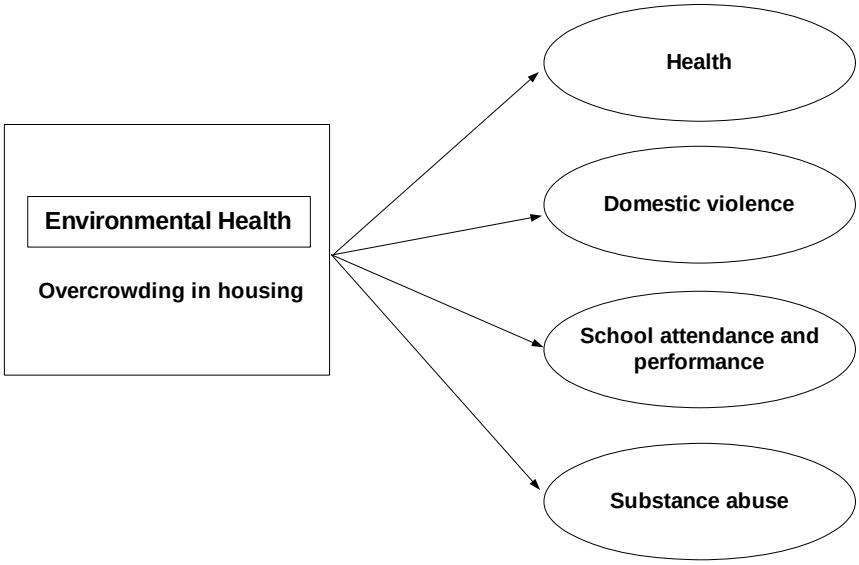
Disadvantage can have multiple causes

Employment is influenced by years 10 and 12 retention and tertiary attainment. These in turn are influenced by school engagement and early child development. Environmental factors such as substance abuse and families and communities affect all these outcomes, as do the inter-generational effects of parental income, employment and education levels.



But some actions can have multiple effects

Targeted actions can lead to improvements across a range of indicators. Reducing overcrowding in housing can contribute to improvements in health, school attendance and performance, substance abuse and family and community violence.



Things that work

Not everything that matters can be captured in broad indicators. Changes occurring at a community level may not show up in state or national data, and some information is better presented in words, rather than numbers. The main body of this Report includes many case studies of 'things that work' — examples of activities that are making a difference at the community level. This Overview summarises the case studies in the discussion of each headline indicator or strategic area for action.

These examples of positive outcomes may help to balance negative perceptions of Indigenous issues, and demonstrate to both Indigenous communities and governments what might be successful elsewhere. They also illustrate the factors that contribute to successful programs. Analysis of the 'things that work', together with wide consultation with governments and Indigenous people, identified the following 'success factors':

- cooperative approaches between Indigenous people and government (and the private sector)
- community involvement in program design and decision-making — a 'bottom-up' rather than 'top-down' approach
- good governance

- on-going government support (including human, financial and physical resources).

Many of those consulted felt that the lack of these factors often contributed to program failures.

Where possible, broader programs demonstrating sustained success have been reported. However, programs that are successful in individual communities or for short periods are frequently only funded as pilot projects. Even when evaluated as successful, such programs are not always continued or expanded. The need for greater sustainability of successful programs was a common theme in consultations.

Headline indicators

HEADLINE INDICATORS

- Life expectancy at birth
- Disability and chronic disease
- Years 10 and 12 retention and attainment
- Post secondary education — participation and attainment
- Labour force participation and unemployment
- Household and individual income
- Home ownership
- Suicide and self-harm
- Substantiated child abuse and neglect
- Deaths from homicide and hospitalisations for assault
- Family and community violence
- Imprisonment and juvenile detention rates

The first part of the Report focuses on the twelve headline indicators. These are measures of the major social and economic outcomes that need to improve, if the vision of an Australia in which Indigenous people enjoy the same opportunities and standard of living as other Australians is to be achieved.

Each headline indicator is discussed in turn. Key messages arising out of the data and 'things that work' in each area are presented, with references to relevant sections of the main Report.

Life expectancy at birth

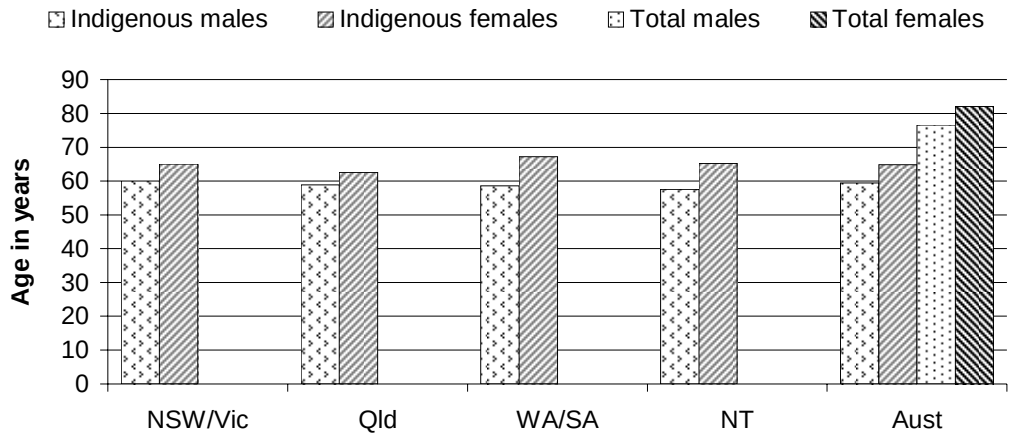
Life expectancy is an indicator of the long-term health and wellbeing of a population. This indicator refers to the average number of years a person could expect to live if there was no change to the population's death rates throughout his or her lifetime. Improvements in outcomes across all of the strategic areas for action have the potential to affect Indigenous life expectancy.

Box 1.1 **KEY MESSAGES**

- The life expectancy of Indigenous people is estimated to be around 17 years lower than that for the total Australian population (figure 3.1.1).
- The most recent estimates indicate that life expectancy at birth is 59 years for Indigenous males compared with 77 years for males in the total population, and 65 years for Indigenous females compared with 82 years for females in the total population (figure 3.1.1).
- In 2005, death rates in all age groups were higher for Indigenous people than for non-Indigenous people. The greatest differences were for those aged between 35 and 54, where Indigenous death rates were five to six times those for non-Indigenous people (table 3.1.2).

Life expectancy can be affected by levels of income and education, and access to effective and appropriate health care. Environmental factors, such as lack of clean drinking water or adequate sanitation, can accentuate health risks, particularly for babies and young children. Lifestyle factors such as consumption of tobacco and excessive alcohol, poor nutrition and lack of exercise can contribute to high levels of chronic disease and lower life expectancy.

Life expectancy at birth, Indigenous 1996–2001, total population 1998-2000



Source: ABS (2004b); table 3A.1.1.

Disability and chronic disease

Box 1.2 **KEY MESSAGES**

- In non-remote areas in 2002, Indigenous adults were twice as likely to report a disability resulting in a profound or severe core activity limitation as non-Indigenous adults.
- From 2001 to 2004-05, there was an increase in the number of long term health conditions for which Indigenous people reported higher rates than non-Indigenous people. In 2001, Indigenous people reported higher rates of asthma, diabetes/high sugar levels and kidney disease than non-Indigenous people. In 2004-05, Indigenous people also reported higher rates of arthritis, back pain/problems and heart and circulatory diseases (figure 3.2.1 and table 3A.2.1).
- In 2004-05, the greatest difference between Indigenous and non-Indigenous rates was for kidney disease, where the Indigenous rate was 10 times as high as the non-Indigenous rate. This gap is widening — in 2001 the Indigenous rate was 5 times as high as the non-Indigenous rate (table 3A.2.1).
- In 2004-05, Indigenous people were three times as likely as non-Indigenous people to have diabetes (figure 3.2.1). There was no improvement in the reported incidence of diabetes among Indigenous people between 2001 and 2004-05 (table 3A.2.1).

Rates of disability and chronic disease have a bearing on, and reflect, the wellbeing of Indigenous people. In addition to serious illness, Indigenous people have high exposure to a range of other 'personal stressors' that may contribute to the development of long term health conditions.

Around 36 per cent of the Indigenous population aged 15 years or over reported a disability or long term health condition in 2002. After taking into account the different age structures of the populations, 21 per cent of Indigenous people aged 18 years and over in non-remote areas reported a disability resulting in core activity limitation. This was almost twice as high as that reported by non-Indigenous people.

As no new data on disability have become available since the 2005 Report, this Report compares rates of selected long term health conditions (that may cause disability) among Indigenous and non-Indigenous people. More information on chronic diseases in the Indigenous population can be found in the 'Access to primary health care' strategic indicator.

Box 1.3 **Things that work**

Disease prevention programs for Indigenous people in NSW include:

- the Aboriginal Vascular Health Program, which applies general disease management approaches for a number of preventable vascular diseases (box 3.2.2)
- a partnership between Justice Health, NSW Aboriginal Community Controlled Health Services and Area Health Services, which provides health care services and disease prevention programs for Indigenous people in custody (box 3.2.2).

Years 10 and 12 retention and attainment

Students who stay on at school and complete year 12 are much more likely to undertake additional education and training. In turn, they will have more, and better, employment options.

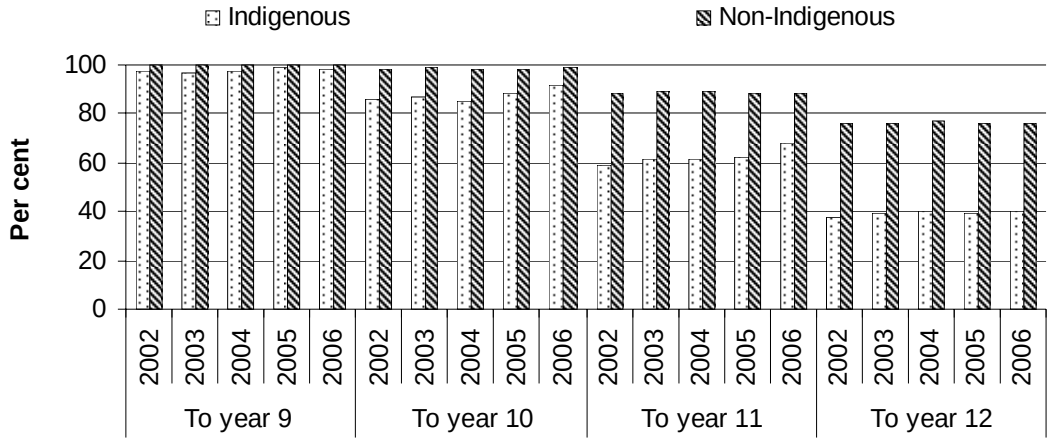
In the long term, people who have completed secondary or post secondary education are more likely to encourage their children to do the same, so that the benefits flow from one generation to another.

Box 1.4 **KEY MESSAGES**

- In 2006, 21 per cent of 15 year old Indigenous people were not participating in school education. Only 5 percent of non-Indigenous 15 year olds were not participating in school education (table 3A.3.2).
- In 2006, Indigenous students were half as likely as non-Indigenous students to continue to year 12 (figure 3.3.4).
- In 2004-05, a smaller proportion (22 per cent) of Indigenous people than non-Indigenous people (47 per cent) had completed year 12 (table 3A.3.18).
- The proportion of Indigenous students who achieved a year 12 certificate (after being enrolled in year 11 the previous year) changed little between 2001 and 2005 (tables 3A.3.11–15).

There has been success in increasing retention rates for Indigenous students in some schools where specific programs have been introduced. Greater recognition of Indigenous culture can help give students the skills and knowledge they need to 'walk in two worlds'.

Apparent retention rates of full time secondary school students, all schools



Source: ABS 2007 (unpublished); table 3A.3.1.

Box 1.5 **Things that work**

- *Deadly Vibe*, a magazine for Indigenous students published by Vibe Australia (an Aboriginal media agency) with funding from the Australian Government, encourages Indigenous students to stay at school (box 3.3.2).
- The Cape York Institute's Higher Expectations Program and St Joseph's Indigenous fund are examples of successful non-government sector sponsorship of scholarship programs for children to board at private schools (box 3.3.2).
- The Clontarf Foundation in WA engages and supports young Indigenous men to complete year 12 and then provides assistance to find employment. The Foundation establishes Football Academies in partnership with mainstream schools (box 3.3.2).
- Where on-site secondary education is unavailable in the NT, the Northern Territory Open Education Centre is working closely with small remote schools to support students undertaking secondary school subjects (box 3.3.2).

Post secondary education — participation and attainment

People who have participated in post secondary study have greatly improved employment prospects. They are also more likely to earn higher incomes. An individual's education can also affect their health, and the health of their children, as well as their ability to make informed life decisions.

Positive outcomes in virtually all of the strategic areas for action could contribute to better educational achievement.

Box 1.6 **KEY MESSAGES**

- Although not strictly comparable, between 1994 and 2004-05, the proportion of Indigenous people participating in post secondary education increased from 5 per cent to 11 per cent (table 3A.4.2).
- The proportion of Indigenous people with a qualification of certificate level 3 or above increased from 8 per cent in 1994 to 21 per cent in 2004-05 (figure 3.4.3).
- In 2004-05, non-Indigenous people were more than twice as likely as Indigenous people to have completed a post secondary qualification of certificate level 3 or above (table 3A.4.10).
- Higher education success rates (between 2001 and 2004) and TAFE pass rates (between 2002 and 2005) increased for Indigenous students (figures 3.4.4 and 3.4.5).

Box 1.7 **Things that work**

- The Australian Master Bricklayers Association and the Victorian Department of Education are working in partnership to provide construction skills and work readiness training to unemployed Indigenous people in Robinvale (box 3.4.2).
- A training culture in many Queensland prisons has contributed to a decrease in the probability of Indigenous offenders returning to custody (box 3.4.2).
- A program developed in 2004 in partnership between the Construction Forestry Mining and Energy Union and TAFE NSW is assisting unemployed Indigenous people interested in working in the building and construction industry (box 3.4.2).

Labour force participation and unemployment

Having a job that pays adequately and provides opportunities for self development is important to most people.

Employment is important to living standards, self-esteem and overall wellbeing. It is also important to the family. Children who have a parent who is employed are more likely to attend school and stay on past the compulsory school age. They are also more likely to enter into post secondary education and gain employment.

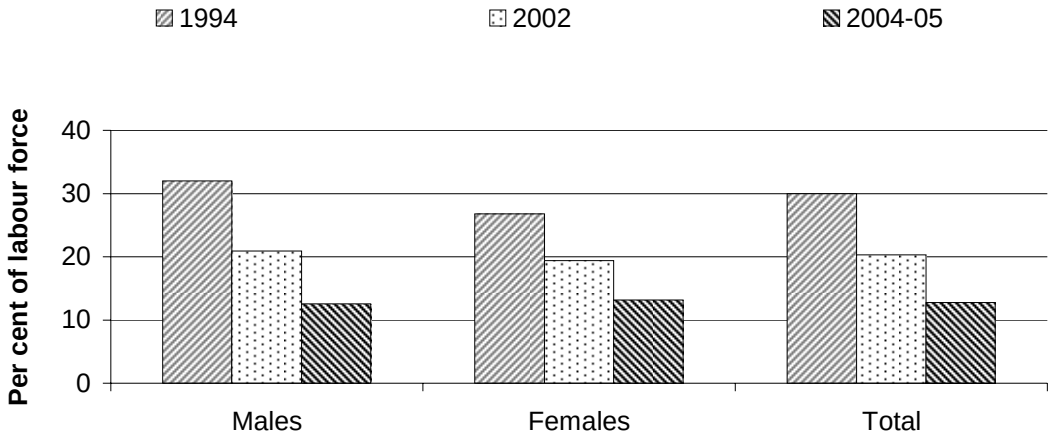
Unemployment can have a major impact on a number of areas covered in this Report, including poor health and mortality, domestic violence, homelessness and substance misuse.

The labour force participation rate will, to some extent, reflect the limited employment opportunities available to Indigenous people in remote areas, along with the employment opportunities provided by CDEP. Information in this section does not reflect recent changes made to the CDEP program.

Box 1.8 **KEY MESSAGES**

- In 2004-05, after adjusting for age differences:
  - the labour force participation rate for Indigenous people (58.5 per cent) was about three quarters of that for non-Indigenous people (78.1 per cent) (figure 3.5.3)
  - the unemployment rate for Indigenous people (13 per cent) was about 3 times the rate for non-Indigenous people (4 per cent) (figure 3.5.6).
- From 1994 to 2004-05:
  - the participation rate for Indigenous women increased from 42 per cent to 53 per cent. The rate for Indigenous men was constant (figure 3.5.5)
  - the Indigenous unemployment rate fell from 30 per cent to 13 per cent. The unemployment rate fell for both women and men (figure 3.5.9)
  - CDEP participation rates remained stable (figure 3.5.2). CDEP participation significantly reduces recorded Indigenous unemployment rates and increases recorded labour force participation rates, particularly in remote areas.

Indigenous unemployment rate, people aged 18 to 64 years



Source: ABS 2004-05 NATSIHS and NHS, 1994 NATSIS, and 2002 GSS and NATSISS (unpublished); table 3A.5.3.

Household and individual income

The economic wellbeing of individuals is largely determined by their income and wealth. Differences in household and individual income between Indigenous and non-Indigenous people are important indicators of differences in material wealth.

Box 1.9 **KEY MESSAGES**

- For the period 2002 to 2004-05, after adjusting for inflation, median (mid point) gross weekly equivalised household income for Indigenous people rose by 10 per cent (from $308 to $340). This compares to $618 for non-Indigenous households in 2004-05 (figure 3.6.2).
- In 2004-05, over half of Indigenous people (52 per cent) received most of their individual income from government pensions and allowances, followed by salaries and wages (34 per cent) and CDEP (10 per cent) (figure 3.6.6).

Income is linked to overall wellbeing. Higher income can enable the purchase of better food, housing, recreation and health care. There may also be psychological benefits such as a greater sense of personal control and self-esteem. Low income can be both a cause and an effect of disadvantage — for example, low income can contribute to health problems, which in turn limit people's ability to work and increase their incomes.

Home ownership

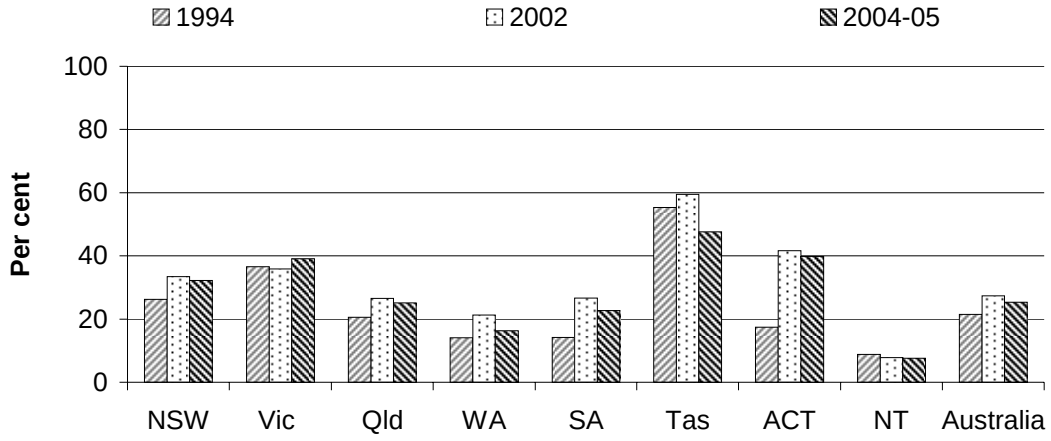
Box 1.10 **KEY MESSAGES**

- The proportion of Indigenous adults living in homes owned or being purchased by a member of the household increased from 22 per cent in 1994 to 25 per cent in 2004-05 (figure 3.7.1).
- In 2004-05, the proportion of Indigenous adults living in homes owned or being purchased by a member of the household in remote (18 per cent) and very remote (3 per cent) areas was much lower than in major cities (29 per cent) and inner and outer regional areas (39 and 32 per cent, respectively) (figure 3.7.2).
- In 2002, the most recent year for which both Indigenous and non-Indigenous data are available, a much lower proportion of Indigenous adults (27 per cent) than non-Indigenous adults (74 per cent) lived in homes owned or being purchased by a member of the household (table 3A.7.2).

Home ownership is an important economic indicator of wealth and saving, and is positively related to employment and income indicators. Home ownership provides a secure asset base that can contribute to financial stability and against which people can borrow.

During consultations for this Report, many Indigenous people said that home ownership was an important part of improving Indigenous wellbeing. Others suggested that not all Indigenous people want to own their own homes, and that those in more remote areas and living more traditional lifestyles may prefer a more communal form of ownership. Information on communally owned land is reported in the section on 'Indigenous owned and controlled land'.

Indigenous people aged 18 years and over living in homes someone in their household owned or was purchasing



Source: ABS 1994 NATSIS, 2002 NATSISS and 2004-05 NATSIHS (unpublished); tables 3A.7.1 and 3A.7.2.

Box 1.11 **Things that work**

- An Indigenous home ownership program, now known as IBA Homes, was established in 1975. It has helped more than 12 000 Indigenous families buy their own homes (box 3.7.2).
- In South Australia, HomeStart Finance introduced Nunga Home Loans in March 2004. Almost 300 applicants have purchased homes with a Nunga Loan (box 3.7.2).
- The Tasmanian Government provides funding to the Tasmanian Aboriginal Centre to assist Aboriginal and Torres Strait Islander first home buyers with the payment of stamp duties (box 3.7.2).

Suicide and self-harm

Suicide and self-harm cause great grief in many Indigenous communities. Suicide rates are higher for Indigenous people than other Australians, and particularly for those aged 25 to 34.

Box 1.12 **KEY MESSAGES**

- Suicide death rates were higher for Indigenous people (between 19 and 45 per 100 000 population) than non-Indigenous people (between 11 and 16 per 100 000 population) in Queensland, WA, SA and the NT for 2001 to 2005 (figure 3.8.1).
- In 2004-05, after adjusting for age differences, three in every 1000 Indigenous people were hospitalised for non-fatal intentional self-harm, compared with two per 1000 non-Indigenous people (table 3.8.1). There were no significant trends between 2001-02 and 2004-05 (figure 3.8.4).

Indigenous suicide is influenced by a complex set of factors. There are significant differences in suicidal behaviour not only between Indigenous and non-Indigenous populations, but also between different Indigenous communities. Suicide is often impulsive, and may be preceded by interpersonal conflicts. But suicide frequently occurs in communities that have experienced similar losses in the past, and where 'lifestyles of risk' are common.

Research suggests that Indigenous suicide and self-harm are most common among young men (although suicide attempts seem to be more common for Indigenous women). Suicide and self-harm are generally associated with disadvantage such as unemployment and low levels of education. Other factors include interpersonal conflicts and alcohol and substance misuse (although only 15 per cent of Indigenous people report consuming alcohol at a risky level). Other factors are incarceration, violence and family breakdown. Anxiety and depression are major contributors, particularly among young Indigenous people.

Box 1.13 **Things that work**

- The Yarrabah Family Life Promotion program in Queensland, established in 1995, has developed a successful set of strategies for suicide prevention, intervention, aftercare and life promotion (box 3.8.2).

Substantiated child abuse and neglect

Many Indigenous families and communities live under severe social strain, caused by a range of social and economic factors. Alcohol and substance misuse, and overcrowded living conditions are just some of the factors that can contribute to child abuse and violence.

This indicator provides some indication of the extent of abuse, neglect and/or harm to children in the family environment. However, the substantiation data refer only to those matters which have been notified and investigated. No credible data exist on actual levels of abuse.

Box 1.14 **KEY MESSAGES**

- From 1999-2000 to 2005-06, for both Indigenous and non-Indigenous children, the rate of substantiated notifications for child abuse or neglect increased (figure 3.9.1).
- In 2005-06, Indigenous children were nearly four times as likely as other children to be the subject of a substantiation of abuse or neglect (table 3A.9.1).

Deaths from homicide and hospitalisations for assault

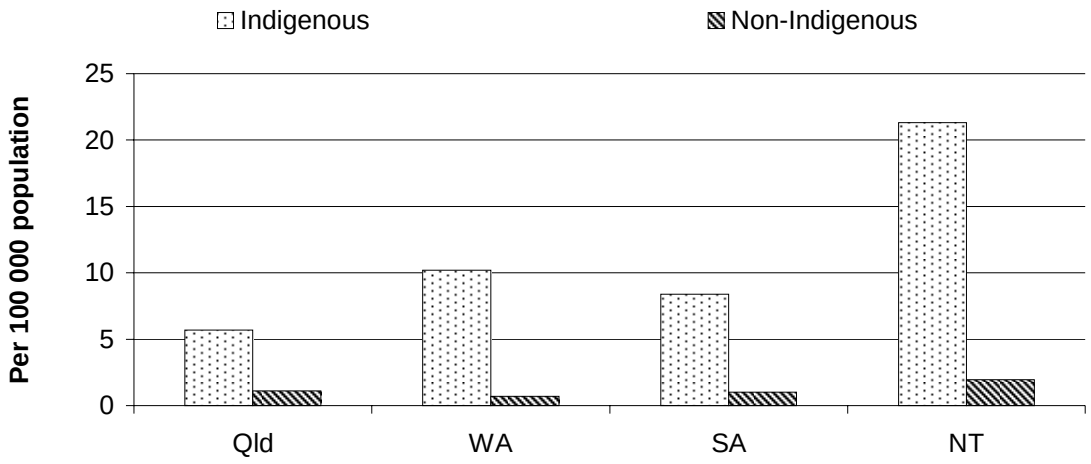
Box 1.15 **KEY MESSAGES**

- Homicide makes up a very small proportion of total deaths but can indicate broader levels of family and community violence. There were 37 Indigenous homicide victims in Australia in 2004-05 (table 3A.10.5).
- Of 245 homicides in Australia in 2004-05, Indigenous people accounted for 15 per cent of homicide victims and 16 per cent of homicide offenders (table 3A.10.6).
- After adjusting for age differences, the homicide rate in the Indigenous population was 5 to 15 times the rate in the non-Indigenous population in Queensland, WA, SA and the NT, between 2001 and 2005 (figure 3.10.1).
- From 1999-2000 to 2004-05, the rate of Indigenous homicides in remote, outer regional and very remote areas (13 to 17 per 100 000 population) was around three times the rate in major cities and inner regional areas (5 per 100 000). Indigenous homicide rates were higher than non-Indigenous rates in all remoteness areas (figure 3.10.6).
- In 2004-05, in the four jurisdictions for which data are available, Indigenous people were hospitalised for assault at 17 times the rate of non-Indigenous people. Indigenous females were 44 times as likely to be hospitalised for assault as non-Indigenous females (figure 3.10.1 and table 3A.10.12).

Indigenous people are over-represented in all forms of violent crime in Australia, as both victims and offenders. The impact of homicide and hospitalisations for assault extends beyond the offender and immediate victim. Families and communities are severely affected, and the impact may be felt from one generation to another.

Indigenous homicides and assaults are frequently associated with substance misuse, including alcohol consumption. Indigenous homicides tend to involve family members, with disputes within families being one of the main factors.

Homicide death rate, age standardised, 2001–2005



Source: ABS Causes of Death 2005 (unpublished); table 3A.10.1.

Comparatively high rates of Indigenous homicide are paralleled by high levels of other forms of violence such as self-harm and assault. Actions in a number of the strategic areas have the potential to make a difference, by addressing the circumstances which can lead to dysfunctional families and violent behaviour.

Family and community violence

There is a growing body of research into violence in Indigenous communities, particularly family violence. Community and family violence problems are complex. Social, economic and environmental conditions such as unemployment, low income, housing overcrowding and alcohol and substance misuse can all contribute to violence.

The presence of family violence is a strong predictor of child abuse, and partner violence has a damaging effect on children's emotional, behavioural and cognitive development.

Box 1.16 **KEY MESSAGES**

- Comparable data on the extent of family and community violence are not currently available. From the available data, Indigenous people are more likely than non-Indigenous people to be victims of domestic violence related assault.
- The main reason both Indigenous and non-Indigenous people sought Supported Accommodation Assistance Program (SAAP) assistance in 2005-06 was to escape domestic or family violence (31 per cent of Indigenous people and 21 per cent of non-Indigenous people) (figure 3.11.1).
- In 2005-06, over 4000 Indigenous people and 15 000 non-Indigenous people who sought SAAP assistance to escape domestic or family violence had accompanying children (table 3A.11.3).

Box 1.17 **Things that work**

- Since 2001, the 'Pathways to Prevention' project in Queensland has assisted disadvantaged families and their young children, and empowered their families, schools and communities to provide supportive environments (box 3.11.2).
- An early intervention project in SA, 'Rekindling Indigenous Family Relationships in the Riverland Program' is assisting the Aboriginal community to resolve family violence and child abuse issues (box 3.11.2).
- In 2000, the NT Government launched the 'Strong Families, Strong Communities, Strong Future' project, currently being trialled with eight Indigenous communities in the Katherine region and Tiwi Islands (box 3.11.2).

Imprisonment and juvenile detention rates

Indigenous people are highly over-represented in the criminal justice system, as both young people and adults. The early involvement of young people in the criminal justice system puts them at much higher risk of being imprisoned as adults.

Poverty, unemployment, low levels of educational attainment, and lack of access to social services are associated with high crime rates and high levels of imprisonment.

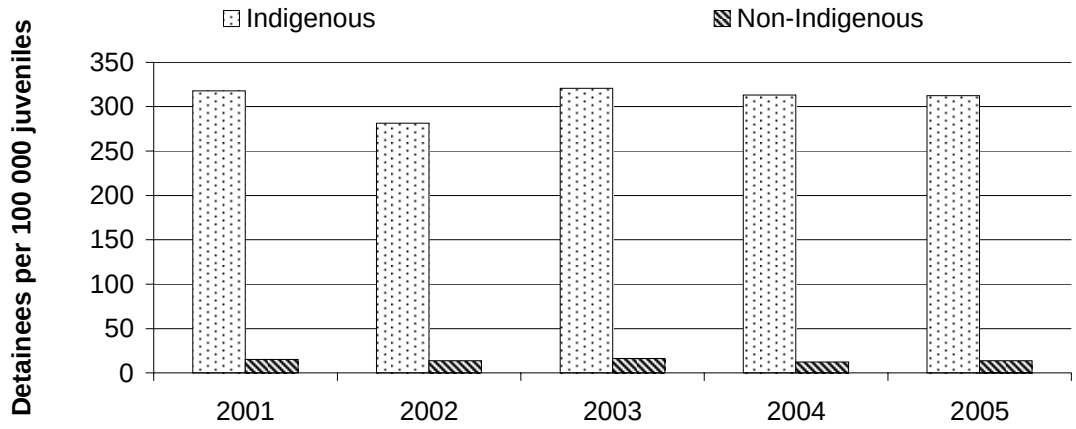
Box 1.18 **KEY MESSAGES**

- Indigenous imprisonment rates increased by 32 per cent between 2000 and 2006 (figure 3.12.1).
- Between 2002 and 2006, the imprisonment rate increased by 34 per cent for Indigenous women and by 22 per cent for Indigenous men (table 3A.12.7).
- In 2006, after adjusting for age differences, Indigenous people were 13 times more likely than non-Indigenous people to be imprisoned (table 3.12.1).
- At 30 June 2005, Indigenous juveniles were 23 times more likely to be detained than non-Indigenous juveniles. The difference between the Indigenous and non-Indigenous juvenile detention rates has increased since 2001 (figure 3.12.4).

Box 1.19 **Things that work**

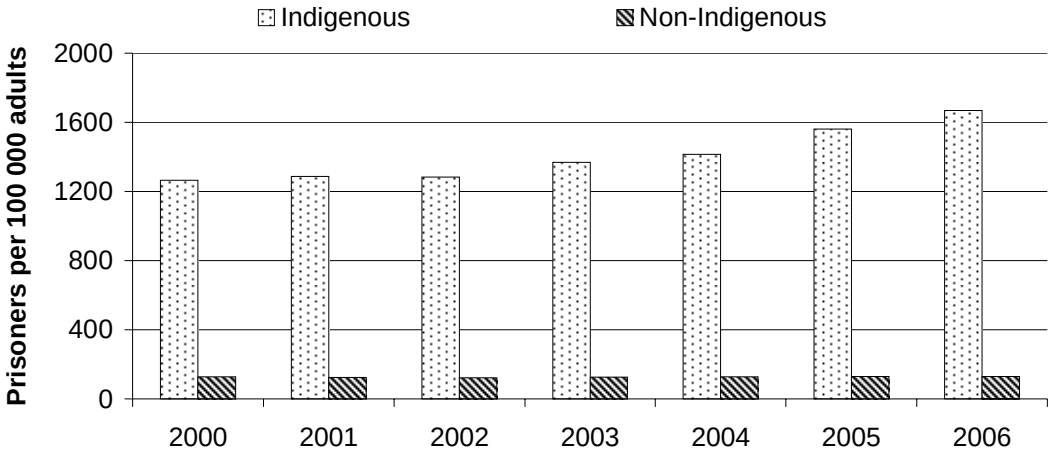
- Victoria's Koori Courts, SA's Nunga Courts and Queensland's Murri Courts reduce cultural alienation for Indigenous offenders and give Indigenous people more input into the judicial process, particularly sentencing (boxes 3.12.2–4).

Juvenile detention rates, aged 10–17 years, at 30 June each year



Source: Taylor (2006); table 3A.12.17.

Age standardised adult imprisonment rates, 30 June each year



Source: ABS (2006); table 3A.12.4.

Strategic areas for action

This part of the Report is concerned with the strategic areas for action and the strategic change indicators. These areas have been chosen for their potential to have a significant impact on Indigenous disadvantage. Some key messages arising out of the data and 'things that work' in each area are presented, with references to where more information can be found in the main Report.

Strategic areas for action	Strategic change indicators
Early child development and growth (prenatal to age 3)	• Injury and preventable diseases • Infant mortality • Birthweight • Hearing impediments • Children with tooth decay
Early school engagement and performance (preschool to year 3)	• Preschool and early learning • School attendance • Year 3 literacy and numeracy
Positive childhood and transition to adulthood	• Years 5 and 7 literacy and numeracy • Retention at year 9 • Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies • Juvenile diversions as a proportion of all juvenile offenders • Transition from school to work
Substance use and misuse	• Alcohol consumption and harm • Tobacco consumption and harm • Drug and other substance use and harm

Strategic areas for action	Strategic change indicators
Functional and resilient families and communities	• Children on care and protection orders • Repeat offending • Access to primary health care • Mental health • Proportion of Indigenous people with access to their traditional lands • Participation in organised sport, arts or community group activities • Engagement with service delivery
Effective environmental health systems	• Rates of diseases associated with poor environmental health (including water and food borne diseases, trachoma, tuberculosis and rheumatic heart disease) • Access to clean water and functional sewerage • Overcrowding in housing
Economic participation and development	• Employment (full-time/part-time) by sector (public/private), industry and occupation • Self employment and Indigenous business • Indigenous owned or controlled land • Governance capacity and skills • Case studies in governance arrangements

Early child development and growth (prenatal to age 3)

Providing a child with a good start can have a profound effect on the rest of their life. Health, growth and development in the first three years of life play crucial roles in later outcomes. Stress and neglect in these early years can have significant effects on later health and educational outcomes. Policy action in these early years can lead to significant benefits in the longer term.

Injury and preventable diseases

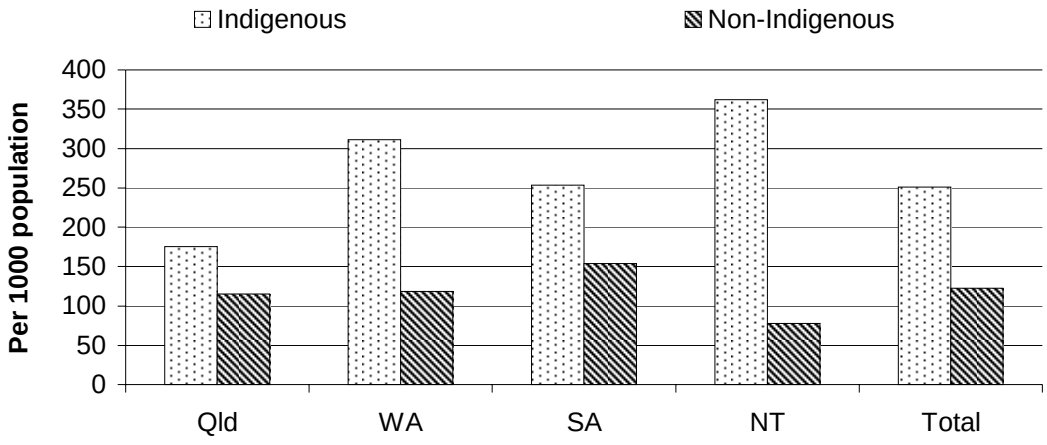
A wide range of social, cultural, physical and economic factors influence the health of children. The actions of communities and governments can promote the health of

children — most childhood diseases and injuries can be successfully prevented or treated without hospitalisation. This indicator examines injury and preventable diseases that result in children being hospitalised.

Box 1.20 **KEY MESSAGES**

- In 2004-05, Indigenous children under four were twice as likely to be hospitalised for potentially preventable diseases and injuries than non-Indigenous children (251 per 1000 compared to 123 per 1000) (table 5.1.1).
- For the period 2001 to 2005, the death rate from external causes and preventable diseases was around five times as high for Indigenous children (from 6 to 11 per 10 000 population) as for non-Indigenous children (from 1 to 3 per 10 000 population) in Queensland, WA, SA and the NT (figure 5.1.2).

Potentially preventable hospitalisations, for children aged less than 4 years, 2004-05



Source: AIHW National Hospital Morbidity Database (unpublished); table 5A.1.1.

Box 1.21 **Things that work**

- The Jabba Jabba Indigenous Immunisation program, in Queensland's Sunshine Coast, was developed to provide culturally appropriate access for 'hard to reach' sections of the Indigenous community and an entry point to mainstream health services (box 5.1.2).
- The Keeping Kids Healthy Makes a Better World program has operated in four communities in the NT: Mt Liebig, Titjikala, Nyirripi and Willowra. As well as improving the nutrition of 0–5 year olds, the program has improved engagement in the community, cultural awareness and family cohesion (box 5.1.2).
- A team approach to child nutrition on Tiwi Islands (NT) started in 2006. A nutritionist worked with a multidisciplinary team, the crèche and local women to support the nutrition of children aged less than five years (box 5.1.2).

Infant mortality

The survival of infants in their first year of life is generally viewed as an indicator of the general health and wellbeing of a population. While there has been a dramatic decline in infant mortality rates in the past century for all Australians, the mortality rate for Indigenous infants is still significantly higher than for infants in the rest of the population.

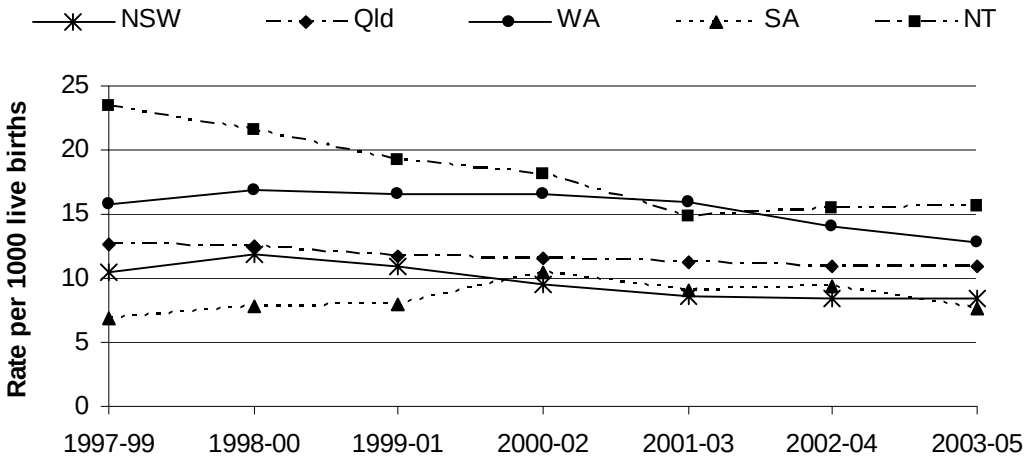
Box 1.22 **KEY MESSAGE**

- Indigenous infant mortality rates in most of the states and territories for which data are available have improved in recent years. Nevertheless, mortality rates for Indigenous infants in these jurisdictions remain two to three times as high as those for the total population of infants (figures 5.2.1 and 5.2.2).

Box 1.23 **Things that work**

- The NSW Aboriginal Maternal and Infant Health Strategy, operating since 2001, improves access to culturally appropriate maternity services for Aboriginal mothers (box 5.2.2).
- The 'Mums and Babies' project, operating since 2000, provides a collaborative model of antenatal and postnatal care for women at the Townsville Aboriginal and Islander Health Service (Queensland) (box 5.2.2).

Indigenous infant mortality



Source: ABS Deaths Australia (various issues); table 5A.2.1.

Birthweight

Infants with a low birthweight are more likely to die or have problems early in life. Low birthweight may influence the development of chronic diseases in adulthood, including diabetes and heart disease.

Box 1.24 **KEY MESSAGES**

- From 2002 to 2004, babies born to Indigenous mothers were more than twice as likely to have low birthweight (13 per 1000 live births) than babies born to non-Indigenous mothers (6 per 1000 live births) (table 5.3.2).
- Average birthweights and proportions of low birthweight babies to Indigenous mothers did not change between 1998–2000 and 2002–2004 (tables 5A.3.1 to 5A.3.5).
- From 2002 to 2004, the average birthweight of live births to Indigenous mothers was 3161 g, compared with 3380 g for babies born to non-Indigenous mothers — a difference of 219 g (table 5.3.2).

Box 1.25 **Things that work**

- Congress Alukura, based in Alice Springs, NT, is a women's health and birthing centre developed in the 1980s to address the needs of Aboriginal women in Central Australia (box 5.3.2).
- The Strong Women, Strong Babies, Strong Culture Program in the NT supports Indigenous women to teach young pregnant women and new mothers to care for themselves and their children in ways that reflect traditional cultural values and practices (box 5.3.2).
- Djuli Galban operates in Kempsey, NSW, with a focus on antenatal and early postnatal care and education (box 5.3.2).
- The Koori Maternity Strategy in Victoria provides culturally appropriate maternity care to Koori women (box 5.3.2).
- The Marrang Aboriginal Child and Family Health Model was developed to improve access and health outcomes for Aboriginal families in Orange, NSW (box 5.3.2).
- Nganampa Health Council Child and Maternal Health Program is an intensive antenatal and early postnatal care program operating in the Anangu Pitjantjatjara lands of SA since the mid 1980s (box 5.3.2).
- Ngua Gundi — the Mother/Child Project — was funded by the Commonwealth Birthing Services Project to address the low use of antenatal services by young Aboriginal mothers in Woorabinda, Queensland (box 5.3.2).

Hearing impediments

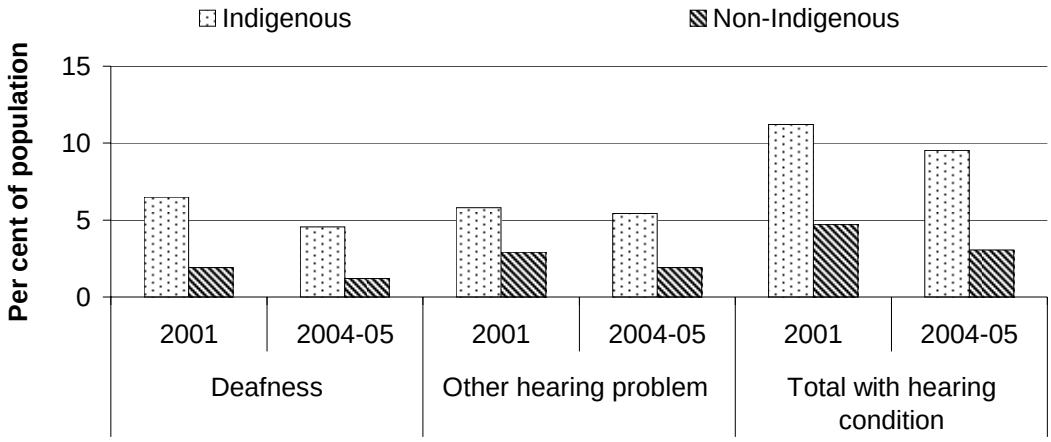
Otitis media, the main cause of hearing problems experienced by Indigenous children, is characterised by very early onset, persistence and high rates of severity. It can become a chronic disease which is carried from childhood into adolescence.

Box 1.26 **KEY MESSAGES**

- In 2004-05, the prevalence of hearing conditions for Indigenous children was three times as high as for non-Indigenous children (table 5A.4.1).
- Between 2001 and 2004-05, there was no statistically significant change in the overall prevalence of hearing problems among Indigenous children (figure 5.4.1).
- From 2001-02 to 2004-05, hospitalisations for middle ear and mastoid diseases decreased for Indigenous children aged 0–3 years (from 13 per 1000 to 10 per 1000) (tables 5A.4.6 to 5A.4.9).

Hearing impediments, if not treated early, may affect children's attendance at school, and their capacity to learn and socialise. This, in turn, can contribute to future disadvantage.

Hearing conditions in children aged 0–14 years



Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); ABS 2001 NHS (unpublished); tables 5A.4.1 and 5A.4.2.

Box 1.27 **Things that work**

- There was a decrease in rates of skin infections and ear perforations after the installation of a swimming pool in Burringurrah (box 5.4.3).
- Following a 2005 study of hearing loss in children in a Townsville primary school, in-class and out-of-class hearing assessment tools and professional development programs were developed to maximise students' academic success (box 5.4.3).

Children with tooth decay

Dental health is an indicator of early growth and development, including nutrition and access to dental health care. Unless treated early, tooth decay may result in pain, infection and destruction of soft tissue in the mouth. Poor dental health can affect speech and language development, as well as school attendance and performance, with implications for self-esteem, employment and social wellbeing.

Box 1.28 **KEY MESSAGES**

- Data on tooth decay were available only for NSW, SA and the NT. For these jurisdictions:
  - Indigenous children had higher numbers of both infant and adult teeth with decay than non-Indigenous children, in both metropolitan and rural areas (table 5.5.1)
  - fewer Indigenous children than non-Indigenous children had decay-free infant and adult teeth across all age groups and in both metropolitan and rural areas (table 5.5.2).
- National data on dental hospitalisation rates and procedure rates showed:
  - Indigenous children aged less than five years had the highest dental hospitalisation rate of any age group, almost one and a half times the rate for non-Indigenous children of that age group (table 5A.5.8)
  - extraction rates were greater for Indigenous children than for non-Indigenous children. The rate of extraction procedures for Indigenous boys was almost one and a half times as high as the rate for non-Indigenous boys (figure 5.5.4).

Historically, Indigenous people had less tooth decay due to their traditional diet. As their diet changed to include food rich in fermentable carbohydrates, they have become as exposed to tooth decay risk factors as non-Indigenous people. This risk is worsened where there is limited access to dental health services and lack of preventive measures and education.

Box 1.29 **Things that work**

- Since 2005, the Wuchopperen Indigenous Health Service 'Filling the Gap Indigenous Dental Program', has provided care to approximately 20 000 Aboriginal and Torres Strait Islander people in and around Cairns, Queensland (box 5.5.2).
- Following the successful employment of an Aboriginal Liaison Officer in Northern Adelaide, the SA Dental Service established a broader Aboriginal Liaison Program in late 2005 to improve access to dental care by Indigenous people (box 5.5.3).

Early school engagement and performance (preschool to year 3)

The extent to which Indigenous children begin formal learning at an early age, attend school regularly, and are healthy, safe and supported by their families and communities, all have a bearing on educational outcomes in the short and long term.

Research shows that the children most likely to have learning difficulties often have nutritional, hearing or other health problems.

There are no data available on attendance for the period from preschool to year 3. Participation rates only indicate the number of children enrolled as a proportion of the population group.

Preschool and early learning

Children who have access to, and attend, good quality early childhood education have a head start at school. Gaps in children's basic skills for life and learning that appear at age five or six are often difficult to close, even with targeted school interventions.

In Australia, preschool attendance is not compulsory. Fees and program availability may create barriers to access to preschool, particularly in remote and very remote regions.

Box 1.30 **KEY MESSAGES**

- Preschool participation was slightly higher for Indigenous 3 year olds (19 per cent) than non-Indigenous 3 year olds (17 per cent) (table 6.1.1). However, preschool participation rates for Indigenous 4 and 5 year olds were lower than for non-Indigenous children of the same ages (table 6.1.1).
- Between 2002 and 2005, the number of Indigenous children aged 3–5 years old enrolled in preschool increased slightly, from 8729 to 9015 (from 24 per cent to 25 per cent of Indigenous children aged 3–5) (table 6A.1.2).

Box 1.31 **Things that work**

- A NT Government funded mobile program provides a regular preschool program for Indigenous children in six remote sites (box 6.1.2).
- The Yappera Centre in metropolitan Melbourne assists Koori families to participate in childcare and kindergarten (box 6.1.2).
- For over 30 years, Aboriginal 3 year olds in SA have been able to access state preschools. Staff work with families and communities to develop shared understandings, positive relationships and culturally inclusive practices (box 6.1.2).

School attendance

In Australia, school attendance is compulsory for people between 6 and 15 years of age (with some variation across jurisdictions). Research has shown a direct

relationship between the number of days absent from school and academic performance.

Box 1.32 **KEY MESSAGE**

- In 2006, the school participation rate for Indigenous five to eight year old children (97 per cent) was similar to that for non-Indigenous children (94 per cent) (figure 6.2.1, table 6A.2.1).

All the strategic areas have some relevance to achieving good outcomes for young children in education. In addition, parental support is very important to ensure young children attend school regularly.

Box 1.33 **Things that work**

- The Ngaripirliga'ajirri program, operating in three Tiwi (NT) primary schools in 2000–04, is a culturally relevant early intervention program for Tiwi children of primary school age and their parents (box 6.2.2).

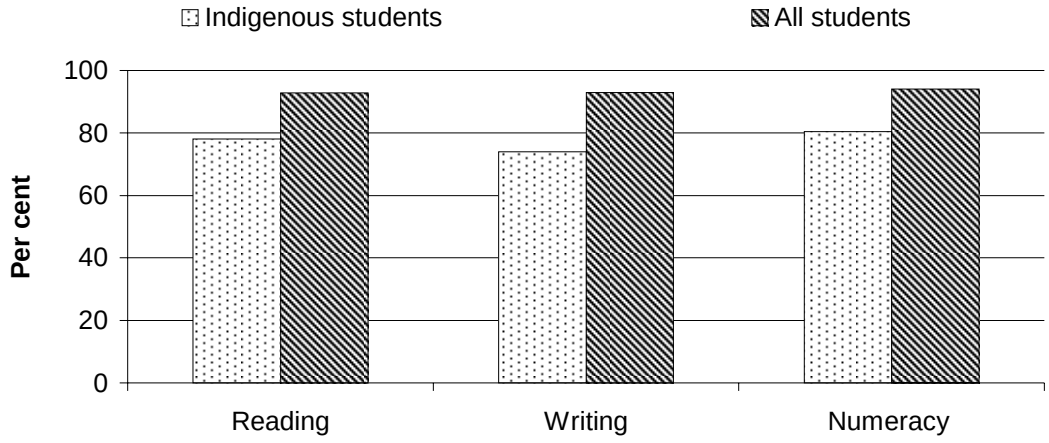
Year 3 literacy and numeracy

Achievement in the early years of schooling has major implications for retention and attainment in later years. Children who have already fallen behind in year 3 will have difficulty progressing through school and are less likely to attend school beyond the compulsory age. This in turn has implications for employment options and long term disadvantage.

Box 1.34 **KEY MESSAGES**

- Between 1999 and 2005, Indigenous students' performance against the national reading, writing and numeracy benchmarks fluctuated, with no statistically significant trend (figures 6.3.1, 6.3.3 and 6.3.5).
- In 2005, the proportion of Indigenous year 3 students who did not achieve the national benchmark was substantially higher than the proportion of all students, for:
  - reading (22 per cent compared to 7 per cent) (figure 6.3.2)
  - writing (26 per cent compared to 7 per cent) (figure 6.3.4)
  - numeracy (20 per cent compared to 6 per cent) (figure 6.3.6).

Year 3 students who achieved national benchmarks, 2005



Source: MCEETYA (2007); table 6A.3.1.

The gap in school performance between Indigenous and non-Indigenous students is evident from year 1 onwards. Studies have shown that, unless preschool learning and early primary school assistance are provided, underperforming students are rarely able to catch up. Support for Indigenous parents, who may themselves have limited education, is a key factor in ensuring that their children are encouraged to do well at school.

Box 1.35 **Things that work**

- The Scaffolding Literacy Program improved the literacy levels of Indigenous children at the Kulkarriya Community School on Noonkanbah station in the Kimberley region of WA, and has been extended to other schools in the region (box 6.3.2).
- Since 2005, a MULTILIT (Making Up Lost Time In Literacy) Tutorial Centre has operated at Coen State School, a remote community in Cape York (box 6.3.2).
- The Yachad Accelerated Learning Project is a professional tuition programme underway in five locations throughout Australia. It provides after hours tutoring for the lowest performing students (box 6.3.2).
- Sixty-two schools in the NT participate in the Accelerated Literacy Program, with significant improvements in literacy outcomes for the students involved (box 6.3.2).

Positive childhood and transition to adulthood

The later years of childhood, adolescence and the transition to adulthood are critical phases in a person's development. A good foundation in early childhood can be

built upon, or interventions can assist those who had childhood difficulties to make the transition to a more positive adulthood.

There are strong links between a positive childhood and transition to adulthood and several of the headline indicators and other strategic areas for action. Outcomes in these years can have far reaching consequences. Good educational outcomes for young Indigenous people will enhance their opportunities as adults. Young people who avoid the juvenile justice system are less likely to become involved in the adult correctional system and a cycle of re-offending.

Years 5 and 7 literacy and numeracy

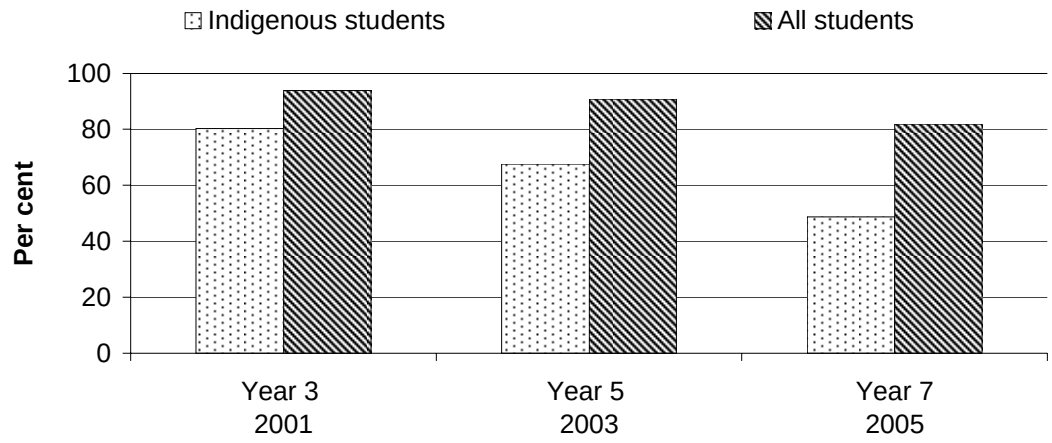
Research has shown that achievement in years 5 and 7 literacy and numeracy is a key determinant of whether children go on to year 12 and higher education. A lack of basic literacy and numeracy skills also results in poor employment prospects.

Other research has found that low literacy is one of the biggest hurdles to improving the health of Indigenous people.

Box 1.36 **KEY MESSAGES**

- Between 1999 and 2005, year 5 Indigenous students' performance against the national reading, writing and numeracy benchmarks fluctuated, with no statistically significant trend (figures 7.1.1, 7.1.3 and 7.1.5).
- Between 2001 and 2005, year 7 Indigenous students' performance against the national reading, writing and numeracy benchmarks also fluctuated, with no statistically significant trend (figures 7.1.7, 7.1.9 and 7.1.11).
- In 2005, the proportion of year 5 Indigenous students who did not achieve the national benchmark was substantially higher than the proportion of all students for:
  - reading (37 per cent compared to 13 per cent) (figure 7.3.2)
  - writing (26 per cent compared to 7 per cent) (figure 7.1.4)
  - numeracy (34 per cent compared to 9 per cent) (figure 7.1.6).
- In 2005, the proportion of year 7 Indigenous students who did not achieve the national benchmark was substantially higher than the proportion of all students for:
  - reading (36 per cent compared to 10 per cent) (figure 7.1.8)
  - writing (28 per cent compared to 8 per cent) (figure 7.1.10)
  - numeracy (51 per cent compared to 18 per cent) (figure 7.1.12).
- As Indigenous students progress through school the proportion who achieve the national minimum benchmarks decreases (figures 7.1.13 and 7.1.15).

Students who achieved the numeracy benchmark



Source: MCEETYA (2007); table 6A.3.7.

Retention at year 9

For most students, compulsory schooling ends during year 9 or 10. Consultations with Indigenous people revealed that this was a critical time for Indigenous children. Many of those who leave school early have poor literacy and numeracy skills, limiting their post-school options, including employment opportunities.

The available data suggest a high retention rate at year 9. However, apparent retention rates are based on enrolment numbers, and high rates are to be expected because students commencing year 9 are generally of an age at which school education is compulsory. In addition, apparent retention rates do not reflect school attendance or whether the student completed the school year (because these data are collected mid-way through the year). A significant gap between Indigenous and non-Indigenous students' retention appears in year 10.

Box 1.37 **KEY MESSAGES**

- In 2006, 8 per cent of Indigenous people aged 14 years were not participating in school education compared with 1 per cent of non-Indigenous 14 year olds (table 3A.3.2).
- Over the period 2002 to 2006, the Indigenous retention rate to year 9 was relatively stable (figure 3.3.2).
- In 2005, the retention rate for Indigenous students to year 9 was 99 per cent. In 2006, the retention rate for the same group of students (now in year 10) had declined to 91 per cent (figure 3.3.2 and table 3A.3.1).

Indigenous cultural studies in school curriculum and involvement of Indigenous people in their development and delivery

The inclusion of Indigenous cultural studies in school curricula is widely regarded (by both Indigenous and non-Indigenous people) as being a significant factor in an Indigenous student's self-esteem and achievement at school. It can also contribute to the understanding and acceptance of Indigenous people by the wider community. The participation of Indigenous people in the development and delivery of Indigenous cultural studies is also regarded as highly desirable.

Box 1.38 **KEY MESSAGES**

- Between 2001 and 2005, the number of Indigenous teachers and Aboriginal and Islander Education Workers in schools increased from 3238 to 3596 (table 7.3.1).
- Some primary and secondary schools are incorporating Indigenous studies in their curricula, and Indigenous culture and perspectives are being incorporated into VET programs offered at school. This can improve the number of Indigenous students completing year 12 and improve all students' knowledge and appreciation of Indigenous culture (boxes 7.3.2 to 7.3.6).

Box 1.39 **Things that work**

- The 'Dare to Lead' program fosters Indigenous education programs in schools throughout Australia. In 2005, the Bendigo Senior Secondary College in Victoria was one of six national winners of the Excellence in Leadership in Indigenous Education awards established under the program (box 7.3.2).
- The Swan View Senior High School Access Program in WA offers school-based traineeships. Ongoing involvement of parents, family members and former students has resulted in more Indigenous students completing year 12 (box 7.3.3).
- The Broulee Public School Dhurga Djamanji language program in NSW has been successfully integrated into everyday classroom activities and has received strong support from the school and local communities (box 7.3.4).
- Tauondi College, an independent, Indigenous, community-run training organisation in SA, has a culturally-appropriate approach to VET in schools (box 7.3.5).
- An (unidentified) remote community school includes Indigenous studies programs in the curriculum over a two year cycle, ensuring all students are exposed to Indigenous studies during their schooling (box 7.3.6).
- The Remote Area Teacher Education Program in Queensland is assisting Indigenous community teachers to become registered teachers (box 7.3.7).

Juvenile diversions

In some states and territories, diversion programs allow young offenders to be dealt with outside the traditional court processes. This might involve a caution or attendance at community and family conferences. Programs vary from one State to another. Diversionary mechanisms, in combination with sports and cultural programs can contribute to a reduction in antisocial behaviour and offending.

Box 1.40 **KEY MESSAGES**

- Although data on juvenile diversions are not comparable between states and territories, a smaller proportion of Indigenous juveniles were diverted from court by formal cautioning or referrals than non-Indigenous juveniles in each State and Territory for which data were available.

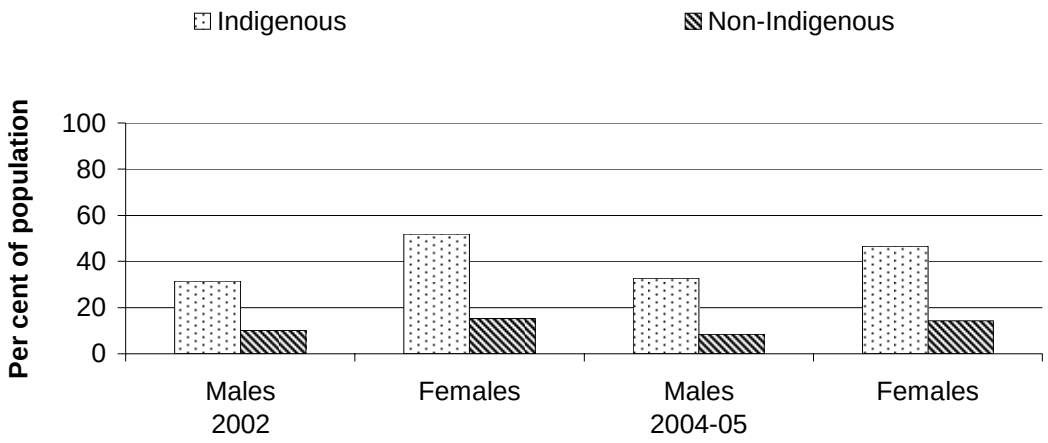
Box 1.41 **Things that work**

- The Circular Head Aboriginal Corporation Youth Justice Program, in north-west Tasmania, supports children aged 10 to 18 years who are at risk of adverse contact with the criminal justice system (box 7.4.1).
- Community Grant Programs, part of the Victorian Aboriginal Justice Agreement, enable Koori communities to design and deliver localised early intervention/prevention strategies for Koori youth (box 7.4.2).

Transition from school to work

Two approaches are used to analyse the transition from school to work. The 'at risk' approach examines the proportion of young adults who are neither in employment nor engaged in study, and are therefore considered to be 'at risk' of long term disadvantage. The second approach looks at outcomes from education.

People aged 18 to 24 years who were not employed and not studying



Source: ABS 2004-05 NATSIHS and NHS, 2002 NATSISS and GSS (unpublished); table 7A.5.2.

Box 1.42 **KEY MESSAGES**

- In 2004-05, for young people aged 18 to 24 years:
  - a higher proportion of Indigenous young people than non-Indigenous young people were not employed and not studying, for both men and women, and in all remoteness areas (figures 7.5.1 and 7.5.2)
  - a higher proportion of Indigenous young people living in very remote areas were not employed and not studying (52 per cent), compared with those in major cities (34 per cent) (figure 7.5.1)
  - both Indigenous and non-Indigenous young women were more likely than their male counterparts to be neither employed nor studying (figure 7.5.2).
- In 2004-05, for people aged 18 years and over:
  - both labour force participation and employment rates for Indigenous people were lower than for non-Indigenous people, whether or not they had achieved a certificate level 3 or higher qualification (table 7.5.1)
  - for both Indigenous and non-Indigenous people, those with a certificate level 3 or higher qualification were more likely to participate in the labour force than those with lower levels of qualifications or without qualifications (table 7.5.1).

Box 1.43 **Things that work**

- The Aboriginal and Torres Straight Islander Education to Employment Scheme began in Queensland in 1998. The scheme aims to increase training and employment opportunities for Indigenous youth (box 7.5.2).

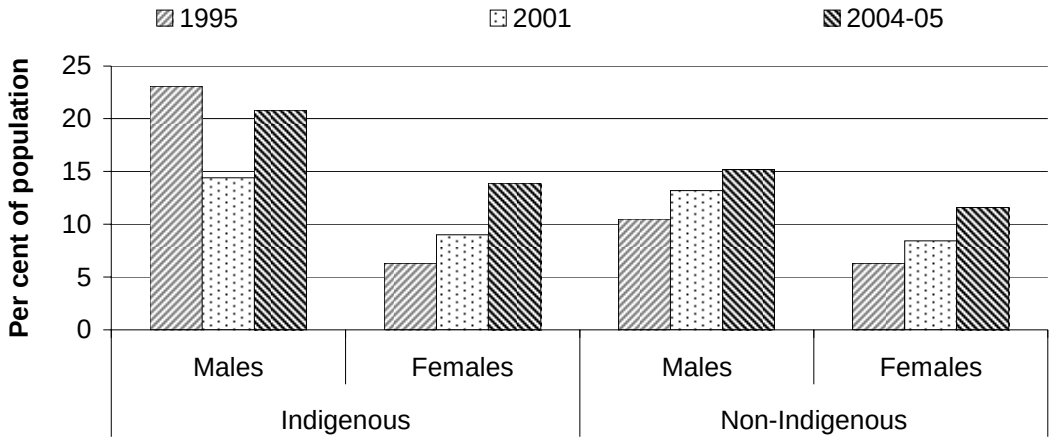
Substance use and misuse

Substance use and misuse can have far reaching effects on a person's quality of life and health, and on those around them. The end result may be a reduction in life expectancy. A range of social factors can influence the misuse of substances, such as socioeconomic status, unemployment and poor education.

Alcohol consumption and harm

Excessive alcohol consumption is associated with increased illness. As well as health risks to the individual, high levels of alcohol consumption also contribute to domestic violence, financial problems, child abuse and family breakdowns. In the case of pregnant women, excessive alcohol consumption can also affect the health of new born infants.

Alcohol consumption at long term risky to high risk levels, adults in non-remote areas, 2004-05



Source: AIC NHMP (unpublished); table 8A.1.5.

Box 1.44 **KEY MESSAGES**

- In 2004-05, after adjusting for age differences, survey results indicated that:
  - a higher proportion of Indigenous adults reported that they did not drink or had never drunk alcohol (53 per cent) compared to non-Indigenous adults (36 per cent) (table 8.1.2)
  - among those who drank alcohol, the reported rate of long term risky to high risk drinking for Indigenous people was not statistically different to that for non-Indigenous people (figure 8.1.2); the rate of short term risky to high risk drinking for Indigenous people (17 per cent) was nearly double the rate for non-Indigenous people (8 per cent) (table 8.1.3).
- Among Indigenous people living in non-remote areas, more Indigenous women reported long term risky to high risk alcohol consumption in 2004-05 (14 per cent) than in 1995 and 2001 (6 and 9 per cent respectively) (figure 8.1.3). There was little change in long term risky to high risk alcohol consumption by Indigenous men over the same periods.
- Over the period from 1999-2000 to 2004-05, Indigenous homicides were more than three times as likely as non-Indigenous homicides to have involved both the offender and victim having consumed alcohol (figure 8.1.4). However, the overall level of alcohol involvement in Indigenous homicides fell from 85 to 71 per cent over the period (figure 8.1.5).

Box 1.45 **Things that work**

- The Groote Eylandt Liquor Management Plan in the NT was developed in 2005 to reduce the number and harm of liquor related incidents in Groote Eylandt and Bickerton Island (box 8.1.2).

Tobacco consumption and harm

Tobacco use is an important contributor to premature death and ill-health. It is estimated that smoking is responsible for 20 per cent of all cancers and 21 per cent of heart disease in Australia. In addition to the long term health risks, tobacco use among low income groups can have immediate, insidious effects, by diverting scarce family resources away from beneficial uses.

Box 1.46 **KEY MESSAGES**

- Nationally, in 2004-05:
  - 50 per cent of Indigenous adults were current daily smokers (figure 8.2.1)
  - after adjusting for age differences, Indigenous adults were more than twice as likely as non-Indigenous adults to be daily smokers (46 per cent compared to 21 per cent) (table 8A.2.2).
- From 1995 to 2004-05, the proportion of current daily smokers among both Indigenous women and men living in non-remote areas remained constant (figure 8.2.3).

Tobacco use is often associated with other lifestyle related health risk factors, such as excessive alcohol consumption, low levels of physical activity and poor diet.

Drug and other substance use and harm

Reducing drug-related harm will improve health, social and economic outcomes at both the individual and community level. Illicit drug consumption has played a role in the involvement of Indigenous people in the criminal justice system. There is a strong connection between domestic violence and drug and alcohol use in Indigenous communities. The use of substances such as inhalants (for example, petrol and glue) can lead to brain damage, disability or even death.

Box 1.47 **KEY MESSAGES**

- In 2004-05:
  - 28 per cent of Indigenous adults living in non-remote areas reported illicit substance use in the previous 12 months (table 8.3.1)
  - marijuana (23 per cent), amphetamines (7 per cent) and analgesics/sedatives (for non-medical purposes) (6 per cent) were the most commonly used substances (table 8.3.1).
- For all homicides recorded from 1999-2000 to 2004-05, a lower proportion of Indigenous homicides than non-Indigenous homicides occurred under the influence of drugs (23 per cent compared to 35 per cent) (figure 8.3.2).

Box 1.48 **Things that work**

- The introduction of alternative fuels with low aromatics in more than 50 Indigenous communities in the Central Desert Region of the NT, WA and SA has been successful in reducing the incidence of and harm from petrol sniffing (box 8.3.2).
- The Mt Theo Program successfully eliminated regular petrol sniffing in Yuendumu, a remote Aboriginal community northwest of Alice Springs, NT (box 8.3.2).

Functional and resilient families and communities

Families and communities are the mainstay of our society. The extent to which they are functional and resilient influences a range of outcomes for Indigenous people. A caring, protective and supportive environment, together with positive health outcomes and cultural awareness, are particularly important.

Dysfunctional families and communities can lead to breakdowns in relationships and social alienation, and contribute to physical and mental health problems. Ultimately, life expectancy, education, imprisonment, violence, employment and income can be affected.

Box 1.49 **Things that work**

The Lake Tyers Community Renewal Project is a partnership in progress between the Lake Tyers Aboriginal community and the Victorian Government. Strategies under the Renewal Project have improved community infrastructure and created opportunities for positive community engagement (box 9.1).

Children on care and protection orders

Data on children under care and protection orders show the extent to which some form of legal intervention has been made for their protection.

Not all orders are due to neglect and abuse — in some cases, family difficulties such as a parent being hospitalised or dying may be the reason why a child is placed in care. However, legal intervention is usually a last resort, after other interventions have not been possible or have failed, and these data may provide some indication of the social and cultural stress under which many people in Indigenous communities live.

Box 1.50 **KEY MESSAGES**

- Almost 30 out of every 1000 Indigenous children aged 0–17 years were on care and protection orders at 30 June 2006, compared to 5 per 1000 for non-Indigenous children (table 9.1.2).
- From 1999-2000 to 2005-06, the rate of children on care and protection orders increased for both Indigenous and non-Indigenous children in all states and territories (table 9A.1.1).

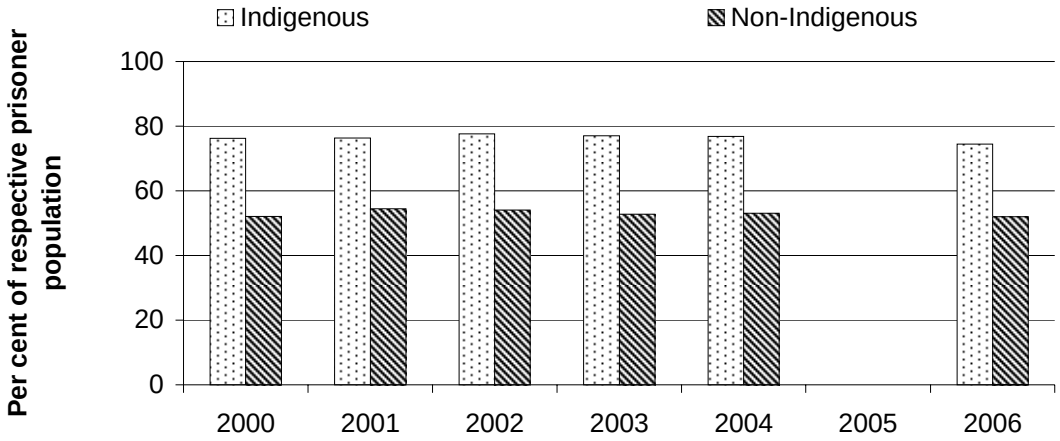
Repeat offending

Cycles of intergenerational offending, where children of prisoners commit offences that result in their own imprisonment, is common for Indigenous families. This cycle of Indigenous imprisonment has severe effects on families and communities. It is important that people who have contact with the criminal justice system have the opportunity to integrate back into the community, lead productive lives, and not re-offend.

Box 1.51 **KEY MESSAGES**

- In 2006, a greater proportion of Indigenous prisoners (74 per cent) than non-Indigenous prisoners (52 per cent) had prior adult imprisonment (figure 9.2.1).
- From 2000 to 2006, there was no significant change at the national level in the proportion of Indigenous prisoners with prior adult imprisonment (table 9A.2.3).
- In studies on juvenile offenders carried out in NSW, Queensland, WA and SA, Indigenous juveniles experienced a higher number of court reappearances and higher rates of repeat offending than non-Indigenous juveniles (table 9A.2.6 and figures 9.2.4, 9.2.6 and 9.2.7).

Prisoners, by known prior adult imprisonment under sentence



Data for 2005 are not available for publication.
Data source: ABS (2000 to 2006); table 9A.2.3.

Box 1.52 **Things that work**

- Since February 2002, Circle Sentencing in Nowra, NSW, has provided an alternative sentencing court for adult Indigenous offenders. It has reduced reoffending among Indigenous offenders and contributed to the Indigenous community. Circle Sentencing Courts have since been established in eight other locations in NSW (box 9.2.2).
- The Rumbalara Women's Mentoring Program was established in Victoria in 2002 to reduce reoffending by Indigenous women. Following the success of the Rumbalara pilot, the mentoring program has been expanded to five locations for both Indigenous men and women (box 9.2.3).

Access to primary health care

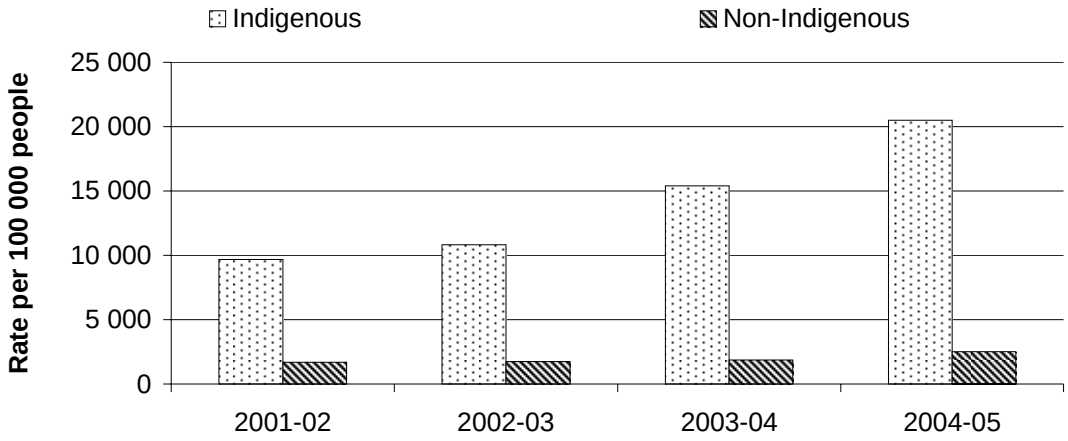
Access to health services is important in order to identify and treat diseases in a timely way. Many chronic conditions are potentially preventable if treated early. Vaccination can be effective in the prevention of diseases such as influenza. A lack of access contributes to the high prevalence of diseases such as diabetes and lung diseases in many Indigenous communities.

Access to primary health care can affect outcomes in a range of headline indicators and strategic areas for action, including life expectancy, infant mortality, disability and chronic disease, early child development and growth, substance use and misuse, and functional and resilient families and communities. Poor health can also affect people's educational attainment and ability to work.

Box 1.53 **KEY MESSAGES**

- In 2001-02, expenditure per Indigenous person on primary health care, including that paid through the Medicare Benefits Scheme, was less than half the expenditure per non-Indigenous person (table 9.3.1).
- In 2004-05, the hospitalisation rate for Indigenous people with potentially preventable chronic conditions was 8 times the rate for non-Indigenous people, and the rate for potentially preventable acute conditions was 3 times the rate for non-Indigenous people (tables 9.3.2 and 9.3.4). For Type 2 diabetes, the Indigenous hospitalisation rate was 7 times the rate for non-Indigenous people (table 9.3.3).
- Hospitalisation rates for influenza decreased for both Indigenous and non-Indigenous people between 2003-04 and 2004-05. However, the reduction was greater for non-Indigenous people (table 9.3.5).
- Hospitalisation rates for Indigenous people for sexually transmitted infections were between 13 and 67 times the rates for non-Indigenous people in 2004-05 (table 9.3.6).

Hospitalisations for potentially preventable conditions, 2004-05



Source: AIHW National Hospital Morbidity Database (unpublished); tables 9A.3.1 and 9A.3.2.

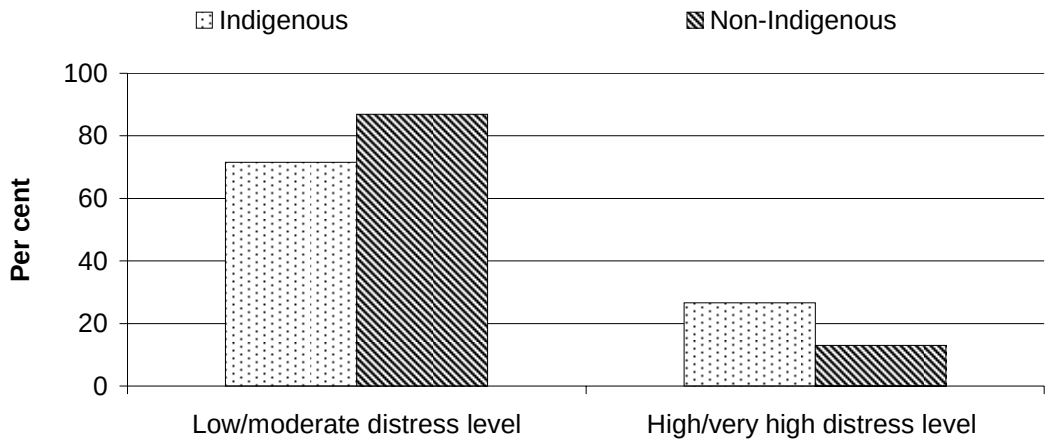
Box 1.54 **Things that work**

- The Marrang Aboriginal Child and Family Health Model was developed to improve access to health care services and health outcomes among Indigenous families living in Orange, NSW (box 9.3.2).
- The Condom Social Marketing for Indigenous Australia project aims to reduce unplanned teenage pregnancies and the incidence of sexually transmitted infections in Indigenous communities (box 9.3.3).
- Jirrawun Health, a non-government body based in Kununurra, WA, works with mainstream health services to improve the health of the Gija people (box 9.3.4).

Mental health

Mental health is defined in terms of an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity. For many Indigenous people, health, including mental health, is holistic — encompassing not just the physical wellbeing of the individual but the social, emotional, spiritual and cultural wellbeing of the community.

Level of psychological distress, people aged 18 years and over, age standardised, 2004-05



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

Box 1.55 **KEY MESSAGES**

- In 2004-05, psychological distress data showed that 27 per cent of Indigenous adults had experienced a high to very high level of distress, compared with 13 per cent of non-Indigenous adults (figure 9.4.1).
- In 2004-05, 56 per cent of Indigenous adults reported feeling calm or peaceful all or most of the time and 71 per cent reported being happy all or most of the time (table 9A.4.13).
- From 2001-02 to 2004-05, Indigenous people had higher rates of hospitalisation for mental and behavioural disorders than non-Indigenous people (figure 9.4.3).
- 'Life stress events' has been identified as the factor most strongly associated with high risk of clinically significant emotional or behavioural difficulties in Aboriginal children. In WA, in 2001 and 2002, over one in five Aboriginal children aged 0–17 years were living in families where 7 to 14 major life stress events, such as death, imprisonment, violence and severe hardship, had occurred in the 12 months prior to the survey (Western Australian Aboriginal Child Health Survey) (section 9.4).
- In WA, Indigenous children in remote communities had better mental health than those living in Perth, suggesting that growing up in very remote communities, where adherence to traditional culture and ways of life are strongest, may be protective against emotional and behavioural difficulties in Aboriginal children (section 9.4).

Issues of mental health and wellbeing cover a broad range of problems which can result from domestic violence, substance misuse, physical health problems, imprisonment, family breakdown and social disadvantage. For Indigenous people, there are also broader social and historic issues, such as forced separation or forced relocation, which influence mental health and wellbeing.

Box 1.56 **Things that work**

- The school-based 'Family Wellbeing Empowerment Program' for remote Indigenous school children in Cape York, Queensland, aims to enhance the life skills and psychosocial development of young Indigenous people (box 9.4.2).
- In NSW, the Aboriginal Mental Health Workforce Training Program aims to increase the representation of Aboriginal people in mental health professions (box 9.4.2).

Proportion of Indigenous people with access to their traditional lands

Indigenous people derive social, cultural and economic benefits from their connection to traditional country. Culturally, access to land and significant sites may allow Indigenous people to practise and maintain their knowledge of

ceremonies, rituals and history. Socially, land can be used for recreational, health, welfare and educational purposes. The economic benefits of land are discussed under 'Economic participation and development'.

This indicator aims to show access by all Indigenous people to traditional lands. However, available data are for Indigenous adults in non-remote areas, and are not representative of all Indigenous people.

Box 1.57 **KEY MESSAGES**

- In 2004-05, there were no data on access to traditional lands for people in remote or very remote areas.
- The proportion of Indigenous adults living in non-remote areas who did not recognise an area as their homelands increased from 29 per cent in 1994 to 38 per cent in 2004-05 (figure 9.5.3).
- In non-remote areas, the proportion of Indigenous adults who lived on their homelands decreased from 22 per cent in 1994, to 15 per cent in 2004-05. The proportion who were allowed to visit their homelands remained steady, ranging from 44 per cent to 48 per cent, between 1994 and 2004-05 (figure 9.5.3).

Participation in organised sport, arts or community group activities

Taking part in organised sport, arts or community group activities can foster self-esteem, social interaction and the development of skills and teamwork. Early participation in these activities can lead to stronger bodies, the prevention of chronic diseases and improved learning and academic performance. Reductions in substance misuse, self-harm, and crime may also result.

Box 1.58 **KEY MESSAGES**

- In 2002, almost one quarter of Indigenous people aged 15 years and over had attended an Aboriginal or Torres Strait Islander ceremony in the previous 12 months (ABS 2004). Indigenous people in remote areas were three times more likely to have attended an Aboriginal or Torres Strait Islander ceremony than those in non-remote areas (ABS 2006).
- The proportion of Indigenous people who were engaged in moderate or high levels of exercise decreased from 30 per cent in 1995 to 24 per cent in 2004-05 (table 9A.6.2).

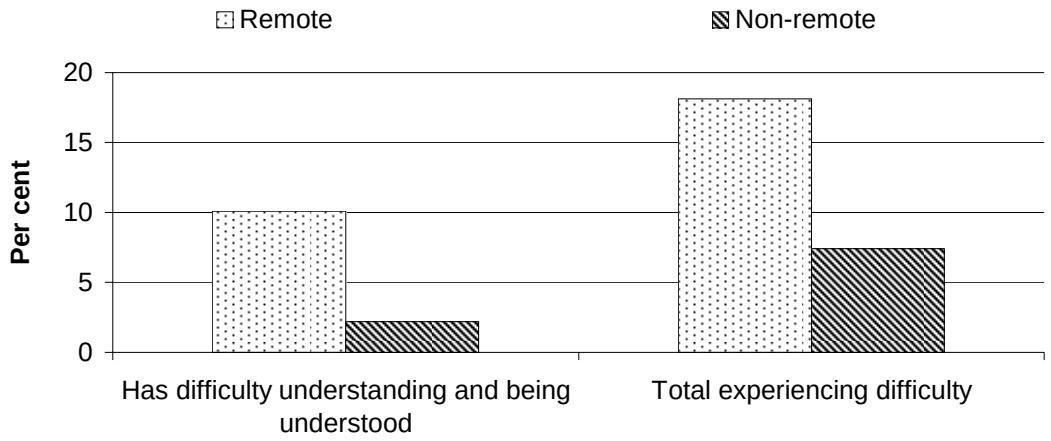
Box 1.59 **Things that work**

- In the Tirrapendi Aboriginal Youth Disco Program in SA, police and Aboriginal families work together to plan and supervise Aboriginal youth discos (box 9.6.2).
- Blue Light NT conducts self-supporting discos at remote communities such as Milingimbi and Ramingining (box 9.6.2).
- In 2006, the Little Yuin Aboriginal Preschool established a holiday program at Wallaga Lake in NSW (box 9.6.3).
- The Swan Nyungar Sports Education Program at Balga Senior High School, WA, aims to encourage Aboriginal students at school and improve their success, participation in post-school education and employment prospects (box 9.6.4).
- The Rumbalara Football and Netball Club in Shepparton, Victoria, operates programs that support education, employment and healthy lifestyles (box 9.6.5).
- The Athletics for the Outback Program focuses on remote and rural Indigenous communities, and provides resources and assistance to create a 'whole of life' activity linking education, life skills and responsibilities with sport (box 9.6.6).
- Yirra Yaakin, established in 1993 in WA, has become a world class theatre company and leader in community development, supporting positive self-enhancement through artistic expression (box 9.6.7).
- The Australian Government has supported independent Indigenous broadcasters since 1987. It has agreed to fund a National Indigenous Television Service. The ABC and SBS also provide Indigenous television programming (box 9.6.8).

Engagement with service delivery

Engagement with service delivery covers both impediments to Indigenous people accessing services and the appropriate delivery of services (including culturally relevant programs). In remote areas, lack of services and long distances create additional barriers to access.

Communication with service providers, Indigenous people 15 years or over, 2002



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

Box 1.60 **KEY MESSAGES**

- In 2002, based on survey data, Indigenous people aged 55 years and over had the most difficulty understanding and being understood by service providers (table 9A.7.7).
- In 2004-05, an estimated 26 500 Indigenous adults needed to go to hospital in the previous 12 months, but did not go because of cost, personal reasons, logistical reasons or other barriers (figure 9.7.1 and table 9A.7.1).
- The Western Australian Aboriginal Child Health Survey found that, even though there was a high proportion of Aboriginal children at high risk of clinically significant emotional and behavioural difficulties, very few children had had contact with Mental Health Services (section 9.7).

Box 1.61 **Things that work**

- From 2001 to 2005, the *Sharing the True Stories* project identified and addressed communication barriers between Indigenous patients and health care workers (box 9.7.2).
- The Jalaris Aboriginal Corporation (WA) coordinates a holistic approach to family strength and health issues (box 9.7.3).
- The Improving Care for Aboriginal and Torres Strait Islander Patients program aims to improve identification of, and quality care for, Aboriginal and Torres Strait Islander patients in Victoria (box 9.7.4).
- 15 people in Port Augusta with Aboriginal language skills received training to become accredited interpreters (box 9.7.5).
- Improvements to Medicare and Pharmaceutical Benefits Scheme (PBS) arrangements have improved access to health care for Indigenous people (box 9.7.6).
- The book 'Yarning about Mental Health' uses pictures and traditional Aboriginal stories to identify and explain some of the causes, symptoms and treatments of mental health problems (box 9.7.7).
- A pre-hospital care model for remote Indigenous communities has been implemented in Coen, Horn Island, Cooktown and Kowanyama in Queensland (box 9.7.8).

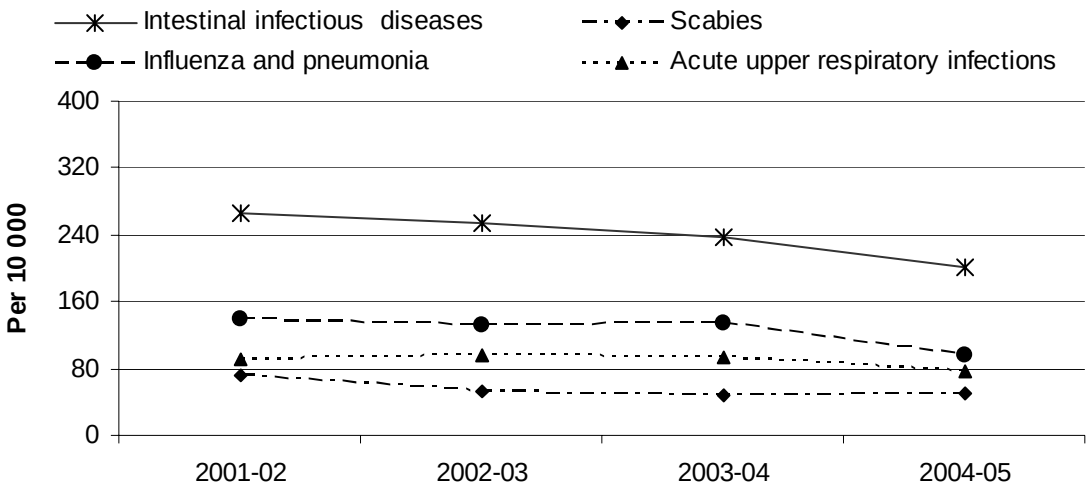
Effective environmental health systems

Environmental health is about safe and healthy living conditions. It depends, among other things, on the buildings in which people live, the water they drink, the safe removal of waste and the control of pests. Just as important is the food people eat and their ability to clean themselves, their clothes and their homes.

Rates of diseases associated with poor environmental health

Sanitation, drinking water quality, food safety, disease control and housing conditions are major contributors to health and quality of life. However, many rural and remote Indigenous communities still struggle to achieve the basic level of environmental health that has been achieved for the rest of the population.

Hospitalisation rates for Indigenous children 0–14 years



Source: AIHW National Hospital Morbidity Database (unpublished); table 10A.1.1.

Research in Indigenous communities has found that infected secretions from eyes, noses, ears and coughs play a major role in transmitting infectious diseases — especially in overcrowded households. Inadequate waste disposal is also a major source of infectious disease.

Box 1.62 **KEY MESSAGES**

- Indigenous people had higher hospitalisation rates than non-Indigenous people for all diseases associated with poor environmental health (table 10.1.1).
- Between 2001-02 and 2004-05, hospitalisation rates for the 0–14 age group decreased for intestinal infectious diseases (25 per cent decrease), scabies (32 per cent decrease), acute upper respiratory infections (14 per cent decrease) and influenza and pneumonia (31 per cent decrease) (figure 10.1.3).
- Between 2001-02 and 2004-05, hospitalisation rates for older Indigenous people (65 years and over) increased for bacterial disease (10 per cent increase), influenza and pneumonia (32 per cent increase) and acute upper respiratory infections (17 per cent increase) (table 10A.1.2).
- In the four jurisdictions for which data are available, death rates from diseases associated with poor environmental health were much higher for Indigenous people (between 113 and 230 deaths per 100 000 people) than for non-Indigenous people (between 25 and 40 deaths per 100 000) (table 14A.1.4).

Access to clean water and functional sewerage

Contaminated drinking water can be a source of sickness and disease. An adequate and reliable supply of water is necessary for personal hygiene and for washing food, kitchen utensils and clothes, which is important to prevent infectious diseases and other illnesses. A functional sewerage system prevents contamination of drinking water and food.

Box 1.63 **KEY MESSAGES**

- The number of discrete Indigenous communities without an organised sewerage system decreased from 91 in 2001, to 25 in 2006 (table 10A.2.4).
- In 2006, of the 322 discrete Indigenous communities with a reported usual population of 50 or more:
  - 165 (51 per cent) had experienced water supply interruptions in the previous 12 months (table 10A.2.2)
  - 130 (40 per cent) had experienced sewerage overflows or leakages in the previous 12 months (table 10A.2.5).

Box 1.64 **Things that work**

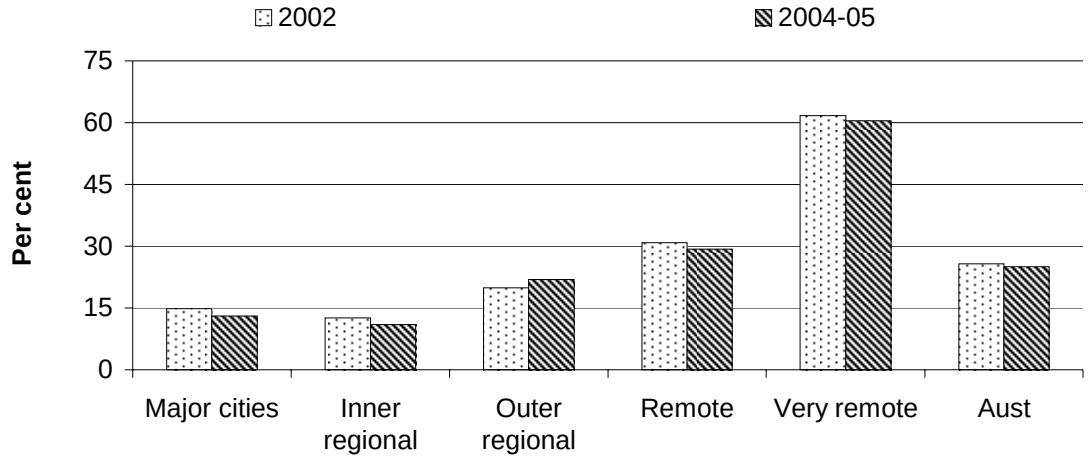
The Aboriginal Communities Development Program in NSW is raising the health and living standards of 22 priority Aboriginal communities, with new housing and upgrading existing housing, roads, footpaths and street lighting (box 10.2.2).

Overcrowding in housing

Overcrowding in housing (as well as housing quality and condition) can contribute to poor health, family violence and poor educational performance.

The housing occupancy standard reported here compares the number of bedrooms with the number of people in a dwelling, to determine overcrowding. However, particularly in larger households, the number of bathrooms and toilets, and the size of kitchens, bedrooms and other living spaces, may be as important as the number of bedrooms.

Indigenous people 15 years and over living in overcrowded housing



Source: ABS 2002 NATSISS and 2004-05 NATSIHS (unpublished); table 10A.3.2.

Box 1.65 **KEY MESSAGES**

- In 2004-05, 25 per cent of Indigenous people aged 15 years and over lived in overcrowded housing (figure 10.3.1). There have been no statistically significant changes in the rates of overcrowding since 2002 (table 10A.3.3).
- In 2004-05, overcrowding was most common in very remote areas, where 63 per cent of Indigenous people lived in overcrowded households (figure 10.3.2).

Economic participation and development

The extent to which people participate in the economy is closely related to their living standards and broader wellbeing. It also influences how they interact at the family and community levels.

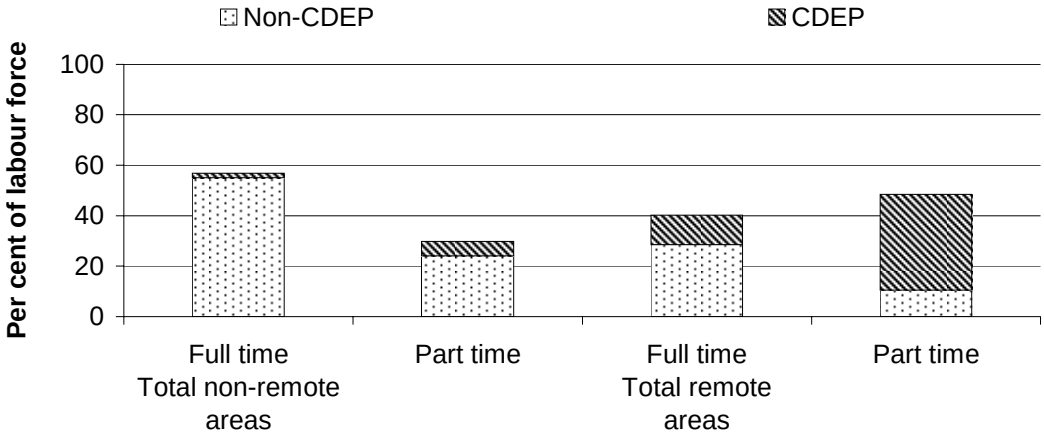
This report examines economic development through employment opportunities, influence over land resources, and aspects of education and training that are relevant to the goals of good governance and the capacity to govern.

Employment by sector, industry and occupation

Having a job (and, to an extent, the type of employment), leads to improved incomes and standards of living for people and their families. This in turn has a positive influence on health and the education of children. It also enhances

self-esteem and reduces social alienation. More broadly, where people are employed, benefits also flow on to the wider community.

Employment, Indigenous people aged 18 to 64 years, 2004-05



Source: ABS 2004-05 NATSIHS (unpublished); table 11A.1.4.

Box 1.66 **KEY MESSAGES**

- The full time employment rate for Indigenous people increased from 45 per cent to 52 per cent between 1994 and 2004-05, and the part time employment rate increased from 26 per cent to 35 per cent over the same period (figure 11.1.6).
- In 2004-05, after adjusting for age differences:
  - Indigenous people in the labour force were more likely than non-Indigenous people to be employed part time (35 per cent compared to 28 per cent) and less likely to be employed full time (54 per cent compared to 69 per cent) (table 11A.1.2)
  - a higher proportion of Indigenous people than non-Indigenous people were employed in lower skilled occupations, including elementary clerical, sales and service workers and labourers, and related workers (26 per cent compared to 16 per cent) (figure 11.1.9).
- For Indigenous people in 2004-05:
  - full time employment decreased with remoteness, while part time employment increased with remoteness (figure 11.1.2)
  - CDEP participation comprised a significant proportion of Indigenous employment in remote and very remote areas, accounting for 64 per cent of Indigenous employment in the public sector and 48 per cent of Indigenous employment in the private sector (figure 11.1.7).

Box 1.67 **Things that work**

- The Aboriginal Employment Strategy in NSW is a community strategy in partnership with government and the corporate sector to create jobs for Aboriginal people. Following success in Moree, the program has been expanded to four offices in regional NSW and three offices in Sydney (box 11.2.2).
- The Accor Asia Pacific Corporate Leaders for Indigenous Employment Project encourages private sector companies to create job opportunities using the Australian Government's Indigenous Employment Programme (box 11.2.2).
- The Sunraysia Area Consultative Committee Structured Training and Employment Project was established in 2003. The project focuses on full time skilled or professional employment for Indigenous people (box 11.1.2).
- Under the Port Hedland Regional Partnership Agreement, the Australian Government and the Minerals Council of Australia aim to create employment and business opportunities for Indigenous people in mining regions (box 11.1.2).

Self employment and Indigenous business

Self employment is one way that Indigenous people can reduce dependence on government welfare and improve self reliance. It also enables them to participate in the economy and improve their economic wellbeing. Indigenous business has the potential to contribute to economic participation and development for Indigenous people.

Box 1.68 **KEY MESSAGES**

- In non-remote areas in 2004-05, the rate of self employment for Indigenous people was markedly lower than that for non-Indigenous people (table 11A.2.1).
- The most recent nationally comparable data that can be reported for the Indigenous self employment and business indicator are the ABS 2001 Census data that were published in the 2003 Report.
- The 2003 Report noted that differences in the rates of self employment between non-Indigenous and Indigenous people varied significantly across remoteness areas; the largest difference was found in very remote areas, where non-Indigenous people were nine times as likely as Indigenous people to be self employed.

Box 1.69 **Things that work**

- Through a small, Indigenous-owned enterprise, Wujal Wujal Walker Family Tours provide guided walking tours through the Daintree Rainforest in Queensland. The enterprise works with non-Indigenous tourism businesses in the region (box 11.2.2).
- Ngarda Civil and Mining, based in Port Hedland WA, in conjunction with Indigenous Business Australia, Henry Walker Eltin and the Ngarda Ngarli Yarndu Foundation, has achieved higher Indigenous employment staffing rates than other businesses in the mining sector (box 11.2.3).
- Indigenous Business Australia's Business Development Programme, known as IBA Enterprises, directly assists Indigenous individuals, families and partnerships to succeed in business, through support, mentoring and business loans (box 11.2.4).

Indigenous owned or controlled land

Indigenous owned or controlled land is reported as an indicator of economic participation and development. It is, however, also important in terms of the social and cultural relationships between Indigenous peoples and their land.

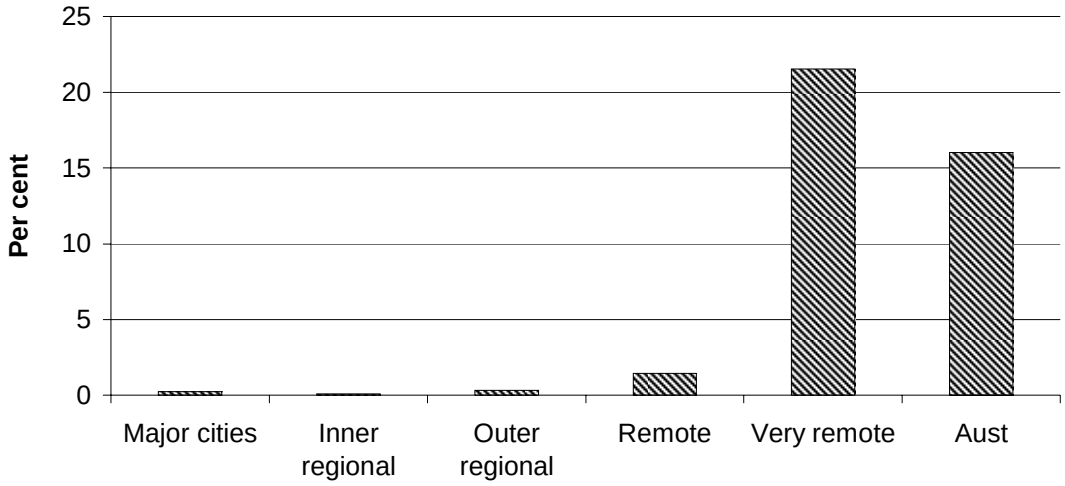
Box 1.70 **KEY MESSAGES**

- Indigenous (and non-Indigenous) people obtain a variety of economic, social and cultural benefits from land they own or control.
- In June 2006, native title had been determined to exist in full or part in 8 per cent of the area of Australia, compared with 5 per cent in June 2004. The national increase was around 264 210 km², with the major increase occurring in WA (figure 11.3.3).
- The number of registered Indigenous Land Use Agreements (ILUAs) increased from 84 in June 2003 to 250 in June 2006 (figure 11.3.4). Over this period, the total land area subject to ILUAs grew from 239 219 km² to 812 866.3 km², or 11 per cent of the total area of Australia.
- Indigenous land interests are also protected under various forms of legislation that enable the grant or purchase of land by governments for Indigenous ownership or use. The Indigenous Land Corporation has acquired 201 properties across Australia, covering more than 5.5 million hectares. Examples of State and Territory grants and transfers of land to Indigenous people are included in the main Report (section 11.3).

Ownership and control of land can provide both economic and cultural benefits to Indigenous people. As well as yielding benefits from customary activities (for example, fishing, hunting and gathering) and commercial activities (for example,

mining royalties and tourism), Indigenous owned or controlled land can provide people with a place to live, through either individual home ownership or community housing.

Indigenous owned land as a proportion of each remoteness area, December 2006



Source: ILC (unpublished); table 11A.3.2.

Box 1.71 **Things that work**

- The main Report contains several examples of the benefits deriving from Indigenous ownership and control of land, in terms of:
  - the customary economy
  - residential use and home ownership
  - commercial business
  - service delivery
  - land management/tradeable assets
  - eco-services (section 11.3).
- The Indigenous Pastoral Program was established in 2003 in the NT to increase sustainable pastoral production on Indigenous land and Indigenous involvement in the pastoral industry (box 11.3.2).

Governance capacity and skills

Capacity building for good governance can take many forms. This indicator provides information on Indigenous participation in mainstream courses that are regarded as useful in developing skills relevant to governance. These include

management and commerce, economics and business law. Students in other courses may also be well equipped to provide leadership and contribute to good governance.

Box 1.72 **KEY MESSAGES**

- In 2005, lower proportions of Indigenous than non-Indigenous students enrolled in university and TAFE courses relevant to governance and management (figures 11.4.1 and 11.4.3).
- Both Indigenous and non-Indigenous male students were more likely than females to enrol in university courses relevant to governance and management (figure 11.4.2).
- Both Indigenous and non-Indigenous female students were more likely than males to enrol in TAFE courses relevant to governance and management (figure 11.4.4).

Box 1.73 **Things that work**

- The Office of the Registrar of Aboriginal Corporations (ORAC) has developed a range of corporate governance training programs for Indigenous corporations and their governing committees/boards (box 11.4.2).
- The Managing in Two Worlds Governance Training Program aims to strengthen the management capacity of Victorian Aboriginal community organisations and improve service delivery, using programs developed by ORAC (box 11.4.2).

Case studies in governance arrangements

Many Indigenous bodies provide important services to their communities. Generally speaking, community governance refers to the ways Indigenous people come together to deal with community affairs, and organisational governance refers to governance of Indigenous bodies established to undertake social, economic and cultural activities. A comprehensive picture of Indigenous governance should also consider governments' engagement with Indigenous organisations and communities — government governance.

Governance is closely linked with economic development and disadvantage, because it contributes to Indigenous organisations' and communities' ability to make and implement decisions. Each Indigenous community and organisation has unique historical and cultural characteristics that are reflected in its governance arrangements, but some key determinants have general application to good governance, while allowing for the unique cultures of different organisations and communities.

Box 1.74 **KEY MESSAGES**

- Six determinants have general application to good Indigenous governance, while allowing for the unique cultures of different organisations and communities:
  - governing institutions
  - leadership
  - self-determination
  - capacity building
  - cultural match
  - resources.
- No one determinant in isolation is enough to lead to good governance arrangements — all determinants are necessary for sustained success.
- A comprehensive picture of Indigenous governance should also consider 'government governance' — government engagement with Indigenous organisations and communities.

Box 1.75 **Things that work**

The ***Indigenous Governance Awards*** are a partnership project between Reconciliation Australia and BHP Billiton, established in 2005, to encourage, reward and promote best practice in Indigenous governance.

Indigenous Governance Awards Finalists

2005

- *Winner*: Koorie Heritage Trust (Melbourne)
- *Highly commended*: Central Australian Aboriginal Congress (Alice Springs)
- *Highly commended*: Sunrise Health Service (Katherine)
- *Finalist*: Goldfields Land and Sea Council (Kalgoorlie)
- *Finalist*: Institute for Aboriginal Development (Alice Springs)
- *Finalist*: North Coast Aboriginal Corporation for Community Health (Maroochydore)
- *Finalist*: Maari Ma Health Aboriginal Corporation (Broken Hill)
- *Finalist*: Tiwi Islands Local Government (NT)

2006

Organisations under 10 years old

- *Winner*: Gannambarra Enterprises (Wagga Wagga)
- *Highly commended*: Wunan Foundation (Kununurra)
- *Finalist*: Muru Mittigar Aboriginal Cultural and Education Centre (Penrith)
- *Finalist*: Nyirranggulung Mardrulk Ngadberre Regional Council (Katherine)

Organisations over 10 years old

- *Winner*: WuChopperen Health Service Limited (Cairns)
- *Highly commended*: Yirra Yaakin Aboriginal Corporation (Perth)
- *Finalist*: Wangka Maya Pilbara Aboriginal Language Centre (Port Hedland)
- *Finalist*: Yarrabah Shire Council (Qld)

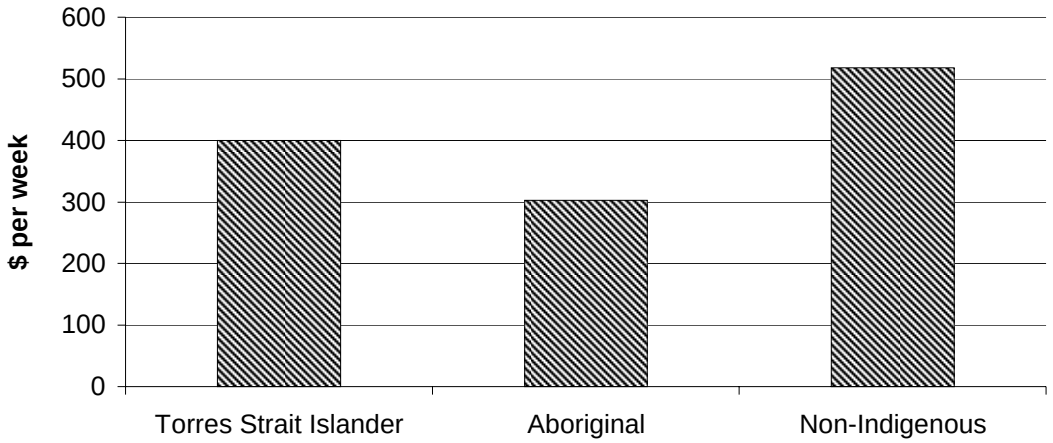
Outcomes for Torres Strait Islander people

Torres Strait Islander people are a culturally distinct group of Indigenous Australians. As a relatively small proportion of the Australian population, small numbers in surveys and administrative data collections make it difficult to report reliable data. The main Report includes a selection of results that separately identify outcomes for Torres Strait Islander people, Aboriginal people and non-Indigenous people. In these data, 'Torres Strait Islander' includes people who identified as 'Torres Strait Islander only' and 'Aboriginal and Torres Strait Islander'.

Box 1.76 **KEY MESSAGES**

- Around 6 per cent of Indigenous people identify as Torres Strait Islander only, while an additional 4 per cent identify as both Aboriginal and Torres Strait Islander.
- Fifty-nine per cent of Torres Strait Islander people live in Queensland.
- In 2004-05:
  - the proportions of Aboriginal and Torres Strait Islander adults with a long term health condition were similar (tables 12A.5.5 and 12A.5.6)
  - a higher proportion of Torres Strait Islander adults (22 per cent) than Aboriginal adults (14 per cent) had year 12 as their highest level of education (figure 12.5.1), but similar proportions had completed a post-secondary qualification of certificate level 3 or higher (table 12A.5.1)
  - the labour force participation rate for Torres Strait Islander people aged 18 to 64 years (70 per cent) was higher than for Aboriginal people (62 per cent) (figure 12.5.2). The proportions of people who were unemployed or who were participating in CDEP were similar (tables 12A.5.4 and 12A.5.6)
  - the median (mid point) weekly income of Torres Strait Islander adults ($400) was higher than for Aboriginal adults ($303) but lower than for non-Indigenous adults ($518) (figure 12.5.3)
  - the proportions of Aboriginal and Torres Strait Islander adults living in homes someone in their household owned or was purchasing were similar (table 12A.5.2).

Median (mid point) individual income, people aged 18 years or over, 2004-05



Data source: ABS 2004-05 NATSIHS; ABS 2004-05 NHS; table 12A.1.3.

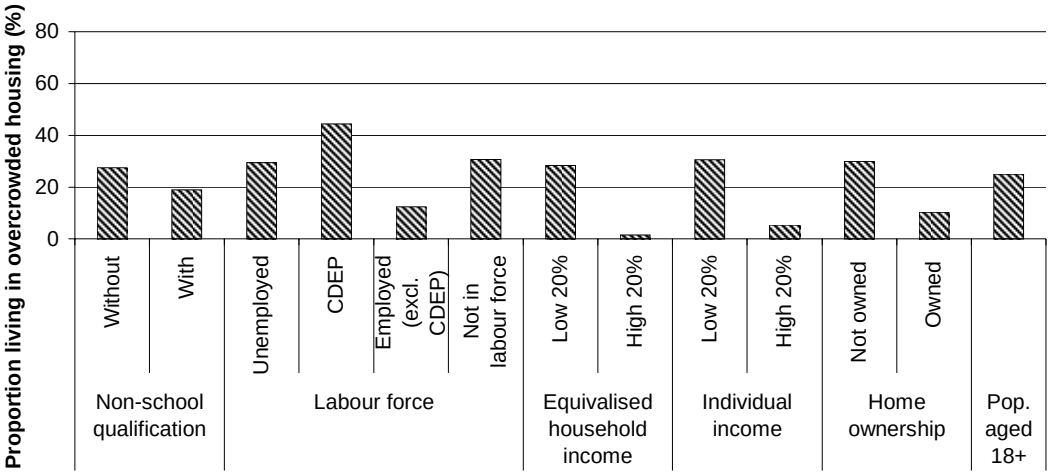
Measuring multiple disadvantage

Different aspects of disadvantage often seem to occur together — for example, poor education appears to be linked with poor employment outcomes, and both are linked with poor income. Using comparable data from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the National Health Survey (NHS), the main Report identifies some aspects of disadvantage that tend to occur together. This analysis does not identify cause and effect (that is, it does not say that disadvantage in one area is the *cause* of another poor outcome).

Box 1.77 **KEY MESSAGES**

- In 2004-05, Indigenous people were markedly disadvantaged when compared with non-Indigenous people against the three measured headline dimensions — education, labour force and income. Different patterns of disadvantage were observed according to age, sex and remoteness areas (figures 12.1.1–12.1.3).
- Overcrowded housing is associated with most headline dimensions of disadvantage, including poor education and employment outcomes and low household and individual incomes (figure 12.3.3).
- Health risk behaviours among Indigenous people are associated with many headline dimensions of disadvantage — daily smoking is associated with poor outcomes in education, employment and income (figure 12.3.1), and illicit drug use is associated with unemployment and poor outcomes in home ownership (figure 12.3.2).

Characteristics of Indigenous people aged 18 years and over living in overcrowded housing



Source: ABS 2004-05 NATSIHS (unpublished); tables 13A.3.1 and 13A.3.2.

FUTURE DIRECTIONS IN DATA

Notwithstanding some improvements, data for Indigenous people are of poor quality in several key areas.

Indicator	Data priority
Life expectancy and causes of death	• Continue work on improving quality and availability of Indigenous data, including changes over time.
Substantiated child abuse and neglect; children on care and protection orders	• Develop data collections to better reflect the underlying extent of child protection issues that are not necessarily apparent from administrative data on substantiations, notifications and orders.
Alcohol and tobacco consumption; drug and other substance use	• Collect regular data comparing Indigenous and non-Indigenous consumption and more robust data by jurisdictional and geographic levels.
Birthweight	• Extend data collections to focus on the Indigenous status of babies (rather than mothers).
Hearing impediments	• Collect data to enable the assessment of the true burden of hearing loss and the type and severity of ear infections in the Indigenous population.
Hospitalisation data	• Improve quality of Indigenous identification in hospital administrative systems.
Social and emotional wellbeing	• Improve data on comparable measures of social and emotional wellbeing.
Family and community violence	• Improve data on relationship of victim to offender and comparability between states and territories.
Children with tooth decay	• Expand the availability of comparable data on children's dental health.
Juvenile diversions	• Collect comparable national data.
Self employment and Indigenous business	• Collect regular data on Indigenous business and self-employment.
Access to clean water and functional sewerage	• Collect regular data allowing comparison between services in Indigenous communities and those

	delivered by major utilities.

1 Introduction

In April 2002, the Council of Australian Governments (COAG) commissioned the Steering Committee for the Review of Government Service Provision to:

> produce a regular report against key indicators of Indigenous disadvantage. This report will help to measure the impact of changes to policy settings and service delivery and provide a concrete way to measure the effect of the Council's commitment to reconciliation through a jointly agreed set of indicators (COAG 2002, see appendix 1).

The first Report on *Overcoming Indigenous Disadvantage: Key Indicators* was released in November 2003. A second edition of the report was published in July 2005. Both editions have been widely welcomed and generally well received, and have been the subject of considerable discussion and debate amongst Indigenous organisations, governments and public sector agencies, non-government organisations, and many individuals — both Indigenous and non-Indigenous.

This is the third Report in the series. It has been greatly informed by the ongoing consultations that have taken place. While not everyone agrees with all aspects of the framework, there is widespread endorsement of its vision of 'a society where Aboriginal and Torres Strait Islander peoples should enjoy a similar standard of living to that of other Australians, without losing their cultural identity' (CAR 2000). The Report has led to constructive debate, based on the best available information. It has provided depth to the discussion and improved the potential for practical solutions to entrenched problems.

1.1 Not just another statistical report

This Report does more than provide information about outcomes for Indigenous Australians — although this is an important aspect of the Report. The Report was conceived as a strategic document to assist governments to identify the focus for policy attention, and to measure whether these policies are working.

A large amount of information on Indigenous Australians has been gathered by a range of people and organisations, resulting in numerous reports and academic publications. There are also substantial lists of performance indicators in a number of service areas, particularly health. It is not the aim of this Report to replicate what is being done elsewhere.

COAG nominated two core objectives for the Report. The first is to inform Australian governments about whether policy programs and interventions are achieving improved outcomes for Indigenous people. The second is to produce a Report that is meaningful to Indigenous people.

Therefore, the Report on Overcoming Indigenous Disadvantage is more than a collection of data — it is both visionary and strategic. The vision, outlined in the 'priority outcomes', is that Indigenous people will one day enjoy the same opportunities as other Australians, together with a strong cultural identity. The rest of the Report framework underpins a strategy to achieve this vision.

The information presented in the Report provides policy makers with a broad view of the current state of Indigenous disadvantage and where things need to change if the Report's vision is to be achieved. The headline indicators measure progress toward the priority outcomes, while the strategic areas for action and strategic change indicators identify agreed areas of focus for policy effort, and the results of that effort. Over time, editions of this Report will track where governments have had an impact on Indigenous disadvantage — and where work still needs to be done.

The Report also provides a practical tool for government agencies and Indigenous organisations. The Report's outcome focus can encourage agencies to think beyond their existing policy frameworks, and agencies can incorporate Report indicators into monitoring and evaluation. Indigenous organisations can use the framework indicators to monitor their own outcomes, and to hold governments to account.

The Report is influencing how governments address Indigenous disadvantage. Implementation of the Overcoming Indigenous Disadvantage framework by all governments is summarised in appendix 2. In July 2006, COAG agreed that a long-term, generational commitment is needed to overcome Indigenous disadvantage:

> COAG agreed the importance of significantly closing the gap in outcomes between Indigenous people and other Australians in key areas for action as identified in the *Overcoming Indigenous Disadvantage: Key Indicators Report* … (COAG 2006)

COAG has established a working group to develop a detailed proposal for generational change:

> The working group will consider how to build clearer links between the OID framework, the National Framework of Principles for Delivering Services to Indigenous Australians, the COAG Reconciliation Framework and the bilateral agreements between the Commonwealth and State and Territory Governments. (COAG 2006)

In order to provide a comprehensive picture of outcomes for Indigenous people, this Report uses some data that might be considered imperfect for the purposes of other reports. But the Steering Committee considers that, providing data are not misleading, imperfect information is better than no information. Moreover, publishing imperfect data (with qualifications where necessary) can lay the foundation for developing better data over time. There is a clear need for improvements in data, if COAG's objectives in commissioning this Report are to be fully met. Data issues, including future directions in data, are summarised at the end of each chapter of the Report, and the most significant data gaps summarised at the end of the Overview. Chapter 2 explores the Report's approach to data in more detail.

While concentrating on outcomes for Indigenous Australians at the national or jurisdictional level, the Report recognises the diversity of Aboriginal and Torres Strait Islander cultures and experience; and acknowledges that disadvantage may come in different forms for urban, regional and remote dwellers. Wherever possible, information has been broken down to report separately for Aboriginal people and Torres Strait Islander people, and by remoteness. However, data limitations, and a desire to keep the Report to a manageable size, mean that much of the Report is at a high level of aggregation. Some jurisdictions, and even individual Indigenous communities, have taken up the challenge of producing more disaggregated reports to meet their specific needs.

This Report recognises that many factors bear on change — no one action is going to eradicate Indigenous disadvantage. A key message from consultations with Indigenous people was that the Report should not imply that the efforts of governments acting alone would be enough to achieve fundamental, long term change. The drivers of change must include actions on the part of the private sector, the general community and, not least, Indigenous people themselves.

1.2 Background

In its response to the Council for Aboriginal Reconciliation's Report, *National Strategies to Advance Reconciliation* (CAR 2000), COAG acknowledged the unique status of Indigenous Australians, and agreed that 'many actions are necessary to advance reconciliation, from governments, the private sector, community organisations, Indigenous communities, and the wider community' (COAG 2000; appendix 1). Heads of government committed to a partnership approach, which recognised the contributions that all of these elements could bring to addressing Indigenous disadvantage. Priority actions in three areas were agreed:

- Investing in community leadership initiatives.

- Reviewing and re-engineering programmes and services to ensure they deliver practical measures that support families, children and young people. In particular, governments agreed to look at measures for tackling family violence, drug and alcohol dependence and other symptoms of community dysfunction.
- Forging greater links between the business sector and Indigenous communities to help promote economic independence (COAG 2000; appendix 1).

In December 2000, the final report of the Council for Aboriginal Reconciliation, called for COAG to agree on a framework for all governments (and the Aboriginal and Torres Strait Islander Commission) to set measurable program performance benchmarks and annually report performance against those benchmarks.

Also in December 2000, the Prime Minister wrote to the Ministerial Council for Aboriginal and Torres Strait Islander Affairs (MCATSIA), requesting it to develop its action plan on reconciliation to include performance reporting strategies and benchmarks. A framework was developed by early 2002. It identified three priority areas for action, headline indicators and strategic change indicators. This framework formed the basis of the Steering Committee's consultations in 2002, before production of the first Overcoming Indigenous Disadvantage report in 2003.

The Review

The Steering Committee for the Review of Government Service Provision comprises representatives from all Australian governments and is chaired by the Chairman of the Productivity Commission, which also provides the secretariat.

Up until 2003, the Review's principal output had been the annual Report on Government Services (the 'Blue Book'), now in its twelfth edition. The Blue Book provides information on the efficiency and effectiveness of, and equity of access to, mainstream services in the areas of education, justice, emergency management, health, community services and housing. It brings together data that provide a national overview of government service delivery. The services covered add up to some $100 billion (or around one-third of total government spending). Since 2003, the Review has published a separate Compendium of information relating to the delivery of mainstream services to Indigenous people, drawn from the Blue Book (SCRCSSP 2003a; SCRGSP 2004–2007a).

Overcoming Indigenous Disadvantage represents a departure from the type of reporting that is in the Blue Book. In his letter to the Chairman of the Steering Committee formally requesting this Report, the Prime Minister noted that the task will be to:

> Identify indicators that are of relevance to all governments and Indigenous stakeholders and that can demonstrate the impact of programme and policy interventions (p. xvi).

The Report on Government Services focuses on the efficiency and effectiveness of specific services. The Overcoming Indigenous Disadvantage Report focuses on outcomes for Indigenous people and does not report on specific services.

1.3 The process

This Report focuses on the underlying factors that ultimately cause disadvantage; relying on experience, evidence and logic to identify areas where targeted policies will have the greatest impact. This task has required input from governments and relevant experts, but most particularly, from Indigenous people.

The Working Group

The Report's development is guided by a Working Group. This group, established by the Steering Committee to develop the framework for the 2003 Report, has been involved in each edition of the Report. The Working Group comprises representatives from central agencies in all governments, as well as the MCATSIA.[1] The Australian Bureau of Statistics and the Australian Institute of Health and Welfare also participate as observers. The Working Group was originally convened by Gary Banks, the Chairman of the Steering Committee and Productivity Commission, and since 2004 has been convened by Commissioner Robert Fitzgerald of the Productivity Commission.

The consultation process

An extensive consultation process was undertaken in developing the framework for the 2003 Report. The Australian, State and Territory governments conducted consultations within their jurisdictions, and officials representing MCATSIA and the former Aboriginal and Torres Strait Islander Services consulted within their organisations. In addition, the Chairman of the Steering Committee and the head of the Secretariat held discussions with a number of Indigenous leaders and organisations, and a range of officials and researchers across the country. The Chairman also wrote to key organisations and individuals seeking written comments

[1] Aboriginal and Torres Strait Islander Services (ATSIS) was represented on the original Working Group. Since the abolition of ATSIS, the Office of Indigenous Policy Coordination within the Australian Government has been represented on the Working Group.

on the framework. A report was produced summarising these consultations (SCRCSSP 2003b).

Following release of the 2003 Report, the consultation process continued, with a different focus. Whereas the earlier consultations had concentrated on the reporting framework, consultations in 2004 were about the Report itself. Those consultations largely fell into two categories. The first involved obtaining feedback from Indigenous people and organisations about the Report; while the second involved discussions with government agencies about how the Report was being used.

Following the release of the 2005 Report, the Steering Committee decided to review the indicator framework before preparing the 2007 Report. Once again, working group members conducted consultations within their jurisdictions, and the Convenor of the working group and the Secretariat held meetings with all Australian governments, with researchers and with Indigenous people and organisations across Australia. A number of written submissions were also made.

As far as possible, consultations with Indigenous people were held in communities not previously consulted. Meetings were held across the country, from very remote locations to regional centres and metropolitan areas. Not surprisingly, the range of issues raised during these meetings reflected the diversity of the Indigenous population. The outcomes of these consultations have been published as a separate report (SCRGSP 2007b). Feedback obtained during the consultations and a list of the changes made to the framework following the consultations are included in chapter 2 of this Report.

1.4 References

CAR (Council for Aboriginal Reconciliation) 2000, *National Strategies to Advance Reconciliation*, Sydney.

COAG (Council of Australian Governments) 2000, *Communiqué* Meeting 3 November 2000, Canberra.

—— 2002, *Communiqué* Meeting 5 April 2002, Canberra.

—— 2004, *Communiqué* Meeting 25 June 2004, Canberra.

—— 2006, *Communiqué* Meeting 14 July 2006, Canberra.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2003a, *Report on Government Services Indigenous Compendium*, Productivity Commission, Canberra.

—— 2003b, *Draft Framework for Reporting on Indigenous Disadvantage: Report on Consultations*, Productivity Commission, Canberra.

—— 2004–2007a, *Report on Government Services Indigenous Compendium*, Productivity Commission, Canberra.

——2007b, *Framework for Reporting on Indigenous Disadvantage: Report on Consultations 2006*, Productivity Commission, Canberra.

2 The framework

The first two sections of this chapter describe the underpinnings and the structure of the Report's framework. Knowing how the framework has been constructed is fundamental to understanding how it can assist governments; and fundamental also in making the Report meaningful to Indigenous people.

Section 2.3 provides feedback from the consultations that were conducted following the release of the 2005 Report. These consultations were generally supportive of the approach taken, although a range of suggestions were made for improving indicators. Indigenous people made many comments about the Report's approach to cultural issues. In section 2.4, the cultural indicators are explained, against the backdrop of suggestions received from Indigenous people during consultations.

2.1 The underpinnings

The Council of Australian Governments (COAG) has been clear in its direction that this Report must help inform policy development within jurisdictions. Reports about the performance of governments generally focus on the delivery of services; for example, whether they were on time and on budget. As a rule, such reports are agency focused — education is reported by departments of education, health by health departments — and so on.

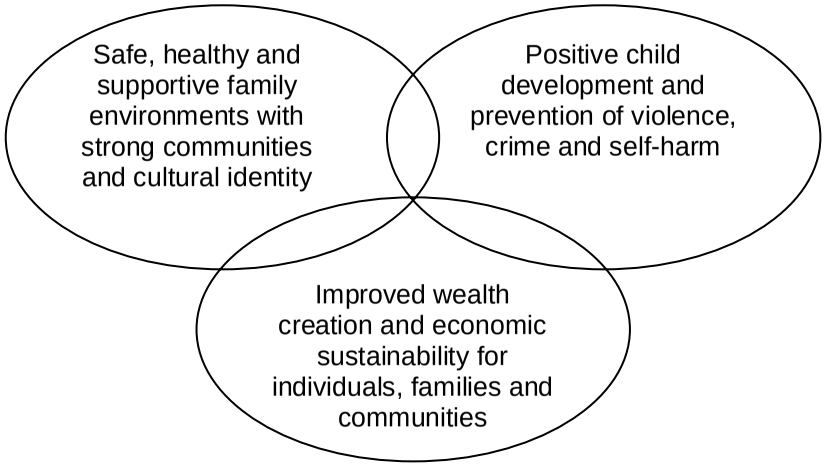
While information on the delivery of outputs is valuable, this Report does something different. The Report framework emphasises the importance of interaction — between sectors and between governments, and with Indigenous people themselves — in achieving good outcomes. Improvements in the wellbeing of Indigenous Australians will require the involvement of more than one government agency, and will need action on a whole-of-government basis.

The indicator framework is depicted in figure 2.2.1. Changes to indicators since the 2005 Report are marked in italic.

Figure 2.2.1 **Multi-level indicator framework *(changes to indicators since the 2005 Report are marked in italic)***

1. Priority outcomes

Indigenous people and governments have agreed the following outcomes. These outcomes are closely linked to each other —progress in one area can assist progress in the others



2.

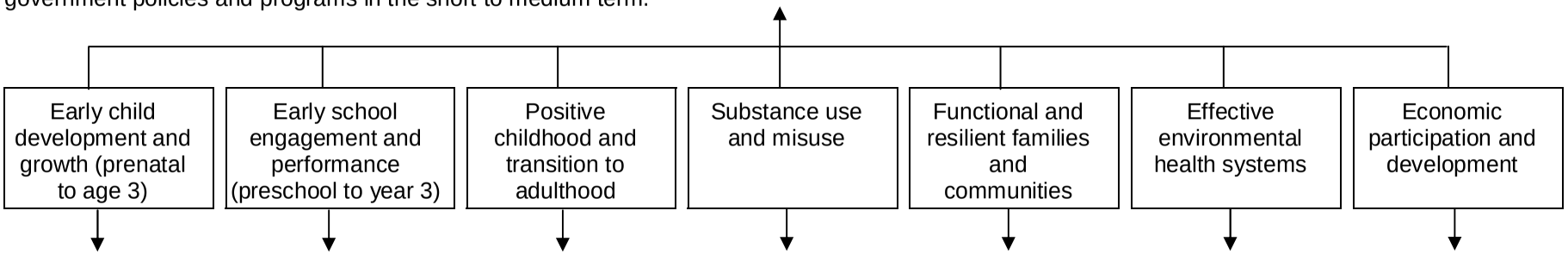
Headline indicators

The headline indicators measure progress in achieving the priority outcomes. They are a small set of high level indicators, which usually take some time to respond to changes in government policies.

• Life expectancy at birth • *Disability and chronic disease* • Years 10 and 12 retention and attainment • Post secondary education — participation and attainment	• Labour force participation and unemployment *(CDEP and long term unemployment data included here)* • Household and individual income • Home ownership • Suicide and self-harm	• *Substantiated child abuse and neglect* • Deaths from homicide and hospitalisations for assault • *Family and community violence* • Imprisonment and juvenile detention rates

3. Strategic areas for action

Governments have agreed to focus policy attention on the following seven strategic areas. Over time, progress in these areas is expected to lead to improvement in the headline indicators and priority outcomes. Progress is measured by a series of strategic change indicators, which can be influenced by government policies and programs in the short to medium term.



- *Injury and preventable diseases*
- Infant mortality
- Birthweight
- Hearing impediments
- *Children with tooth decay*

- Preschool *and early learning*
- School attendance
- Year 3 literacy and numeracy

- Years 5 and 7 literacy and numeracy
- Retention at year 9
- Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies
- Juvenile diversions as a proportion of all juvenile offenders
- Transition from school to work

- *Alcohol consumption and harm*
- *Tobacco consumption and harm*
- *Drug and other substance use and harm*

- Children on care and protection orders
- Repeat offending
- *Access to primary health care*
- *Mental health*
- Proportion of Indigenous people with access to their traditional lands
- Participation in organised sport, arts or community group activities
- *Engagement with service delivery*

- Rates of diseases associated with poor environmental health (including water and food borne diseases, trachoma, tuberculosis and rheumatic heart disease)
- Access to clean water and functional sewerage
- Overcrowding in housing

- Employment (full-time/part-time) by sector (public/private), industry and occupation
- Self employment and *Indigenous business*
- Indigenous owned or controlled land
- *Governance capacity and skills*
- Case studies in governance arrangements

Essentially, the framework is about looking forward. A range of circumstances — historical, economic and social — have created the need for a concentration of policy on Indigenous disadvantage. The framework seeks to ensure that the circumstances which are the root cause of continuing disadvantage become the focus of policy attention.

2.2 The framework

Three priority outcomes sit at the top of the framework. These outcomes are interlinked and should not be viewed in isolation. They reflect COAG's vision for reducing disadvantage, and were widely endorsed by Indigenous people.

However, it is extremely difficult to measure progress in achieving these outcomes, particularly in the short term. Therefore, the framework incorporates two further tiers with more measurable indicators. The goal is that measured progress in these two tiers of the framework will, in time, overcome the disadvantage which prevents the priority outcomes for a large number of Indigenous people and communities.

- The first tier (the headline indicators) provides an overview of the state of Indigenous disadvantage, with twelve high level indicators, that will take some time to change. The headline indicators serve to keep a national focus on the long term challenge of reducing disadvantage, and provide proxy measures for the priority outcomes.
- The second tier (the strategic areas for action) is of more immediate relevance to policy. Governments and Indigenous people have agreed that action in the seven agreed priority areas will lead to improvements in the headline indicators over time. A series of strategic change indicators measure whether policy actions are making a difference in the strategic areas for action.

Prevention and early intervention lie at the heart of the framework. The focus is on encouraging action in the 'strategic areas for action' that, over time, will lead to improvements in headline outcomes. For example, it is predictable that a child who is not performing well at year 3 is less likely to progress to year 10 or 12, or to perform well at those levels. A focus by policy makers on improving the strategic change indicators of preschool and early learning, school attendance, and year 3 literacy and numeracy is necessary to improve the headline indicators of years 10 and 12 retention and attainment and, in turn, higher education and employment outcomes.

Headline indicators

The headline indicators are set out in figure 2.2.1. Following consultations, minor changes have been made to some headline indicators since the 2005 Report.

Disability and chronic disease

The previous 'Rates of disability and/or core activity restriction' indicator has been renamed 'Disability and chronic disease'. The broader measure of morbidity, health outcomes and disability reflects the importance of chronic disease in overall health outcomes for Indigenous people.

Substantiated child abuse and neglect

The previous 'Substantiated child protection notifications' indicator has been renamed 'Substantiated child abuse and neglect' to make it more understandable to a non-specialist audience. There are currently no reliable data on the incidence of child abuse, however, and substantiated child protection notifications remain the primary source of data for the indicator.

Family and community violence

The previous 'Victim rates of crime' indicator has been renamed 'Family and community violence' to draw greater attention to the domestic and community violence aspects of this indicator, which are of particular concern in some Indigenous communities.

Strategic areas for action

The seven strategic areas for action were chosen for their potential to have a significant and lasting impact in reducing Indigenous disadvantage.

As noted, more than one government agency will usually have to take action in order to achieve better outcomes in each area. For example, in the area of 'Early school engagement', the school system has an important role to play, but so do agencies dealing with transport availability, housing arrangements and health.

The diagrams in figures 2.2.2 and 2.2.3 illustrate the many linked factors that can affect outcomes. Different aspects of disadvantage are often interrelated, and action may be needed in several areas to make progress. In figure 2.2.2, the headline outcome of employment is influenced by years 10 and 12 retention and tertiary

attainment, but these in turn are influenced by early school engagement and early child development. And environmental factors such as those found in the 'substance use and misuse' and 'functional and resilient families and communities' strategic areas for action affect all these outcomes. Employment and education outcomes can also be influenced by the inter-generational effects of parental income, employment and education levels.

Figure 2.2.2 **A preventive model — multiple causes**

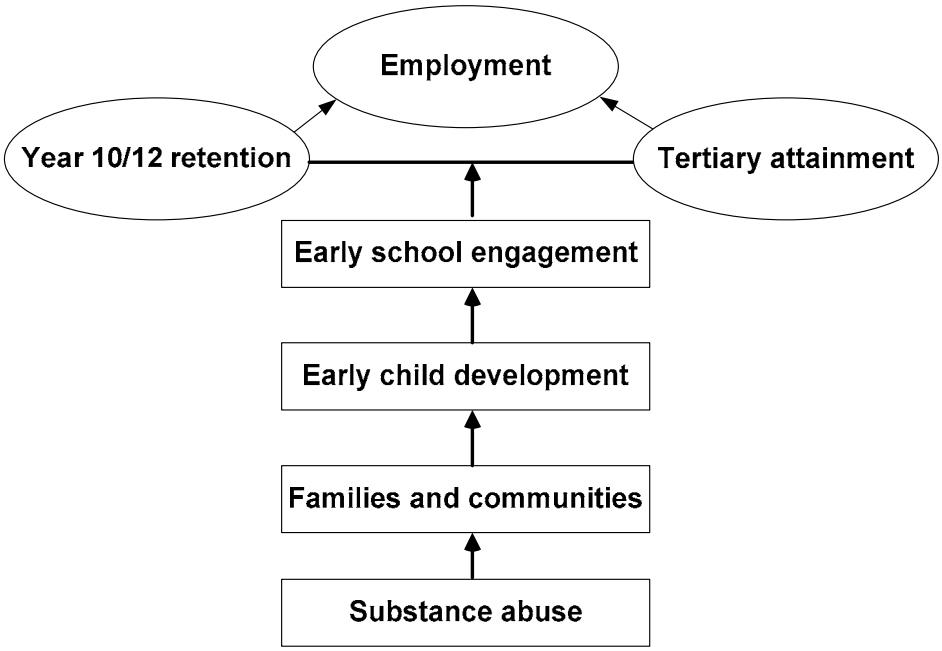
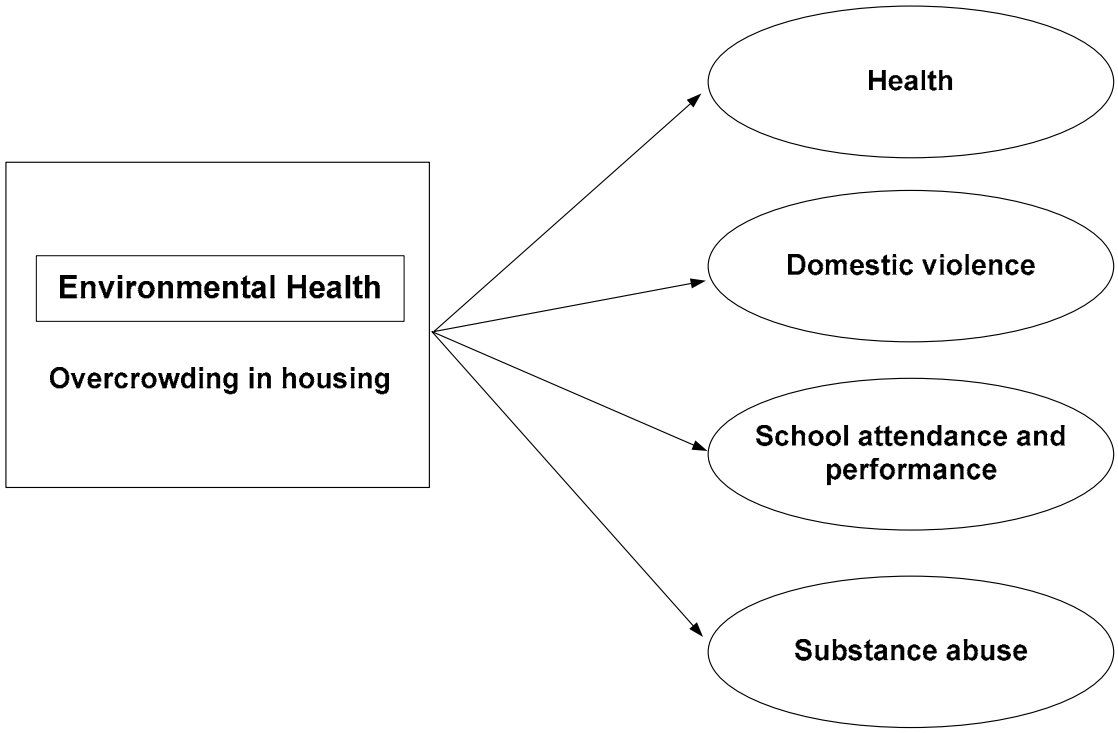


Figure 2.2.3 shows how inter-relationships between outcomes mean that well targeted actions can lead to improvements across a whole range of indicators. Reducing overcrowding in housing can contribute to improvements in health, school attendance and performance, substance use and misuse, and even family and community violence (although other influences are also important in each of these areas).

Figure 2.2.3 **A preventive model — multiple impacts**



Strategic change indicators

The strategic change indicators were chosen for their potential to lead to change in the headline indicators over time. Most indicators are linked to outcomes — not to specific policy actions or service outputs. However, some outputs are so closely tied to outcomes that they have been included: for example, water, sewerage, and access to primary health care. The framework is based on the understanding that individual agencies in each jurisdiction will examine their capacity to contribute to improvements in these indicators.

The following sections provide a brief rationale for each strategic area for action, and list the relevant strategic change indicators. Any changes to indicators from the 2005 Report are identified.

Early child development and growth (prenatal to age 3)

Providing a child with a good start in life can have a profound effect on his or her passage through the life cycle. Health, growth and development in the first three years play a critical role in later outcomes. Key indicators are:

- Injury and preventable diseases

- Infant mortality
- Birthweight
- Hearing impediments
- Children with tooth decay.

The previous 'Rates of hospital admission for infectious diseases' indicator has been renamed 'Injury and preventable diseases' to provide a more comprehensive picture of health outcomes for Indigenous children and to focus efforts on obtaining data on the underlying incidence of disease and injury.

The previous 'Primary school children with dental caries' indicator has been renamed 'Children with tooth decay'. The words 'tooth decay' rather than 'dental caries' make the indicator more understandable to a general audience. The indicator has been moved from 'Early school engagement and performance' to 'Early child development and growth'. Consultations indicated that tooth decay is more a lagged indicator of childhood development than of school engagement and performance. (That is, although decay shows up during preschool to year 3, the circumstances that led to decay generally occurred during early childhood).

Early school engagement and performance (preschool to year 3)

Early school engagement is important for establishing a foundation for educational achievement, retention in secondary schooling, opportunities in employment and minimising contact with the justice system later in life. Key indicators are:

- Preschool and early learning
- School attendance
- Year 3 literacy and numeracy.

The previous 'Preschool and school attendance' indicator has been split into two indicators, 'Preschool and early learning' and 'School attendance', to distinguish between distinct aspects of early school engagement and allow expanded coverage of early learning.

Positive childhood and transition to adulthood

Ongoing participation in school and vocational education encourages self-esteem and a more positive basis for achieving employment. Such participation also leads to reduced contact with the justice system. Key indicators are:

- Years 5 and 7 literacy and numeracy

- Retention at year 9
- Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies
- Juvenile diversions as a proportion of all juvenile offenders
- Transition from school to work.

Substance use and misuse

Abuse of alcohol and other substances affects physical and mental health, family and community relationships, and can result in contact with the justice system. Key indicators are:

- Alcohol consumption and harm
- Tobacco consumption and harm
- Drug and other substance use and harm.

The indicators in this strategic area have been renamed to clarify reporting, by bringing together data for each of the three main substance types.

Functional and resilient families and communities

Functional and resilient families and communities influence the physical and mental health of adults and children, and affect contact with the justice system. Problems in families and communities can lead to breaks in education, disrupted social relationships and social alienation. Key indicators are:

- Children on care and protection orders
- Repeat offending
- Access to primary health care
- Mental health
- Proportion of Indigenous people with access to their traditional lands
- Participation in organised sport, arts or community group activities
- Engagement with service delivery.

The previous indicator ‘Access to the nearest health professional’ has been renamed ‘Access to primary health care’ to provide a broader measure of access to health services.

‘Mental health’ has been included in recognition of the significance of mental health and wellbeing in Indigenous health.

‘Engagement with service delivery’ has been included to focus attention on service accessibility for Indigenous people, for both mainstream and Indigenous specific services. Appropriate access to services is crucial to reducing Indigenous disadvantage.

Effective environmental health systems

Clean water and adequate sewerage, housing and other essential infrastructure are important to physical wellbeing and the physical development and health of children and adults. Key indicators are:

- Rates of diseases associated with poor environmental health (including water and food borne diseases, trachoma, tuberculosis and rheumatic heart disease)
- Access to clean water and functional sewerage
- Overcrowding in housing.

Economic participation and development

Having a job or being involved in a business activity leads to higher incomes for families and communities, with positive effects on health, education of children, etc.). It also enhances wellbeing and reduces social alienation. Well governed communities and organisations play a key role in achieving a wide range of outcomes for Indigenous people. Key indicators are:

- Employment (full-time/part-time) by sector (public/private), industry and occupation
- Self employment and Indigenous business
- Indigenous owned or controlled land
- Governance capacity and skills
- Case studies in governance arrangements.

The previous indicator ‘CDEP participation’ has been removed as a separate strategic change indicator. Data on CDEP participation are now included as a component of the headline indicator ‘Labour force participation and unemployment’. Data on CDEP participation helps readers interpret data on Indigenous labour force participation and unemployment.

Similarly, the previous indicator ‘Long term unemployment’ has been removed as a separate strategic change indicator. Data on long term unemployment are included in the headline indicator ‘Labour force participation and unemployment’.

The previous indicator, ‘Self employment’, has been renamed ‘Self employment and Indigenous business’ to allow data and case studies on Indigenous business more generally to be reported, including self employment.

The previous indicator, ‘Accredited training in leadership, finance or management’ has been renamed ‘Governance capacity and skills’ to allow reporting of a broader range of information and better reflect the true intent of the indicator.

Criteria for selection of strategic change indicators

The consultations raised numerous suggestions for strategic change indicators. All suggestions were assessed against the criteria shown in box 2.2.1. For the most part, the indicators included in the framework met most or all of the criteria. They have also been broadly accepted by Indigenous people as meaningful, and by governments as relevant to policy actions.

Box 2.2.1 **Criteria used to select strategic change indicators**

- Relevance to priority outcomes
- Sensitive to policy interventions and changes in policy settings
- Actions in the strategic areas for action result in positive outcomes over time in the headline indicators
- Meaningful to stakeholders and principally to the Indigenous community
- Supported by strong logic or empirical evidence
- Unambiguous and clear in meaning and interpretation
- The existence of, or ease of developing, supporting data sets

The first criterion ‘relevance to priority outcomes’ provides the focus. Without exception, all of the indicators need to demonstrate that policy action in that activity would ultimately contribute to achieving the priority outcomes.

The second criterion, ‘Sensitive to policy interventions and changes in policy settings’, requires that government policies or programs have the potential to influence the indicator. An indicator that governments could not influence would not be included in the framework.

One of the most important criteria is the existence of an underlying theory of causality and the availability of an evidence base. Without strong evidence or logic for the selection of each strategic change indicator, the framework would lose its predictive power, and with it, much of its utility. For the most part, empirical evidence has provided the basis for satisfying this criterion. For some indicators, however, there was little empirical evidence, but the logic and feedback from consultations were considered compelling.

The existence of data sets or ease of developing them is clearly an important practical consideration. In many cases, the selected indicators are a compromise, due not only to the absence of data, but also because it is unlikely any data will become available in the foreseeable future. In some cases an indicator has been included even when the data are not available on a national basis, or are substantially qualified. These are indicators where there is some likelihood that data quality and availability will improve over time. (For more information on data, see section 2.5.)

In two cases where there were no reliable data available (Indigenous cultural studies and governance), the indicators were nevertheless considered to be so important that qualitative indicators using case studies have been included in the Report.

There is also the potential for some data to yield ambiguous results. For example, an increase in notifications of child abuse or neglect does not necessarily mean that there has been an increase in the incidence of such behaviour, because the proportion of incidents reported may change over time. Nevertheless, because of its importance, child protection has been included in the framework (see sections 3.9 and 9.1).

2.3 Feedback from consultations

As mentioned in chapter 1, consultation with Indigenous people, government agencies and researchers has been an important part of the development of the indicator framework and Report. Initial consultations in 2002-03 provided a foundation for developing the framework (reported in SCRCSSP (2003)).

Following the release of the first Report in November 2003, the Chair of the Steering Committee and the Convenor of its Indigenous Working Group, commenced another round of consultations to obtain feedback on the Report and to explore how the issue of Indigenous governance should be presented in future reports.

In 2006, following publication of the 2005 Report, the Steering Committee held a third round of consultations to review the indicator framework and seek further feedback on the Report. A detailed description of the consultation process and feedback received was published in SCRGSP (2007a). Changes made to indicators in the framework in response to the consultations are set out in section 2.2.

A wide range of suggestions were made during the 2006 consultations. However, there were some common themes:

- Most importantly, there was broad support for the existing framework — generally, Indigenous people recognised that the indicators reflected the issues that were affecting their communities and causing disadvantage.
- It was often stated that wider distribution of the Report was required to Indigenous organisations and communities and within all governments.
- It was agreed that revisions to the framework should be pursued (see section 2.2), but there was strong support for maintaining its strategic approach, and focusing on a limited number of key indicators.
- There was support for more linkages in the Report, to illustrate the connections between key outcomes.
- There was a desire for greater disaggregation of data between urban, regional and remote areas and, where possible, specific information on Torres Strait Islander people.
- The 'things that work' boxes were seen as being very useful. Many people felt there should be more, including for headline indicators — and some suggested inclusion of 'things that don't work'.
- There was strong support for identifying the 'success factors' behind the 'things that work' — particularly where they highlighted government's interaction with Indigenous organisations and communities.
- Cultural issues were regarded as significant to the wellbeing of Indigenous Australians but there was general acceptance of the difficulty of defining specific indicators relevant for a report on overcoming disadvantage (see section 2.4 for more discussion of culture).
- There were acknowledged difficulties regarding 'language' as a purely cultural indicator. The diversity of views mean that further work is required to develop an appropriate indicator.
- There was a general view that improving governance remains critically important at organisational, community and governmental levels and should continue to be targeted in the Report. Participants suggested additional key

determinants including a bottom-up approach, adequate resources and government engagement with Indigenous communities and organisations.

Reflecting the diversity within the Indigenous population, there were different perspectives on some of the indicators, particularly home ownership and those relating to land. Nevertheless, the acceptance of these indicators within the framework is widespread.

During the course of the consultations, many people asked how governments' progress in addressing the strategic areas for action would be monitored. While the processes for reform and analysis of specific programs and services is beyond the scope of this Report, a summary of implementation measures being adopted by individual governments is contained in appendix 2. Data on Indigenous people's access to a range of government services are included in the Indigenous Compendium of the Review's annual Report on Government Services (SCRGSP 2007b)

Finally, there were many examples of initiatives that were underway, often at the community level, that are producing some good results. As there is no way of reporting these on a national level (or even in most cases, on a State or Territory level), some have been included in boxes on 'things that work' throughout the Report. These examples are important, because they illustrate how things can change for the better, and provide models that other communities can draw upon and adapt for their own use.

2.4 Culture

The representation of culture in the framework has been a constant topic of discussion during consultations with Indigenous people. Many comments have been made and many suggestions for new indicators have been proposed.

One of the messages that came through clearly during consultations in 2002 and 2003 was that no single indicator could adequately reflect the place of culture in the lives of Indigenous people. Culture was so important that it pervaded every aspect of the lives of Indigenous people, and where there was a breakdown in culture, (for example, loss of traditional ways or language) disadvantage was likely to be greater.

Many of the Indigenous people consulted noted the challenge of identifying indicators that could both meet the criteria (for example, data availability and responsiveness to policy action) and have relevance to a broad range of Indigenous people. A further challenge was the need to recognise the diversity of Indigenous culture across Australia.

Suggested cultural indicators were tested against the criteria (see box 2.2.1). All were 'meaningful to stakeholders and principally to the Indigenous community', but many were not sensitive to 'policy interventions and changes in policy settings', and often there were no 'supporting data sets or the potential to develop them', particularly at a national level. These are essential criteria if the Report is to be an ongoing record of whether, and to what extent, government interventions are being successful.

After assessing suggestions against the criteria, the following cultural indicators were selected for reporting. Because of the pervasive importance of culture to Indigenous people, the cultural indicators are spread across the strategic areas for action, rather than being reported as a separate 'stand-alone' group. As emphasised across this Report, there are links across the strategic areas for action and between these areas and the headline indicators. These links are particularly strong for many of the cultural indicators.

Learning about culture

Many Indigenous people said that culturally appropriate curriculum improved the motivation of Indigenous children to attend or remain at school, particularly in the early and middle years of high school. Furthermore, many people raised the scope for Indigenous cultural studies to benefit both Indigenous and non-Indigenous young people, and to address the ignorance and misunderstanding that often underlie racism.

The 'Positive childhood and transition to adulthood' strategic area for action includes the indicator:

- **Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies**.

Data are limited in this area, and it is desirable that in time more information is collected. Section 7.3 includes information on:

- culturally inclusive curricula, including some selected case studies
- Indigenous employment in schools.

Participation in Indigenous cultural activities.

Ideas for indicators in this area reflect the diversity of Indigenous culture. Suggestions for this indicator covered a range of activities, including festivals and cultural events; kinship, hunting, gathering and initiation; sport and recreation; art

and ceremony. The point was made that art and ceremony are significant markers of a society's spiritual and cultural strength in both western and Indigenous contexts.

The 'Functional and resilient families and communities' strategic area for action includes the indicator:

- **Participation in organised sport, arts or community group activities.**

There is strong anecdotal evidence that these activities can foster self-esteem, social interaction, and the development of skills and teamwork, leading to outcomes such as a reduction in juvenile crime. Unfortunately, no data are available for Indigenous people under the age of 15 years.

Section 9.6 includes information on the proportion of people 15 years and over participating in sport, recreation or fitness. Case studies have been included to describe some of the activities that are taking place in various communities.

Land

There has been widespread support for the inclusion of land as a cultural indicator. However, many Indigenous organisations and individuals also stressed the importance of land as an economic indicator. From a slightly different perspective, Torres Strait Islanders have commented that the sea was more culturally important to them than land, although land was important in economic terms. A number of views (sometimes conflicting) were also reflected about native title.

Although there was unanimous agreement that the recognition of the cultural significance of land needed to be included in the Report, there were no concrete suggestions as to what the indicator should be. On the other hand, there was widespread support for the inclusion of the ownership or control of land as an economic indicator.

The 'Functional and resilient families and communities' strategic area for action includes the indicator:

- **Proportion of people with access to their traditional lands.**

Section 9.5 reports information from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) for people in non-remote areas, including:

- recognition of homelands/traditional country
- whether currently living on homelands
- whether allowed to visit homelands.

The ‘Economic participation and development’ strategic area for action includes the related indicator ‘Indigenous owned or controlled land’ (see section 11.3).

Governance and culture

Several aspects of Indigenous governance were raised during the consultations, and culture was intrinsic to all of them. Governance was seen as an issue which had the capacity to affect people at the individual, community and organisational level.

The ‘Economic participation and development’ strategic area for action includes the indicator:

- **Case studies in governance arrangements.**

In its various dimensions, culture defines how governance arrangements are arrived at and how they operate. On the basis of research and consultations with Indigenous people and organisations, some key determinants of governance have emerged as having general application. Section 11.5 examines each of the following determinants using a series of case study examples:

- governing institutions
- leadership
- self determination
- capacity building
- cultural match
- resources.

Other suggestions — language, heritage and law

The 2006 consultations included discussion of three possible new cultural indicators: language; heritage; and law.

- **Language**

A language indicator attracted widespread support. Indigenous language is fundamentally linked with Indigenous culture and law, and all are intrinsically linked with Indigenous wellbeing. However, there was no clear consensus about the form of a language indicator. The new indicator of ‘engagement with service delivery’ (section 9.7), in part, addresses communication between service providers and Indigenous people but is not proposed as a cultural indicator.

- **Heritage**

Many Indigenous people and organisations expressed the view that government had a role in ensuring that cultural heritage was protected and maintained. However, it was not possible to identify a measurable outcome indicator that met the selection criteria.

- **Indigenous culture and law**

Several Indigenous organisations emphasised the importance of official recognition of Indigenous culture by governments and the legal system. Suggested indicators included: observance of Indigenous protocols in ceremonies and recognition of Indigenous law and governance. Some aspects of these suggestions are reflected in the governance case studies in section 11.5 of the Report, but no specific indicator could be identified that met the selection criteria.

Consultation participants recognised each of these as important for the wellbeing of Indigenous people but there was no consensus on specific indicators. Consequently, this Report includes additional contextual information on culture where appropriate, and gives greater prominence to the existing cultural indicators in the Report Overview. No additional cultural indicators have been added to the 2007 Report. Continuing research will be undertaken on other possible cultural indicators for future reports.

2.5 Data issues

The data in this Report are the most recent available, and generally reflect the frequency of the data collections. There are some significant data issues that readers need to be aware of when interpreting data in this Report. Appendix 4 contains more information about data limitations.

Sources

The data for this Report have been drawn from three types of sources — census, survey and administrative data (see appendix 4 for more information on data limitations). Each has strengths and weaknesses:

- *Census* data: censuses take place every 5 years, with the most recent in 2006. Data for the 2006 Census will be published by the ABS from the second half of 2007 onwards. Censuses are generally rich in information and have the potential for extensive disaggregation. There is limited use of Census data in this Report but it will be a major data source for the next Report.

- *Survey* data: surveys, such as the NATSIHS and the NHS, provide a rich source of data at higher levels of aggregation, for example, national and State and Territory data, and sometimes remoteness area disaggregations. The ABS has introduced a three yearly rolling program of Indigenous household surveys, the next being the 2008 NATSISS. These surveys are designed so that core data items are retained for each survey cycle, to enable key data comparisons over time. Data are subject to sample error, especially when disaggregated further than the survey sample was designed to allow.
- *Administrative* data are frequent (often annual) but are prone to variations in the level of Indigenous identification across jurisdictions and over time. There may also be disparities between states and territories in the definitions used within collections, which make it difficult to compare across jurisdictions or to estimate national totals.

There has been a significant reduction in the availability of hospital data on Indigenous people for this report. Hospital data are now only available for Queensland, WA, SA and the NT. Data from NSW, Victoria, Tasmania and the ACT are considered to be of insufficient quality for analytical purposes. See appendix 4 for more discussion of hospital data quality.

Interpreting the data

Indigenous identification

The accuracy of data on Indigenous people depends on both their willingness, and the opportunities provided, to identify themselves as Indigenous. This can vary across data collections.

This is particularly relevant to interpreting time series data. Improvements over time in data collections (for example, the adoption or correct application of the standard ABS question on Indigenous status) will improve the level of Indigenous identification, but in some cases will also make trend analysis difficult. For example, an increase in the recorded use of a service by Indigenous people might reflect an actual increase in use, or better identification of existing service users.

This Report uses ABS estimates of the Indigenous population. These estimates are based on a set of assumptions about likely trends in Indigenous population growth. Information about these assumptions is contained in box 2.5.1. Information about the composition of the Indigenous population can be found in appendix 3.

Box 2.5.1 **Indigenous population growth**

In September 2004, the ABS released a new series of experimental Indigenous population estimates and projections (ABS catalogue number 3238.0). This publication contains experimental estimates of the Indigenous population for Australia, and states and territories for 2001; and projections from 2002 to 2009.

Based on ABS 'low series' assumptions on Indigenous fertility and mortality, which assume no further 'unexplained' growth in the Indigenous population, (that is, growth that cannot be explained by natural increase), Australia's Indigenous population is projected to increase from 459 000 in 2001 to 529 000 in 2009 (an annual average rate of 1.8 per cent). Under the ABS 'high series' assumptions, which assume that the 'unexplained' growth experienced between 1996 and 2001 continues, the Indigenous population is projected to grow to 600 000 in 2009 (or 3.4 per cent annually).

Under either set of assumptions, the Indigenous population is projected to grow much faster than the total Australian population rate of 1.2 per cent during 2001-02.

In this Report, the 2001 estimates and 'low series' projections from ABS catalogue number 3238.0 have been used where relevant as population denominators for the purpose of calculating rates and proportions.

Revised Indigenous population estimates and projections based on the 2006 Census are likely to be published by the ABS in 2007 and 2008.

Source: ABS (2004a) unpublished.

Care should be taken in interpreting the results for some indicators, because of differences in data collections across jurisdictions. Significant differences in definitions or data collections are noted as appropriate.

Results can also be affected by Indigenous people's willingness (or 'propensity') to access particular services. For example:

- different rates of substantiated child abuse and neglect (section 3.9) across jurisdictions or over time may be a result of different propensities to report child abuse, rather than differences in its occurrence
- different rates of hospitalisation for assault (section 3.10) across jurisdictions or over time may be a result of different propensities to present at a hospital and/or report that an injury was caused by assault.

Interpreting survey data (standard errors, error bars and confidence intervals)

The Report draws extensively on ABS survey data, including the:

- 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

- 2004-05 National Health Survey (NHS)
- 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS)
- 2002 General Social Survey (GSS)
- 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS).

The results from these and other surveys are subject to sampling error, because they are based on samples of the total population. Where survey data are shown in charts in this Report, error bars are included, showing 95 per cent confidence intervals. There is a 95 per cent chance that the true value of the data item lies within the interval shown by the error bars. If there is an overlap between confidence intervals for different data items, it cannot be stated for certain that there is a statistically significant difference between the results. The Review has tested the statistical significance of differences between survey items and only highlighted differences in the text where they are statistically significant (although it should be noted that 'statistically significant' differences are not necessarily material or important).

Relative standard errors (RSEs) for all survey data included in the Report are shown in the attachment tables referred to in the Report, which are available on the Review website (www.pc.gov.au/gsp). The 95 per cent confidence intervals shown in the error bars in the charts are equivalent to 1.96 times the RSEs above and below the estimate. See ABS (2004b) for more information about RSEs, confidence intervals and tests of statistical significance. Information on the calculation of error bars is included in the glossary.

Data on years 3, 5 and 7 literacy and numeracy also include 95 per cent confidence intervals, which are explained in sections 6.2 and 7.1.

Disaggregation

Most of the indicators in this Report are expressed as rates, or as a proportion of a particular population. Estimates of numbers of people are sometimes included, but raw numbers do not show the relative disadvantage of different groups. Using rates makes it easier to compare Indigenous and non-Indigenous people, and where possible, to compare State and Territory breakdowns.

Indicator results can vary according to a range of factors, such as where people live and their age. To show these variations, some indicators are broken down by various categories — for example, by gender, remoteness and age. Such analysis will often indicate that Indigenous people are disadvantaged compared to non-Indigenous people. However, the extent of disadvantage may vary between the

different groups of Indigenous people. Where useful, rate ratios are calculated to compare rates between different groups.

Remoteness areas used in this Report are from the ABS Australian Standard Geographical Classification (ASGC). Some tables are disaggregated into five categories (major cities, inner regional, outer regional, remote, and very remote). When data quality does not support disaggregation into five categories, they are sometimes collapsed into three (major cities, regional — inner and outer regional; and remote — remote and very remote) or two categories (non-remote — major cities, inner and outer regional); and remote (remote and very remote).

The ASGC Remoteness classification identifies a location in Australia as having a particular degree of remoteness based on its distance from population centres of various sizes.

The aim of the ASGC remoteness structure is not to provide a measure of the remoteness of a particular location but to divide Australia into five broad categories of remoteness for comparative statistical purposes. The degree of remoteness of a place is determined using the Accessibility/Remoteness Index of Australia (ARIA). Places with similar ARIA scores are added together to form the remoteness areas in each State and Territory. A map of Australia showing geographic areas according to each of the five remoteness categories is included in section 11.3. For more information on how ARIA and remoteness are defined see ABS (2001a, 2001b).

Age standardisation

The Indigenous population has a younger age profile than the non-Indigenous population. Age standardisation, which accounts for differences in the age structures of populations, enables more realistic comparisons to be made between populations, and in this Report has been applied to relevant data on health, labour market and justice outcomes.

2.6 References

ABS (Australian Bureau of Statistics) 2001a, *ABS Views on Remoteness, 2001*, Cat. no. 1244.0, Canberra.

—— 2001b, *Outcomes of ABS Views on Remoteness Consultation, Australia*, Cat. no. 1244.0.00.001, Canberra.

—— 2004a, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0, Canberra.

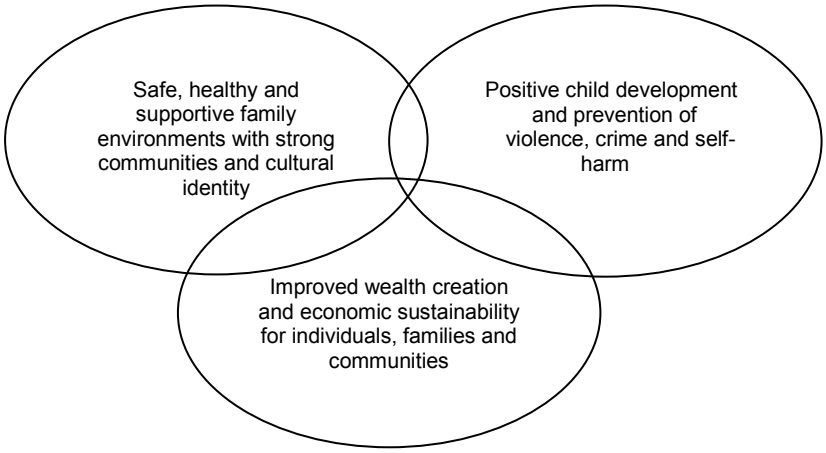
—— 2004b, *National Aboriginal and Torres Strait Islander Social Survey 2002*, Cat. no. 4714.0, Canberra.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2003, *Draft Framework for Reporting on Indigenous Disadvantage: Report on Consultations*, Productivity Commission, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2007a, *Framework for Reporting on Indigenous Disadvantage: Report on Consultations 2006*, Productivity Commission, Canberra.

——2007b, *Report on Government Services 2007: Indigenous Compendium*, Productivity Commission, Canberra.

3 Headline indicators



Headline indicators

- Life expectancy at birth
- Disability and chronic disease
- Years 10 and 12 retention and attainment
- Post secondary education — participation and attainment
- Labour force participation and unemployment
- Household and individual income
- Home ownership
- Suicide and self-harm
- Substantiated child abuse and neglect
- Deaths from homicide and hospitalisations for assault
- Family and community violence
- Imprisonment and juvenile detention rates

As noted, the three priority outcomes which sit at the apex of this Report's framework depict wellbeing at the highest level. They are not isolated outcomes, but are interdependent. 'Positive child development and prevention of violence, crime and self-harm' are key determinants in the achievement of 'safe, healthy and supportive family environments with strong communities and cultural identity'. And, without these conditions in place, the potential to achieve 'improved wealth creation and economic sustainability' is impaired.

The headline indicators reflect the extent to which this vision is becoming a reality. Generally, improvements in those indicators are only likely to be apparent over the

medium to long-term, and then only if there have been effective strategies in place in the 'strategic areas for action' identified in the framework (see following chapters). Nevertheless, small improvements have been identified for some indicators and are described later in this chapter.

As discussed previously, few of the headline indicators are likely to improve solely as the result of a single policy or a single agency. Positive change will generally require action across a range of areas. In keeping with the priority outcomes themselves, there is a strong thread of interdependence in the headline indicators. For example, post-secondary educational attainment is linked to years 10 and 12 retention and attainment; which in turn are linked to household income and family and community violence, and so on. Again, improvements in these areas have the capacity collectively to make a positive impact on priority outcomes.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 3A.2.3). A list of attachment tables is in section 3.14. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

3.1 Life expectancy at birth

Box 3.1.1 **Key messages**

- The life expectancy of Indigenous people is estimated to be around 17 years lower than that for the total Australian population (figure 3.1.1).
- The most recent estimates indicate that life expectancy at birth is 59 years for Indigenous males compared with 77 years for males in the total population, and 65 years for Indigenous females compared with 82 years for females in the total population (figure 3.1.1).
- In 2005, death rates in all age groups were higher for Indigenous than non-Indigenous people. The greatest differences were for those aged between 35 and 54, where the Indigenous death rates were five to six times those for non-Indigenous people (table 3.1.2).

Life expectancy is an indicator of health status and refers to the average number of years a person of a given age and sex can expect to live, if current trends (age

specific death rates[1]) continued throughout his or her lifetime. Life expectancy is widely viewed as a key measure of the health of populations. As well as being a fundamental health indicator, studies have found life expectancy to be highly correlated with a range of other factors including employment, education and overall economic wellbeing (Becker, Philipson and Soares 2003; Carson et al. 2007).

There are no new data on Indigenous life expectancy available since the 2005 Report was published. In 2008, the ABS will analyse 2006 Population Census results and final death registration data for 2001 to 2006, to compile 2001 to 2006 Indigenous life tables and life expectancy. This Report includes some additional data on Indigenous mortality (median age at death and leading causes of death).

Life expectancy

Life expectancy is an indicator of the long-term health and wellbeing of Indigenous Australians. Improvements in outcomes across all of the strategic areas for action have the potential to affect life expectancy.

Disparities in life expectancy can be influenced by differences in income and education levels, the quality of the health system and the ability of people to access it, genetic and social factors, and environmental factors including overcrowded housing, lack of clean drinking water and adequate sanitation (see sections 3.3, 3.4, 3.5, 9.3, 9.7, 10.1, 10.2 and 10.3 for more information on these factors). People from lower socioeconomic groups tend to suffer from higher rates of ill health and death, and are more likely to exhibit behaviour risk factors such as the consumption of tobacco and excessive alcohol, poor nutrition, and lack of exercise.

Environmental factors also influence life expectancy. The lack of clean drinking water and adequate sanitation, for example, can accentuate risks to health, particularly for infants and young children. Overcrowding of households can increase the chances of contracting and spreading disease. Improving the quality and level of access to health services can have a positive impact on life expectancy through increased levels of preventative care, increased early diagnosis of diseases (such as diabetes) and effective treatment of chronic diseases.

[1] Age-specific death rates are the number of deaths registered (or occurring) during a calendar year at a specified age, per 100 000 of the estimated resident population of the same age (ABS 2006).

The Australian Bureau of Statistics (ABS) has advised that:

- While the life expectancy estimates presented here are the best that can be compiled with currently available data, it is not possible to present time-series or trend statistics for Indigenous life expectancies.
- Variation in life expectancies between Indigenous males and females and for Indigenous Australians in different states and territories should be interpreted with care as they are sensitive to the demographic assumptions and differential quality of data across jurisdictions.

State and Territory breakdowns should be interpreted with care. At present, the ABS can only publish, with confidence, individual jurisdiction Indigenous life expectancy estimates for Queensland and the Northern Territory. In order to produce more reliable estimates, the ABS combines data for Victoria with NSW and SA with WA (giving two pairs of geographically nearby jurisdictions). Due to a combination of poor data quality and small numbers, estimates have not been produced for Tasmania and the ACT (for these jurisdictions the ABS suggests using the NSW/Victoria estimates) (ABS 2004a; 2004b).

The calculation of national Indigenous life tables using conventional direct methods is not possible due to the absence of complete and consistent (over time) identification of Indigenous status in death registrations in all six states and the ACT. Consequently, the ABS does not publish time series of Indigenous life expectancy. (Indigenous identification in deaths data for the NT has been much more accurate since the 1960s — research on mortality over time in the NT is reported later in this section.)

Table 3.1.1 **Estimated Indigenous life expectancies at birth, 1996–2001**[a, b]

Sex	*NSW and Victoria*	*Queensland*	*SA and WA*	*NT*	*Australia*
Male	60.0	58.9	58.5	57.6	59.4
Female	65.1	62.6	67.2	65.2	64.8

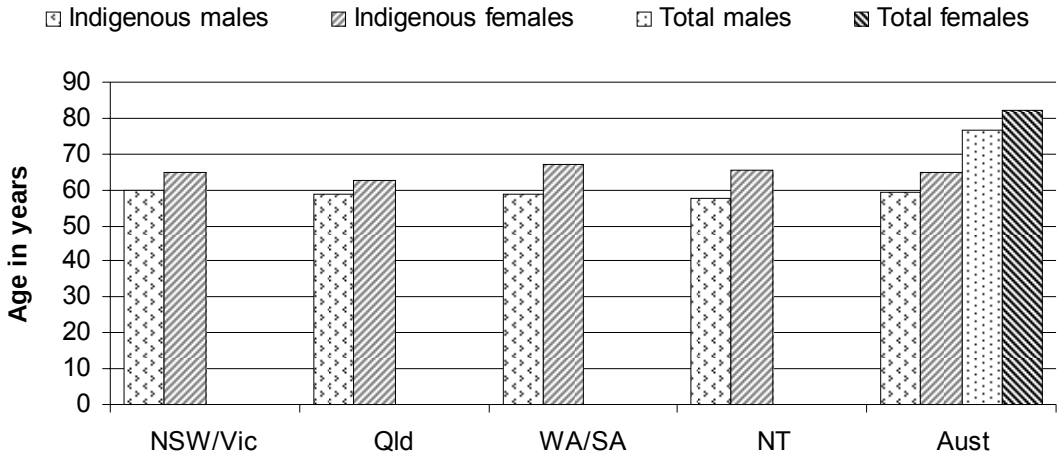
[a] For Tasmanian and ACT estimates, use NSW/Victorian data. [b] Data are subject to a degree of uncertainty and apparent differences in life expectancy estimates between jurisdictions may not be statistically significant.

Source: ABS (2004b); table 3A.1.1.

- The ABS estimates that, for both males and females, life expectancy at birth in the Indigenous population is 17.2 years less than in the total Australian population (table 3.1.1, figure 3.1.1).
- The life expectancy of Indigenous males born between 1996–2001 is 59.4 years compared with 76.6 years for total males born in a similar period (1998–2000),

while the life expectancy of Indigenous females is 64.8 years compared with 82.0 years for total females.[2]

Figure 3.1.1 **Life expectancy at birth, Indigenous 1996–2001, total population 1998–2000**[a, b, c, d]



[a] Indigenous data are for the Australian Aboriginal and Torres Strait Islander population, and include an adjustment for undercoverage of Indigenous deaths. [b] Indigenous life expectancy excludes Tasmania and the ACT. For Tasmania and the ACT, use data for NSW and Victoria. [c] Life expectancy data for Indigenous males and Indigenous females are for the period 1996–2001. Data for total males and females cover the period 1998–2000, the approximate mid-point of the Indigenous data. [d] Data are subject to a degree of uncertainty and apparent differences in life expectancy estimates between jurisdictions may not be statistically significant.

Source: ABS (2004b); table 3A.1.1.

- In both the Indigenous and total populations, females tend to live longer than males. Life expectancies at birth for Indigenous females are currently 5.4 years higher than for Indigenous males. The size of the 'gender gap' in the total Australian population is also 5.4 years (figure 3.1.1).

The NT is the only State or Territory where Indigenous identification in mortality has been of sufficient and sustained quality to allow time series analysis. A recent study by Wilson, Condon and Barnes (2007) found that the life expectancy of Indigenous people in the NT had risen by eight years for men (from 52 to 60 years) and 14 years for women (from 54 to 68 years) over the past 40 years (1967 to 2004). Over the same period, total Australian life expectancy rose from 68 to 78 years for males and from 74 to 83 years for females. The gap between Indigenous and non-Indigenous life expectancies in the NT remains large, however, for

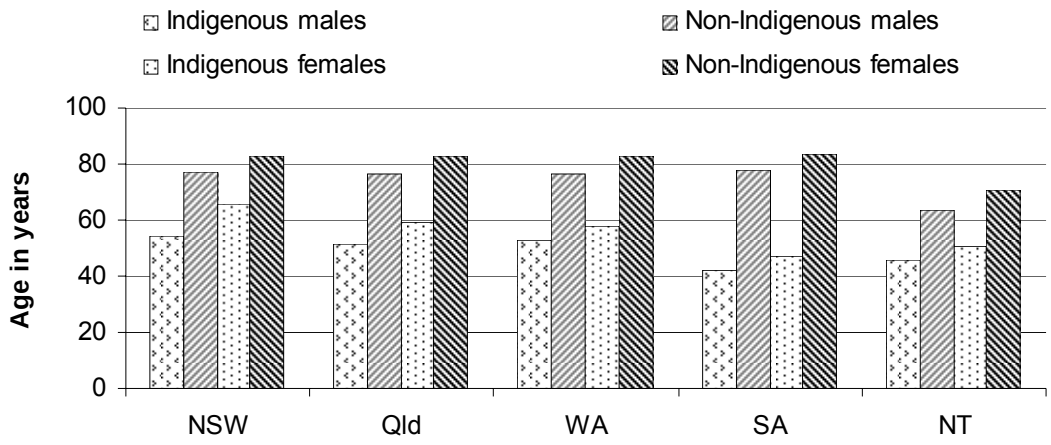
[2] The ABS has not produced estimates of total male and female life expectancies for the period 1996–2001. The total population life expectancy data presented are for the period 1998–2000, which is the approximate mid-point of the 1996–2001 period covered by the Indigenous data.

females, the gap between Indigenous and non-Indigenous life expectancy has narrowed from 20 to 15 years (Wilson, Condon and Barnes 2007).

Median age at death and age specific death rates

Median age at death is another way of looking at Indigenous mortality, however, differences in coverage rates by age can lead to biased summary results. For example, higher coverage of infant deaths than deaths in older age groups may lead to underestimates of median age at death. The Indigenous population has a younger age structure than the non-Indigenous population, which also influences median age at death values (ABS 2006), therefore, estimates should be treated with caution.

Figure 3.1.2 **Median age at death, 2005**



a Victoria, Tasmania and the ACT are excluded due to poor coverage rates or small numbers. **b** Care should be exercised when comparing median age at death of Indigenous and non-Indigenous people because of differential rates of Indigenous identification by age and different age structures in the two populations.

Source: ABS (2006) *Deaths Australia 2005*; table 3A.1.2.

- In 2005, median ages at death in all states and territories for which data were available were significantly lower for Indigenous males and females than non-Indigenous males and females (figure 3.1.2).
- Median ages at death for Indigenous people fluctuated between 2000 and 2005 but no overall trend was apparent (table 3A.1.2).

Table 3.1.2 **Age specific death rates, 2001–2005**[a, b, c]

	Males			*Females*		
Age (years)	*Indigenous*[d]	*Non-Indigenous*	*Rate ratio*[e]	*Indigenous*[d]	*Non-Indigenous*	*Rate ratio*[e]
0[f]	15.0	4.8	3.1	10.4	4.1	2.5
1–4	74.1	29.2	2.5	70.5	20.3	3.5
5–14	29.8	13.5	2.2	23.0	9.7	2.4
15–24	207.7	76.6	2.7	96.0	28.6	3.4
25–34	416.3	106.6	3.9	185.2	39.8	4.7
35–44	823.6	141.3	5.8	469.0	77.4	6.1
45–54	1393.5	286.2	4.9	850.8	173.5	4.9
55–64	2543.9	711.3	3.6	1723.2	410.1	4.2
65 years and over	6270.0	4325.5	1.4	4956.9	3690.6	1.3

[a] Data for Queensland, WA, SA and the NT combined. [b] Deaths per 100 000 population except age zero. [c] Data are subject to a degree of uncertainty and apparent differences in mortality estimates between jurisdictions may not be statistically significant. [d]Indigenous rates are based on observed Indigenous deaths and are, therefore, likely to be underestimated. [e] Indigenous rate divided by the non-Indigenous rate. [f] Infant deaths per 1000 live births.

Source: ABS (2006) *Deaths Australia 2005*.

- In 2005, age specific death rates (deaths per 100 000 population) were higher for Indigenous than non-Indigenous people for all age groups (table 3.1.2).
- For all age groups below 65 years, the age-specific death rates for Indigenous people were at least twice the rate for non-Indigenous people.
- The greatest differences were for those aged between 35 and 54, where the rates were about five to six times those for non-Indigenous people.

An independent examination of mortality for the NT only, over a long period (1967–2000), reported that Indigenous all-cause mortality rates in the NT declined overall and for all age groups. Declines were greater for females than males, and greater in younger and older age groups than in the early and middle adult years (25–64 years). The declines in Indigenous mortality, however, 'did not keep pace with the relative decline for the total Australian population. NT Indigenous mortality declined for communicable, maternal and nutritional conditions and injury but did not decline for non-communicable diseases' (Condon et al. 2004).

Table 3.1.3 **Causes of death by Indigenous status, Qld, WA, SA and the NT, 2001–2005**[a]

	Indigenous	*Non-Indigenous*	*Indigenous*	*Non-Indigenous*	*Ratio*
	%	%	Age standardised rate per 100 000	Age standardised rate per 100 000	
Underlying cause of death					
Circulatory diseases	26.6	36.8	783.9	228.9	3.4
Accidents, poisonings and violence	16.2	6.3	123.5	39.3	3.1
Cancer	15.1	29.7	306.9	179.8	1.7
Lung cancer	3.6	5.7	79.3	34.9	2.3
Cervical cancer	0.4	0.2	5.8	1.1	5.3
Endocrine, metabolic & nutritional disorders	9.0	3.5	204.3	21.6	9.5
Diabetes	8.0	2.4	202.8	14.8	13.7
Respiratory diseases	8.7	8.7	243.2	54.1	4.5
Digestive diseases	5.7	3.3	131.0	20.6	6.4
Conditions originating in the perinatal period	2.8	0.4	7.9	2.9	2.7
Nervous system diseases	2.5	3.3	50.4	20.7	2.4
Infectious and parasitic diseases	2.3	1.2	39.1	7.3	5.4
Kidney diseases	2.0	1.5	64.0	9.6	6.7
Other causes	9.1	5.3	143.7	37.1	3.9
All causes	100.0	100.0	2043.7	621.7	3.3
Number of deaths	7 544	227 393			

[a] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the Non-Indigenous population. Calculations of rates for the Non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS 2006, Causes of Death 2005, Cat. no. 3303.0 (unpublished); table 3A.1.3.

- In the period 2001 to 2005, age standardised death rates from all causes combined were more than three times as high as for Indigenous people as those for non-Indigenous people (2043.7 per 100 000 compared with 621.7 per 100 000) (figure 3.1.3).
- Indigenous death rates were higher than non-Indigenous rates for all categories of disease (figure 3.1.3).
- Indigenous people died from diabetes at nearly 14 times the rate for non-Indigenous people.

3.2 Disability and chronic disease

Box 3.2.1 **Key messages**

- In non-remote areas in 2002, Indigenous adults were twice as likely to report a disability resulting in a profound or severe core activity limitation than non-Indigenous adults.
- From 2001 to 2004-05, there was an increase in the number of long term health conditions for which Indigenous people reported higher rates than non-Indigenous people. In 2001, Indigenous people reported higher rates of asthma, diabetes/high sugar levels and kidney disease than non-Indigenous people. In 2004-05, Indigenous people also reported higher rates of arthritis, back pain/problems and heart and circulatory diseases (figure 3.2.1 and table 3A.2.1).
- In 2004-05, the greatest difference between Indigenous and non-Indigenous rates was for kidney disease; where the Indigenous rate was 10 times as high as the non-Indigenous rate. This gap is widening — in 2001 the Indigenous rate was 5 times as high as the non-Indigenous rate (table 3A.2.1).
- In 2004-05, Indigenous people were 3 times as likely as non-Indigenous people to have diabetes (figure 3.2.1). There was no improvement in the reported incidence of diabetes among Indigenous people between 2001 and 2004-05 (table 3A.2.1).

The 2005 Report included data on the incidence of disability and the degree of core activity limitation among Indigenous people, sourced from the 2002 ABS NATSISS (the major findings are summarised in the first part of this section). As no new data on disability have become available since the 2002 ABS NATSISS, this Report compares the rates of selected long term health conditions (that may cause disability) among Indigenous and non-Indigenous people (obtained from the 2004-05 ABS NATSIHS). These rates are accompanied by standardised hospitalisation rates for selected long term health conditions for Indigenous people sourced from the AIHW National Hospital Morbidity Database.

A ‘disability’ is generally defined as a limitation, restriction, impairment, disease or disorder which limits a person’s ability to perform everyday activities (for example, work, study, self care, mobility and communication) for long periods (that is, at least six months) (ABS 2004). Rates of disability and chronic disease have been selected as a headline indicator because they can have a bearing on, and reflect, the relative wellbeing of a population group.

Generally, chronic diseases are not caused by infection or passed on by contact. Instead, they develop over long periods of time and are the result of numerous risk factors acting in combination, such as:

- biomedical factors (for example, obesity, high blood pressure and high cholesterol levels)
- genetics (for example, genetic makeup and family history)
- risk behaviours (for example, smoking, excessive alcohol consumption, physical inactivity and poor diet)
- environment (for example, poor living conditions)
- psychological factors (for example, neglect, violence and death of family members)
- socioeconomic factors (for example, poverty, unemployment, low educational attainment, limited access to social services and discrimination/racism) (AIHW 2006).

Adverse socioeconomic and environmental conditions are the likely underlying causes of the behavioural factors that contribute to poor health among Indigenous people (Carson et al. 2007). A family history of poor health and chronic disease may also influence whether an individual has a genetic predisposition to certain long term health conditions (AIHW 2006). Some successful programs aimed at preventing the development of chronic diseases among Indigenous people through education, primary health care and disease management have been implemented across Australia. An example of a successful program by the NSW Department of Health and a range of collaborators is provided in box 3.2.2.

Box 3.2.2 **'Things that work' – disease prevention programs for Indigenous people in NSW**

NSW Aboriginal Vascular Health Progam

In July 2000, the NSW Department of Health established the Aboriginal Vascular Health Program based on the premise that there are shared risk factors and risk conditions and common disease management approaches for a number of preventable vascular diseases including diabetes, cardiovascular disease, renal disease, stroke and hypertension. Since 2001, the NSW Department of Health has funded 23 Aboriginal Vascular Health project sites in locations throughout the state, with an additional nine sites operating through Justice Health. These projects work through local partnerships and collaborations between service providers and communities to develop culturally acceptable approaches for use in the prevention and management of Aboriginal chronic disease. The Aboriginal Vascular Health program continues to make significant gains, including: increasing access to care, improving service and program co-ordination, and supporting disease self-management for those identified with vascular disease. Critical to the success of the programs has been the recruitment of designated Aboriginal Vascular Health Workers to work as part of the local primary health care team.

Health services for Indigenous people in custody, NSW

Indigenous people in custody in NSW have access to a range of culturally sensitive healthcare services and disease prevention programs. These services and programs are provided through working partnerships between Justice Health, NSW Aboriginal Community Controlled Health Services and Area Health Services. Currently, 41 per cent of Indigenous men and 58 per cent of Indigenous women in custody have access to this range of dedicated services. Justice Health has specific health promotion and education programs targeted at the Indigenous population in the correctional environment. In 2006, 338 participants accessed disease prevention programs and 375 participants took part in Aboriginal Men's Health and Indigenous Games exercise activities.

The potentially debilitating long term health conditions reported in this chapter include: arthritis, asthma, back pain/problems, diabetes/high sugar levels, ear/hearing problems, eye/sight problems, heart and circulatory problems/diseases, kidney disease, neoplasms/cancer and osteoporosis. For diabetes/high sugar levels, the rates are also disaggregated by the type of usual daily activities affected by the condition (for example, work, study and other day to day activities).

In addition to serious illness, Indigenous people have high exposure to a range of other 'personal stressors' that may contribute to the development of long term health conditions. Most prevalent among these stressors are death of a family member or close friend, alcohol and drug problems, family member(s) sent to prison or currently in prison, overcrowding at home, and not being able to get a job

(ABS and AIHW 2005). An attachment table reports the proportions of Indigenous people with selected long term health conditions disaggregated by the types of personal stressors experienced by the individual, their family or friends (table 3A.2.7).

Rates for long term health conditions should be interpreted with caution. In particular, rates among Indigenous Australians may be underreported:

- Definitions of 'long term health condition' and/or 'disability' used by non-Indigenous health professionals might not necessarily be the same as definitions used by Indigenous people.
- Research has shown that a person's perception of their own disability/long term condition is dependent on their knowledge of available aids and services. This may have a substantial impact on reporting rates of disability/long term health conditions, particularly when the methodology depends on self reporting (AIHW and DHFS 1998).

Disability and/or core activity restriction among Indigenous people

In the 2002 NATSISS, disability or core activity restriction was defined as a limitation, restriction, impairment, disease or disorder, which had lasted, or was likely to last for six months or more, and which restricted a person's ability to perform everyday activities. Some people were identified as having a schooling or employment restriction only, while others were restricted in the performance of one or more core activities such as self care, mobility and communication, which had lasted, or was likely to last, for at least six months and restricted everyday activities (ABS 2004).

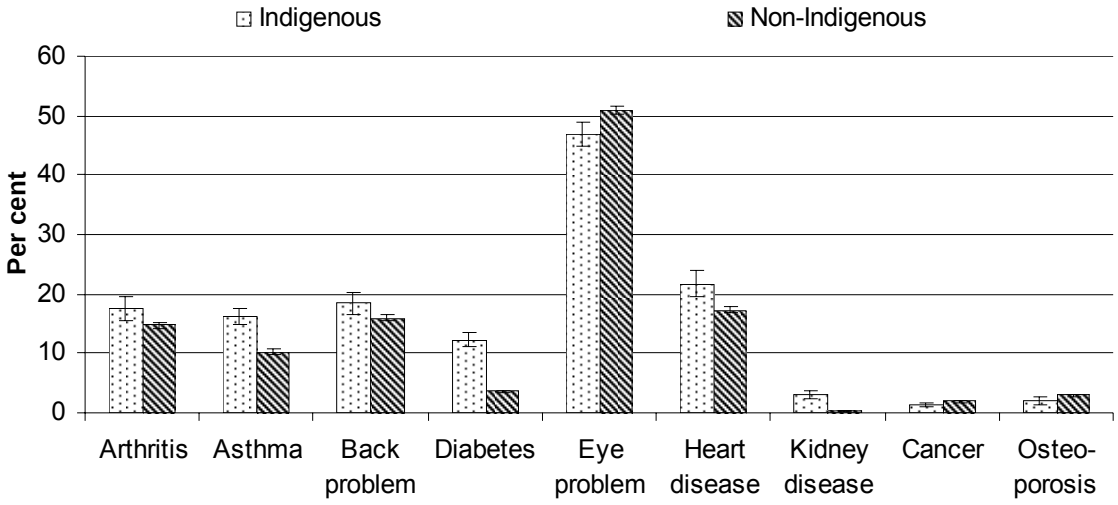
Around 36 per cent of the Indigenous population aged 15 years or over reported a disability or long term health condition in 2002 (ABS 2004). Data from the 2002 NATSISS indicated that Indigenous Australians living in remote and non-remote areas reported broadly similar levels of disability.

After taking into account the different age structures of the Indigenous and non-Indigenous populations, the proportion of Indigenous people in non-remote areas (aged 18 years and over) reporting a disability resulting in a profound or severe core activity limitation (10.5 per cent) was 2.1 times as high as that reported by non-Indigenous people (5.0 per cent) in 2002 (ABS and AIHW 2005). Significant differences in the proportions of Indigenous and non-Indigenous people with profound or severe core activity limitation were evident across all age groups (ABS and AIHW 2005).

In 2002, the proportion of Indigenous people aged 18 years and over in non-remote areas experiencing a disability or long term health condition was higher than for non-Indigenous people for all types of disability (including sight, hearing and speech, physical, intellectual, and psychological disability) (ABS and AIHW 2005). Indigenous people in non-remote areas were about one and a half times as likely as non-Indigenous people to have a physical disability and over three times as likely to have an intellectual disability (ABS and AIHW 2004).

Rates for long term health conditions

Figure 3.2.1 **People with selected long term conditions, age-standardised, by type of condition and Indigenous status, Australia, 2004-05[a]**



[a] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

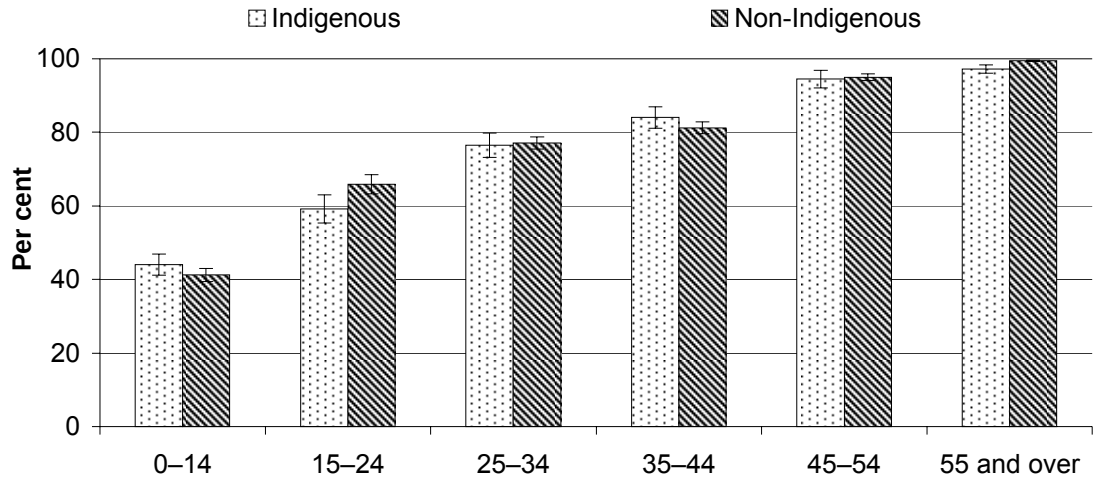
Source: ABS 2004-05 NATSIHS, NHS (unpublished); table 3A.2.1.

- Age standardised rates for six of the nine long term health conditions presented in figure 3.2.1 were significantly greater for Indigenous people than non-Indigenous people in 2004-05 (arthritis, asthma, back pain/problems, diabetes, heart and circulatory diseases, and kidney disease). In 2001, the rates for three out of nine long term conditions were significantly greater for Indigenous people (asthma, diabetes and kidney disease) (table 3A.2.1).
- The greatest difference between Indigenous and non-Indigenous rates was for kidney disease; the Indigenous rates were 5.3 and 10.0 times as high as the non-Indigenous rates in 2001 and 2004-05, respectively (table 3A.2.1).
- In 2004-05, the rate of Indigenous people with diabetes was 3.4 times as high as the rate of non-Indigenous people with diabetes (12.3 per cent compared to

3.6 per cent) (figure 3.2.1). In 2001, the rate of Indigenous people with diabetes was 3.8 times as high as the rate for non-Indigenous people (table 3A.2.1).

- Indigenous people reported lower rates of cancer and osteoporosis than non-Indigenous people in 2004-05 although overall prevalence was low in both populations (figure 3.2.1).

Figure 3.2.2 **People with one or more long term condition(s), by age group, Australia, 2004-05[a]**



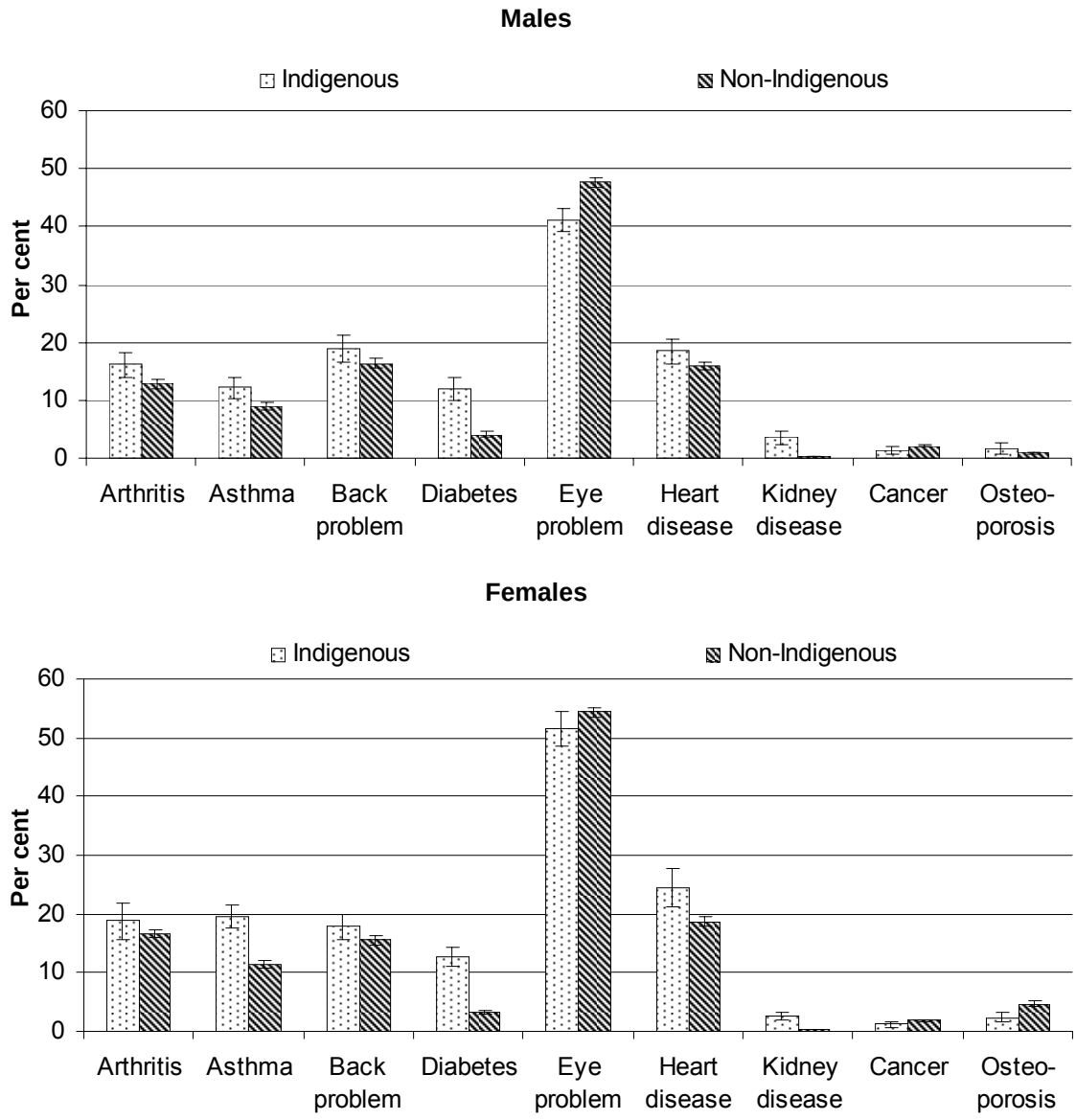
[a] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS, NHS (unpublished); table 3A.2.2.

- The prevalence of long term health conditions increased with age for both Indigenous and non-Indigenous people in 2004-05 (figure 3.2.2).
- Indigenous children (aged 0–14 years) were significantly more likely than non-Indigenous children to have asthma or ear/hearing problems (table 3A.2.2).
- Among young people (aged 15–24 years) the Indigenous rates for ear/hearing problems and kidney disease were significantly higher than the non-Indigenous rates for these conditions (table 3A.2.2).
- A further five long term conditions were significantly more prevalent among Indigenous people aged 25–34 years — arthritis, asthma, back problems, diabetes and heart/circulatory problems (table 3A.2.2).
- Among those in the age range 35–54 years, Indigenous people reported significantly higher rates for all selected conditions, apart from eye/sight problems, neoplasms (cancers) and osteoporosis (table 3A.2.2).

- Among older people (aged 55 years and over), the Indigenous rates for asthma, diabetes, heart/circulatory diseases and kidney disease were significantly higher than the non-Indigenous rates for these conditions (table 3A.2.2).

Figure 3.2.3 **People with selected long term conditions, age-standardised, by type of condition, gender and Indigenous status, Australia, 2004-05[a]**



[a] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS, NHS (unpublished); table 3A.2.3

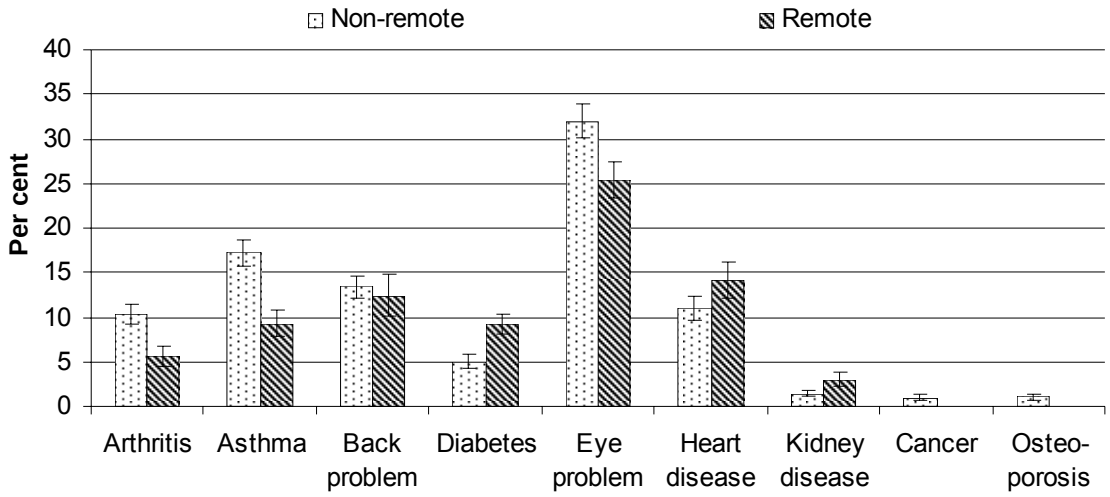
- Indigenous males and females reported significantly higher rates of asthma, back problems, diabetes/high sugar levels, and kidney disease than non-Indigenous males and females in 2004-05 (figure 3.2.3).

- Indigenous females had significantly higher rates of heart/circulatory diseases than non-Indigenous females, while Indigenous males were more likely to have arthritis than non-Indigenous males (figure 3.2.3).
- For both males and females, the greatest difference between Indigenous and non-Indigenous rates was for kidney disease; the rates for Indigenous males and females were 17.5 and 8.3 times as high as the rates for non-Indigenous males and females, respectively (table 3A.2.3).
- The proportion of Indigenous females reporting three or more long term conditions (47.1 per cent) was significantly greater than the proportion of non-Indigenous females with three or more conditions (41.7 per cent) (table 3A.2.3). A significant difference was not observed between Indigenous and non-Indigenous males reporting three or more long term conditions (38.3 per cent compared to 37.0 per cent, respectively) (table 3A.2.3).

Table 3A.2.4 presents the Indigenous and non-Indigenous rates for selected long term conditions by State/Territory in 2004-05.

Figure 3.2.4 compares the rates for nine long term conditions among Indigenous people living in remote and non-remote areas.

Figure 3.2.4 **Indigenous people with selected long term health conditions, by type of condition and remoteness, Australia, 2004-05[a]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS, NHS (unpublished); table 3A.2.5.

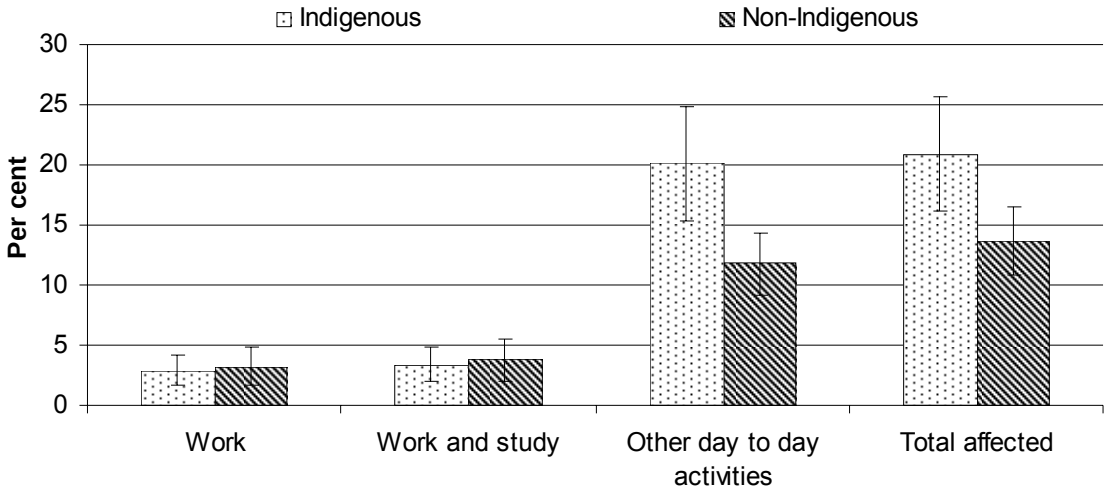
- Overall, 56.5 per cent of Indigenous people in remote areas reported one or more long term health conditions compared to 67.5 per cent in non-remote areas (table 3A.2.5). There were no significant changes in the rates of Indigenous

people with at least one long-term condition (by remoteness) between 2001 and 2004-05 (table 3A.2.5).

- In 2004-05, Indigenous people living in remote areas reported significantly higher rates of diabetes/high sugar levels (9.2 per cent), heart and circulatory diseases (14.1 per cent), and kidney disease (3.0 per cent) than Indigenous people living in non-remote areas (figure 3.2.4). This pattern was also observed in 2001 for diabetes/high sugar levels and kidney disease (table 3A.2.5).
- Indigenous people living in non-remote areas were more likely to report arthritis, asthma, back problems and eye/sight problems than Indigenous people living in remote areas in 2004-05 (figure 3.2.4).

Long term conditions interfering with usual daily activities

Figure 3.2.5 **People with diabetes/high sugar levels who find the condition interferes with their usual daily activities, age-standardised, by type of activity and Indigenous status, Australia, 2004-05[a]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS; NHS (unpublished); table. 3A.2.6.

- In 2004-05, 20.1 per cent of Indigenous people reported that diabetes/high sugar levels affected 'other day to day activities', considerably greater than the 11.8 per cent of non-Indigenous people whose 'other day to day activities' were affected and much greater than the proportions of Indigenous and non-Indigenous people whose work or study were affected (figure 3.2.5).

Personal stressors and long term health conditions

Potential interrelationships between personal stressors experienced by Indigenous people in the previous 12 months and rates for long term health conditions are presented in table 3A.2.7. Indigenous people with a long term health condition were significantly more likely to have experienced at least one personal stressor than those without a long term health condition (79 per cent compared with 68 per cent). Indigenous people with a long term health condition were more likely than those without a condition to report stresses such as death of a family member, alcohol and drug problems, inability to get a job, discrimination/racism, abuse or violent crime, divorce or separation, a serious accident, and involuntary loss of job (table 3A.2.7).

Age standardised hospitalisation rates for Indigenous people

Hospitalisation rates for long term health conditions are reported in this section. While hospitalisation is not a measure of prevalence of a condition in the community, it does provide an indication of serious illness being treated in hospitals. The age standardised hospitalisation ratios presented in table 3.2.1 are calculated by dividing the Indigenous hospitalisation rate by the non-Indigenous hospitalisation rate. A ratio of one means the underlying rates are the same. A rate of more than one means the Indigenous rate is higher than the non-Indigenous rate.

More information on chronic diseases in the Indigenous population can be found in section 9.3 of this Report, which presents hospitalisation rates for 'potentially preventable chronic conditions' as part of the 'Access to primary health care' strategic indicator.

Table 3.2.1 **Age standardised hospitalisation rate ratios of Indigenous to non-Indigenous people, by type of chronic disease and sex, Queensland, WA, SA and public hospitals in the NT, 2004-05[a, b, c, d, e]**

Type of long term health condition	*Male*	*Female*
Cancer (C00–C96)	0.6	0.6
Lung cancer (C33–C34)	1.6	1.6
Cervical cancer (C53)	..	3.4
Mental and behavioural disorders (F00–F99)	2.1	1.4
Circulatory diseases (I00–I99)	1.6	2.2
Ischaemic heart diseases (I20–I25)	1.8	3.0
Stroke (I60–I69)	1.6	2.8
Hypertension (I10–I15)	3.6	4.2
Rheumatic heart diseases (I05–I09)	3.9	6.8
Other		
Diabetes (E10–E14)	4.2	6.2
End stage renal diseases (N18–N19, Z49)	10.9	21.4
Chronic obstructive pulmonary diseases (J41–J44)	4.9	5.9

a Hospitalisations were based on ICD-10-AM classifications. The principal diagnosis was used to select diseases. **b** The rate ratio is calculated by dividing the Indigenous age-standardised rate by the non-Indigenous age-standardised rate. **c** Rate ratios were calculated using 2001 Australian population data. **d** Indigenous hospitalisations data are reported for Queensland, WA, SA and the NT only. These four jurisdictions are considered to have the highest level of accuracy of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Hospitalisation data for these four jurisdictions should not be assumed to represent the hospitalisation experience in the other jurisdictions. **e** Non-Indigenous data includes hospitalisations of people identified as not Indigenous as well as those with a 'not stated' Indigenous status. **..** Not applicable.

Source: AIHW National Hospital Morbidity Database (unpublished); tables 3A.2.11 and 3A.2.15.

- In 2004-05, the age standardised rate of hospitalisation was higher for Indigenous males and females than non-Indigenous males and females for all chronic diseases listed in table 3.2.1, except for cancer.
- For all chronic diseases listed in table 3.2.1, except for all cancers, lung cancer and mental and behavioural disorders, the difference between the Indigenous and non-Indigenous hospitalisation rate was greater for females than males (that is, females had a higher rate ratio for each of these chronic diseases) (table 3.2.1).
- The greatest difference between the Indigenous and non-Indigenous hospitalisation rate was for end stage renal diseases; the rates for Indigenous males and females were 10.9 and 21.4 times as high as the rates for non-Indigenous males and females, respectively (table 3.2.1).
- Between 2001-02 and 2004-05, the ratio of Indigenous to non-Indigenous hospitalisation rates for males increased for chronic obstructive pulmonary diseases (3.7 to 4.9) and end stage renal disease (9.6 to 10.9). Hospitalisation

rate ratios for males decreased for diabetes (4.5 to 4.2), hypertension (5.4 to 3.6) and rheumatic heart disease (4.5 to 3.9) (tables 3A.2.8 to 3A.2.11).

- Between 2001-02 and 2004-05, the ratio of Indigenous to non-Indigenous hospitalisation rates for females decreased for diabetes (6.7 to 6.2), hypertension (4.7 to 4.2) and rheumatic heart diseases (7.7 to 6.8), and increased for ischaemic heart diseases (2.5 to 3.0) and end stage renal diseases (18.8 to 21.4) (tables 3A.2.12 to 3A.2.15).

3.3 Years 10 and 12 retention and attainment

Box 3.3.1 **Key messages**

- In 2006, 21 per cent of 15 year old Indigenous people were not participating in school education. Only 5 percent of non-Indigenous 15 year olds were not participating in school education (table 3A.3.2).
- In 2006, Indigenous students were half as likely as non-Indigenous students to continue to year 12 (figure 3.3.4).
- In 2004-05, a smaller proportion (22.1 per cent) of Indigenous people than non-Indigenous people (46.6 per cent) had completed year 12 (table 3A.3.18).
- The proportion of Indigenous students who achieved a year 12 certificate (after being enrolled in year 11 the previous year) changed little between 2001 and 2005 (tables 3A.3.11 and 3A.3.15).

There is persistent evidence showing the importance of finishing school rather than leaving at year 10 (Dusseldorp Skills Forum 2006). Young people who do not complete year 12 are less likely to be fully engaged in study or work than young people who do complete year 12. The fewer the years of schooling completed, the greater the likelihood of being less than fully engaged (Long 2006).

When the period of compulsory education ends the proportion of Indigenous children who no longer attend school is substantially higher than for non-Indigenous students, reducing their chances of academic and vocational success beyond the school years. Initiatives that have been successful in increasing Indigenous secondary school participation can be found in box 3.3.2.

A large body of research emphasises the pivotal role of education in reducing long term disadvantage of Indigenous peoples (ACER 2003, 2004a; Buckskin 2000; OECD 2004; WHO 1986). Improving academic performance and completion of year 12 are key components to improving the economic and social status of Indigenous people. School completion is linked to people's economic and social

wellbeing (and other positive health behaviours) and can also reduce the need for remedial education and social welfare services (Barnett 1993 and Reynolds et al. 2002).

Box 3.3.2 **'Things that work' — increasing secondary school participation and attainment**

***Deadly Vibe* magazine**

Deadly Vibe is a magazine for Indigenous students published by Vibe Australia (an Aboriginal media agency) with funding from the Australian Government. The magazine has been successful in improving educational outcomes. The Australian Council for Educational Research (ACER) conducted an evaluation of *Deadly Vibe* and found that the magazine was having a positive impact. Some of the results include:

- 68 per cent of Indigenous students surveyed had been inspired to complete secondary school
- 43 per cent of Indigenous students surveyed were encouraged to go to school more often
- increased engagement with reading translated into improved literacy outcomes (ACER 2004b).

Cape York Higher Expectations Program and St Joseph's Indigenous fund

Non-government sector involvement in Indigenous education has been mainly aimed at secondary and tertiary levels in urban areas. The Cape York Institute's Higher Expectations Program (HEP) and St Joseph's Indigenous fund are two examples of non-government sector sponsorship of successful scholarship programs for children to board at private schools.

The HEP provides Indigenous children living in the Cape York region with access to secondary education at Queensland's most academically successful boarding schools. The HEP provides both financial assistance and ongoing support from a Program Administrator and Student Support Officer. The Program Administrator and Student Support Officer maintain regular contact with students, school staff, parents/guardians and home communities, and assist students and their families with transition and communication issues.

The HEP has gone from having six active scholarship participants in 2005 to 24 for 2006. Though only a fraction of Cape York students will participate in the HEP, their success (completion of secondary school and enrolment in tertiary studies) will greatly impact on Cape York educational statistics and provide Cape communities with a pool of talented and educated future leaders.

The St Joseph's Indigenous fund offers scholarships to Indigenous boys to attend St Joseph's College at Hunters Hill in Sydney. Started in 1998 with one year 7 student from Walgett, the program has more than 40 Indigenous children whose fees are paid

(Continued next page)

Box 3.3.2 (continued)

through assistance from the Australian Government, parents, the school and other donors. Six boys have already completed their higher school certificate and in 2005 one of the boys in year 10 improved his academic ranking from 51st to sixth and topped the class in English.

Both programs demonstrate that Indigenous youth have the capacity to excel and achieve when they have access to an extensive curriculum, quality facilities and specialist staff.

Clontarf Foundation, WA

In WA, the Clontarf Foundation engages and supports young Indigenous men to complete year 12 and then provides assistance to find employment. The Foundation establishes Football Academies in partnership with mainstream schools. In order to remain at the Football Academy, participants must consistently endeavour to attend school regularly, apply themselves to the study of appropriate courses and embrace the Academy's requirements for behaviour and self discipline. The first Football Academy was established in 2000 with 25 students, in 2006 there were six Football Academies and 424 students enrolled.

The Foundation's approach has been very successful, in 2005:

- attendance rates were better than 80 per cent
- year on year retention rates were over 90 per cent
- 75 per cent of school graduates found full time work (Clontarf Foundation 2006).

Remote secondary schooling in the NT

The 2005 Report included a case study on increasing access to secondary education for students in remote and very remote communities in the NT. High school accreditation was given to schools in the communities of Maningrida, Kalkaringi, Minyerri, Yirrkala and Elcho Island.

In 2003, three students at Kalkaringi completed year 12 in their home community. In 2004, there were five students at Kalkaringi studying years 11 and 12 and this increased to 24 students in 2005.

Maningrida began delivering secondary education in 2003, with four students completing the Northern Territory Certificate of Education (NTCE) in 2004. In 2006, 11 students from Maningrida completed the NTCE.

Across the NT, the number of Indigenous students completing the NTCE increased from 106 in 2005 to 130 in 2006. Of these, 30 Indigenous students completed the NTCE in remote communities.

In addition, where on-site secondary education is unavailable, the Northern Territory Open Education Centre (NTOEC) is working closely with small remote schools to support students undertaking secondary subjects. In 2006, 6 NTOEC students from remote communities achieved a NTCE.

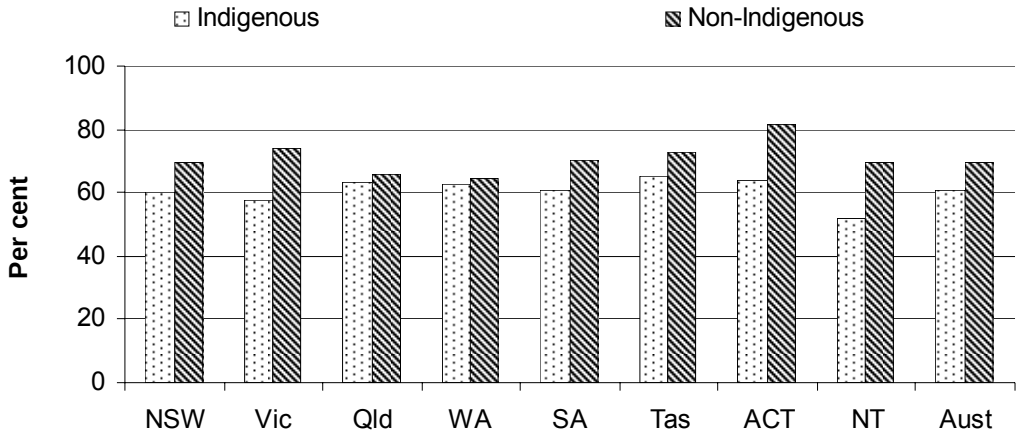
Health and education are intimately connected. If children have poor health outcomes early in life, then by the time they enter school they are unlikely to be able to concentrate fully or participate well socially (Zubrick et al. 2006). Preschool and early education programs have long been known to be associated with increasing levels of school completion and enhancing literacy and social skills necessary for school success (Ou and Reynolds 2004; Reynolds et al. 2001; Schweinhart 2005). The provision of early educational services to children at ages three or four may also provide an opportunity for early intervention to address developmental problems such as hearing, language and visual problems (see section 5.4 regarding hearing impediments).

There is evidence to suggest a connection between educational disadvantage and involvement in crime. An examination of the link between education and crime by Mackenzie (2002) concluded that improving school performance and retention reduced the risk of juvenile involvement in crime. A recent study on correlations between Indigenous contact with the justice system and social factors found that failure to complete year 12 has only a small effect on the risk of imprisonment but a significant effect on the likelihood of being charged (Weatherburn, Snowball and Hunter 2006). The authors of the study noted that their findings were consistent with empirical research but acknowledged that it is unclear whether the relationship between poor school performance and offending is actually causal or a reflection of some other factors (Maguin and Loeber 1996).

Secondary school participation and retention

Apparent retention rates estimate the percentage of full time students who progress through secondary school. These measures are under examination because apparent retention rates do not reflect the increasing number of students who enrol in school part time or choose to pursue their senior secondary studies or an equivalent vocational education and training qualification at TAFE. The method of calculation for apparent retention rates does not take into account impacts of migration and overseas students, and students repeating a year level or moving interstate (ABS 2006). Apparent retention rates do not reflect students who do not make the transition from primary to secondary school. Supplementary age-specific participation measures have been included in this section to provide a comprehensive picture of Indigenous education.

Figure 3.3.1 **School participation rates of full time students aged 12–19 years, all schools, 2006[a, b]**



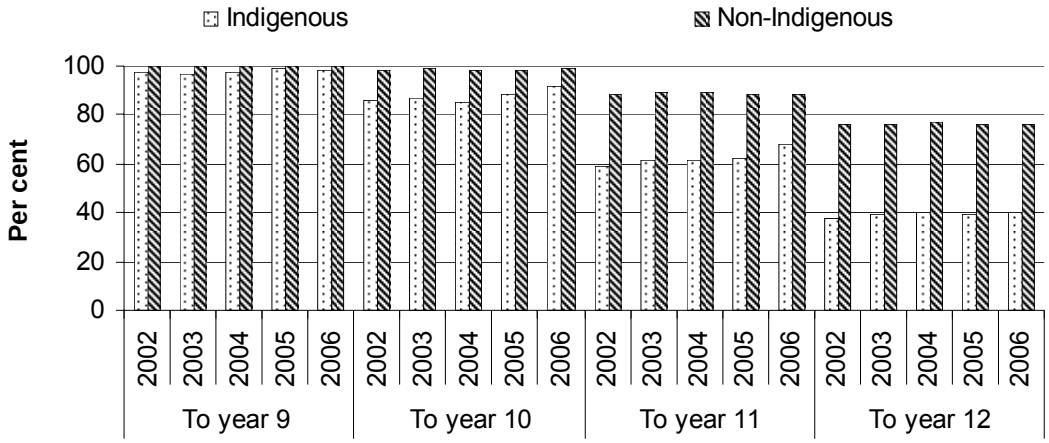
a The participation rate is the number of full time school students of a particular age, expressed as a proportion of the estimated resident population of the same age at June in 2006. **b** Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS Schools Australia 2006 (unpublished); table 3A.3.2.

- Nationally in 2006, 60.5 per cent of Indigenous people aged 12–19 years were enrolled in schools compared with 69.7 per cent of non-Indigenous people (figure 3.3.1).
- The participation rate in 2006 for Indigenous and non-Indigenous people aged 12–14 years was generally over 90 per cent. High participation rates are to be expected because school education was compulsory in all states and territories for people between 6 and 15 years of age in 2006 (extending to 16 years of age in SA and Tasmania) (table 3A.3.2).
- The participation rate for Indigenous people 15 years old was 79.4 per cent compared with 95.2 per cent for non-Indigenous people (table 3A.3.2).
- In general, the age of students in year 12 is 17 years (ABS 2007). In 2006, 31.8 per cent of Indigenous people aged 17 years were participating in school education. For non-Indigenous people, 64.7 per cent of 17 year olds were participating in school education (table 3A.3.2).
- Table 3A.3.2 shows that for both Indigenous and non-Indigenous people, participation rates declined as students exceeded the compulsory school age.

School participation rates by states and territories and by age can be found in table 3A.3.2.

Figure 3.3.2 **Apparent retention rates of full time secondary school students, all schools[a]**

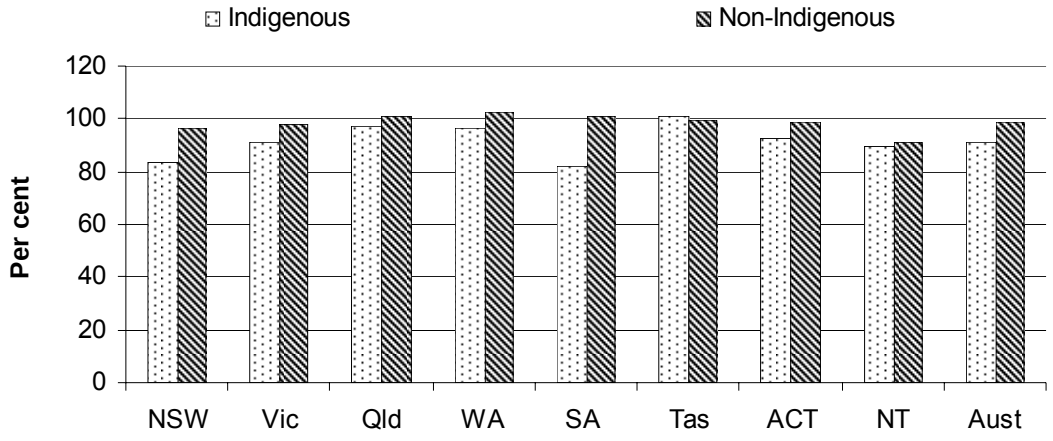


a The apparent retention rate is the percentage of full time students who continued to year 9, 10, 11 and 12 from respective cohort groups at the commencement of their secondary schooling (year 7/8). See notes to table 3A.3.3 for more detail.

Source: ABS Schools Australia 2006 (unpublished); table 3A.3.1.

- Apparent retention rates for Indigenous students from the beginning of secondary school to both year 10 and year 12 have increased over the last five years (figure 3.3.2). The rate to year 10 increased from 86.4 per cent in 2002 to 91.4 per cent in 2006 and the rate to year 12 increased from 38.0 per cent in 2002 to 40.1 per cent in 2006. These rates remain substantially lower than the rates for non-Indigenous students (table 3A.3.1).
- In 2006, the retention rate for Indigenous students decreased from 91.4 per cent in year 10 to 67.7 per cent in year 11 (a difference of 23.7 percentage points). By comparison, the rate for non-Indigenous students decreased less dramatically from year 10 to year 11 from 98.9 per cent to 88.8 per cent (a difference of 10.1 percentage points) (figure 3.3.2).
- The most significant differences between Indigenous and non-Indigenous retention rates were at the post compulsory years 11 and 12.

Figure 3.3.3 **Apparent retention rates from year 7 or 8 to year 10, of full time secondary students, all schools, 2006[a, b, c]**

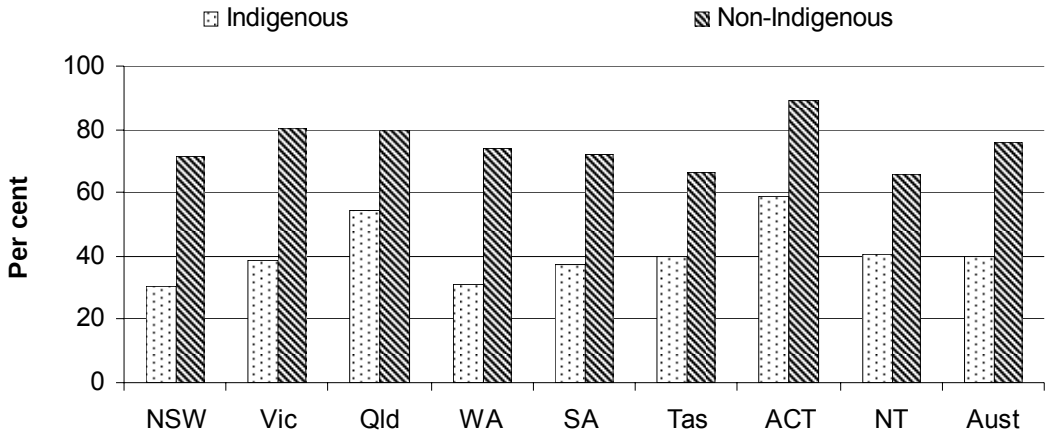


a The apparent retention rate is the percentage of full time students who continued to year 10 from respective cohort groups at the commencement of their secondary schooling (year 7/8). See notes to table 3A.3.3 for more detail. Retention rates are affected by factors that vary across jurisdictions. For this reason, variations in apparent retention rates over time within jurisdictions may be more useful than comparisons across jurisdictions. Retention rates can exceed 100 per cent for a variety of reasons, including student transfers between jurisdictions after the base year. **b** The exclusion of part time students from standard apparent retention rate calculations has implications for the interpretation of results for all jurisdictions, but particularly for SA, Tasmania and the NT where there is a high proportion of part time students. **c** Ungraded students are not included in the calculation of apparent retention rates. This exclusion has particular implications for the NT and as a result, Indigenous apparent retention rates may misrepresent the retention of students in secondary schooling in the NT.

Source: ABS Schools Australia 2006 (unpublished); table 3A.3.3.

- Nationally, the apparent retention rate to year 10 for Indigenous students was 91.4 per cent, or 7.5 percentage points lower than the rate for non-Indigenous students (98.9 per cent) (figure 3.3.3).
- Figure 3.3.3 shows that nationally in 2006, 8.6 per cent of Indigenous students who started secondary school had left school before year 10.

Figure 3.3.4 **Apparent retention rates from year 7 or 8 to year 12, of full time secondary students, all schools, 2006[a, b, c]**



a The apparent retention rate is the percentage of full time students who continued to year 12 from respective cohort groups at the commencement of their secondary schooling (year 7/8). See notes to table 3A.3.3 for more detail. **b** The exclusion of part time students from standard apparent retention rate calculations has implications for the interpretation of results for all jurisdictions, but particularly for SA, Tasmania and the NT where there is a high proportion of part time students. **c** Ungraded students are not included in the calculation of apparent retention rates. This exclusion has particular implications for the NT and as a result, Indigenous apparent retention rates may misrepresent the retention of students in secondary schooling in the NT.

Source: ABS Schools Australia 2006 (unpublished); table 3A.3.3.

- Nationally in 2006, Indigenous students were around half as likely to continue to year 12 as non-Indigenous students (figure 3.3.4).
- Retention rates for Indigenous students were considerably lower than those for non-Indigenous students in all jurisdictions.

Table 3A.3.8 shows apparent retention rates of full time students who continued to year 12 from year 10. Nationally, Indigenous students' retention from year 10 to year 12 in 2006 was 46.7 per cent compared with 77.0 per cent for non-Indigenous students.

Secondary school attainment

Educational attainment is the ability to complete the year and achieve graduation. Evidence from a range of sources indicates that successful completion of year 12 is necessary if young people are to have access to the full range of further education, training, employment and life chances consistent with their abilities (ACER 2004a; OECD 2005). This Report derived attainment data from the Indigenous Education Strategic Initiatives Programme (IESIP) performance reports. The IESIP

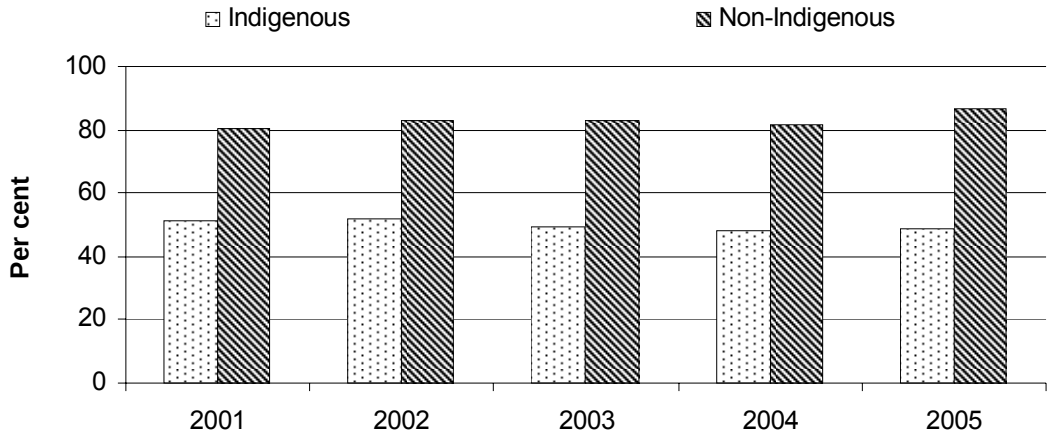
performance reports collected data on students achieving a year 12 certificate in 2005 as a proportion of students who were enrolled in year 11 in 2004.

Data on year 10 attainment are problematic because there is no acknowledged year 10 qualification in some jurisdictions. Jurisdictions that do issue year 10 certificates generally only require reasonable school attendance rather than demonstrated academic achievement.

The ABS 2004-05 NATSIHS and the ABS 2004-05 NHS collected information on the highest level of schooling completed. An analysis of these data show that:

- A smaller proportion (22.1 per cent) of Indigenous people than non-Indigenous people had completed year 12 (46.6 per cent) (table 3A.3.18)
- Indigenous people who had completed year 12 were less likely to be unemployed (9.5 per cent) than those who had only completed year 9 or below (24.3 per cent) (table 3A.3.19).

Figure 3.3.5 **Students who achieved a year 12 certificate (as a proportion of students who were enrolled in year 11 in the previous year), government and Catholic systems, 2001–2005**[a, b, c]



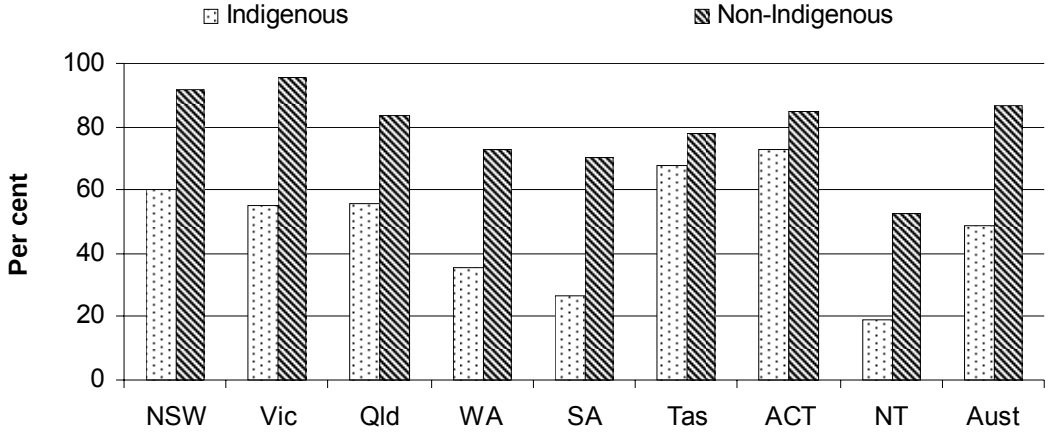
[a] The requirements for the awarding of a year 12 certificate vary in each jurisdiction. [b] Enrolled in year 11 at the time of the annual national school census in August the previous year. [c] Care needs to be taken when comparing attainment outcomes for Indigenous students over the period 2001–2005 because of the small number of Indigenous students represented.

Source: Department of Education, Science and Training (unpublished); tables 3A.3.11–15.

- Many Indigenous students leave school before completing year 10, and of those who enter senior secondary years, results show that they are less likely to obtain a year 12 certificate than their non-Indigenous counterparts (figure 3.3.5). Figure 3.3.2 showed that large proportions of Indigenous students leave school between years 10 and 11 and between years 11 and 12.

- Nationally, the proportion of Indigenous students who achieved a year 12 certificate (as a proportion of students who were enrolled in year 11 in the previous year), decreased from 51.1 per cent in 2001 to 48.7 per cent in 2005. By comparison, the proportion of non-Indigenous students increased from 80.3 per cent in 2001 to 86.8 per cent in 2005 (tables 3A.3.11–15).
- Figure 3.3.5 shows that between 2001 and 2005 the gap between Indigenous and non-Indigenous students who achieved a year 12 certificate (after being enrolled in year 11 the previous year) increased by 8.9 percentage points.
- Indigenous students who obtain a year 12 certificate are less likely than non-Indigenous students to gain a Universities Admissions Index[3] (UAI) (DEST 2002, 2005, 2006).
- Indigenous students who obtain a UAI are less likely than non-Indigenous students to gain a UAI at a level which will enable admission to university (DEST 2002, 2005, 2006).
- Indigenous students are more likely to gain a vocational educational qualification while completing the year 12 certificate than non-Indigenous students (DEST 2002, 2005, 2006).

Figure 3.3.6 **Students who achieved a year 12 certificate in 2005 (as a proportion of students who were enrolled in year 11 in the previous year), government and Catholic systems[a, b]**



a The requirements for the awarding of a year 12 certificate vary in each jurisdiction. **b** Enrolled in year 11 at the time of the annual national school census in August the previous year.

Source: Department of Education, Science and Training (unpublished); table 3A.3.11.

3 Eligibility for admission to a public university in Australia on the basis of merit is determined in each State and Territory through the use of a score – the UAI. Calculating the UAI varies in each State and Territory.

- Nationally, the proportion of Indigenous students who were enrolled in year 11 in 2004 and attained a year 12 certificate in 2005 was 48.7 per cent compared with 86.8 per cent for non-Indigenous students (table 3A.3.11).
- The proportions of Indigenous students who achieved a year 12 certificate in 2005 (after commencing year 11 the previous year) varied significantly across states and territories (figure 3.3.6).
- Between 2001 and 2005, the number of Indigenous students who attained a year 12 certificate increased in all states and territories (tables 3A.3.11 and 3A.3.15).

3.4 Post secondary education — participation and attainment

Box 3.4.1 **Key messages**

- Although not strictly comparable, between 1994 and 2004-05, the proportion of Indigenous people participating in post secondary education increased from 5.0 per cent to 11.4 per cent (table 3A.4.2).
- The proportion of Indigenous people with a qualification of certificate level 3 or above increased from 8.3 per cent in 1994 to 20.8 per cent in 2004-05 (figure 3.4.3).
- In 2004-05, non-Indigenous people were more than twice as likely as Indigenous people to have completed a post secondary qualification of certificate level 3 or above (3A.4.10).
- Higher education success rates (between 2001 and 2004) and TAFE pass rates (between 2002 and 2005) increased for Indigenous students (figures 3.4.4 and 3.4.5).

Post secondary education may lead to more than just better employment prospects and higher incomes. Section 7.5 shows that people with a skilled vocational qualification or higher (equivalent to certificate 3 or higher) are more likely to be employed than those without such qualifications. There are also many potential social effects of an individual's education. These include:

- the schooling of their children — parental education is a positive influence on student performance (OECD 2004; Wolfe and Haveman 2001; Zubrick et al. 2006)
- efficiency of their choices — making the most of the opportunities on offer throughout life (Wolfe and Haveman 2001; Zubrick et al. 2006)

- their health outcomes and their children's health outcomes — accessing health care as required assists in ensuring healthy successive generations (Wolfe and Haveman 2001; Zubrick et al. 2006).

Post secondary education includes both vocational education and training (VET) at institutions such as TAFE colleges, and higher education at universities. Research suggests that young people who are not participating full time in education, training, work or some combination of these activities are more likely to have difficulty in making a transition to full time employment by their mid-20s (Dusseldorp Skills Forum 2006; Marks 2006).

Research undertaken by the Dusseldorp Skills Forum (2006) found that almost as many school leavers were studying at TAFE as at university. TAFE is a particularly important destination for early school leavers (Dusseldorp Skills Forum 2006). Indigenous people, especially young Indigenous people, participate in VET at rates above those for non-Indigenous people (Saunders et al. 2003). Young Indigenous people may be more likely to participate in VET because year 12 Indigenous students are less likely than non-Indigenous students to attain a sufficiently high score to enable admission to university (see section 3.3)[4].

VET provides an opportunity for Indigenous people to attain post school qualifications and improve their employment prospects. In addition, participation in VET may improve self-esteem, literacy and increase confidence (Gelade and Stehlik 2004; O'Callaghan 2005; NCVER 2005).

However, Indigenous VET students do not achieve the same outcomes as their non-Indigenous counterparts. Indigenous VET students tend to study lower level and shorter courses compared with non-Indigenous students (ANTA 2005; Buckskin 2001; Saunders et al. 2003). In 2005, the proportion of Indigenous students in diploma or higher courses was 4.2 per cent compared with 38.3 per cent of other full-time students (NCVER 2006a).

Employment outcomes from VET remain lower for Indigenous students compared with other students (ANTA 2005; Buckskin 2001; NCVER 2006b; O'Callaghan 2005; Saunders et al. 2003). In 2006, 66.1 per cent of Indigenous students were employed after VET training compared with 80.0 per cent of non-Indigenous students (NCVER 2006b).

Locality can influence Indigenous peoples' participation in post secondary education (ACER 2002). There is evidence that Indigenous people in regional and

4 Eligibility for admission to a public university in Australia on the basis of merit is determined in each State and Territory through the use of a score – the Universities Admissions Index (UAI). Calculating the UAI varies in each State and Territory.

remote areas are substantially less likely to participate in higher education than Indigenous people in major cities. In 2004-05, the proportion of Indigenous people currently participating in post secondary education in major cities was 14.8 per cent compared with 7.3 per cent in remote areas (table 3A.4.4).

Although Indigenous people are less likely to participate in post secondary education compared to non-Indigenous people, several programs have been successful in preparing Indigenous students for post secondary education (box 3.4.2).

Box 3.4.2 **'Things that work' — increasing post secondary education attainment**

Construction skills and work readiness training, Robinvale, Victoria

The Australian Master Bricklayers Association (AMBA) and the Victorian Department of Education worked in partnership to provide construction skills and work readiness training to unemployed Indigenous people living in Robinvale.

Fifteen people began the eight week course in 2006 and 8 completed the course and were awarded either a Certificate I in General Construction or statements of attainment. Four participants gained full-time employment since completing the course. Course participants demonstrated high-level skills and aptitude and, with the right motivation and support, are moving into successful careers in a range of trades in the building and construction industry.

Vocational training for prisoners in Queensland

A training culture is emerging in many prisons and there have been positive results for Indigenous prisoners. In Queensland, being involved in a vocational education program before initial release is associated with a 30 per cent decrease in the chance of offenders returning to custody (O'Callaghan 2005; Callan and Gardner 2005).

Construction skills for Indigenous people in NSW

The 2005 Report included an example of a program specifically designed for unemployed Indigenous people interested in working in the building and construction industry. The program was developed in partnership between the Construction Forestry Mining and Energy Union and TAFE NSW and has been operating since 2004. Run over six to eight weeks, the program leads to relevant licences and tickets in the industry. In 2006 two programs were delivered. These programs had a retention rate of around 80 per cent and approximately 40 per cent of program participants were employed in the construction industry.

Although participation itself may have some benefits, the major impact on improved outcomes for Indigenous people results from attainment of a qualification or completion of a course of study. This indicator uses survey data to examine the

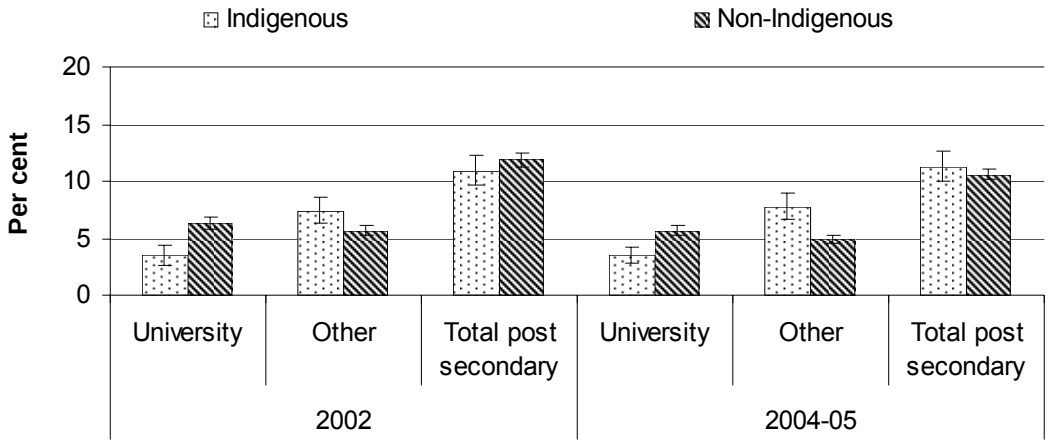
extent to which people over 18 years (1) participate in post secondary education and (2) have attained a particular level of qualification.

The broad types of courses Indigenous people are undertaking at higher education institutions along with load pass rates for VET courses and success rates for higher education are also examined.

Post secondary participation

ABS surveys, including the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS), 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 2002 General Social Survey (GSS), 2004-05 NATSIHS and the 2004-05 NHS, provide information on the proportion of people who had left school and were attending a technical or further educational institution (including TAFE colleges, business colleges and industry skills centres), or university or other higher educational institutions.

Figure 3.4.1 **Participation in post secondary education by persons aged 18 years and over, 2002 and 2004-05[a, b]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). **b** Other includes TAFE, technical college, business college, industry skills centre.

Source: ABS 2002 NATSISS (unpublished); ABS 2002 GSS (unpublished); ABS 2004-05 NHS and NATSIHS (unpublished); table 3A.4.1.

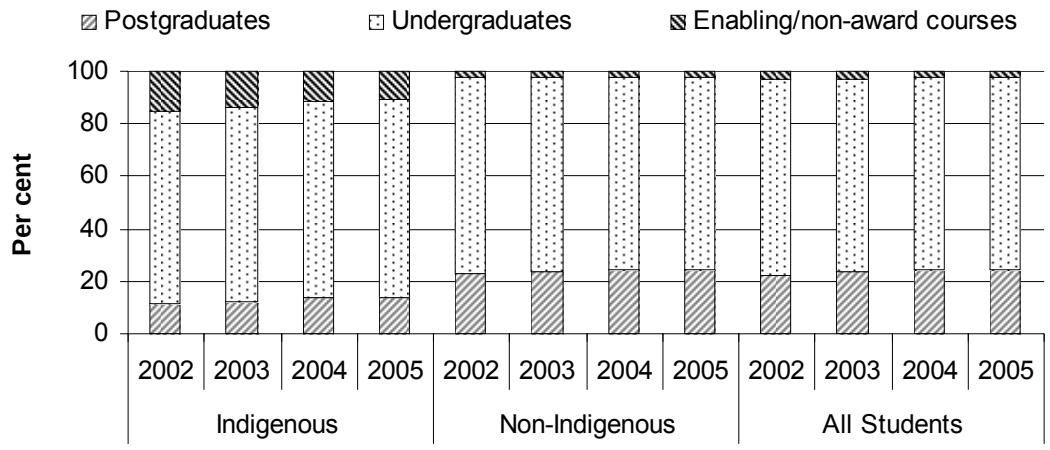
- Figure 3.4.1 shows that there was no significant change in participation in post secondary education for Indigenous people between 2002 and 2004-05.
- Nationally in 2004-05, non-Indigenous people were 1.6 times as likely as Indigenous people to attend a university, while Indigenous people were more

likely to attend a TAFE, technical college, business college or industry skills centre (table 3A.4.1).

- Although not strictly comparable, the proportion of Indigenous people participating in post secondary education increased from 5.0 per cent in 1994 to 11.4 per cent 2004-05 (table 3A.4.2).

More data on post secondary participation across states and territories, by age, sex and remoteness areas can be found in tables 3A.4.1–5.

Figure 3.4.2 **Post secondary participation at higher education institutions, 2002–2005**



Source: DEST higher education statistics collection (unpublished); table 3A.4.6–9.

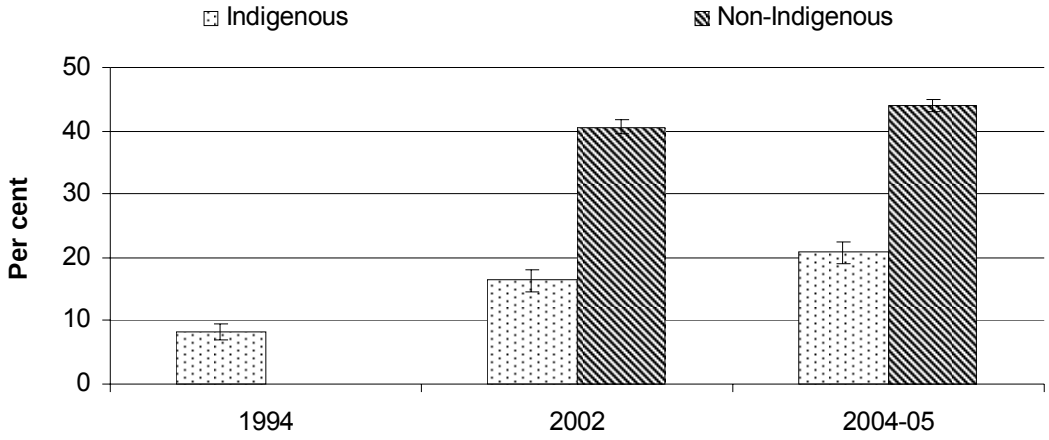
- Figure 3.4.2 shows that Indigenous students were more likely to be enrolled in enabling and non-award courses, and less likely to be enrolled in postgraduate courses, than non-Indigenous students.
- Between 2002 and 2005, the proportion of Indigenous students enrolled in enabling or non-award courses decreased from 15.2 per cent to 10.4 per cent while the proportions enrolled in undergraduate and postgraduate courses increased (73.2 per cent to 75.8 per cent and 11.6 per cent to 13.8 per cent, respectively) (tables 3A.4.6–9).

More data on the types of courses Indigenous people are undertaking by State and Territory can be found in tables 3A.4.6–9.

Post secondary attainment

One measure of attainment is the proportion of the population that have completed a particular level of qualification. Data from the ABS 1994 NATSIS, 2002 NATSISS, 2002 GSS, 2004-05 NATSIHS and 2004-05 NHS on the proportion of people aged 18 years and over who indicated that their highest level of qualification completed was a level 3 certificate or above (that is, post graduate degree, graduate diploma or certificate, bachelor degree, advanced diploma, diploma, and certificate levels 3 and 4) are used to indicate educational attainment.

Figure 3.4.3 **Post secondary attainment of certificate level 3 or above by persons aged 18 years and over, 1994, 2002, 2004-05[a, b, c]**



[a] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). [b] There is no comparable dataset for non-Indigenous post secondary attainment for 1994. [c] Care should be taken when analysing trends between 1994, 2002 and 2004-05 because education data were collected on a different basis.

Source: ABS 1994 NATSIS (unpublished); ABS 2002 NATSISS (unpublished); ABS 2002 GSS (unpublished); ABS 2004-05 NHS and NATSIHS (unpublished); tables 3A.4.10 and 11.

- Although not strictly comparable, between 1994 and 2004-05, the proportion of Indigenous people with a certificate level 3 or above increased from 8.3 per cent to 20.8 per cent (figure 3.4.3).
- In 2002 and 2004-05, non-Indigenous people were more than twice as likely as Indigenous people to have completed a post secondary qualification of certificate level 3 or above (3A.4.10).
- In 2004-05, for both Indigenous and non-Indigenous people, a higher proportion of people in non-remote areas had attained a post secondary qualification of certificate level 3 or above (25.0 per cent and 44.0 per cent, respectively)

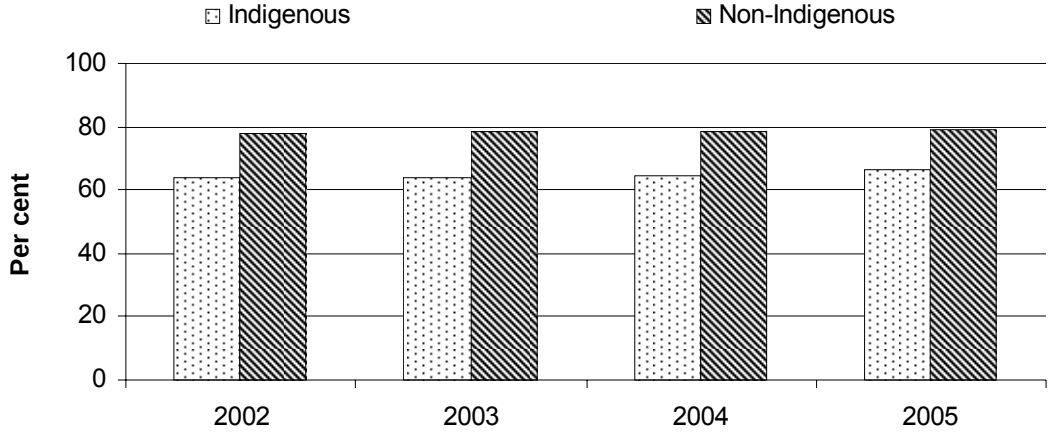
compared with people in remote areas (14.5 per cent and 34.3 per cent, respectively)[5] (table 3A.4.14).

More data on post secondary attainment by State and Territory, age and remoteness areas can be found in tables 3A.4.12–15.

Another measure of attainment is the extent to which people complete or pass the course they are undertaking. This is known in the VET system as the load pass rate and in the higher education system as the success rate. There is a consistent and marked difference in VET load pass rates by age, with younger Indigenous students (15−19 years) having the lowest load pass rates and older Indigenous students the highest (ANTA 2005).

The VET load pass rate indicates the extent to which students pass assessment in an assessable module or unit of competency. Load pass rates are calculated as the ratio of hours attributed to students who passed assessment in an assessable module or unit of competency to all students who were assessed and either passed, failed or withdrew. The calculation is based on the nominal hours supervised for each assessable module or unit of competency. Care needs to be taken in comparing data because average module durations and standards of competencies achieved by students vary across jurisdictions.

Figure 3.4.4 **VET load pass rate, 2002–2005**



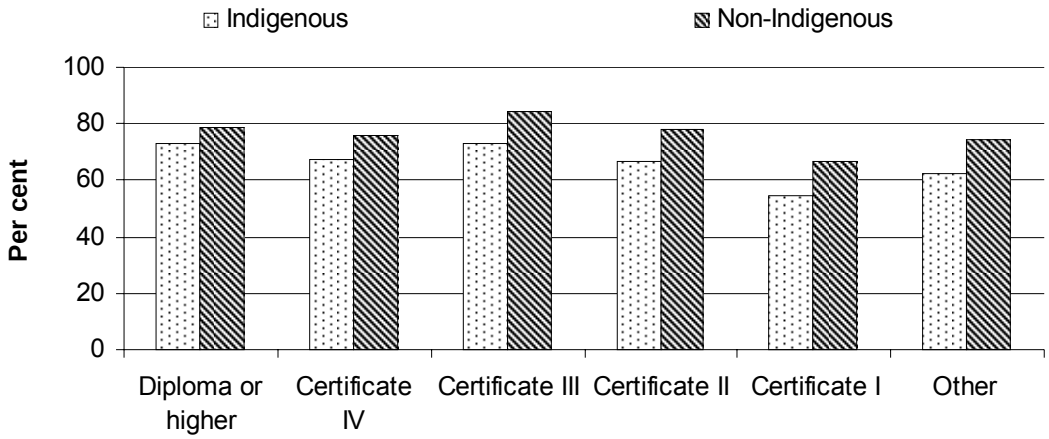
Source: National 2002–2005 VET provider collections (unpublished); table 3A.4.17.

5 Non-remote includes major cities and inner and outer regional areas. Remote includes remote and very remote areas. See glossary for definitions of remoteness areas.

- In 2005, the national load pass rate for Indigenous students (66.6 per cent) was lower than the national load pass rate for non-Indigenous students (79.2 per cent) (figure 3.4.4).
- In 2002 there was 13.9 percentage points difference between Indigenous and non-Indigenous VET load pass rates, in 2005 the gap was 12.6 percentage points.
- The load pass rate for Indigenous students increased nationally from 63.8 per cent in 2002 to 66.6 per cent in 2005. Over the same period, the load pass rate for non-Indigenous students also increased, from 77.7 per cent to 79.2 per cent (table 3A.4.17).

The load pass rates for Indigenous and non-Indigenous students by State and Territory and remoteness areas can be found in tables 3A.4.16 and 17.

Figure 3.4.5 **VET load pass rate by course level, 2005[a]**



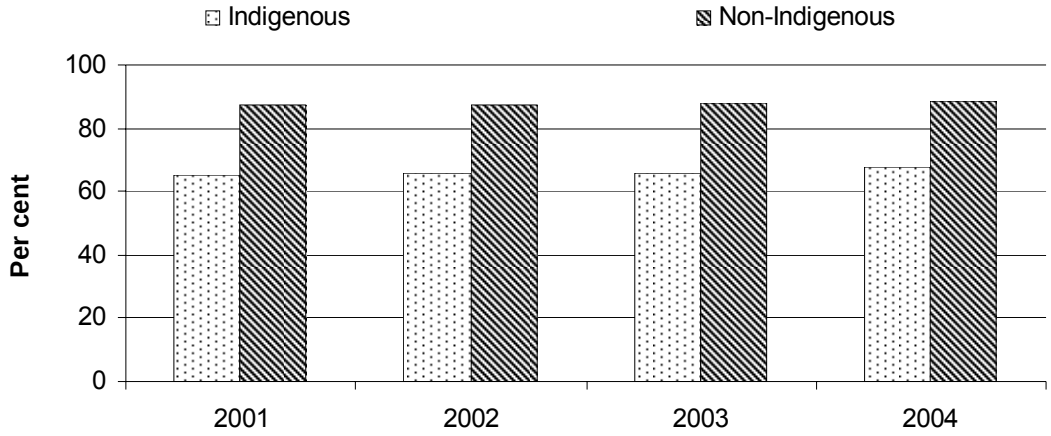
a Other includes senior secondary education and other education (bridging and enabling courses). Does not include non-award courses and individual subjects (no qualification).

Source: National 2002–2005 VET provider collections (unpublished); table 3A.4.18.

- In 2005, the highest national load pass rates achieved by Indigenous students were in the groups who undertook training at certificate level 3 (72.9 per cent) and diploma or higher (72.8 per cent) (figure 3.4.5).
- Between 2002 and 2005 there was an increase in load pass rates for all course levels for both Indigenous and non-Indigenous students (table 3A.4.18).

Although the measures are based on different calculations, the success rate for higher educational institutions shows similar results to the load pass rate for VET. The success rate is the proportion of units passed within a year compared with the total units enrolled.

Figure 3.4.6 **Higher education success rate, 2001–2004[a]**



a Success is defined as the student progress rate, which is the proportion of units passed within a year compared with the total units enrolled.

Source: DEST Selected Higher Education Statistics (unpublished); tables 3A.4.19–22.

- Figure 3.4.6 shows that higher education success rates are lower for Indigenous students than non-Indigenous students.
- In 2001 there was a 22.2 percentage points gap between Indigenous and non-Indigenous students success rates. In 2004, the gap was 21.0 percentage points (tables 3A.4.19–22).
- The success rate for Indigenous students increased from 65.1 per cent in 2001 to 67.5 per cent in 2004. For non-Indigenous students the success rate also increased, from 87.3 per cent to 88.5 per cent.

3.5 Labour force participation and unemployment

Box 3.5.1 **Key messages**

- In 2004-05, after adjusting for age differences:
  - the labour force participation rate for Indigenous people (58.5 per cent) was about three quarters of that for non-Indigenous people (78.1 per cent) (figure 3.5.3)
  - the unemployment rate for Indigenous people (12.9 per cent) was about 3 times the rate for non-Indigenous people (4.4 per cent) (figure 3.5.6).
- From 1994 to 2004-05:
  - the participation rate for Indigenous women increased from 41.5 per cent to 52.6 per cent. The rate for Indigenous men remained constant (figure 3.5.5)
  - the Indigenous unemployment rate fell from 30.0 per cent to 12.8 per cent. The unemployment rate fell for both men and women (figure 3.5.9)
  - CDEP participation rates remained stable (figure 3.5.2). CDEP participation significantly reduces recorded Indigenous unemployment rates and increases recorded labour force participation rates, particularly in remote areas.

Labour force participation and unemployment has been chosen as a headline indicator because labour market outcomes are directly related to people's living standard and many aspects of their wellbeing. Being employed leads to improved income for families and communities (which in turn has a positive influence on health and the education of children). It also enhances self-esteem, increases opportunities for self development, influences interaction at the family and community levels and reduces social alienation. Employment is discussed in more detail in chapter 11. The focus of this section is the extent to which people are participating in the labour force or are unemployed.

The labour force is the most widely used measure of the economically active population or the formal supply of labour.

The labour force is a measure of the number of people contributing to, or willing to contribute to, the supply of labour and, as defined by the ABS, comprises two mutually exclusive categories of people:

- the employed (people who have worked for at least one hour in the reference week, including those who have participated in Community Development Employment Projects (CDEP))
- the unemployed (people who are without work, but are actively looking for work and available to start work within four weeks).

The remainder of the population are not in the labour force. There are many reasons why people may not be in the labour force. They may not wish or be able to work because they are in education, retired, caring for family members, have a disability or poor health or have some other means of financial support. Alternatively, they could be discouraged jobseekers who would like work but are not actively looking for work. People may become discouraged jobseekers because they believe that there is not a suitable job in their area, the costs of searching are too great, or they believe that they do not have the appropriate skills or qualifications (Hunter and Gray 1999). It is likely that the extent of unemployment, particularly long term unemployment, is underestimated because of discouraged jobseekers. After people have been unemployed for long periods of time they are more likely to drop out of the labour force. Indigenous people may also be engaged in activities outside of the labour force, through participation in traditional or customary activities, or occupied with activities that often generate income such as the production of Indigenous art but which are not always recorded as employment (Altman et al. 2006).

Data for the labour force participation and unemployment indicator in this Report are from several ABS surveys, including the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the 2004-05 National Health Survey (NHS), 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 2002 General Social Survey (GSS) and the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS).

Most 2004-05 data for this indicator are reported for the population aged 15 to 64 years, as this is used by the ABS in measuring the economic participation of a population. The age of 15 years is the lowest practical limit above the compulsory schooling age of young people at which it is feasible to measure the participation of young people in economic activity with acceptable accuracy. The age of 64 years is when most people have left the workforce for retirement. Data for people aged 18 to 64 years are also reported to compare outcomes in 2004-05 with those in 1994 and 2002.

When comparing the Indigenous and non-Indigenous labour force in this Report, data are age standardised to take account of the differing age structures of the Indigenous and non-Indigenous populations. Where data by age group are being compared, adjustment for the differing age structures is not required.

The labour force participation and unemployment data used in this chapter are influenced by the Community Development Employment Projects (CDEP) program. The CDEP program is an Australian Government funded initiative that provides activities for unemployed Indigenous people to develop work skills and move into employment. The original aim of the CDEP scheme, when introduced in 1977, was to create local employment opportunities in remote Indigenous

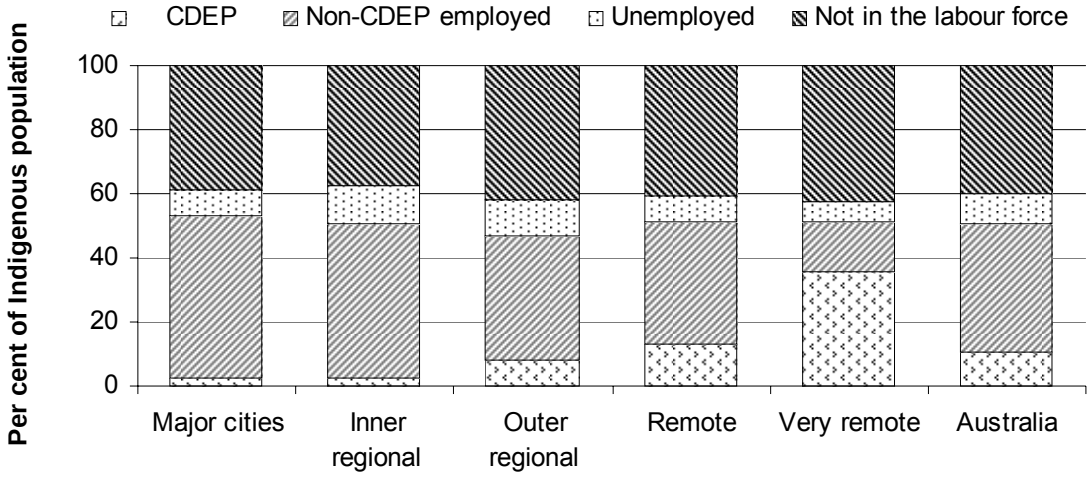
communities where the labour market might not otherwise offer employment. The scheme was later extended to all remoteness areas, but most CDEP organisations continued to be located in regional and remote areas of Australia. Recently announced changes by the Australian Government will remove funding for CDEP in urban and regional centres and the programme will operate once again in remote and limited regional areas only.

Since July 2004, the Australian Government has made changes to CDEP to increase movement of participants into other employment. Changes since 1 July 2006 include the introduction of a youth participant rate to encourage young Indigenous people to complete education. Other changes limited the duration of entitlement to CDEP for new participants in urban and regional centres and required participants in these areas to register as job seekers with a Job Network employment provider. Where no Job Network is available (in many remote areas), CDEP participants must develop a 'participation plan' to move into other employment. More changes from 1 July 2007 will remove funding for CDEP employment in urban and major regional centres with strong employment opportunities. This funding will instead be directed to additional Structured Training and Employment Project (STEP) programs to assist job seekers move into work (DEST 2006). The more substantial changes to CDEP occurred after the 2004-05 NATSIHS was conducted and are not reflected in the data in this Report.

For statistical purposes the ABS classifies participants in CDEP as employed rather than as unemployed or not in the labour force, consequently the employment rate for Indigenous people may be overstated. It is important to consider CDEP when analysing the labour force and unemployment data because:

- CDEP has elements of both unemployment and employment, especially in remote and very remote areas. Some CDEP activities are similar to those undertaken by participants in Work for the Dole, while other activities are essential roles in municipal services, health care, community services, education and other sectors that would be considered employment in mainstream communities and organisations.
- CDEP participant payments are received in place of an income support payment such as NewStart Allowance for which recipients are considered unemployed.

Figure 3.5.1 **CDEP participation, unemployment and labour force participation for Indigenous people aged 15 to 64 years, 2004-05[a]**



a The ABS advise that CDEP participation data in the figure are not directly comparable with those reported in the 2005 Report as different interview questions were used in the 2002 NATSISS and the 2004-05 NATSIHS.

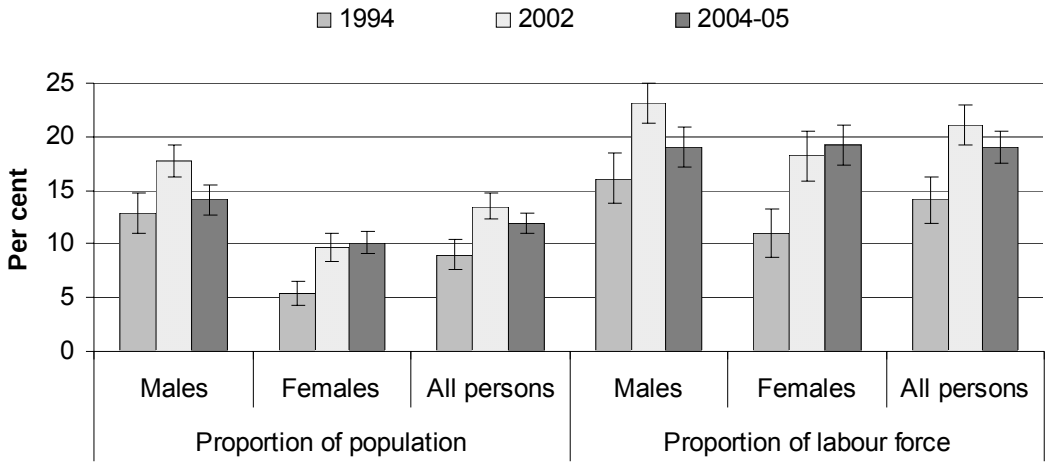
Source: ABS NATSIHS 2004-05 (unpublished); table 3A.5.4.

Nationally in 2004-05 there were over 30 000 Indigenous CDEP participants.[6]

- CDEP participation increased with geographic remoteness, ranging from 2.2 per cent of the Indigenous population in major cities to 35.6 per cent in very remote areas (figure 3.5.1).
- Non-CDEP employment declined with increasing remoteness from 50.9 per cent in major cities to 15.8 per cent in very remote areas (figure 3.5.1) (see detailed discussion of Indigenous employment in chapter 11.).
- The NT had the highest CDEP participation rate (23.9 per cent), with substantial CDEP participation rates also in WA and SA (20.7 and 12.5 per cent respectively) (table 3A.5.5).

6 The 2004-05 NATSIHS estimated 30 600 Indigenous people on CDEP in 2004-05, which was much lower than records in administrative data, for example, DEWR (2005) reported 34 775 CDEP participants as at 30 June 2005.

Figure 3.5.2 **CDEP participation, Indigenous people aged 18–64 years**[a, b, c, d]



[a] Data are not age standardised. [b] Percentages represent proportions of total Indigenous people and total Indigenous labour force.[c] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). [d] The ABS advises that CDEP participation data for 1994 and 2002 are not directly comparable with 2004-05 data as different interview questions were used in the 2005 NATSIHS.

Source: ABS NATSIHS 2004-05 (unpublished); ABS NATSISS 2002 (unpublished); ABS NATSIS 1994 (unpublished); table 3A.5.9.

For the period 1994 to 2004-05:

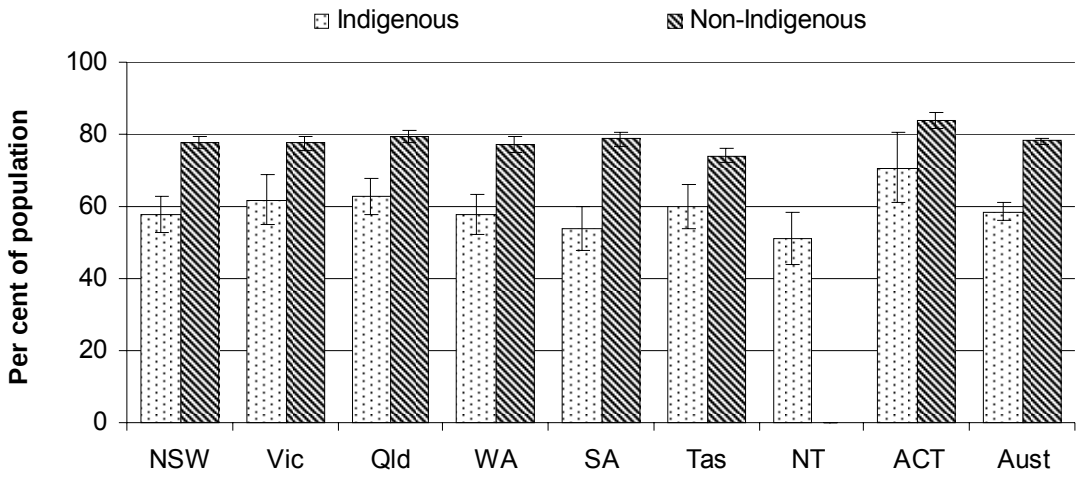
- The CDEP participation rate for Indigenous people remained fairly stable as a proportion of the total adult Indigenous population and as a proportion of the total Indigenous labour force (figure 3.5.2).
- Female CDEP participation, as a proportion of the Indigenous labour force, increased from 11.0 per cent in 1994 to 19.2 per cent in 2004-05. However, this should be treated with caution as the 1994 data are not directly comparable with data for 2002 and 2004-05. CDEP participation remained fairly constant for males (figure 3.5.2).
- Numbers of CDEP participants (from administrative data) for this time period were:
  - 24 098 participants in 1993-94 (ATSIC 1994)
  - 35 182 participants in 2002-03 (ATSIC 2003)
  - 34 775 participants as at 30 June 2005 (DEWR 2005).

Labour force participation

The labour force participation rates used in this section are calculated as the number of people who are employed or are available for work (the labour force), in the age group of interest, divided by the population in that age group.

In general, labour force participation varies through life cycle stages, initially increasing with age as young people move from education and training (often combined with part-time work) into full-time jobs, remaining relatively high during prime working ages, and then declining towards retirement.

Figure 3.5.3 **Age standardised labour force participation as a proportion of the population aged 15 to 64 years, 2004-05[a, b]**



a The sample size in the NT was considered too small to produce reliable estimates for the NT in the ABS 2004-05 NHS, but NT records in the survey have been attributed appropriately to national estimates. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.5.1.

In 2004-05, after taking into account the different age structures of the Indigenous and non-Indigenous populations:

- Nationally, Indigenous people aged 15 to 64 years had a labour force participation rate of 58.5 per cent compared to 78.1 per cent for non-Indigenous people (figure 3.5.3).
- Labour force participation rates for Indigenous people were lower than those for non-Indigenous people in all jurisdictions for which data were available (figure 3.5.3).

Table 3.5.1 **Labour force participation as a proportion of the population aged 15 to 64 years, 2004-05 (per cent)**

	Indigenous			*Non-Indigenous*		
	Males	*Females*	*Persons*	*Males*	*Females*	*Persons*
15–24	61.3*	50.4*	55.8	75.1*	74.5*	74.8
25–34	83.3	52.1	66.7	94.7	75.1	84.8
35–44	80.7	59.6	69.3	93.5	74.6	84.0
45–54	68.5	52.3	60.0	90.1	75.3	82.7
55–64	30.9*	28.5*	29.6	66.9	45.2	56.1
Total 15–64	69.4	51.4	60.0	85.0	70.1	77.6
AS total 15 years	67.8	50.2	58.5	85.6	70.7	78.1

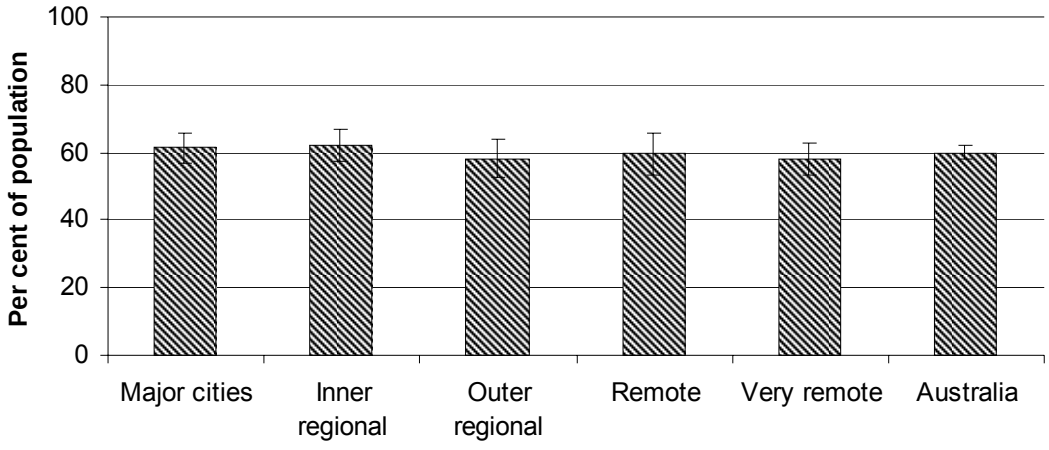
AS = age standardised. * indicates that the difference between data for males and females within the Indigenous and non-Indigenous populations is not statistically significant.

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.5.1.

In 2004-05:

- Labour force participation rates for Indigenous people were lower than those for non-Indigenous people for both sexes and in all age groups (table 3.5.1).
- Among both Indigenous and non-Indigenous people, females were less likely to participate in the labour force than males; and the labour force participation rate was markedly lower for those aged 55 to 64 years than for the younger age groups (table 3.5.1).

Figure 3.5.4 **Labour force participation as a proportion of the Indigenous population aged 15 to 64 years, by remoteness, 2004-05[a, b]**

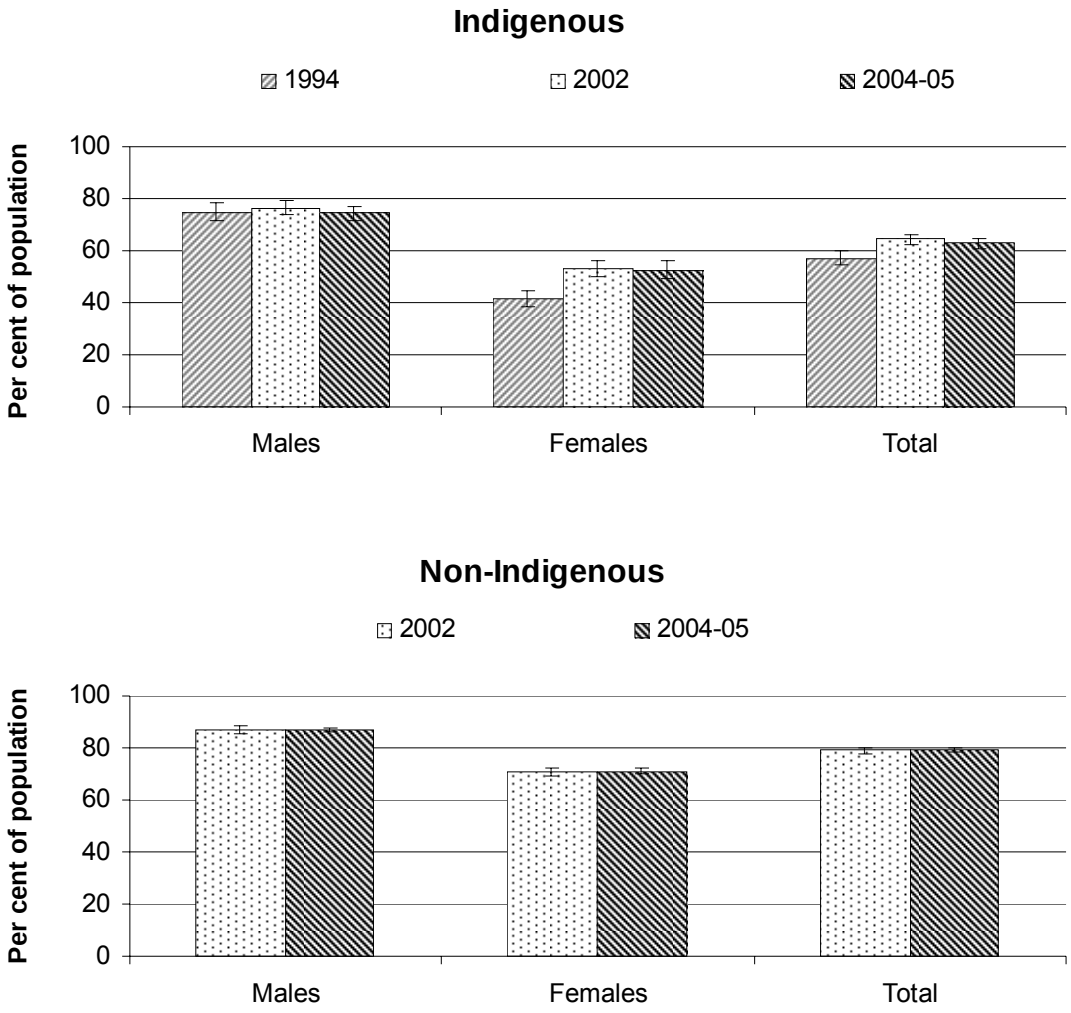


[a] Data are not age standardised. [b] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS (unpublished); table 3A.5.7.

- There was little variation in the labour force participation rate for Indigenous people across remoteness areas (figure 3.5.4). (The actual national rate in figure 3.5.4 (60.0 per cent) is higher than the age standardised national rate shown in figure 3.5.3 (58.5 per cent)).
- In remote and very remote areas, 13.0 per cent and 35.6 per cent, respectively, of Indigenous people in the labour force participated in CDEP (figure 3.5.1).

Figure 3.5.5 **Labour force participation as a proportion of the population aged 18 to 64 years[a, b, c]**



a Data are not age standardised. **b** Non-Indigenous data for 1994 are not available on a comparable basis with those for 2002 and 2004-05. **c** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS, 1994 NATSIS, 2002 NATSISS and GSS (unpublished); table 3A.5.3.

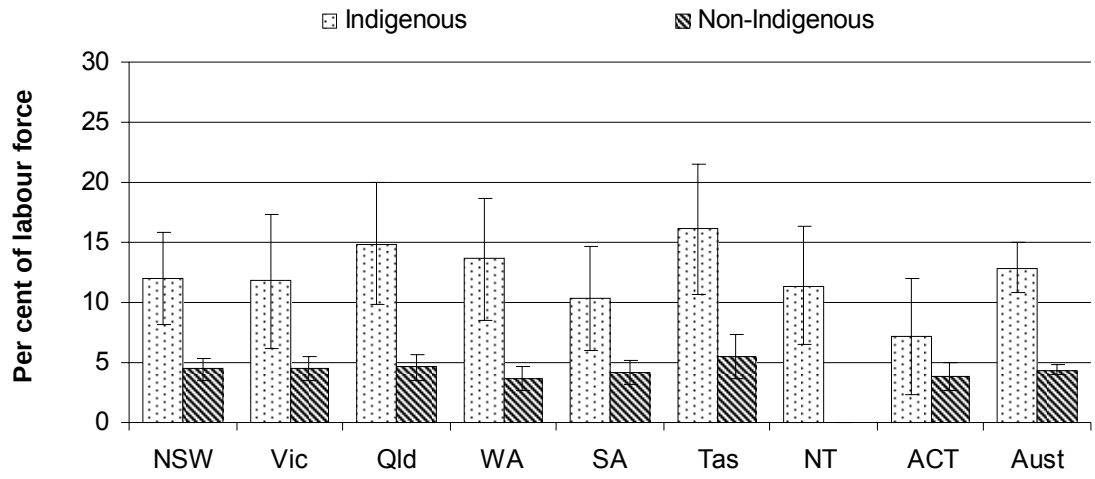
- Nationally, the labour force participation rate for Indigenous people aged 18 to 64 years increased from 57.3 per cent in 1994 to 62.7 per cent in 2004-05, although there was little change between 2002 and 2004-05 (figure 3.5.5).
- The participation rate for Indigenous women increased from 41.5 per cent in 1994 to 52.6 per cent in 2004-05, while there was no statistically significant change in the rate for Indigenous men over the same period.
- Non-Indigenous data for 1994 are not available on a comparable basis with those for 2002 and 2004-05. Between 2002 and 2004-05, for which data are available, there was little change in the labour force participation of non-Indigenous women and men. The ABS (2002, 2006) also found that there had been little change in the participation rate for the Australian population aged 15 years and over from 1995-96 to 2004-05 (63.6 per cent compared to 64.0 per cent).

Unemployment

The unemployment rate, which is the number of unemployed people expressed as a percentage of the labour force (employed plus unemployed people), is a widely used measure of potentially underutilised labour resources in the economy.

The ABS statistical data on unemployment need to be considered alongside data on CDEP participation, especially for Indigenous people in remote areas. CDEP participants are counted as employed rather than unemployed or not in the labour force in ABS statistics. This accounts for a relatively large number of Indigenous people, particularly in remote areas (figure 3.5.1).

Figure 3.5.6 **Age standardised unemployment rate of people aged 15 to 64 years, 2004-05[a, b]**



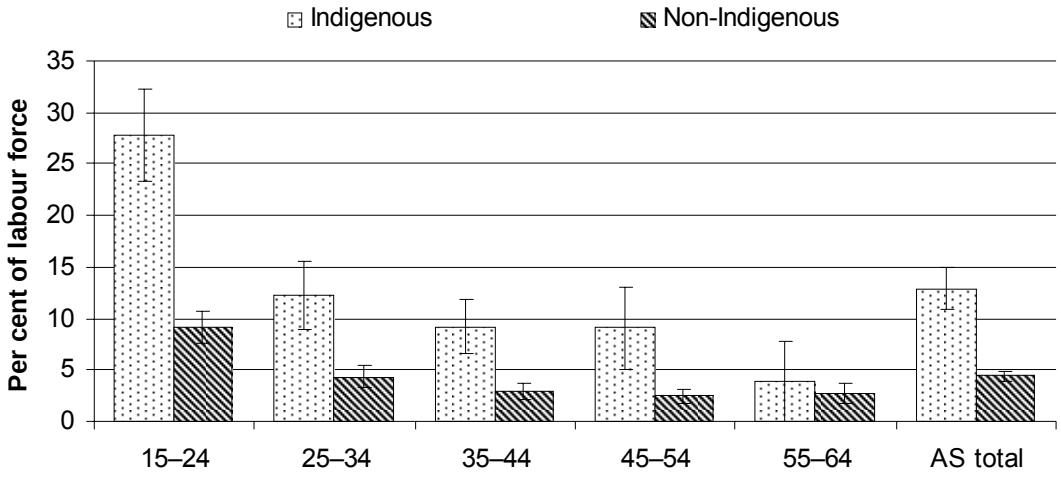
a The sample size in the NT was considered to be too small to produce reliable estimates for the NT in the ABS 2004-05 NHS, but NT records in the survey have been attributed appropriately to national estimates. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.5.1.

- After taking into account the different age structures of the Indigenous and non-Indigenous populations, the national unemployment rate in 2004-05 for Indigenous people (12.9 per cent) was about three times that for non-Indigenous people (4.4 per cent) (figure 3.5.6).

Regardless of Indigenous status, the likelihood of being unemployed is related to life cycle stages. The unemployment rate for both Indigenous and non-Indigenous people tends to be highest among young people. Young people typically have less developed work-related skills and are more likely to be entering the labour force for the first time than older people, which leads to higher unemployment.

Figure 3.5.7 **Unemployment rate of people aged 15 to 64 years, 2004-05[a, b]**



AS = age standardised.

a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). **b** Estimate for Indigenous persons 55–64 has a relative standard error greater than 50 per cent and is considered too unreliable for general use.

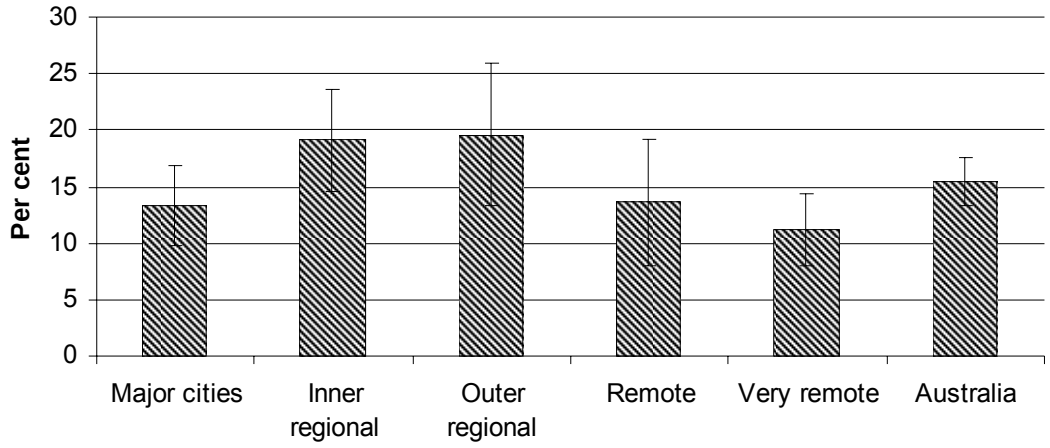
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.5.1.

In 2004-05:

- Indigenous people aged between 15 and 54 years were more likely to be unemployed than non-Indigenous people in the same age range (figure 3.5.7).
- The unemployment rate for Indigenous people aged 15 to 24 years was three times that for non-Indigenous people of the same age group (27.8 per cent compared to 9.2 per cent) (figure 3.5.7).

Opportunities for work vary across Australia with the nature and strength of the economic base, the relative growth of industries and the skill base of residents (ABS 2001). These factors can be significant for understanding differing rates of unemployment for Indigenous and non-Indigenous people and differences across remoteness areas (see figures 3.5.4 and 3.5.8).

Figure 3.5.8 **Unemployment rate of Indigenous people aged 15 to 64 years, by remoteness, 2004-05[a, b]**



[a] Data are not age standardised. [b] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS NATSIHS 2004-05 (unpublished); table 3A.5.7.

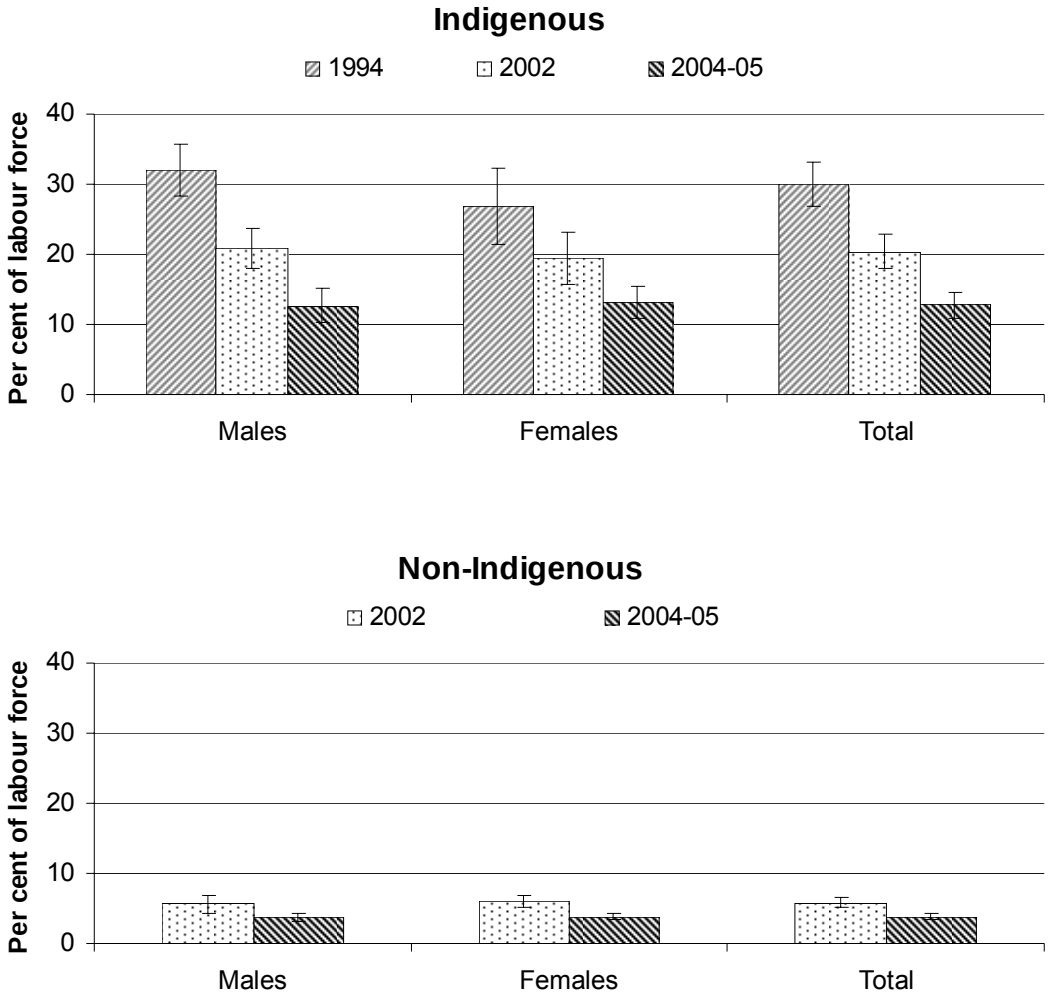
In 2004-05:

- People in inner and outer regional areas were significantly more likely to be unemployed than those in very remote areas (figure 3.5.8). However, in very remote areas, 35.6 per cent of Indigenous people in the labour force participated in CDEP and were classified as employed (figure 3.5.1).

Age standardised unemployment rates for Indigenous and non-Indigenous people in four remoteness areas (major cities, inner and outer regional areas, and remote areas), are included in table 3A.5.7. Indigenous and non-Indigenous comparisons are not possible for very remote areas as non-Indigenous data for very remote areas were not collected in the 2004-05 NHS.

- The age standardised unemployment rates for Indigenous people in the four remoteness areas for which data were available were all significantly higher than those for non-Indigenous people (table 3A.5.3).

Figure 3.5.9 **Unemployment rate of people aged 18 to 64 years**[a, b, c]



[a] Data are not age standardised. [b] Non-Indigenous data for 1994 are not available on a comparable basis with those for 2002 and 2004-05. [c] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS, 1994 NATSIS, and 2002 GSS and NATSISS (unpublished); table 3A.5.3.

Nationally, in the period from 1994 to 2004-05 there have been significant falls in the unemployment rate for both Indigenous women and men:

- The unemployment rate for Indigenous people aged 18 to 64 years fell from 30.0 per cent in 1994 to 20.3 per cent in 2002 and 12.8 per cent in 2004-05 (figure 3.5.9).
- This is consistent with an overall declining trend in unemployment that occurred in Australia from the latter part of the 1990s to 2005. The unemployment rate for the total Australian population aged 15 years and over fell from 8.1 per cent in 1995-96 to 5.3 per cent in 2004-05 (ABS 2002, 2006).

For both Indigenous and non-Indigenous people, males and females tended to have similar rates of unemployment (figure 3.5.9), although there was some variation between age groups (table 3A.5.3).

The long term unemployed are defined as unemployed people who have been without work for a year or more. People who have been unemployed for long periods may experience greater financial hardship, and may have more difficulties in finding employment because of the loss of relevant skills and employers' perceptions of their 'employability'. The socioeconomic costs of unemployment become greater for those who have been unemployed long term.

Nationally in 2004-05, after taking into account the different age structures of the Indigenous and non-Indigenous populations:

- Indigenous people were 5 times as likely as non-Indigenous people to have been unemployed long term (4.7 per cent of the labour force compared to 0.9 per cent).
- Long term unemployment as a proportion of total unemployment was also higher than for Indigenous people than for non-Indigenous people (41.6 per cent compared to 27.4 per cent) (table 3A.5.6).
- These results on long term unemployment need to be interpreted alongside data on the labour force participation and CDEP participation of Indigenous people, which are likely to mask the unemployment and long term unemployment of Indigenous people, particularly in remote areas (figure 3.5.1).

Figure 3.5.10 **Long term unemployment for Indigenous people aged 18 to 64 years** [a, b, c]

[a] Data are not age standardised. [b] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). [c] Percentages represent proportions of the total Indigenous labour force and total Indigenous people unemployed.

Source: ABS 1994 NATSIS, 2002 NATSISS, 2004-05 NATSIHS (unpublished); table 3A.5.8.

Consistent with the trend in overall unemployment over the period from 1994 to 2004-05, there was a large fall in the long term unemployment rate in the Indigenous labour force aged 18 to 64 years.

- The long term unemployment rate of the Indigenous labour force in 2004-05 (5.1 per cent) was less than half of that in 1994 (14.2 per cent) (figure 3.5.10).
- The number of long term unemployed Indigenous people as a proportion of all unemployed Indigenous people in 2004-05 was not significantly different to that in 1994 (figure 3.5.10).

Employment undertaken by Indigenous people is discussed in more detail in chapter 11, including employment by fulltime and part time status, by sector, industry and skill level (section 11.1), and self employment and Indigenous business (section 11.2).

3.6 Household and individual income

Box 3.6.1 **Key messages**

- For the period 2002 to 2004-05, after adjusting for inflation, median (mid point) gross weekly equivalised household income for Indigenous people rose by 10 per cent (from $308 to $340). This compares to $618 for non-Indigenous households in 2004-05 (figure 3.6.2).
- In 2004-05, over half of Indigenous people (51.6 per cent) received most of their individual income from government pensions and allowances, followed by salaries and wages (33.9 per cent) and CDEP (10.1 per cent) (figure 3.6.6).

The economic wellbeing of people is largely determined by their income and wealth. Capacity to own a home or accumulate other assets will depend upon whether people have sufficient disposable income. In the absence of data on wealth, the extent to which income for Indigenous people is lower than for non-Indigenous people is a major indicator of material disadvantage. The main sources of income are employment, assets and welfare payments.

Income is an important determinant of socioeconomic status. People with low incomes are often disadvantaged in terms of factors such as health, life expectancy, education, substance abuse, social participation, crime and violence.

Adverse health outcomes and higher mortality rates are important examples of the effect that low income can have on people. People who have low incomes, or are socially disadvantaged in other ways, tend to live shorter lives and suffer more illness than those who are well off. In Australia, men and women with lower socioeconomic status, including many Indigenous people, bear a higher burden of disease (AIHW 2004). It is widely acknowledged that health status is affected by the availability of material resources and the income to buy them. Higher incomes can enable the purchase of health-related goods and services such as better food, housing, recreation and health care, and may provide psychological benefits such as a greater sense of security and control. Increasingly, it is also being suggested that less favourable social and economic circumstances can cause anxiety, low self-esteem and social isolation, which in turn can influence health-related behaviours and health itself (AIHW 2004).

The link between income and health occurs through the income level of the country, the income of individuals, and the distribution of income within a society (AIHW 2004). Low income can be both a cause and a result of these disadvantages, for example, health problems caused by low income can in turn limit a person's ability to earn income.

Chapter 12 of this Report discusses in more detail the association between low incomes and poor education outcomes, labour force participation and employment, and health risk behaviour (including smoking, risky to high risk alcohol consumption and illicit drug use).

This indicator examines both household and individual income. While income is usually received by individuals, people living in families or group households generally contribute to the purchase of goods and services shared by other household members, particularly children. Therefore, household income measures the economic resources available to every person in a household, including dependent adults and children. It reflects directly the economic resources available for each household member to maintain his/her standard of living. Levels of income are closely related to paid work (through salaries and wages), though for many people government income support is their main source of income. In 2004-05 over half of Indigenous adults (51.6 per cent) received most of their individual income from government pensions and allowances (table 3A.6.8). Individual income directly reflects the earning capacity of adults in the work force, which in turn impacts on household income.

Data for the household and individual income indicator in this Report are from several ABS surveys, including the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the 2004-05 National Health Survey (NHS), the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), and the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS).

While for most income analysis, disposable (after tax) income is the preferred basis of income measurement, no attempt is made to adjust for income taxes in these ABS surveys. Nor is any adjustment made for the cost of living. This is particularly relevant for people living in remote areas, where costs for some goods and services are high, and the costs for others are low. For example, the cost of fresh food can be high in remote areas, which has an impact on health outcomes. In contrast, rent in remote areas is, on average, less than half the rent levels experienced in major cities.

The household income estimates in these ABS surveys are adjusted by equivalence factors (see box 3.6.2) to take into account household size and composition, and the economies of scale that arise from the sharing of a dwelling. It is important to note that while equivalised household income refers to household income, it is not a measure of total income for each household. Rather, it is a measure of income for each member in a household which has been adjusted for the size and composition of that household.

Box 3.6.2 **Derivation of income measures**

Equivalised household income

Equivalised income is the income of households adjusted for the different income needs of households of different size and composition. The costs of maintaining households and families, are believed to vary with household size and composition, and sometimes the number of employed people in the household and other household characteristics. Notwithstanding the economies of scale, larger households normally require a greater level of income to maintain the same material standard of living as smaller households, and the needs of adults are normally greater than the needs of children.

The conventional technique of adjusting for the income needs of households with different characteristics is to apply an equivalence scale to the raw household income. The equivalence scale used to obtain equivalised incomes in the ABS surveys was developed for the OECD and is referred to as the 'modified OECD scale'. The scale gives a weight of 1 to the first adult in the household, for each additional adult (persons aged 15 years and over) a weight of 0.5, and for each child a weight of 0.3. Equivalised household income is derived by dividing the total household income by the sum of the weights for the members of that household. The resulting measure of income is gross weekly equivalised household (GWEH) income, and is the measure used for household income in this Report. For example, if a household received a combined income of $2100 per week and comprised two adults and two children (combined household equivalence points of 2.1) the GWEH income for each household member would be $1000 per week.

It is important to note that while GWEH income refers to household income, it is not a measure of total income for each household. Rather, it is a measure of income for each member in a household which has been adjusted for the size and composition of that household.

Mean versus median income

In the 2003 and 2005 Reports, the mean values of equivalised household income and individual income were used to measure the income levels of Indigenous and non-Indigenous people. In this Report, median income values are also used to measure levels of both equivalised household income and individual income.

A mean income value is the average value of a set of income data. It is calculated by adding up all the values in a set of data and then dividing that sum by the number of values in the dataset. Median value is the mid point of a set of income data. If the values in a set of income data are arranged from largest to smallest, the one in the centre is the median income value (if the centre point lies between two numbers, the median value is the average value of the two numbers).

(Continued next page)

Box 3.6.2 (continued)

Median value is a better measure for income than mean as mean income values are more influenced by extreme income values (including the lowest and highest incomes). This is particularly significant when comparing incomes of Indigenous and non-Indigenous people, where more Indigenous people have low incomes and more non-Indigenous people have higher incomes (see Glossary for examples of how mean and median values are derived and the extent to which the two income measures differ).

Income quintiles

The distribution of household income is also an important indicator of a population's economic wellbeing. The percentage of households or individuals with incomes in particular ranges is a measure of relative advantage or disadvantage. Income quintiles are presented in this Report for both Indigenous and non-Indigenous people as measures of both household and individual income distribution.

The income quintiles are groupings that result from ranking all people in the population in ascending order (from lowest to highest) according to their incomes and then dividing the population into five equal groups, each comprising 20 per cent of the population.

The income quintile boundaries in this Report are based on income distributions for the total Australian population at the time of the 2004-05 NHS. After all households or individuals were ranked from lowest to highest according to their income, the boundaries of income quintiles were:

- lowest quintile — (the lowest 20 per cent) — less than $295 per week
- second quintile (the second lowest 20 per cent) — $295–$478 per week
- third quintile (the third 20 per cent) — $479–$688 per week
- fourth quintile (the fourth 20 per cent) — $689–$996 per week
- highest quintile (the fifth 20 per cent) — $997 or more per week.

These have been applied to both the Indigenous and non-Indigenous populations.

Source: ABS (2003); ABS (2004); ABS 2004-05 NHS (unpublished).

Box 3.6.2 provides more information about the derivation of the income measures used in this Report.

The incomes of Indigenous people are generally below those of non-Indigenous people, and there tends to be a relatively higher proportion of Indigenous people with lower incomes, and a lower proportion with higher incomes. Lower rates of mainstream (non-CDEP) employment among Indigenous people (see section 3.5), and a greater likelihood of working part time and/or in lower skilled occupations

(see sections 11.1 and 11.2) are the main factors that contribute to the income disparity between Indigenous and non-Indigenous people.

Gross weekly equivalised household income

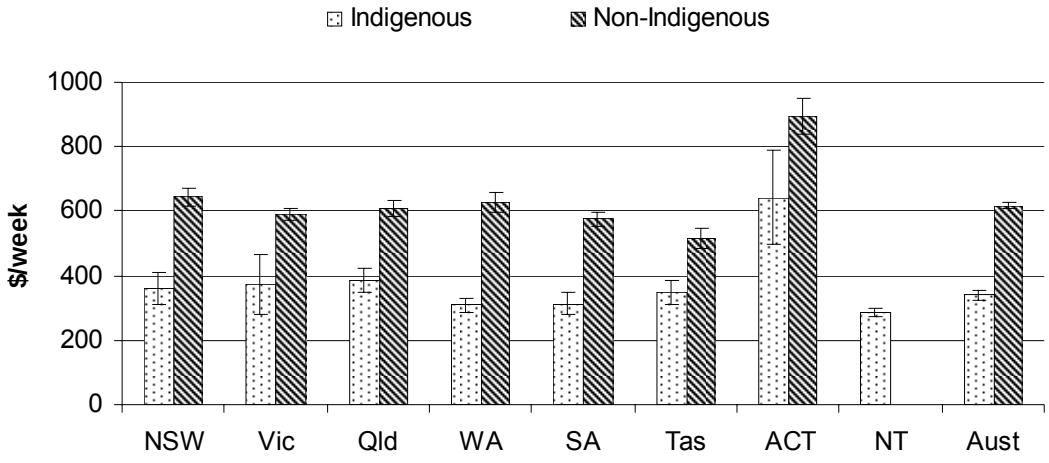
The measure used in this Report for household income is gross weekly equivalised household (GWEH) income (box 3.6.2). GWEH income calculated for Indigenous people, while adjusting for household size and composition to some extent, may not reflect adequately the household circumstances of Indigenous people, and the data need to be considered with this in mind. For example, Daly and Smith (1995), Gray (1990), and Hunter, Kennedy and Smith (2003) have found that there are substantial differences in family size and composition (structure) between Indigenous households and non-Indigenous households. Compared to non-Indigenous households:

- Indigenous people are more likely to live in larger households with large numbers of dependants and smaller incomes.
- Indigenous households are more likely to extend over generations.
- High Indigenous adult mortality can impact upon household living arrangements.
- Indigenous people are substantially more likely to live in single parent households.
- Indigenous people, especially those living outside the cities, may live in households with resource commitments to their extended families living elsewhere.
- Indigenous households tend to have a large number of visitors, who may not be accounted for in a data collection that takes a snapshot on a particular day.

Section 10.3 (Overcrowding in housing) provides more information on the housing and living arrangements of Indigenous people and differences between Indigenous and non-Indigenous households.

While equivalised household income is the generally preferred measure for the analysis of people's income, the different concepts and structures of households where Indigenous people live compared with those where no Indigenous people live can result in income measurement that is not fully reflective of the circumstances for Indigenous household incomes (Hunter, Kennedy and Smith, 2003).

Figure 3.6.1 **Median gross weekly equivalised household income, people aged 18 years and over, 2004-05[a, b]**



a The sample size in the NT was considered too small to produce reliable non-Indigenous estimates for the NT in the ABS 2004-05 NHS, but NT records in the survey have been attributed appropriately to national estimates. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

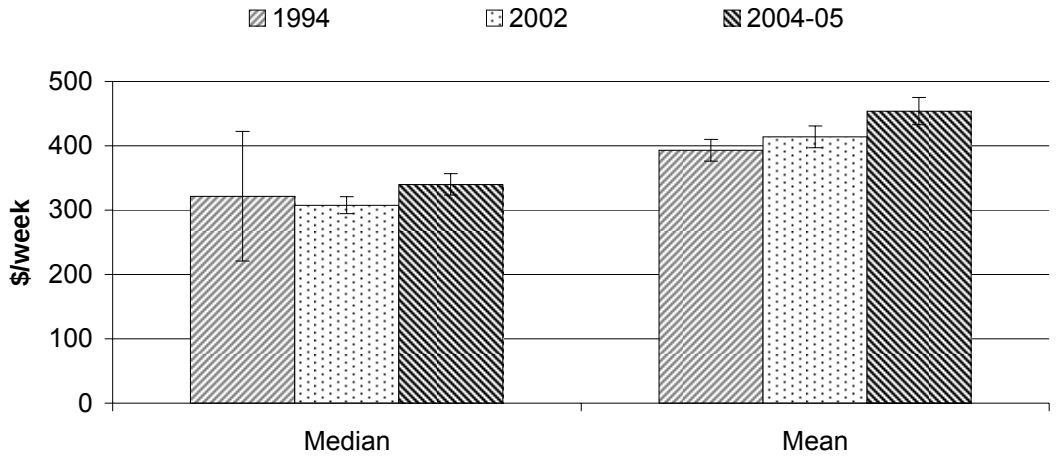
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.6.1.

The median value is the mid point of a set of income data. The difference in median income between Indigenous and non-Indigenous people is an indicator of the income gap between two populations.

In 2004-05:

- Nationally, the median (mid point) gross weekly equivalised household income for Indigenous adults was $340 compared with $618 for non-Indigenous adults (figure 3.6.1).
- The equivalised household income for Indigenous adults was higher than that for non-Indigenous adults in all states and territories (except the NT, for which non-Indigenous data are not available) (figure 3.6.1).

Figure 3.6.2 **Median and mean real gross weekly equivalised household income, Indigenous people aged 18 years and over (2004-05 dollars)[a, b]**



a Adjusted for inflation using the Consumer Price Index for the June quarter 1994 and the December quarter 2002 and 2004-05. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 1994 NATSIS, 2002 NATSISS and 2004-05 NATSIHS; table 3A.6.2.

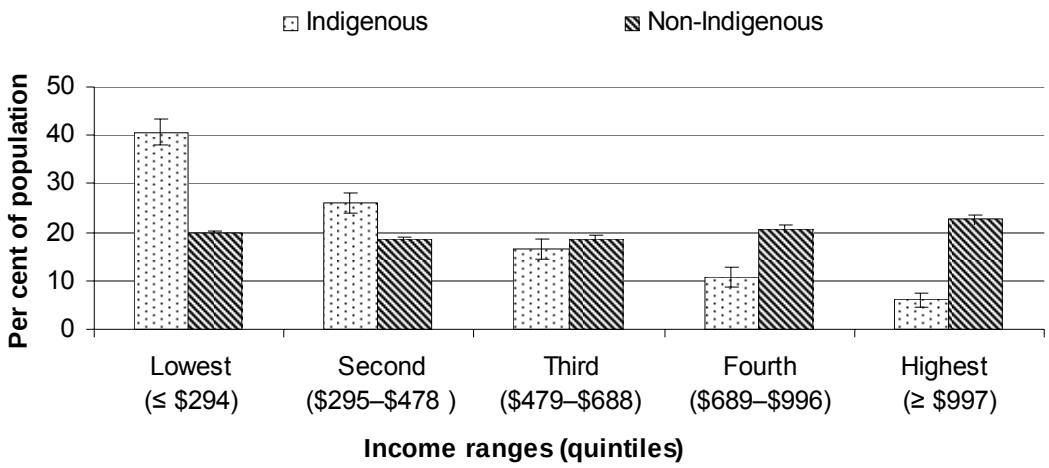
- Between 1994 and 2004-05 there were significant increases in both median and mean Indigenous household incomes (increases between reference years were only significant between 2002 and 2004-05 and not between 1994 and 2002) (figure 3.6.2).
- Between 1994–95 and 2003–04, the average (mean) real income of all Australian households increased by 21 per cent. There was a comparable increase for each of the different income groups; 22 per cent for low income households, and 22 and 19 per cent for middle income and high income groups respectively (ABS 2006). [7]

The distribution of household income is also an important indicator of a population's economic wellbeing. The percentage of households which have incomes that lie in particular ranges is a measure of relative advantage or disadvantage. The income quintiles as measures of income distribution are groupings that result from ranking all people in the population in ascending order according to their gross weekly equivalised household incomes and then dividing

7 Income values are in 2003–04 dollars and are measured by equivalised disposable household income. After all households are ranked from lowest to highest by their household income, low income households are those whose incomes are between the lowest 10 and 30 per cent, middle income households are those between 50 and 60 per cent, and high income household are those between 90 and 100 per cent.

the population into five equal groups, each comprising 20 per cent of the population. Box 3.6.2 provides detailed definitions of income quintiles.

Figure 3.6.3 **Distribution of gross weekly equivalised household incomes, people aged 18 years and over, 2004-05[a, b]**



a The income quintiles are groupings that result from ranking all people in the population in ascending order (from the lowest to the highest) according to their incomes and then dividing the population into five equal groups, each comprising 20 per cent of the population. Box 3.6.2 provides details of income quintile boundaries used in this Report. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.6.3.

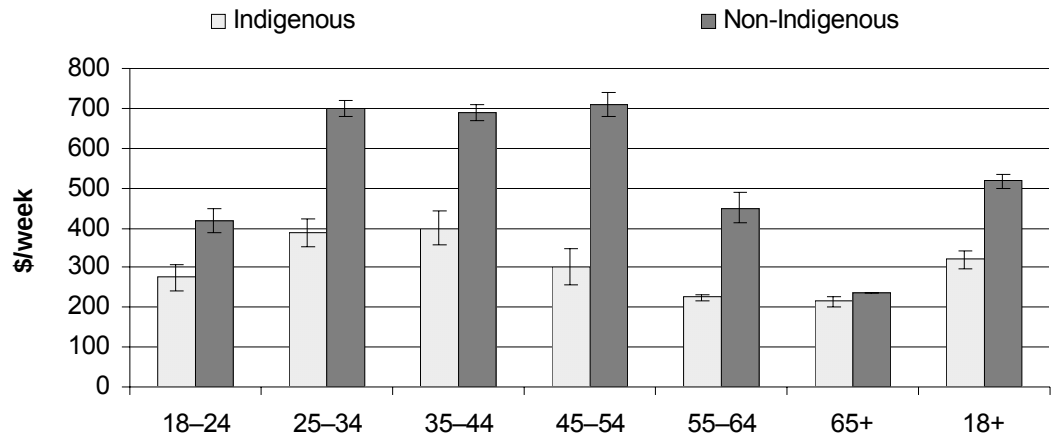
In 2004-05:

- Indigenous people (40.7 per cent) were twice as likely as non-Indigenous people (19.7 per cent) to have equivalised household incomes in the lowest range (quintile) (less than $295 per week) (figure 3.6.3).
- The proportion of people with an equivalised household income in the second lowest range ($295–$478) was also higher for Indigenous people than for non-Indigenous people (26.0 compared to 18.4 per cent).
- Indigenous people (6.0 per cent) were less than one third as likely as non-Indigenous people (22.6 per cent) to have an equivalised household income in the highest range ($997 or more per week).
- The proportion of people with an equivalised household income in the fourth range ($689–$996 per week) was also lower for Indigenous people than for non - Indigenous people (10.8 compared to 20.7 per cent).

More information on distributions of gross weekly equivalised household income by State and Territory are in table 3A.6.3 and by remoteness are in table 3A.6.4.

Individual income

Figure 3.6.4 **Median gross weekly individual income, by age, 2004-05[a]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

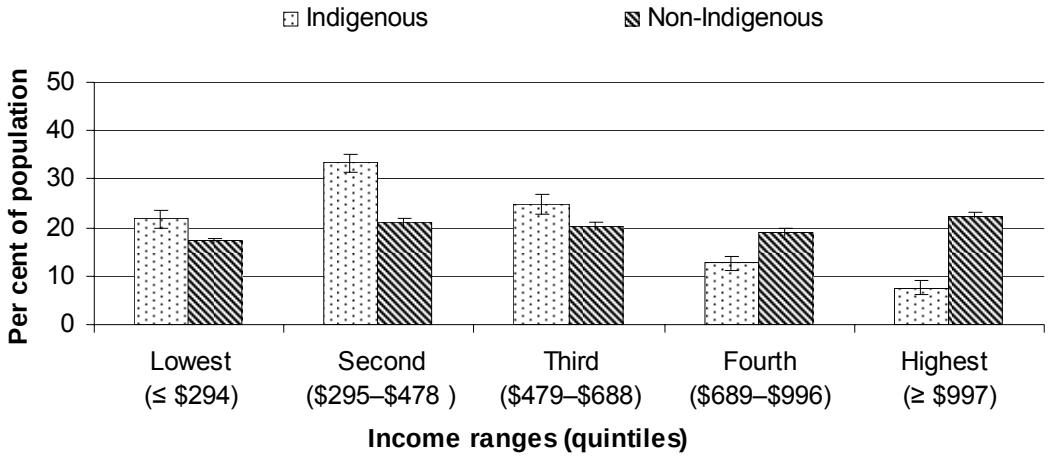
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.6.5.

For median gross weekly individual income for 2004-05:

- Income for Indigenous adults was significantly lower than for non-Indigenous adults across all age groups.
  - Although the gap in income was smallest for Indigenous adults over 65 years of age, the difference was still statistically significant ($215 compared to $235).
  - The largest difference in income between Indigenous and non-Indigenous adults was for those 45 to 54 years of age, with non-Indigenous incomes 2.4 times as high as Indigenous incomes (figure 3.6.4).
- There was a significant difference in income reported for Indigenous male and Indigenous female adults compared to income for non-Indigenous male and female adults. While Indigenous adults of both genders reported lower incomes than non-Indigenous adults of the same sex, the ratio of female Indigenous to female non-Indigenous income (80 per cent of non-Indigenous income) was considerably higher than for males (50 per cent of non-Indigenous income) (table 3A.6.5).

The proportions of individuals who have incomes that lie in particular ranges is a measure of relative advantage/disadvantage. As with the GWEH income quintiles, individual income in this Report is presented in income quintiles (see box 3.6.2 for detailed definitions of income quintiles).

Figure 3.6.5 **Distribution of gross weekly individual income (quintiles), people aged 18 years and over, 2004-05[a, b]**



a The income quintiles are groupings that result from ranking all people in the population in ascending order (from the lowest to the highest) according to their incomes and then dividing the population into five equal groups, each comprising 20 per cent of the population. Box 3.6.2 provides details of income quintile boundaries used in this Report. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

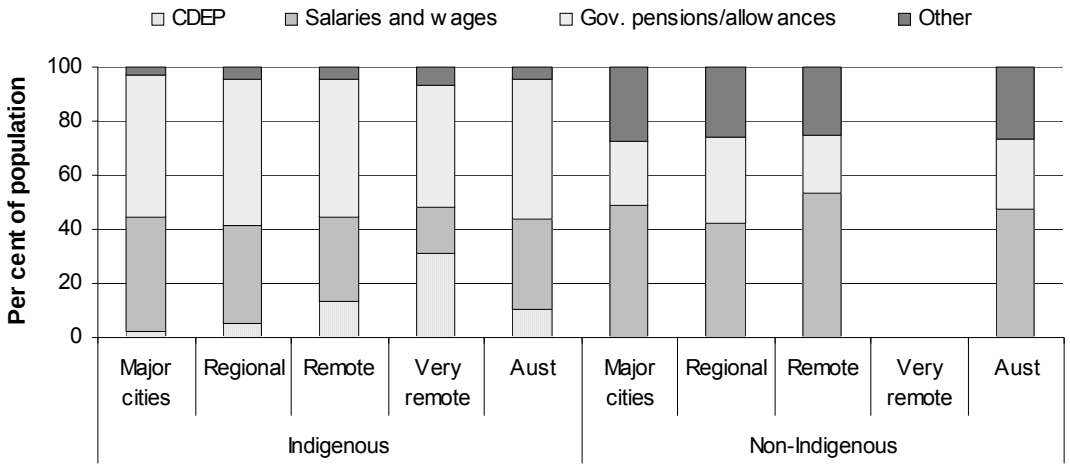
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.6.6.

In 2004-05:

- Higher proportions of Indigenous people (55.0 per cent) than non-Indigenous people (38.1 per cent) had a gross weekly individual income in the lower ranges (less than $479 per week) (figure 3.6.5).
- A lower proportion of Indigenous people (44.9 per cent) than non-Indigenous people (61.8 per cent) had an individual income in the higher ranges ($479 or more per week).
- In particular, the proportion of Indigenous people with an individual income in the highest range ($997 or more per week) was one third of that for non-Indigenous people (7.5 per cent compared to 22.5 per cent).

Distributions of gross weekly individual income by State and Territory can be found in table 3A.6.7.

Figure 3.6.6 **Main sources of individual gross weekly income, people aged 18 years and over, 2004-05[a, b]**



[a] Other' category includes 'other cash incomes' and source of income 'not stated/not know. 'Regional' includes inner and outer regional areas. [b] Non-Indigenous data are not available for very remote areas as they were not collected in the 2004-05 NHS. The records for the very remote areas have been attributed appropriately to national estimates.

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 3A.6.8.

In 2004-05:

- Over half of Indigenous people (51.6 per cent) received most of their individual income from government pensions and allowances, followed by salaries and wages (33.9 per cent) and CDEP (10.1 per cent) (figure 3.6.6).
- The proportion of Indigenous people with salaries and wages as the main source of individual income decreased with remoteness, while the proportion with CDEP as the main source of individual income increased with remoteness.
- In contrast, 47.1 per cent of non-Indigenous people reported salaries and wages as their main source of individual income, followed by government pensions and allowances (26.2 per cent) and other cash income (20.3 per cent) (figure 3.6.6).
- Non-Indigenous people in regional areas were more likely to report government pensions and allowances as their main source of individual income (31.8 per cent) and less likely to report salaries and wages (42.5 per cent), compared to those in major cities (23.8 and 49.0 per cent, respectively) and remote areas (21.3 and 53.2 per cent, respectively) (figure 3.6.6).

Section 12.1 of chapter 12 in this Report examines in detail how levels of income for both Indigenous and non-Indigenous people varied according to age, sex and remoteness. The key findings are:

- Age-related patterns in income tend to follow patterns in labour force participation (and employment) (figure 12.1.1).
- Indigenous people were more likely to have low equivalised household incomes than non-Indigenous people regardless of age.
- For both Indigenous and non-Indigenous people, those aged 15 to 24 years were most likely to have individual incomes in the lowest ranges, while those aged 55 years and over were most likely to have equivalised household incomes in the lowest range.
- Indigenous people aged 25 to 34 years were more than four times as likely as their non-Indigenous counterparts to have equivalised household incomes in the lowest ranges.
- Indigenous people aged 45 to 54 years were nearly twice as likely as their non-Indigenous counterparts to have individual incomes in the lowest range (figure 12.1.1).
- Unlike non-Indigenous people, there were no statistically significant differences between Indigenous women and men in low income. For non-Indigenous people, women were more likely than men to have lower incomes (figure 12.1.2).
- Indigenous people living in outer regional areas were more likely than those living in inner regional areas to have low individual incomes (figure 12.1.3).

3.7 Home ownership

Box 3.7.1 **Key messages**

- The proportion of Indigenous adults living in homes owned or being purchased by a member of the household increased from 21.5 per cent in 1994 to 25.4 per cent in 2004-05 (figure 3.7.1).
- In 2004-05, the proportion of Indigenous adults living in homes owned or being purchased by a member of the household in remote (17.6 per cent) and very remote (2.7 per cent) areas was much lower than in major cities (29.0 per cent) and inner and outer regional areas (38.9 and 31.5 per cent, respectively) (figure 3.7.2).
- In 2002, the most recent year for which both Indigenous and non-Indigenous data are available, a much lower proportion of Indigenous adults (27.4 per cent) than non-Indigenous adults (73.7 per cent) lived in homes owned or being purchased by a member of the household (table 3A.7.2).

Home ownership is an important indicator of wealth and saving, and is likely to be positively related to employment and income indicators. Home ownership provides

a secure asset base that can contribute to financial stability and against which people can borrow. Home ownership also provides security of tenure, which is not always available with rental housing. A home can be passed from one generation to another. Home ownership also allows households to build or modify a dwelling to suit their particular needs.

Improvements in the strategic areas for action, particularly those relating to education and economic participation and development are the main drivers of home ownership and could increase the level of Indigenous home ownership in the future.

During consultations for this Report, many Indigenous people said that home ownership was an important part of improving Indigenous wellbeing and an essential indicator in the framework. Some Indigenous people said that home ownership was important to them as a connection to the land, particularly in closely settled regions where there are limited opportunities for land grants and determinations that native title exists. Others suggested that not all Indigenous people want to own their own homes. It was argued that those in more remote areas and living more traditional lifestyles may prefer a more communal form of ownership, and that those Indigenous people who move frequently for family and cultural reasons may prefer to rent accommodation. Information on communally owned Indigenous land is included in section 11.3.

Home ownership is included in the Report primarily as an economic indicator of wealth and saving. Examples of successful home ownership programs are in box 3.7.2. The availability of appropriate, affordable and secure housing, which is a more immediate concern for many Indigenous people, is covered in section 10.3, Overcrowding in housing.

Box 3.7.2 **'Things that work' — home ownership**

IBA Homes

A home ownership program, now marketed as IBA Homes, was established in 1975 under the Aboriginal Loans Commission and was administered by successive statutory authorities before being transferred to Indigenous Business Australia on 24 March 2005.

Since the program's establishment, it has helped 12 413 Indigenous families to buy their own homes. IBA Homes provides access to affordable home finance including a range of products such as low interest rate loans to Indigenous people who are buying a home or land, building a new home, carrying out home improvements or home maintenance and repairs.

Recently, IBA Homes introduced a gap deposit loan product to assist Indigenous Australians to enter into mortgages in response to rising house prices and rising deposits required to enter into home ownership.

While the program is predominantly self funding ($80 million in revenue estimated for 2006-07), the Australian Government provided two capital injections, in 2004-05 and 2006-07, each totalling $20 million.

Lending by IBA Homes is based on commercial home-lending practices with concessional interest rates that commence at 4.5 per cent per annum and increase annually up to a maximum of 1 per cent below the standard rate of the Commonwealth Bank of Australia. As occurs in the broader home loan market, IBA Homes assesses loan applications on the client's ability to service the loan and an independent property valuation. Loans are secured by registered mortgage.

The number of loans has increased from 469 loans in 2003-04 to 580 loans in 2005-06. The average loan size grew by 14.3 per cent from $210 000 in 2005-06 to $230 000 in 2006-07. At 31 January 2007, IBA Homes had 3 438 active loans across Australia on its books:

NSW	Vic	Qld	WA	SA	Tas	ACT	NT
1 065	362	1 021	327	153	86	53	371

(Indigenous Business Australia, unpublished).

(Continued next page)

Box 3.7.2 (continued)

HomeStart Nunga Home Loan (SA)

In response to the low ownership rates amongst Indigenous South Australians, HomeStart Finance began a trial of a new product designed specifically for this market, called the Nunga Home Loan, in March 2004. Between March 2004 and March 2007 293 applicants successfully purchased their own home with a HomeStart Nunga Loan.

To gain a greater understanding of the needs of Nunga applicants, HomeStart conducted research into why Nunga customers had previously been unsuccessful in gaining approval for existing HomeStart home loan products. The results demonstrated that lack of funds for a deposit, an adverse credit history and a high level of consumer debt were the main barriers preventing successful home loan approval. In light of this research, HomeStart designed the Nunga Loan with the following features:

- a maximum Lending Value Ratio (LVR) of 105 per cent
- acceptance of a limited number and amount of credit defaults
- the ability to refinance smaller consumer loans within the 105 per cent LVR to assist the customer in their overall monthly repayment commitments (SA Government, unpublished).

Stamp duties assistance for first home buyers (Tasmania)

The Tasmanian Government provides funding to the Tasmanian Aboriginal Centre Inc. to assist Aboriginal and Torres Strait Islander first home buyers with the payment of stamp duties. First home buyers are able to combine this with the first home owners grant and loan funding from Indigenous Business Australia to make the purchase of their first home much more affordable (Tasmanian Government unpublished).

Measuring Indigenous home ownership can be complex. The surveys used as a source of data for this Report do not ask for details about who the actual owners of a home are, so the Indigenous status of the owner(s) cannot be determined precisely.

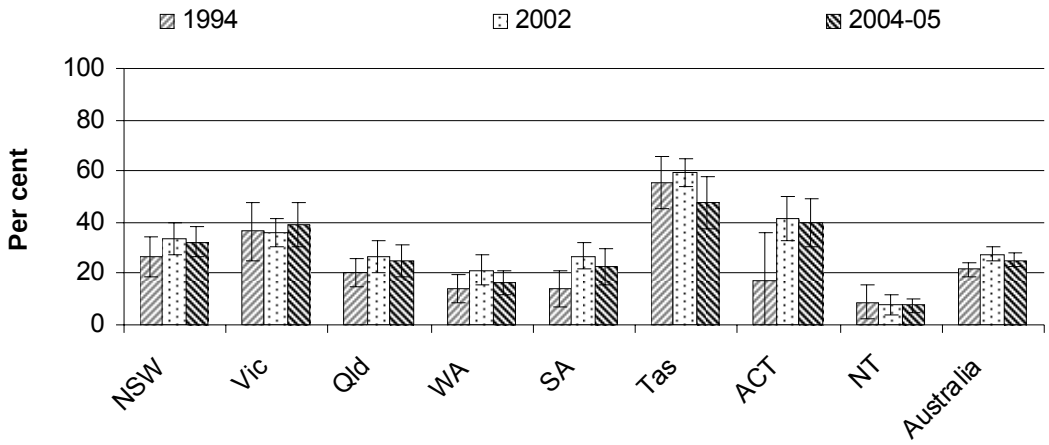
Another approach would be to count Indigenous households owning or purchasing their own home, however, there are problems in defining an Indigenous household (that is, what proportion of household members need to be Indigenous for the household to be classified as Indigenous?)

Therefore, home ownership is explored in this Report by looking at the proportion of Indigenous people living in a home owned or being purchased by a member of their household. These households are referred to as home owner/purchaser households. Not all people living in a household owned by someone in the household (for example, boarders) will share in the long-term economic benefits of home ownership. Some Indigenous people counted this way may be in households where the owner is non-Indigenous. Overall, however, the approach used is

reasonably simple to derive and provides a good approximation of levels of home ownership in the Indigenous population.

Data on home ownership in this Report are survey data from the ABS 2004-05 NATSIHS, 2002 NATSISS, 2002 GSS, and 1994 NATSIS. Data for 2004-05 are more limited than those available for previous Reports — non-Indigenous comparisons and data on rental of community housing are not available.

Figure 3.7.1 **Proportion of Indigenous people aged 18 years and over living in home owner/purchaser households, by State/Territory[a, b]**



a Includes homes being purchased under a rent/buy scheme. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). Estimates with an RSE of 25 per cent to 50 per cent should be interpreted with caution. Estimates with an RSE greater than 50 per cent are considered too unreliable for general use.

Source: ABS 1994 NATSIS, 2002 NATSISS and 2004-05 NATSIHS (unpublished); tables 3A.7.1 and 3A.7.2.

- In 2004-05, 25.4 per cent of Indigenous people aged 18 years and over lived in home owner/purchaser households (figure 3.7.1).
- The proportion of Indigenous people aged 18 years and over living in home owner/purchaser households increased from 21.5 per cent in 1994 to 25.4 per cent in 2004-05.
- The proportion of Indigenous people aged 18 years and over living in home owner/purchaser households varied between states and territories.
- In 2002, the most recent year for which both Indigenous and non-Indigenous data are available, a much lower proportion of Indigenous people aged 18 years and over (27.4 per cent) than non-Indigenous people (73.7 per cent) lived in home owner/purchaser households (table 3A.7.2).

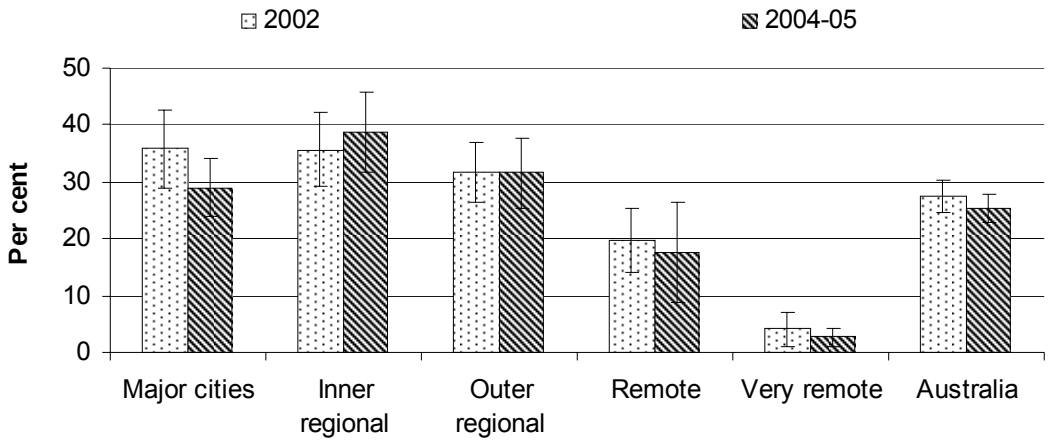
The significant number of Indigenous people living on Indigenous communally owned or controlled land influences the rates of Indigenous home ownership. Although some land in regional areas is communally owned, most communally owned land is located in remote and very remote areas. Usually, such land cannot be sold and the land itself cannot be mortgaged. This ensures its continuing ownership by Indigenous people, but means that developments on the land, including home ownership and private sector financing, need to be pursued through sub-leasing arrangements. Unlike the United States and Canada, where similar situations arise on Indigenous communally owned land, in Australia the legislative provisions which provide for sub-leasing and private sector financing have yet to be fully utilised. Information on Indigenous owned or controlled land is included in section 11.3.

In September 2006, the Australian Government passed the *Aboriginal Land Rights (Northern Territory) Amendment Act 2006*. The Act was intended to encourage individual property rights in town areas on Indigenous communally owned land in the NT. The Act enables 99 year head leases to government entities, which can subsequently make sub-leases, which can be used for private home ownership, business or other purposes. Data used in this Report are from 2004-05, before the Act was changed. The amendments to the Act only affect the NT. Land ownership in other states and territories is determined by separate legislation in each jurisdiction. Long term leases for home ownership on Indigenous communal land are possible under land tenure arrangements in some states and territories but are not common. More information on Indigenous land tenure is included in section 11.3.

Most housing on Indigenous communally owned land is owned by Indigenous community or cooperative housing organisations, which rent houses to families and individuals. Community rental housing is different to home ownership by individual households and families. It is, however, a communal form of Indigenous ownership and control of housing.

Data on community rental housing are not available from the ABS 2004-05 NATSIHS. AIHW (2005) published administrative data on Indigenous community housing, as well as data on Indigenous housing from other sources such as the ABS Census and the ABS 2001 Community Housing and Infrastructure Needs Survey (CHINS). Data on Indigenous community rental housing were included in the 2005 Report (SCRGSP 2005). Some of these data are also included in the Report on Government Services (SCRGSP 2007).

Figure 3.7.2 **Proportion of Indigenous people aged 18 years and over living in home owner/purchaser households, by remoteness areas[a, b]**

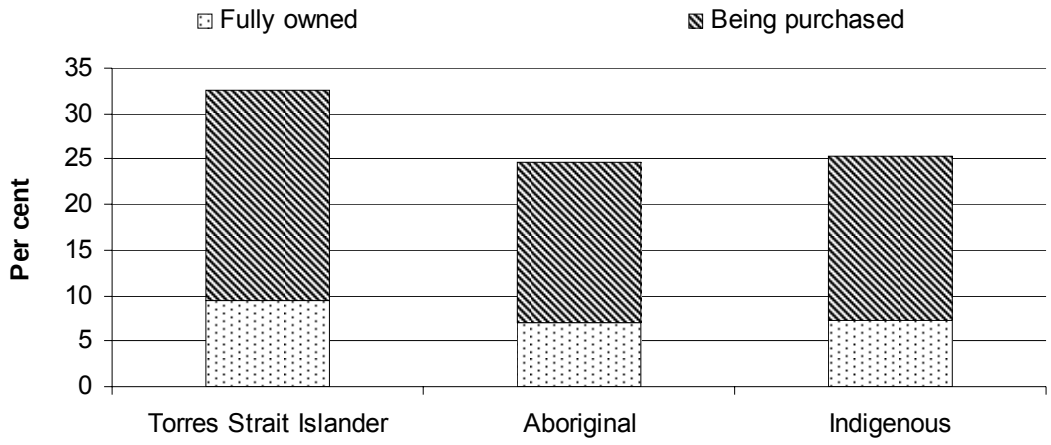


a Includes homes being purchased under a rent/buy scheme. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). Estimates with an RSE of 25 per cent to 50 per cent should be interpreted with caution. Estimates with an RSE greater than 50 per cent are considered too unreliable for general use.

Source: ABS 2002 NATSISS and 2004-04 NATSIHS (unpublished); tables 3A.7.3 and 3A.7.4.

- In 2004-05, the proportion of Indigenous people aged 18 years and over living in home owner/purchaser households was much lower in remote (17.6 per cent) and very remote (2.7 per cent) areas than in major cities (29.0 per cent) and inner and outer regional areas (38.9 and 31.5 per cent, respectively). The differences between data for major cities and inner and outer regional areas were not statistically significant (figure 3.7.2).
- Between 2002 and 2004-05, there were no statistically significant changes over time in the proportions of Indigenous people aged 18 years and over living in home owner/purchaser households, nationally or by remoteness areas (tables 3A.7.3 and 3A.7.4).

Figure 3.7.3 **Proportion of people aged 18 years and over living in home owner/purchaser households, 2004-05[a, b]**



a Includes homes being purchased under a rent/buy scheme. **b** Torres Strait Islander includes those identified as either of Torres Strait Islander origin, or of both Aboriginal and Torres Strait Islander origin.

Source: ABS 2004-05 NATSIHS (unpublished); table 3A.7.5.

- In 2004-05, 7.3 per cent of Indigenous people aged 18 years and over lived in homes fully owned by someone living in their household and 18.1 per cent lived in homes being purchased by someone living in their household (figure 3.7.3).
- In 2004-05, there was no statistically significant difference in the proportions of Torres Strait Islander and Aboriginal people living in home owner/purchaser households.
- Data on the proportions of Torres Strait Islander and Aboriginal people living in home owner/purchaser households in 1994 and 2002 are included in table 3A.7.6.

Attachment tables 3A.7.1 to 3A.7.9 include data on those living in rental housing as well as more detail on people living in homes owned by someone in the household. Many Indigenous people live in public housing provided by State and Territory Government housing authorities. Information on public housing provided to Indigenous people is included in the annual Report on Government Services (SCRGSP 2007). The charts and commentary in this section are for Indigenous people aged 18 years and over to ensure consistency and comparability with data available for earlier periods. However, some data on home ownership and housing tenure for Indigenous people aged 15 years and over are available in tables 3A.7.7 to 3A.7.9.

3.8 Suicide and self-harm

Box 3.8.1 **Key messages**

- Suicide death rates were higher for Indigenous people (between 18.8 and 45.0 per 100 000 population) than non-Indigenous people (between 10.8 and 15.5 per 100 000 population) in Queensland, WA, SA and the NT for 2001 to 2005 (figure 3.8.1).
- In 2004-05, after adjusting for age differences, 3 in every 1000 Indigenous people were hospitalised for non-fatal intentional self-harm, compared with 2 per 1000 non-Indigenous people (table 3.8.1). There were no significant trends in hospitalisation rates for intentional self-harm between 2001-02 and 2004-05 (figure 3.8.4).

Suicide and self-harm cause great grief in both Indigenous and non-Indigenous communities. Studies investigating suicide in Indigenous communities have been undertaken in NSW and the ACT (Tatz 1999), North Queensland (Hunter et al. 2001; Hunter and Harvey 2002) and the NT (Measey et al. 2006; Parker and Ben-Tovim 2001).

Many studies (Elliott-Farrelly 2004; Hunter et al. 2001; Hunter and Harvey 2002; Parker and Ben-Tovim 2001; Tatz 1999) have suggested that there are significant differences in suicidal behaviour not only between Indigenous and non-Indigenous populations, but also between different Indigenous communities. This indicates that Indigenous suicide is influenced by a complex set of factors relating to history of dispossession, removal from family, discrimination, resilience, social capital and socio-economic status.

Studies have found that Indigenous suicides appear to occur in clusters, and that the victims may share common age groups, genders and methods (Elliott-Farrelly 2004). Suicide frequently occurs in communities that have experienced similar losses in the past, and where 'lifestyles of risk' are common. Suicide is often impulsive, and may be preceded by interpersonal conflicts (Hunter et al. 2001; Tatz 1999).

Evidence indicates that Indigenous suicide is most common among young men, while suicide attempts seem to be more prevalent for women (Elliott-Farrelly 2004).

A study by Hunter on self-harming behaviour among young Indigenous people (1993) found that those who had attempted suicide reported a high level of anxiety and depression. Mental and behavioural disorders are often associated with an increased risk of self-harm, as is alcohol and substance abuse (Swan and Raphael

1995; Vicary and Westerman 2004). Other researchers have disputed the purported relationship between mental illness and Aboriginal suicide (Tatz 1999; Reser 1991, cited in Elliott-Farrelly 2004).

Environmental, sociocultural and economic risk factors have also been associated with a higher rate of suicide. Relevant family factors may include having parents who are substance dependent, have been imprisoned, or have violent tendencies, particularly if this translates into family violence.

Unemployment and poor long-term job prospects are considered risk factors for suicide, particularly in the regional and remote areas where a substantial proportion (70 per cent) of Indigenous people live (appendix 3, table A.6). Section 3.5 presents data showing the higher unemployment rates and lower labour force participation rates of Indigenous compared to non-Indigenous people.

Box 3.8.2 **'Things that work' — Yarrabah Family Life Promotion program**

Following three suicide clusters between the mid 1980s and mid 1990s, the Yarrabah community in Queensland developed a set of strategies for suicide prevention, intervention, aftercare and life promotion. The Yarrabah Family Life Promotion program, established in 1995, has been facilitated by the locally-controlled Community Council and Primary Health Care service, and external resources engaged by the community.

Life promotion strategies, which primarily sought to mitigate community risk factors, included:

- training community members in crisis intervention and counselling
- a crisis centre and crisis line
- one-on-one grief and loss counselling, and family and men's support groups
- information for suicide survivors, families of suicide victims, and people who self-harm
- workshops on parenting and relationships
- promotion of sport, recreation and cultural activities
- development of networks across family and clan groups.

Other measures complementing the Family Life Promotion program included initiatives addressing alcohol misuse, especially as a cause of self-harm.

Between 2000 and 2004, there were three suicide deaths in Yarrabah, compared to 12 from 1992 to 1996 and none from 1997 to 1999 (Queensland Health, unpublished). Incidents of self-harm have also reportedly fallen, as have hospital presentations for accidental trauma and police interventions for alcohol-related problems.

(Continued next page)

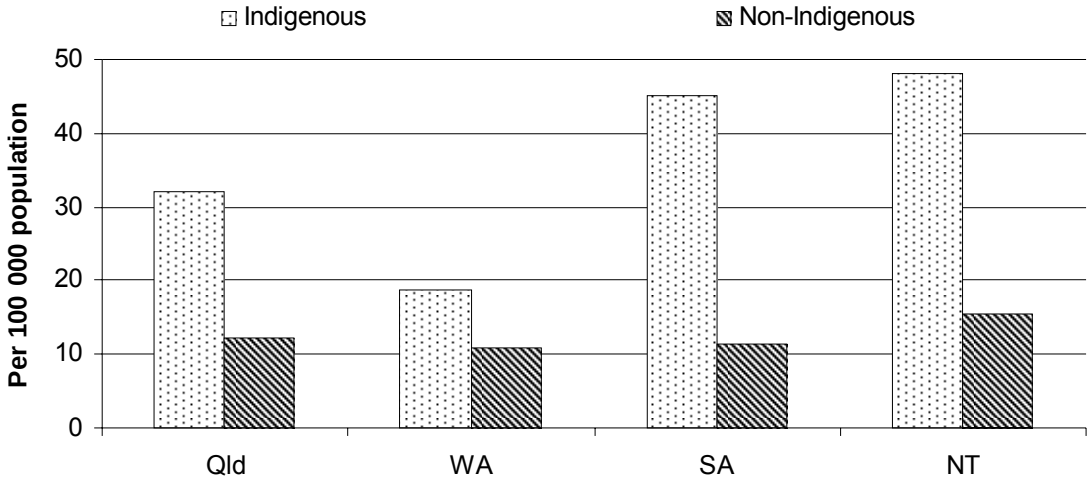
Box 3.8.2 (continued)

A study found that community ownership of the problem and the solution was fundamental in the success of the Yarrabah program. This was considered particularly critical as historical factors had led to feelings of chronic helplessness and hopelessness, which contributed to an increased risk of suicide. This finding was supported in an Action Research study in which the community 'identified the reclamation of 'spirit' or responding to the experience of hopelessness, as fundamental to the achievement of health improvement' (Baird, Mick-Ramsamy and Percy 1998, quoted in Mitchell 2000, p. 22).

The study noted that while the apparent lack of structure of the program had sometimes been a barrier when applying for funding, formal structure may work to inhibit community engagement where community ownership has not already been established.

Source: Baird, Mick-Ramsamy and Percy (1998); Clapham (2004, pp. 68–72, 126–7); Hunter et al. (2001); Mitchell (2000, p.22); Mitchell (2005, pp. 16–18).

Figure 3.8.1 **Intentional self-harm (suicide) deaths per 100 000 population, age standardised, 2001–2005[a, b, c, d, e]**



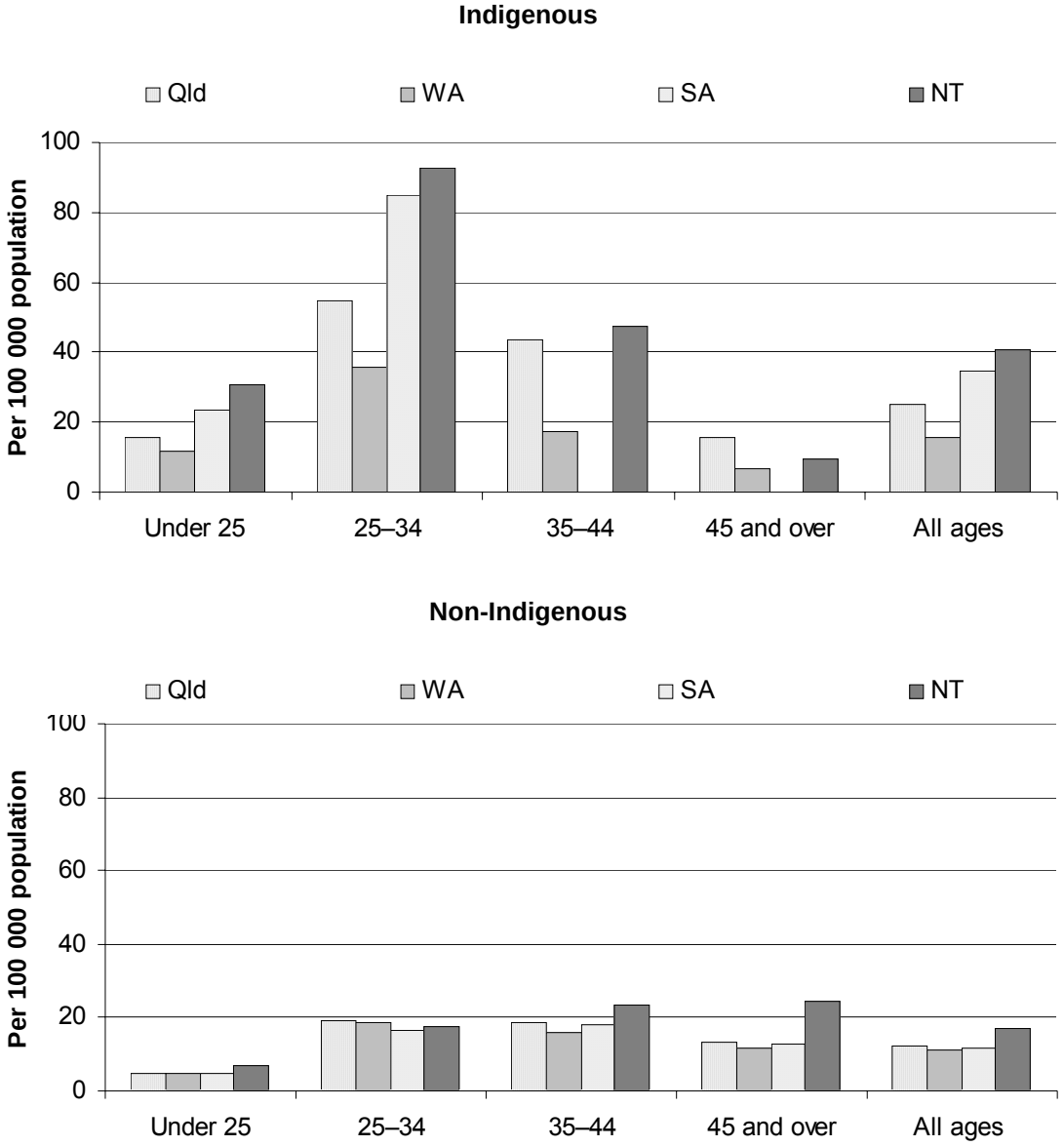
a Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. **b** Data on Indigenous causes of death are not available separately from the ABS for NSW, Victoria, Tasmania and the ACT due to a combination of comparatively small numbers and relatively low coverage of Indigenous deaths. **c** Deaths from intentional self-harm are defined as causes of death with ICD codes X60–X84. **d** Data are subject to a degree of uncertainty and apparent differences in mortality estimates between jurisdictions may not be statistically significant. **e** Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS *Causes of Deaths 2005*, Cat. no. 3303.0 (unpublished); table 3A.8.1.

- Suicide death rates were higher for Indigenous people (between 18.8 and 48.2 per 100 000 population) than non-Indigenous people (between 10.8 and 15.5 per 100 000 population) in Queensland, WA and SA and the NT between 2001 and 2005 (figure 3.8.1). Non-age-standardised data are included in table 3A.8.3.

Figure 3.8.2 shows that suicide rates in both the Indigenous and non-Indigenous populations vary between different age groups.

Figure 3.8.2 **Intentional self-harm (suicide) death rate by age, 2001–2005** [a, b, c, d, e, f]

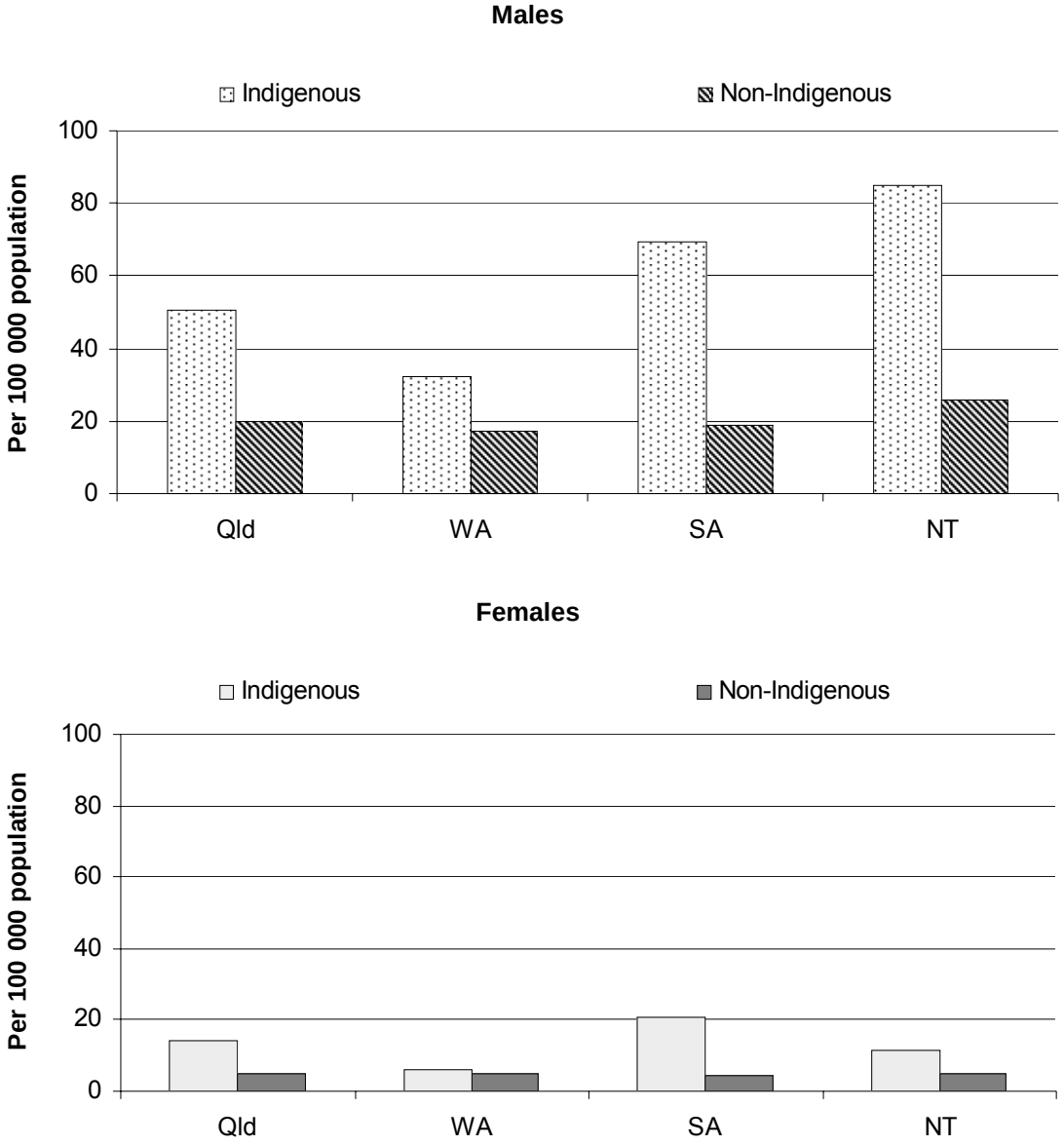


[a] Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. [b] Data on Indigenous causes of death are not available separately from the ABS for NSW, Victoria, Tasmania and the ACT due to a combination of comparatively small numbers and relatively low coverage of Indigenous deaths. [c] Deaths from intentional self-harm are defined as causes of death with ICD codes X60–X84. [d] Data are subject to a degree of uncertainty and apparent differences in mortality estimates between jurisdictions may not be statistically significant. [e] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. [f] SA data for Indigenous people in the age groups 35–44 and 45 and over were not available for this Report.

Source: ABS *Causes of Deaths 2005*, Cat. no. 3303.0 (unpublished); table 3A.8.2.

- Suicide death rates varied by age group in 2001–2005, with Indigenous people aged 25–34 having particularly high suicide rates (between 35.6 and 92.6 per 100 000 people) (figure 3.8.2).
- Suicide rates for people aged 45 and over were higher for non-Indigenous people than Indigenous people, in all states and territories except Queensland, where rates were similar (figure 3.8.2).

Figure 3.8.3 **Average annual suicide death rates by sex, age standardised, 2001–2005**[a, b, c, d, e]



a Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. **b** Data on Indigenous causes of death are not available separately from the ABS for NSW, Victoria, Tasmania and the ACT due to a combination of comparatively small numbers and relatively low coverage of Indigenous deaths. **c** Deaths from intentional self-harm are defined as causes of death with ICD codes X60–X84. **d** Data are subject to a degree of uncertainty and apparent differences in mortality estimates between jurisdictions may not be statistically significant. **e** Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS *Causes of Deaths 2005*, Cat. no. 3303.0 (unpublished); tables 3A.8.1.

In the period 2001 to 2005, after taking into account the different age structures of the two populations, in the four states and territories for which data are available:

- Suicide rates for Indigenous males were significantly higher (between 32.3 and 84.9 per 100 000) than those for non-Indigenous males (between 17.0 and 25.8 per 100 000) (figure 3.8.3).
- Suicide death rates were also higher for Indigenous females (between 6.2 and 21.0 per 100 000) than non-Indigenous females (between 4.3 and 5.1 per 100 000) (figure 3.8.3).
- Suicide death rates were higher for males than females for both Indigenous and non-Indigenous people (figure 3.8.3).
- Suicides as a proportion of all deaths were higher for Indigenous people than for non-Indigenous people (2.6 to 6.9 per cent compared to 1.4 to 2.0 per cent) (table 3A.8.4).

A 2006 study of NT suicides between 1981 and 2002 (Measey et al. 2006), using data from ABS death registrations and the NT's Coroner's office, found that:

- the age-adjusted rate of suicide in NT had been higher than the national rate since 1996, and was rising.
- Between 1981 and 2002:
  - The incidence of Indigenous suicide has increased since low levels in the early 1980s and has become an increasing problem.
  - Averaged over the whole period, Indigenous and non-Indigenous rates were similar but Indigenous suicide rates rose rapidly and are now significantly higher than non-Indigenous rates.
  - The suicide rate for Indigenous males rose by 800 per cent while the rate for non-Indigenous males rose by 30 per cent.
  - The overall rate of suicide by Indigenous males increased by an annual average of 17.4 per cent, while the Indigenous female rate increased by an annual average of 25.8 per cent.
  - 87 per cent of all NT suicides were by males.
  - 75 per cent of NT suicides were by non-Indigenous people, who make up 72 per cent of the population.
  - Amongst Indigenous people, males aged 25–44 years had the highest suicide rate, and males aged 10–24 had the second highest rate.
  - Amongst non-Indigenous people, males over the age of 65 were most at risk.

- Analysis of data from the Top End[8] between 2000 and 2002 found:
  - a history of diagnosed mental illness (including depression) in 49 per cent of all suicides.
  - use of alcohol around the time of death in 56 per cent of all cases, and drug use in a further 16 per cent of all cases.
  - 41 per cent of all suicides were by unemployed people, who constitute 4 per cent of the Top End population.

Table 3.8.1 **Standardised non-fatal hospitalisations for intentional self-harm, Qld, SA, WA, and public hospitals in the NT, 2004-05**[a, b, c]

	Number of hospitalisations				*Age standardised hospitalisation rate (per 1000 people)*[d]	
	Indigenous	*Non-Indigenous*	*Not stated*	*Total*	*Indigenous*	*Non-Indigenous*[e]
Males	382	4 287	125	4 794	2.7	1.2
Females	448	7 096	148	7 692	3.0	2.0
All people	830	11 383	273	12 486	2.9	1.6

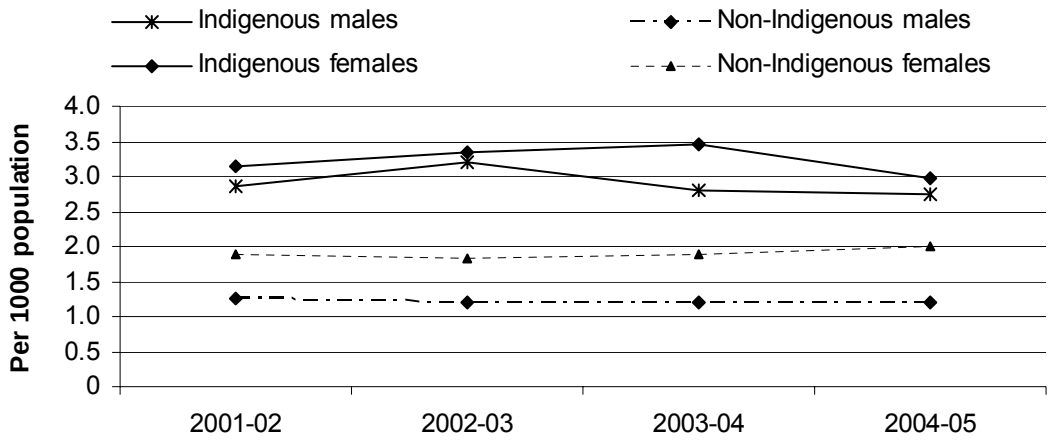
[a] Non-fatal refers to records where the hospitalisation was not equal to 'died'. Intentional self-harm refers to hospitalisations with at least one external cause in X60–X84, based on the ICD-10-AM classification. [b] Data based on State of usual residence. [c] Indigenous data are reported for Queensland, WA, SA and the NT only. These four jurisdictions are considered to have the highest level of accuracy of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Hospitalisation data for four jurisdictions should not be assumed to represent the hospitalisation experience in the other jurisdictions. [d] The rates per 1000 population were directly age standardised using the ABS estimated resident population data as at 30 June 2001. [e] The non-Indigenous rate includes 'not stated' hospitalisations.

Source: AIHW National Hospital Morbidity Database (unpublished); table 3A.8.5.

- In 2004-05, the age standardised non-fatal hospitalisation rate for intentional self-harm was higher for Indigenous people — 2.9 per 1000 Indigenous people compared with 1.6 per 1000 non-Indigenous people (table 3.8.1).
- Indigenous females (3.0 per 1000 Indigenous females) had a higher age standardised hospitalisation rate for self-harm than Indigenous males (2.7 per 1000 Indigenous males.). The same was true for non-Indigenous females and males (2.0 per 1000 and 1.2 per 1000 respectively).

8 The Top End refers to the northern part of the NT.

Figure 3.8.4 **Standardised non-fatal hospitalisations for intentional self-harm, Qld, SA, WA, and public hospitals in the NT[a, b, c, d, e]**



[a] Non-fatal refers to records where the hospitalisation was not equal to 'died'. Intentional self-harm refers to hospitalisations with at least one external cause in X60–X84, based on the ICD-10-AM classification. [b] Data based on State of usual residence. [c] Indigenous data are reported for Queensland, WA, SA and the NT only. These four jurisdictions are considered to have the highest level of accuracy of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Hospitalisation data for four jurisdictions should not be assumed to represent the hospitalisation experience in the other jurisdictions. [d] The rates per 1000 population were directly age standardised using the ABS estimated resident population data as at 30 June 2001. [e] The non-Indigenous rate includes 'not stated' hospitalisations.

Source: AIHW National Hospital Morbidity Database (unpublished); table 3A.8.5.

- Between 2001-02 and 2004-05, the age standardised hospitalisation rates for intentional self-harm fluctuated for both Indigenous and non-Indigenous males and females, however, it is not possible to discern any trends (figure 3.8.4).

3.9 Substantiated child abuse and neglect

Box 3.9.1 **Key messages**

- From 1999-2000 to 2005-06, for both Indigenous and non-Indigenous children, the rate of substantiated notifications for child abuse or neglect increased (figure 3.9.1).
- In 2005-06, Indigenous children were nearly four times as likely as other children to be the subject of a substantiation of abuse or neglect (table 3A.9.1).

This headline indicator was chosen because child abuse and neglect contribute to the severe social strain under which many Indigenous people live (Keel 2004; Stanley, Tomison and Pocock 2003). Ensuring that Indigenous children are safe,

healthy and supported by their families will contribute to building functional and resilient communities.

There are no reliable data on actual levels of child abuse and neglect. Substantiated child protection notifications are the primary source data for this indicator. Substantiated notifications record children who come into contact with community services for protective reasons. Information on sexually transmitted infection (STI) diagnoses in Indigenous children and police administrative data on child sexual assault victims have been provided to supplement the primary data source.

Factors underlying child abuse and neglect are well documented (Atkinson 1996; Clapham, Stevenson and Lo 2006; Gordon, Hallahan and Henry 2002; Robertson 2000; UN 2006; UNICEF Innocenti Research Centre 2004). Researchers agree that no single risk factor causes child abuse and neglect (Stanley 2005; Memmott et al. 2001; Gordon, Hallahan and Henry 2002). Factors acting in combination, include:

- behaviour (for example, domestic violence and alcohol and substance abuse)
- environment (for example, overcrowded home environment and poor living conditions)
- psychological factors (for example, high stress levels, lack of family and community resilience and mental health)
- socioeconomic factors (for example, economic deprivation, poverty, unemployment, poor education, limited access to social services and discrimination/racism).

For Indigenous people these factors sit within a broader context of social and historic issues, such as loss of lifestyle, loss of culture, deterioration of traditional social controls and marginalisation from society (Matthews 1997; Stanley 2005). Acknowledging the shared causal pathways that contribute to child abuse and neglect increases the potential to devise preventative strategies (Stanley 2005; Libesman 2004).

Substantiated child protection notifications

Care should be taken in interpreting the substantiation data. No credible data exist on actual levels of child abuse or neglect. The number and rate of substantiations are collected by community service departments and may under-estimate the true extent of abuse or neglect occurring within the community, because not all cases are reported. Furthermore, each State and Territory has its own legislation, policies and

practices in relation to child protection, so there are differences between jurisdictions in the data provided.

Children who come into contact with community services for protective reasons include those:

- who have been or are being abused, neglected or otherwise harmed
- whose parents cannot provide adequate care or protection (AIHW 2006a).

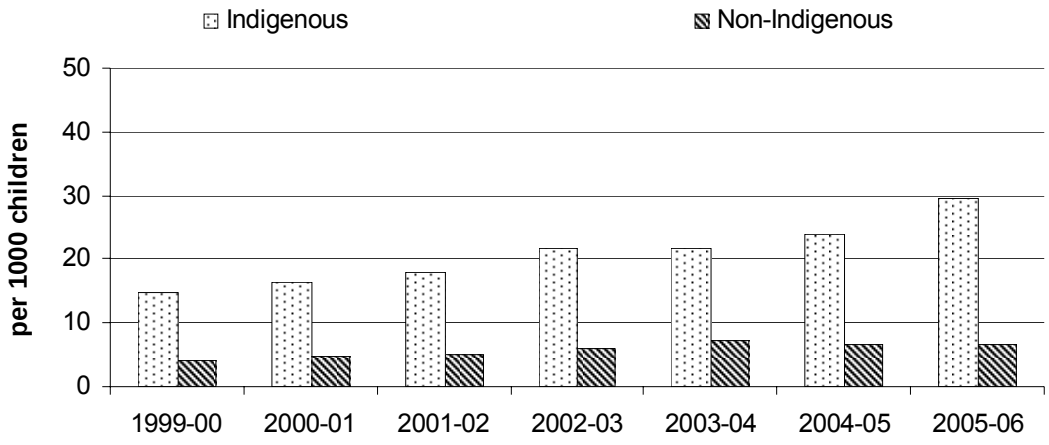
Before a matter is considered 'substantiated' by authorities, the matter must first be notified and investigated. A notification will be substantiated where it is concluded after investigation that the child has been, is being, or is likely to be abused, neglected or otherwise harmed. The criteria for substantiation vary across jurisdictions. Some jurisdictions substantiate situations where child abuse and neglect have occurred or are likely to occur, while others substantiate situations where the child has been harmed or is at risk of harm, and the parents have failed to act to protect the child (AIHW 2006a).

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

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

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

Figure 3.9.1 **Rate per 1000 children aged 0–16 years who were the subject of substantiations[a, b]**



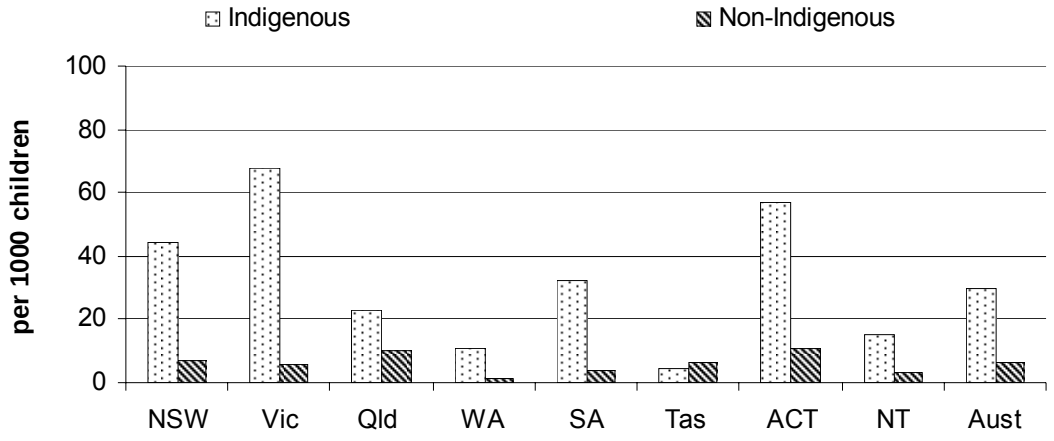
a Non-Indigenous includes Indigenous status not stated. **b** Rates of children in substantiations were calculated as the number of children aged 0–16 years in each category (including those whose age was not stated) divided by the estimated population of children aged 0–16 years at 31 December, multiplied by 1000. For Indigenous children, the June projections for two years were averaged to obtain a population figure for December of the relevant year.

Source: AIHW, *Child Protection Notifications, Investigations and Substantiations, Australia* data collection (unpublished); table 3A.9.1.

- From 1999-2000 to 2005-06 the substantiation rate for Indigenous children increased from 14.8 per 1000 children to 29.5 per 1000 children (figure 3.9.1).
- Over the same period, the rate for non-Indigenous children increased from 4.2 per 1000 children to 6.5 per 1000 children.

Attachment table 3A.9.1 includes the number of children and the rate per 1000 children aged 0–16 years in substantiations by State and Territory for the period 1999-2000 to 2005-06.

Figure 3.9.2 **Rate per 1000 children aged 0–16 years who were the subject of substantiations, 2005-06[a, b, c]**

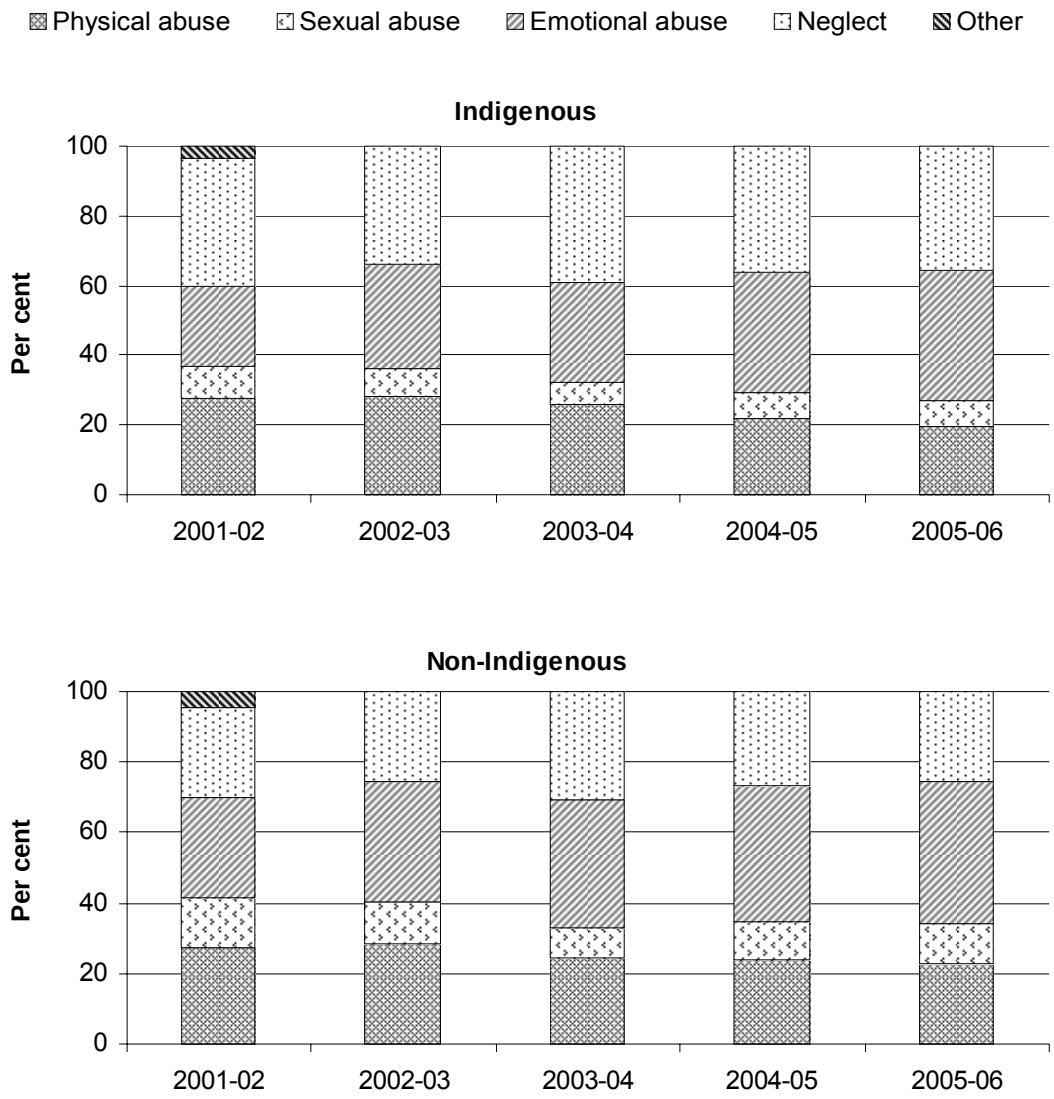


a Non-Indigenous includes Indigenous status not stated. **b** Rates of children in substantiations were calculated as the number of children aged 0–16 years in each category (including those whose age was not stated) divided by the estimated population of children aged 0–16 years at 31 December, multiplied by 1000. For Indigenous children, the June projections for two years were averaged to obtain a population figure for December of the relevant year. **c** Care should be taken in interpreting the rates for Indigenous children in Tasmania due to lower rates of recording Indigenous status at the time of the substantiation.

Source: AIHW, *Child Protection Notifications, Investigations and Substantiations, Australia* data collection (unpublished); table 3A.9.1.

- In 2005-06, the substantiation rate for Indigenous children was higher than the rate for non-Indigenous children in all jurisdictions except Tasmania (figure 3.9.2).

Figure 3.9.3 **Children aged 0–16 years who were the subject of a substantiation: type of abuse or neglect[a, b, c, d]**



a Non-Indigenous includes Indigenous status not stated. **b** If a child was the subject of a substantiation for more than one type of abuse or neglect, then type of abuse and/or neglect is classified as the type most likely to be the most severe in the short term or most likely to place the child at risk in the short term, or if such an assessment is not possible, to the most obvious form of abuse. **c** In 2001-02 and 2002-03, the category 'other' was used in NSW and comprised children identified as being at high risk but with no identifiable injury; Queensland data related to children aged 0–17 years; Tasmanian data are not included due to the very small Indigenous numbers. **d** NSW data are not included in 2003-04 because NSW was unable to provide data due to the implementation of a new data system.

Source: AIHW, *Child Protection Notifications, Investigations and Substantiations, Australia* data collection (unpublished); table 3A.9.2–6.

Variations in the distribution of types of abuse or neglect over time are likely to be the result of differences in the classification of substantiations by jurisdictions, as well as differences in the types of incidents that are substantiated (figure 3.9.3).

From 2001-02 to 2005-06, for both Indigenous and non-Indigenous children, the proportion of:

- physical abuse substantiations decreased (from 27.5 per cent to 19.8 per cent and 27.0 per cent to 22.6 per cent, respectively)
- substantiations for sexual abuse decreased (9.5 per cent to 7.2 per cent and 14.6 per cent to 11.2 per cent, respectively)
- emotional abuse substantiations increased (from 22.6 per cent to 37.3 per cent and 28.2 per cent to 40.7 per cent, respectively)
- neglect substantiations were unchanged (tables 3A.9.2 and 3A.9.6).

Attachment tables 3A.9.2–5 include the number of children and the rate per 1000 children aged 0–16 years who were the subject of a substantiation, by type of abuse or neglect by State and Territory for the period 2002-03 to 2005-06.

Sexually transmitted infection diagnoses in children and child sexual assault victims

There is growing awareness of the prevalence of child sexual abuse in some Indigenous communities (ACSAT 2006; Coorey 2001; Dunne et al. 2006; Keel 2004; Lawrence 2006; Memmott et al. 2001; NT 2006; Robertson 2000; SNAICC 2004, 2005; Stanley 2003; Stanley et al. 2002; Stanley, Tomison and Pocock 2003).

Data on the rate of STIs in children is not a reliable measure of the rate of child sexual abuse. A greater rate of STIs in Indigenous children may be a result of the higher prevalence of STIs in the Indigenous adult population rather than a greater rate of abuse. However, as Abbott (2006) commented '…it's hard to see how sexually transmitted diseases in very young patients can be the result of anything other than abuse'.

New diagnoses of genital chlamydia, gonorrhoea and syphilis are notifiable conditions in all states and territories of Australia. Data on the number of diagnoses of chlamydia, gonorrhoea and syphilis by Indigenous status are only available for Victoria, WA, SA and the NT. New South Wales, Tasmania and the ACT were unable to provide these data by Indigenous status.

Notifications are collated in the Australian National Notifiable Diseases Surveillance System (NNDSS), which records a unique record reference number, State or Territory identifier, disease code, date of onset, date of notification to the relevant health authority, sex, age, Indigenous status and postcode of residence.

Table 3.9.1 **Number of diagnoses of chlamydia, gonorrhoea and syphilis in children by age group, Victoria, WA, SA and the NT, 2001–2005[a]**

	Chlamydia		*Gonorrhoea*		*Syphilis*		*Total STIs*
	0–4	5–14	0–4	5–14	0–4	5–14	0–14
Indigenous	19	520	52	685	3	66	1345
Non-Indigenous[b]	41	325	11	121	4	8	510

[a] Data for children aged 0–4 may include children who acquired the infection through non-sexual contact (for example in-utero or at birth). [b] Includes diagnoses in people whose Indigenous status was not reported.

Source: NNDSS published in NCHECR 2006.

- Numbers of diagnoses of chlamydia, gonorrhoea and syphilis are higher for both Indigenous and non-Indigenous children aged five to 14 years than for children aged under four years (figure 3.9.1).
- The number of Indigenous children diagnosed with a STI is higher than the number of non-Indigenous children diagnosed, except for children aged under four years for diagnoses of chlamydia and syphilis. Given that Indigenous children comprise a small proportion of the total population, compared to non-Indigenous children, they are overrepresented in the numbers of children diagnosed with a STI.
- In Queensland, during 2003 and 2004, notifications of STIs for Indigenous children aged 10–14 years were higher than non-Indigenous children (6.1 per 1000 compared with 0.2 per 1000, respectively). STI notification rates for Indigenous children in remote and regional areas were significantly higher than those in major cities and inner regional areas (1.5 per 1000 compared with 10.8 per 1000) (Department of Communities 2006; Queensland Health Notifiable Disease Register 2005 (unpublished)).
- In 2003 and 2004, in Queensland, STI notification rates for Indigenous people aged 15–24 years old were 56.7 per 1000. For non-Indigenous people the rate was 9.0 per 1000. STI notification rates for Indigenous people aged 15–24 years old increased with remoteness, ranging from 18.0 per 1000 in major city areas to 115.5 in remote areas (Department of Communities 2006; Queensland Health Notifiable Disease Register 2005 (unpublished)).

Police administrative data on child sexual assault victims for NSW, Victoria, Queensland, WA and the NT can be found in attachment tables 3A.11.5 – 3A.11.49. These data are not comparable across jurisdictions. (See section 3.11 for more information on family and community violence.)

3.10 Deaths from homicide and hospitalisations for assault

Box 3.10.1 **Key messages**

- Homicide makes up a very small proportion of total deaths but can indicate broader levels of family and community violence. There were 37 Indigenous homicide victims in Australia in 2004-05 (table 3A.10.6).
- Of 245 homicides in Australia in 2004-05, Indigenous people accounted for 15.1 per cent of homicide victims and 16.3 per cent of homicide offenders (table 3A.10.6).
- After adjusting for age differences, the homicide rate in the Indigenous population was 5 to 15 times the rate in the non-Indigenous population in Queensland, WA, SA and the NT (figure 3.10.1).
- From 1999-2000 to 2004-05 the rate of Indigenous homicides in remote, outer regional and very remote areas (13.1–16.7 per 100 000 population) was around 3 times the rate in major cities and inner regional areas (4.6–4.9 per 100 000). Indigenous homicide rates were higher than non-Indigenous rates in all remoteness areas (1.4–2.4 per 100 000) (figure 3.10.5).
- In 2004-05, in the four jurisdictions for which data are available, Indigenous people were hospitalised for assault at 17.3 times the rate of non-Indigenous people. Indigenous females were 44.1 times more likely to be hospitalised for assault than non-Indigenous females (figure 3.10.1 and table 3A.10.12).

The indicator 'Deaths from homicide and hospitalisations for assault' compares information on violence for Indigenous and non-Indigenous people across Australia, including homicide victimisation and offending rates, factors associated with homicide and trends over time. This indicator also provides statistics on hospitalisations resulting from interpersonal violence.

Indigenous people are over-represented in all forms of violent crime in Australia (Memmott et al. 2001). Indigenous people are much more likely to be both victims and perpetrators of homicide than other Australians (AIC 1993; Mouzos 2001).

Violence in Indigenous communities is frequently associated with substance abuse, and often occurs within family networks (Aboriginal and Torres Strait Islander Social Justice Commissioner 2006; Bolger 1991; Gordon, Hallahan and Henry 2002; Memmott et al. 2001; Mouzos 2001).

Mouzos (2001) found that, compared to non-Indigenous homicides (see footnote to table 3.10.1 for definitions), Indigenous homicides are more likely to occur in non-urban areas. However, this may be expected because there are proportionally more

Indigenous than non-Indigenous people residing in non-urban areas. Research suggests that family violence is more prevalent in rural and remote areas of Australia, particularly in Indigenous communities (NHMRC 2002). Data on homicide by remoteness shows that Indigenous homicides are highest in remote, very remote and outer regional areas. Although Indigenous homicide rates are lower in major cities and inner regional areas, the rates are considerably higher than for non-Indigenous people (see figure 3.10.1).

Comparatively high rates of Indigenous homicide are paralleled by high levels of other forms of violence such as self-harm (see section 3.8) and assault. High rates of violence appear to coincide with other factors of disadvantage, such as poor health and lower income, employment and education levels (Memmott et al. 2001; Robertson 2000, cited in Gordon, Hallahan and Henry 2002). Family violence has been associated with medical and psychiatric disorders, homelessness, substance abuse and delinquency (National Research Council 1998, cited in Gordon, Hallahan and Henry 2002).

Several programs and activities attempting to reduce violence in Indigenous communities are included as case studies in section 3.11 (Family and community violence). Programs that reduce alcohol and substance misuse can help reduce violent behaviour in Indigenous communities — examples are included in chapter 8. Programs that reduce the involvement of Indigenous people in the criminal justice and corrections systems or that lower rates of reoffending can also contribute to reducing violent crime — for examples see sections 3.12, 7.4 and 9.2. Section 9.4 explores mental health, which can influence the extent of violent behaviour.

This section is organised into two parts. The first part uses data from the ABS and Australian Institute of Criminology (AIC) to report on deaths from homicide. The second part uses data from the Australian Institute of Health and Welfare (AIHW) to report on hospitalisations for assault.

Deaths from homicide

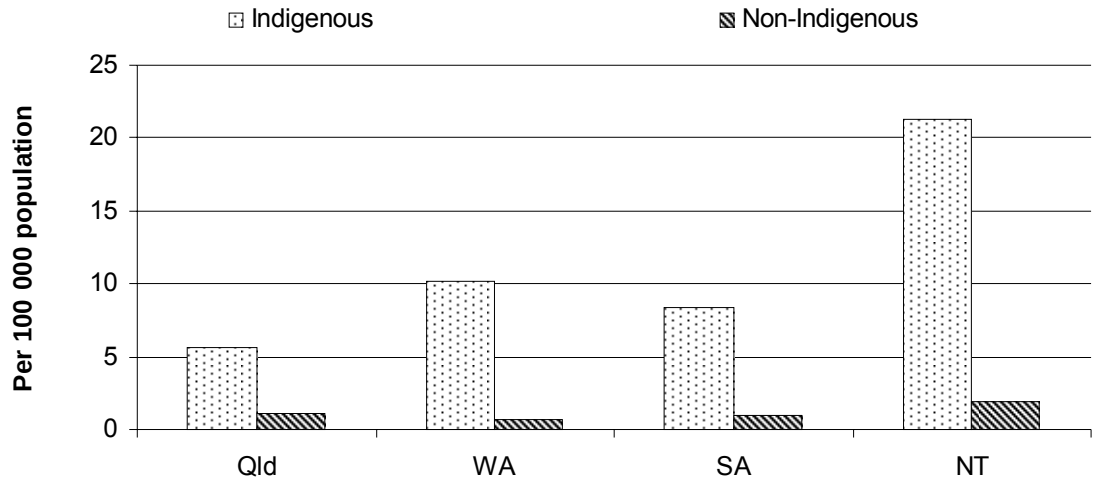
Indigenous homicides differ in several respects from non-Indigenous homicides. Most Indigenous homicides tend to involve family members, with domestic altercations being one of the main motives. Alcohol consumption at the time of the homicide incident by both the victim and offender is much more prevalent in Indigenous homicides than non-Indigenous homicides (see section 8.1). Furthermore, most Indigenous victims and offenders (eight out of ten cases in 2004-05 compared to four out of ten for non-Indigenous homicides) tend to be unemployed at the time of the homicide .

The analysis on homicides below is based on separate data from the AIC (collected as part of the National Homicide Monitoring Program) and the ABS. The method for collecting homicide data differs between the AIC and the ABS. The AIC data are collected from offence reports of homicide coming to the attention of the Australian police and from coronial records across Australia, while the ABS data are based on information supplied to the Registrars of Births, Deaths and Marriages (who are responsible for registering all deaths in their jurisdiction).

One limitation of the AIC data is that the method used for determining Indigenous status of both the victim and offender varies across states and territories. Indigenous status may be identified by police solely on the external appearance of the victim and offender in some areas, while for others it is by self identification (see sections 3.11 and 3.12). In ABS data Indigenous identification is supplied by the next of kin when registering the death. Also, details of the cause(s) of death are provided by the certifying medical practitioner or coroner.

Despite the above limitations, the AIC and ABS data allow for some detailed examination of the circumstances and characteristics of homicide occurring in the Indigenous and non-Indigenous populations.

Figure 3.10.1 **Homicide death rates, age standardised, by jurisdiction, 2001–2005**[a, b, c, d]

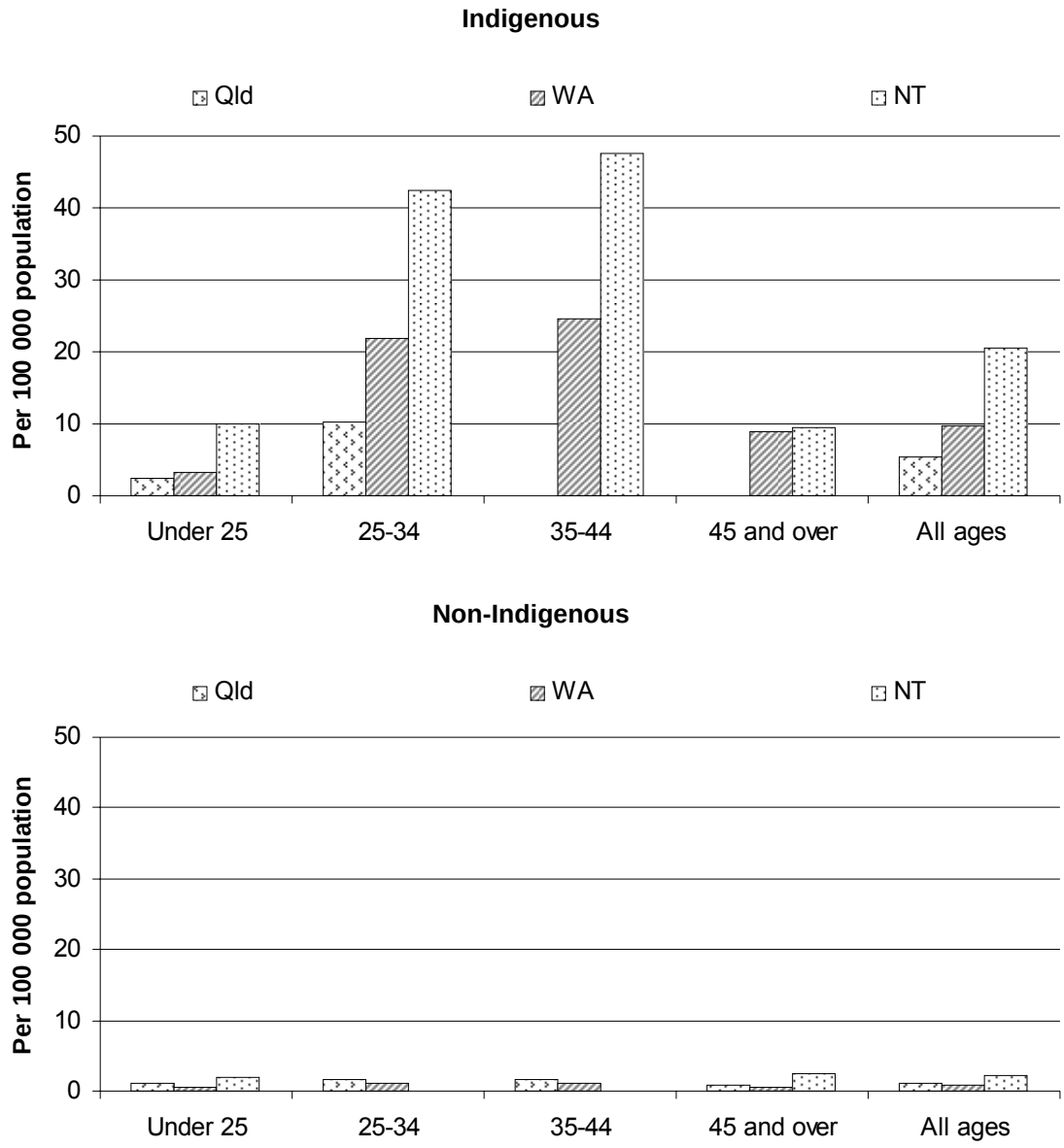


[a] Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of Indigenous identification across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. [b] Data on Indigenous causes of death are not available separately from the ABS for NSW, Victoria, Tasmania and the ACT due to a combination of comparatively small numbers and relatively low coverage of Indigenous deaths [c] Deaths from homicide are defined as causes of death with ICD codes X85–Y09. [d] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS Causes of Death 2005, Cat. no. 3303.0 (unpublished); table 3A10.1.

- Taking into consideration the different age structures in the populations, there was a much higher rate of homicide in the Indigenous population (between 5.7 and 21.3 per 100 000 population) than the non-Indigenous population (between 0.7 and 2.0 per 100 000) between 2001–2005, in Queensland, WA, SA and the NT (figure 3.10.1).
- Homicide is a very small proportion of total deaths but can be indicative of broader levels of family and community violence. There were 37 Indigenous homicide victims in Australia in 2004-05 (table 3A.10.6).

Figure 3.10.2 **Homicide death rates by age, 2001–2005**[a, b, c, d, e]

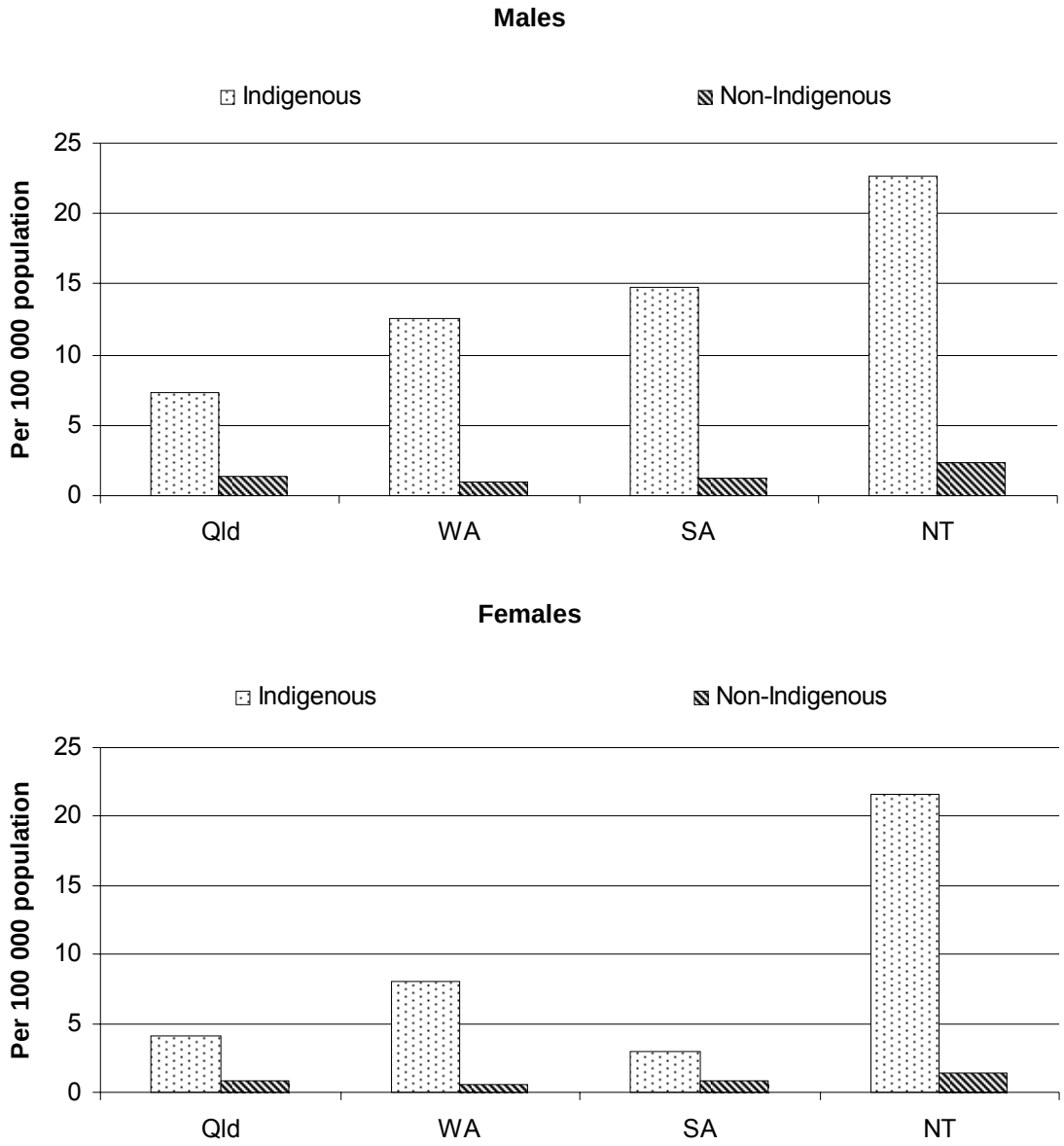


[a] Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of Indigenous identification across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. [b] Data on Indigenous causes of death are not available separately from the ABS for NSW, Victoria, SA, Tasmania and the ACT due to a combination of comparatively small numbers and relatively low coverage of Indigenous deaths. [c] Homicide death rates were not published for Qld for 'under 25' and '45 and over'. [d] Deaths from homicide are defined as causes of death with ICD codes X85–Y09. [e] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS Causes of Death 2005, Cat. no. 3303.0 (unpublished); table 3A.10.2.

- Homicide death rates for Indigenous people were particularly high for people in the age groups 25–34 and 35–44 (figure 3.10.2).

Figure 3.10.3 **Average annual homicide death rates, age standardised, by sex, 2001–2005**[a, b, c, d]



a Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of Indigenous identification across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. **b** Data on Indigenous causes of death are not available separately from the ABS for NSW, Victoria, Tasmania and the ACT due to a combination of comparatively small numbers and relatively low coverage of Indigenous deaths **c** Deaths from homicide are defined as causes of death with ICD codes X85–Y09. **d** Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS Causes of Death 2005, Cat. no. 3303.0 (unpublished); table 3A.10.1.

In the period 2001 to 2005, after taking into account the different age structures of the two populations, in the four states and territories for which data are available:

- Homicide death rates for Indigenous males were significantly higher than those for non-Indigenous males (ranging from 7.3 to 22.6 per 100 000 compared with 0.9 to 2.4 per 100 000) (figure 3.10.3).
- Homicide death rates were higher for Indigenous females (ranging from 3.0 to 21.6 per 100 000) than non-Indigenous females (from 0.5 to 1.4 per 100 000) (figure 3.10.3).
- Non-age standardised homicide death rates for males and females are included in table 3A.10.3.

Table 3.10.1 **Comparative statistics on Indigenous and non-Indigenous homicides, Australia, 2004-05[a]**

	Indigenous homicides [b]		*Non-Indigenous homicides*		*Inter-racial homicides* [c]		*Total homicides*	
	no.	*%*	*no.*	*%*	*no.*	*%*	*no.*	*%*
Gender								
Male offender on male victim	14	40.0	114	56.4	6	85.7	134	54.9
Male offender on female victim	12	34.3	51	25.2	1	14.3	64	26.2
Female offender on male victim	7	20.0	25	12.4	–	..	32	13.1
Female offender on female victim	2	5.7	12	5.9	–	..	14	5.7
Employment status								
Victim and offender working	1	5.0	25	20.7	1	16.7	27	18.4
Neither working	16	80.0	52	43.0	4	66.7	72	49.0
Victim working and offender not working	2	10.0	24	19.8	1	16.7	27	18.4
Victim not working and offender working	1	5.0	20	16.5	–	..	21	14.3
Motive of the killing								
Domestic altercation	15	42.9	40	19.7	–	..	55	22.4
Alcohol-related argument	7	20.0	12	5.9	1	14.3	20	8.2
Other argument	6	17.1	86	42.4	3	42.9	95	38.8
No apparent motive/unknown	7	20.0	65	32.0	3	42.9	75	30.6
Victim-offender relationship								
Intimate partners and other family	27	77.1	81	39.9	–	..	108	44.0
Friends and acquaintances	7	20.0	60	29.6	3	42.9	70	28.6
Strangers	1	2.9	32	15.8	4	57.1	37	15.1
Other relationship	–	..	22	10.8	–	..	22	9.0
Unknown	–	..	8	3.9	–	..	8	3.3
Total	**35**	**100**	**203**	**100**	**7**	**100**	**245**	**100**

a Where an offender has been identified. **b** Both victims and offenders of homicide are either Aboriginal and/or Torres Strait Islanders. **c** Inter-racial homicides are where either the victim or the offender is Indigenous (including homicides involving an Indigenous offender and a non-Indigenous victim, and a non-Indigenous offender and an Indigenous victim). − Nil or rounded to zero. **.. np** not applicable.

Source: Australian Institute of Criminology, National Homicide Monitoring Program, 2004-2005 [computer file]; table 3A.10.7

Based on AIC data, there were 245 homicide incidents throughout Australia in 2004-05, of which 35 incidents (14.3 per cent) were Indigenous homicides[9], 203 incidents (82.9 per cent) involved non-Indigenous people only, and the remaining 7 incidents (2.9 per cent) were inter-racial homicides (table 3.10.1).

- Out of 245 homicides in 2004-05, Indigenous people accounted for 15.1 per cent of homicide victims and 16.3 per cent of homicide offenders throughout Australia (table 3A.10.6).
- Indigenous females have a higher representation as both victims (40.0 per cent) and offenders (25.7 per cent) of the total Indigenous homicides than non-Indigenous females of total non-Indigenous homicides. In non-Indigenous homicides, females were 31.1 per cent of victims and 18.3 of per cent of offenders of the total non-Indigenous homicides in 2004-05 (table 3.10.1).
- The overwhelming majority of Indigenous homicides involved persons who were unemployed at the time of the incident. In 2004-05, 80.0 per cent of both victims and offenders were unemployed at the time of the incident compared with 43.0 per cent of both victims and offenders for non-Indigenous homicides (table 3.10.1). However, this is not unexpected given the higher unemployment rate for Indigenous people (see section 3.5).
- For 2004-05, domestic altercation was the main homicide motive identified in a significantly higher proportion of Indigenous homicides (42.9 per cent) than non-Indigenous homicides (19.7 per cent). The main motive in non-Indigenous homicides was other arguments[10] (42.4 per cent) (table 3.10.1).
- Alcohol-related argument was the second most common motive for Indigenous homicides (20.0 per cent). The second most common motive for non-Indigenous homicides was domestic altercation (19.7 per cent).
- Overall, most Indigenous homicides took place within families. In 2004-05, 77.1 per cent of Indigenous homicides involved intimate partners and other family members while 39.9 per cent of non-Indigenous homicides took place amongst these groups (table 3.10.1).
- The use of a knife or other sharp instrument as a weapon accounted for 51.4 per cent of the Indigenous homicides in 2004-05, while in non-Indigenous homicides they accounted for 29.6 per cent (table 3A.10.7).

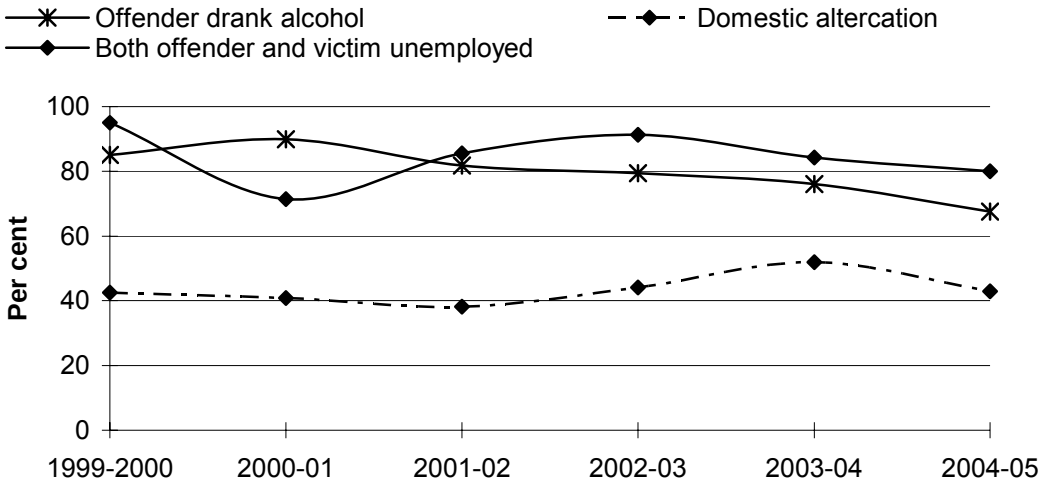
9 Indigenous homicides refers to homicides where both victims and offenders of homicide are either Aboriginal and/or Torres Strait Islanders; non-Indigenous homicides refers to homicides where both victims and offenders are not Indigenous but are Caucasian, Asian and Maori/Pacific islanders; and inter-racial homicides where either the victim or the offender, but not both, is Indigenous (AIC unpublished 2003).

10 Other arguments refers to argument over money/drugs, revenge, and racial/sexual vilification (hate crimes), sexual gratification, envy, and other motives.

Patterns and trends

Patterns and trends in the characteristics of both victims and offenders are included in this section to enable comparison of the key characteristics of both the victim and the offender and the circumstances associated with homicide. The trend analysis here is based on six years data from 1999-2000 to 2004-05 obtained from the AIC.

Figure 3.10.4 **Trends in key factors associated with Indigenous homicide, 1999-2000 to 2004-05**



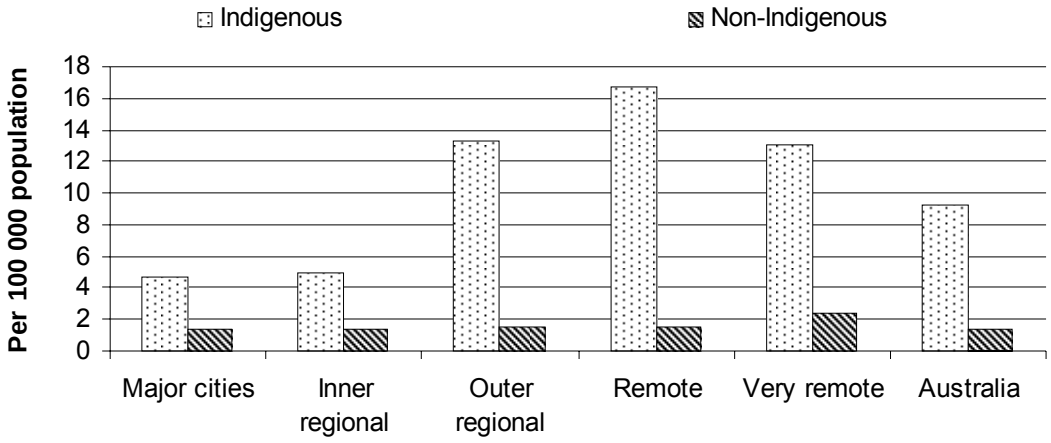
Source: AIC National Homicide Monitoring Program, 1999-2000 to 2004-05; table 3A.10.8.

- From 1999-2000 to 2004-05, domestic altercation was the major motive for most Indigenous homicides (figure 3.10.4).
- Most Indigenous homicides involved persons who were unemployed at the time of the homicide. In 2004-05, 80.0 per cent of both victims and offenders were unemployed (figure 3.10.4).
- There has been a decline in the proportion of Indigenous homicides where the offender was under the influence of alcohol from 85.0 per cent in 1999-2000 to 67.6 per cent in 2004-05 (figure 3.10.4).

Figure 3.10.5 contains data analysing homicide rates by remoteness. These data should be interpreted with caution. Six years data have been combined for this analysis to reduce the effect of fluctuations from year to year in the number of homicides. Homicides have been assigned to remoteness areas by the AIC using an ABS concordance of postcodes to remoteness areas, however, it is not always possible to assign homicides precisely to remoteness areas because postcode and remoteness area boundaries may not coincide and postcodes, particularly in regional and remote areas, may cover more than one remoteness area. Population

denominators derived for this analysis may also have a margin of error.[11] It is not known if there is variation between remoteness areas in the likelihood of Indigenous people being identified as Indigenous in the AIC homicide monitoring data. In some other data collections, the likelihood of Indigenous people being identified as Indigenous increases with remoteness.

Figure 3.10.5 **Homicide rate, by remoteness, 1999-2000 to 2004-05**



a Indigenous homicides are where both victims and offenders of homicide are either Aboriginal and/or Torres Strait Islanders. Non-Indigenous homicides are where neither the victim nor the offender is Indigenous.

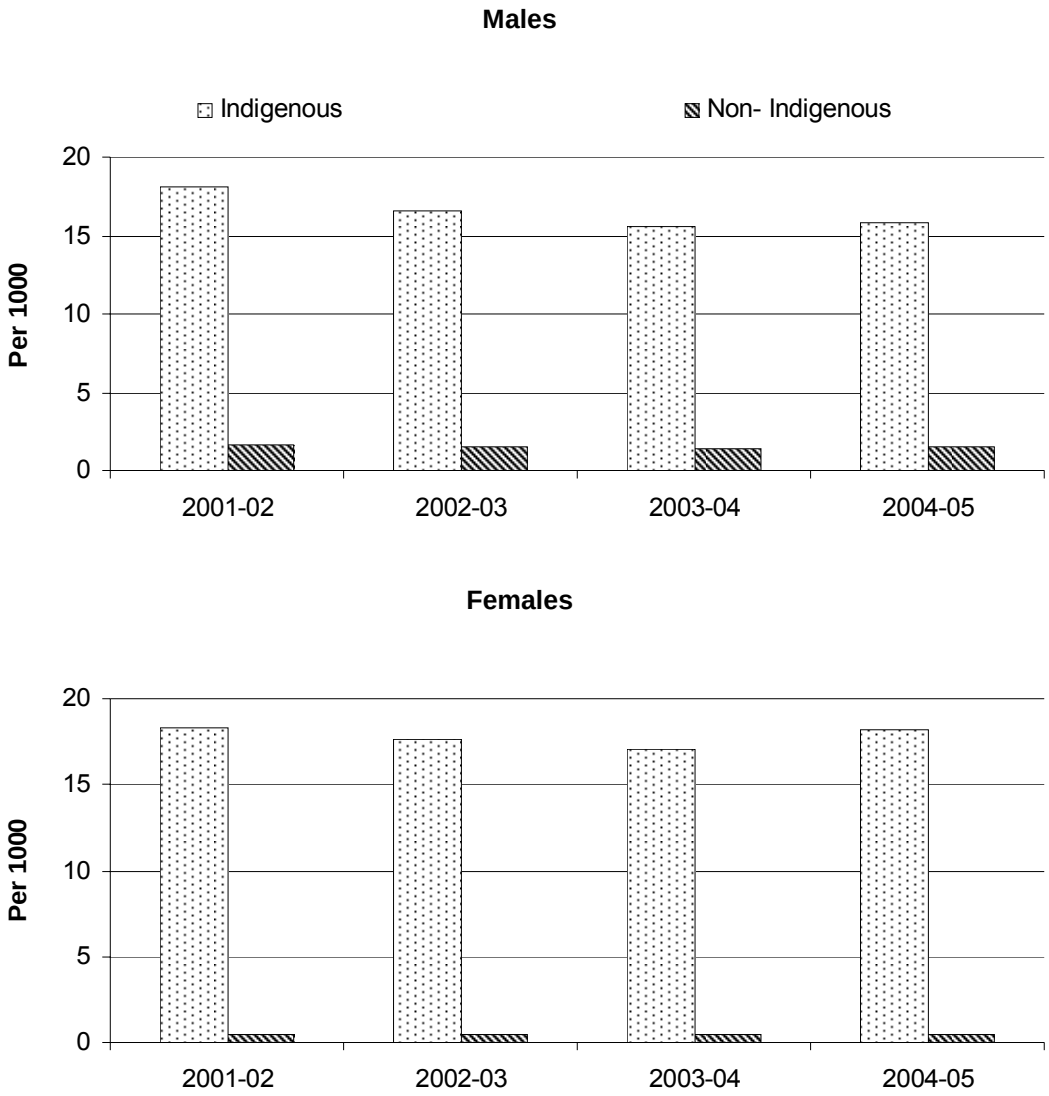
Source: ABS (2004) *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2009*; AIC (unpublished); table 3A.10.5.

- From 1999-2000 to 2004-05 a higher rate of Indigenous homicides occurred in remote, outer regional and very remote areas (13.1–16.7 per 100 000) compared with major cities and inner regional areas (4.6–4.9 per 100 000) (figure 3.10.5).
- Indigenous homicide rates were higher than non-Indigenous rates in all remoteness areas between 1999-2000 and 2004-05 (1.4–2.4 per 100 000) (figure 3.10.5).
- In remote areas Indigenous homicides occurred at ten times the rate (per 100 000 people) of non-Indigenous homicides (figure 3.10.5).

[11] Population denominators for remoteness areas have been derived by applying the proportions of Indigenous people living in each remoteness area in 2001 to experimental estimates and projections (low series) of the Indigenous population published by the ABS. Non-Indigenous denominators have been derived by applying proportions of non-Indigenous people in each remoteness area in 2001 to non-Indigenous population estimates derived by subtracting ABS Indigenous population projections from the ABS total Estimated Resident Population for each year.

Hospitalisations for assault

Figure 3.10.6 **Non-fatal hospitalisation rates for assault, by sex** [a, b, c, d, e, f]



[a] Non-fatal refers to records where the mode of separation was not equal to 'died'. [b] Rate per 1000 population was directly age standardised using the 2001 Australian population. [c] Non-Indigenous includes hospitalisations where Indigenous status was unknown. [d] Indigenous data are reported for Queensland, WA, SA and the NT only. These four jurisdictions are considered to have the highest level of accuracy of Indigenous identification, although the level of accuracy varies by jurisdiction and hospital. Data for these four jurisdictions over-represent Indigenous populations in less urbanised and more remote locations. Hospitalisation data for four jurisdictions should not be assumed to represent the hospitalisation experience in the other jurisdictions. [e] Hospitalisation is the discharge, transfer, death or change of episode of care of an admitted patient. [f] Hospitalisations for assault are defined using ICD codes X85–Y09.

Source: AIHW National Hospital Morbidity Database (unpublished); table 3A.10.9–12.

- In 2004-05, in the four jurisdictions for which data are available, Indigenous people were hospitalised for assault at 17.3 times the rate of non-Indigenous

people (17.1 per 1000 compared with less than 1.0 per 1000) (figure 3.10.6 and table 3A.10.12).

- In 2004-05, Indigenous females were 44.1 times more likely to be hospitalised for assault than non-Indigenous females. Indigenous males were 10.3 times more likely to be hospitalised for assault than non-Indigenous males (figure 3.10.6 and table 3A.10.12).
- Indigenous females (18.2 per 1000) were more likely to be hospitalised for assault than Indigenous males (15.9 per 1000), whereas non-Indigenous females (0.4 per 1000) were much less likely to be hospitalised for assault than non-Indigenous males (1.6 per 1000) (figure 3.10.6).
- Hospitalisation rates for assault decreased for Indigenous males between 2001-02 and 2004-05 from 18.1 per to 15.9 per 1000. Hospitalisation rates for assault for Indigenous females and non-Indigenous males and females remained unchanged over the same period (figure 3.10.6).

3.11 Family and community violence

Box 3.11.1 **Key messages**

- Comparable data on the extent of family and community violence are not currently available. From the available data, Indigenous people are more likely than non-Indigenous people to be victims of domestic violence related assault.
- The main reason both Indigenous and non-Indigenous people sought Supported Accommodation Assistance Program (SAAP) assistance in 2005-06 was to escape domestic or family violence (31.4 per cent of Indigenous people and 21.3 per cent of non-Indigenous people) (figure 3.11.1).
- In 2005-06, over 4 000 Indigenous people and 15 000 non-Indigenous people who sought SAAP assistance to escape domestic or family violence had accompanying children (table 3A.11.3).

Following consultations on the 2003 and 2005 Reports, this indicator has been renamed to focus on the prevalence of family and community violence. Previously, this indicator reported victim rates for crime.

There is no nationally agreed definition of domestic violence or family violence. To many people, domestic violence implies violence by a partner, and may also be known as intimate partner violence, spousal violence, spousal abuse, wife abuse and personal violence or battering (AIHW 2006). Family violence is often regarded as a broader category, including violence by extended family or household members.

The lack of a common definition means that accurately reporting and comparing data on violence is difficult.

Definitions vary between jurisdictions, studies, organisations and cultures. Macdonald (2001) states that Aboriginal women prefer the term 'family violence' because it includes the broad range of marital and kin relationships in which violence may occur. Indigenous people may view family violence as occurring between members of their larger family network including aunts, uncles, grandparents, cousins and others in the wider community, whereas non-Indigenous people may view family violence as violence within the immediate family only.

Data on domestic and family violence in this chapter are drawn from jurisdictional police collections. The statistical definitions used to identify cases of domestic and family violence differ from the broad definitions above, and differ across jurisdictions.

A number of data sources provide some information on family and community violence among Indigenous people:

- survey data
- persons accessing the Supported Accommodation Assistance Program (SAAP) because of family violence
- police data on victims of assault and other violence (including data on the relationship between victim and perpetrator)
- deaths resulting from family and intimate partner violence and hospitalisations for assault (see section 3.10).

These sources under-estimate the true extent of family and community violence as they only capture reported violence. Not all victims report violence or seek assistance.

There is a growing body of literature highlighting the experience of violence in Indigenous communities, particularly family violence (Clapham, Stevenson and Lo 2006; Gordon, Hallahan and Henry 2002; HREOC 2006; Memmott et al. 2001; Mouzos 2001).

Family and community violence problems are complex. They are interrelated with other health issues, and socioeconomic and environmental conditions (Stanley 2005; Clapham, Stevenson and Lo 2006; Matthews 1997). Alcohol and substance use have also been identified as common contributing factors to violence in Indigenous communities (HREOC 2006; Gordon, Hallahan and Henry 2002; Memmott et al. 2001; Mouzos 2001; Weatherburn, Snowball and Hunter 2006). See

sections 3.10, 8.1 and 8.3 for more information on homicides as a result of domestic altercations and alcohol and substance use related arguments.

The presence of family violence is a strong predictor of child abuse (Goddard and Hiller 1992; Stanley and Goddard 2003; Taft, Hegarty and Feder 2006), and partner violence has a damaging effect on children's emotional, behavioural and cognitive development (Stanley and Goddard 2003; Taft, Hegarty and Feder 2006). Family violence is a reason for notification to State and Territory child protection authorities. In NSW and Tasmania, the child protection legislation requires mandatory reporting of children affected by domestic violence. In all other states and territories, family violence is captured under 'emotional abuse'. For more information on substantiated child abuse and neglect see section 3.9.

There is a lack of information about the extent of family and community violence across different geographical regions. A report on violence in rural and remote Australia acknowledged that from the limited literature available there are higher rates of family violence in rural and remote areas, particularly in Indigenous communities (NHMRC 2002).

Some initiatives that have been successful in reducing family and community violence are described in box 3.11.2.

Box 3.11.2 **'Things that work' — reducing violence in Indigenous communities**

Rekindling Indigenous Family Relationships, Riverland, SA

An early intervention project, 'Rekindling Indigenous Family Relationships (RIFR) in the Riverland Program' in SA is assisting the Aboriginal community to resolve family violence and child abuse issues. The project uses a holistic approach to focus on family and community development in order to identify and change the social circumstances for many Aboriginal people. The project explores historical grief and loss issues and violence and abuse issues, as well as responding effectively to crisis situations. A project team provides community education and awareness and links with appropriate Riverland services and programs. Transportation and childcare services are also provided to facilitate regular attendance.

(Continued next page)

Box 3.11.2 (continued)

A key component of the RIFR Project is the delivery of the Family Wellbeing (FWB) Program. The FWB program focuses on understanding conflict, emotions and effective resolution, changing family violence patterns, self-development and building healthy relationships. Eleven community members have completed the first module and while some progressed to the second module, other participants chose to repeat the first module in order to support other family and community members who are set to begin the program. More participants completed modules 1 and 2 in December 2006 (SA Government unpublished).

Pathways to Prevention, Queensland

The Pathways to Prevention project began in 2001 in a particularly disadvantaged area in Brisbane, which included Indigenous, Pacific Islander and Vietnamese community groups. The program targeted families with children aged four to six years old who were in transition to school, and focused on enhancing their communication and social skills, and empowering their families, schools and ethnic communities to provide supportive environments for positive development.

The multilayered interventions included a Family Independence Program (FIP). The main outcome achieved by families attending FIP programs was the strengthening of family relationships and improved communication between family members. In addition, the FIP improved relationships between families and schools and there was a reduction in social isolation (Homel et al. 2006). Data on the characteristics of participants shows that the FIP was used by some of the most vulnerable and difficult-to-reach families who were experiencing high levels of family adversity, dysfunction or stress (Homel et al. 2006).

The involvement of a child's parents in the FIP, in addition to the child's direct involvement in the Preschool Intervention Program (PIP), led to the most marked improvements in behaviour. Moreover, children who were not involved in the PIP but whose parents were involved in the FIP improved as much as children who participated in the PIP directly. This suggests that indirect effects via parents can be as powerful as the direct effects of programs specifically for children.

Results of the cost analysis of the Pathways program (costs of development, implementation and evaluation phases of both the community based and school based interventions) indicated that preventative intervention was cheaper than later remedial interventions for both behaviour management and literacy enhancement programs.

There is strong evidence that the Pathways programs (FIP and PIP) both made a difference to outcomes for children, especially for boys' behaviour. There were improvements in language skills, prosocial behaviour and school readiness.

The Pathways to Prevention project won the 2004 National Crime and Violence Prevention Award (sponsored by the heads of Australian governments and members of the Australasian Police Ministers' Council.)

Survey data

Data on the prevalence of violence from the ABS 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) were included in the 2005 Report. Some of the findings from the NATSISS include:

- 21.2 per cent of Indigenous people aged 15 years and over reported family violence as a problem in their neighbourhood or community (ABS 2004)
- 19.9 per cent perceived assault as a problem in their neighbourhood or community and 8.1 per cent reported sexual assault as a problem (ABS 2004)
- 18.3 per cent of Indigenous women experienced physical or threatened violence in the previous 12 months, compared with 7.0 per cent of non-Indigenous women (SCRGSP 2005)
- Of the 24.3 per cent of Indigenous people aged 15 years or over who had been a victim of violence in the past 12 months, around one third were living in households with Indigenous children under five years of age (ABS 2004)
- Indigenous people who had been removed from their natural families experienced a higher rate of victimisation than those who had not been removed (33.5 per cent compared to 18.1 per cent) (MCATSIA 2006).

After accounting for age differences between the Indigenous and non-Indigenous populations, Indigenous adults (aged 18 years and over) were:

- twice as likely as non-Indigenous adults to have been a victim of physical or threatened violence in the previous 12 months (ABS 2004)
- three times as likely as non-Indigenous adults to report abuse or violent crime as a problem for them or someone close to them (ABS 2002 NATSISS unpublished)
- five times as likely as non-Indigenous adults to report witnessing violence as a problem for them or someone close to them (ABS 2002 NATSISS unpublished).

The ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) asked participants whether they took a health-related action as a result of an attack. Consistent with the results from the ABS 2001 National Health Survey (Indigenous supplement):

- 1 per cent of Indigenous people reported having been attacked by another person in the previous four weeks.

Findings from the Australian component of the International Violence Against Women Survey (IVAWS) 2002-03 include:

- Indigenous women reported higher levels of physical, sexual and any violence during the 12 months preceding the IVAWS compared with non-Indigenous women (Mouzos and Makkai 2004)
- 20 per cent of Indigenous women reported experiencing physical violence, compared with 7 per cent of non-Indigenous women (Mouzos and Makkai 2004)
- Three times as many Indigenous women reported experiencing an incident of sexual violence, compared to non-Indigenous women (12 per cent compared with 4 per cent) (Mouzos and Makkai 2004).

The Australian Institute of Criminology conducted a survey of police about their perceptions of negative outcomes associated with illicit drug use in Indigenous communities. The survey included urban and country areas in Queensland, WA, SA and the NT. Some of the findings included:

- Police indicated that heavy cannabis use exacerbated many existing problems among local Indigenous residents, especially domestic/family violence (73 per cent urban; 76 per cent non-urban) and mental health problems (73 per cent urban; 74 per cent non-urban) (Putt and Delahunty 2006).
- Nearly every community involved in the field research for the survey voiced concerns about the impact substance use has on family violence, declining participation in community life, child neglect, and sexual exploitation of young people (Putt and Delahunty 2006).

SAAP National Data Collection

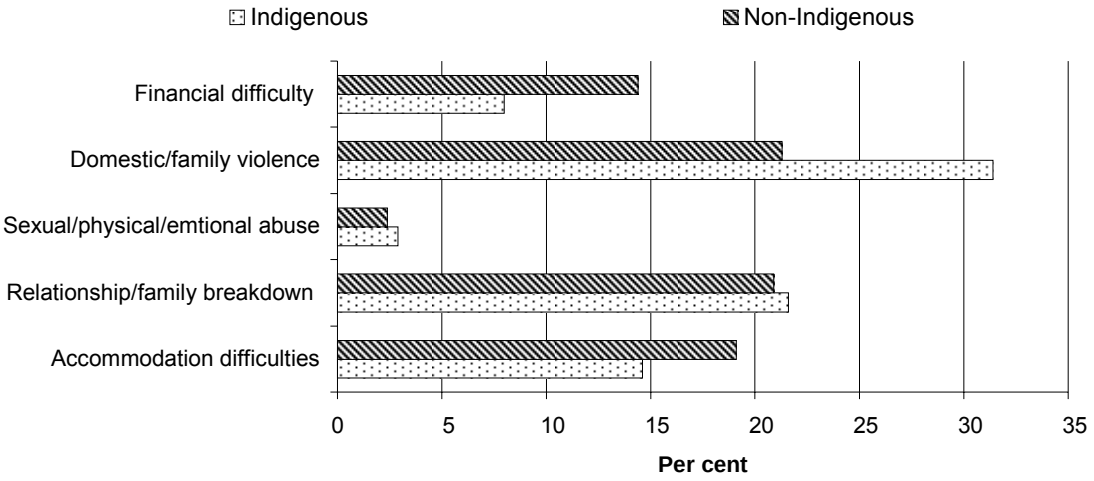
The SAAP National Data Collection provides information on the number of people seeking assistance from agencies funded under the SAAP, for reasons to do with family violence.

These data will under-estimate the true extent of family violence occurring within the community, because:

- not all victims of violence access these services
- victims may be turned away because the support required cannot be provided (AIHW 2006).

The number of people seeking SAAP assistance in 2005-06 for reasons to do with family violence as a proportion of the total number of people seeking assistance are shown in figure 3.11.1.

Figure 3.11.1 **SAAP support periods: main reason clients sought support, Australia, 2005-06[a, b, c, d]**

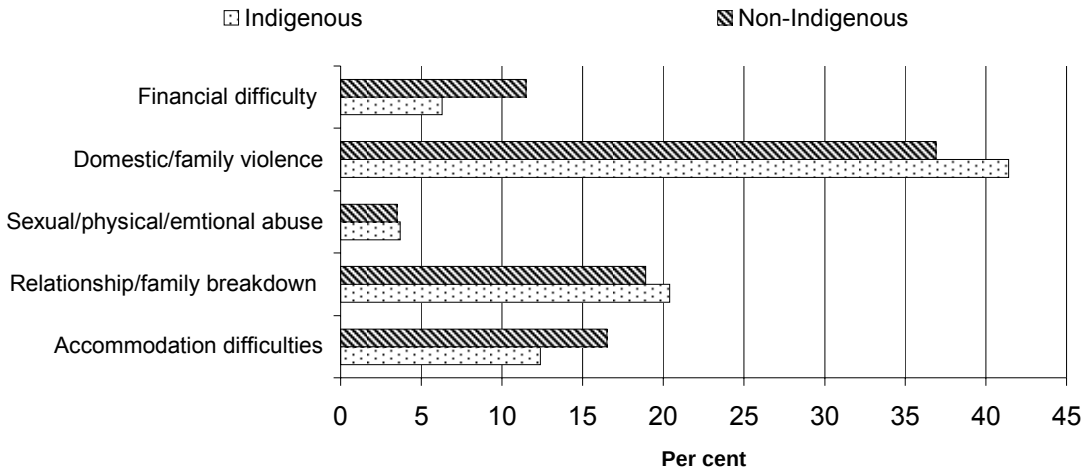


a Non-Indigenous includes Indigenous status not stated. **b** Accommodation difficulties includes overcrowding issues, eviction/asked to leave, emergency accommodation ended, and previous accommodation ended. **c** Relationship/family breakdown includes time out from family/other situation and interpersonal conflict. **d** Financial difficulty includes budgeting problems, rent too high and other financial difficulty.

Source: Australian Institute of Health and Welfare (AIHW), Supported Accommodation Assistance Program (SAAP) National Data Collection Agency (NDCA) (unpublished).

- Escaping domestic/family violence was the main reason Indigenous and non-Indigenous people sought SAAP assistance in 2005-06 (figure 3.11.1).
- In 2005-06, the number of Indigenous people who sought SAAP assistance to escape domestic/family violence as a proportion of the total number of Indigenous people who sought assistance was 31.4 per cent, compared with 21.3 per cent of non-Indigenous people (table 3A.11.1).
- For both Indigenous and non-Indigenous people, domestic violence affects a large proportion of children in SAAP (AIHW 2005). In 2005-06, of the 34 800 Indigenous and non-Indigenous SAAP clients who sought assistance to escape domestic/family violence (table 3A.11.1), 19 700 had accompanying children (table 3A.11.3).
- In 2005-06, 55.7 per cent of Indigenous people who sought SAAP assistance to escape domestic/family violence had accompanying children. For non-Indigenous people 56.5 per cent had accompanying children (tables 3A.11.1 and 3A.11.3).
- In 2003-04, 15 per cent of Indigenous women escaping domestic/family violence had four or more accompanying children (AIHW 2006).

Figure 3.11.2 **SAAP support periods: main reason female clients sought support, Australia, 2005-06**[a, b, c, d]



a Non-Indigenous includes Indigenous status not stated. **b** Accommodation difficulties includes overcrowding issues, eviction/asked to leave, emergency accommodation ended, and previous accommodation ended. **c** Relationship/family breakdown includes time out from family/other situation and interpersonal conflict. **d** Financial difficulty includes budgeting problems, rent too high and other financial difficulty.

Source: AIHW, SAAP NDCA (unpublished); table 3A.11.2.

- Escaping domestic/family violence was the main reason both Indigenous and non-Indigenous women approached a SAAP agency (figure 3.11.2).
- Of the 33 700 female SAAP clients escaping domestic/family violence, 7 700 were Indigenous and 26 000 were non-Indigenous (table 3A.11.2).
- A higher proportion of Indigenous women (41.4 per cent) sought SAAP assistance to escape domestic/family violence compared with non-Indigenous women (36.9 per cent) (table 3A.11.2).
- In 2003-04, the rate of Indigenous women seeking SAAP assistance to escape domestic/family violence was highest in remote areas (78.7 per 1000) compared with major cities (25.9 per 1000) (AIHW 2006). Patterns of usage around SAAP services and the availability of SAAP and other services in different areas may affect this rate.

More information on the reasons people sought SAAP support by Indigenous status and across states and territories can be found in table 3A.11.4.

State and Territory Police records

There is no national data collection on Indigenous crime victimisation reported to police. Data on crime victimisation for selected offences and victim-offender

relationships are presented in this section for NSW, Victoria, Queensland and the NT. For Victoria, Queensland and the NT the offence category 'assault' includes 'domestic violence related assault' (that is, domestic violence related assault is a subset of assault).

Victim-offender relationship data by selected offences against the person (murder, assault, domestic violence related assault, sexual assault, sexual assault (victims aged 0–15) and robbery) are presented to provide some information on police recorded community violence. There are no standard definitions for the four broad categories of victim-offender relationships (family, stranger, other and unstated). These definitions vary between states and territories and may be based on a subjective assessment by a police officer.

Data from other jurisdictions are not published in this Report, either because there is no process to identify Indigenous status or, where data are collected, they are not of sufficient coverage or quality to publish.

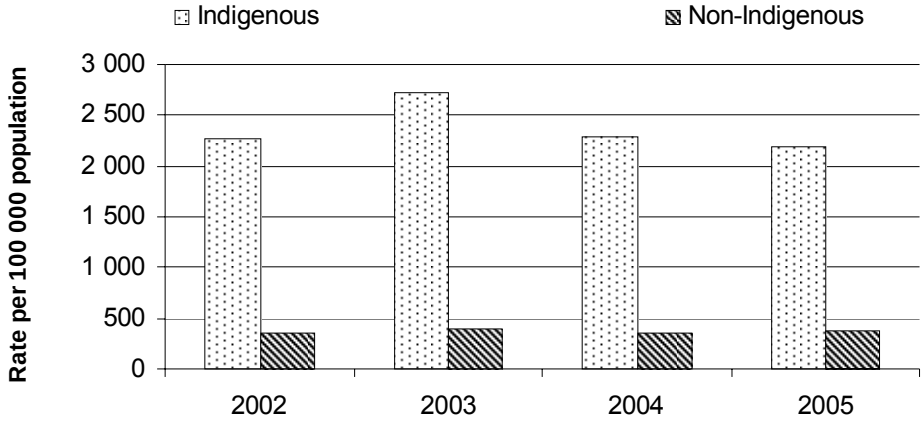
Police data provide some insight into the level of Indigenous victimisation within these states. These data are not comparable between jurisdictions and are subject to the caveats included in the figures and tables.

Using police records to measure family and community violence raises some issues, including:

- The data do not represent all victims of crime, just those that come to the attention of, and whose details are recorded by, police.
- The data presented generally reflect victims of violent criminal incidents where the violent incident was reported to, or otherwise detected by, police.
- The tendency to report criminal victimisation to police may differ between Indigenous and non-Indigenous people (and there is no way of estimating the level of under-reporting).

New South Wales

Figure 3.11.3 **Victims recorded by NSW Police for domestic violence related assault**[a, b, c, d, e]



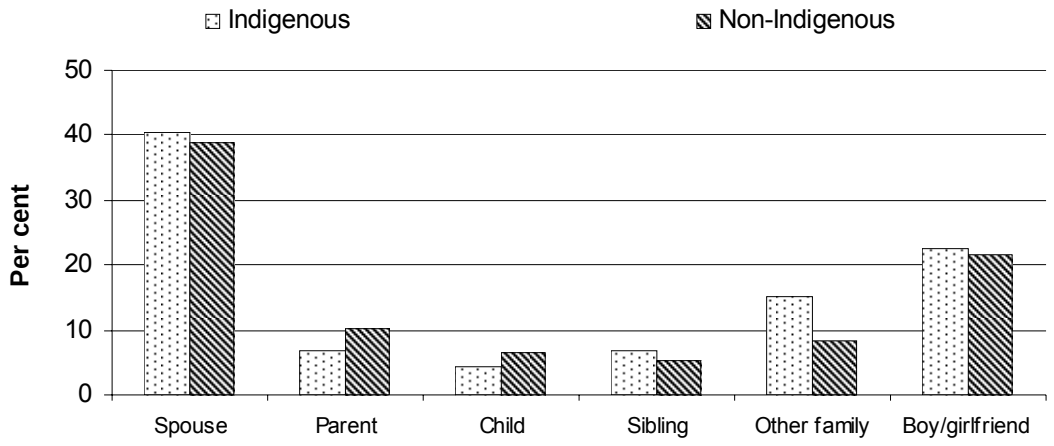
[a] Indigenous status is based on self-identification. [b] These data do not represent all victims of crime, just those who come to the attention of and whose details are recorded by NSW Police. [c] The tendency to report criminal victimisation to police may differ between Indigenous and non-Indigenous people. [d] The category 'domestic violence related assault' is a subset of 'assault'. [e] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: NSW Bureau of Crime Statistics and Research (unpublished); ABS (2006); ABS Experimental Indigenous Projections by State, Age and Sex: Low Series (unpublished); tables 3A.11.5–8.

- From 2002 to 2005 the rate of Indigenous victims of domestic violence decreased (with fluctuations in between) from 2 276.7 per 100 000 people to 2 197.8 per 100 000 people. Over the same period, the rate for non-Indigenous victims increased from 356.1 per 100 000 people to 368.2 per 100 000 people (tables 3A.11.5 to 3A.11.8).
- Over the period, the rate of domestic violence for Indigenous people was approximately six to seven times that of the non-Indigenous population (tables 3A.11.5–8).
- Indigenous people in NSW in 2005 were more than twice as likely to be a victim of assault than non-Indigenous people (table 3A.11.5).
- In 2005, Indigenous women in NSW were nearly seven times as likely to be a victim of domestic violence than non-Indigenous women (table 3A.11.9).

More information on victims recorded by NSW Police for murder, assault, sexual assault and sexual assault against victims aged 0–15 can be found in tables 3A.11.5–8. More information on female victims is in tables 3A.11.9–12.

Figure 3.11.4 **Relationship of offender to victim recorded by NSW Police for victims of domestic violence related assault, 2005**[a, b, c, d, e, f, g]



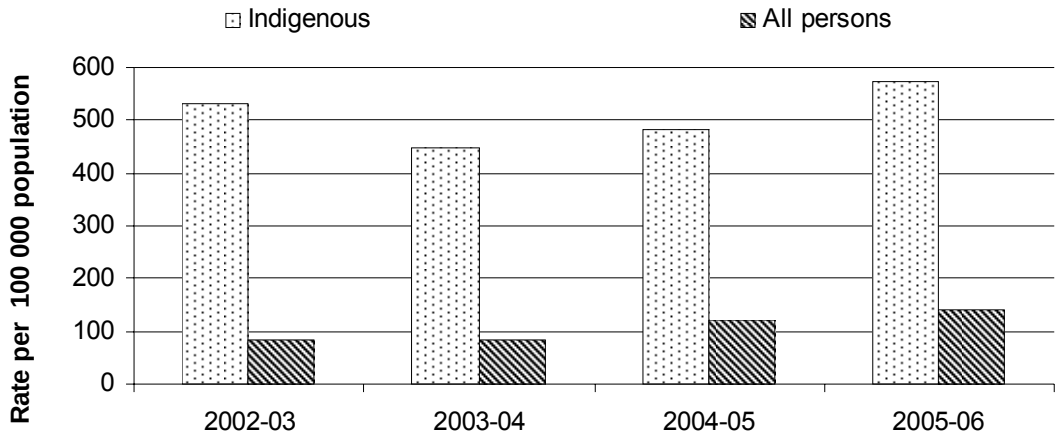
[a] Indigenous status is based on self-identification. [b] These data do not represent all victims of crime, just those who come to the attention of and whose details are recorded by NSW Police. [c] The tendency to report criminal victimisation to police may differ between Indigenous and non-Indigenous people. [d] The category 'domestic violence related assault' is a subset of 'assault'. [e] Spouse includes partner, ex-spouse and ex-partner. [f] Parent includes guardian. [g] Boy/girlfriend includes ex-boy/girlfriend.

Source: NSW Bureau of Crime Statistics and Research (unpublished); table 3A.11.13.

- For Indigenous people, the spouse was the offender in 40.3 per cent of domestic violence related assault offences (compared with 38.8 per cent for non-Indigenous).
- For both Indigenous and non-Indigenous people, offences against the person are most likely to occur in residential dwellings (58.0 per cent of offences against Indigenous people occurred in residential dwellings compared with 44.8 per cent for non-Indigenous people) (table 3A.11.14).

Victoria

Figure 3.11.5 **Victims recorded by Victoria Police for domestic violence related assault[a, b, c, d]**



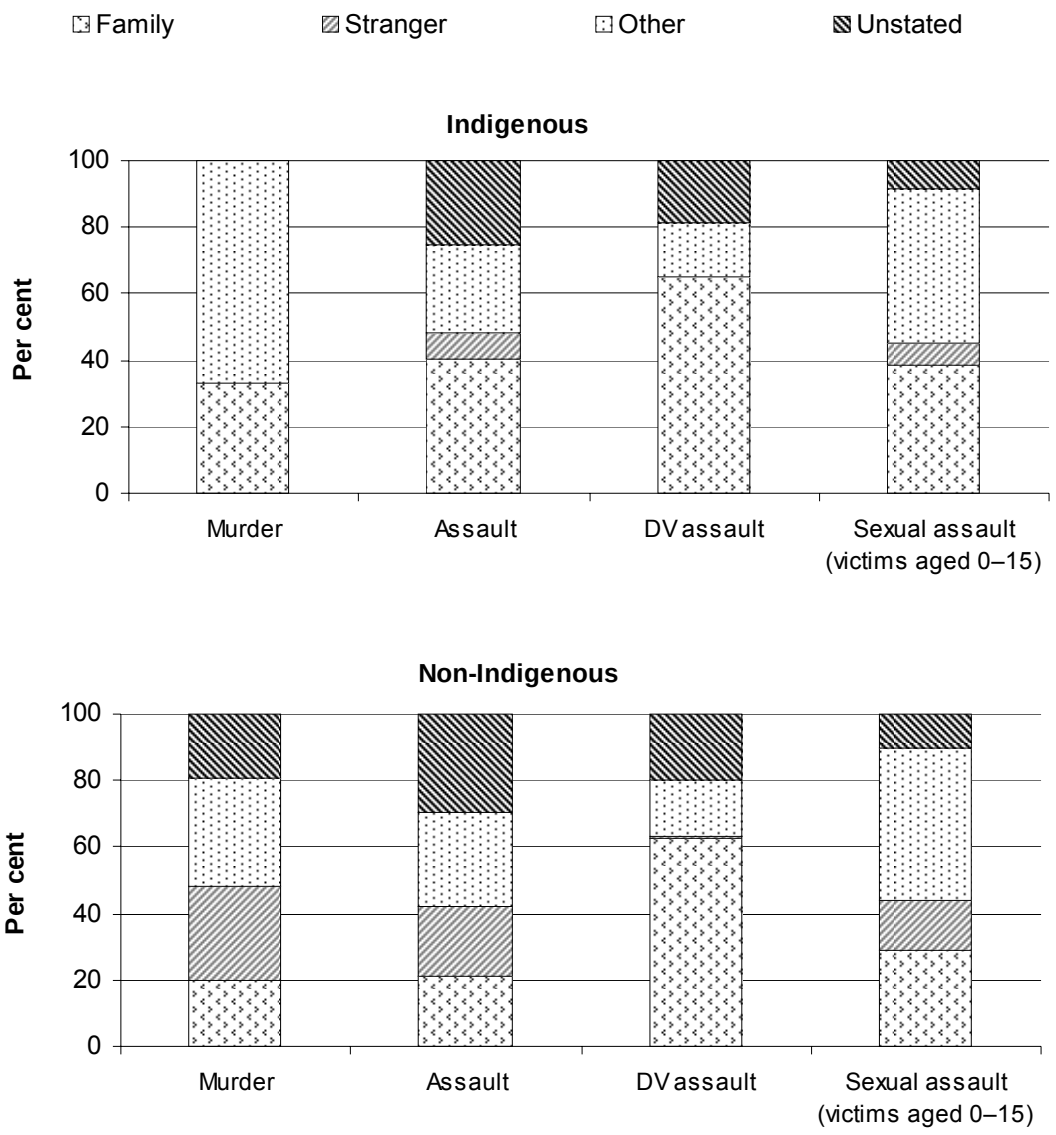
[a] Any police members receiving a report of an incident must make sufficient initial inquiries to satisfy themselves that a crime has been committed. [b] Indigenous status is derived from the racial appearance of the victim which is a subjective assessment by the police officer. [c] Domestic violence related assault is defined as a family violence report and an assault occurring in the same incident. [d] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: Victoria Police (unpublished); table 3A.11.15–18.

- In Victoria, from 2002-03 to 2005-06, the rate of Indigenous victims of domestic violence increased from 533.1 per 100 000 people to 574.1 per 100 000 people. Over the same period, the rate for all persons increased from 84.6 per 100 000 people to 141.0 per 100 000 people (tables 3A.11.15 to 3A.11.18).
- In 2005-06, Indigenous people were more than four times as likely to be a victim of domestic violence related assault than all persons (table 3A.11.15).
- For Indigenous females in Victoria in 2005-06, the rate of domestic violence related assault was nearly five times as high as the rate of the total female population (table 3A.11.19).

More information on victims, female victims and juvenile victims recorded by Victoria Police for murder, assault, sexual assault and sexual assault against victims aged 0–15 can be found in tables 3A.11.15–26.

Figure 3.11.6 **Victim-offender relationships recorded by Victoria Police for selected offences against the person, 2005-06**[a, b, c, d, e, f, g]



[a] Any police members receiving a report of an incident must make sufficient initial inquiries to satisfy themselves that a crime has been committed. [b] Indigenous status is derived from the racial appearance of the victim which is a subjective assessment of the police officer. [c] The category 'domestic violence related assault' is a subset of 'assault'. Similarly, the category 'sexual assault against victims 0–15' is a subset of 'sexual assault'. Domestic violence related assault is defined as a family violence report and an assault occurring in the same incident. [d] For sexual assault (victims aged 0–15) the age of the victims represents the age of the victim at the time of reporting the offence. [d] Family includes parent, child, step parent/child, spouse, defacto, former spouse or defacto, sibling and other lineal relationship. [f] Other includes boyfriend/girlfriend, employer/employee, co-resident, acquaintance, police on duty, police off duty, other law enforcement, other known, neighbour, former boyfriend/girlfriend, gay domestic partner and lesbian domestic partner. [g] Unstated includes cannot be determined and unspecified.

Source: Victoria Police (unpublished); table 3A.11.27.

- As illustrated in figure 3.11.6, the offender was a family member in more than half of the domestic violence related assault cases for both Indigenous and

non-Indigenous people (65.3 per cent for Indigenous and 62.4 per cent for non-Indigenous) (table 3A.11.27).

- In 2005-06, the offender was a family member in 40.1 per cent of assaults on Indigenous people, whereas for non-Indigenous assault victims the offender was a family member in 20.8 per cent of cases (table 3A.11.27).
- For both Indigenous and non-Indigenous people most offences against the person occurred in a dwelling (58.9 per cent for Indigenous people and 44.1 per cent for non-Indigenous people) (table 3A.11.29).

Further information on victims of offences against the person in Victoria is included in tables 3A.11.27–30.

Queensland

Table 3.11.1 **Victims recorded by Queensland Police, per 100 000 people, 2005-06**[a, b]

	Indigenous[c]	*Non-Indigenous*	*Ratio: Indigenous to non-Indigenous*
Total victims, per 100 000 population[d]			
Murder	4.3	1.1	3.8
Assault	1 948.7	437.1	4.5
Domestic violence related assault[e]	757.9	52.7	14.4
Sexual assault	421.3	115.9	3.6
Sexual assault (victims aged 0–15)[f]	671.5	299.9	2.2
Female victims, per 100 000 female population[d]			
Murder	2.8	1.0	2.8
Assault	2 550.4	296.6	8.6
Domestic violence related assault[e]	1 277.3	72.2	17.7
Sexual assault	709.8	192.0	3.7
Sexual assault (victims aged 0–15)[f]	1 168.3	487.7	2.4

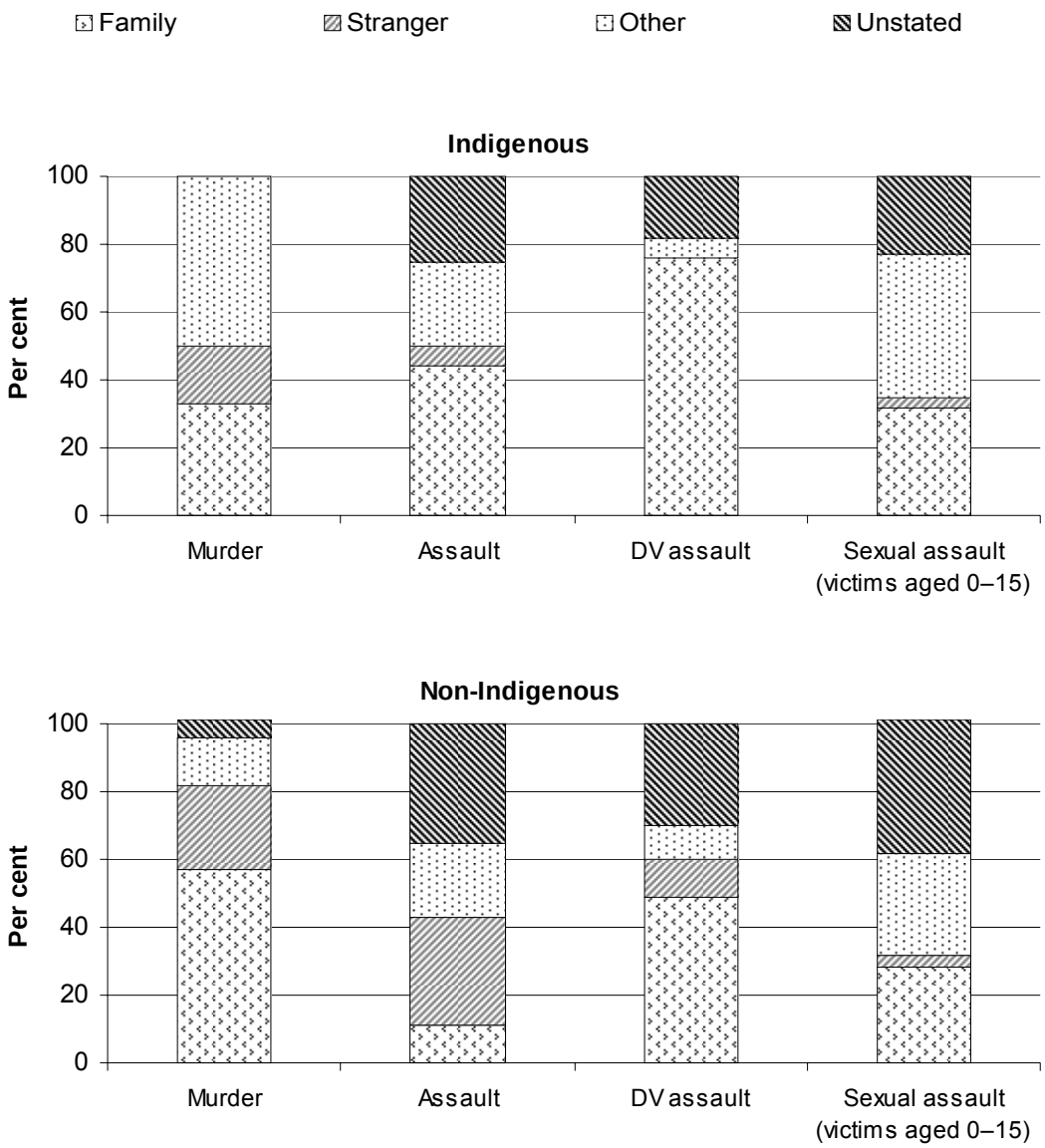
[a] These data do not represent all victims of crime, just those that come to the attention of and whose details are recorded by Queensland Police. [b] Data are not a unique victim count as one person may be counted several times if they were the victim of more than one offence. [c] Indigenous status is based on self identification. [d] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. [e] The category 'domestic violence related assault' is a subset of 'assault'. Similarly, the category 'sexual assault against victims 0–15' is a subset of 'sexual assault'. [f] The age of the victims represents the age of the victim at the time of reporting the offence.

Source: Queensland Police (unpublished); tables 3A.11.31 and 3A.11.33.

- Table 3.11.1 shows that in Queensland in 2005-06, Indigenous people were 14.4 times as likely as non-Indigenous people to be a victim of domestic violence related assault.
- The rate of domestic violence for Indigenous females was nearly 18 times as high as the rate for non-Indigenous females (table 3.11.1).
- Indigenous people in Queensland, were 4.5 times as likely to be victims of assault than non-Indigenous people, while Indigenous females were 8.6 times as likely as non-Indigenous females to be victims of assault (table 3.11.1).

Tables 3A.11.32 and 3A.11.34 contain data on victims of selected crimes in Queensland for 2004-05.

Figure 3.11.7 **Victim-offender relationships recorded by Queensland Police for selected offences against the person, 2005-06**[a, b, c, d, e, f, g]



[a] These data do not represent all victims of crime, just those that come to the attention of and whose details are recorded by Queensland Police. [b] Data are not a unique victim count as one person may be counted several times if they were the victim of more than one offence. [c] Indigenous status is based on self-identification. [d] The category 'DV assault' means domestic violence related assault and is a subset of 'assault'. Similarly, the category 'sexual assault against victims 0–15' is a subset of 'sexual assault'. [e] For sexual assault (victims aged 0–15) the age of the victims represents the age of the victim at the time of reporting the offence. [f] The relationship of 'unstated' represents the victims where an offender has not yet been apprehended for the offence. [g] Percentages have been rounded to the nearest whole number. Therefore, although the percentages are correct they may not add to 100 per cent.

Source: Queensland Police (unpublished); table 3A.11.35.

- Figure 3.11.7 provides details on the types of relationships between offenders and victims for selected offences against the person. In 76.0 per cent of

Indigenous domestic violence related assaults, the offender was a family member. For non-Indigenous people, 49.0 per cent of domestic violence related assaults were committed by a family member (table 3A.11.35).

- In 2005-06, the offender was a family member in 44.0 per cent of assaults on Indigenous people, whereas for non-Indigenous victims, the offender was a family member in 11.0 per cent of cases (table 3A.11.35).
- In 2005-06, for both Indigenous and non-Indigenous people, offences against the person most commonly occurred in a dwelling (59.0 per cent for Indigenous people and 39.0 per cent for non-Indigenous people) (table 3A.11.37).

Tables 3A.11.36 and 3A.11.38 contain data on Indigenous victim-offender relationships for victims of offences against the person in 2004-05.

Western Australia

The 2003 and 2005 Reports included data on victimisation rates for WA (tables 3A.11.39–43). Western Australian Police record the age, Indigenous status and sex of victims of offences against the person. Unfortunately, the Indigenous status of the victim was not recorded for a large proportion of offences against the person. Owing to the large proportion of unrecorded Indigenous status, WA is unable to estimate the relative risks of victimisation for Indigenous persons. Victim-offender relationship data is also unavailable because in most cases of offences against the person the relationship was not stated.

Table 3.11.2 **Victims recorded by the NT Police, 2005**[a, b, c, d]

	Indigenous[e]	*Non-Indigenous*	*Ratio: Indigenous to non-Indigenous*
Total victims, per 100 000 population[f]			
Murder	18.2	0.7	26.1
Assault	3 783.1	913.8	4.1
Domestic violence related assault[g]	2 875.5	202.1	14.2
Sexual assault	162.3	74.1	2.2
Sexual assault (victims aged 0–15)[g]	158.5	98.3	1.6
Female victims, per 100 000 female population [f]			
Murder	19.9	–	..
Assault	6 211.3	780.2	8.0
Domestic violence related assault[g]	5 210.9	312.1	16.7
Sexual assault	304.8	150.0	2.0
Sexual assault (victims aged 0–15)[g]	300.1	176.5	1.7

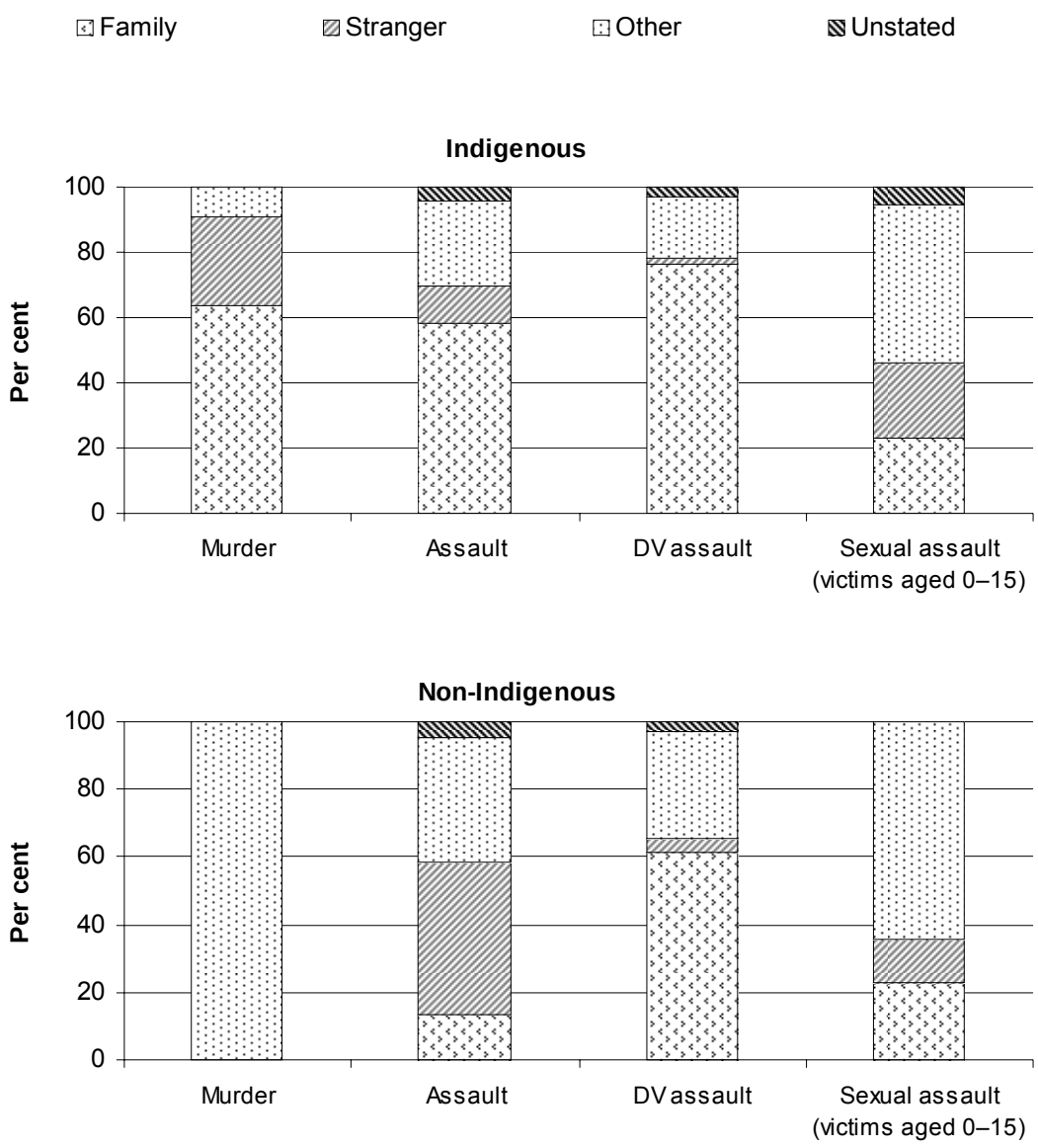
[a] These data do not represent all victims of crime, just those that come to the attention of and whose details are recorded by NT Police. [b] An increase in 2005 is partly due to the introduction of a domestic violence initiative. [c] Data are compiled on the basis of the date an offence is reported to police and recorded within a reference period. [d] Police statistical databases are 'live' systems with records being updated or entered on a daily basis as a result of continuing investigations. Therefore, crime statistics produced for a given period may change with the passage of time. [e] Indigenous status is based on appearance. [f] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. [g] The category 'domestic violence related assault' is a subset of 'assault'. Similarly, the category 'sexual assault against victims 0–15' is a subset of 'sexual assault'. – Nil or rounded to zero. **..** Not applicable.

Source: NT Police (unpublished); table 3A.11.44 and 3A.11.46.

- In the NT in 2005, Indigenous people were 26.1 times as likely as non-Indigenous people to be a victim of murder, and 14.2 times as likely to be a victim of domestic violence related assault (table 3.11.2).
- Table 3.11.2 shows that in the NT in 2005, Indigenous females were 8.0 times as likely as non-Indigenous females to be a victim of assault.
- The rate of domestic violence for Indigenous females was nearly 17 times as high as the rate for non-Indigenous females (table 3.11.2).

Data on victims of crime in the NT for 2004 are included in tables 3A.11.45 and 3A.11.47.

Figure 3.11.8 **Victim-offender relationships recorded by the NT Police for selected offences against the person, 2005-06**[a, b, c, d, e]



a These data do not represent all victims of crime, just those that come to the attention of and whose details are recorded by NT Police. **b** Indigenous status is based on appearance. **c** The category 'DV assault' is domestic violence related assault and is a subset of 'assault'. Similarly, the category 'sexual assault against victims 0–15' is a subset of 'sexual assault'. **d** Family includes partner, spouse, siblings, parents and immediate family members. Other includes relatives, friends and acquaintances. Stranger includes where victim/offender are relatively unknown to each other. **e** Non-Indigenous murder data represent one murder.

Source: NT Police (unpublished); table 3A.11.48.

- Figure 3.11.8 shows the types of relationships between offenders and victims for selected offences against the person. In 2005, the offender was a family member in 63.6 per cent of Indigenous murders, whereas for the one non-Indigenous

murder the offender was 'other' (relative, friend or acquaintance) (table 3A.11.48).

- In 76.3 per cent of Indigenous domestic violence related assaults, the offender was a family member. For non-Indigenous victims, 61.2 per cent of domestic violence related assaults were committed by a family member (table 3A.11.48).
- In 2005, the offender was a family member in 58.0 per cent of assaults on Indigenous people, whereas for non-Indigenous victims the offender was a family member in 13.5 per cent of cases (table 3A.11.48).

3.12 Imprisonment and juvenile detention rates

Box 3.12.1 **Key messages**

- Indigenous imprisonment rates increased by 31.9 per cent between 2000 and 2006 (figure 3.12.1).
- Between 2002 and 2006, the imprisonment rate increased by 34.0 per cent for Indigenous women and by 21.6 per cent for Indigenous men (table 3A.12.7).
- In 2006, after adjusting for age differences, Indigenous people were 12.9 times more likely than non-Indigenous Australians to be imprisoned (table 3.12.1).
- At 30 June 2005, Indigenous juveniles were 23 times more likely to be detained than non-Indigenous juveniles. The difference between the Indigenous and non-Indigenous juvenile detention rates has increased since 2001 (figure 3.12.4).

The headline indicator 'Imprisonment and juvenile detention rates' provides an insight into the level of involvement of Indigenous people in the criminal justice system as offenders.

Australia's Indigenous people are highly over-represented in the criminal justice system (Woodward 2003). Adverse socioeconomic conditions in Indigenous communities (such as, poverty, unemployment, low levels of educational attainment, and lack of access to social services) are associated with high crime rates. The 1991 Royal Commission into Aboriginal Deaths in Custody (RCIADIC) identified links between the formal education system, child welfare practices, juvenile justice, health, and employment opportunities as contributors to the disproportionate representation of Aboriginal people in police and custodial facilities (RCIADIC 1991). Putt, Payne and Milner (2005) found that for many Indigenous male offenders, substance abuse, particularly alcohol intoxication, was associated with criminal behaviour.

A recent study by the NSW Bureau of Crime Statistics and Research found that a higher rate of Indigenous offenders were sent to prison than non-Indigenous offenders because of a higher rate of conviction for violent crime and higher rate of re-offending (Snowball and Weatherburn 2006).

One of the major factors highlighted by the WA Department of Justice (2002a) was that the early involvement of Aboriginal juveniles in the criminal justice system was likely to place them at significantly greater risk of imprisonment as adults. Lynch, Buckman and Krenske (2003) reported that Indigenous juvenile offenders were more likely than non-Indigenous juvenile offenders to progress to the adult criminal justice system and end up in prison. The study found that 86 per cent of Indigenous juvenile offenders entered the adult correction system, with 65 per cent of them serving at least one prison term. For non-Indigenous juvenile offenders, 75 per cent entered the adult correction system with 41 per cent of them serving at least one prison term.

The 1991 Royal Commission into Aboriginal Deaths in Custody stated that changes to the operation of the criminal justice system alone will not have a significant impact on the number of Indigenous people entering custody (RCIADIC 1991). Nevertheless, there has been some success in reducing the reoffending rates of Indigenous people by implementing culturally appropriate justice practices. Boxes 3.12.2, 3.12.3 and 3.12.4 describe the success of the Koori Courts in Victoria, Nunga Courts in SA and Murri Courts in Queensland, respectively.

Box 3.12.2 **'Things that work' — Culturally appropriate justice practices for Indigenous people in Victoria**

In 2005, The Australian Institute of Criminology awarded the Shepparton Koori Court the Australian Crime and Violence Prevention Award for their successful operation of a special sentencing court for Indigenous offenders. This specialised court within the Magistrates Court created an informal atmosphere which allowed greater participation of the Koori Community (that is, the Koori Elder, the Aboriginal Justice Worker and members of the offender's family) in the sentencing process and support programs.

Shepparton was chosen as one of the two sites for the two-year pilot program because it has the largest Koori population outside of metropolitan Melbourne. The success of the pilots at Shepparton and Broadmeadows paved the way for Koori Courts to become a permanent part of the Victorian justice system. Koori Courts have now also been established in Warrnambool, Mildura, the La Trobe Valley and Bairnsdale, with another planned for Swan Hill. There is also a Koori Children's Court in Melbourne and another is scheduled to open in Mildura.

(Continued next page)

Box 3.12.2 (continued)

Victoria's Koori Courts are a blend of Aboriginal custom and culture with the Anglo-Australian legal system. They reduce the perceptions of cultural alienation and tailor sentences to the cultural needs of the Koori offenders. The Koori Court, particularly the traditional elders and the offender's family members, identify the causal issues facing the offender and encourage the offender to take responsibility for his or her actions.

A review of the Shepparton and Broadmeadows Koori Courts over the two-year pilot period found that recidivism rates in those areas dropped by 12.5 per cent and 15.5 per cent, respectively. The number of offenders who breached community corrections orders fell and fewer Koori defendants failed to show for their court appearances. Further, the role of Koori Elders in court has reinforced the status and authority of these leaders and strengthened the fabric of the Koori community as a whole (Office of the Attorney-General 2005).

Box 3.12.3 **'Things that work' — Nunga Courts in SA**

In SA, Nunga Courts are specialist magistrates courts which aim to make the justice system more culturally appropriate to Indigenous people. Nunga courts were established in 1999 and currently operate at Port Adelaide, Murray Bridge, Coober Pedy, Port Augusta and Ceduna (Office of Crime Statistics and Research 2004). There has been positive feedback from the Indigenous community on Nunga courts as they are seen to provide a more culturally relevant environment that gives Indigenous people more input into the judicial process, particularly in relation to sentencing.

Attendance rates for Indigenous people to Nunga courts are frequently around 80 per cent compared with less than 50 per cent for general magistrates courts. The Nunga court has had success in reducing arrests for non-appearance by defendants on bail and in breaking the cycle of Indigenous imprisonment for unpaid fines by applying alternative penalties such as community service and allowing the gradual payment of fines (Office of Crime Statistics and Research 2004).

Box 3.12.4 **'Things that work' — Murri Courts in Queensland**

The Murri Court is a Queensland Magistrates Court, or Children's Court constituted by a magistrate, which sentences Indigenous offenders who plead guilty to an offence. The Murri Court currently operates in Brisbane, Rockhampton, Townsville, Mt. Isa, Caboolture (Youth Murri Court only), and has recently commenced operation in Ipswich and Cherbourg.

The Murri Court was established by the magistracy in 2002 in response to Indigenous over-representation in the justice system. The Murri Court delivers more personal and culturally appropriate justice by allowing Aboriginal and Torres Strait Islander elders and respected persons the opportunity to have input. The elders and respected persons provide insight into how the offending is affecting the local community and have input into the sentencing options considered by the Court. The legal processes of the Murri Court are more informal and less intimidating and, where possible, sentences have a rehabilitative focus.

A review has recently been conducted on the Murri Court and a Report on the Murri Court Review was released in December 2006 (Parker and Pathé 2006). The Report made 18 recommendations focusing on practical improvements to the Murri Court. The Review confirmed the involvement of elders and respected persons assists the offenders in developing trust in the court (Parker and Pathé 2006).

A further independent evaluation of the Murri Court will be undertaken to assess the role of the Murri Court in reducing imprisonment, decreasing the rate of re-offending and cutting the number of Indigenous offenders failing to appear in court.

The information presented in this chapter on imprisonment and juvenile detention takes account of only one aspect of Indigenous contact with the criminal justice system. By their nature, the offences which result in imprisonment or juvenile detention tend to be of a more serious nature. As a result, the data do not address:

- arrests that do not proceed to court (for example, as a result of diversion or restitution) (see section 7.4 'Juvenile diversions')
- convictions that lead to outcomes that are not administered by custodial facilities (for example, community service orders and fines)
- police custody (for example, for public drunkenness).

The data on adult Indigenous imprisonment are sourced from the National Prisoner Census, the results of which are published by the ABS in *Prisoners in Australia* (ABS 2006). The census is a count of all prisoners who are held in gazetted adult prisons in Australia, as at midnight on 30 June of each year. The Prisoner Census provides a snapshot of the number of people in prison, and is not representative of the flow of prisoners. People held in juvenile institutions, psychiatric facilities or immigration custody are not included.

People under 18 years are treated as juveniles in most Australian courts and are not held in custody in adult prisons, other than in exceptional circumstances. In Queensland, however, 'adult' refers to people aged 17 years and over.

For juvenile detention, the data are sourced from the Australian Institute of Criminology (AIC) publication *Statistics on Juvenile Detention in Australia: 1981-2005* (Taylor 2006). These data contain information on the number of young people in the custody of each jurisdiction's juvenile justice agency on the last day of each quarter. Only those juveniles detained on each census night are counted, and as such, the count is not necessarily representative of the actual daily average of juvenile detainees in each State and Territory.

While detailed national data are currently available on the number of young people held in juvenile detention centres at the end of each quarter, these detention data only illustrate one aspect of the juvenile justice system. The vast majority of juveniles in the care of juvenile justice agencies are not placed into detention; rather, they are placed on community service orders or other types of order (Charlton and McCall 2004). In February 2006, the AIHW, in collaboration with the Australasian Juvenile Justice Administrators, released their first report on juvenile justice in Australia (AIHW 2006). This report published nationally consistent data on juvenile justice supervision from 2000-01 to 2003-04.

Imprisonment

Age standardised imprisonment rates for Indigenous and non-Indigenous people are presented in table 3.12.1. Age standardisation adjusts for the younger age profile of the Indigenous population compared to the non-Indigenous population (ABS 2001) — for both populations, younger adults are much more likely to be in prison than older people.

Table 3.12.1 **Age standardised imprisonment rates per 100 000 adult population, 30 June 2006[a, b]**

	Indigenous	*Non-Indigenous*	*Ratio of Indigenous to non-Indigenous*[c]
NSW[d]	1 892.7	153.5	12.3
Victoria	940.4	96.5	9.7
Queensland	1 463.5	137.8	10.6
WA	2 668.5	144.8	18.4
SA	1 451.9	116.1	12.5
Tasmania	410.6	143.3	2.9
ACT[e]	812.1	72.6	11.2
NT	1 416.3	115.1	12.3
Australia	1 668.2	129.8	12.9

a Indigenous imprisonment rates are calculated using the low series population projections for 30 June 2006 (ABS Cat. no. 3238.0). **b** Prisoners with unknown Indigenous status are excluded from the calculation of age standardised imprisonment rates. **c** The ratio of Indigenous to non-Indigenous imprisonment is calculated by dividing the Indigenous age standardised imprisonment rate by the non-Indigenous age standardised imprisonment rate. **d** Data for NSW exclude ACT prisoners held in NSW prisons. **e** Data for the ACT include ACT prisoners held in the ACT as well as ACT prisoners held in NSW.

Source: ABS (2006); table 3A.12.3.

- Nationally in 2006, Indigenous people were 12.9 times more likely than non-Indigenous people to be imprisoned, with an age standardised imprisonment rate of 1668.2 prisoners per 100 000 adult Indigenous population compared with 129.8 per 100 000 for non-Indigenous prisoners (table 3.12.1).
- There were 6 091 Indigenous prisoners in Australia at 30 June 2006, increasing each year from 4 494 Indigenous prisoners counted at 30 June 2002 (table 3A.12.1). Of the 25 790 prisoners in Australia at 30 June 2006 (table 3A.12.1), Indigenous prisoners accounted for 23.6 per cent of the prisoner population (table 3A.12.5). This proportion has increased from 20.0 per cent in 2002 (table 3A.12.5).

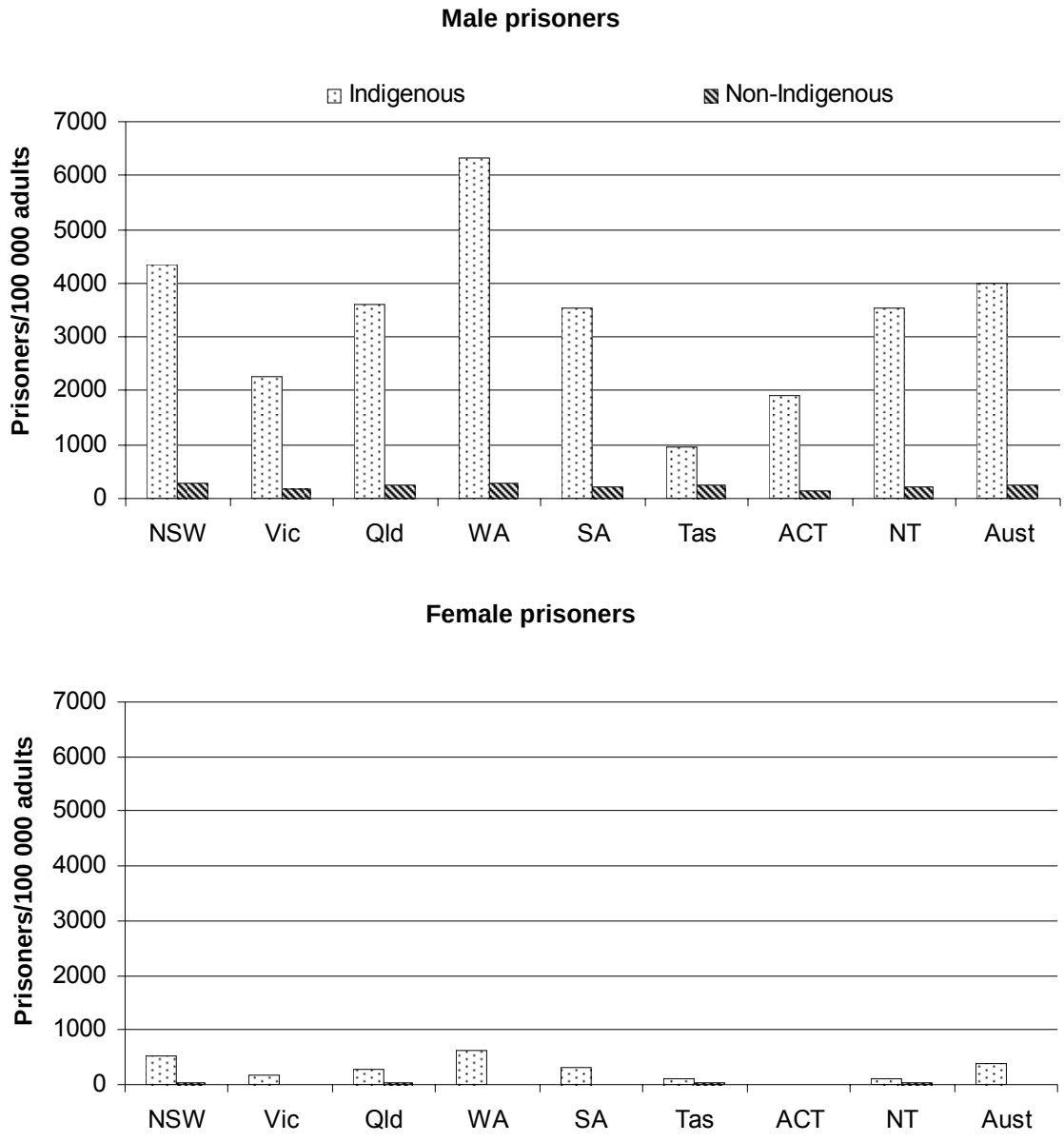
Figure 3.12.1 **Age standardised imprisonment rates per 100 000 adult population, by year, Australia[a, b]**

a Indigenous imprisonment rates are calculated using low series population projections (ABS Cat. no. 3238.0).
b Rates are based on prisoner census and population data at 30 June each year.

Source: ABS (2006); table 3A.12.4.

- Figure 3.12.1 shows an increase in the rate of Indigenous imprisonment from 1 264.5 in 2000 to 1668.2 in 2006 (figure 3.12.1). The non-Indigenous rate only changed slightly, from 128.0 in 2000 to 129.8 in 2006.

Figure 3.12.2 **Crude imprisonment rates, by gender, 30 June 2006**[a, b, c]



a Indigenous imprisonment rates are calculated using the low series population projections for June 30 2006 (ABS Cat no. 3238.0) and are not age standardised. **b** Data for NSW excludes ACT prisoners held in NSW prisons. **c** Data for the ACT includes ACT prisoners held in the ACT as well as ACT prisoners held in NSW.

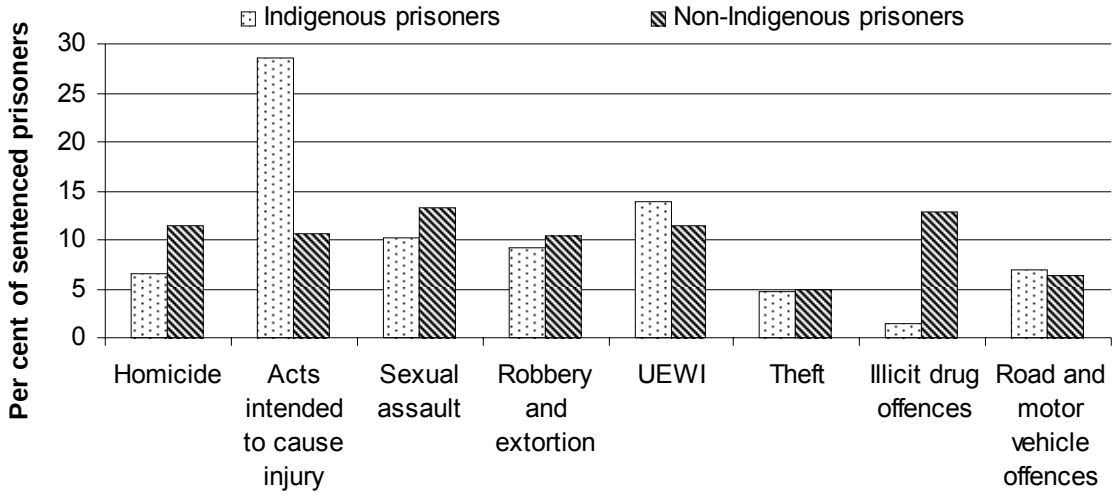
Source: ABS (unpublished); table 3A.12.7.

- Figure 3.12.2 shows that imprisonment rates for Indigenous and non-Indigenous males are considerably greater than imprisonment rates for Indigenous and non-Indigenous females across all states and territories.
- Nationally, on 30 June 2006, Indigenous males were 16.8 times more likely than non-Indigenous males to be in prison, and Indigenous females were 23.1 times more likely than non-Indigenous females to be in prison (figure 3.12.2). Over the

past five years, the rates of imprisonment for Indigenous males and females have increased annually (table 3A.12.7).

- Female prisoners comprise a small but growing proportion of the Australian prison population (table 3A.12.6) and have some specific needs not shared by most male prisoners, such as those associated with being a carer for young children. Because there are fewer prisons for women, Indigenous females are often detained in centres far from their children and communities (ABS 2004) and may also face communication difficulties. In a recent study of women prisoners in WA, the WA Department of Justice (2002b) found that 14 per cent of Indigenous women spoke an Aboriginal dialect as their first language.
- The imprisonment rate for Indigenous females increased by 34.0 per cent between 2002 and 2006. The imprisonment rate for Indigenous males increased by 21.6 per cent over the same period (table 3A.12.7).

Figure 3.12.3 **Sentenced prisoners by most serious offence, 30 June 2006**



UEWI = 'Unlawful entry with intent'.

Source: ABS (2006); table 3A.12.9.

- Data on sentenced prisoners by most serious offence in figure 3.12.3 provide a picture of people in prison at 30 June 2006. Prisoners serving long-term sentences for serious offences are over-represented in annual prisoner census data. An examination of the flow of offenders in and out of prison during the year would consist primarily of people serving short sentences for lesser offences.
- Of the 4 801 Indigenous sentenced prisoners used to calculate the percentages presented in figure 3.12.3, 28.5 per cent had been sentenced with 'acts intended

to cause injury' as their most serious offence, 2.7 times the proportion of non-Indigenous prisoners sentenced with the same offence (figure 3.12.3).

- In contrast, only 1.4 per cent of Indigenous prisoners had been sentenced for 'illicit drug offences' as their most serious offence, a considerably smaller proportion than in the non-Indigenous prisoner population (12.9 per cent) (figure 3.12.3).
- For Indigenous and non-Indigenous prisoners, only 0.7 per cent and 0.9 per cent had been sentenced for public order offences, respectively (table 3A.12.9).

Attachment tables 3A.12.8 and 3A.12.9 show the number and proportion of sentenced prisoners by most serious offence and expected time to serve (mean and median months) at 30 June 2005 and 30 June 2006, respectively. Nationally, Indigenous prisoners were expected to serve shorter sentences than the overall prisoner population in most of the selected offence categories presented in figure 3.12.3, but were serving longer sentences for sexual assault and theft. According to the ABS (2006), unsentenced Indigenous prisoners spent less time in remand for most of the offence categories listed in tables 3A.12.8 and 3A.12.9 than non-Indigenous prisoners in 2006 (in mean number of months), but were spending more time in remand for sexual assault, public order and miscellaneous offences.

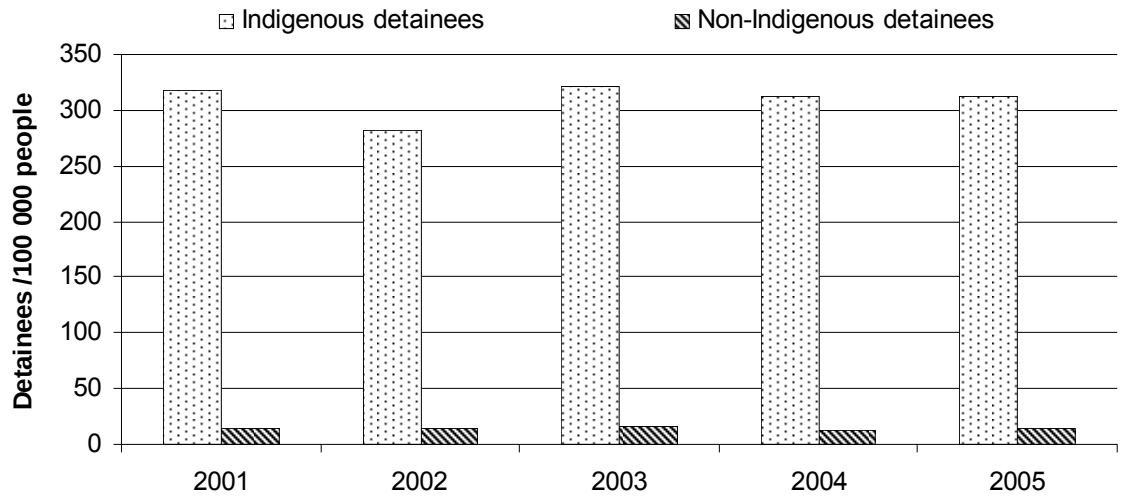
The number of prisoners and rate of imprisonment, by age group, are shown in tables 3A.12.10 (at 30 June 2005) and 3A.12.11 (at 30 June 2006). The mean and median age of prisoners at 30 June 2005 and 30 June 2006 are shown in tables 3A.12.12 and 3A.12.13, respectively. In 2006, the mean (average) age of Indigenous prisoners was 31.6 years, some 4.2 years younger than the average age of non-Indigenous prisoners (35.8 years) (table 3A.12.13).

Data by jurisdiction on the proportion of prisoners on remand[12] are contained in table 3A.12.14 (at 30 June 2005) and 3A.12.15 (at 30 June 2006). Nationally in 2006, the proportion of unsentenced Indigenous prisoners (21.0 per cent) was similar to the proportion of unsentenced non-Indigenous prisoners (21.3 per cent) (table 3A.12.15). From 2005 to 2006, the proportions of unsentenced Indigenous and non-Indigenous prisoners have increased slightly on a national basis (tables 3A.12.14 and 3A.12.15).

12 According to the ABS (2006), remand prisoners are those persons who have been placed in custody while awaiting the outcome of their court hearing. They may be unconvicted (remanded in custody for trial), convicted but awaiting sentence or awaiting deportation.

Juvenile detention

Figure 3.12.4 **Juvenile detention rates, aged 10–17 years, by year, Australia[a, b]**



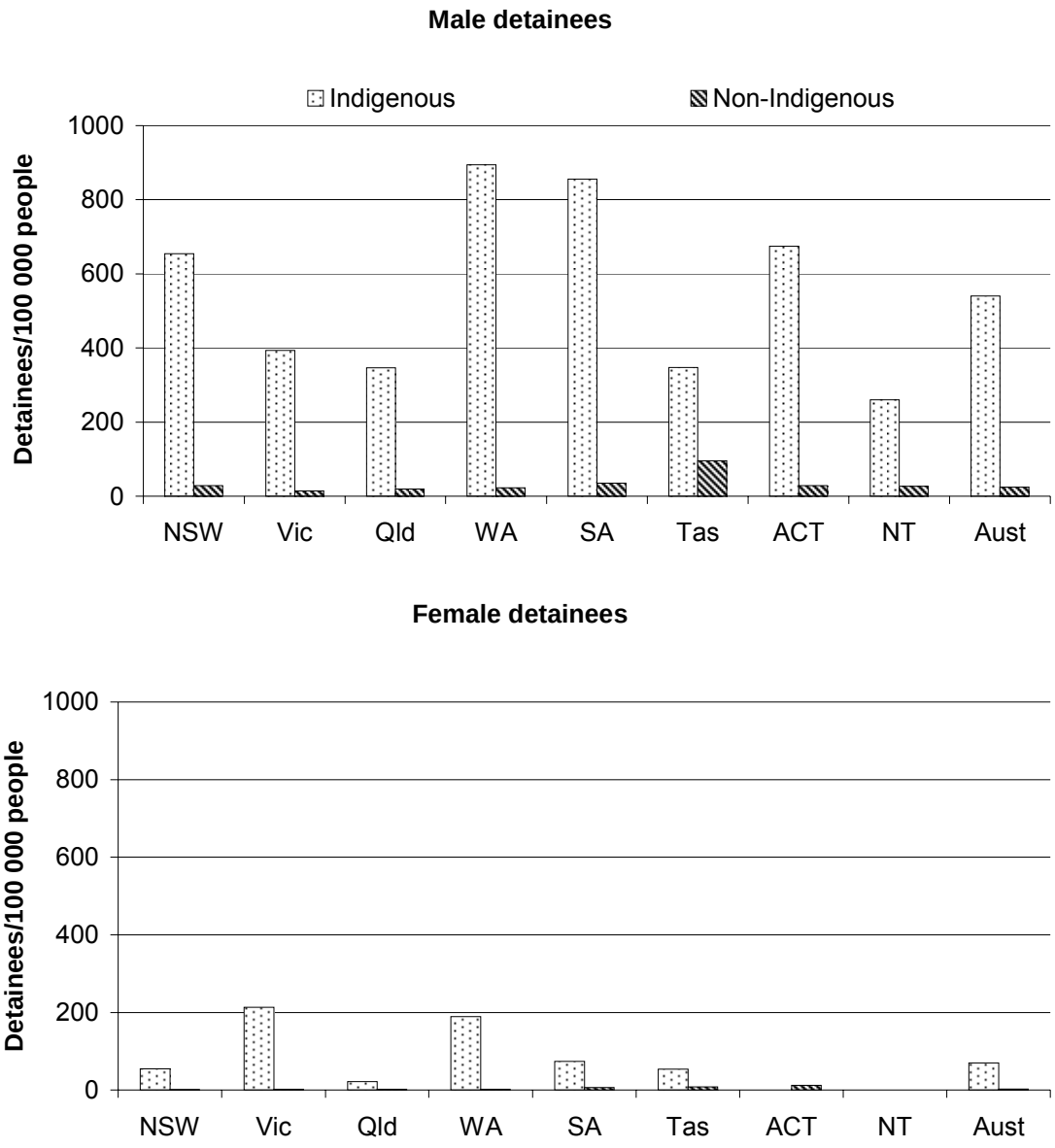
a All data are taken from the census count at 30 June of the relevant year. **b** Indigenous rates were calculated using high series population data (ABS Cat. no. 3238.0). Any variation in derived rates may be due to the assumptions and limitations of the base population data.

Source: Taylor (2006); table 3A.12.17.

- Figure 3.12.4 shows that from 2001 to 2005 Indigenous juveniles were much more likely than non-Indigenous juveniles to be in detention. In 2005, Indigenous juveniles were 23 times as likely to be in detention.
- Although detention rates for both Indigenous and non-Indigenous juveniles fluctuated between 2001 and 2005, the gap between Indigenous and non-Indigenous detention rates remained large.
- There were 317 Indigenous juveniles in detention and 288 non-Indigenous juveniles in detention at 30 June 2005 (table 3A.12.16). The number of Indigenous juveniles in detention increased from 261 in 2001 while the number of non-Indigenous juveniles in detention decreased from 306 on 30 June 2001.

Juvenile detention rates can be highly variable in states and territories with: small populations of Indigenous people; small numbers of young people in juvenile detention; and/or small numbers of Indigenous people in juvenile detention. This particularly applies in Victoria, Tasmania, the ACT and the NT. Attachment tables 3A.12.16 and 3A.12.17 present the numbers and rates of Indigenous and non-Indigenous juveniles (aged 10–17 years) in detention from 2001 to 2005 by State and Territory.

Figure 3.12.5 **Juvenile detention rates, aged 10–17 years, by gender, 30 June 2005[a]**



a Indigenous rates were calculated using high series population data provided by the ABS (Cat. no. 3238.0). Any variation in derived rates may be due to the assumptions and limitations of the base population data.

Source: Taylor (2006); table 3A.12.19.

- For both Indigenous and non-Indigenous juveniles, males were much more likely to be in detention than females (figure 3.12.5).
- As shown in figure 3.12.5, the rates of Indigenous male and female juvenile detainees per 100 000 people were considerably higher than the detention rates for non-Indigenous males and females in all jurisdictions. Nationally, there were 283 Indigenous males and 34 Indigenous females in juvenile detention on 30 June 2005 (table 3A.12.18).

- Nationally on 30 June 2005, the rate of Indigenous females in juvenile detention was 34.6 times higher than the rate of non-Indigenous females in juvenile detention. Indigenous males were 22.2 times as likely to be in juvenile detention as non-Indigenous males (figure 3.12.5). The ACT and NT had no Indigenous females in detention on 30 June 2005 (table 3A.12.18).

To accompany figure 3.12.5, tables 3A.12.18 and 3A.12.19 present the numbers and rates of Indigenous and non-Indigenous juveniles (aged 10–17 years) in detention from 2001 to 2005 by State and Territory and sex.

The numbers and rates of juveniles in detention, by age category, are shown in tables 3A.12.20 and 3A.12.21, respectively. Data on the proportion of juveniles who were in detention and under sentence (as opposed to being on remand) on 30 June 2005 are available in table 3A.12.22, while data on the number of people in juvenile detention (all ages) are available from table 3A.12.23.

3.13 Future directions in data

3.1 Life expectancy at birth

The ABS is working with registrars in each State and Territory to progressively improve the quality of mortality data for Indigenous people by improving the quality of Indigenous identification in death registrations. Indigenous mortality data provide the basis for calculating Indigenous life expectancy estimates. A further enhancement of Indigenous life expectancy estimates would be the development of health adjusted life expectancy, where healthy life expectancy is estimated (by subtracting later years of life affected by disability and the burden of disease).

3.2 Disability and chronic disease

The ABS included a disability related 'core activity need for assistance' question in the 2006 Census, which will provide a useful source of both national and small area data on Indigenous and non-Indigenous people with a need for assistance in core activities.

A new Indigenous disability network has been proposed, to promote better understanding of disability among Indigenous peoples, consultation among those responsible for service design and delivery, and cross-border coordination in some areas of Australia. The new network should provide advice to the AIHW and the ABS on Indigenous disability data collection.

3.3 Years 10 and 12 retention and attainment

Improving reporting of year 10 and 12 completion rates is important for obtaining nationally comparable data for future reports.

3.5 and 3.6 Labour force participation, unemployment and income

In addition to the five-yearly Census, the ABS program of ongoing Indigenous specific surveys provides labour (including CDEP) and income data on a three-yearly cycle, including the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the National Aboriginal and Torres Strait Islander Social Survey (NATSISS). Additional annual estimates of Indigenous labour force data over the period 2002 to 2005 are also available, which were compiled from the monthly Labour Force Survey (see ABS 2005). Data from the 2006 Census will provide much detailed, high quantity labour force and income data for the next Report.

Future Reports will need to reflect the recent changes to CDEP arrangements noted in this section.

3.9 Substantiated child abuse and neglect

Substantiated child protection notifications data have been used to give an insight into the prevalence of child abuse and neglect, and more specifically, the extent of sexual abuse. Even as a proxy indicator of abuse and neglect, it is acknowledged that the substantiated child protection data do not adequately address the issue. More work is required on developing data to report on the prevalence of child abuse and neglect, particularly sexual abuse.

Often children at risk of child abuse or neglect are in an environment where family violence is prevalent. Data on family and community violence provides information on the extent of children at risk of child abuse or neglect. The National Information Development Plan for Crime and Justice Statistics (ABS Cat. no. 4520.0) has prioritised the development of statistics on family and domestic violence for all people, including Indigenous people. The ABS/AIHW Family and Domestic Violence Statistics Working Group (FDVWG) was established to recommend strategies to improve the range, availability and quality of family violence statistical information in the health and welfare and crime and justice fields. Progress by the working group includes a report examining key national data sources (AIHW 2006b). A project has commenced to develop a conceptual framework for domestic and family violence statistics.

3.11 Family and community violence

The National Information Development Plan for Crime and Justice Statistics (ABS Cat. no. 4520.0) has prioritised the development of statistics on family and domestic violence for all people, including Indigenous people. The ABS/AIHW Family and Domestic Violence Statistics Working Group was established to recommend strategies to improve the range, availability and quality of family violence statistical information in the health and welfare and crime and justice fields. Progress by the working group includes a report examining key national data sources (AIHW 2006). A project has commenced to develop a conceptual framework for domestic and family violence statistics.

The ABS National Centre for Crime & Justice Statistics is working with the National Criminal Courts Statistics Unit Advisory Group to collect and publish nationally comparable crime victimisation data and data on the relationship between victims and perpetrators, by Indigenous status. This should help generate more comparable information in future years.

3.14 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 3A.3.2 is table 2 in the attachment tables for section 3.3). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

3.1 Life expectancy at birth

Table 3A.1.1	Estimated life expectancies at birth (years)
Table 3A.1.2	Median age at death, NSW, Queensland, WA, SA, NT, 2000–2005
Table 3A.1.3	Causes of death by Indigenous status, Qld, WA, SA and the NT, 2001–2005

3.2 Disability and chronic disease

Table 3A.2.1	Age standardised rates of people with selected long term conditions, by type of condition and Indigenous status, Australia, 2001 and 2004-05
Table 3A.2.2	Rates of people with selected long term conditions, by age and Indigenous status, Australia, 2004-05

3.6 Household and individual income

3.7 Home ownership

3.8 Suicide and self-harm

3.11 Family and community violence

Table 3A.12.19 Juvenile detention rate per 100 000 people aged 10–17 years, by gender

Table 3A.12.20 Number of people in juvenile detention, by age

Table 3A.12.21 Juvenile detention rate per 100 000, by age

Table 3A.12.22 Sentenced people aged 10–17 years as a percentage of total detainees

Table 3A.12.23 Number of people in juvenile detention (all ages)

3.15 References

3.1 Life expectancy at birth

ABS (Australian Bureau of Statistics) 2004a *Deaths Australia 2003*, Cat. no. 3302.0, Canberra.

——2004b, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians 30 June 1991 to 30 June 2009*, Cat. no. 3238.0, Canberra.

——2006, *Deaths Australia 2005*, Cat. no. 3302.0, Canberra.

Becker, G., Philipson, P. and Soares, G. 2003, *The Quantity and Quality of Life and the Evolution of World Inequality*, http://economics.uchicago.edu/download/BPS-AER_final_version-06-17.pdf (accessed 12 March 2005).

Carson, B., Dunbar, T., Chenhall, R. and Baillie, R. 2007, *Social Determinants of Indigenous Health*, Allen and Unwin, Sydney.

Condon, J.R., Barnes, T., Cunningham, J. and Smith L. 2004, 'Improvements in Indigenous mortality in the Northern Territory over four decades, *Australian and New Zealand Journal of Public Health*, vol. 28, no. 5, pp. 445–51.

Wilson, T., Condon, J. and Barnes, T. 2007, 'Northern Territory Indigenous life expectancy improvements, 1967–2004', in *Australian and New Zealand Journal of Public Health*, vol. 31, no. 2, pp. 184–188.

3.2 Disability and chronic disease

ABS (Australian Bureau of Statistics) 2004, *National Aboriginal and Torres Strait Islander Social Survey, 2002*, Cat. no. 4714.0, Canberra.

—— 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0, Canberra.

—— and AIHW (Australian Institute of Health and Welfare) 2005, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, ABS Cat. no. 4704.0, AIHW Cat. no. IHW 14, Canberra.

AIHW (Australian Institute of Health and Welfare) 2006, *Chronic Diseases and Associated Risk Factors in Australia*, Cat no. PHE 81, Canberra.

—— and DHFS (Department of Health and Family Services) 1998, *Indigenous Disability Data, Current and Future Prospects*, Canberra.

Carson, B., Dunbar, T., Chenhall, R. and Bailie, R. 2007, *Social Determinants of Indigenous Health*, Allen and Unwin, Sydney.

3.3 Years 10 and 12 retention and attainment

ABS (Australian Bureau of Statistics) 2007, *Schools Australia 2006*, Cat. no. 4221.0, Canberra.

ACER (Australian Council for Educational Research) 2003, *Patterns of Participation in Year 12*, Research Report 33, Victoria.

—— 2004a, *The Case for Change: A Review of Contemporary Research in Indigenous Education Outcomes*, Victoria.

—— 2004b, *Engaging Indigenous Students at School: An Evaluation of the Deadly Vibe Magazine*, Victoria.

Barnett, W.S. 1993, 'Benefit-cost analysis of preschool education: findings from a 25-year follow-up', *American Journal of Orthopsychiatry*, vol. 63(4), pp. 500–508.

Buckskin, P. 2000, Achieving Educational Equality for Indigenous Australians: a pathway of hope, paper presented at the 2000 Curriculum Corporation Seventh National Conference, Curriculum Corporation (Australia), Carlton South, Victoria, http://www.curriculum.edu.au/conference/papers/buckskin.pdf (accessed 1 August 2003).

Clontarf Foundation 2006, *Information Memorandum*, Western Australia, http://www.clontarffootball.com/ (accessed 16 February 2007).

DEST (Department of Education, Science and Training) 2002, *National Report to Parliament on Indigenous Education and Training 2001*, Canberra.

—— 2005, *National Report to Parliament on Indigenous Education and Training 2003*, Canberra.

—— 2006, *National Report to Parliament on Indigenous Education and Training 2004*, Canberra.

Dusseldorp Skills Forum 2006, *How Young People are Faring 2006: An Update about the Learning and Work Situation of Young Australians,* Dusseldorp Skills Forum, Glebe.

Long, M. 2006, *The Flipside of Gen Y: Social Background and Full-time Engagement, Personal and Financial stress, Social Inclusion, Satisfaction with Life*, ACER (Australian Council for Educational Research) Centre for the Economics of Education and Training, Melbourne.

MacKenzie, D.L. 2002, 'Reducing the criminal activities of known offenders and delinquents: Crime prevention in the courts and corrections', in L.W. Sherman, D.P. Farrington, B.C. Welsh and D.L. MacKenzie (eds), *Evidence-Based Crime Prevention*, Routledge, London, pp. 330–404.

Maguin, M. and Loeber, R. 1996, 'Academic performance and delinquency,' in M. Tonry, (ed), *Crime and Justice: An Annual Review of Research*, vol. 20, The University of Chicago Press, Chicago, pp. 145–264.

OECD (Organisation for Economic Co-operation and Development) 2004, *Learning for Tomorrow's World — First Results from PISA 2003*, France.

—— 2005, *Education at a Glance*, France.

Ou, S., and Reynolds, A.J. 2004, 'Preschool education and school completion', in Tremblay, R.E., Barr, R.G. and Peters, R.DeV. (eds), *Encyclopaedia on Early Childhood Development*, Montreal, Centre of Excellence for Early Childhood Development, http://www.excellence-earlychildhood.ca/documents/Ou-ReynoldsANGxp.pdf (accessed 2 November 2006).

Reynolds, A.J., Temple, J.A., Robertson, D.L. and Mann, E.A. 2001, 'Long-term effects of an early childhood intervention on educational achievement and juvenile arrest — a 15-year follow-up of low-income children in public schools', *Journal of the American Medical Association*, vol. 285, pp. 2339–2346.

Reynolds, A.J., Temple, J.A., Robertson, D.L. and Mann, E.A. 2002, 'Age 21 cost-benefit analysis of the Title I Chicago Child-Parent Centers', *Educational Evaluation and Policy Analysis 2002*, vol. 24(4), pp. 267–303.

Schweinhart, L.J. 2005, *The High/Scope Perry Preschool Study Through Age 40 Summary, Conclusions, and Frequently Asked Questions*, Ypsilanti, High/Scope Press.

Weatherburn, D., Snowball, L. and Hunter, B. 2006, *The Economic and Social Factors Underpinning Indigenous Contact with the Justice System: Results from the 2002 NATSISS Survey*, Contemporary Issues in Crime and Justice Bulletin no. 104, New South Wales Bureau of Crime Statistics and Research, Sydney.

WHO (World Health Organisation) 1986, *Ottawa Charter for Health Promotion*, First International Conference on Health Promotion, Ottawa,

http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf (accessed 2 November 2006).

Zubrick, S.R., Silburn, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Dalby, R.B., Mitrou, F.G., Lawrence, D.M., Hayward, C., Pearson, G., Milroy, H., Milroy, J. and Cox, A. 2006, *The Western Australian Aboriginal Child Health Survey: Improving the Educational Experiences of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

3.4 Post secondary education — participation and attainment

ACER (Australian Council for Educational Research) 2002, *Education Participation and Outcomes by Geographic Location*, Research Report 26, Victoria.

ANTA (Australian National Training Authority) 2005, *Annual National Report 2004*, Brisbane.

Buckskin, P. 2001, Improving pathways outcomes for young Indigenous Australians, paper presented at the 2001 ACER Research Conference 'Understanding Youth Pathways: What does the Research tell us?', Melbourne, 15–16 October 2001.

Callan, V. and Gardner, J. 2005, *Vocational Education and Training Provision and Recidivism in Queensland Correctional Institutions*, NCVER, Adelaide.

Dusseldorp Skills Forum 2006, *How Young People are Faring 2006: An Update about the Learning and Work Situation of Young Australians,* Dusseldorp Skills Forum, Glebe.

Gelade. S. and Stehlik, T. 2004, *Exploring Locality: The Impact of Context on Indigenous Vocational Education and Training Aspiration and Outcomes*, NCVER, Adelaide.

Marks, G. 2006, *The Transition to Full-Time Work of Young People who do not go to University*, Longitudinal Surveys of Australian Youth (LSAY) Research Report 49, ACER, Victoria.

NCVER (National Centre for Vocational Education Research) 2005, *Australian Vocational Education and Training Statistics: Indigenous Australians' Training Experiences 2004 — First Finding*, Adelaide.

—— 2006a, *Australian Vocational Education and Training Statistics: Students and Courses 2005*, Adelaide.

—— 2006b, *Australian Vocational Education and Training Statistics: Student Outcomes 2006*, Adelaide.

O'Callaghan, K. 2005, *Indigenous Vocational Education and Training: At a Glance*, NCVER, Adelaide.

OECD (Organisation for Economic Co-operation and Development) 2004, *Learning for Tomorrow's World — First Results from PISA 2003*, France.

Saunders, J., Jones, M., Bowman, K., Loveder, P. and Brooks, L. 2003, *Indigenous People in Vocational Education and Training: A Statistical Review of Progress*, NCVER, Adelaide.

Wolfe, B. and Haveman, R. 2001, 'Accounting for the social and non-market benefits of education', in Helliwell, J. (ed.), *The Contribution of Human and Social Capital to Sustained Economic Growth and Well-Being*, OECD and Human Resources Development Canada, University of British Columbia Press, Vancouver.

Zubrick, S.R., Silburn, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Dalby, R.B., Mitrou, F.G., Lawrence, D.M., Hayward, C., Pearson, G., Milroy, H., Milroy, J. and Cox, A. 2006, *The Western Australian Aboriginal Child Health Survey: Improving the Educational Experiences of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

3.5 Labour force participation and unemployment

ABS (Australian Bureau of Statistics) 2001, 'Unemployment trends and patterns', in *Australian Social Trends 2001*, Cat. no. 4102.0, ABS, Canberra.

—— 2002, *Year Book Australia 2002,* no. 84, Cat. no. 1301.0, Canberra.

—— 2005, *Labour Force Characteristics of Aboriginal and Torres Strait Islander Australians, Experimental Estimates from the Labour Force Survey, 2005,* Cat. no. 6287.0, Canberra.

—— 2006, *Year Book Australia 2006,* no. 88, Cat. no. 1301.0, Canberra.

Altman, J., Buchanan, G., and Biddle, N. 2006, 'The real 'real' economy in remote Australia', In Hunter, B. (ed.) *Assessing the Evidence on Indigenous Socioeconomic Outcomes: A Focus on the 2002 NATSISS*, Research Monograph no. 26, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra, pp. 139–152.

ATSIC (Aboriginal and Torres Strait Islander Commission) 1994, *Annual Report 1993-94*, Canberra.

—— 2003, *Annual Report 2003-04*, Canberra.

Hunter, B. and Gray, M. 1999, *Further Investigations into Indigenous Labour Supply: What Discourages Discouraged Workers?* Working paper no. 2, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

DEWR (Department of Employment and Work Relations) 2005, *Annual Report 2005-05*, Canberra, http://www.annualreport.dewrsb.gov.au/2005/chapter2_3/1404.htm (accessed 17 February 2007).

—— 2006, *Indigenous Potential Meets Economic Opportunity,* Discussion Paper, Canberra.

3.6 Household and individual income

ABS (Australian Bureau of Statistics) 2003, *Household Income and Income Distribution, Australia, 2000-01*, Cat. no. 6523.0, Canberra.

—— 2004, *National Aboriginal and Torres Strait Islander Social Survey 2002,* Cat. no. 4714.0, Canberra.

—— 2006, *Measuring Australia's Progress*, Cat. no. 1370.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2004, *Australia's Health 2004*, Canberra.

Daly, A. and Smith, D. 1995, *The Economic Status of Indigenous Australian Families*, Discussion Paper no. 93, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Gray, A. (ed) 1990, *A Matter of Life and Death: Contemporary Aboriginal Mortality*, Aboriginal Studies Press, Canberra.

Hunter, B.H., Kennedy, S. and Smith, D. 2003, 'Household consumption, equivalence scales and the reliability of income distributions: some evidence for Indigenous and other Australians', *Economic Record*, vol. 79 (244), pp. 70–83.

3.7 Home ownership

AIHW (Australian Institute of Health and Welfare) 2005, *Indigenous Housing Indicators 2003-04*, Cat. no. HOU 127, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2005, *Overcoming Indigenous Disadvantage: Key Indicators 2005*, Productivity Commission, Canberra.

—— 2007, *Report on Government Services 2007*, Productivity Commission, Canberra.

3.8 Suicide and self-harm

Baird, L., Mick-Ramsamy, L. and Percy, F. 1998, *Yarrabah Community Multi-purpose Primary Health Care Service Feasibility Study: Final Report*. Yarrabah Health Council, Yarrabah.

Clapham, K. 2004, *Injury Prevention Activity Among Aboriginal and Torres Strait Islander Peoples, Volume II: Programs, Projects and Actions*, Department of Health and Ageing, Canberra, pp. 68–72, 126–7

Elliott-Farrelly T. 2004, 'Australian Aboriginal suicide: the need for an Aboriginal suicidology?', *Australian e-Journal for Advancement of Mental Health* 3(3), http://www.auseinet.com/journal/vol3iss3/elliottfarrelly.pdf (accessed 8 April 2005).

Hunter, E. 1993, *Aboriginal Health and History: Power and Prejudice in Remote Australia*, Cambridge University Press, Melbourne.

Hunter, E. and Harvey, D. 2002, 'Indigenous suicide in Australia, New Zealand, Canada and the United States', *Emergency Medicine*, vol. 14 (1), pp.14–23.

Hunter, E., Reser, J., Baird, M. and Reser, P. 2001, *An Analysis of Suicide in Indigenous Communities of North Queensland: the Historical, Cultural and Symbolic Landscape*, Commonwealth Department of Health and Aged Care, Canberra.

Measey, M.L., Li, S.Q., Parker, R. and Wang, Z. 2006, 'Suicide in the Northern Territory, 1981–2002', *Medical Journal of Australia*, vol. 185 (6), pp. 315–9.

Mitchell, P. 2000, 'Yarrabah, a success story in community empowerment', *Youth Suicide Prevention Bulletin No. 4*, Australian Institute of Family Studies, http://www.aifs.gov.au/institute/pubs/ysp/bulletin4.pdf (accessed 5 January 2006).

Mitchell, S. (ed.) 2005, *Mental Health and Wellbeing: Small Grants Storybook*, Adelaide: The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet), pp. 16–18.

Parker, R. and Ben-Tovim, D.I. 2001, 'A study of factors affecting suicide in Aboriginal and 'other' population in the Top End of the Northern Territory through an audit of coronial records', *Australian and New Zealand Journal of Psychiatry*, vol. 36(3), pp.404–410.

Reser, J.P. 1991, 'Aboriginal mental health: conflicting cultural perspectives', cited in Elliott-Farrelly T. 2004, 'Australian Aboriginal suicide: the need for an Aboriginal suicidology?', *Australian e-Journal for Advancement of Mental Health* 3(3), http://www.auseinet.com/journal/vol3iss3/elliottfarrelly.pdf (accessed 8 April 2005).

Swan, P. and Raphael, B. 1995, *Ways Forward, National Aboriginal and Torres Strait Islander Mental Health Policy, National Consultancy Report*, AGPS, Canberra.

Tatz, C. 1999, *Aboriginal Suicide is Different — Aboriginal Youth Suicide in New South Wales, the Australian Capital Territory and New Zealand: Towards a Model of Explanation and Alleviation*, Criminology Research Council, http://www.aic.gov.au/crc/reports/tatz/ (accessed on 8 April, 2005)

Vicary, D. and Westerman, T. 2004, 'That's just the way he is: some implications of Aboriginal mental health beliefs', *Australian e-Journal for the Advancement of Mental Health*, vol. 3, issue 3, www.auseinet.com/journal/vol3iss3/vicarywesterman.pdf (accessed 27 October 2006).

3.9 Substantiated child abuse and neglect

Abbott, T. 2006, 'Speech notes for the launch of *Australia's Health 2006*', at the Australian Institute of Health and Welfare Conference, Canberra, 21 June.

ACSAT (Aboriginal Child Sexual Assault Taskforce) 2006, *Breaking the Silence: Creating the Future: Addressing Child Sexual Assault in Aboriginal Communities in NSW*, Attorney General's Department, ecoDesign ecoPrint, Sydney.

AIHW (Australian Institute of Health and Welfare) 2006a, *Child Protection Australia 2004-05*, Cat. no. CWS-24, Canberra.

—— 2006b, *Family Violence Among Aboriginal and Torres Strait Islander Peoples*, Cat. no. IHW 17, Canberra.

Atkinson, J. 1996, 'A nation is not conquered', *Aboriginal Law Bulletin*, vol. 3, no. 80, pp. 4–6.

Clapham, K., Stevenson, M. and Lo, S.K. 2006, 'Injury profiles of Indigenous and non-Indigenous people in New South Wales', *The Medical Journal of Australia*, vol. 184, no. 5, pp. 217-220.

Coorey, L. 2001, *Child Sexual Abuse in Rural and Remote Australian Indigenous Communities: A Preliminary Investigation*, Report tabled to the Senate Select Committee on the Administration of Indigenous Affairs on its Inquiry into the Administration of Indigenous Affairs, http://www.aph.gov.au/Senate/committee/indigenousaffairs_ctte/hearings/lyla_coorey_report_march05.pdf (accessed 2 November 2006).

Dunne, M., Adams, M., Lang, C. and DeKretser, D. 2006, Silence by Men about Early Trauma: Undisclosed Child Sexual Abuse of Indigenous Australian Males, paper presented at the International Congress on Child Abuse and Neglect, York, United Kingdom, 3-6 September.

Gordon, S., Hallahan, K., Henry, D. 2002, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, Department of Premier and Cabinet, Western Australia.

Keel, M. 2004, *Family Violence and Sexual Assault in Indigenous Communities*, Australian Institute of Family Studies, Australian Centre for the Study of Sexual Assault, Briefing no. 4, Melbourne.

Lawrence, C. 2006, 'A national disgrace: violence against women and children in Indigenous communities', *Aboriginal and Islander Health Worker Journal*, vol.30, no.5, pp. 29, 32-33.

Libesman, T. 2004, *Child Welfare Approaches for Indigenous Communities: International Perspectives*, National Child Protection Clearing House, no. 20 Autumn 2004, Australian Institute of Family Studies, Melbourne.

Matthews, J. 1997, 'Historical, social and biological understanding is needed to improve Aboriginal health', Recent Advances in Microbiology, vol. 5, pp. 257–334.

Memmott, P., Stacy, R., Chambers, C., and Keys, C. 2001, *Violence in Indigenous Communities*, Crime Prevention Branch, Commonwealth Attorney-General's Department, Canberra.

NCHECR (National Centre in HIV Epidemiology and Clinical Research) 2006, *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia, Annual Surveillance Report 2006*, NCHECR, The University of New South Wales and AIHW, Sydney.

NT (Northern Territory Government) 2006, Inquiry into the Protection of Aboriginal Children from Sexual Abuse, http://www.nt.gov.au/dcm/inquirysaac/members.html (accessed 2 November 2006).

Robertson, B. 2000, *The Aboriginal and Torres Strait Islander Women's Task Force on Violence Report*, Queensland Department of Aboriginal and Torres Strait Islander Policy and Development, Brisbane.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2007, *Report on Government Services 2007,* Productivity Commission, Canberra.

SNAICC (Secretariat of National Aboriginal and Islander Child Care) 2004, *Research Priorities for Indigenous Children & Youth*, Melbourne.

—— 2005, *Through Young Black Eyes: A Handbook to Protect Indigenous Children from the Impact of Family Violence and Child Abuse*, 2nd edn, Australian Government Department of Family and Community Services (FaCS), Melbourne.

Stanley, F. 2005, The linking of records and analysis of population data for epidemiological and public health research, Transcript of lecture to Queensland Conservatorium, Griffith University, http://www.aracy.org.au/pdf/presentations/2006_griffithlecture05transcript.pdf (accessed 2 November 2006).

Stanley, J. 2003, Child sexual abuse in Indigenous communities, paper presented at the Child Sexual Abuse: Justice Response or Alternative Resolution Conference, Adelaide,. 1-2 May.

Stanley, J., Kovacs, K., Cripps, K. and Tomison, A.M. 2002, *Child Abuse and Family Violence in Aboriginal Communities: Exploring Child Sexual Abuse in Western Australia*, Report for the Western Australian Government Inquiry into Responses by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities, Australian Institute of Family Studies, Melbourne.

Stanley, J., Tomison, A. and Pocock, J. 2003, *Child Abuse and Neglect in Indigenous Australian Communities*, Australian Institute of Family Studies, Child Abuse Prevention Issues, no. 19, Melbourne.

Department of Communities (Office for Aboriginal and Torres Strait Islander Partnerships) 2006, *Partnerships Queensland Baseline Report, 2006*, Brisbane.

UN (United Nations) 2006, *Study on Violence against Children*, Office of the United Nations High Commissioner for Human Rights, http://www.ohchr.org/english/bodies/crc/docs/study/SGSVAC.pdf (accessed 2 November 2006).

UNICEF Innocenti Research Centre 2004, *Ensuring the Rights of Indigenous Children*, Innocenti Digest no. 11, Florence.

3.10 Deaths from homicide and hospitalisations for assault

Aboriginal and Torres Strait Islander Social Justice Commissioner 2006, *Ending Family Violence and Abuse in Aboriginal and Torres Strait Islander Communities*, HREOC, Canberra, http://www.hreoc.gov.au/Social_Justice/familyviolence/index.html (accessed 24 October 2006).

ABS (Australian Bureau of Statistics) 2004, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2009*, Cat. no. 3238.0, Canberra.

AIC (Australian Institute of Criminology) 1993, Tangentyere Night Patrol, in Prevention Awards 1993, Australian Institute of Criminology, Canberra, pp. 34–42.

Bolger, A. 1991, *Aboriginal Women and Violence,* Australian National University, North Australia Unit, Darwin, NT.

Gordon, S., Hallahan, K., Henry, D. 2002, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, Department of Premier and Cabinet, Western Australia.

Martin, D.F. 1992, 'Aboriginal and Non-Aboriginal Homicides: Same but Different', in *Homicides: Patterns, Prevention and Control*, Proceedings of Conference 12–14 May, Australian Institute of Criminology, Canberra, pp. 167–176.

Memmott, P., Stacy, R., Chambers, C., and Keys, C. 2001, *Violence in Indigenous Communities,* Attorney General's Department, Canberra, in association with Aboriginal Environments Research Centre, University of Queensland (http://www.ncp.gov.au/agd/WWW/ncphome.nsf/Page/Publications_All_Publications_Family_Violence).

Mouzos, J. 2001, *Indigenous and Non-Indigenous Homicides in Australia: A Comparative Analysis,* Trends and Issues in Crime and Criminal Justice, June 2001, Australian Institute of Criminology, Canberra.

NHMRC (National Health and Medical Research Council) 2002, *Report on a Review of Literature on the Epidemiology of Violence in Rural and Remote Australia and Resources to the Management of Violence*, Canberra, http://www.nhmrc.gov.au/publications/_files/hp16lit.pdf (accessed 24 October 2006).

National Research Council 1998, *Violence in Families, Assessing Prevention and Treatment Programs*, Chalk, R. and King, P. (eds), Washington, D.C.

Robertson, B. 2000, *The Aboriginal and Torres Strait Islander Women's Task Force on Violence Report*, Department of Aboriginal and Torres Strait Islander Policy and Development, Queensland.

3.11 Family and community violence

ABS (Australian Bureau of Statistics) 2004, *National Aboriginal and Torres Strait Islander Social Survey, 2002*, Cat. no. 4714.0, Canberra.

—— 2006, *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2005, *Female SAAP Clients and Children Escaping Domestic and Family Violence 2003-04*, Bulletin, Issue 30 September, Canberra.

—— 2006, *Family Violence Among Aboriginal and Torres Strait Islander Peoples*, Cat. no. IHW 17, Canberra.

Clapham, K., Stevenson, M. and Lo, S.K. 2006, 'Injury profiles of Indigenous and non-Indigenous people in New South Wales', *The Medical Journal of Australia*, vol. 184, no. 5, pp. 217–220.

Cummings, E. 2005, 'Empowering Families in Remote Indigenous Communities to Deal with Social Issues', paper presented at the Indigenous Service Delivery Outcomes: Applying Principles of the New National Framework Conference, Darwin, 22–23 March.

Goddard, C.R. and Hiller, P.C. 1992, *Tracking Physical and Sexual Abuse Cases from a Hospital Setting into Victoria's Criminal Justice and Child Protection Systems: A Report for the Victorian Law Foundation*, Department of Social Work and Department of Anthropology and Sociology, Monash University, Melbourne.

Gordon, S., Hallahan, K., Henry, D. 2002, *Putting the Picture Together: Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, Department of Premier and Cabinet, Western Australia.

HREOC (Human Rights and Equal Opportunity Commission) 2006, *Ending Family Violence and Abuse in Aboriginal and Torres Strait Islander Communities – Key Issues*, Sydney.

Homel, R., Freiberg, K., Lamb, C., Leech, M., Batchelor, S., Carr, A., Hay, I., Teague R., and Elias, G. 2006, *The Pathways to Prevention Project: Doing Developmental Prevention in a Disadvantaged Community*, Trends and Issues in Crime and Criminal Justice, No. 323, Australian Institute of Criminology, Canberra.

Macdonald, H. 2001, 'Defining 'domestic violence' and 'homelessness'', *Parity (supplement)*, vol. 14, pp. 15–16.

Matthews, J. 1997, 'Historical, social and biological understanding is needed to improve Aboriginal health', *Recent Advances in Microbiology*, vol. 5, pp 257–334.

MCATSIA (Ministerial Council for Aboriginal and Torres Strait Islander Affairs) 2006, *Bringing Them Home: A Report on the Economic and Social Characteristics of those Affected by Past Practices of Forcible Removal of Children*, Department of Indigenous Affairs, Perth.

Memmott, P., Stacy, R., Chambers, C., and Keys, C. 2001, *Violence in Indigenous Communities,* Attorney-General's Department and the Aboriginal Environments Research Centre, Canberra.

Mouzos, J. 2001, *Indigenous and Non-Indigenous Homicides in Australia: A Comparative Analysis,* Trends and Issues in Crime and Criminal Justice, No. 210, Australian Institute of Criminology, Canberra.

Mouzos, J. and Makkai, T. 2004, *Women's Experiences of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)*, Australian Institute of Criminology, Canberra.

NHMRC (National Health and Medical Research Council) 2002, *Report on a Review of Literature on the Epidemiology of Violence in Rural and Remote Australia and Resources to the Management of Violence*, Canberra.

Putt, J. and Delahunty, B. 2006, *Illicit Drug Use in Rural and Remote Indigenous Communities*, Trends and Issues in Crime and Criminal Justice, No. 322, Australian Institute of Criminology, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2005, *Overcoming Indigenous Disadvantage: Key Indicators 2005*, Productivity Commission, Canberra.

Stanley, F. 2005, The linking of records and analysis of population data for epidemiological and public health research, Transcript of lecture to Queensland Conservatorium, Griffith University, http://www.aracy.org.au/pdf/presentations/2006_griffithlecture05transcript.pdf (accessed 2 November 2006).

Stanley, J. and Goddard, C. 2003, Hearing only half of the story by leaving out half of the violence, paper presented at the Ninth Australasian Conference on Child Abuse & Neglect, Sydney, 24–27 November.

Taft, A.J., Hegarty, K.L. and Feder, G.S. 2006, 'Tackling partner violence in families', *The Medical Journal of Australia*, vol. 185, no. 10, pp. 535–536.

Weatherburn, D., Snowball, L. and Hunter, B. 2006, *The Economic and Social Factors Underpinning Indigenous Contact with the Justice System: Results from the 2002 NATSISS Survey*, Contemporary Issues in Crime and Justice Bulletin no. 104, New South Wales Bureau of Crime Statistics and Research, Sydney.

3.12 Imprisonment and juvenile detention rates

ABS (Australian Bureau of Statistics) 2001, *Population Distribution, Aboriginal and Torres Strait Islander Australians*, Cat. no. 4705.0, Canberra.

—— 2004, *Australian Social Trends, 2004*, Cat. no. 4102.0, Canberra.

—— 2006, *Prisoners in Australia,* Cat. no. 4517.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2006, *Juvenile Justice in Australia, 2000-01 to 2003-04*, Cat. no. JUV1, Canberra.

Charlton, K. and McCall, M. 2004, *Statistics on Juvenile Detention in Australia: 1981-2003*, Technical and Background Paper Series, no. 10, Australian Institute of Criminology, Canberra.

Lynch, M., Buckman, J. and Krenske, L. 2003, *Youth Justice: Criminal Trajectories*, Trends and Issues in Crime and Criminal Justice, no. 265, Australian Institute of Criminology, Canberra.

Office of the Attorney-General (OAG) 2005, *Shepparton Koori Court Gets National Recognition*, Media release, November 10, http://www.dpc.vic.gov.au/domino/Web_Notes/newsmedia.nsf/ (accessed 1 February 2007)

Office of Crime Statistics and Research 2004, *Aboriginal (Nunga) Courts*, Information Bulletin no. 39, Government of SA, Adelaide.

Parker N. and Pathé M. 2006, *Report on the Review of the Murri Court*, State of Queensland, Department of Justice and Attorney-General, Brisbane.

Putt, J., Payne, J. and Milner, L. 2005, *Indigenous Male Offending and Substance Abuse*, Trends and Issues in Crime and Criminal Justice, no. 293, Australian Institute of Criminology, Canberra.

RCIADIC (Royal Commission into Aboriginal Deaths in Custody) 1991, *National Report*, http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/ (accessed 19 June 2003).

Snowball, L. and Weatherburn, D. 2006, *Indigenous Over-Representation in Prison: The Role of Offender Characteristics*, Crime and Justice Bulletin, No. 99, NSW Bureau of Crime Statistics and Research, Sydney.

Taylor, N. 2006, *Juveniles in Detention in Australia, 1981–2005*, Technical and Background Paper, no. 22, Australian Institute of Criminology, Canberra.

WA Department of Justice 2002a, *Strategic Plan for Aboriginal Services, 2002–2005*, Department of Justice, WA.

—— 2002b, *Profile of Women in Prison*, Department of Justice, WA.

Woodward, R. 2003, *Families of Prisoners: Literature Review on Issues and Difficulties*, Occasional Paper no. 10, Australian Government Department of Family and Community Services, Canberra.

4 Strategic areas for action

4.1 The rationale

As explained in chapter 2, the headline indicators reflect the most important long term outcomes for Indigenous people, while the strategic areas for action provide a focus for action by governments and Indigenous people to improve outcomes in the short to medium term.

Evidence and strong logic suggest that targeting government action in the seven strategic areas can help overcome Indigenous disadvantage. The identification of seven strategic areas assists policy makers to focus on the root causes of social and economic disadvantage, so that over time, improvements in the headline indicators can be achieved.

None of the strategic areas is service or agency specific, even though their names may suggest otherwise. For example, although 'Early school engagement and performance (preschool to year 3)' suggests that policy action in the education area is the main focus, education is only one influence on change in that area. Action in a range of other areas is also very important. Housing overcrowding, poor nutrition and hearing impediments are just some of the factors that can affect school attendance and performance.

4.2 Strategic change indicators

For each of the strategic areas for action, a few key indicators have been chosen, based on the selection criteria discussed in chapter 2:

- relevance to priority outcomes
- sensitive to policy interventions and changes in policy settings
- actions in the strategic areas for action result in positive outcomes over time in the headline indicators
- meaningful to stakeholders and principally to the Indigenous community
- supported by strong logic or empirical evidence

- unambiguous and clear in meaning and interpretation
- the existence of, or ease of developing, supporting data sets.

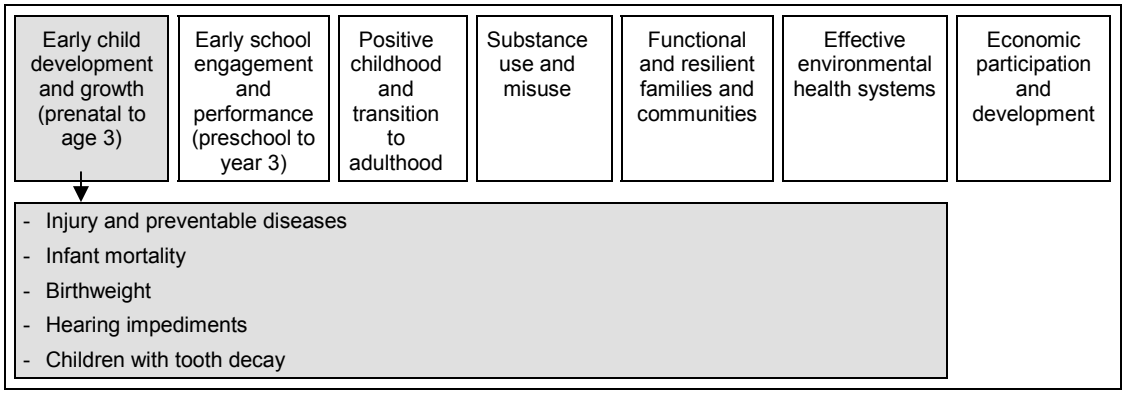
The strategic change indicators reflect the collective efforts of governments, their service delivery agencies and Indigenous people themselves. Most are 'outcome' indicators that measure the actual level of Indigenous disadvantage. Some 'output' indicators, however, are so closely linked to outcomes that they have been included, for example, measures of access to water, sewerage, and primary health care.

Following consultations in 2006, some changes were made to the strategic change indicators included in the 2005 Report. The changes are summarised in chapter 2, and detail on specific indicators is set out in relevant sections of the report.

Although the framework is largely based around reporting statistical data against each indicator, it is not possible to reduce everything that matters to statistics. There are currently no robust statistical measures for key elements of the framework, such as culture and governance. Therefore, the Report includes case studies to illustrate the significance of these elements to overcoming Indigenous disadvantage. Case studies have also been used to supplement statistical reporting for many other indicators across the Report.

5 Early child development and growth

Strategic areas for action



Providing children with a good start in life can have a profound effect on their passage through the life cycle. While options and opportunities in the future can be determined at this early stage, so too can barriers.

Early childhood experiences have a significant influence on health and educational outcomes in later life. Research has shown that health, growth and development in the first three years of life play a crucial role in later outcomes. Brain development is at its greatest to the age of three. Deprivation, stress and neglect in these early years can have significant impacts on later childhood and adult health and educational outcomes (see, for example, McCain and Mustard (1999), and Keating and Hertzman (1999)).

Headline indicators influence, or reflect, the environment in which young children are born and grow up:

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

Early child development and growth can be affected by outcomes in other strategic areas for action including:

- substance use and misuse (alcohol, tobacco, drug and other substance misuse and harm) — chapter 8
- functional and resilient families and communities (access to primary health care, mental health, engagement with service delivery) — chapter 9
- effective environmental health systems (rates of diseases associated with poor environmental health, access to clean water and functional sewerage, overcrowding in housing) — chapter 10
- positive childhood and transition to adulthood (the education of the parents of young children and whether parents have made a good transition from school to work and established themselves well before becoming parents) — chapter 7
- economic participation and development (employment, governance capacity and skills, governance arrangements) — chapter 11

Injury and preventable diseases in early childhood can prove fatal for young children. Even when they are not fatal, they can affect nutrition, growth and mental stimulation at a crucial time when children are developing rapidly. Research has shown that negative stresses in early childhood can adversely affect child development (see McCain and Mustard 1999 for examples). Repeated infections can lead to kidney stones and high blood pressure (DHAC 1999).

Hospitalisation and deaths from injury and preventable diseases are reported in section 5.1.

Infant mortality reflects the most serious outcome of disadvantage and illness during pregnancy and infancy (the first year of life). Infants are growing rapidly and still developing immunity to diseases and are more vulnerable to many illnesses and environmental hazards than older children and adults. Section 5.2 reports on the survival of Indigenous children in their first year of life.

Low birthweight has been shown in several studies to be correlated with coronary heart disease and non-insulin dependent diabetes later in life. Small size and disproportion at birth can indicate lack of nutrients or oxygen during particular stages of pregnancy (see Mackerras 1998; Fall et al. 1995; Barker 1995; Barker et al. 2001). Birthweight is also a key factor affecting neonatal mortality (Sayers and Powers 1997). Section 5.3 examines data relating to babies born to Indigenous mothers.

Hearing impediments in Indigenous children are often the result of recurring ear infections. Chronic ear infections and subsequent hearing loss are generally agreed to impair language development and educational achievement (Bowd (2002); Couzos, Metcalf and Murray (1999); and Smith Mackenzie and Hatcher (1995)

cited in Couzos, Metcalf and Murray (2001)). A recent study found that school attendance rates were much lower for Indigenous children with chronic ear infections when compared with other children (NACCHO 2003).

Hearing impediments in early childhood may not be diagnosed until children begin school and are unable to hear properly in the classroom. Deafness makes learning much more difficult for children throughout their schooling and later life and is a particular problem for children for whom English is not their first language (NTDE 1999). From the results of a large scale survey conducted in 2001 and 2002, Zubrick et al. (2004) found that:

> Recurrent and discharging ear infections, which affected one in eight Aboriginal children in WA, had a very significant impact on rates of hearing loss and on speech, language and learning problems.

Data on hearing impediments are contained in section 5.4.

The indicator of children with tooth decay has been moved from the strategic area 'Early school engagement and performance (preschool to year 3)' in recognition of the importance of good oral health as part of early child development and growth. The level of tooth decay, missing or filled teeth in primary school aged children (where most data are available) reflects diet, dental hygiene and access to treatment in the early years of life. Aboriginal and Torres Strait Islander children suffer from much higher rates of decayed or missing teeth than non-Indigenous children, which can also indicate poor access to, and unmet need for, dental care (AHMAC 2006).

Healthy teeth are an important part of overall good health, as tooth decay causes illness and pain. Other effects can include difficulties chewing and discomfort while eating, as well as impaired speech and language development. Tooth decay can also exacerbate chronic disease, and generate negative psycho-social effects such as embarrassment and social isolation (AHMAC 2006).

Data on tooth decay from school dental services, as well as data on hospitalisations for dental problems are contained in section 5.5.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 5A.1.1). A list of attachment tables is in section 5.7. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

5.1 Injury and preventable diseases

Box 5.1.1 **Key messages**

- In 2004-05, Indigenous children under four were twice as likely to be hospitalised for potentially preventable diseases and injuries than non-Indigenous children (251.0 per 1000 compared to 122.6 per 1000) (table 5.1.1).
- For the period 2001 to 2005, the death rate from external causes and preventable diseases was around five times as high for Indigenous children (from 5.7 to 10.8 per 10 000 population) as for non-Indigenous children (from 1.4 and 2.5 per 10 000 population) in Queensland, WA, SA and the NT (figure 5.1.2).

Since the 2005 Report, this indicator has been changed from 'rates of hospital admission for infectious diseases' to 'injury and preventable diseases'. This reflects comments received during consultations on the 2003 and 2005 Reports that the health of Indigenous children involved more than just infectious diseases. This report covers a wide range of preventable conditions, including infectious diseases, non-infectious diseases and injury (includes injuries caused by transport accidents, other accidents, assault and complications of medical and surgical care).

Until the second half of the 20th century, infectious diseases were a prominent cause of death in Australia. Between 1921 and 1995, age standardised death rates from infectious diseases fell from 185 per 100 000 population to 6 per 100 000 (ABS 1997). In 2005, the death rate from certain infectious and parasitic diseases in Australia (total persons, both Indigenous and non-Indigenous) was 7.8 per 100 000 population (ABS 2007).

Infectious diseases range in severity from minor conditions such as the common cold, to serious illnesses such as meningococcal infection and tuberculosis, which can result in death. Disease is caused by organisms such as bacteria, viruses or parasitic worms, and can be transmitted directly (for example, through droplet infection) between people, or from insects and animals to people. Disease can also be indirectly transmitted (for example, through contaminated food or water) and through the environment. Infection can also result from the pathological growth of organisms already present in a person's body (ABS 1997).

Some infections that may appear minor can have serious longer term health effects. Recurring skin and throat infections (caused by group A streptococcal bacteria) in

some Aboriginal communities are associated with the highest worldwide rates of acute rheumatic fever (Currie and Carapetis 2000).[1]

> the major pathogen of skin infection, group A streptococcus, is also associated with chronic renal failure — a prevalent and highly burdensome condition of Aboriginal adults. (Zubrick *et al.* 2004, p.150)

In Australia, many childhood diseases are generally prevented or successfully treated without requiring hospitalisation. The main focus of this indicator is to examine the range of diseases and injuries experienced by children that result in a hospital admission.

A wide range of social, cultural, physical and economic factors influence the health of children. Health initiatives of communities and governments can assist in the prevention of disease and promote the health of children. These initiatives include education on the benefits of breastfeeding, good nutrition and sanitation, and the provision of adequate housing (see chapter 10 for more information on diseases associated with poor environmental health). Access to effective and appropriate health care services (including dental and immunisation services) can also influence the health of children in both the short and long term. More information on immunisation rates in children and the prevalence of vaccine preventable diseases as well as access to primary health care in general, is included in section 9.3. Section 5.4 includes information on ear infections in children and section 5.5 covers tooth decay in children.

[1] The role of group A streptococcal bacteria (in skin and throat infections) leading to acute rheumatic fever is contentious but it appears likely in Australia that it plays a role. Interventions which aim to reduce group A streptococcal throat and skin infection are likely to reduce the rate of acute rheumatic fever. Acute rheumatic fever is an auto-immune disease initiated by infection with group A streptococcal bacteria. The important of acute rheumatic fever is its major complication, rheumatic heart disease. After an initial episode of acute rheumatic fever, a person is at risk of recurrent episodes, each of which can increase the risk of rheumatic heart disease. Rheumatic heart disease is caused by the damage done to the heart valves during an episode of acute rheumatic fever (ABS and AIHW 2003; Online Medical Dictionary 2005). Acute rheumatic fever and rheumatic heart disease are now rare in populations with good living conditions — optimal hygiene and minimal household overcrowding — and easy access to quality medical care (things that Indigenous people often lack).

Box 5.1.2 'Things that work' — injury and preventable diseases

Jabba Jabba Indigenous Immunisation Program — Sunshine Coast, Queensland

Indigenous vaccination programs in the past have sometimes had limited success, and those most in need and at risk of disease have been most difficult to reach. The Jabba Jabba Indigenous Immunisation program operated initially as a pilot between March 2002 and June 2004 to enable culturally appropriate access for 'hard to reach' sections of the Indigenous community and to provide an entry point to mainstream health services. The program now operates on a permanent basis in recognition of its success in providing Indigenous clients with an entry point to mainstream health services.

The program operates within an Indigenous child and family health model and provides first time vaccinations for children who would otherwise have missed their vaccination schedules. It also provides follow up to children who were long overdue for vaccinations. The program was designed to have a high degree of cultural sensitivity. For example Indigenous health workers assist the nurse immuniser during home visiting. This not only breaks down cultural barriers but also enhances the skills and knowledge of Indigenous health workers. Importantly the community has become aware of other Indigenous services and has shown increased use of those services (Queensland Government and Central Public Health Unit Network Sunshine Coast 2005).

Keeping Kids Healthy Makes a Better World, NT

This program operated in four communities in the Northern Territory: Mt Liebig, Titjikala, Nyirripi and Willowra. Funded by UNICEF, Waltja and the Telstra Foundation, its initial aim was to improve the nutrition of 0–5 year olds, but over time it was used to achieve other outcomes such as engagement in the community, cultural awareness and strength and greater family cohesion, including an emphasis on the role of men.

Program strategies included education, providing better access to healthy foods at the community store, healthy breakfast programs, bush tucker and bush medicine activities with elders, and gardening. The whole community was involved in these activities. Local workers were trained as nutrition workers. Community engagement was an essential element of program design — in the selection of foods to grow and stock, in the development of priorities and in developing activities that achieved program aims. The program itself was developed in response to concerns from the local communities about diet.

Outcomes included decreased numbers of children failing to thrive, increased awareness of the importance of nutrition, better access to healthy foods, decreased incidence of anaemia in children and coordination between community-based agencies such as the clinic, school, store and council. The communities involved continued to focus on better nutrition even after the project came to an end.

(Continued next page)

Box 5.1.2 (continued)

Growth Assessment and Action and Healthy School-Age Kids Programs are now being implemented across all remote communities, supported by the Maternal, Child and Youth Health Team (MCYH), in collaboration with Remote Health and Workforce Support. Comprehensive under-five child health promotion, action planning for children who are not thriving and early identification and treatment of ear infection programs are being developed. Interdivisional collaboration is integrating health and wellbeing assessments and interventions in a 'one-stop shop' approach (NT Government, unpublished).

Team approach to children's nutrition (0 to 5 years) on Tiwi Islands, NT

A new approach to child nutrition on Tiwi Islands started in 2006 built on knowledge that a team approach was the best form of management for child nutrition issues in remote communities. A nutritionist worked with a multidisciplinary team, the crèche and local women to support the nutrition of children aged less than five years. The Tiwi child health strategy became part of routine practice at the health centre to be continued after the nutritionist left. In the first six months of implementation began only one child (who had other complex health issues) had to be sent away for failure to thrive. The outcomes are shared with the Strong Women group (see section 5.3), who are happy with and support the strategy, which has highlighted the importance of child health and growth in the community (NT Government, unpublished).

Box 5.1.2 describes programs to reduce rates of preventable diseases in Indigenous children.

Despite overall improvements in the health of most Australian children, significant inequalities still exist. Hospitalisation data indicate that Indigenous children under age four are hospitalised for injury and preventable diseases at twice the rate of non-Indigenous children of the same age.

Time series data on hospitalisations for injury and preventable diseases are not included in this Report. Definitions of potentially preventable diseases and injury (and the conditions that should be included) are currently being reviewed by national health data committees. The conditions included in table 5.1.1 are based on advice from the AIHW and include conditions that could have potentially been prevented by the provision of appropriate non-hospital health services as well as injuries that could potentially have been prevented (usually outside the health system in broader society). Some of the disease codes included in table 5.1.1 may also include some non-preventable conditions. Once definitions have been agreed it should be possible to provide more precise, as well as time series, data for future Reports.

Table 5.1.1 **Potentially preventable hospitalisations for children aged less than 4 years, Qld, WA, SA, and public hospitals in the NT, 2004-05[a, b, c]**

ICD-10-AM code and description	Hospitalisations (number)			Age specific rate (per 1000 population)	
	Indigenous	Non-Indigenous[d]	Total	Indigenous	Non-Indigenous[d]
Certain infectious and parasitic diseases (A00–B99)	1 731	7 792	9 523	59.8	22.0
Nutritional anaemias (D50–D53) and malnutrition (E40–E46)	104	43	147	3.6	0.1
Diseases of the ear and mastoid process (H60–H95)	303	5 813	6 116	10.5	16.4
Diseases of the respiratory system (J00–J99)	3 416	19 285	22 701	118.1	54.5
Diseases of oral cavity salivary glands and jaws (K00–K14)	297	2 146	2 443	10.3	6.1
Diseases of the skin and subcutaneous tissue (L00–L99)	594	1 273	1 867	20.5	3.6
Injury, poisoning and certain other consequences of external causes (S00–T98)[e]	815	7 003	7 818	28.2	19.8
Transport accidents (V01–V99)[e]	62	286	348	2.1	0.8
Other external causes of accidental injury (W00–X59)[e]	602	6 067	6669	20.8	17.2
Assault (X85–Y09)	73	79	152	2.5	0.2
Complications of medical and surgical care (Y40–Y84)[e]	66	551	617	2.3	1.6
Other[e]	12	20	32	0.4	0.1
Total potentially preventable hospitalisations	**7 260**	**43 355**	**13 063**	**251.0**	**122.6**

[a] Data are based on principal diagnosis as classified by the ICD-10-AM code and description. [b] Data are based on state of usual residence. [c] Age specific rates are as per 1000 people in that age group (based on ABS estimated resident population (ERP)). [d] Hospitalisations where Indigenous status was not stated are included in the non-Indigenous numbers and rates. [e] External causes sub-categories classified by first external cause.

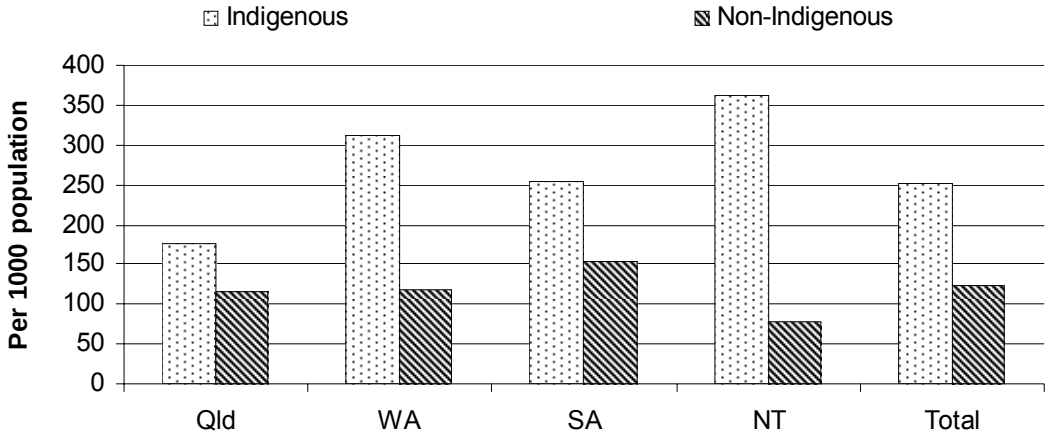
Source: AIHW National Hospital Morbidity Database (unpublished); table 5A.1.1.

- In 2004-05, Indigenous children aged less than four years were twice as likely to be hospitalised for potentially preventable diseases and injuries than non-Indigenous children (251.0 per 1000 compared to 122.6 per 1000) (table 5.1.1).
- Diseases of the respiratory system were the most common cause of potentially preventable hospitalisations for both Indigenous and non-Indigenous children aged less than four years, however the rate for Indigenous children (118.1 per 1000) was twice as high as for non-Indigenous children (54.5 per 1000).
- Indigenous children aged less than four years suffered from nutritional anaemias and malnutrition at 29.6 times the rate for non-Indigenous children (3.6 per 1000 compared to 0.1 per 1000). However, it was the least common potentially

preventable condition for which Indigenous children aged less than four years were hospitalised (104 Indigenous hospitalisations).

- Data on hospitalisations of children aged less than four years for potentially preventable diseases and injuries by state and territory are included in table 5A.1.1.

Figure 5.1.1 **Potentially preventable hospitalisations for children aged less than 4 years, Qld, WA, SA, and public hospitals in the NT, 2004-05[a, b, c, d]**



a Data are based on principal diagnosis as classified by the ICD-10-AM code and description. **b** Data are based on state of usual residence. **c** Age specific rates are as per 1000 people in that age group (based on ABS estimated resident population(ERP)). **d** Hospitalisations where Indigenous status was not stated are included in the non-Indigenous numbers and rates.

Source: AIHW National Hospital Morbidity Database (unpublished); table 5A.1.1.

- Hospitalisations for potentially preventable diseases and injuries were higher for Indigenous than non-Indigenous children aged less than four years in 2004-05 for each of the four states and territories for which data are available (figure 5.1.1).

Results from the Western Australian Aboriginal Child Health Survey (Zubrick et al. 2004) undertaken in 2001 and 2002 are outlined below.

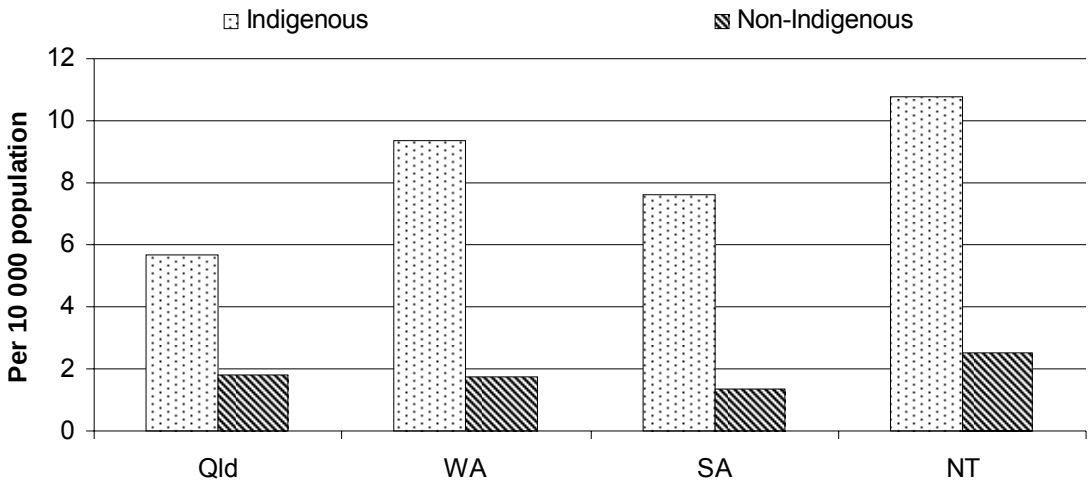
- Recurring chest infections affected 12.3 per cent of Indigenous children aged 0–17 years, with infection rates highest in children aged 0–3 years and lowest in children aged 12–17 years. There was no association between infection rates and levels of relative isolation.[2]

2 Zubrick et al. (2004) used a different series of geographic region (remoteness) categories than the standard ABS categories used elsewhere in this Report and discussed in chapter 2. Both sets of categories are based on the Accessibility Remoteness Index of Australia (ARIA). The ABS

- An estimated 8.5 per cent of Indigenous children had recurring skin infections such as school sores or scabies. Children aged 4–11 years were the most likely to have recurring skin infections. The prevalence was 17.6 per cent in extremely isolated areas, more than twice the rate in all other areas.
- An estimated 5.6 per cent of Indigenous children suffered from recurring gastrointestinal infections, with infection rates twice as high in extremely isolated areas as in other areas. Prevalence decreased significantly after 12 years of age.
- Some 18.1 per cent of Indigenous children had recurring ear infections. Older children aged 12–17 years were significantly less likely to have recurring ear infections (13.6 per cent) than children aged 0–3 years (20.4 per cent) and children aged 4–11 years (19.9 per cent).
- An estimated 9.7 per cent of Indigenous children reported more than one of recurring chest, skin, gastrointestinal and/or ear infections, with 6.9 per cent suffering from two types, 2.3 per cent suffering from three types and 0.5 per cent suffering from all four types. Significantly more children in areas of extreme isolation (17.9 per cent) had more than one type of recurring infection than children in less isolated areas.
- An estimated 16.3 per cent of children in households where their primary carer reported financial strain suffered from more than one type of recurring infection, which was significantly higher than the prevalence in households where the primary carer could 'save a bit now and again' (8.4 per cent) or could 'save a lot' (7.2 per cent). There was no association between the primary carer's educational attainment and either recurring infections or ear infections.

categories are a widely used version known as ARIA+, whereas the version used by Zubrick et al. (2004) is known as ARIA++, which has been designed to allow greater distinction between locations that are all classified as very remote in the ABS ARIA+ version. The five ARIA++ categories used by Zubrick et al. (2004) are called levels of relative isolation and comprise the categories: none (Perth metropolitan area), low, moderate, high and extreme.

Figure 5.1.2 **Deaths from external causes and preventable diseases as a proportion of total population for children aged less than five years, 2001–2005[a, b]**



[a] Data are subject to a degree of uncertainty and apparent differences in life expectancy estimates between jurisdictions may not be statistically significant. [b] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS Causes of Deaths 2005, Cat. no. 3303.0 (unpublished); table 5A.1.4.

- Between 2001–2005, the death rate from external causes and preventable diseases was five times as high for Indigenous children (between 5.7 and 10.8 per 10 000 population) as the rate for non-Indigenous children (between 1.4 and 2.5 per 10 000 population) in Queensland, WA, SA and the NT (the four jurisdictions for which data were available) (figure 5.1.2).

5.2 Infant mortality

Box 5.2.1 **Key message**

Indigenous infant mortality rates in most of the states and territories for which data are available have improved in recent years. Nevertheless, mortality rates for Indigenous infants in these jurisdictions remain two to three times as high as those for the total population of infants (figures 5.2.1 and 5.2.2).

The rate of infant mortality (the number deaths of children under one year of age per 1000 live births)[3] is commonly viewed as an indicator of the general health and wellbeing of a population. A low infant mortality rate is a major contributor to increased life expectancy for a population.

There was a dramatic decline in infant mortality rates in Australia over the 20th century (the rate of infant deaths decreased from 103 deaths per 1000 live births in 1900 to 4.8 deaths per 1000 live births in 2003). During the first half of the 20th century, a significant share of the decline in infant mortality was associated with improvements in public sanitation and health education. By the 1940s, the development of vaccines and mass vaccination programs resulted in further gains. Improved medical technology (including improvements in neonatal intensive care) and education campaigns about the importance of immunisation, and more recently, in the case of sudden infant death syndrome, infant sleeping position, have led to further modest declines in infant deaths in the last half of the century (ABS 1996 and 2004).

The main causes of Indigenous infant deaths are congenital disorders, sudden infant death syndrome, respiratory and cardiovascular disorders, and accidents (ABS 1996).

Box 5.2.2 **'Things that work'— infant mortality**

NSW Aboriginal Maternal and Infant Health Strategy

The NSW Aboriginal Maternal and Infant Health Strategy commenced in 2001. It aims to improve access to culturally appropriate maternity services for Aboriginal mothers, including antenatal visits for pregnant women. The purpose of antenatal visits is to monitor the health of both the mother and baby, provide information, identify antenatal complications and provide appropriate intervention at the earliest time.

In those areas of NSW where the strategy has been implemented, 78 per cent of Aboriginal women had their first antenatal visit before 20 weeks gestation in 2003-04, compared with 64 per cent for these areas in the period 1996–2000 (prior to the strategy).

(Continued next page)

[3] Infant deaths are usually divided into 'neonatal' (occurring in the first 28 days after birth (0–27 days)) and 'postneonatal' periods (those occurring in the remainder of the first year (28 days to 364 days).

Box 5.2.2 (continued)

Between 1993–95 and 2002–04, the perinatal mortality[4] rate among babies born to Aboriginal mothers in NSW decreased from 19.7 to 12.5 per 1000 live births. The NSW Aboriginal Maternal and Infant Health Strategy may have been one of several factors and programs contributing to the decrease in mortality over this period (NSW Government, unpublished).

Townsville Aboriginal and Islander Health Service, Queensland — Mums and Babies program

In February 2000, the Mums and Babies project commenced at Townsville Aboriginal and Islander Health Service (TAIHS). Under a partnership arrangement between the Queensland Health Child Health Unit and the Aboriginal and Islander Health Team, the Kirwan Women's Hospital, and TAIHS, a collaborative model of antenatal and postnatal care for women was developed. The program encompasses regular antenatal and postnatal medical examinations, pregnancy nutrition advice, birthing information and support, supervised childcare, and a transport service. The program has seen a decrease in perinatal deaths by 62 per cent, pre-term births by 44 per cent and the incidence of low birthweight by 26 per cent since 2000. The Mums and Babies clinic also sees large numbers of infants and children who are regularly monitored for growth, development, and hearing. The program has been extended to include primary health care for children up to eight years of age (TAIHS 2005; Atkinson 2001; Panaretto et al. 2005; Queensland Government (unpublished)).

As well as those mentioned in box 5.2.2, a variety of programs have been developed to improve the health of Indigenous babies and young children, some of which are included as case studies in sections 5.1 and 5.3. Efforts to improve the health of mothers and babies through better antenatal care, immunization and greater use of maternal and child health services are likely to help reduce infant mortality.

At present, estimates of the infant mortality rate among Australia's Indigenous population are imprecise:

> The exact scale of difference between the Indigenous and total population mortality is difficult to establish conclusively, due to data quality issues with Indigenous deaths data and the uncertainties inherent with estimating and projecting the Indigenous population over time. Caution should be exercised when undertaking precise analysis of Indigenous mortality and trends in Indigenous data. (ABS 2006)

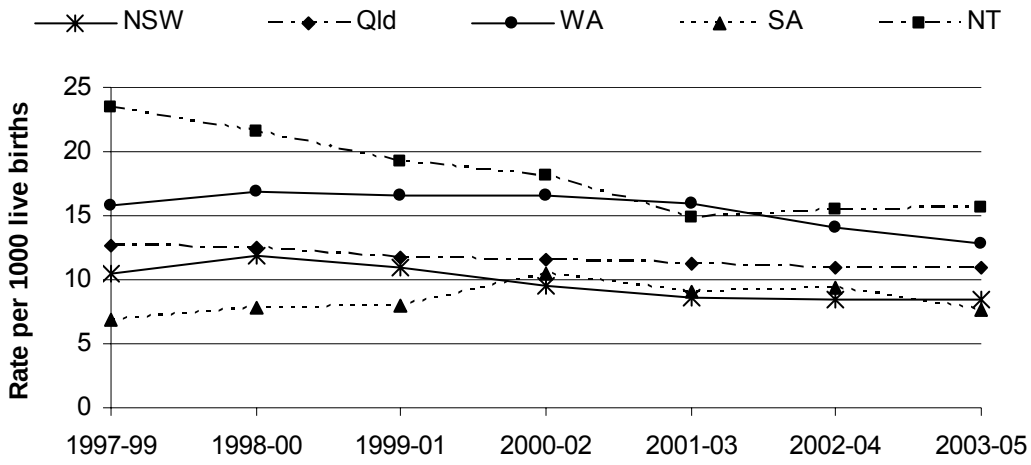
The ABS suggests that under-coverage of Indigenous infant mortality is mainly due to under reporting. Although each jurisdiction now asks a standard question about the Indigenous status of the deceased, it is sometimes left unanswered or recorded

[4] Perinatal mortality is the death of an infant within 28 days of birth (neonatal death) or of a fetus (unborn child) that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.

incorrectly. There is some evidence that under-identification of Indigenous deaths is primarily caused by Indigenous people being incorrectly recorded as not Indigenous, rather than from their Indigenous status not being recorded at all. The ABS suggests accuracy of Indigenous status data varies with how the information is collected (for example, by surveys or through administrative data) and who provides the information (for example, the person of interest, a relative, a health professional or an official) and other factors that influence data collected for death certificates (ABS 2006).

Although the total proportion of deaths for which Indigenous status is not stated is quite small (1.2 per cent), comparison with population projections based on Census data suggests that many Indigenous deaths are incorrectly recorded as non-Indigenous. The implied coverage of Indigenous deaths, for the period 2001 to 2005, ranged from 92 per cent in the NT, to 45 per cent and 31 per cent in NSW and Victoria respectively (ABS 2006).[5] Consequently, in this Report, Indigenous infant mortality data are only presented for NSW, Queensland, WA, SA, and the NT.

Figure 5.2.1 **Indigenous infant mortality**

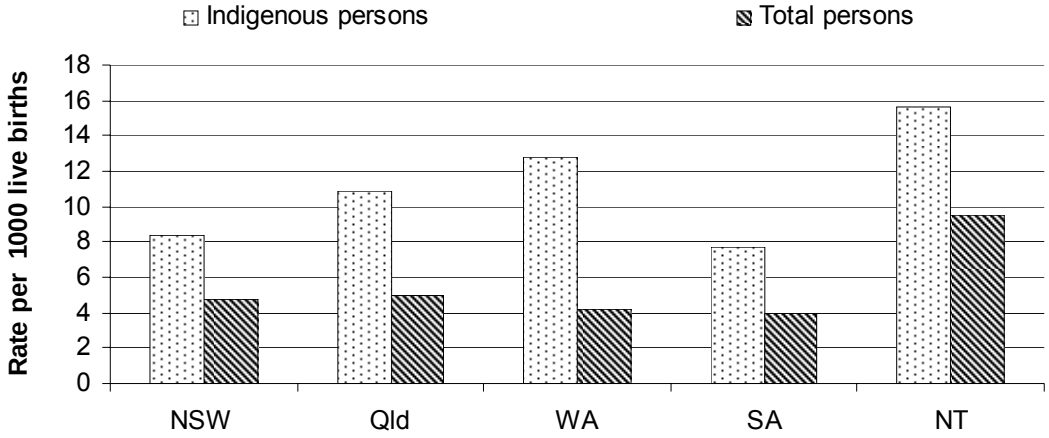


Source: ABS (2006), *Deaths Australia, 2005* (and previous issues); table 5A.2.1.

- Between 1997–1999 and 2003–2005, Indigenous infant mortality fell in NSW, Queensland, WA and the NT. Because of the incomplete identification of Indigenous deaths and as the rates are based on small numbers of deaths, which fluctuate from year to year, and because changes in some states are small, trends should be interpreted with caution (figure 5.2.1).
- Infant mortality rates for all persons (Indigenous plus non-Indigenous) also fell over the same time periods (table 5A.2.1 and ABS (2006)).

[5] Coverage ratios for Tasmania and the ACT are not calculated due to small numbers.

Figure 5.2.2 **Infant mortality, by Indigenous status, 2003–2005[a]**

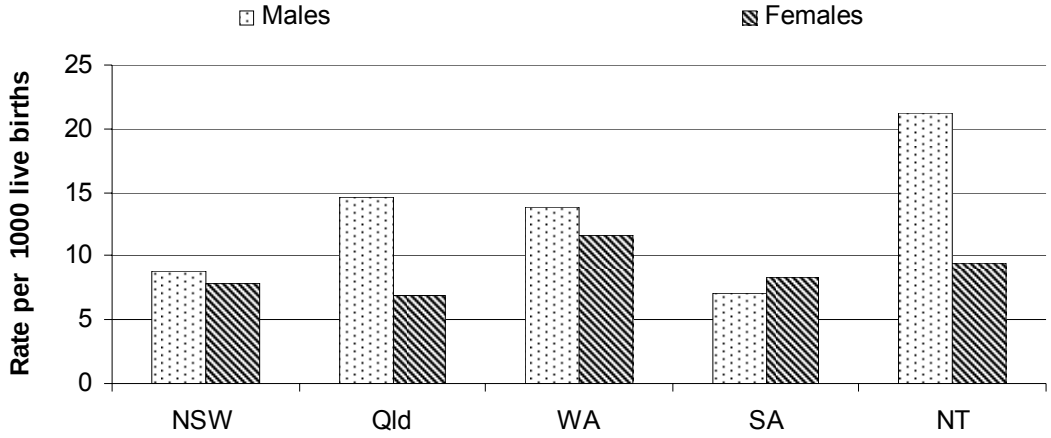


a Total includes Indigenous status not stated.

Source: ABS (2006), *Deaths Australia, 2005*; table 5A.2.1.

- Infant mortality rates among Indigenous people were about two to three times those for total persons for the period 2003–2005, in states and territories for which data are available (figure 5.2.2).
- In the NT, the significant proportion (28.8 per cent in 2001) of Indigenous people in the total population skews the comparison between Indigenous and total persons. The Indigenous infant mortality rate for the NT is best compared with the total Australian infant mortality rate (5.0 per 1000 live births) (ABS 2006). For other states and territories Indigenous people comprised approximately 2.4 per cent of the total population in 2001, therefore, infant mortality for total persons represents mostly non-Indigenous births (for population data see table A.6 of appendix 3).
- Data in figure 5.2.2 compare Indigenous with total population infant mortality, which allows the inclusion of data for NSW. Data comparing Indigenous and non-Indigenous infant mortality for Queensland, WA, SA and the NT (but excluding NSW) have been published by AHMAC (2006, p.65).
- Indigenous infants in the US, Canada and New Zealand have higher mortality rates than infants in the general populations of those countries, but the gap is not as large as for Aboriginal and Torres Strait Islander infants in Australia (AHMAC 2006, p.64).

Figure 5.2.3 **Indigenous infant mortality by sex, 2003–2005**



Source: ABS (2006), *Deaths Australia, 2005*; table 5A.2.1.

- In the period 2003–2005, infant mortality was higher for Indigenous males than females in NSW, Queensland, WA and the NT (figure 5.2.3).
- The male infant mortality rate for the total population has been consistently higher than the female infant mortality rate over the past 20 years (ABS 2006).

5.3 Birthweight

Box 5.3.1 **Key messages**

- From 2002 to 2004, babies born to Indigenous mothers were more than twice as likely to have low birthweight (13.0 per 1000 live births) than babies born to non-Indigenous mothers (6.1 per 1000 live births) (table 5.3.2).
- Average birthweights and proportions of low birthweight babies to Indigenous mothers did not change between 1998–2000 and 2002–2004 (tables 5A.3.1 to 5A.3.5).
- From 2002 to 2004, the average birthweight of live births to Indigenous mothers was 3161 g, compared with 3380 g for babies born to non-Indigenous mothers — a difference of 219 g (table 5.3.2).

The birthweight of a baby is a key indicator of health status. Children with low birthweights are more likely to have problems early in life, or even die in infancy. Low birthweight can also have long-term influences on the development of chronic diseases in adulthood, including diabetes and heart disease (Mackerras 1998; Fall et al. 1995). For many Indigenous children, health risks associated with low

birth weight are compounded by high rates of infectious disease and poor infant nutrition (Singh and Hoy 2003).

Low birthweight is defined as less than 2500 g. Within this category, babies weighing less than 1500 g are considered as very low birthweight and those less than 1000 g as extremely low birthweight (AIHW 2003). Generally, a higher proportion of female infants are born with a low birthweight compared to male infants. However, female infants tend to do better than male infants of the same weight.

Low birthweight might be a result of being born early (pre-term), although the infant may be within the expected size range for its gestational age. Alternatively, the infant may be small for its gestational age (fetal growth retardation). Low birthweight can also result from a combination of these two factors (ABS/AIHW 2003). Mackerras (1998) and Sayers and Powers (1997) identify fetal growth retardation as the main cause of low birthweight among Indigenous babies born in non-remote areas. Conversely, Rousham and Gracey (2002), in a study of Indigenous infants in the Kimberley region of WA, identified pre-term birth as the more likely cause of low birthweight in this rural population.

Predictors for fetal growth retardation and pre-term birth are listed in table 5.3.1. Some predictors cannot be altered (for example, infant sex or race), others may take at least a generation to change (for example, maternal birthweight), while others might be influenced in the short-term (for example, maternal weight or cigarette smoking). Fetal-alcohol syndrome, which is more prevalent in Indigenous than non-Indigenous populations (see section 8.1), can also lead to low birthweight. Presence of multiple births can also influence an infant's birthweight (ABS/AIHW 2003).

Table 5.3.1 **Predictors of fetal growth retardation and pre-term birth[a]**

	Fetal growth retardation	*Pre-term birth*
Direct	infant sex, race/ethnic origin, maternal height, maternal pre-pregnancy weight, paternal height and weight, maternal birthweight, parity, prior low birthweight infant, gestational weight gain, energy intake, general morbidity, malaria, maternal cigarette smoking, alcohol consumption, and tobacco chewing.	maternal pre-pregnancy weight, prior preterm birth, prior spontaneous abortion, maternal cigarette smoking, in utero diethylstilboestrolb exposure, maternal diabetes, urogenital infections, bacterial vaginosis, and placental, cervical or uterine abnormalities.
Indirect	Very young maternal age, socio-economic status (including maternal education)	

a Excludes deliveries in women with an underlying chronic illness. **b** Diethylstilboestrol is a drug prescribed widely from the 1940s to 1970s that has been associated with increased risks of vaginal and cervical cancers and other disorders in people who were exposed to the drug in the uterus when their mothers were given it while pregnant.

Source: Mackerras 1998.

Factors that may reduce low birthweight in the long term include:

- increasing attendance for antenatal care in the first trimester, which would allow for the identification and possible modification of factors (such as smoking) that might compromise the mother's and child's health. Plunkett et al. (1996) found that Indigenous women are less likely than non-Indigenous women to attend early antenatal care. Some Indigenous women face difficulties in accessing antenatal care, such as a lack of local facilities or suitable transport, cost, and a lack of culturally accessible programs.
- introducing nutritional assessment and monitoring into prenatal care, with evaluation of their use and effectiveness
- evaluating strategies to improve maternal nutrition by increased weight gain during pregnancy (Mackerras 1998).

A study undertaken by the Nganampa Health Council on people residing in the Anangu Pitjantjatjara Lands in the far north-west of SA found that better antenatal care for expectant mothers led to positive outcomes in perinatal mortality and improved birthweights (ABS/AIHW 2003).

Box 5.3.2 provides examples of successful programs providing antenatal care to Indigenous women.

Box 5.3.2 **'Things that work' — birthweight**

Congress Alukura Women's Health Program

Based in Alice Springs, NT, Congress Alukura is a women's health and birthing centre developed in the 1980s to address the needs of Aboriginal women in Central Australia.

The services include the provision of culturally appropriate antenatal, intrapartum, postnatal and women's health care through a midwifery led maternity service and women's health clinic. The service includes home visiting, transport, specialist/hospital liaison, limited mobile bush service and adult and youth health education. The program employs a full-time medical officer, midwives, women's health nurse, liaison officer, educators, traditional grandmothers and administrative/support staff.

A large proportion of Aboriginal mothers use Alukura for antenatal care (in 1994, 98 per cent of urban women and 18 per cent of rural women). Mean birthweight of Aboriginal infants in the Alice Springs urban area increased from 3168 g in 1986–90 to 3271 g in 1991–95 (an increase of 103 g or 3.3 per cent) and was maintained at 3268 g in 1996–99 (Ah Chee, Alley and Milera 2001; Carter et al. 2004).

(Continued next page)

Box 5.3.2 (continued)

Strong Women, Strong Babies, Strong Culture

The Strong Women, Strong Babies, Strong Culture (SWSBSC) Program is a bi-cultural program that supports Indigenous women to look after and teach young pregnant women and new mothers to care for themselves and their children in ways that reflect traditional cultural values and practices.

The aims of SWSBSC are:

- to address the modifiable health risks during pregnancy for low birthweight
- support involvement in cultural ceremonies and traditions for women
- encourage early presentation for antenatal care
- support families to care for their women during pregnancy and after the birth of the baby
- support and encourage women to care for their babies and young children.

The program is delivered 'by Aboriginal women, for Aboriginal women'. The local community-based Strong Women Workers are supported to provide information and health promotion by regional SWSBSC Coordinators, who are employed by the NT Department of Health and Community Services. The program is built on the respect and understanding of Aboriginal women's cultural ways for the health of women and children by keeping 'grandmother's law' strong.

The SWSBSC program was set up in 1993-94 and evaluation has shown a reduction in low birthweight in participating communities compared to those without the program. The program is currently funded in 15 communities (NT Government, unpublished).

Djuli Galban, NSW

Djuli Galban operates in Kempsey, NSW, with a focus on antenatal and early postnatal care and education.

The format is an accessible, community based, culturally sensitive outreach program. Participating women are provided with individualised, flexible and supportive care and education that is appropriate to their individual needs. 'At risk' pregnancies (including teenage pregnancies) are monitored and referred to specialist services. Culturally appropriate resources have been developed to facilitate the delivery of education and care. In addition, the delivery of education has been adapted to suit the needs of the local community (one-on-one sessions are used, as group sessions were found to be less effective). The program aims to create close relationships and trust between staff and clients. Transport assistance is provided.

(Continued next page)

Box 5.3.2 (continued)

The service uses an electronic registration and recall system to keep track of appointments and vaccinations. Women using the program are invited to participate in the early postnatal care and education program. Home visits are provided if desired.

- 88 per cent of Aboriginal women in the Macleay area presented for antenatal care before 20 weeks gestation.
- 93 per cent of women use the postnatal service.
- Child immunisation coverage has increased to 95.2 per cent.
- The rate of premature birth is lower than for the total NSW Aboriginal population, but there is significant variation over time. In 2004-05 the rate was 10.5 per cent.

(Aspery, Jarrett and Donovan 1998).

Koori Maternity Strategy, Victoria

The main aim of the service is to provide culturally appropriate maternity care to Koori women and align their birthing experiences and outcomes with those experienced by all Australian women. The strategy operates across Victoria.

The program provides both ante and postnatal care, antenatal education, birthing support and a health service for children in early childhood. Transport is provided for mothers to facilitate access to the clinic. Aboriginal women still have their babies in the local hospital, but it is not uncommon for them to be discharged after only two days. The birthing program is able to provide support for mothers in this situation, particularly in relation to continuation of breastfeeding after discharge from hospital.

A self assessment of the strengths of the program pointed to the cultural appropriateness of the service provided, its flexibility and reliability, with confidentiality assured, and to the fact that it is community based, owned and controlled.

There has been an increase in Koori women accessing antenatal care and earlier in pregnancy. Social networks have improved and better working relationships with mainstream organisations have been established (Dwyer 2005).

Marrang Aboriginal Child and Family Health Model, NSW

The Marrang Aboriginal Child and Family Health Model was developed to improve access and health outcomes for Aboriginal families in Orange, NSW. It is based on a two person team consisting of an Aboriginal Health Worker and a child and family health nurse dedicated to servicing Aboriginal families. The model engages Aboriginal families in a culturally appropriate manner.

(Continued next page)

Box 5.3.2 (continued)

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

The main change in the service delivery model was the formation of a two person team dedicated to Aboriginal families. Aboriginal clients who had been referred through the antenatal clinic or maternity service were allocated to the new team. Each client was followed up personally, either at the hospital or through a home visit to determine if they wanted to access the service and, more importantly, how they wanted to access the service. The 'how' component needed to consider other health and social issues within the family unit.

The form of the contact is the key to the success of the new service delivery model. The contact recognised socio-economic factors affecting the Aboriginal community which have often been overlooked. These may be low literacy levels, no telephone or not having transport. Improved health access was achieved by being an interpreter, providing transport, encouraging clients to seek additional health services, ensuring health appointments are attended and providing health education.

Referrals from within the Aboriginal community or through the more traditional health services and health professionals and attendances at antenatal clinics increased. The sustained contact by the dedicated team increased trust within the community (Bootle and Toomey 2006).

Nganampa Health Council Child and Maternal Health Program, SA

Nganampa Health Council Child and Maternal Health Program is an intensive antenatal and early postnatal care program operating in the Anangu Pitjantjatjara lands of SA since the mid 1980s.

The program introduced standard protocols for antenatal and child health care. An electronic registration and recall system helps to achieve these protocols. Dedicated positions were created to collect and review data with a focus on improving outcomes. The development of culturally appropriate resources appears to have been a key factor in the program's success.

The program is founded upon close relationships between midwives and pregnant women. Individual Growth Action Plans are developed with parents and carers, supported by culturally appropriate resource materials. The program is integrated within the Health Council, enabling continuity of care for pregnant women, infants and even school age children.

(Continued next page)

Box 5.3.2 (continued)

Rates of low birth weight in the region have fallen to the level of the national Australian figure and are substantially better than those in many other Aboriginal communities. 84 per cent of pregnant women have at least five antenatal visits during pregnancy and two thirds of all pregnant women have a first antenatal assessment in the first trimester. Eighty-three per cent of five year olds, 80 per cent of 10 year olds and 66 per cent of 15 year olds participated in child health screening (school based). Immunisation coverage is high with rates well over 90 per cent in most communities.

However, although wasting has ceased, rates of anaemia and stunted growth in children remain high in the region (Sloman et al. 1999, OATSIH 2001).

Ngua Gundi — the Mother/Child Project, Queensland

Ngua Gundi — the Mother/Child Project — was funded by the Commonwealth Birthing Services Project to address the serious under utilisation of antenatal services by young Aboriginal mothers in Woorabinda, Queensland.

An initial needs analysis indicated that, although there was a lack of local hospital facilities, Aboriginal women were reluctant to attend the Rockhampton Hospital for antenatal classes and/or to have their babies. The promotion and support of breastfeeding and provision of education and support in relation to infant nutrition are integrated into the maternal and child health care services. The program has expanded its range of services to include adolescent and older mothers, birthing support and the health needs of children 0–5 years. Transport is provided for mothers wanting to attend the clinic and the midwife will visit mothers in their own homes.

There is a high level of acceptance of, and involvement with the program. Trust has built up between the community and the Aboriginal Health Workers (Dorman 1997; Perkins 1998, Pholeros, Rainow and Torzillo 1993).

The analyses in this section are based on data provided by the AIHW National Perinatal Statistics Unit. Each jurisdiction has a perinatal data collection in which midwives and other staff, using information obtained from mothers and from hospital or other records, complete notification forms for each birth. Information on Indigenous people based on hospital records is limited by the accuracy with which Indigenous people are identified in these records (see appendix 3). Not all Indigenous mothers are identified as Indigenous, therefore, not all births to Indigenous mothers are recorded as Indigenous.

There are also problems with the reliability of data from jurisdictions with small numbers of babies born to Indigenous mothers. Caution needs to be exercised when examining data from these jurisdictions. The perinatal statistics do not record any information about the father. Therefore, births in the Indigenous population reported here only include those from Indigenous mothers, and do not include births to Indigenous fathers and non-Indigenous mothers. In 2003, 27 per cent of Indigenous

babies had non-Indigenous mothers and Indigenous fathers (ABS and AIHW 2005, p. 78). Hence, these figures underestimate the total number of Indigenous babies born in a given period.

Table 5.3.2 **Birthweight, by live births and fetal deaths, 2002–2004**[a, b]

Births to Indigenous mothers[c]	*Live births*		*Fetal deaths*[d]		*Total births*	
Mean birthweight (grams)	3 161		1 300		3 140	
	no.	%	no.	%	no.	%
Low birthweight (<2500g)	3 459	13.0	241	78.2	3 700	13.8
Very low birthweight (<1500g)	630	2.4	206	66.9	836	3.1
Extremely low birthweight (<1000g)	296	1.1	184	59.7	480	1.8
All births	26 583	100.0	308	100.0	26 891	100.0
Births to non-Indigenous mothers	*Live births*		*Fetal deaths*		*Total births*	
Mean birthweight (grams)	3 380		1 297		3 366	
	no.	%	no.	%	no.	%
Low birthweight (<2500g)	43 974	6.1	3 822	76.7	47 796	6.6
Very low birthweight (<1500g)	7 275	1.0	3 219	64.6	10 494	1.4
Extremely low birthweight (<1000g)	3 182	0.4	2 858	57.4	6 040	0.8
All births	720 309	100.0	4 981	100.0	725 290	100.0
All births[e]	*Live births*		*Fetal deaths*		*Total births*	
Mean birthweight (grams)	3 372		1 293		3 358	
	no.	%	no.	%	no.	%
Low birthweight (<2500g)	48 652	6.4	4 197	77.0	52 849	6.9
Very low birthweight (<1500g)	8 108	1.1	3 538	64.9	11 646	1.5
Extremely low birthweight (<1000g)	3 549	0.5	3 141	57.6	6 690	0.9
All births	763 773	100.0	5 452	100.0	769 225	100.0

a Birthweight is collected at birth and includes stillbirths of at least 20 weeks gestation or 400g birthweight. **b** Data are presented in a three year grouping due to small numbers from year to year. **c** Indigenous data relate to babies born to Indigenous mothers only, and exclude babies born to non-Indigenous mothers and Indigenous fathers. Thus, the information is not based on the total count of Indigenous babies. **d** The denominator for the fetal death percentages is fetal deaths rather than births. **e** Includes babies to mothers of unknown Indigenous status. The number of all births is greater than the sum of births to Indigenous plus non-Indigenous mothers because births for Tasmania are included in the total births but were not available by Indigenous status for Tasmania and so are not included in the Indigenous and non-Indigenous totals for Australia.

Source: AIHW National Perinatal Data Collection, National Perinatal Statistics Unit (unpublished); table 5A.3.1.

The following analyses are based on table 5.3.2. The data on Indigenous babies relate to babies born to Indigenous mothers only, as the data collection excludes babies born to non-Indigenous mothers and Indigenous fathers:

- During 2002–2004, there was a total of 763 773 live births in Australia, of which 94.3 per cent were babies born to non-Indigenous mothers and 3.5 per cent were babies born to Indigenous mothers[6].
- The mean birthweight of live births to Indigenous mothers was 3161 g, compared with 3380 g for babies born to non-Indigenous mothers — a difference of 219 g (non-Indigenous births were 6.9 per cent heavier).
- The proportion of live births to Indigenous mothers with low birthweight was more than twice that of non-Indigenous mothers (13.0 per cent compared with 6.1 per cent). Further, the proportion of live births to Indigenous mothers with very low and extremely low birthweights (2.4 and 1.1 per cent respectively) was higher than for babies born to non-Indigenous mothers (1.0 and 0.4 per cent).
- Of all live births, 6.4 per cent had low birthweight compared with 77.0 per cent of all fetal deaths.
- 1.1 per cent of babies born to Indigenous mothers, compared with 0.7 per cent of babies born to non-Indigenous mothers, were fetal deaths.
- Of those fetuses that died, over half — for both Indigenous and non-Indigenous mothers — had extremely low birthweights.

Across states and territories, there was little variation in the proportion of live births with low birthweight for babies born to non-Indigenous mothers (table 5A.3.1). Mean birthweights and proportions of low birthweight babies in 2002–2004 have not changed in the period since 1998–2000 (except for some minor fluctuations) (tables 5A.3.1 to 5A.3.5). In general, comparisons of birthweights of babies to Indigenous mothers between states and territories and over time should be interpreted with care.

6 Proportions do not add to 100 per cent because births for Tasmania are included in the total live births but were not available by Indigenous status for Tasmania and so are not included in the Indigenous and non-Indigenous totals for Australia.

5.4 Hearing impediments

Box 5.4.1 **Key messages**

- In 2004-05, the prevalence of hearing conditions for Indigenous children was three times as high as for non-Indigenous children (table 5A.4.1).
- Between 2001 and 2004-05, there was no change in the overall prevalence of hearing problems among Indigenous children (figure 5.4.1).
- From 2001-02 to 2004-05, hospitalisations for middle ear and mastoid diseases decreased for Indigenous children aged 0–3 years (from 12.9 per 1000 to 9.5 per 1000) (tables 5A.4.6 to 5A.4.9).

This indicator presents data on the prevalence of hearing problems for Indigenous and non-Indigenous children, and information on ear or hearing problems that resulted in admission to a hospital for Queensland, WA, SA and the NT.

In 2004-05, rates of hearing loss were higher among Indigenous people than non-Indigenous people in all age groups up to 55 years of age (ABS 2006). The greatest disparity was between Indigenous and non-Indigenous children aged 0–14 years (ABS 2006). Between July 2002 and June 2004, Indigenous children aged 0–14 years were hospitalised for tympanoplasty[7] procedures due to middle ear infection at a rate five times as high as other children (AHMAC 2006). The excessive burden of ear disease, particularly otitis media, in Indigenous populations has long been recognised (Burrow and Thomson 2006; Coates et al. 2002; Howard and Hampton 2006; Lowell 1991 cited in Nienhuys 1992; Morris et al. 2005; Thorne 2004; WHO 2006; Zubrick et al. 2004).

The Australian Health Ministers' Advisory Council (2006) identified children's hearing loss as a health issue that needs improvement. Children's hearing loss is a performance measure in the Aboriginal and Torres Strait Islander Health Performance Framework (AHMAC 2006).

The most common causes of hearing loss among Indigenous people are disorders of the middle ear. Otitis media, which is an inflammation of the middle ear, often occurs as a result of another illness (such as a cold), caused by bacterial and viral infections (Burrow and Thomson 2006; Morris et al. 2005; Couzos, Metcalf and Murray 2001).

[7] Tympanoplasty is a surgical procedure to repair the tympany, or eardrum, perforated as a result of chronic otitis media (infections of the middle ear). The procedure restores the hearing of children affected by a perforated eardrum.

The rates of otitis media remain extremely high for Indigenous children (Burrow and Thomson 2006; Morris et al. 2005; Morris et al. 2006). A recent study based on the assessment of 709 Aboriginal children aged 6–30 months living in 29 remote Aboriginal communities across Northern Australia found:

- 25 per cent of the children had acute otitis media without perforation
- 6 per cent had acute otitis media with perforation.

The authors of the study noted that no other published surveys in other populations have documented such high prevalence rates of acute otitis media (Morris et al. 2006).

The Western Australian Aboriginal Child Health Survey (WAACHS) revealed that Indigenous children aged four to 17 with recurring ear infections not only had an increased risk of abnormal hearing but also a significantly greater risk of language problems and learning difficulties (Zubrick et al. 2004).

There are various forms of otitis media. Generally accepted definitions are provided in box 5.4.2. The types of otitis media observed among Indigenous people are different from those common among non-Indigenous Australians. Indigenous people are more likely to suffer from acute and chronic suppurative forms of otitis media while otitis media with effusion is a major problem among non-Indigenous people (Burrow and Thomson 2003; Couzos, Metcalf and Murray 2001).

Box 5.4.2 **Types of otitis media**

- Otitis media with effusion (OME) is inflammation of the middle ear characterised by fluid behind the eardrum without signs or symptoms of acute otitis media. Sometimes referred to as 'glue ear'.
- Acute otitis media without perforation (AOM without perforation) is acute inflammation of the middle ear and eardrum (tympanic membrane) with signs or symptoms of infection. AOM is characterised by fluid behind the eardrum combined with one or more of the following: bulging eardrum, red eardrum, recent discharge of pus, fever, ear pain or irritability. Bulging of the eardrum is the most reliable indicator of AOM in Aboriginal children.
- Recurrent acute otitis media (rAOM) is where there are three or more attacks of AOM within six months.
- Acute otitis media with perforation (AOM with perforation) is where there is discharge of pus through a perforation (hole) in the eardrum within the last six weeks.

(Continued next page)

Box 5.4.2 (continued)

- Chronic otitis media is a persistent inflammation of the middle ear. It can occur with or without perforation, either as chronic suppurative otitis media or as otitis media with effusion.
- Chronic suppurative otitis media (CSOM) is recurrent or persistent bacterial infection of the middle ear, with discharge of pus through a perforation in the eardrum for at least six weeks. Sometimes referred to as 'runny ears'.
- Dry perforation is the presence of a perforation in the eardrum without any signs of discharge or fluid behind the eardrum.

Sources: Close, Murphy and Goodwin 1996; Coates et al. 2002; Couzos, Metcalf and Murray 1999 and Menzies School of Health Research 2001 cited in Burrow and Thomson 2006.

Otitis media in Indigenous children is characterised by very early onset, persistence and high rates of severe disease — resulting in a chronic disease which Indigenous people carry from childhood into adolescence (Morris et al. 2005; Morris et al. 2006; Leach et al. 1994). In contrast, otitis media in non-Indigenous children typically resolves with age and is rarely seen amongst non-Indigenous children over the age of eight (Burrow and Thompson 2003).

Persistent bacterial colonisation, which is said to come from poor environmental factors such as overcrowded living conditions and poor hygiene, contribute to the chronic nature and severity of otitis media in Indigenous people (Coates et al. 2002; Jones and Smith 2006; WHO 2006; Zubrick et al. 2004). The condition is often exacerbated by inadequate health infrastructure, ineffective treatment and poor nutrition and exposure to passive smoking (Burrow and Thomson 2003; WHO 2006; Zubrick et al. 2004).

The impact of conductive hearing loss, due to otitis media, on the quality of life of Indigenous children and their caregivers is well documented (Brouwer et al. 2005; Howard and Hampton 2006; Nienhuys 1992; Thorne 2004). Indigenous children suffer significantly from conductive hearing loss in early infancy and their hearing level may not recover fully before adulthood. The fluctuation of hearing level during childhood has implications for children's auditory, linguistic, cognitive and psychosocial development (Brouwer et al. 2005; Nienhuys 1992).

To a large extent, otitis media is preventable and treatable. A surgical procedure (myringotomy) can be performed to assist in restoring hearing. This is achieved by releasing the fluid that builds up in the middle ear (NSW DoH 2002).

Identifying risk factors for otitis media might increase the chances for early prevention and intervention. Some of the possible risk factors are outlined below.

- There is relatively higher bacterial colonisation in Indigenous infants, which is strongly correlated with the onset of middle ear effusion (this tended to occur within the first 12 weeks of life in 66 per cent of Indigenous infants). No correlation is found between colonisation and the onset of otitis media in non-Indigenous infants. Further, once established, it is significantly less likely for an Indigenous infant compared with a non-Indigenous infant to clear the bacterial pathogens (Morris et al. 2006). The early bacterial colonisation in Indigenous infants might be linked to the fact that Indigenous communities are more exposed to factors such as a greater number of siblings in an overcrowded household, which increases the risk factors for bacterial colonisation and acute otitis media.
- Some studies have found a link between the early first onset of otitis media and the increased risk of recurrent infections (that is, 'early and often appears to be the rule'). Indigenous infants tend to have persistent acute otitis media and other ear infections that are rarely resolved (Boswell and Nienhuys 1996; Morris et al. 2006).
- The incidence of acute otitis media in other family members may significantly increase the risk of ear infection, especially in children.
- Although few studies have evaluated this relationship, malnutrition in Indigenous children might be associated with the development of chronic otitis media (Jones and Smith 2006).
- High rates of smoking within the Indigenous population might contribute to the prevalence of otitis media among Indigenous children (see section 8.2 for more information on tobacco use).

Box 5.4.3 provides examples of programs that have improved health outcomes for Indigenous children.

Box 5.4.3 **'Things that work' — improving health outcomes**

Swimming pools in remote communities

Indigenous children in remote areas suffer from high rates of skin diseases, including pyderma, which is associated with chronic renal failure, and otitis media. Many Indigenous children also suffer from perforated tympanic membranes and some degree of hearing loss, which can create learning difficulties.

The 2005 Report presented the outcomes of a preliminary study into the health benefits of swimming pools in remote communities (Lehmann et al. 2003). A final report (TICHR 2006) from the Telethon Institute for Child Health Research compared the heath status of children from the Burringurrah Aboriginal community before and after the swimming pool was opened. The installation of the swimming pool was part of a 'no school, no pool' initiative. In Burringurrah the pool is open continuously each summer season.

The first health examinations were conducted in 2000, before the pool was built. The final health examinations were conducted in early 2005. Some of the findings include:

- before the pool opened, 62 per cent of children had skin infections (which included 30 per cent who had severe skin infections requiring antibiotics). In April 2005, these figures were 10 per cent and 2 per cent, respectively.
- 33 per cent of children had an ear perforation before installation of the pool. In April 2005, this had decreased to 15 per cent of children.

The Telethon Institute noted that the outcomes from the study provided evidence to support the importance of providing infrastructure in remote communities (TICHR 2006).

Improved hearing assessment for primary school children in Townsville

A 2005 study by the Townsville Learning and Engagement Centre (LEC), Education Queensland and Queensland Health assessed the hearing of children in a local Townsville primary school. The study found that 44.8 per cent of year 2 students were identified as having possible conductive hearing loss (this confirmed an earlier study that found at least 40 per cent of Indigenous children have an unidentified conductive hearing loss).

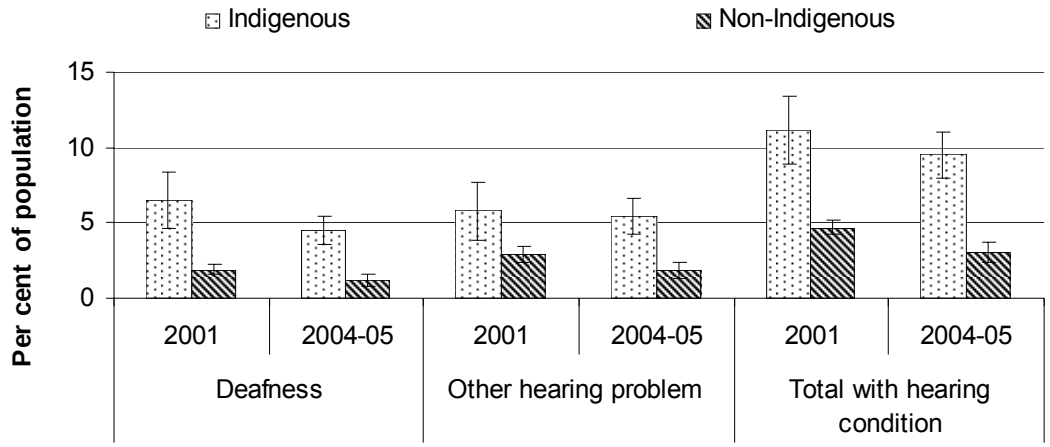
A high proportion of the students assessed at the local Townsville primary school were Indigenous and many were not achieving high results in literacy and numeracy and were also identified as demonstrating behavioural concerns. This led the LEC to:

- develop in-class hearing assessment tools for teaching staff
- develop hearing assessment games for parents and
- provide professional development for both teachers and parents to identify any hearing loss that may reduce the opportunity for academic and schooling success.

Prevalence of hearing conditions

Survey data provide information on the prevalence of hearing conditions for Indigenous and non-Indigenous children.

Figure 5.4.1 **Prevalence of hearing conditions in children aged 0–14 years[a, b, c]**

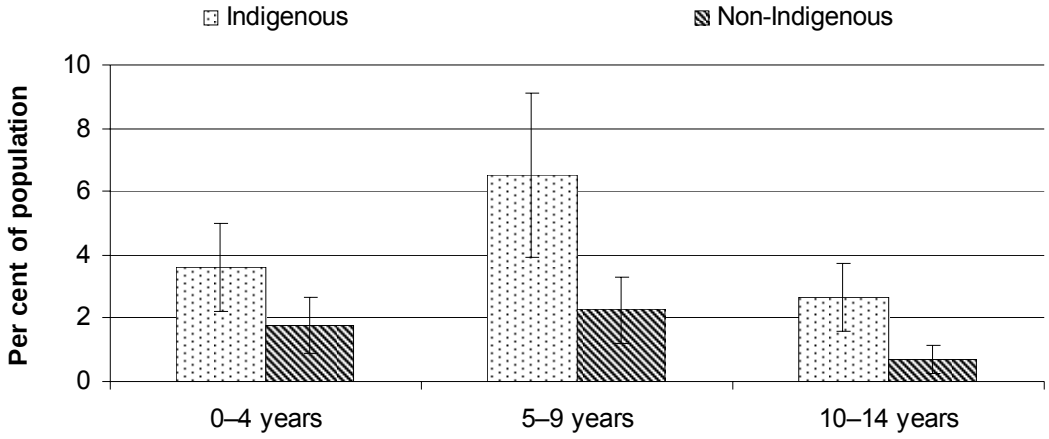


[a] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). [b] Other hearing problem includes otitis media, tinnitus and Meniere's disease/vertiginous syndrome. [c] Total with hearing condition includes 'Type of ear/hearing problem' not known.

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); ABS 2001 NHS (unpublished); tables 5A.4.1 and 5A.4.2.

- In 2001 and 2004-05, Indigenous children aged 0–14 years old were more likely to suffer from hearing problems than non-Indigenous children (figure 5.4.1).
- There was no statistically significant difference in the prevalence of hearing problems among Indigenous children between 2001 and 2004-05, while there was a statistically significant reduction in prevalence for non-Indigenous children (tables 5A.4.1 and 5A.4.2).
- In 2004-05 the prevalence of hearing conditions, including total/partial hearing loss and otitis media, was higher for Indigenous children aged 0–14 (9.5 per cent) than non-Indigenous children (3.0 per cent) (table 5A.4.1).
- The prevalence of hearing conditions in the Indigenous population (all ages) did not vary with remoteness in 2001 or 2004-05 (tables 5A.4.3 and 5A.4.4).

Figure 5.4.2 **Prevalence of otitis media, 2004-05[a]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); table 5A.4.5.

- In 2004-05, the prevalence of otitis media among Indigenous children aged five to nine years was 6.5 per cent (compared with 2.3 per cent for non-Indigenous children) (figure 5.4.2).
- Across all age groups Indigenous children were two to four times as likely as non-Indigenous children to suffer from hearing problems (table 5A.4.5).

Hospitalisations for ear and hearing problems

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

Table 5.4.1 **Age specific hospitalisations where the principal diagnosis was diseases of the ear and mastoid process, Qld, WA, SA, and public hospitals in the NT, 2004-05[a, b, c]**

Principal diagnosis	*Indig.*	*Non -Indig.*	*Not stated*	*Total*	*Indig.*	*Non-Indig.*[d]
	no.	no.	no.	no.	per 1000	
People aged 0–3 years						
Diseases of external ear	18	94	np	np	0.6	0.3
Diseases of middle ear and mastoid	275	4 956	466	5 697	9.5	15.3
Suppurative and unspecified otitis media	164	1 596	110	1 870	5.7	4.8
Diseases of inner ear	–	7	–	7	–	–
Other disorders of ear	10	277	9	296	0.3	0.8
People aged 4–14 years						
Diseases of external ear	27	316	12	355	0.3	0.3
Diseases of middle ear and mastoid	558	5 419	485	6 462	7.0	5.5
Suppurative and unspecified otitis media	148	1 140	74	1 362	1.9	1.1
Diseases of inner ear	–	13	np	np	–	–
Other disorders of ear	19	261	7	287	0.2	0.2

[a] Hospitalisation is the discharge, transfer, death or change of episode of care of an admitted patient (see glossary for a detailed definition). [b] Data are based on state of usual residence. [c] Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Vic, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information). [d] Includes separations where Indigenous status was not reported. – Nil or rounded to zero. np Not published.

Source: AIHW National hospital morbidity database (unpublished); table 5A.4.6.

Hospitalisations data only include those who access medical services, and have been diagnosed and admitted to hospital for the specified conditions. Therefore, when examining hospital statistics on ear and hearing problems it should be noted that only ear or hearing related illness resulting in admission to a hospital are collected. Cases that result in a visit to a general practitioner or to an emergency department, but do not lead to hospitalisation, are excluded. This is likely to include a large share of 0–3 year olds where parents may not be aware that their children have an ear or hearing problem or where access to hospitals may be limited.

Based on data available from Queensland, WA, SA and the NT, in 2004-05:

- The most common hospitalisation rate (for both populations and age groups) was for diseases of the middle ear and mastoid.
- Indigenous children three years and under had a higher hospitalisation rate for suppurative and unspecified otitis media than non-Indigenous children (5.7 per 1000 compared with 4.8 per 1000) but a lower rate of hospitalisation than non-Indigenous children for all diseases of the middle ear and mastoid (table 5.4.1).

- Although the hospitalisation rate for suppurative and unspecified otitis media for children aged four to 14 years is lower than the hospitalisation rate for children aged under three years, Indigenous children aged between four and 14 years still had a higher hospitalisation rate than non-Indigenous children aged between four and 14 years (1.9 per 1000 compared with 1.1 per 1000).
- Indigenous children aged between four and 14 years had a higher hospitalisation rate for diseases of the middle ear and mastoid than non-Indigenous children (7.0 per 1000 compared with 5.5 per 1000).

Data for Queensland, WA, SA and the NT show that from 2001-02 to 2004-05:

- Hospitalisation rates for middle ear and mastoid diseases decreased for Indigenous children aged 0–3 years (from 12.9 per 1000 to 9.5 per 1000) and non-Indigenous children aged 0–3 years (16.2 per 1000 to 15.3 per 1000) (tables 5A.4.6 to 5A.4.9).
- The hospitalisation rate for suppurative and unspecified otitis media decreased for Indigenous children under the age of three years from 7.0 per 1000 in 2001-02 to 5.7 per 1000 in 2004-05 (tables 5A.4.6 to 5A.4.9).

5.5 Children with tooth decay

Box 5.5.1 **Key messages**

- Data on tooth decay were available only for NSW, SA and the NT. For these jurisdictions:
  - Indigenous children had higher numbers of both infant and adult teeth with decay than non-Indigenous children, in both metropolitan and rural areas (table 5.5.1)
  - fewer Indigenous children than non-Indigenous children had decay-free infant and adult teeth across all age groups and in both metropolitan and rural areas (table 5.5.2).
- National data on dental hospitalisation rates and procedure rates showed:
  - Indigenous children aged less than five years had the highest dental hospitalisation rate of any age group, almost one and a half times the rate for non-Indigenous children of that age group (table 5A.5.8)
  - extraction rates were greater for Indigenous children than for non-Indigenous children. The rate of extraction procedures for Indigenous boys was 1.3 times as high as the rate for non-Indigenous boys (figure 5.5.4).

In the 2005 Report, data on tooth decay among Indigenous children were presented under the indicator 'Primary school children with dental caries', which was part of

the ‘Early school engagement and performance (preschool to year 3)’ strategic area for action. For the 2007 Report, data on the dental health of Indigenous children have been expanded and moved to the ‘Early child development and growth’ strategic area for action. Dental health status was considered more an indicator of growth and development rather than school engagement.

Tooth decay is caused by acid-producing bacteria living in the mouth and is often caused by a diet of sugary or sticky foods and inadequate dental hygiene. Unless treated in its early stage, tooth decay may result in pain, infection, and destruction of soft tissues in the mouth (AIHW 2000). It has a significant impact on self-esteem, psychological and social wellbeing, employment, interpersonal relations and quality of life (National Advisory Committee on Oral Health 2004). While tooth decay is fully reversible if treated early, when left untreated, it requires complex and costly procedures to prevent tooth loss (Harford, Spencer and Roberts-Thomson 2003).

Historically, Indigenous people had less tooth decay due to their traditional diet. As their diet changed to include food rich in fermentable carbohydrates, they have become as exposed to tooth decay risk factors as non-Indigenous people (Davies et al. 1997). This risk is worsened by limited access to dental health services and lack of preventive measures and education in some parts of Australia (Harford, Spencer and Roberts-Thomson 2003).

While the dental health of non-Indigenous children has generally improved since the introduction of the School Dental Scheme in 1977 and the addition of fluoride to public drinking water supplies, the dental health of Indigenous children appears to have deteriorated in the last couple of decades (AIHW 1996 and 1998, cited in Al-Yaman, Bryant and Sargeant 2002).

A paper by Endean, Roberts-Thomson and Wooley (2004) found that the dental health of Indigenous children living in an Indigenous community in the north west of South Australia deteriorated between 1987-88 and 2000. This paper compared the dental health of Indigenous children aged 4 to 10 years in 2000 with information obtained from the Nganampa Health Council (NHC) Dental Program in 1987. AHMAC (2006) reported that Indigenous children had more decayed than filled teeth in SA, NSW and the NT, reflecting a large unmet need for dental care.

In far north Queensland, a privately-funded dental health program was successfully implemented in 2005, with the aim of improving the dental health of Indigenous people in and around Cairns (see box 5.5.2). Box 5.5.3 describes a program successfully established by the SA Dental Service to increase the use of dental services and improve the oral health of the Indigenous community around Adelaide.

Box 5.5.2 'Things that work' — 'Filling the Gap': Indigenous Dental Program

Wuchopperen Indigenous Health Service provides care to approximately 20 000 Aboriginal and Torres Strait Islander people in and around Cairns (far north Queensland). Oral health is an important component of Wuchopperen's services, with two fully equipped dental rooms at the clinic in Cairns plus a mobile dental van ready to travel to outlying communities. However, up until recently, there was a severe shortage of dentists, limiting Wuchopperen's dental services (for example, there was a waiting list of one year for basic care). This lack of access to dental care worsened the continuing poor standard of dental health amongst Aboriginal and Torres Strait Islander people in this region.

The 'Filling the Gap Indigenous Dental Program' has partly alleviated this problem by making full use of the existing facilities by supplying volunteer dentists from around Australia to assist the Wuchopperen clinic. This privately funded volunteer program provides air fares to Cairns, accommodation and the cost of registration with the Queensland Dental Board in return for one to two weeks of a dentist's time. With a generous $10 000 donation from an anonymous donor and word-of-mouth promotion, Filling the Gap got off the ground in late 2005 and the first dentists flew to Cairns in January 2006 (University of NSW 2006).

Box 5.5.3 'Things that work' — SA Dental Service Aboriginal Liaison Program

In February 2005, a dental therapist from the northern area of Adelaide commenced work as an Aboriginal Liaison Officer for the SA Dental Service. The aim of her role was to develop a partnership with the local Aboriginal and Torres Strait Islander community through involvement with the Muna Paiendi Health Service and Kaurna Plains Primary School. She regularly attended community based events, including a diabetes luncheon and young mothers' group, and provided clinical services for the school children at the local school dental clinic.

The Aboriginal Liaison Officer's continued enthusiasm and genuine interest has since gained her respect within the local Aboriginal and Torres Strait Islander community and increased the community's confidence and trust in mainstream dental services. Children are now transported via school bus to the dental clinic for examinations and treatment twice a week. The dental clinic staff frequently attend Kaurna Plains School to provide classroom education and oral health information resources. Increased attendance at the school dental clinic has been the direct result of this more interactive and flexible approach.

(Continued next page)

Box 5.5.3 (continued)

A broader Aboriginal Liaison Program was then established in late 2005 to build on the achievements in the north of Adelaide. The aim of the program is to improve oral health outcomes for Aboriginal and Torres Strait Islander people by increasing the number who access dental care. Five Aboriginal Liaison Officers are currently working with local Aboriginal Health Services and Aboriginal communities to develop sustainable pathways for referring clients to dental services and to increase knowledge about oral health care (SA government unpublished).

Tooth decay is measured as the sum of the number of untreated decayed teeth (D), missing teeth (M) extracted due to caries[8], and filled teeth (F) restored following caries (that is DMFT = D+M+F). While DMFT is used for permanent (adult) teeth, dmft (in lower case) refers to infant teeth and is derived in the same way as DMFT. The indicator DMFT=0 (dmft=0 for infant teeth) refers to caries-free teeth and is used to refer to the number/proportion of teeth that are free of decay (Armfield and Roberts-Thomson 2004).

The data for this indicator are sourced from four published articles prepared by the Australian Research Centre for Population Oral Health (Ellershaw, Spencer and Slade 2005; Jamieson, Armfield and Roberts-Thomson 2006a, 2006b; Jamieson and Roberts-Thomson 2006). The first part of this section reports on the extent of tooth decay among Indigenous and non-Indigenous children enrolled in school dental services in NSW, SA and the NT (Jamieson, Armfield and Roberts-Thomson 2006a). The second and third parts focus on the dental health of Indigenous and non-Indigenous children in the NT (Jamieson, Armfield and Roberts-Thomson 2006b) and SA (Ellershaw, Spencer and Slade 2005), respectively. The fourth part presents hospital dental admission and procedure rates based on separations data from 1297 public and private hospitals located across Australia (Jamieson and Roberts-Thomson 2006).

Indigenous children's dental health in NSW, SA and the NT combined

Measures of tooth decay for Indigenous and non-Indigenous children enrolled in school dental services in metropolitan and rural NSW, SA and the NT presented in tables 5.5.1 and 5.5.2 are based on data collected over three 12-month periods; 2000 for NSW, 2002 for the NT, and 2003 for SA. Of the 326 099 children examined, 10 743 (3.2 per cent) were Indigenous (Jamieson, Armfield and Roberts-Thomson 2006a).

8 Dental caries is a technical term for tooth decay.

Table 5.5.1 **Children's mean number of teeth with decay, by remoteness and age group, NSW, SA and the NT, selected years between 2000 and 2003[a]**

	Metropolitan				*Rural*			
	Indigenous		*Non-Indigenous*		*Indigenous*		*Non-Indigenous*	
Age	*Mean*	*SE*	*Mean*	*SE*	*Mean*	*SE*	*Mean*	*SE*
Mean dmft score (for infant teeth)								
4 years	2.89	0.33	1.31	0.03	3.56	0.19	1.39	0.05
5 years	2.63	0.20	1.20	0.01	4.13	0.15	1.68	0.03
6 years	2.74	0.18	1.42	0.02	4.09	0.15	1.82	0.03
7 years	2.09	0.13	1.44	0.01	3.43	0.12	1.86	0.02
8 years	2.20	0.15	1.48	0.02	3.16	0.11	1.87	0.03
9 years	1.98	0.12	1.26	0.01	2.28	0.09	1.60	0.02
10 years	1.39	0.13	1.00	0.01	1.66	0.08	1.27	0.02
Mean DMFT score (for permanent (adult) teeth)								
6 years	0.13	0.04	0.08	0.00	0.18	0.03	0.05	0.00
7 years	0.22	0.03	0.22	0.00	0.36	0.03	0.22	0.01
8 years	0.44	0.06	0.30	0.01	0.53	0.04	0.28	0.01
9 years	0.56	0.05	0.39	0.01	0.68	0.04	0.36	0.01
10 years	0.77	0.08	0.47	0.01	1.00	0.06	0.44	0.01
11 years	0.80	0.07	0.59	0.01	1.05	0.06	0.59	0.01
12 years	1.08	0.11	0.77	0.01	1.33	0.09	0.70	0.02
13 years	1.44	0.16	0.88	0.01	1.77	0.17	0.90	0.01
14 years	1.83	0.31	1.18	0.03	2.27	0.24	1.19	0.04

SE = Standard error.

a D=number of untreated decayed teeth; M=number of missing teeth; F=number of filled teeth; DMFT=D+M+F (for permanent adult teeth); dmft refers to infant teeth and is derived in the same way as DMFT. The indicator DMFT=0 (dmft=0 for infant teeth) refers to decay-free teeth.

Source: Jamieson, Armfield and Roberts-Thomson (2006a); table 5A.5.1 and 5A.5.2.

- The mean (average) number of infant teeth with decay was higher for Indigenous children than non-Indigenous children across all ages (from four to 10 years) and for both metropolitan and rural areas (table 5.5.1).
- The highest number of infant teeth with decay for Indigenous children was 2.89 for children four years of age in metropolitan areas and 4.13 for five-year-old Indigenous children living in rural areas (table 5.5.1).
- The mean number of permanent (adult) teeth with decay was higher for Indigenous children than non-Indigenous children across all ages except for seven-year-olds in metropolitan areas (both had the same DMFT score of 0.22) (table 5.5.1).
- The mean number of permanent teeth with decay for Indigenous children living in metropolitan areas ranged from 0.13 for six-year-olds to 1.83 for 14-year-olds, compared with 0.08 for non-Indigenous six-year-olds and 1.18 for non-Indigenous 14-year-olds (table 5.5.1).

- The level of decay on infant teeth was higher for both Indigenous and non-Indigenous children living in rural areas than those living in metropolitan areas (table 5.5.1).
- For both Indigenous and non-Indigenous children living in metropolitan and rural areas, the mean number of permanent teeth with decay increased with age (table 5.5.1).

Table 5.5.2 **Proportion of children with decay-free teeth, by remoteness and age group, NSW, SA and the NT, selected years between 2000 and 2003[a]**

	Metropolitan				*Rural*			
	Indigenous		*Non-Indigenous*		*Indigenous*		*Non-Indigenous*	
Age	*%*	*SE*	*%*	*SE*	*%*	*SE*	*%*	*SE*
Per cent dmft=0 (decay-free infant teeth)								
4 years	41.6	4.4	69.7	0.6	31.0	2.3	64.3	0.5
5 years	47.7	2.5	70.9	0.2	31.8	1.6	62.2	0.5
6 years	36.6	2.8	64.5	0.4	24.2	1.7	56.8	0.3
7 years	51.8	2.2	62.9	0.3	28.8	1.5	54.2	0.5
8 years	43.6	2.9	58.9	0.4	28.6	1.6	51.6	0.6
9 years	48.9	2.3	62.2	0.3	38.1	1.6	54.2	0.5
10 years	57.0	2.9	66.1	0.4	44.9	1.8	59.7	0.6
Per cent DMFT=0 (decay-free permanent (adult) teeth)								
6 years	93.8	1.4	96.7	0.1	90.4	1.2	97.1	0.1
7 years	89.5	1.3	90.4	0.2	83.5	1.3	90.1	0.3
8 years	78.7	2.4	86.0	0.3	74.6	1.5	86.7	0.4
9 years	74.7	2.0	83.1	0.2	68.9	1.6	83.3	0.4
10 years	66.6	2.8	78.9	0.3	60.6	1.8	79.1	0.5
11 years	67.8	2.2	75.4	0.3	60.5	1.7	75.3	0.4
12 years	59.3	3.2	70.6	0.4	53.5	2.2	70.9	0.6
13 years	57.4	3.2	70.0	0.3	52.3	3.1	65.6	0.6
14 years	41.3	5.1	62.1	0.6	40.0	4.1	59.1	0.9

SE = Standard error.

a D=number of untreated decayed teeth; M=number of missing teeth; F=number of filled teeth; DMFT=D+M+F (for permanent adult teeth); dmft refers to infant teeth and is derived in the same way as DMFT. The indicator DMFT=0 (dmft=0 for infant teeth) refers to decay-free teeth.

Source: Jamieson, Armfield and Roberts-Thomson (2006a); table 5A.5.1 and 5A.5.2.

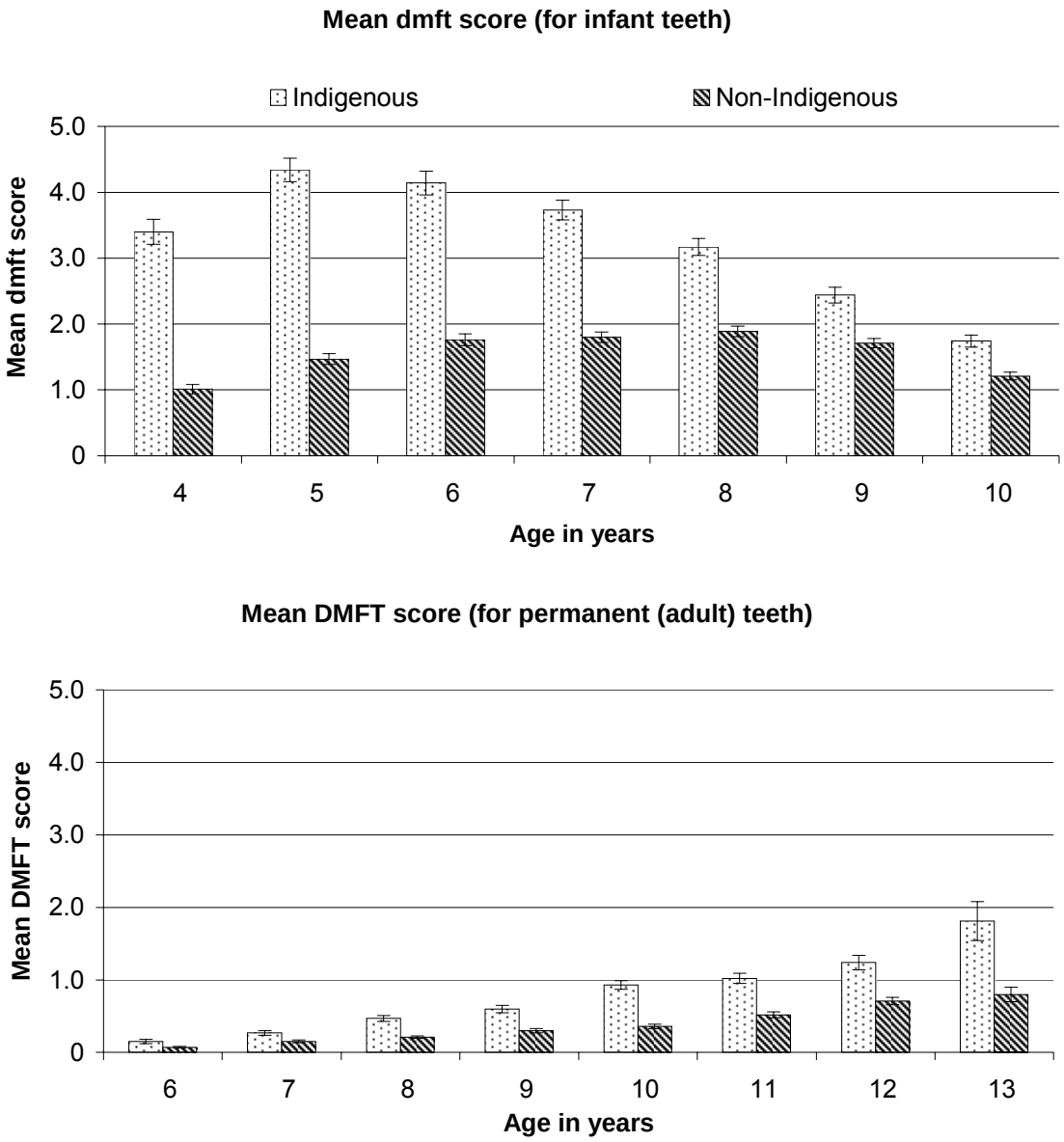
- In both metropolitan and rural areas and across all age groups (from four to 10 years), the proportion of Indigenous children with decay-free infant teeth was lower than the proportion of non-Indigenous children without decay (table 5.5.2).
- The proportion of Indigenous children with decay-free permanent teeth was lower than the proportion of non-Indigenous children without decay, across all age groups (from six to 14 years) in rural areas and for eight to 14-year-olds in metropolitan areas (table 5.5.2).

- The percentage of Indigenous children with decay-free infant teeth was greater in metropolitan areas than rural areas (table 5.5.2).
- For both Indigenous and non-Indigenous children living in metropolitan and rural areas, the proportion of children with decay-free permanent teeth decreased with age (table 5.5.2).

Tooth decay among Indigenous and non-Indigenous children in the NT

Tooth decay measures for Indigenous and non-Indigenous children enrolled in school dental services in the NT presented in figure 5.5.1 and table 5.5.3 were calculated using data collected in 2002-03. Of the 12 584 children examined, 4 417 (35.1 per cent) were Indigenous (Jamieson, Armfield and Roberts-Thomson 2006b).

Figure 5.5.1 **Mean number of teeth with decay for 4–13 year old Indigenous and non-Indigenous children, by age group, NT School Dental Service, 2002-03[a, b]**



a D=number of untreated decayed teeth; M=number of missing teeth; F=number of filled teeth; DMFT=D+M+F (for permanent adult teeth); dmft refers to infant teeth and is derived in the same way as DMFT. The indicator DMFT=0 (dmft=0 for infant teeth) refers to decay-free teeth. **b** Error bars represent 95 per cent confidence intervals around each mean.

Source: Jamieson, Armfield and Roberts-Thomson (2006b); table 5A.5.3.

- Average numbers of infant teeth with decay were higher for Indigenous children than non-Indigenous children across all ages (from four to 10 years) in the NT school dental service in 2002-03 (figure 5.5.1).
- The highest scores for infant teeth decay for Indigenous children were 4.34 and 4.14 for five and six-year-olds, respectively (figure 5.5.1). The greatest

difference in scores between Indigenous and non-Indigenous children was for 5-year-olds (4.34 for Indigenous children compared to 1.47 for non-Indigenous children) (figure 5.5.1).

- Average numbers of adult teeth with decay for Indigenous children ranged from 0.15 for six-year-olds to 1.81 for 13-year-olds, compared to 0.07 for non-Indigenous six-year-olds and 0.80 for non-Indigenous 13-year-olds (figure 5.5.1).
- The greatest difference in permanent tooth decay scores between Indigenous and non-Indigenous children was for 13-year-olds; the score for Indigenous children was 2.3 times as high as the score for non-Indigenous children (figure 5.5.1).
- For both Indigenous and non-Indigenous children, permanent tooth decay scores increased with age (figure 5.5.1).

Attachment tables 5A.5.4 and 5A.5.5 presents average infant and adult tooth decay scores for Indigenous and non-Indigenous children aged four to 13 years enrolled in the NT school dental service classified by the Socio-Economic Indices for Areas (SEIFA). The SEIFA was developed by the ABS using data derived from the 2001 Census of Population and Housing, using a range of measures to rank areas based on their relative social and economic wellbeing. A SEIFA category of '1' denotes the most disadvantaged areas and '4' denotes the least disadvantaged areas (Jamieson, Armfield and Roberts-Thomson 2006b). None of the NT tooth decay data for Indigenous children fell into category '4' of the SEIFA (the least disadvantaged areas.

Average infant tooth decay scores were higher for Indigenous children than non-Indigenous children across all ages (from four to 10 years) and SEIFA categories '1', '2' and '3' (table 5A.5.4). The highest scores for Indigenous children were consistently associated with SEIFA category '1' and the lowest scores with SEIFA category '3' (table 5A.5.4). This provides evidence that Indigenous children from the most disadvantaged areas tend to have a greater number of decayed infant teeth.

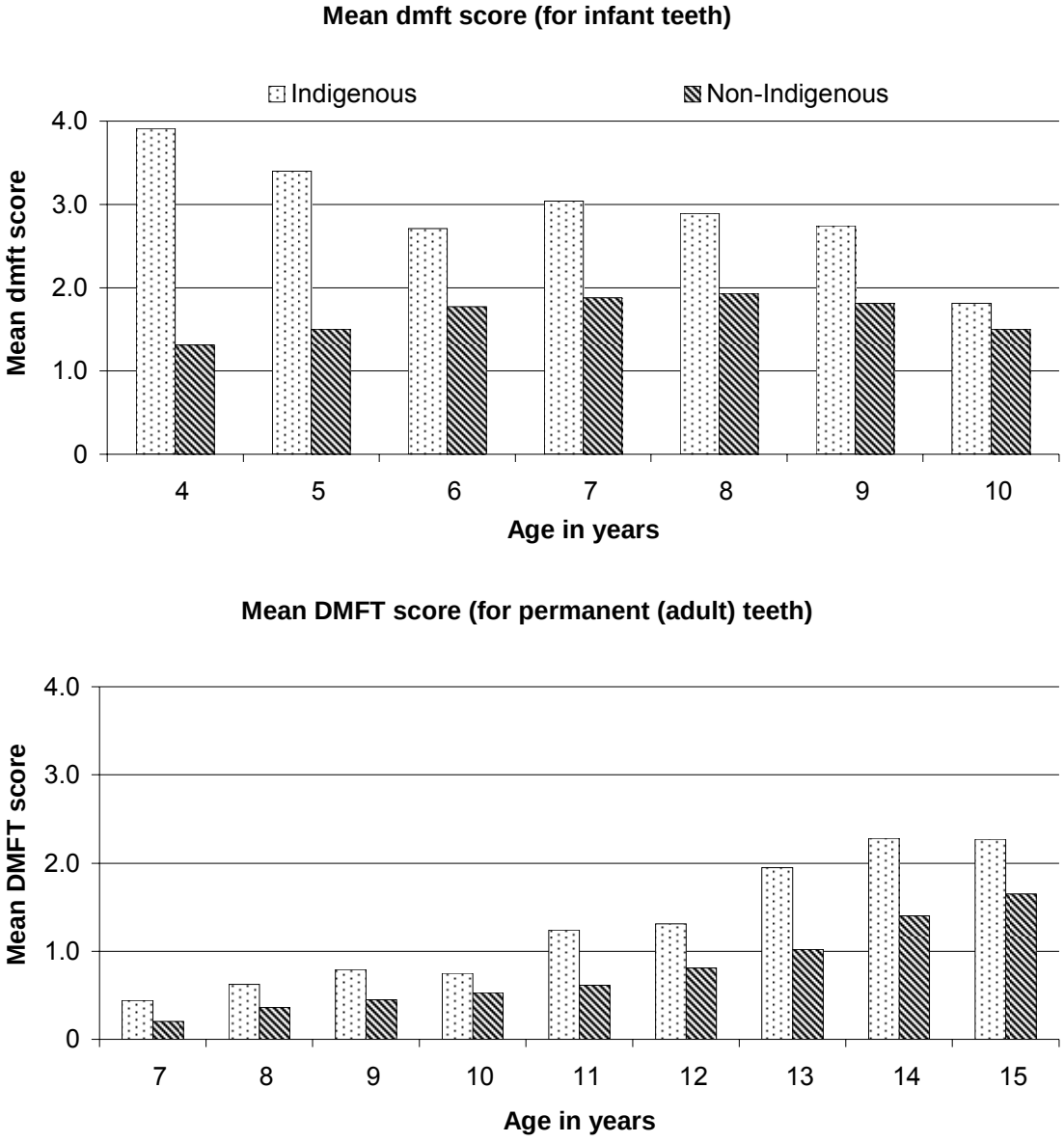
A similar trend was found for permanent tooth decay scores for Indigenous children, with the average number of decayed teeth decreasing as the level of disadvantage decreased from SEIFA category '1' to '3' (table 5A.5.5). Average scores were higher for Indigenous children than non-Indigenous children across all ages (from six to 13 years) in SEIFA category '1' (table 5A.5.5).

For non-Indigenous children, there was no consistent pattern between the average number of decayed teeth (infant and permanent) and the level of disadvantage as measured by SEIFA (tables 5A.5.4 and 5A.5.5).

Tooth decay among Indigenous and non-Indigenous children in SA

Average tooth decay scores for Indigenous and non-Indigenous children attending school dental services in SA, presented in figure 5.5.2, were calculated using data from the 2002 Child Dental Health Survey (Ellershaw, Spencer and Slade 2005).

Figure 5.5.2 **SA, mean number of teeth with decay for 4–15 year old Indigenous and non-Indigenous children, by age group, 2002 Child Dental Health Survey[a]**

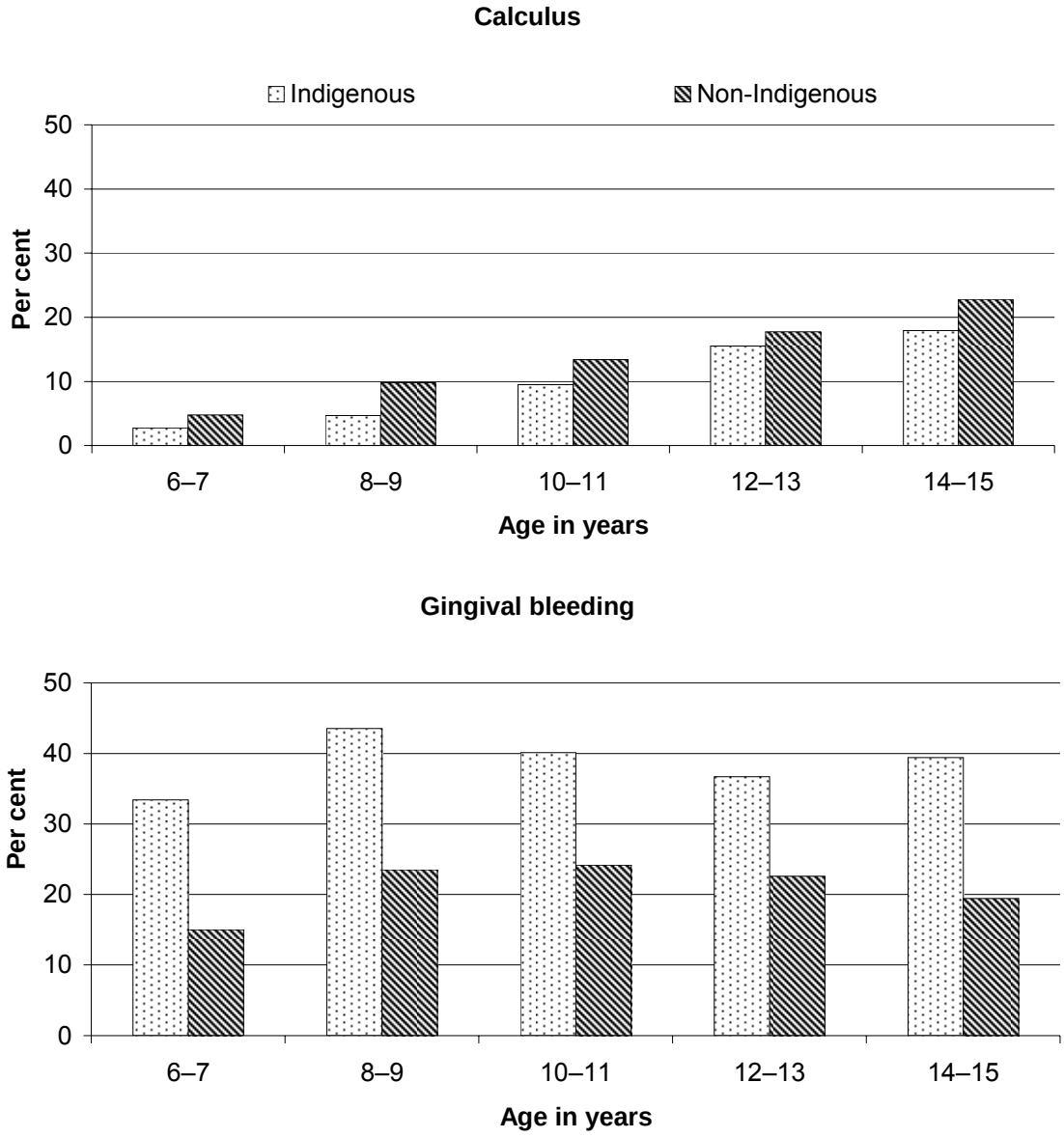


a D=number of untreated decayed teeth; M=number of missing teeth; F=number of filled teeth; DMFT=D+M+F (for permanent adult teeth); dmft refers to infant teeth and is derived in the same way as DMFT. The indicator DMFT=0 (dmft=0 for infant teeth) refers to decay-free teeth.

Source: Ellershaw, Spencer and Slade (2005); table 5A.5.6.

- According to the 2002 Child Dental Health Survey, average numbers of infant teeth with decay were higher for Indigenous children than non-Indigenous children across all ages (from four to 10 years) in SA. The highest scores for Indigenous children were 3.91 and 3.40 for four and five-year olds, respectively (figure 5.5.2). The greatest difference in scores between Indigenous and non-Indigenous children was for four-year-olds (3.91 for Indigenous children compared to 1.31 for non-Indigenous children) (figure 5.5.2).
- For both Indigenous and non-Indigenous children, permanent tooth decay scores increased with age (figure 5.5.2). Average scores for Indigenous children ranged from 0.44 for seven-year-olds to 2.27 for 15-year-olds, compared with 0.20 for non-Indigenous seven-year-olds and 1.65 for non-Indigenous 15-year-olds (figure 5.5.2). The greatest relative difference in scores between Indigenous and non-Indigenous children was for seven-year-olds; the score was 2.2 times greater for Indigenous children than non-Indigenous children (figure 5.5.2).

Figure 5.5.3 **SA, proportion of Indigenous and non-Indigenous children with calculus and gingival bleeding, by age group, 2002 Child Dental Health Survey[a, b]**



a Gingival bleeding is bleeding of the gums associated with gingivitis, which is an inflammation of the gums surrounding the teeth caused by a buildup of plaque or food particles. **b** Calculus is a hard deposit of mineralized plaque which is attached to crowns and/or roots of teeth.

Source: Ellershaw, Spencer and Slade (2005); table 5A.5.7.

- For each age group presented in figure 5.5.3, a smaller proportion of Indigenous children had calculus than non-Indigenous children. For both Indigenous and non-Indigenous children, the proportion with calculus increased with age. Eighteen per cent and 22.8 per cent, respectively, of 14–15-year old Indigenous and non-Indigenous children had calculus.

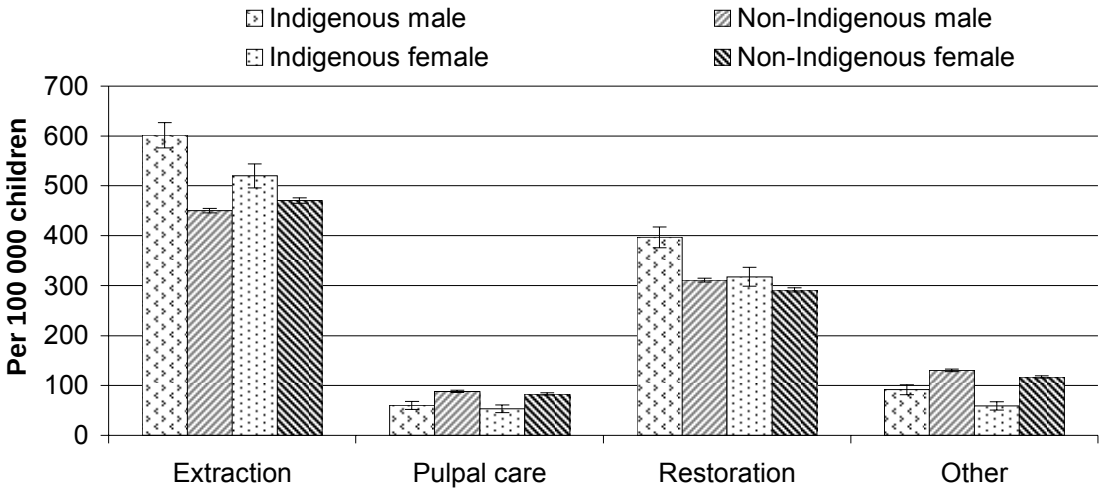
- A greater proportion of Indigenous children had gingival bleeding than non-Indigenous children across all age groups (figure 5.5.3). Forty-four per cent of Indigenous children aged 8–9 years suffered from gingival bleeding, greater than any other age group.

Hospital dental admission and procedure rates for Indigenous children living in all Australian states and territories

In 2002-03, dental hospitalisation rates for male and female Indigenous children (aged two to 14 years) were higher than the rates for male and female non-Indigenous children, based on dental hospitalisations data from 1297 public and private hospitals (AIHW National Hospital Morbidity Database) (table 5A.5.8). Dental hospitalisation rates for Indigenous children aged under five years and those living in remote areas were particularly high compared with rates for non-Indigenous children and Indigenous children of other age groups or remoteness areas (table 5A.5.8).

Figures 5.5.4, 5.5.5 and 5.5.6 compare the hospital dental procedure rates for Indigenous and non-Indigenous children aged two to 14 years by sex, age group and remoteness. Over 80 dental procedure codes (International Classification of Diseases Australian Modification) were grouped into ‘extraction’, ‘pulpal care’, ‘restorative care’, or ‘other’ (including the provision of splints, crowns or bridges) (Jamieson and Roberts-Thomson 2006).

Figure 5.5.4 **Hospital dental procedure rates for children aged 2–14 years, by type of procedure and sex, 2002-03**[a, b, c, d, e]

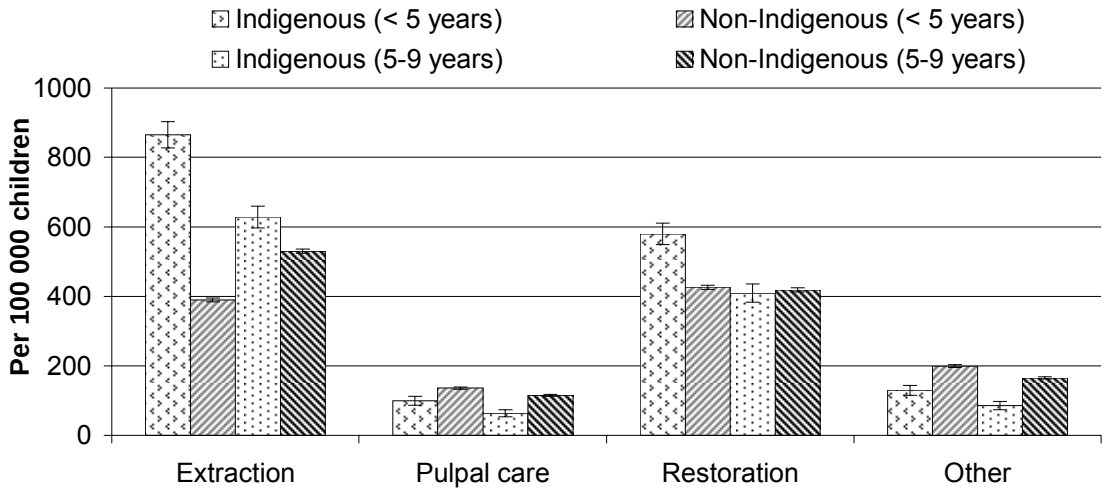


[a] Error bars represent 95 per cent confidence intervals around each estimate. [b] Extraction procedures are performed to remove decayed, damaged, malformed, or malpositioned teeth. [c] Pulpal care refers to procedures carried out on the soft inner structure of a tooth, consisting of nerve and blood vessels. [d] Restoration procedures involve placing a material in a tooth to restore function and morphology when tooth structure has been lost due to decay or fracture (generally, because of extensive caries), or to improve the aesthetics of the tooth. [e] Other includes the provision of splints, crowns or bridges.

Source: Jamieson and Roberts-Thomson (2006); table 5A.5.9.

- Extraction is an invasive procedure used on patients with excessive decay (that is, when multiple teeth are affected or when time constraints preclude more comprehensive care) (Jamieson and Roberts-Thomson 2006). For Indigenous and non-Indigenous children, the rate of extraction procedures was greater than any other procedure rate presented in figure 5.5.4.
- For 'extraction' and 'restoration' procedures, rates for Indigenous males and females were greater than the rates for these procedures for non-Indigenous males and females (figure 5.5.4). The rate of 'extraction' procedures for Indigenous males was 1.3 times the rate for non-Indigenous males.
- For 'pulpal' and 'other' procedures, the rates for Indigenous males and females were less than the rates for these procedures for non-Indigenous males and females (figure 5.5.4).

Figure 5.5.5 **Hospital dental procedure rates for children aged 2–9 years, by type of procedure and age, 2002-03**[a, b, c, d, e]

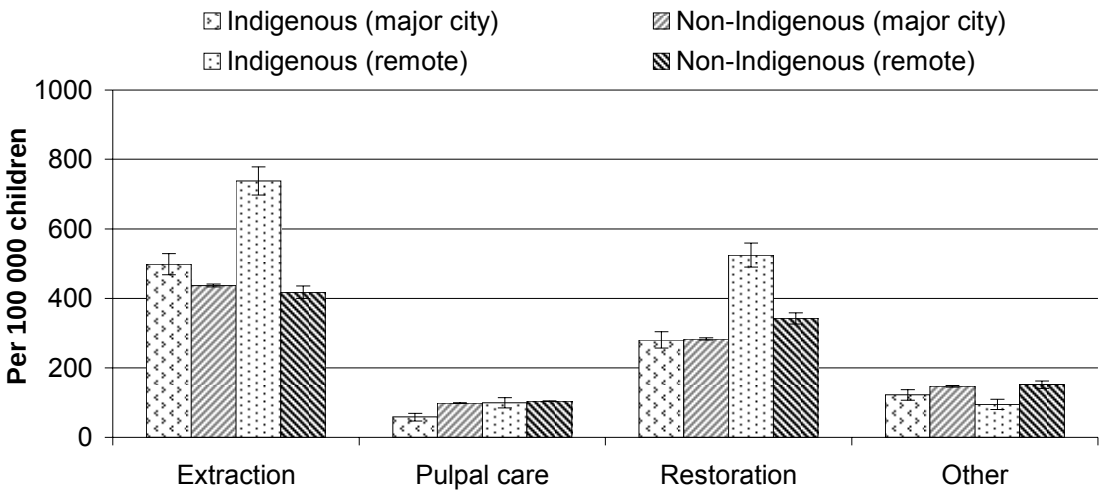


[a] Error bars represent 95 per cent confidence intervals around each estimate. [b] Extraction procedures are performed to remove decayed, damaged, malformed, or malpositioned teeth. [c] Pulpal care refers to procedures carried out on the soft inner structure of a tooth, consisting of nerve and blood vessels. [d] Restoration procedures involve placing a material in a tooth to restore function and morphology when tooth structure has been lost due to decay or fracture (generally, because of extensive caries), or to improve the aesthetics of the tooth. [e] Other includes the provision of splints, crowns or bridges.

Source: Jamieson and Roberts-Thomson (2006); table 5A.5.10.

- Indigenous children aged less than 5 years and 5–9 years of age experienced higher rates of 'extraction' procedures than non-Indigenous children in the same age groups (figure 5.5.5). The rate of 'extraction' procedures for Indigenous children aged less than five years was 2.2 times the rate for non-Indigenous children.
- The rate for 'restoration' procedures was also greater for Indigenous children aged less than 5 years; 1.4 times greater than the 'restoration' procedure rate for non-Indigenous children (figure 5.5.5).
- Similar to the pattern shown in figure 5.5.4, rates for 'pulpal' and 'other' procedures were lower among Indigenous children than non-Indigenous children in both age groups (figure 5.5.5).
- Indigenous children aged 10 to 14 years were hospitalised for extractions at around one third the rate for non-Indigenous children of the same age (table 5A.5.10).

Figure 5.5.6 **Hospital dental procedure rates for children aged 2–14 years, by type of procedure and remoteness area, 2002-03**[a, b, c, d, e]



[a] Error bars represent 95 per cent confidence intervals around each estimate. [b] Extraction procedures are performed to remove decayed, damaged, malformed, or malpositioned teeth. [c] Pulpal care refers to procedures carried out on the soft inner structure of a tooth, consisting of nerve and blood vessels. [d] Restoration procedures involve placing a material in a tooth to restore function and morphology when tooth structure has been lost due to decay or fracture (generally, because of extensive caries), or to improve the aesthetics of the tooth. [e] Other includes the provision of splints, crowns or bridges.

Source: Jamieson and Roberts-Thomson (2006); table 5A.5.11.

- Indigenous children in major cities and remote areas experienced greater rates of 'extraction' procedures than non-Indigenous children in the same locations. The rate of 'extraction' procedures for Indigenous children living in remote areas was nearly twice the rate for non-Indigenous children (figure 5.5.6). The rate for 'restoration' procedures for Indigenous children living in remote areas was 1.5 times greater than the rate for non-Indigenous children (figure 5.5.6).
- For 'pulpal care' and 'other' procedures, the rates for Indigenous children living in major cities were lower than the rates for non-Indigenous children (figure 5.5.6).

5.6 Future directions in data

Hearing impediments

There are only limited data available on the burden of hearing loss in Indigenous children. Comprehensive, up-to-date data need to be collected to enable the assessment of the type and severity of ear infections in the Indigenous population.

The proposed Longitudinal Study of Indigenous Children (LSIC) may collect data on hearing impediments.

Children with tooth decay

Reliable data on the dental health status of Indigenous children are currently limited to three jurisdictions (NSW, SA and NT). There is considerable scope to expand the availability of comparable data on Indigenous children's dental health so that a national picture can be seen as well as variations over time and by remoteness area.

5.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 5A.2.1 is table 1 in the attachment tables for section 5.2). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

5.1 Injury and preventable diseases

Table 5A.1.1	Number and rate of hospitalisations for injury and potentially preventable diseases for children aged less than 4 years, Qld, WA, SA, and public hospitals in the NT, 2004-05
Table 5A.1.2	Deaths from external causes and preventable diseases for children aged less than 5 years, 2001−2005

5.2 Infant mortality

Table 5A.2.1	Infant mortality rates (per 1000 live births)

5.3 Birthweight

Table 5A.3.1	Baby's birthweight, by live births and fetal deaths, 2002–2004
Table 5A.3.2	Baby's birthweight, by live births and fetal deaths, 2001–2003
Table 5A.3.3	Baby's birthweight, by live births and fetal deaths, 2000–2002
Table 5A.3.4	Baby's birthweight, by live births and fetal deaths, 1999–2001
Table 5A.3.5	Baby's birthweight, by live births and fetal deaths, 1998–2000

5.4 Hearing impediments

Table 5A.4.1 Persons with a long-term hearing problem: type of ear/hearing problem, by age and Indigenous status, 2004-05 (per cent of population)

Table 5A.4.2 Persons with a long-term hearing problem: type of ear/hearing problem, by age and Indigenous status, 2001 (per cent of population)

Table 5A.4.3 Persons with a long-term hearing problem: type of ear/hearing problem, by remoteness areas and Indigenous status, 2004-05 (per cent of population)

Table 5A.4.4 Persons with a long-term hearing problem: type of ear/hearing problem, by remoteness areas and Indigenous status, 2001 (per cent of population)

Table 5A.4.5 Persons with otitis media, by age and Indigenous status, 2004-05 (per cent of population)

Table 5A.4.6 Age specific separations where the principal diagnosis was diseases of the ear and mastoid process, Qld, WA, SA, and public hospitals in NT, 2004-05

Table 5A.4.7 Age specific separations where the principal diagnosis was diseases of the ear and mastoid process, Qld, WA, SA, and public hospitals in NT, 2003-04

Table 5A.4.8 Age specific separations where the principal diagnosis was diseases of the ear and mastoid process, Qld, WA, SA and public hospitals in NT, 2002-03

Table 5A.4.9 Age specific separations where the principal diagnosis was diseases of the ear and mastoid process, Qld, WA, SA and public hospitals in NT, 2001-02

5.5 Children with tooth decay

Table 5A.5.1 Decayed and decay-free infant teeth in 4- to 10-year-old children enrolled in school dental services in NSW, SA and the NT, by Indigenous status and location

Table 5A.5.2 Decayed and decay-free permanent teeth in 6- to 14-year-old children enrolled in school dental services in NSW, SA and the NT, by Indigenous status and location

Table 5A.5.3 Mean number of teeth with decay for children enrolled in the NT School Dental Service, by age and Indigenous status, 2002-03

Table 5A.5.4 Mean tooth decay (dmft) for 4- to 10-year-old children enrolled in the NT School Dental Service, by SEIFA index of relative socio-economic disadvantage, age and Indigenous status, 2002-03

Table 5A.5.5 Mean tooth decay (DMFT) for 6- to 13-year-old children enrolled in the NT School Dental Service, by SEIFA index of relative socio-economic disadvantage, age and Indigenous status, 2002-03

Table 5A.5.6 SA, infant and permanent tooth decay, mean dmft and DMFT by Indigenous status and age, 2002 Child Dental Health Survey

Table 5A.5.7 SA, proportion of children with calculus and gingival bleeding by Indigenous status and age, children attending school dental service, 2002 Child Dental Health Survey

Table 5A.5.8 Dental hospitalisations for children aged 2 to 14 years, per 100 000 children, by sociodemographic characteristics and Indigenous status, 2002-03

Table 5A.5.9 Hospital dental procedure rates for children aged 2 to 14 years, per 100 000 children, by sex and Indigenous status, 2002-03

Table 5A.5.10 Hospital dental procedure rates for children aged 2 to 14 years, per 100 000 children, by age group and Indigenous status, 2002-03

Table 5A.5.11 Hospital dental procedure rates for children aged 2 to 14 years, per 100 000 children, by remoteness area and Indigenous status, 2002-03

5.8 References

5 Early child development and growth (prenatal to age 3)

AHMAC (Australian Health Ministers' Advisory Council) 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*, AHMAC, Canberra.

Barker, D.J.P. 1995, 'Fetal origins of coronary heart disease', *British Medical Journal*, July 1995, 311:171–174, http://bmj.bmjjournals.com/cgi/content/full/311/6998/171?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&author1=Barker&title=Fetal+origins+of+coronary+heart+disease&searchid=1066711293030_23493&stored_search=&FIRSTINDEX=0&sortspec=relevance&resourcetype=1,2,3,4,10 (accessed 20 August 2003).

—— Forsen, T., Uutela, A., Osmond, C. and Eriksson, J.G. 2001, 'Size at birth and resilience to effects of poor living conditions in adult life: longitudinal study', *British Medical Journal*, December 2001, 323:1273, http://bmj.bmjjournals.com/cgi/content/full/323/7324/1273?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&author1=barker&title=size+at+birth+and+resilience&searchid=1066711789231_23529&stored_search=&FIRSTINDEX=0&sortspec=relevance&resourcetype=1,2,3,4,10 (accessed 20 August 2003).

Bowd, A. 2002, *Otitis Media: Its Health, Social and Educational Consequences Particularly for Canadian Inuit, Metis and First Nations Children and Adolescents*, Centre of Excellence for Children and Adolescents with Special Needs, Lakehead University, Thunder Bay, Ontario.

Couzos, S., Metcalf, S. and Murray, R. 1999, *Aboriginal Primary Health Care: An Evidence - Based Approach*, Oxford University Press, Melbourne.

Couzos, S. Metcalf, S. and Murray, R.B. 2001, *Systematic Review of Existing Evidence and Primary Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations*, National Aboriginal Community Controlled Health Organisation (NACCHO) for the Office of Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Ageing, Canberra.

DHAC (Commonwealth Department of Health and Aged Care) 1999, *The National Environmental Health Strategy*, Canberra.

Fall, C., Vijayakumar, M., Barker, D., Osmond, C. and Duggelby, S. 1995 'Weight in infancy and prevalence of coronary heart disease in adult life', *British Medical Journal*, no. 310, pp.17–19.

Keating, D.P. and Hertzman, C. (eds) 1999, *Developmental Health and the Wealth of Nations: Social, Biological and Educational Dynamics*, Guilford Press, New York.

Mackerras, D. 1998, *Evaluation of the Strong Women, Strong Babies, Strong Culture Program: Results for the Period 1990-1996 in the Three Pilot Communities*, Menzies Occasional Papers, Issue No 2/98, Menzies School of Health Research, Darwin.

McCain, M.N. and Mustard, J.F. 1999, *Reversing the Real Brain Drain, Early Years Study, Final Report*, Ontario Children's Secretariat, Toronto.

NACCHO (National Aboriginal Community Controlled Health Organisation) 2003, *NACCHO Ear Trial and School Attendance Project*, final report to the Department of Education Science and Training, NACCHO, Canberra.

NTDE (Northern Territory Department of Education) 1999, *Learning Lessons, An Independent Review of Indigenous Education in the Northern Territory*, Darwin.

Sayers, D., and Powers, J. 1997, 'Risk factors for Aboriginal low birthweight, intrauterine growth retardation and preterm birth in the Darwin Health Region', *Australian and New Zealand Journal of Public Health*, 21(5):524-530.

Smith, A., McKenzie, I. and Hatcher, J. 1995, 'Treatment of chronic suppurative otitis media' in Douglas, R., Berman, S., Black, R.E., Bridges-Webb, C., Campbell, H., Glezen, P., Goodman, S., Lozano, J., Margolis, P., Shimouchi, A., Steinhoff, M., Wang, E. and Zhu, Z. (eds), *Acute Respiratory Infections Module of the Cochrane Database of Systematic Reviews*, [updated 24 February 1995], BMJ Publishing Group, London.

Zubrick, S.R., Lawrence, D.M., Silburn, S.R., Blair, E., Milroy, H., Wilkes, T., Eades, S., D'Antoine, H., Read, A., Ishiguchi, P., Doyle, S. 2004, *The Western Australian Aboriginal Child Health Survey: the Health of Aboriginal Children and Young People*, Telethon Institute for Child Health Research, Perth.

5.1 Injury and preventable diseases

ABS (Australian Bureau of Statistics) 1997, *Australian Social Trends 1997 Health - Mortality & Morbidity: Infectious diseases*, http://www.abs.gov.au/Ausstats/abs@.nsf/0/61bbd6935d9ef749ca2569bb00164f67?OpenDocument (accessed 20 August 2003).

——2007, *Causes of Death, Australia 2005*, Cat. no. 3303.0, Canberra.

ABS and AIHW (Australian Institute of Health and Welfare) 2003, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2003*, ABS Cat. no. 4704.0, AIHW Cat. no. IHW11, Canberra.

Central Public Health Unit Network Sunshine Coast 2005, *Jabba Jabba Immunisation Program Final Evaluation*, Queensland Health, Queensland.

Currie, B.J. and Carapetis, J.R. 2000, 'Skin infection and infestations in Aboriginal communities in northern Australia', *Australian Journal of Dermatology* vol. 41, pp. 139–145, quoted in Zubrick *et al.* (2004).

Central Public Health Unit Network Sunshine Coast 2005, *Jabba Jabba Immunisation Program Final Evaluation May 2005*, Queensland Health, Maroochydore, Queensland.

On-line Medical Dictionary, http://cancerweb.ncl.ac.uk/omd/ (accessed 26 June 2005).

Zubrick, S.R., Lawrence, D.M., Silburn, S.R., Blair, E., Milroy, H., Wilkes, T., Eades, S., D'Antoine, H., Read, A., Ishiguchi, P., Doyle, S. 2004, *The Western Australian Aboriginal Child Health Survey: the Health of Aboriginal Children and Young People*, Telethon Institute for Child Health Research, Perth.

5.2 Infant mortality

ABS (Australian Bureau of Statistics) 2004, *Deaths, Australia 2003*, Cat. no. 3302.0, Canberra.

—— 2006, *Deaths, Australia 2005*, Cat. no. 3302.0, Canberra.

—— 1996, *Occasional Paper: Mortality and Indigenous Australians*, Cat. no. 3315.0, Canberra.

AHMAC (Australian Health Ministers' Advisory Council) 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*, Canberra.

Atkinson, R. 2001, 'Antenatal care and perinatal health – how to do it better in an urban Indigenous community. *Proceedings of the 6th National Rural Health Conference*, Canberra, 2001.

Panaretto, K.S., Lee, H.M., Mitchell. M.R., Larkins, S.L., Manessis, V., Buettner, P.G., Watson., D. 2005, 'Impact of a collaborative shared antenatal care program for urban Indigenous women: a prospective cohort study', *Medical Journal of Australia*, vol. 182, pp. 514–519.

TAIHS (Townsville Aboriginal and Islander Health Service) 2005, *Mums and Babies Project: Project Report*, Townsville, Queensland.

5.3 Birthweight

ABS (Australian Bureau of Statistics) and AIHW (Australian Institute of Health and Welfare) 2003, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Cat. no. 4704.0, Canberra.

—— 2005, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Cat. no. 4704.0, Canberra.

Ah Chee, D., Alley, S. and Milera, S. 2001, 'Congress Alukura — women's business', *Proceedings of the 4th Australian Women's Health Conference*, Adelaide, 19–21 February, pp. 167–174.

AIHW 2003, *Australia's Mothers and Babies 2000*, Cat. no. PER 21, National Perinatal Statistics Unit Sydney, http://www.npsu.unsw.edu.au/ps12.pdf (accessed 11 August 2003).

Aspery, W., Jarrett, J. and Donovan, I., 1998, 'Durri Aboriginal Corporation Medical Service — Djuligalban Program', pp. 75–77 in: Groos, A., Engeler, T., Miller, M. and McDonald, M.A, *Stories & Ideas from around Australia. Giving Aboriginal and Torres Strait Islander Babies the Best Start in Life: Supporting Breastfeeding and Good Food Choices for Infants*, Department of Social and Preventative Medicine, Northern Clinical School, University of Queensland, the Tropical Public Health Unit; and Apunipima, Cape York Health Council, Cairns.

Bootle, L. and Toomey, R. 2006, 'Marrang, "Good and Friend" — an Aboriginal child and family health model', presentation from the Greater Western Area Health Service at the NSW Health Expo, 19–20th October, http://www.archi.net.au/e-ibrary/health_administration/awards06/access/marrang (accessed 29 March 2007).

Carter, E., Lumley, J., Wilson, G., Bell, S. 2004, 'Alukura … for my daughters and their daughters and their daughters. A review of Congress Alukura', *Australian and New Zealand Journal of Public Health*; vol. 28, pp. 229–34.

Dorman, R. 1997, 'Ngua Gundi (Mother and Child) Program', *Aboriginal and Islander Health Worker Journal* vol. 21, pp. 2–6.

Dwyer, G. 2005, 'Koori Maternity Services', presentation to the Rural Health Conference, 18–19 May, Beechworth, Victoria, http://www.vha.org.au/content/Presentations/2005/Rural%20Health_2005/A1_Gil%20Dwyer.pdf (accessed 29 March 2007).

Fall, C., Vijayakumar, M., Barker, D., Osmond, C. and Duggelby, S. 1995 'Weight in infancy and prevalence of coronary heart disease in adult life', *British Medical Journal*, no. 310, pp.17–19.

Mackerras D 1998, *Evaluation of the Strong Women, Strong Babies, Strong Culture Program: Results for the Period 1990-1996 in the Three Pilot Communities*, Menzies Occasional Papers, Issue No 2/98, Menzies School of Health Research, Darwin.

OATSIH (Office for Aboriginal and Torres Strait Islander Health) 2001, *Better Health Care*. Canberra.

Perkins, S. 1998, *The Ngua Gundi (Mother/Child) Project 1993–1996*, Queensland Health, Rockhampton.

Pholeros, P., Rainow, S. and Torzillo, P. 1993, *Housing for Health. Towards a Healthy Living Environment for Aboriginal Australia*, HealthHabitat, Newport Beach.

Plunkett, A., Lancaster, P. and Huang, J. 1996, *Indigenous Mothers and their Babies Australia 1991–1993*, AIHW National Perinatal Statistics Unit: Perinatal Statistics Series No. 4, Sydney.

Rousham, E. and Gracey, M. 2002 'Factors affecting birthweight of rural Australian Aborigines', *Annals of Human Biology*, vol. 29, no. 4, pp. 363–372.

Sayers, D. and Powers, J. 1997, 'Risk factors for Aboriginal low birthweight, intrauterine growth retardation and preterm birth in the Darwin Health Region', *Australian and New Zealand Journal of Public Health*, 21(5):524–530.

Singh, G. and Hoy, W. 2003, 'The association between birthweight and current blood pressure: a cross-sectional study in an Australian Aboriginal community', *Medical Journal of Australia*, vol. 179, pp. 532–535, November.

Sloman, D., Shelley, J., Watson, L. and Lumley, J. 1999, 'Obstetric and Child Health Outcomes on the Anangu Pitjantjatjara Lands, 1984-1996: A preliminary analysis', proceedings of the Canberra: National Rural Health Alliance 5th National Rural Health Conference, 14-17 March, Adelaide.

5.4 Hearing impediments

ABS (Australian Bureau of Statistics) 2006, *National Aboriginal and Torres Strait Islander Health Survey, 2004-05*, Cat. no. 4715.0, Canberra.

AHMAC (Australian Health Ministers' Advisory Council) 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*, Canberra.

AIHW (Australian Institute of Health and Welfare) 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Cat. no. HSE 101, Canberra.

Bailie, R.S., Stevens, M.R., McDonald, E., Halpin, S., Brewster, D., Robinson, G. and Guthridge, S. 2005, 'Skin infection, housing and social circumstances in children living in remote Indigenous communities: testing conceptual and methodological approaches', *BMC Public Health*, vol. 8, no. 5, p. 128.

Boswell, J. and Nienhuys, T.1996, 'Patterns of persistent otitis media in the first year of life in Aboriginal and non-Aboriginal infants', *The Annals of Otology, Rhinology and Laryngology*, vol. 105, no. 11, pp. 898–900.

Brouwer, C.N., Rovers, M.M., Maille, A.R., Veenhoven, R.H., Grobbee, D.E., Sanders, E.A. and Schilder, A.G. 2005, 'The impact of recurrent acute otitis media on the quality of life of children and their caregivers', *Clinical Otolaryngology*, vol. 30, no. 3, pp. 258–65.

Burrow, S. and Thomson, N. 2003, 'Ear Disease and Hearing Loss', in Thomson, N. (eds), *The Health of Indigenous Australians*, Oxford University Press, South Melbourne, pp. 247–272.

Burrow, S. and Thomson, N. 2006, 'Summary of Indigenous health: ear disease and hearing loss', *Aboriginal and Islander Health Worker Journal*, vol. 30, no. 1, pp. 10–11.

Close, G.R., Murphy, E.P. and Goodwin, A. 1996, 'Guidelines on the prevention and control of otitis media and its sequelae in Aboriginal children', *Medical Journal of Australia*, vol. 164 (Supplement), pp. S1–S17.

Coates, H.L., Morris, P.S., Leach, A.J. and Couzos, S. 2002, 'Otitis media in Aboriginal children: tackling a major health problem', *The Medical Journal of Australia*, vol. 177, no. 4, pp. 177–178.

Couzos, S., Metcalf, S. and Murray, R.B. 1999, 'Ear health', in Couzos, S. and Murray, R. (eds), *Aboriginal Primary Health Care: An Evidence-based Approach*, Oxford University Press, South Melbourne, pp. 240–320.

Couzos, S. Metcalf, S. and Murray, R.B. 2001, *Systematic Review of Existing Evidence and Primary Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations*, National Aboriginal Community Controlled Health Organisation (NACCHO) for the Office of Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Ageing, Canberra.

Howard, D. and Hampton, D. 2006, 'Ear disease and Aboriginal families', *Aboriginal and Islander Health Worker Journal*, vol. 30, no. 3, pp. 9–11.

Jones, R. and Smith, F. 2006, 'Are there health benefits from improving basic nutrition in a remote Aboriginal community?', *Australian Family Physician*, vol. 35, no. 6, pp. 453–4.

Leach, A.J., Boswell, J.B., Asche, V., Nienhuys, T.G. and Mathews, J.D. 1994, 'Bacterial colonisation of the nasopharynx predicts very early onset and persistence of otitis media in Australian Aboriginal infants', *The Pediatric Infectious Disease Journal*. vol.13, pp. 983–989.

Lehmann, L., Tennant, M., Silva, D., McAullay, D., Lannigan, F., Coates, H. and Stanley, F. 2003, 'Benefits of swimming pools in two remote Aboriginal communities in Western Australia: intervention study', *British Medical Journal*; 327(7412):415-419.

Lowell, A. 1991, 'Effects of Otitis media on the development of communications skills in Aboriginal Children', paper presented at the Education for All Conference, Darwin, September (cited in Nienhuys (1992)).

Menzies School of Health Research 2001, *Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander populations*, Commonwealth Department of Health and Aged Care, Canberra.

Morris, P.S., Leach A.J., Silberberg P., Mellon G., Wilson C., Hamilton E. and Beissbarth J. 2005, 'Otitis media in young Aboriginal children from remote communities in Northern and Central Australia: a cross-sectional survey', *BMC Pediatrics*, vol. 20, no. 5, pp. 27–36.

Morris, P.S., Leach, A.J., Halpin, S., Mellon, G., Gadil, G., Wigger, C., Mackenzie, G., Wilson, C., Gadil, E. and Torzillo, P. 2006, 'An overview of acute otitis media in Australian Aboriginal children living in remote communities', *Vaccine*, September 22.

Nienhuys, T.G. 1992, 'The significance of prelingual conductive hearing loss for auditory and linguistic development of Aboriginal infants', *Conference Proceedings Medical Options for Prevention and Treatment of Otitis Media in Australian Aboriginal Infants,* Menzies School of Health Research and the Australian Doctors Fund Darwin, 16–18 February, http://www.adf.com.au/archive.php?doc_id=137 (accessed 9 June 2005).

New South Wales Department of Health (NSW DoH) 2002, *Report of the New South Wales Chief Health Officer Aboriginal and Torres Strait Islander Peoples Otitis Media and Myringotomy by Indigenous Status,* http://www.health.nsw.gov.au/public-health/chorep/atsi/atsi_om.pdf (accessed 21 July 2003).

TICHR (Telethon Institute for Child Health Research) 2006, *The Swimming Pool Study, 2000–2006*, Western Australian Department of Housing and Works and Western Australian Department of Health, Perth.

Thorne, J.A. 2004, 'Middle ear problems in Aboriginal school children cause developmental and educational concerns', *Contemporary Nurse*, vol. 16, no. 1–2, pp. 145–150.

WHO (World Health Organisation) 2006, *Deafness and Hearing Impairment*, http://www.who.int/mediacentre/factsheets/fs300/en/index.html (accessed 20 November 2006)

Zubrick, S.R., Lawrence, D.M., Silburn, S.R., Blair, E., Milroy, H., Wilkes, T., Eades, S., D'Antoine, H., Read, A., Ishiguchi, P., Doyle, S. 2004, *The Western Australian Aboriginal Child Health Survey: the Health of Aboriginal Children and Young People*, Telethon Institute for Child Health Research, Perth.

5.5 Children with tooth decay

AIHW (Australian Institute of Health and Welfare) 1996, '*Australia's Health*', quoted in Al-Yaman, F., Bryant, M. and Sargeant, H. 2002, *Australia's Children: their Health and Wellbeing 2002*, Cat. no. PHE 36, AIHW, Canberra, p. 225.

—— 1998, '*International Health, How Australia Compares*' quoted in Al-Yaman, F., Bryant, M. and Sargeant, H. 2002, *Australia's Children: their Health and Wellbeing 2002*, Cat. no. PHE 36, AIHW, Canberra, p. 225.

—— 2000, *Oral Health and Access to Dental Services among Indigenous Australians*, Cat. no. DEN 64, University of Adelaide, Adelaide.

Al-Yaman, F., Bryant, M. and Sargeant, H. 2002, *Australia's Children: their Health and Wellbeing 2002*, Cat. no. PHE 36, AIHW, Canberra.

Armfield, J.M. and Roberts-Thomson, K.F. 2004, *Child Dental Health Survey, Northern Territory 2001*, AIHW and the University of Adelaide, Adelaide.

AHMAC (Australian Health Ministers' Advisory Council) 2006, *Aboriginal and Torres Strait Islander Health Performance Framework*, Department of Health and Ageing, Canberra.

Davies, M.J., Spencer, A.J., Westwater, A., and Simmons, B. 1997, 'Dental caries among Australian Aboriginal, non-Aboriginal Australian born, and overseas-born children', *Bulletin of the World Health Organisation*, 75 (3), pp. 197–203.

Ellershaw, A., Spencer, A.J., Slade, G.D. 2005, *Oral Health in South Australia 2004*, Australian Research Centre for Population Oral Health, University of Adelaide.

Endean, C., Roberts-Thomson, K., and Wooley, S. 2004, 'Anangu oral health: the status of the Indigenous population of the Anangu Pitjantjatjara lands', *Australian Journal of Rural Health*, 12, pp. 99–103.

Harford, J., Spencer, J., Roberts-Thomson, K. 2003, 'Oral health', in Thomson, N., (ed.), *The Health of Indigenous Australians*, Oxford University Press, South Melbourne, pp. 247–272.

Jamieson, L., Roberts-Thomson, K.F., 2006, 'Indigenous children and receipt of hospital dental care in Australia', *International Journal of Paediatric Dentistry*, 16, pp. 327–34.

Jamieson, L., Armfield, J.A., Roberts-Thomson, K.F., 2006a, 'The role of location in Indigenous and non-Indigenous child oral health', *Journal of Public Health Dentistry*, 66, pp. 123–30.

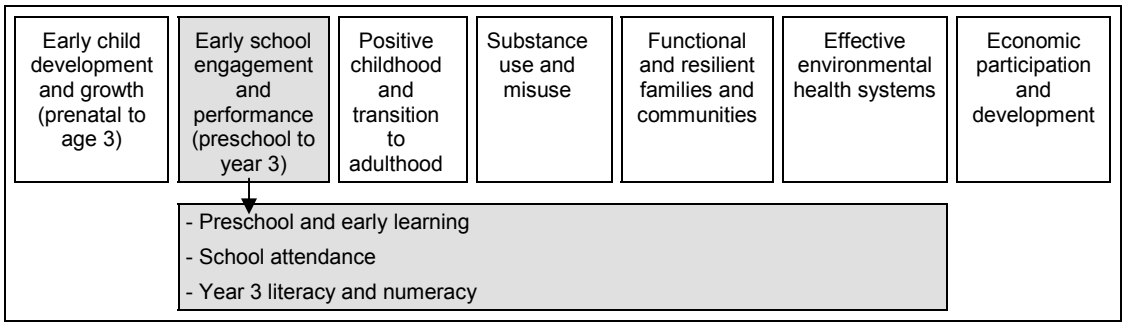
Jamieson, L., Armfield, J.A., Roberts-Thomson, K.F., 2006b, 'Oral health inequalities among Indigenous and non-Indigenous children in the Northern Territory of Australia', *Community Dentistry and Oral Epidemiology*, 34, pp. 267–76.

National Advisory Committee on Oral Health 2004, *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*, for South Australia Department of Health.

University of NSW 2006, *Filling the Gap*, http://www.fillingthegap.com.au (accessed 27 February 2007).

6 Early school engagement and performance (preschool to year 3)

Strategic areas for action



The indicators in this chapter concentrate on the early years of schooling. Actions to improve early years school attendance and learning can improve outcomes in the immediate, medium and long term for Indigenous children.

As a result of consultation after the 2005 Report, the preschool and school attendance indicator from the 2005 Report has been split into two separate indicators — one for preschool and early learning and the other for school attendance. The change better reflects the importance of preschool as preparation for later schooling.

There is a growing recognition that early access to early childhood education and care provides young children, particularly from low-income and second-language groups, with a good start in life (OECD 2006). One of the findings from the Program for International Student Assessment (PISA) 2003 was that children who attended preschool for more than a year showed a statistically significant performance advantage in later school achievement over those without preschool attendance (OECD 2004). As no data are available on attendance, participation rates for preschool are contained in section 6.1.

Regular school attendance is critical to successful student outcomes. Children who are regularly absent from school are at the greatest risk of dropping out of school early, becoming long-term unemployed, being caught in the poverty trap, depending on welfare and being involved in the justice system (House of Representatives

Standing Committee on Employment, Education and Training 1996). As no data are available on attendance, participation rates for school (year 1 to year 3) are contained in section 6.2.

Australian and international research since the 1960s has examined the link between poverty and poor educational outcomes with increasing recognition of the complexity of the individual, family, community, social, cultural, political and economic factors involved (see Connell et al 1982; Connell, White and Johnston 1991; Fine 1991; Thomson 2002). This relationship between student performance and socio-economic status may explain in part the lower literacy and numeracy achievement of Indigenous primary school students compared with non-Indigenous students. Achievements against literacy and numeracy benchmarks are examined in sections 6.3 and 7.1.

Providing high quality schooling that children attend regularly, can help Indigenous children gain the best educational start. Learning outcomes also depend on a safe learning environment, good health and family and community support.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 6A.2.3). A list of attachment tables is in section 6.5. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

6.1 Preschool and early learning

Box 6.1.1 **Key messages**

- Preschool participation was slightly higher for Indigenous three year olds (18.6 per cent), than non-Indigenous three year olds (16.7 per cent) (table 6.1.1). However, preschool participation rates for Indigenous four and five year olds were lower than for non-Indigenous children in these age groups (table 6.1.1).
- Between 2002 and 2005, the number of Indigenous children aged three to five years old enrolled in preschool increased slightly, from 8729 to 9015 (from 24.2 per cent to 25.1 per cent of Indigenous children aged three to five) (table 6A.1.2).

Children who have access to, and attend, good quality early childhood (0–8 years) education programs have a head start at school (Elliott 2006; Frigo and Adams

2002). Gaps that appear in children's basic skills for life and learning that appear at age five or six are often difficult to close, even with targeted school interventions (Elliott 2006). This indicator examines preschool participation for Indigenous children aged 3–5 years.

In Australia, preschool attendance is not compulsory. There are some barriers to access to preschool in the forms of fees and program availability, particularly in remote and very remote regions (ANAO 2002; HREOC 2000; NTDE 1999). Overall, Indigenous children are less likely to participate in preschool than their non-Indigenous peers (MCEETYA 2001). In 2006, the COAG National Reform Agenda identified the importance of closing the gap between Indigenous and non-Indigenous children in the proportion of children who commence school with the basic skills for life and learning (COAG 2006).

Comparable attendance data for preschool were unavailable for this Report. Instead, data in this section present participation rates, which are based on enrolments as a proportion of children in the population. Participation rates do not reflect whether a child actually attends preschool on a regular basis. Zubrick et al (2006) contains data on pre-primary school and school attendance in Western Australia. Of the 970 Indigenous pre-primary school children in the sample, roughly half missed 26 or more pre-primary school days per year.

The impact of remoteness on preschool attendance is not explored in this Report, as data are not available by geographic regions. However, given that a higher proportion of Indigenous than non-Indigenous people live in rural and remote areas, any effect location might have on attendance would probably be more pronounced for Indigenous children.

Box 6.1.2 'Things that work' — increasing preschool attendance and learning outcomes

NT mobile preschool program

In the NT, a mobile preschool program is provided to Indigenous 3–5 year olds in the Eastern Plenty and Sandover Highways region, which has increased preschool access for Indigenous children in this remote area. The Australian Government is funding this project until 30 June 2007. The mobile service delivery model had been piloted in three hubs of up to six sites. During 2006, staff were recruited and playgroup coordinators commenced services at Engawala, Alparra, Mulga Bore, Harts Range and Ampilatwatja. The long term goal is to transfer service delivery to local community councils.

(Continued next page)

Box 6.1.2 (continued)

Yappera Children's Service Cooperative, Victoria

Yappera Children's Service Cooperative Ltd, based in Thornbury in metropolitan Melbourne (Victoria), is a Multifunctional Aboriginal Children's Service that provides a variety of services and assists Koori families in the surrounding area to participate in childcare as well as kindergarten. The centre supports 60 children per day and is linked to organisations that provide additional services such as speech therapy, exercise programs, drama workshops, parent/carer activities and programs, dental visits, audiology visits, optometry testing and support services for a smooth transition to primary school. The committee members are all Koori, and their approach to management and support enables strong links with the local community and promotes a philosophy of strengthening culture and participation.

Preschools in SA

For over 30 years, the South Australian preschool policy has enabled Aboriginal three year olds to access state preschools. Qualified teachers and early childhood workers emphasise working with families and communities to develop shared understandings, positive relationships and culturally inclusive practices. Programs are guided by the South Australian Curriculum, Standards and Accountability Framework, which supports ongoing learning across children's services and schools. Eight broad outcomes for children aged 0–5 years include trust and confidence, personal and group identity, positive relationships with others, effective communication, intellectual inquisitiveness, physical competencies and wellbeing. In the last four years, enrolments have increased, and reached 1156 in 2006. This is the highest ever number of Aboriginal children accessing preschool education in South Australia.

The number of children enrolled in preschool in 2005 was obtained from the National Indigenous Preschool Census (NIPC). As the definition of a preschool varies between jurisdictions, the NIPC uses the generic sense of the term 'preschool' to include all such State and Territory specific terminology. For example, what is termed a preschool in NSW, ACT and the NT, can also be called a kindergarten in Victoria, Queensland, WA and Tasmania, and a Child Parent Centre in SA (DEST 2006). At the time these data were collected, the term 'preschool' was used in Queensland. The term 'kindergarten' is also used in Queensland, mainly for the year before preschool.

Table 6.1.1 shows the participation rates in preschool for Indigenous and non-Indigenous 3, 4 and 5 year olds. The data do not include preschool services delivered in long day care centres.

Table 6.1.1 **Participation rates in preschool for Indigenous and non-Indigenous children, 2005**[a, b, c, d]

	Three year olds[e]		*Four year olds*		*Five year olds*[e]	
	Indigenous children (%)	*Non-Indigenous children (%)*	*Indigenous children (%)*	*Non-Indigenous children (%)*	*Indigenous children (%)*	*Non-Indigenous children (%)*
NSW	26.1	21.4	41.2	40.4	10.6	16.7
Victoria[f]	5.8	25.6	41.9	64.6	30.6	40.1
Queensland[g]	6.3	9.1	11.3	16.0	3.8	3.2
WA	13.8	2.3	93.0	87.0	4.1	2.9
SA	63.3	12.2	91.3	97.8	5.3	4.6
Tasmania	–	2.6	36.9	46.1	47.2	45.8
ACT	38.5	6.4	66.7	71.3	19.2	22.1
NT	25.7	9.6	70.3	82.5	16.1	8.1
Australia[h]	18.6	16.7	46.2	51.0	10.5	18.3

[a] The participation rate was derived by dividing enrolments for three, four and five year olds by the respective population of 3, 4 and 5 year olds in the jurisdiction. In practice, most children who attend preschool do so for one year, often when they are four years old, although some three year olds and five year olds attend preschool as well. Preschool programs in different jurisdictions target different age groups. [b] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. [c] The data exclude some children in preschool whose ages were unknown. [d] Preschool enrolments and participation rates reported in this table may include activities not funded by states and territories. [e] A small number of two year olds may be in the three year olds category and a small number of six year olds may be in the five year olds category. [f] The Victorian Government funds a kindergarten year for all children in the year before school entry. The cohort comprises four and five year old children, shown in two separate columns in this table. [g] Prior to 2007, the Queensland Government offered free non-compulsory, non-universal preschool in preschool centres attached to state primary schools, usually on a 0.5 week basis. From 2003 to 2006, a preparatory year was also offered to some students instead of preschool, on a trial basis. From 2007, all Queensland children will have access to a full-time preparatory (Prep) year of education before starting year 1. Children born between 1 January and 30 June 2002 are eligible to enrol in Prep in 2007. In 2008, the compulsory school starting age will increase so that children must be six by 30 June in the year they enrol in year 1. [h] The enrolment estimates for Australia exclude other territories. However, the population estimates for Australia include other territories, which reduces the comparability of the datasets. – Nil or rounded to zero.

Source: DEST 2006; ABS 2005 ERP (unpublished); table 6A.1.2.

- Table 6.1.1 shows that nationally in 2005, preschool participation was slightly higher for Indigenous 3 year olds (18.6 per cent), compared to non-Indigenous 3 year olds (16.7 per cent) Preschool participation rates for Indigenous 4 year olds and 5 year olds were lower than for non-Indigenous children in these age group.
- Overall, 25.1 per cent of Indigenous children aged 3–5 years were enrolled in preschools, compared to 28.8 per cent of non-Indigenous children aged 3-5 years. (table 6A.1.2).

- Total Indigenous preschool enrolment numbers increased slightly between 2002 and 2005, from 8729 to 9019 (from 24.2 per cent to 25.1 per cent of all Indigenous 3–5 year olds) (tables 6A.1.1, 6A.1.3).

6.2 School attendance (year 1 to year 3)

Box 6.2.1 **Key message**

- In 2006, the school participation rate for Indigenous five to eight year old children (96.9 per cent) was similar to that for non-Indigenous children (93.8 per cent) (figure 6.2.1, table 6A.2.1).

In Australia, school attendance is compulsory for children between 6 and 15 years of age (extending to 16 years of age in SA and from 5 to 16 in Tasmania). The Western Australian Aboriginal Child Health Survey has shown a direct relationship between the number of days absent from school and academic performance (Zubrick et al. 2006).

Studies have found that Australia's Indigenous children have lower school enrolment rates and lower school attendance rates than non-Indigenous children (UNICEF Innocenti Research Centre 2004; Schwab and Sutherland 2004; Taylor 2004). Further, Indigenous school children are less likely to have parental support, for example, help with homework, compared with non-Indigenous children (UNICEF Innocenti Research Centre 2004). This indicator examines school participation for years 1–3.

Comparable attendance data for school students in years 1–3 were unavailable for this Report. Instead, data in this section present participation rates, which are based on enrolments for five to eight year olds. These rates may identify whether there are children in the community who are not enrolled at school, however, they do not reflect whether a child actually attends school on a daily basis. Zubrick et al. (2006) presented comprehensive data and discussion on school attendance in WA. This survey found that the levels of school attendance of Aboriginal students were well below the levels of non-Aboriginal students.

Recently, the 'mutual obligation' approach has been a prominent policy tool to increase attendance rates at school. For example the 'no school, no pool' strategy has been used successfully in many areas throughout Australia to encourage attendance at school. During 2005, the Australian Government trialled a scheme in Hall's Creek in WA that docked welfare payments for parents, if their children were regularly absent from school. The trial was stopped due to concerns about whether

this approach was legal (DEWR 2006). In evaluating the trial, DEWR found three main contributing factors to low school attendance:

- lack of parental insistence that children go to school in the morning
- teacher quality
- bullying and teasing (DEWR 2006).

Examples of initiatives that have been found to increase attendance for Indigenous children at school are outlined in box 6.2.2.

Box 6.2.2 **'Things that work' — increasing school attendance**

Ngaripirliga'ajirri program, Tiwi Islands, NT

The Ngaripirliga'ajirri program is an early intervention program for Tiwi children of primary school age and their parents. Ngaripirliga'ajirri was implemented between 2000 and 2004 in three Tiwi primary schools.

Children were referred by teachers and other practitioners to attend the program, in groups of 6–8 children with one parent each, over a school term. The program included concurrent groups for children and parents. The work with children focused on social skills, while the work with parents focused on the formulation of behaviour management strategies for them to implement at home. Ngaripirliga'ajirri was redeveloped for the circumstances of Tiwi culture and its complex family structures.

An evaluation of the program found that children participated in more than 95 per cent of sessions, while parental participation was a little lower, with a mean of 66 per cent of sessions attended.

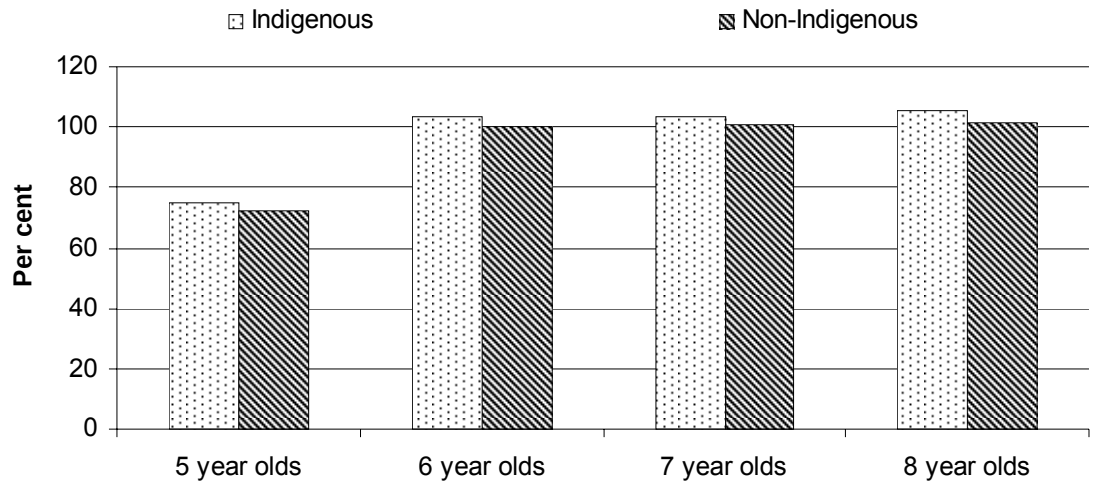
According to qualitative reports from teachers and parents, the outcomes of the program were:

- approximately 80 per cent of children showed a decline in problem behaviours at school, during and after attendance in the program, which were sustained at six months for 40 per cent of those children
- parents of between 60 to 80 per cent of children reported improved communication with their children
- parents of 50 per cent of children reported some improvement in child behaviour at home
- school attendance improved for children upon referral to the program, although this was not sustained for all children (Robinson and Tyler 2006).

The number of children enrolled in primary school in 2006 was based on the National Schools Statistics Collection (NSSC). The NSSC considered students enrolled in year one minus one (or pre-year one) to be in primary school.

In interpreting these data, readers should note that participation rates have been derived by dividing the number of children enrolled at school with the population projection for that age group. For 2006, the Indigenous population projections are likely to be less reliable because they were projected from the Census figures from 2001. For this reason, only the national figures are presented in figure 6.2.1. However, even at the national level, many of the estimates of school participation exceed 100 per cent. The data need to be interpreted with caution.

Figure 6.2.1 **School participation rates for Australian full time students, 2006[a]**



a Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the Non-Indigenous population. Calculations of rates for the Non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS NSSC (unpublished); ABS 2006 ERP (unpublished); table 6A.2.1.

- The projected 2001 Census figures result in participation rates exceeding 100 per cent for some age groups in figure 6.2.1. Overall, it appears that most or all Indigenous and non-Indigenous children of school age are enrolled at school. The estimates are lower for 5 year olds. Some of these children would have been in preschool, or may not have started school as it is not compulsory until six years of age in most states and territories (see table 6.1.1).
- In 2006, the national school participation rate for Indigenous five to eight year old children (96.9 per cent) was similar to that for non-Indigenous children (93.8 per cent) (figure 6.2.1 and table 6A.2.1).
- School enrolment numbers for Indigenous five to eight year olds increased from 45 069 students in 2005 to 46 428 students in 2006 (tables 6A.2.1 and 6A.2.2).

- School participation rates are based on enrolment numbers and do not measure whether enrolled children attend school.

6.3 Year 3 literacy and numeracy

Box 6.3.1 **Key messages**

- Between 1999 and 2005, Indigenous students' performance against the national reading, writing and numeracy benchmarks fluctuated, with no statistically significant trend (figures 6.3.1, 6.3.3 and 6.3.5).
- In 2005, the proportion of Indigenous year 3 students who did not achieve the national benchmark was substantially higher than the proportion of all students, for:
  - reading (22.0 per cent compared to 7.3 per cent) (figure 6.3.2)
  - writing (26.0 per cent compared to 7.2 per cent) (figure 6.3.4)
  - numeracy (19.6 per cent compared to 5.9 per cent) (figure 6.3.6).

The disparity in academic performance between Indigenous students and non-Indigenous students is evident from year 1 onwards, and is maintained until the mid high school years (Zubrick et al. 2006). Studies have shown that, unless preschool learning and early primary school assistance are provided, underperforming students are rarely able to catch up (Ou and Reynolds 2004; Reynolds et al. 2001; Schweinhart 2005). Section 6.1 has more information on preschool and early learning.

Indigenous children in remote areas have, on average, much lower rates of school attendance, achievement and retention than Indigenous children in urban areas and other Australian children (Storry 2006). In remote areas of the NT, only 3 to 4 per cent of Indigenous students achieved the national reading benchmark in 1999 (ANAO 2002). More timely data on the effect of remoteness for Indigenous students is not available.

The Trends in International Mathematics and Science Study (TIMSS) is an initiative of the International Association for the Evaluation of Educational Achievement. TIMSS assesses performance at year 4 and year 8 and focuses on the mathematics and science curriculum, identifying what concepts and processes students have learned, what factors are linked to students' opportunity to learn, and how these factors influence students' achievements. Australia has participated in each TIMSS (conducted in 1994-95, 1998-99 and 2002-03) (Thomson and Fleming 2004).

Some of the findings from the TIMSS 2002-03 for year 4 students include:

- overall, the mathematics and science achievement of Indigenous students was significantly lower than that of non-Indigenous students
- the difference in scores between Indigenous and non-Indigenous students was slightly larger in the TIMSS 2002-03 than in TIMSS 1994-95 (Thomson and Fleming 2004).

This indicator presents nationally comparable learning outcomes data for 2005 for year 3 reading, writing and numeracy. Nationally comparable learning outcomes data for year 3 for 2003 and 2004 are reported in the attachment tables.

In March 1997, national benchmarks for use in reporting years 3, 5 and 7 students' reading, writing and numeracy performance were developed. These benchmarks describe the nationally agreed minimum acceptable standard in each area of study at particular year levels. That is, a student who does not achieve the benchmark standard will have difficulty making sufficient progress at school.

Care needs to be taken in interpreting the learning outcomes data, because differences in student achievement may sometimes be the result of sampling or measurement error. The publication of confidence intervals with the benchmark results reflects the uncertainty associated with the measurement of student achievement and provides a way of making improved inferences about the achievement of students. The tables reporting benchmark achievement percentages include 95 per cent confidence intervals. For example, a result of 80 per cent with a confidence interval of ± 2.7 per cent means that we can say with 95 per cent confidence that 77.3 to 82.7 per cent of the students achieved the benchmark.

Some examples of initiatives that are improving educational outcomes for Indigenous students can be found in box 6.3.2.

Box 6.3.2 **'Things that work' — early literacy engagement**

MULTILIT Tutorial Centre, Coen, Queensland

In July 2005, a MULTILIT (Making Up Lost Time In Literacy) Tutorial Centre was established at Coen State School in Cape York. Coen is a remote Indigenous community about 500 kilometres from Cairns. The program involved taking the 15 least proficient readers and giving them intensive, systematic instruction in phonics for 17 to 18 weeks by specialist teachers. The children, whose reading ability had been three to four years behind the Australian average, gained an average 21.4 months in reading accuracy (IRUA 2006; Devine 2006).

(Continued next page)

Box 6.3.2 (continued)

Scaffolding Literacy Program, Noonkanbah, WA

The 2005 Report included a discussion on the Scaffolding Literacy Program. The scaffolding program improved the literacy levels of Indigenous children at the Kulkarriya Community School on Noonkanbah station in the Kimberley region of WA. Scaffolding sessions require students to study one quality written text per term. The text is broken down into smaller parts in a group learning environment until students can think like the writer and imitate language (DEST 2005).

The scaffolding program has been modified and enhanced over 5 years. It is now an established aspect of the school program with regular professional development and evaluation from consultants who visit the school frequently to demonstrate and reinforce the programme. The National Accelerated Literacy Program provides children with access to the scaffolding process for 1.5 to 2 hours per school day. This has led to improvements at school, with the numbers of non reading students dropping from 25 to 19 in 2006.

Since the initial implementation of the scaffolding program at the Kulkarriya Community School, the program has been introduced into a number of schools in the Kimberley region. This enables children to continue their participation in the scaffolding program when their families move between communities.

Yachad Accelerated Literacy Project

The Yachad Accelerated Learning Project (YALP) is a professional tuition programme underway in five locations: Shepparton (Victoria), Aurukun (Queensland), Halls Creek (WA), North Adelaide (SA), Alice Springs (NT). YALP is a three-year educational intervention program which will conclude in December 2007. The program targets the lowest performing students with after hours tutoring (DEST 2006).

The program describes itself as 'based on whole of community educational approaches developed by the Hebrew University of Jerusalem'. The program's stakeholder report includes anecdotal evidence of the positive outcomes of the program:

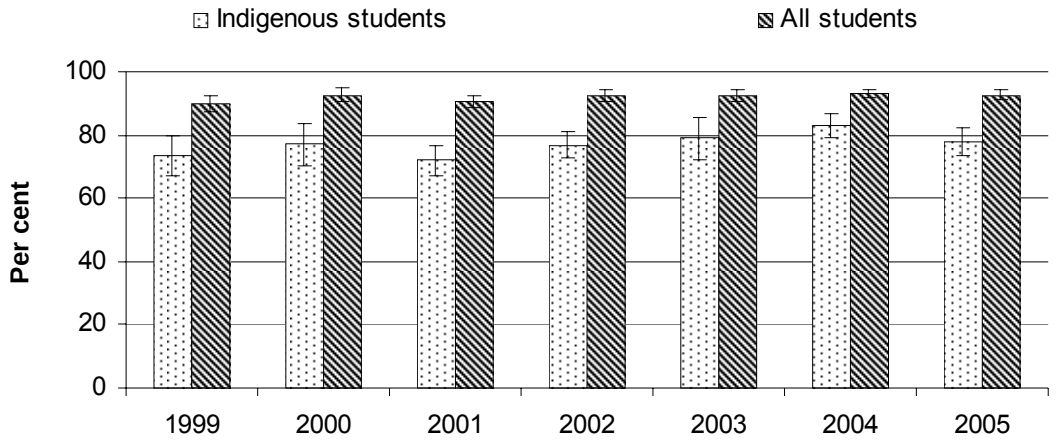
- improvements in student literacy and numeracy skills
- increases in self-confidence for students and educators
- advances in teaching approaches and strategies
- expansion of co-operation and engagement between schools and Indigenous communities (YALP 2006).

Accelerated Literacy Program, NT

Sixty-two schools in the NT participate in the Accelerated Literacy Program. There have been significant improvements in literacy outcomes for the students involved in the program. An evaluation by the Charles Darwin University found that the 2006 average progress rate for NT Accelerated Literacy students was 1.74 reading year levels per year (on average one reading level per year is expected of students).

Reading

Figure 6.3.1 **Proportion of year 3 students who achieved the reading benchmark, 1999–2005[a, b]**

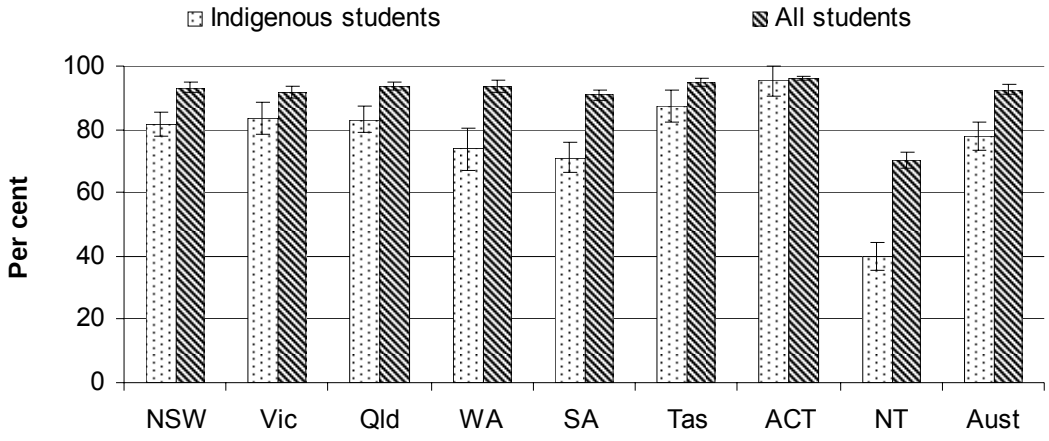


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.1.

- Figure 6.3.1 shows that from 1999 to 2005 there was no clear trend (and no statistically significant difference) in the proportion of year 3 Indigenous students who achieved the reading benchmark.
- The proportion of students who achieved the reading benchmark was consistently lower for Indigenous students for all years between 1999 and 2005 (figure 6.3.1).

Figure 6.3.2 **Proportion of year 3 students who achieved the reading benchmark, by State and Territory, 2005**[a, b, c, d]



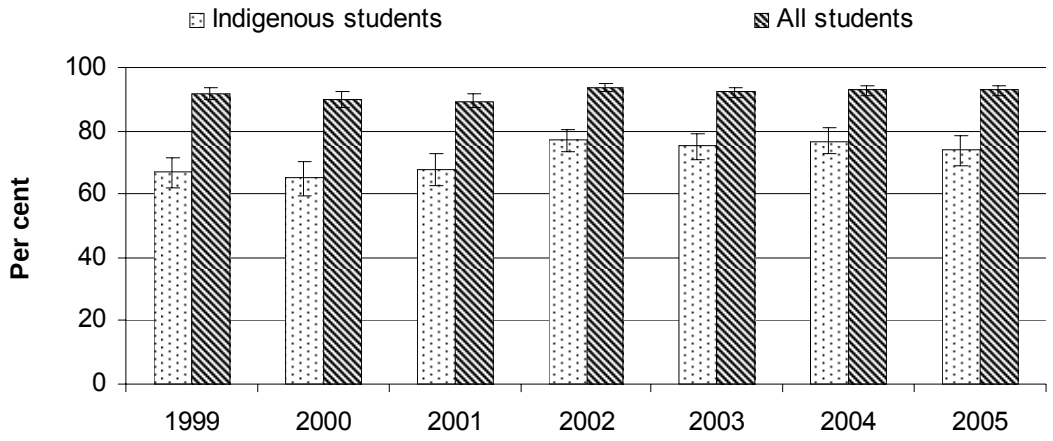
[a] The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. [b] Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.44. Readers are urged to be cautious when comparing results. [c] Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. [d] The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.40.

- Nationally in 2005, 22.0 per cent of Indigenous students did not achieve the reading benchmark compared to 7.3 per cent of all students (table 6A.3.40). Students who do not achieve the reading benchmark standard will have difficulty making sufficient progress at school.

Writing

Figure 6.3.3 **Proportion of year 3 students who achieved the writing benchmark, 1999–2005[a, b]**

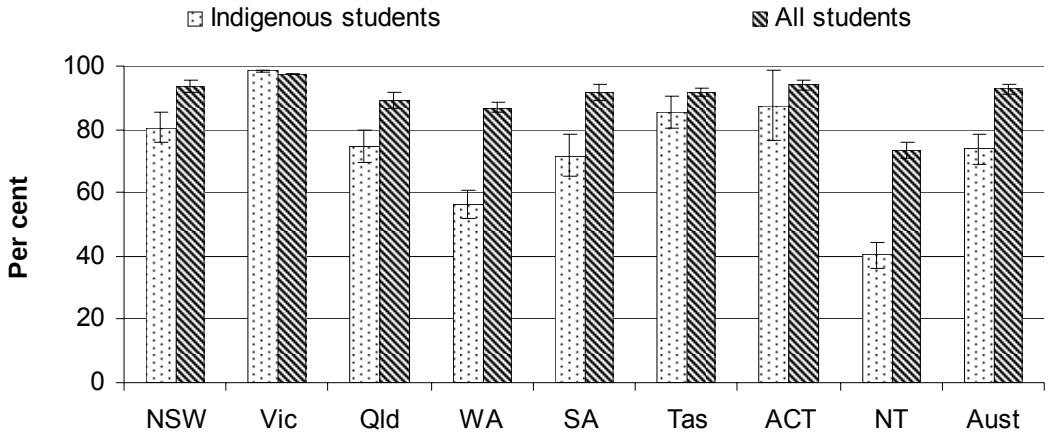


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.2.

- The proportion of year 3 Indigenous students who achieved the writing benchmark fluctuated over the period 1999 to 2005 (figure 6.3.3). In each of these years, a lower proportion of Indigenous students than all students achieved the benchmark.

Figure 6.3.4 **Proportion of year 3 students who achieved the writing benchmark, by State and Territory, 2005[a, b, c, d]**



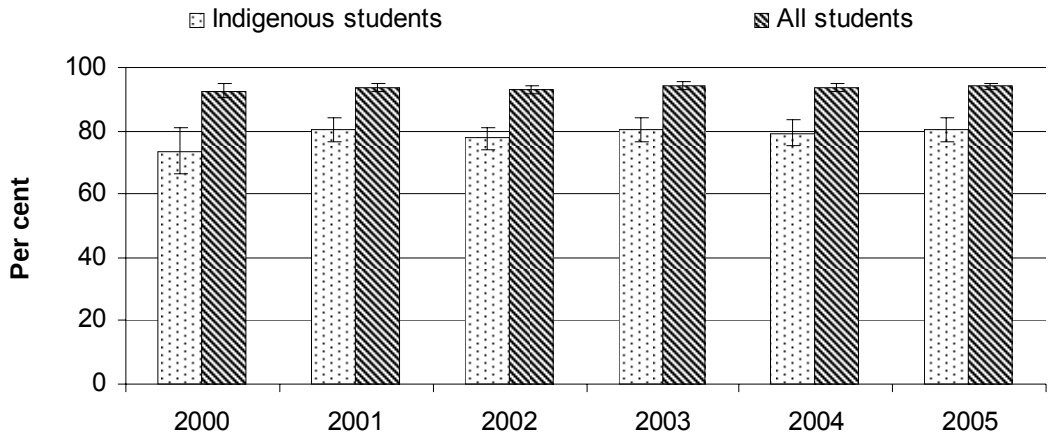
a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.49. Readers are urged to be cautious when comparing results. **c** Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. **d** The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.45.

- The proportion of Indigenous students who achieved the writing benchmark varied significantly across states and territories in 2005 (figure 6.3.4).
- Nationally in 2005, 26.0 per cent of Indigenous students did not achieve the writing benchmark compared to 7.2 per cent of all students (table 6A.3.45). Students who do not achieve the writing benchmark standard will have difficulty making sufficient progress at school.

Numeracy

Figure 6.3.5 **Proportion of year 3 students who achieved the numeracy benchmark, 2000–2005[a, b]**

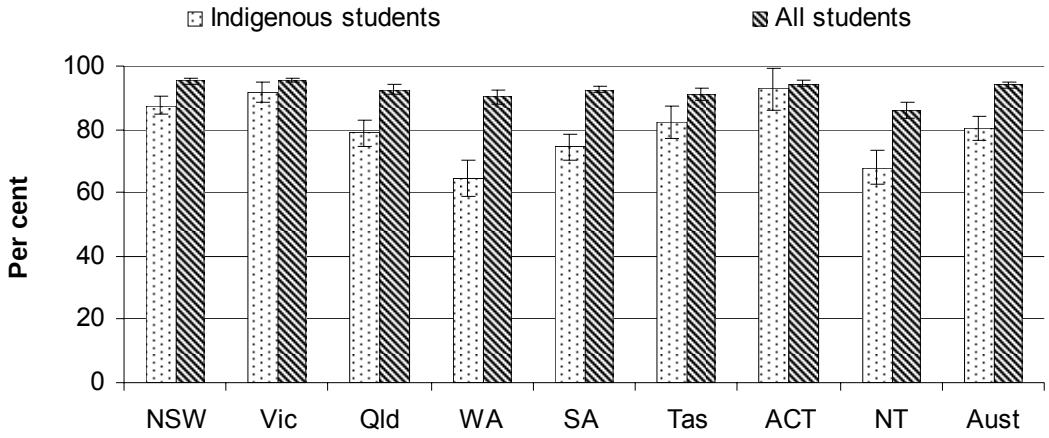


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.3.

- There was no statistically significant change over time (from 2000 to 2005) in the proportion of year 3 Indigenous students who achieved the numeracy benchmark (figure 6.3.5).

Figure 6.3.6 **Proportion of year 3 students who achieved the numeracy benchmark, by State and Territory, 2005[a, b, c, d]**



a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.54. Readers are urged to be cautious when comparing results. **c** Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. **d** The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.50.

- The proportion of Indigenous students who achieved the numeracy benchmark varied significantly across states and territories (figure 6.3.4).
- Nationally in 2005, 19.6 per cent of Indigenous students did not achieve the numeracy benchmark compared to 5.9 per cent of all students (table 6A.3.50). Students who do not achieve the numeracy benchmark standard will have difficulty making sufficient progress at school.

6.4 Future directions in data

Preschool and early learning

In 2007, the National Preschool Census (formerly the National Indigenous Preschool Census) will collect attendance data for Indigenous and non-Indigenous children in non-government preschools. The data should be available by 2008.

School attendance (year 1 to year 3)

The Steering Committee has identified school attendance as an important area for future reporting. Attendance at school has a significant impact on later academic

success and if attendance is erratic then children are unable to reach educational benchmarks (SCRGSP 2005).

There has been no improvement in the availability of data since the 2003 Report. Some jurisdictions collect data on attendance rates at all levels (preschool to year 12). However, lack of uniformity across jurisdictions has created a barrier to national reporting.

COAG made a commitment to improved attendance data in 2006. The MCEETYA Performance Measurement and Reporting Taskforce is developing key performance measures for attendance which may be ready for implementation in 2007.

Year 3 literacy and numeracy

Indigenous learning outcomes data in future reports will need to be improved through the inclusion of more timely data and breakdowns by geographic regions. MCEETYA publishes data by geographic regions for all students, but these are not yet available for Indigenous students.

6.5 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 6A.3.2 is table 2 in the attachment tables for section 6.3). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

6.1 Preschool and early learning

Table 6A.1.1 Total number of children enrolled in preschool, 2005

Table 6A.1.2 Indigenous and non-Indigenous children enrolled in preschool and participation rate, 2005

Table 6A.1.3 Indigenous children enrolled in preschool and participation rate, 2002, 2003

6.2 School attendance (year 1 to year 3)

Table 6A.2.1 Children enrolled in school and participation rate, 2006

Table 6A.2.2 Children enrolled in school and participation rate, 2005

6.3 Year 3 literacy and numeracy

6.6 References

6 Early school engagement

Connell, R.W., White, V.M., and Johnston, K.M. 1991, *Running Twice as Hard: the Disadvantaged Schools Program in Australia,* Deakin University Press, Geelong.

Connell, R.W., Ashenden, D.J., Kessler, S. and Dowsett, G.W. 1982, *Making the Difference: Schools, Families and Social Division,* Allen & Unwin, Sydney.

Fine, M.,1991, *Framing Dropouts: Notes on the Politics of an Urban Public High School,* State University of New York Press, Albany.

House of Representatives Standing Committee on Employment, Education and Training 1996, *Truancy and Exclusion from School*, Australian Government Publishing Service, Canberra.

OECD (Organisation for Economic Co-operation and Development) 2006, *Starting Strong II: Early Childhood Education and Care*, Paris.

—— 2004, *Learning for Tomorrow's World — First Results from PISA 2003*, France.

Thomson, P. 2002, *Schooling the rustbelt kids*, Allen & Unwin, Sydney.

6.1 Preschool and early learning

ANAO (Australian National Audit Office) 2002, *Indigenous Education Strategies: Department of Education, Science and Training*, Audit Report no. 43 2001–2002, Canberra.

COAG (Council of Australian Governments) 2006, *COAG National Reform Agenda (NRA): Human Capital, Competition and Regulatory Reform*, Communiqué, 14 July 2006, Canberra.

DEST (Department of Education, Science and Training) 2006, *National Preschool Census 2005 Aboriginal and Torres Strait Islanders and All Students: Technical Report*, DAA (Data Analysis Australia), Canberra.

Elliott, A. 2006, *Rethinking and Reshaping Early Childhood Care and Education Policy – Visions and Directions for the Future*, Australian Council for Educational Research, National Education Forum Conference, 2006, Brisbane.

Ferrari, J. 2006, 'Aborigines lifted by great expectations', *Australian* 29 March 2006.

HREOC (Human Rights and Equal Opportunity Commission) 2000, *Emerging Themes: National Inquiry into Rural and Remote Education*, Sydney, HREOC, http://www.hreoc.gov.au/pdf/human_rights/emerging_themes.pdf (accessed 28 June 2003).

Frigo, T. and Adams, I. 2002, Diversity and learning in the early years of school, paper presented at the Australian Association for Research in Education (AARE) Annual Conference, 2002, Brisbane.

Liddy, B. 2004, Mobile preschool pilot programs — an initiative to provide preschool programs for children in remote communities throughout the Northern Territory, paper presented at the 3rd National Australian Indigenous Education Conference, Ballarat, 15–18 November.

Morris, S. 2005, 'Contentious no-school, no-dole policy to continue', *Australian Financial Review*, 2 December 2005.

NTDE (Northern Territory Department of Education) 1999, *Learning Lessons, An Independent Review of Indigenous Education in the Northern Territory*, Darwin, http://www.deet.nt.gov.au/education/indigenous_education/learning_lessons_review.pdf (accessed 30 April 2003).

OECD (Organisation for Economic Co-operation and Development) 2004, *Learning for Tomorrow's World — First Results from PISA 2003*, France.

6.2 School attendance (year 1 to year 3)

DEWR (Department of Employment and Workplace Relations) 2006, *Halls Creek Engaging Families Trial February–July 2006 — Evaluation Report*, Australian Government, Canberra.

Robinson, G. and Tyler, B. 2006, *Ngaripirliga'ajirri — An Early Intervention Program on the Tiwi Islands* Final Evaluation Report, School for Social and Policy Research, Charles Darwin University.

Schwab, R.G. and Sutherland, D. 2004, *Literacy for Life: A Scoping Study for a Community Literacy Empowerment Project*, The Fred Hollows Foundation and the Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Taylor, J. 2004, *Social Indicators for Aboriginal Governance: Insights from the Thamarrurr Region, Northern Territory*, Research Monograph no. 24, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

UNICEF Innocenti Research Centre 2004, *Ensuring the Rights of Indigenous Children*, Innocenti Digest no. 11, Florence.

Zubrick S., Silburn S., De Maio J., Shepherd C., Griffin J., Dalby R., Mitrou F., Lawrence D., Hayward C., Pearson G., Milroy H., Milroy J., Cox A., 2006 *The Western Australian Aboriginal Child Health Survey: Improving the Educational Experiences of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

6.3 Year 3 literacy and numeracy

ANAO (Australian National Audit Office) 2002, *Indigenous Education Strategies: Department of Education, Science and Training*, Audit Report no. 43 2001–2002, Canberra.

DEST (Department of Education, Science and Training) 2005, What Works. The Work Program: Improving Outcomes for Indigenous Students, http://www.whatworks.edu.au (accessed 17 March 2005).

——2006, *National Report to Parliament on Indigenous Education and Training 2004*, Canberra.

Devine, M. 2006, 'How intolerance can turn the tide', http://www.smh.com.au/news/opinion/how-intolerance-can-turn-the-tide/2006/09/27/1159337220004.html (accessed 27 September 2006).

IRUA (Innovative Research Universities Australia) 2006, *Response to DEST Knowledge Transfer Project: Developing a Culture of Engagement in Australian Universities through the Formation of Sustainable Partnerships*, http://www.irua.edu.au/policy/policy-20060131.pdf (accessed 28 September 2006).

MCEETYA (Ministerial Council on Education, Employment, Training and Youth Affairs) 2007, *National Report on Schooling in Australia 2005: Preliminary Paper National Benchmark Results Reading, Writing and Numeracy Years 3, 5 and 7*, Melbourne.

Ou, S., and Reynolds, A.J. 2004, 'Preschool education and school completion', in Tremblay, R.E., Barr, R.G. and Peters, R.DeV. (eds), *Encyclopaedia on Early Childhood Development*, Montreal, Centre of Excellence for Early Childhood Development, http://www.excellence-earlychildhood.ca/documents/Ou-ReynoldsANGxp.pdf (accessed 2 November 2006).

Reynolds, A.J., Temple, J.A., Robertson, D.L. and Mann, E.A. 2001, 'Long-term effects of an early childhood intervention on educational achievement and juvenile arrest — a 15-year follow-up of low-income children in public schools', *Journal of the American Medical Association*, vol. 285, pp. 2339–2346.

Schweinhart, L.J. 2005, *The High/Scope Perry Preschool Study Through Age 40 Summary, Conclusions, and Frequently Asked Questions*, Ypsilanti, High/Scope Press.

Storry, K. 2006, Tackling Literacy in Remote Aboriginal Communities, Issue Analysis, no. 73, The Centre for Independent Studies, St Leonards, NSW.

Thomson, S. and Fleming, N. 2004, *Summing it up: mathematics achievement in Australian schools 2002*, Australian Council for Educational Research, Camberwell.

YALP (Yachad Accelerated Learning Project) 2006, *Stakeholder Report: February 2006*, Melbourne.

Zubrick, S.R., Silburn, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Dalby, R.B., Mitrou, F.G., Lawrence, D.M., Hayward, C., Pearson, G., Milroy, H., Milroy, J. and Cox, A. 2006, *The Western Australian Aboriginal Child Health Survey: Improving the Educational Experiences of Aboriginal Children and*

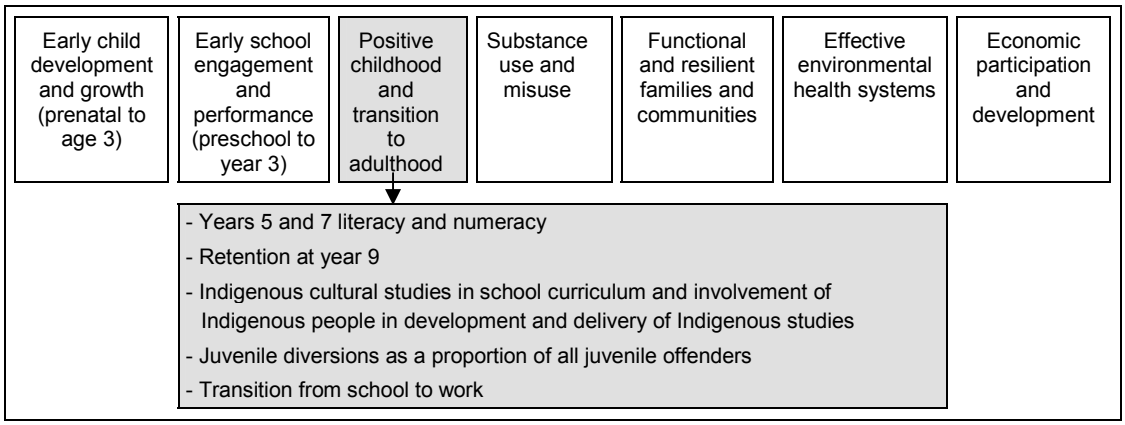
Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

6.4 Future directions

SCRGSP (Steering Committee for the Review of Government Service Provision) 2005, *Overcoming Indigenous Disadvantage: Key Indicators 2005*, Productivity Commission, Melbourne.

7 Positive childhood and transition to adulthood

Strategic areas for action



This strategic area for action reflects the importance of the transition from childhood to adulthood. At this stage of the life cycle, a good foundation in early childhood can be built upon, or interventions can assist those who had a difficult early childhood to make the transition to a more positive adulthood.

Several important transitions occur between early childhood and adulthood:

- from primary school to secondary school
- from compulsory schooling to post-compulsory schooling
- from school to post-secondary study
- from school or post-secondary study to work.

The indicators for this strategic area for action reflect (i) the continuing importance of educational outcomes through childhood to early adulthood, and (ii) alternatives to detention for juvenile offenders that can reduce reoffending and the likelihood of progressing to the adult corrections system.

There are links between outcomes in positive childhood and transition to adulthood and several of the headline indicators:

- disability and chronic disease

- parental education
- labour force participation and unemployment
- income
- suicide and self-harm
- substantiated child abuse and neglect
- family and community violence
- imprisonment and juvenile detention rates.

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

- early child development and growth (hearing impediments) — chapter 6
- early school engagement and performance (preschool and early learning, school attendance and year 3 literacy and numeracy) — chapter 5
- substance use and misuse — chapter 8
- functional and resilient families and communities (children on care and protection orders, access to primary health care, mental health, participation in organised sport, arts or community group activities, engagement with service delivery) — chapter 9
- effective environmental health systems (diseases associated with poor environmental health, access to clean water and functional sewerage, overcrowding in housing) — chapter 10
- economic participation and development (employment, governance capacity and governance arrangements) — chapter 11

Literacy and numeracy at years 5 and 7 is an important indicator of progression in learning and provides a foundation for successful secondary education. Good outcomes at these levels are critical to achieving headline outcomes, such as year 10 and 12 retention and attainment, post-secondary education and employment. Educational attainment is also linked to health outcomes (ABS and AIHW 2005). Achievements against years 5 and 7 literacy and numeracy benchmarks are contained in sections 7.1.

The period during which children move from primary to secondary school can be difficult for many young people. It can be particularly traumatic for young Indigenous people in regional or remote areas who have to leave their communities to undertake secondary studies. ‘Poor preparation, not knowing what to expect, homesickness, distance from family and community support, lack of local support, poor literacy levels and shame at not succeeding lead many young Indigenous people to drop out’ (MCEETYA 2001).

In most states and territories, compulsory education ends in year 9 or 10 for most students. Many of the Indigenous students who choose to leave at this point have poor literacy and numeracy skills. As a result, they have limited options for the future, which often leads to boredom, despair, substance abuse and criminal activity. The retention of Indigenous students at this stage in their education is one of the key outcomes for breaking the cycle of disadvantage. Data on the retention of Indigenous students at year 9 are reported in section 7.2.

The National Statement of Principles and Standards for More Culturally Inclusive Schooling in the 21st Century (MCEETYA 2000) states that schooling should acknowledge the capacity of all young Indigenous people to learn, by providing a curriculum that avoids discrimination; allows Indigenous students the same opportunities as other students while allowing them to be strong in their own cultures; and helps all students to understand and value Indigenous culture and knowledge.

There is a significant body of research that supports the importance of cultural studies in the school curriculum to motivate Indigenous students, increase their attendance and improve their self-identity. Curriculum is one of several factors influencing Indigenous school performance, none of which is sufficient on its own (see Bourke, Rigby and Burden 2000; Harslett et al. 1998; and Purdie et al. 2000).

During consultations on the Report, Indigenous people suggested three outcomes from including Indigenous content in school curriculum:

- The incorporation of Indigenous studies and Indigenous content in the curriculum makes schooling more relevant to Indigenous students and leads to better attendance and better educational outcomes for them.
- An improved understanding of Indigenous culture improves the spiritual health of Indigenous students, which leads to better outcomes in areas such as health, family and community cohesion, education and employment.
- Teaching Indigenous culture, history and other Indigenous knowledge to non-Indigenous students will help address the racism of some non-Indigenous people that Indigenous people believe is founded on fear and ignorance. It has the additional benefit of generally creating a broader knowledge and understanding of Australian history among non-Indigenous Australians.

Case studies about Indigenous cultural studies and information about Indigenous employment in schools are included in section 7.3.

Indigenous young people have a high rate of contact with the juvenile justice system (see section 3.12). Once an Indigenous youth has entered the criminal justice system, the chances of him or her being channelled into more constructive activities

is markedly reduced. Juvenile diversion programs can contribute to a reduction in antisocial behaviour and offending.

Diverting juveniles from detention is an important factor in reducing re-offending. The Royal Commission into Aboriginal Deaths in Custody (1991) found that:

> It is in everyone's interest to ensure that juvenile offenders remain outside of the justice system; not simply by being diverted from it after offences have been committed, but by avoiding the circumstances which lead to the commission of the offences in the first place (chapter 30).

Data on diversions have been provided by some jurisdictions (see section 7.4).

The transition from school to work is a critical period in which young Indigenous people are most at risk of limiting their future options in life. Those who are not actively engaged in education and training, or employed, are at risk of long term disadvantage. Section 7.5 examines the transition of unemployed 15 to 24 years olds 'at risk' (those neither employed nor studying), and employment outcomes for those with different levels of education.

Box 7.1 **'Things that work' — positive childhood and transition to adulthood**

Circular Head Aboriginal Corporation – Youth Justice Program (Tasmania)

The Circular Head Aboriginal Corporation Youth Justice Program is based in Smithton in north west Tasmania and focuses on supporting children aged 10 to 18 years, who are at risk of adverse contact with the criminal justice system. A range of activities including bush survival camps, mentoring at school, drug diversion and mediation between youth and their parents, support a positive transition from childhood to adulthood.

The program receives funding from the Australian Government Attorney-General's Department and has partnerships with local police, alcohol and drug services, the Smithton High School, the local council, a suicide prevention program, Anglicare, the Circular Head Rural Health Service and Centrelink.

At the time of writing, there were 17 individual participants and 8 family mediations.

Source: Attorney-General's Department (unpublished).

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 7A.2.3). A list of attachment tables is in section 7.7. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

7.1 Years 5 and 7 literacy and numeracy

Box 7.1.1 **Key messages**

- Between 1999 and 2005, year 5 Indigenous students' performance against the national reading, writing and numeracy benchmarks fluctuated, with no statistically significant trend (figures 7.1.1, 7.1.3 and 7.1.5).
- Between 2001 and 2005, year 7 Indigenous students' performance against the national reading, writing and numeracy benchmarks also fluctuated, with no statistically significant trend (figures 7.1.7, 7.1.9 and 7.1.11).
- In 2005, the proportion of year 5 Indigenous students who did not achieve the national benchmark was substantially higher than the proportion of all students for:
  - reading (37.2 per cent compared to 12.5 per cent) (figure 7.1.2)
  - writing (25.7 per cent compared to 6.7 per cent) (figure 7.1.4)
  - numeracy (33.5 per cent compared to 9.2 per cent) (figure 7.1.6).
- In 2005, the proportion of year 7 Indigenous students who did not achieve the national benchmark was substantially higher than the proportion of all students for:
  - reading (36.2 per cent compared to 10.2 per cent) (figure 7.1.8)
  - writing (27.7 per cent compared to 7.8 per cent) (figure 7.1.10)
  - numeracy (51.2 per cent compared to 18.2 per cent) (figure 7.1.12).
- As Indigenous students progress through school the proportion who achieve the national minimum benchmarks decreases (figures 7.1.13 and 7.1.15).

Achieving literacy and numeracy benchmarks for years 5 and 7 has a significant effect on participation in year 12 and entry into higher education (ACER 2004). Evidence suggests that school leavers who lack fundamental skills in literacy and numeracy face poor employment prospects (ACER 2004; OECD 2004).

Recent studies have highlighted the link between health and education (Schwab and Sutherland 2004; Zubrick et al. 2006). Low literacy was identified as one of the biggest hurdles when it comes to improving the health of Indigenous people (Schwab and Sutherland 2004).

Emotional distress was one of the factors associated with the academic performance of Aboriginal students in WA. Aboriginal students at high risk of clinically significant emotional or behavioural difficulties were almost three times more likely to have low academic performance compared with Aboriginal students at low risk (Zubrick et al. 2006). Section 9.4 has more information on mental health and social and emotional wellbeing issues for children.

The Program for International Student Assessment (PISA) is a survey of the reading, mathematical, scientific literacy and problem solving skills of 15 year olds. PISA is an initiative of the Organisation for Economic Cooperation and Development (OECD). The results of the Australia PISA sample for 2000 and 2003 can be found in tables 6A.3.55–59. Less than half the proportion of 15 year old Indigenous students surveyed reached the OECD average when compared to all students across all four educational domains in both years. (tables 6A.3.55–59).

Information on learning outcomes is also available from the Trends in International Mathematics and Science Study (TIMSS). For background information on the TIMSS initiative, see section 6.3. Some of the findings from the TIMSS 2002-03 for year 8 students include:

- Indigenous students achieved 79 score points lower than non-Indigenous students in mathematics (the average score was 508 for non-Indigenous students and 429 for Indigenous students).
- Indigenous students were 38 score points lower than the TIMSS international mathematics average and non-Indigenous students were 41 score points above the international average.
- There was no change in Indigenous student achievement for both mathematics and science from TIMSS 1994-95 to TIMSS 2002-03.
- Indigenous students who speak English infrequently in the home achieved at a level below Indigenous students who often speak English at home (Thomson, McKelvie and Murnane 2006).

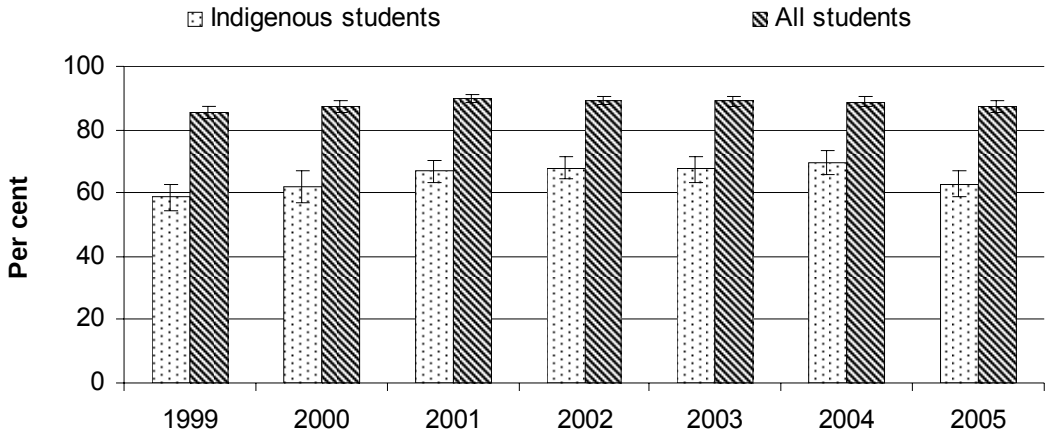
Programs that have been successful in improving literacy outcomes for Indigenous children can be found in chapter 6, box 6.3.2.

This chapter presents nationally comparable learning outcomes data for 2005 for years 5 and 7 reading, writing and numeracy. These data are the proportion of students who achieved the minimum benchmark for reading, writing and numeracy (in contrast to PISA data — the proportion of students who reached the OECD average — which is possibly a higher standard).

Nationally comparable learning outcomes data for years 5 and 7 for 2005 and previous years are reported in the attachment tables. Background information and issues in relation to national benchmarks used in reporting on literacy and numeracy are addressed in section 6.3 of chapter 6.

Year 5 reading

Figure 7.1.1 **Proportion of year 5 students who achieved the reading benchmark, 1999–2005[a, b]**

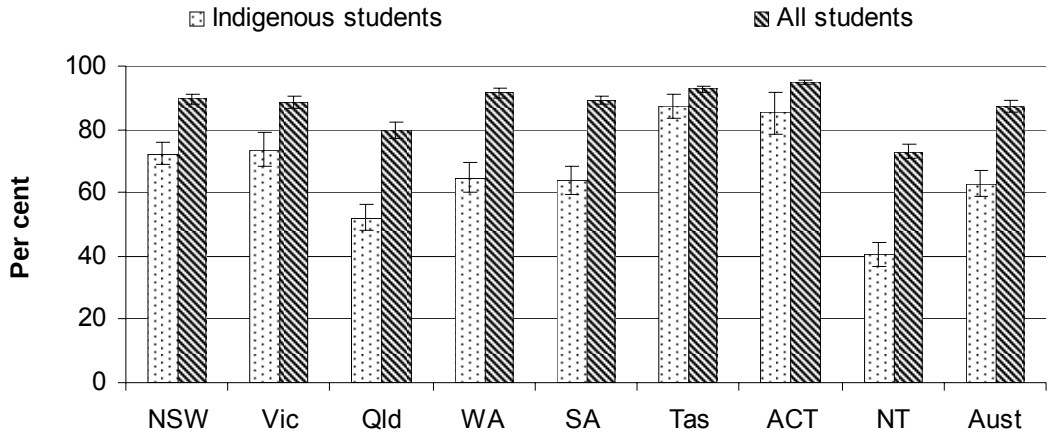


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.4.

- Figure 7.1.1 shows no statistically significant change over time (from 1999 to 2005) in the proportion of year 5 Indigenous students who achieved the reading benchmark. Performance levels for all students have been consistently higher than for Indigenous students over time.
- For all years except 2001 and 2003, the proportion of year 3 Indigenous students who achieved the year 3 reading benchmark was significantly higher than the proportion of year 5 Indigenous students who achieved the year 5 reading benchmark (figures 6.3.1 and 7.1.1). For all students, the proportion of year 3 and 5 students who achieved the respective benchmarks were similar over these years (figures 6.3.1 and 7.1.1).

Figure 7.1.2 **Proportion of year 5 students who achieved the reading benchmark, by State and Territory, 2005[a, b, c, d]**



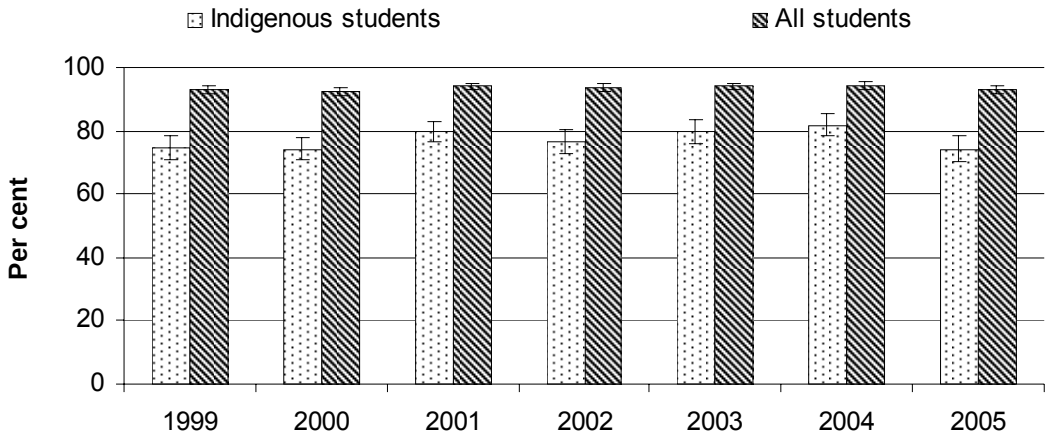
a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.44. Readers are urged to be cautious when comparing results. **c** Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. **d** The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.41.

- The proportion of year 5 Indigenous students who achieved the reading benchmark varied significantly across states and territories in 2005 (figure 7.1.2).
- Nationally in 2005, over a third (37.2 per cent) of year 5 Indigenous students did not achieve the reading benchmark, compared with 12.5 per cent of all students (table 6A.3.41). Students who do not achieve the minimum reading benchmark will have difficulty progressing through school.

Year 5 writing

Figure 7.1.3 **Proportion of year 5 students who achieved the writing benchmark, 1999–2005[a, b]**

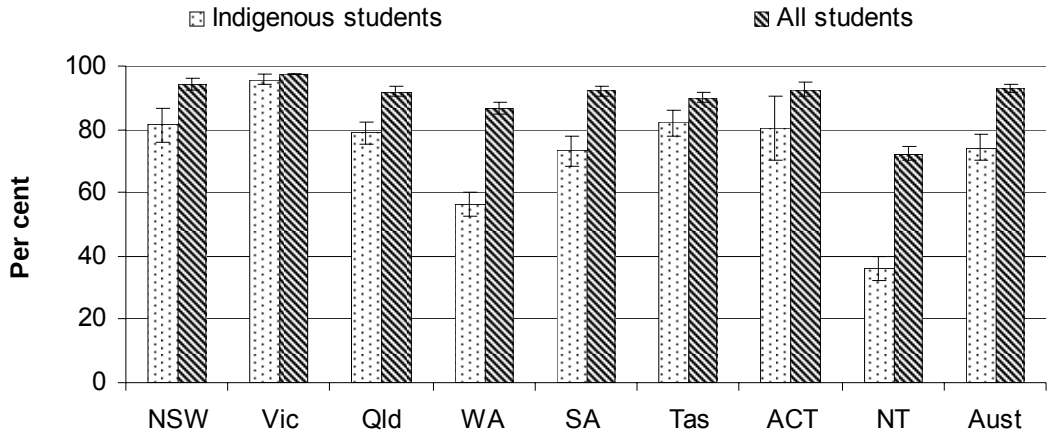


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.5.

- Figure 7.1.3 shows that from 1999 to 2005, there was no clear trend (and no statistically significant difference) in the proportion year 5 Indigenous students who achieved the writing benchmark. Performance levels for all students have been consistently higher than for Indigenous students over time.

Figure 7.1.4 **Proportion of year 5 students who achieved the writing benchmark, by State and Territory, 2005[a, b, c, d]**



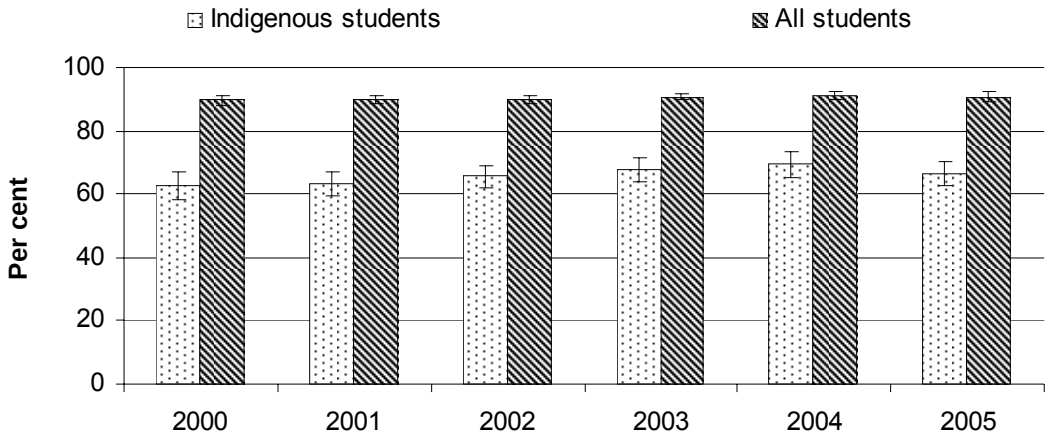
a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.49. Readers are urged to be cautious when comparing results. **c** Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. **d** The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.46.

- In 2005, the proportion of Indigenous students who achieved the writing benchmark varied across states and territories (figure 7.1.4).
- Nationally in 2005, 25.7 per cent of Indigenous students did not achieve the writing benchmark compared to 6.7 per cent of all students (table 6A.3.46). Students who do not achieve the writing benchmark standard will have difficulty progressing through school.

Year 5 numeracy

Figure 7.1.5 **Proportion of year 5 students who achieved the numeracy benchmark, 2000–2005[a, b]**

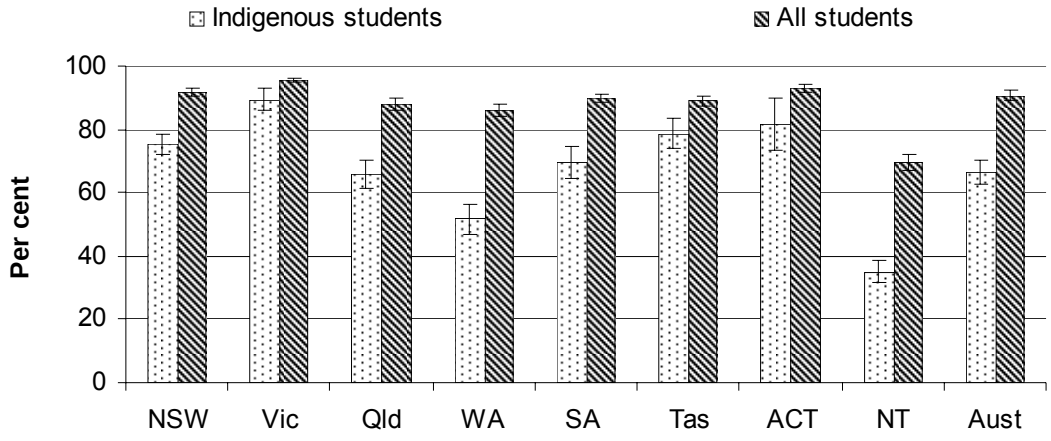


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.6.

- There was no statistically significant change over time (from 2000 to 2005) in the proportion of year 5 Indigenous students who achieved the numeracy benchmark (figure 7.1.5). Performance levels for all students have been consistently higher than for Indigenous students over time.
- For the years 2001 to 2005, the proportion of year 3 Indigenous students who achieved the year 3 numeracy benchmark was significantly higher than the proportion of year 5 Indigenous students who achieved the year 5 numeracy benchmark (figures 6.3.5 and 7.1.5). For all students, the proportion of year 3 and 5 students who achieved the respective benchmarks were similar over these years (figures 6.3.5 and 7.1.5).

Figure 7.1.6 **Proportion of year 5 students who achieved the numeracy benchmark, by State and Territory, 2005[a, b, c, d]**



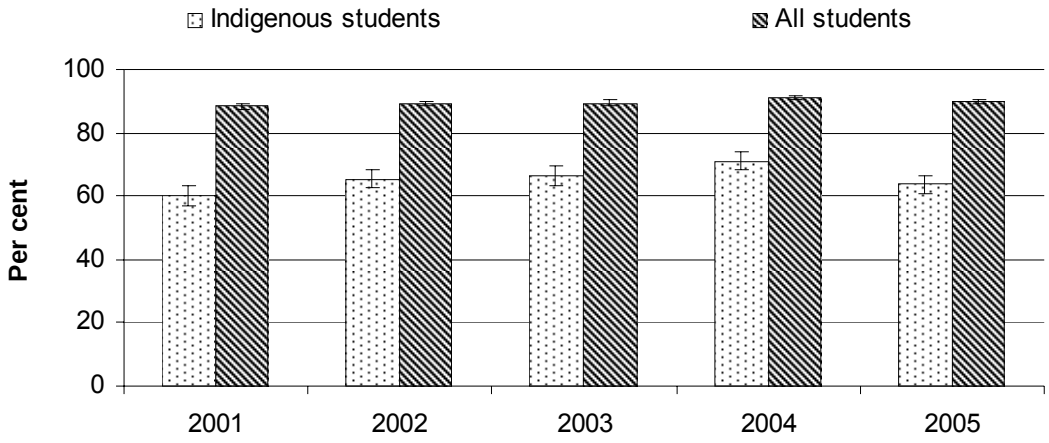
a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.54. Readers are urged to be cautious when comparing results. **c** Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. **d** The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.51.

- In 2005, the proportion of Indigenous students who achieved the numeracy benchmark varied significantly across states and territories (figure 7.1.6).
- Nationally in 2005, a third (33.5 per cent) of year 5 Indigenous students did not achieve the numeracy benchmark compared to 9.2 per cent of all students (table 6A.3.51). Students who do not achieve the numeracy benchmark will have difficulty progressing through school.

Year 7 reading

Figure 7.1.7 **Proportion of year 7 students who achieved the reading benchmark, 2001–2005[a, b]**

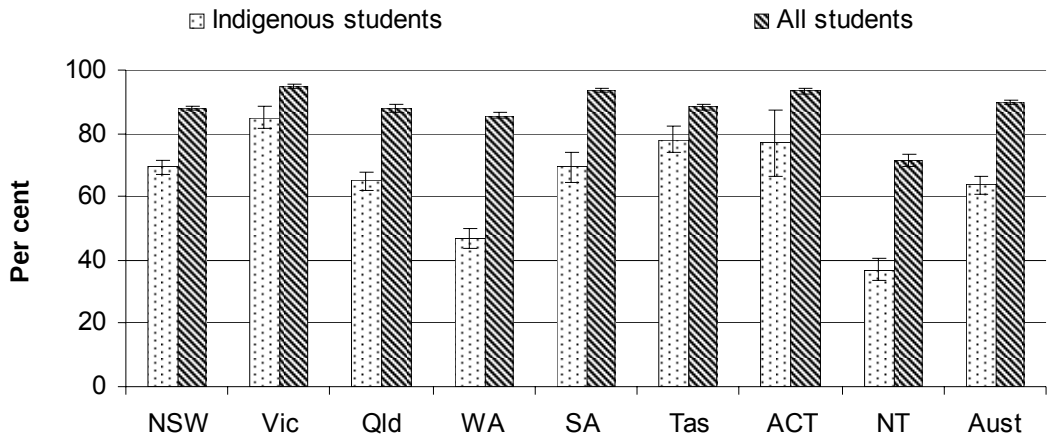


[a] The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. [b] Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.7.

- Figure 7.1.7 shows that from 2001 to 2005, there was no clear trend (and no statistically significant difference) in the proportion of year 7 Indigenous students who achieved the reading benchmark. Performance levels for all students have been consistently higher than for Indigenous students over time.
- For all years (2001 to 2005), the proportion of year 3 Indigenous students who achieved the year 3 reading benchmark was significantly higher than the proportion of year 7 Indigenous students who achieved the year 7 reading benchmark (figures 6.3.1 and 7.1.7). For all students, the proportion of year 3 and 7 students who achieved the respective benchmarks were similar over these years (figures 6.3.1 and 7.1.7).

Figure 7.1.8 **Proportion of year 7 students who achieved the reading benchmark, by State and Territory, 2005**[a, b, c, d]



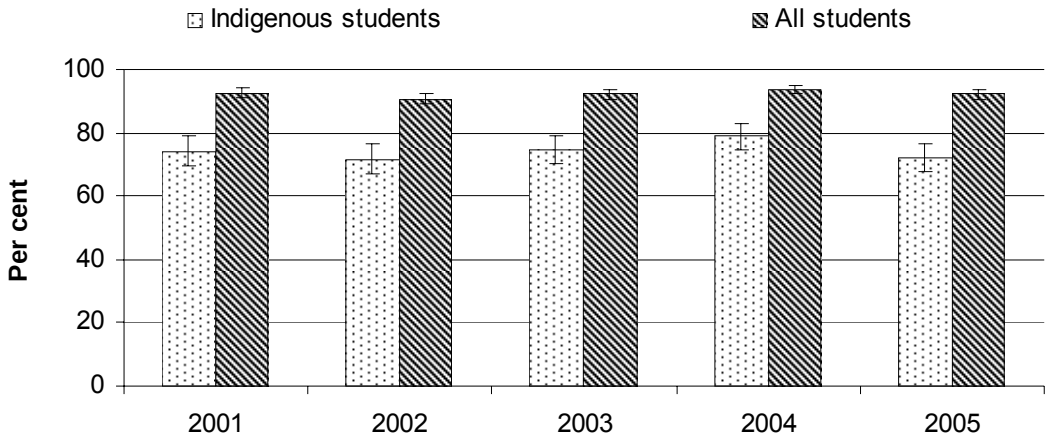
[a] The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. [b] Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.44. Readers are urged to be cautious when comparing results. [c] Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. [d] The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.42.

- In 2005, there was significant variation across states and territories in the proportion of year 7 Indigenous students who achieved the reading benchmark (figure 7.1.8).
- In 2005, the national proportion of year 7 Indigenous students who did not achieve the reading benchmark was 36.2 per cent compared to 10.2 per cent of all students (table 6A.3.42). Students who do not achieve the reading benchmark will have difficulty progressing through school.

Year 7 writing

Figure 7.1.9 **Proportion of year 7 students who achieved the writing benchmark, 2001–2005[a, b]**

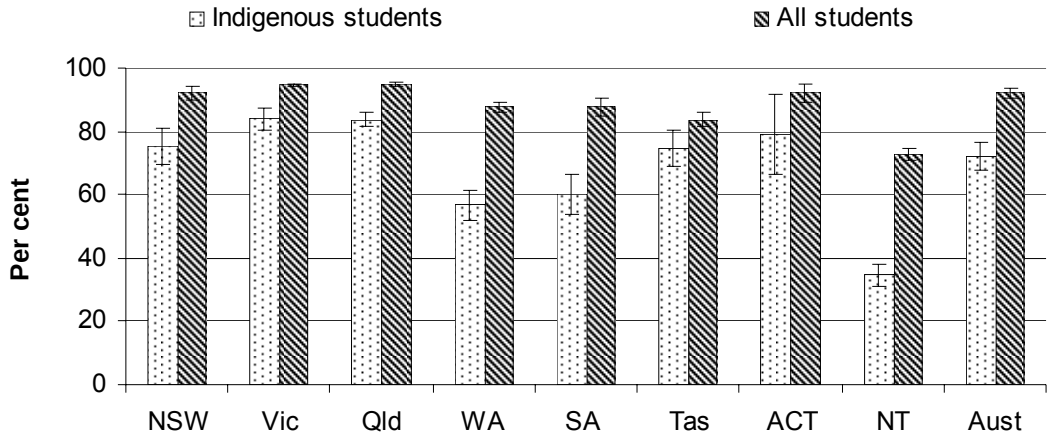


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.8.

- Figure 7.1.9 shows that there was no statistically significant change over time (from 2001 to 2005) in the proportion of year 7 Indigenous students who achieved the writing benchmark. Performance levels for all students have been consistently higher than for Indigenous students over time.
- There was no significant difference between the proportion of year 3, 5 and 7 Indigenous students who achieved the writing benchmark in all years (figures 6.3.3, 7.1.3 and 7.1.9).

Figure 7.1.10 **Proportion of year 7 students who achieved the writing benchmark, by State and Territory, 2005**[a, b, c, d]



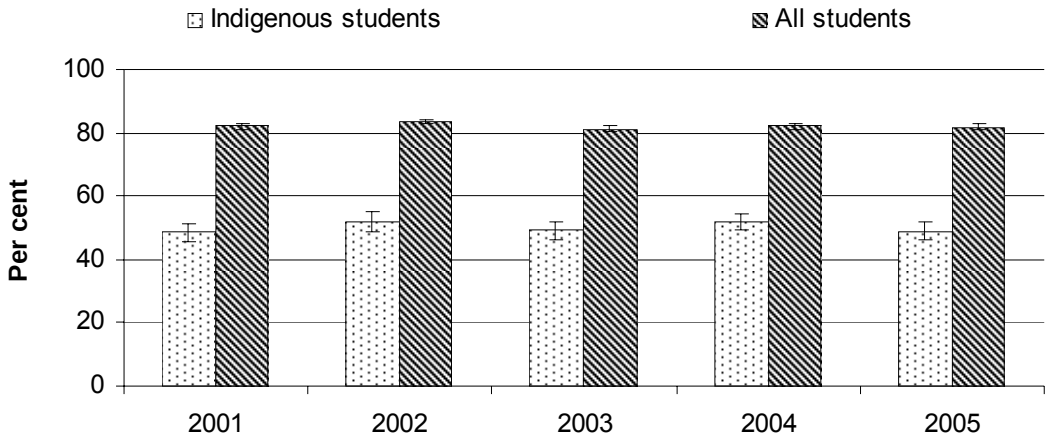
[a] The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. [b] Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.49. Readers are urged to be cautious when comparing results. [c] Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. [d] The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.47.

- The proportion of Indigenous students who achieved the writing benchmark varied significantly across states and territories in 2005 (figure 7.1.10).
- Nationally in 2005, 27.7 per cent of Indigenous students did not achieve the writing benchmark compared to 7.8 per cent of all students. A student that does not achieve the minimum writing benchmark will have difficulty progressing through school.

Year 7 numeracy

Figure 7.1.11 **Proportion of year 7 students who achieved the numeracy benchmark, 2001–2005[a, b]**

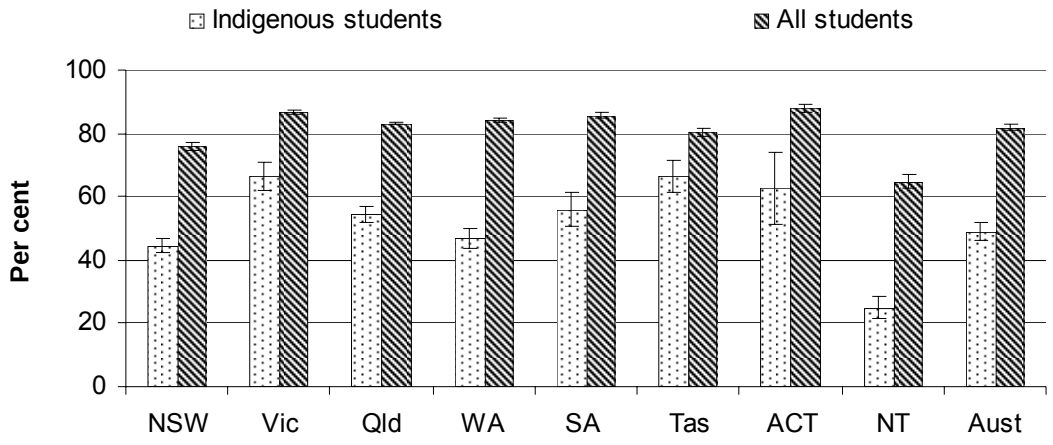


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); table 6A.3.9.

- There was no statistically significant change over time (from 2001 to 2005) in the proportion of year 7 Indigenous students who achieved the numeracy benchmark (figure 7.1.11).
- The proportion of year 3 and 5 Indigenous students who achieved the numeracy benchmark was significantly higher than the proportion of year 7 Indigenous students in all years (2001 to 2005) (figures 6.3.5, 7.1.5 and 7.1.11).

Figure 7.1.12 **Proportion of year 7 students who achieved the numeracy benchmark, by State and Territory, 2005**[a, b, c, d]



[a] The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. [b] Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations. The proportion of absent and withdrawn students varies across jurisdictions, as shown in table 6A.3.54. Readers are urged to be cautious when comparing results. [c] Some movements in the results over time might have occurred because of State/Territory equating processes, and may not reflect actual improvements in student performance. [d] The methods used to identify Indigenous students varied across jurisdictions.

Source: MCEETYA (2007); table 6A.3.52.

- Nationally in 2005, over half (51.2 per cent) of year 7 Indigenous students did not achieve the numeracy benchmark compared to 18.2 per cent of all students (figure 7.1.12). Students who do not achieve the numeracy benchmark will have difficulty progressing through school.

Comparisons of year 3, 5 and 7 learning outcomes

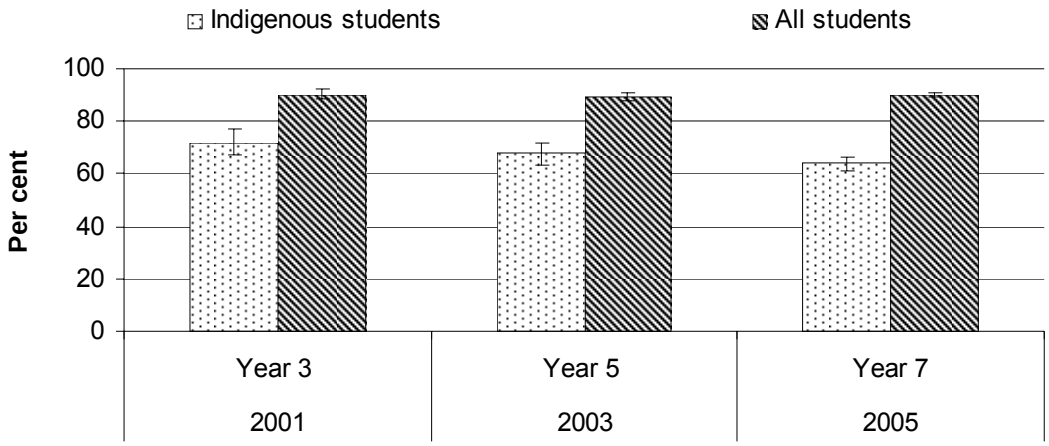
Research suggests that the disparity in academic performance between Indigenous students and non-Indigenous students increases as students progress through the education system and that underperforming students are unable to catch up (Ou and Reynolds 2004; Reynolds et al. 2001; Schweinhart 2005; Zubrick et al. 2006).

National benchmarks for use in reporting years 3, 5 and 7 students' reading, writing and numeracy performance were developed in 1997 (reporting of these benchmarks began in 1999). These data are not longitudinal in design or measurement and therefore there is no certainty that the same cohort of year 3 students in 2001 are tested again in year 5 in 2003 or in year 7 in 2005.

However, the normal progression through school would mean that a large proportion of year 3 students in 2001 would progress through to year 5 in 2003 and

then year 7 in 2005, and be tested at those year levels. The data presented in the next section provide some indication of how students are faring as they progress through the early school years.

Figure 7.1.13 **Proportion of year 3 students in 2001, year 5 students in 2003 and year 7 students in 2005 who achieved the reading benchmark[a, b]**

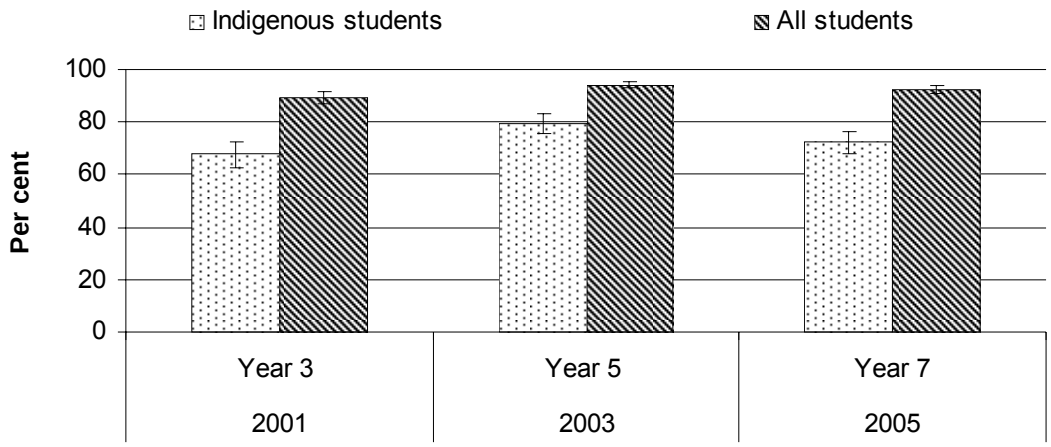


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); tables 6A.3.1; 6A.3.4; 6A.3.7.

- Figure 7.1.13 shows that as Indigenous students progressed through school from year 3 to year 7, the proportion who achieved the national minimum reading benchmark decreased.
- There was no difference in the proportion of all students who achieved the reading benchmark in year 3 in 2001 and year 7 in 2005 (figure 7.1.13).

Figure 7.1.14 **Proportion of year 3 students in 2001, year 5 students in 2003 and year 7 students in 2005 who achieved the writing benchmark[a, b]**

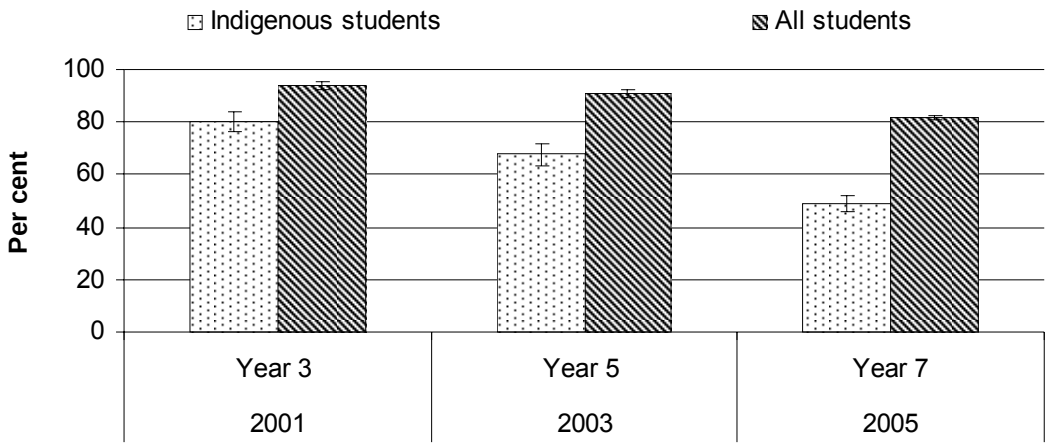


a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); tables 6A.3.2; 6A.3.5; 6A.3.8.

- There was no statistically significant difference in the proportion of Indigenous students who achieved the national minimum writing benchmark at the particular year levels (figure 7.1.14).

Figure 7.1.15 **Proportion of year 3 students in 2001, year 5 students in 2003 and year 7 students in 2005 who achieved the numeracy benchmark[a, b]**



a The achievement percentages reported in this table include 95 per cent confidence intervals, for example, 80 per cent ± 2.7 per cent. **b** Students who were absent or withdrawn from testing are not classified as assessed students and are not included in the benchmark calculations.

Source: MCEETYA (2007); tables 6A.3.3; 6A.3.6; 6A.3.9.

- Figure 7.1.15 shows that as Indigenous students progressed through school from year 3 to year 7, the proportion who achieved the national minimum numeracy benchmark decreased.
- There was also significant decrease in the proportion of all students who achieved the numeracy benchmark between year 5 in 2003 and year 7 in 2005 (figure 7.1.15).

7.2 Retention at year 9

Box 7.2.1 **Key messages**

- In 2006, 7.7 per cent of Indigenous people aged 14 years were not participating in school education compared with 1.4 per cent of non-Indigenous 14 year olds (table 3A.3.2).
- Over the period 2002 to 2006, the Indigenous retention rate to year 9 was relatively stable (figure 3.3.2).
- In 2005, the retention rate for Indigenous students to year 9 was 99.2 per cent. In 2006, the retention rate for the same group of students (now in year 10) had declined to 91.4 per cent (figure 3.3.2 and table 3A.3.1).

Anecdotal evidence suggests that many Indigenous children are leaving school in years 9 and 10 with poor literacy and numeracy skills and with limited post-school options. In 2004-05, Indigenous people who had a year 9 or below level of education were less likely to be employed than those who had vocational or higher education qualifications (15.8 per cent and 43.9 per cent, respectively) (table 3A.3.19).

The available retention data do not reflect this situation, because apparent retention rates are based on enrolment numbers, and high rates are to be expected because normal year level progression means students in year 9 are generally of an age at which school education is compulsory. Apparent retention rates do not reflect school attendance or whether the student completed the school year (because data are collected in August). Some information on methods for calculating retention rates and definitional issues are addressed in section 3.3. Supplementary age-specific participation measures have been included to provide a comprehensive picture of Indigenous education.

There is evidence to suggest that the causes of early school leaving include:

- poor literacy and numeracy skills
- a student's lack of interest
- poverty
- the quality of teaching staff (ACER 2002; Purdie and Corrigan 2004).

The Western Australian Aboriginal Child Health Survey conducted in 2001 and 2002 (Zubrick et al. 2006) found that:

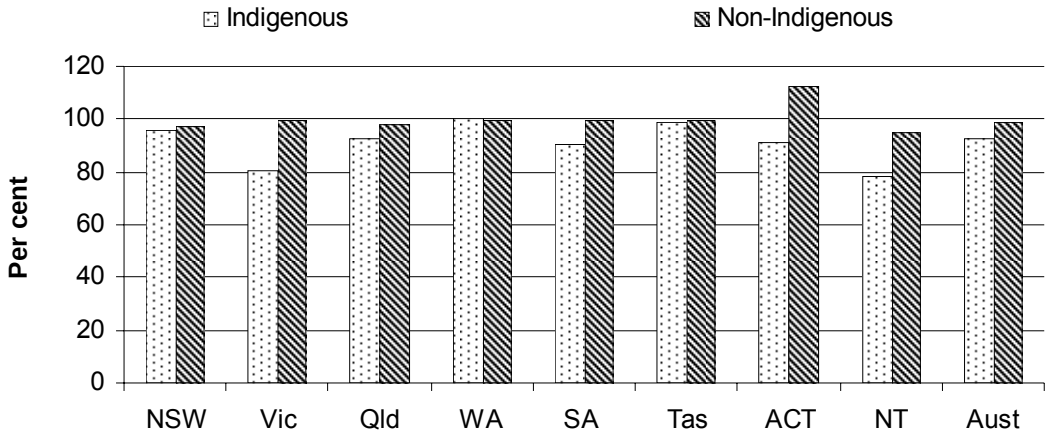
- When the period of compulsory education ends, the proportion of Indigenous children who no longer attend school is substantially higher than that for

non-Indigenous children, reducing their chances of academic and vocational success beyond the school years.

- Of those Indigenous children who left school after the period of compulsory education, one third were neither working nor in any form of education.

Some programs that have been successful in encouraging Indigenous students to stay at school can be found in section 3.3, box 3.3.2.

Figure 7.2.1 **School participation rates of full time students aged 14 years, all schools, 2006[a, b, c]**



a The participation rate is the number of full time school students of a particular age, expressed as a proportion of the estimated resident population of the same age at June in 2006. **b** The ACT rate exceeds 100 per cent, largely as a result of NSW residents from surrounding areas enrolling in ACT schools. **c** Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS 2007 (unpublished); table 3A.3.2.

In general, the age of students in year 9 is 14 years old (ABS 2007). Figure 7.2.1 shows school participation rates for 14 year olds in 2006.

- Nationally in 2006, 7.7 per cent of Indigenous people aged 14 years were not participating in school education. For non-Indigenous people, 1.4 per cent of 14 year olds were not participating in school education (table 3A.3.2).
- High participation rates are to be expected because school education was compulsory in all states and territories for people between 6 and 15 years of age in 2006 (extending to 16 years of age in SA and Tasmania). Rates for Indigenous students, however, were lower than those for non-Indigenous students in all states and territories except WA (figure 7.2.1).

Table 7.2.1 **Apparent retention rates of full time secondary students to year 9, all schools, 2006 (per cent)[a, b, c, d, e]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous									
Male	96.0	100.0	100.4	100.1	90.5	101.8	109.5	89.6	97.6
Female	99.3	105.6	99.9	100.0	90.6	107.1	97.5	94.2	99.2
Total	97.6	102.8	100.2	100.1	90.5	104.3	103.7	91.9	98.4
Non-Indigenous									
Male	99.0	99.6	100.7	101.5	100.1	100.9	98.3	96.5	99.9
Female	99.6	100.6	100.5	101.5	100.4	99.4	99.6	96.2	100.3
Total	99.3	100.1	100.6	101.5	100.2	100.2	98.9	96.4	100.0

a The apparent retention rate is the percentage of full time students who continued to year 9 from respective cohort groups at the commencement of their secondary schooling (year 7/8). **b** Retention rates are affected by factors that vary across jurisdictions, so variations in apparent retention rates over time within jurisdictions may be more useful than comparisons across jurisdictions. Retention rates can exceed 100 per cent for a variety of reasons, including student transfers between jurisdictions after the base year. **c** The exclusion of part time students from standard apparent retention rate calculations has implications for the interpretation of results for all jurisdictions, but particularly for SA, Tasmania and the NT where there is a high proportion of part time students. **d** The small number of Indigenous students in some jurisdictions (the ACT and Tasmania) can result in large fluctuations in the apparent retention rates when disaggregated by gender. **e** Ungraded students are not included in the calculation of apparent retention rates. This exclusion has particular implications for the NT and as a result, Indigenous apparent retention rates may misrepresent the retention of students in secondary schooling in the NT.

Source: ABS 2007 (unpublished); table 3A.3.3.

- From 2002 to 2006, Indigenous apparent retention rates from the start of secondary school to year 9 have remained relatively constant (fluctuating between 97.8 and 98.4 per cent) (figure 3.3.2).
- High rates are to be expected because normal year level progression means students in year 9 are generally of an age at which school education is compulsory. Rates for Indigenous students, however, were lower than those for non-Indigenous students in all states and territories except Victoria, Tasmania and the ACT (table 7.2.1).
- The national retention rate for Indigenous students was 98.4 per cent compared with 100.0 per cent for non-Indigenous students (table 7.2.1).

7.3 Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies

Box 7.3.1 **Key messages**

- Between 2001 and 2005, the number of Indigenous teachers and Aboriginal and Islander Education Workers in schools increased from 3238 to 3596 (table 7.3.1).
- Some primary and secondary schools are incorporating Indigenous studies in their curricula, and Indigenous culture and perspectives are being incorporated into VET programs offered at school. This can improve the number of Indigenous students completing year 12 and improve all students' knowledge and appreciation of Indigenous culture (boxes 7.3.2 to 7.3.6).

In consultations on the 2005 Report (SCRGSP 2007), differing views on this indicator were expressed by various Indigenous organisations and communities. Responses from governments and agencies also differed.

Some Indigenous organisations and communities were concerned that the attention was on culturally appropriate education for Indigenous people rather than good academic outcomes that are comparable to all students. Other Indigenous organisations and communities believed cultural studies consolidated community teaching and could assist to preserve Indigenous language. Indigenous cultural studies also provides an opportunity for Indigenous people to share their knowledge with the wider community.

Approaches to incorporating Indigenous content into the school curriculum vary widely between education systems and between schools. Schools exist in varied contexts and have varying numbers of Indigenous students. A quarter of schools had no Indigenous students in 2005 (25.1 per cent); the remainder had some Indigenous students enrolled (48.1 per cent of schools had 0.1 to 5.0 per cent Indigenous students). In 1.8 per cent of schools, more than 95 per cent of students were Indigenous and in 1.0 per cent of schools all students were Indigenous (DEST unpublished).

Data for reporting against this indicator are very limited. The *National Report to Parliament on Indigenous Education and Training, 2004* (DEST 2006) provides some qualitative and quantitative information for this indicator.

The Department of Education, Science and Training (DEST) collects limited information related to this indicator from Indigenous Education Strategic Initiatives Programme (IESIP) reports completed by individual education systems and schools.

A suite of performance indicators has been developed for the Indigenous Education Program (2005–2008) — Supplementary Recurrent Assistance — and DEST plans to include a measure in this reporting process to encourage more extensive Indigenous involvement in developing and delivering Indigenous studies.

Although there is no systematic collection of data on Indigenous studies in the school curriculum, some examples have been identified and are included in this section.

Culturally inclusive curricula

Most states and territories have developed strategies to incorporate Indigenous perspectives across the curriculum. Many have units devoted to developing Indigenous curriculum materials for use within various subjects and at various stages in schooling.

DEST (2006) reported that a range of projects have been developed by states and territories, such as *The Croc Festivals*, *Deadly Vibe Magazine* (see section 3.3, box 3.3.2) and *Indigenous Mentoring Pilot Project*, to motivate and inspire Indigenous students. These projects are designed to complement programs on cultural studies in school curriculum.

The following case studies boxes (7.3.2 to 7.3.7) are presented as examples of what some schools and education providers are doing to introduce Indigenous culture and perspectives into their curricula. Some case studies demonstrate programs created primarily for Indigenous students to increase their knowledge of their culture and to improve their motivation to attend and succeed at school. Other case studies aim to improve the knowledge and understanding of all students (both Indigenous and non-Indigenous).

Box 7.3.2 **Bendigo Senior Secondary College, Victoria — Dare to Lead program**

The 2005 Report included a case study on the 'Dare to Lead' Program at the Bendigo Senior Secondary College. The program continued successfully in 2006, building on initiatives undertaken in 2004 and 2005 to promote awareness of Indigenous culture. In 2005, the College was one of six national winners of the Excellence in Leadership in Indigenous Education awards established under the 'Dare to Lead' Program. In 2006, the Bendigo Senior Secondary College had 21 Koorie students enrolled out of a total 1781 students.

In 2006, the Program Coordinator at Bendigo Senior Secondary College implemented activities aimed at improving transition, engagement and cultural awareness. These activities included a Formalised Indigenous Transition Program where the College worked with five secondary schools in Bendigo to ensure that the move for students into senior education was culturally sensitive. The transition program has significantly improved retention into the College's senior campus. Koorie students also participated in a number of community events including careers expos, as well as the Crocfest in Swan Hill.

As part of improving cultural awareness, Year 11 students studied the short film works of filmmaker and activist Richard Frankland. In addition:

- health and human development students studied contemporary Indigenous health
- physical education students studied traditional Indigenous games
- Australian history students studied the impact of settlement in the Port Phillip District
- outdoor education classes looked at Indigenous land use and perspectives.

As a result of the targeted program focused on Indigenous culture, the College is beginning to see success in its Indigenous students over a range of areas, including scholarships, retention, and completion. The number of school completions among the Indigenous cohort has increased over the last three years.

Source: Department of Education and Training, Victoria (unpublished).

Box 7.3.3 **Swan View Senior High School, WA**

To encourage Indigenous students to continue to year 12, the Swan View Senior High School has created a comfortable and culturally-affirming environment for learning. To create a supportive and culturally-appropriate model of schooling, the school and the Indigenous community developed the Access Program.

The Access Program offers school-based traineeships. The key to the program's success was the school's engagement with the community and negotiating all aspects of learning. The ongoing involvement of parents, family members and former students in the program has resulted in more Indigenous students completing year 12.

Source: DEST 2006; O'Callaghan 2005.

Box 7.3.4 **Broulee Public School, NSW — language program**

The 2005 Report included a case study on the Broulee Public School in Eurobodalla, NSW. The school has a large population of Aboriginal students and decided to include the Dhurga Djamanji language program into the school curriculum, to teach both Indigenous and non-Indigenous children about Indigenous language and culture.

The Dhurga Djamanji language program offered at Broulee Public School continues to perform strongly. The program has been endorsed by the NSW Aboriginal Educational Consultative Group as an exemplary program and model. The Aboriginal language program has been successfully integrated into everyday classroom activities and has received overwhelming support within the school community and the local Indigenous and non-Indigenous communities.

Source: NSW Government (unpublished).

Box 7.3.5 **Tauondi College, SA**

Vocational education and training (VET) in schools can reaffirm Indigenous students' cultural identity, as well as provide skills for employment, community development and self-development.

Tauondi College, in Port Adelaide, is an independent, Indigenous community-run training organisation that has operated since 1974. Tauondi College is a registered training organisation that has established a culturally-appropriate approach to VET in Schools. Tauondi College deliver nationally accredited VET training packages to secondary school students. The Tauondi VET in Schools program provides dual award courses that combine traditional school studies with VET, which allow students to attain a qualification from both Tauondi College and their secondary school.

Tauondi currently runs VET in Schools courses in hospitality, art, information technology, horticulture, community services and automotive skills. The college operates using cultural protocols and practices and each course incorporates Aboriginal culture. For example, the hospitality students work with native foods as well as western foods.

Source: O'Callaghan 2005.

Box 7.3.6 **Western Arrernte Picture Dictionary, NT — language and cultural program**

Since 2004, the Indigenous staff at the Ntaria School have developed a comprehensive language and cultural program with funding from IESIP. In 2006, a Western Arrernte Picture Dictionary was produced. The dictionary is a simple but comprehensive introduction to the Western Arrernte language, which is spoken in the country to the west of Alice Springs at Hermannsburg, Papunya, Ikuntji (Haasts Bluff), Wallace Rockhole, and in Alice Springs. The dictionary comprises an extensive word list in Western Arrernte and a reverse English-Western Arrernte word finder and is an invaluable resource in the school's ongoing language and culture program.

Source: NT Government (unpublished).

Box 7.3.7 **Remote Independent Community School**

A remote community school (which cannot be identified) was founded in 1978 and is situated on a pastoral lease, which was transferred to the local Aboriginal community in 1976. The local community comprises approximately 250 people, and is remote and isolated, particularly during the wet season.

The primary and secondary school population is approximately 70 students with itinerant students adding to the population seasonally.

Indigenous studies programs are included in the curriculum through a thematic approach to teaching. The themes work on a two year cycle, ensuring that all students get exposed to Indigenous studies during their schooling. In addition, students undertake language and cultural days at the end of each term.

All classes have two Aboriginal Education Workers who work with a qualified teacher. The Aboriginal Education Workers are responsible for ensuring the delivery and development of the Indigenous studies program. When the school travels for cultural days, Indigenous people in the community facilitate the outcomes and the delivery of the program.

The school focuses on the maintenance of two local Aboriginal languages. There are a number of different language based activities carried out at the school, for example:

- paintings were placed around the school and the stories were translated into local languages
- the students undertook three cultural and language days where language was spoken on traditional country
- the school and students produced three language books that were published.

Source: DEST (Supplementary Recurrent Assistance Performance Reports) 2005 (unpublished).

Indigenous employment in schools

While no specific data were available on Indigenous teachers teaching Indigenous studies, some data on Indigenous employment in schools have been included to provide information on Indigenous involvement in school education. Indigenous cultural perspectives are important across the curriculum and the presence of Indigenous staff provide positive role models and contribute to bringing Indigenous perspectives to students.

Table 7.3.1 **Indigenous employment in schools**

	Government schools					*Catholic schools*[a]				
	2001	*2002*	*2003*	*2004*	*2005*	*2001*	*2002*	*2003*	*2004*	*2005*
Number of Indigenous teachers [b, c]	1 338	1 350	1 473	1 493	1 459	52	66	72	73	106
Indigenous teachers as a proportion of all teachers (%) [b, c]	0.8	0.8	0.8	0.8	0.9	0.1	0.2	0.2	0.2	0.2
Indigenous students as a proportion of all students (%) [d]	4.5	4.7	4.9	5.1	5.2	1.3	1.4	1.5	1.6	1.6
Number of AIEWs in schools [b, c, e, f]	1 406	1 441	1 435	1 459	1 570	442	477	495	523	461
Ratio of Indigenous students to Indigenous teachers and AIEWs [b, c, d]	27.1	26.2	26.4	25.9	25.8	28.8	28.0	27.8	27.6	32.1
Number of Indigenous staff in schools including teachers, specialist support staff (including teacher aides and AIEWs), administrative and clerical staff [b, c, g, h]	2 824	3 239	3 211	3 273	3 761	473	535	552	562	548
Total number of staff in schools including teachers, specialist support staff (including teacher aides and AIEWs), administrative and clerical staff	214 363	212 594	232 249	236 524	238 874	56 268	58 451	62 634	64 324	63 647
Indigenous staff as a proportion of all staff in schools (%) [b, c, h]	1.3	1.4	1.4	1.4	1.6	0.8	0.9	0.9	0.9	0.9
Indigenous administrative and clerical staff as a proportion of all administrative and clerical staff (%)	3.5	3.7	3.9	4.0	3.6	3.2	3.3	2.7	2.7	3.3

AIEWs = Aboriginal and Islander Education Workers. [a] The number of Indigenous students in Catholic schools is based on the number in all Catholic schools, not just IESIP funded Catholic systems. Staff numbers are those in IESIP funded Catholic systems. [b] For some states and territories, these figures are based on actual numbers and for some others, it is based on full time equivalent (FTE). [c] Figures are not to be considered as nationally reflective because not all states and territories reported on employment in any one year. [d] Catholic Schools' enrolment data include some other non government schools, including many Indigenous run schools that have greatly influenced the results. [e] Figures for 2001 includes 140 teacher aides in Queensland who are not classified as AIEWs because they are not placed in identified positions. [f] Includes school and non school based AIEWs. [g] Changes in the way staffing in the category 'specialist support staff' was reported by two state departments in 2003, means that it is not possible to provide a consistent picture of change over the period 2002-03. [h] Total for government schools in 2001 is less than the sum of numbers for Indigenous teachers and AIEWs because the total Indigenous staff numbers in government schools does not include 140 teacher aides in Queensland not classified as AIEWs.

Source: DEST IESIP performance reports 2001–2005 (unpublished).

In 2000, the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) decided to include an Indigenous identifier for staff in the National Schools Statistics Collection. (NSSC). In 2006, the decision to use the ABS standard definition for the collection and reporting on Indigenous staffing was implemented and become part of the NSSC reporting requirements. No data are yet available from the NSSC.

Nevertheless, a general indication of the number of Indigenous teachers and Aboriginal and Islander education workers is available from DEST IESIP reports. Table 7.3.1 includes Indigenous Teacher Aides (classified as Indigenous specialist support staff) from Queensland government schools for the first time. Information previously published has been adjusted to reflect this.

- Indigenous teachers and staff in schools are a much smaller proportion of all teachers and staff than Indigenous students are of all students.
- Between 2001 and 2005, there have been increases in the number of Indigenous teachers and other staff in schools.
- There was a 9.0 per cent increase in the number of Indigenous teachers in government schools over the period.
- The ratio of Indigenous students to Indigenous teachers and Aboriginal and Islander Education Workers (AIEWs) decreased from 27.1 per cent in 2001 to 25.8 per cent in 2005.
- The number of AIEWs employed in the government system and the Catholic system fluctuated between 2001–2005.
- In 2004, 2.2 per cent of executive staff in the government system and 1.2 per cent of executive staff in the Catholic system were Indigenous (DEST 2006).

Table 7A.3.2 shows that 39.3 per cent of AIEWs in government schools and 57.5 per cent of AIEWs in Catholic schools had completed or were studying towards formal qualifications in 2005. The proportion who had completed or were studying towards formal qualifications has increased in government schools and Catholic schools since 2001 (31.3 per cent and 47.1 per cent, respectively)[1].

Box 7.3.8 shows a program that provides community based teaching training for Indigenous people.

[1] Smaller numbers of AIEWs in Catholic systems can mean that small changes in numbers studying or total AIEWs can cause proportions to vary from year to year without necessarily indicating a trend.

Box 7.3.8 **RATEP — a community based Indigenous teacher education program in Queensland**

The Remote Area Teacher Education Program (RATEP) is a training and employment program to assist Indigenous community teachers to become registered teachers in communities where they live and work. RATEP is a partnership between the Queensland Department of Education, Training and the Arts, James Cook University, and the Tropical North Queensland Institute of TAFE.

In 2007, 167 students were enrolled in the program, including 63 in Certificate III and IV in Education, 43 in Diploma of Education and 61 in Bachelor of Education courses.

Since its inception in 1990, 113 RATEP graduates have achieved a university qualification, making them eligible for teacher registration and over 500 graduates have achieved a Certificate III or diploma level vocational qualification.

In 2006, the Government expanded RATEP to four additional sites (Ravenshoe, Badu Island, Yorke Island and Darnley Island) and continues to work with training and education providers to replicate the model across other Government human services agencies.

Source: Queensland Government (unpublished).

7.4 Juvenile diversions as a proportion of all juvenile offenders

Box 7.4.1 **Key message**

Although data on juvenile diversions are not comparable between states and territories, a smaller proportion of Indigenous juveniles were diverted from court by formal cautioning or referrals than non-Indigenous juveniles in each State and Territory for which data were available.

Diversion programs allow a juvenile offender to be disciplined without the necessity of interaction with traditional court processes. The most common diversionary mechanisms used by State and Territory juvenile justice systems include:

- cautions or warnings
- infringement notices
- referrals to youth, community or family conferences
- referrals to juvenile justice teams.

Diversionary mechanisms may not reduce the interaction between Indigenous juveniles and the criminal justice system, but in combination with sports and leisure programs have been shown to contribute to reducing antisocial behaviour and offending (Morris, Sallybanks and Willis 2003). Research has also shown that programs that increase young peoples' involvement in sport, arts, or community group activities may reduce the likelihood of Indigenous juveniles having repeated contact with police (Cameron and MacDougall 2000; Mason and Wilson 1988; Morris, Sallybanks and Willis 2003; Randell 2002). This in turn may lead to an improvement in imprisonment and juvenile detention rates (reported in section 3.12) and less directly lead to improvements in year 10 and 12 retention (section 3.3), tertiary qualifications and participation (section 3.4), unemployment (section 3.5), and suicide and self-harm (section 3.8). Some successful initiatives implemented in Victoria to divert Indigenous youth from the criminal justice system are described in box 7.4.2.

In some states and territories, the decision to divert an alleged offender will be left to the discretion of individual police officers. Alternatively, as in NSW, an Act of Parliament governs the process to be followed. In such cases, when the police apprehend a young person, they must consider whether he or she is entitled to be diverted under the appropriate Act.

Box 7.4.2 **'Things that work' – Victorian Aboriginal Justice Agreement Community Grant Programs**

Community Grant Programs, an initiative of the Victorian Aboriginal Justice Agreement, enable Koori communities throughout Victoria to design and deliver localised early intervention/prevention strategies targeting Koori youth. Strategies implemented to date have included programs to assist Koori youth who receive police cautions, improve relations between Koori youth and police, and engage Koori youth in sporting and other club activities that offer social alternatives to offending.

Some examples of programs include:

- *Night Patrol*, which has been established in Shepparton, Mildura, Robinvale, Bairnsdale and the north-western suburbs of Melbourne as a means of:
  - safely transporting young Koories from situations in which they are at risk of negative contact with the criminal justice system
  - developing positive and productive relationships with local police. Qualitative evaluation suggests that people in those communities generally rated the night patrols as effective in reducing alcohol related violence and crimes. Rowland and Toumbourou (2004) reported that the crime rate in a local shopping mall dropped by 39 per cent after the night patrol service commenced in a rural Indigenous community of Victoria.

(Continued next page)

Box 7.4.2 (continued)

- *Police and Youth Groups*, which have been established in Ballarat, Horsham and Halls Gap as a means of:
  - providing a safe place for interaction between local Koori youth and police
  - fostering bonds between local Koori leaders and local Koori youth
  - providing more opportunities for Koori youth to feel like valued members of their community. These youth groups run a range of activities, such as bowling, swimming, movies and football, which have been well attended by local Koori youth.
- *The Youth Contact Minimisation Project,* which was established in Mildura as a means of:
  - encouraging and supporting Koori youth, both personally and financially, to participate in formal organised sport throughout the year
  - encouraging and supporting local Elders and parents to be involved in sports as mentors, coaches, umpires, committee members and support workers
  - assisting Koori youth to develop physical skills, increase self esteem and improve team-building and leadership skills, while also providing a mechanism whereby Koori youth can become accountable and responsible for improving their long-term employment or sporting potential. To date, the project has attracted up to 250 Koori youth, who have competed successfully in the local district soccer competition. The group are currently working in partnership with other recreation and community groups to establish non-soccer activities over the summer (non-playing) season, including a youth group/drop in centre.

There is no national data set on the extent of Indigenous juvenile diversions. The data in this section are from NSW, Victoria, Queensland, WA, SA and the NT, and the focus is on diversions at the police level. The data are not comparable, but have been provided to give some indication of the level of Indigenous juvenile diversions. Diversions can also be exercised at the court level. In this Report, only WA provides some data on referrals to juvenile justice teams by the court. Diversionary mechanisms exercised by courts may be explored further in future Reports.

The availability of data on juvenile diversions by Indigenous status is increasing. In the 2003 report, data were only available for NSW, WA and the NT. In the 2005 Report, data were also available for Victoria and SA. For the 2007 Report, data are available for Queensland, which now allows reporting for six jurisdictions.

The NSW data are from police records and represent persons of interest (POIs) or alleged offenders who have come to the attention of NSW Police for a recorded criminal incident (driving offences are excluded). Not all crimes have an associated

POI. The NSW Department of Juvenile Justice also plays a significant role by administering Youth Justice Conferences, which are the mechanism for juvenile diversions in that State. The NSW Police data does not reflect the activity of Youth Justice Conferences.

In Victoria, data on apprehensions describe offences charged by police as either an 'arrest' or 'summons', and a diversion as a 'caution'. Queensland Police data present diversionary methods of processing as 'caution' and 'community conference', in contrast to an 'arrest', 'notice to appear', 'summons' or 'warrant'. In WA, a juvenile diversion includes both 'cautioning' and 'referrals to juvenile justice teams' by the police. A 'formal caution' and 'transfer to family conference' issued by police in SA are classified as juvenile diversions. For the NT, the data refer to apprehension cases rather than individual persons; therefore, a number of cases can relate to one person.

Indigenous status in Victoria, WA and SA is completed on the basis of the attending officer's subjective assessment of the person's appearance and is recorded for operational purposes only. In NSW, Queensland and the NT, police officers ask juveniles whether they are an Aboriginal or Torres Strait Islander.

Data from Tasmania and the ACT have not been published in this Report. In some instances, this is because there is no Indigenous identifier currently in place or data are not of sufficient size or quality to publish. It is anticipated that in future years a more extensive and comparable set of data will be available from jurisdictions.

Data in the following section have not been adjusted to control for factors which might affect the likelihood of a juvenile being diverted from court by police. These factors include the nature of the offence and the offending history of the young person.

New South Wales

Table 7.4.1 **NSW, number and proportion of juveniles diverted, 2005**[a, b, c, d]

	Unit	*Indigenous*	*Non-Indigenous*	*Total*[e]
Proceeded against other than to court				
Youth conference	no.	334	916	1 287
Caution – Young Offenders Act	no.	1 503	8 332	10 233
Warning	no.	2 048	14 079	17 304
Infringement Notice		446	6 195	7 317
Total	no.	4 331	29 522	36 141
Proceeded against to court	no.	4 821	9 019	14 315
Proportion of juveniles diverted	**%**	**47.3**	**76.6**	**71.6**

[a] This table represents persons of interest (POIs) or alleged offenders who have come to the attention of NSW Police for a recorded criminal incident (driving offences are excluded). Not all crimes have an associated POI. The table only shows POIs whom the police have taken action against. 'Proceeded against to court' includes the issue of court attendance notices, charges and summonses. 'Youth Justice Conference' shows police conference referrals but excludes court referrals. [b] Under the *Young Offenders Act 1997* (NSW), when police apprehend a young person they must first consider whether the young person is entitled to be diverted under the Act by way of warning, caution or youth justice conference. [c] Excluded from this table were 1335 juvenile POIs whose status was recorded by police as 'legal process not further classified'. [d] Indigenous status is based on self-identification by the juvenile. [e] 'Total' includes those juveniles whose status is unknown.

Source: NSW Bureau of Crime Statistics and Research (unpublished); table 7A.4.4.

Table 7.4.1 shows the various legal processes NSW Police can employ against alleged offenders. The proportion of juveniles diverted includes those referred to a 'youth conference' and those given a 'caution', 'warning' or 'infringement notice'; none of which require the juvenile to attend court.

- Indigenous juveniles were diverted at a lesser rate than non-Indigenous juveniles in 2005 (47.3 per cent compared to 76.6 per cent) (table 7.4.1).
- The highest number of cautions and referrals to youth justice conferences issued to Indigenous and non-Indigenous juveniles in NSW was for 'theft' in 2004 (table 7A.4.1) and 2005 (table 7A.4.2).
- The proportion of Indigenous juveniles diverted by police increased from 2004 to 2005 (43.8 per cent in 2004 compared with 47.3 per cent in 2005) (tables 7A.4.3 and 7A.4.4). In 2004, 77.9 per cent of non-Indigenous juveniles were diverted (table 7A.4.3), similar to the 76.6 per cent diverted in 2005 (table 7.4.4).

Victoria

Table 7.4.2 **Victoria, Indigenous and non-Indigenous juvenile alleged offenders and cautions[a]**

	Unit	*Indigenous*	*Non-Indigenous*
2005-06			
Total juvenile alleged offenders	no.	1 607	24 230
Juvenile cautions	no.	157	6 398
Proportion of juveniles cautioned	**%**	**9.8**	**26.4**
2004-05			
Total juvenile alleged offenders	no.	1 551	23 548
Juvenile cautions	no.	181	5 501
Proportion of juveniles cautioned	**%**	**11.7**	**23.4**
2003-04			
Total juvenile alleged offenders	no.	1 476	19 938
Juvenile cautions	no.	162	5 873
Proportion of juveniles cautioned	**%**	**11.0**	**29.5**
2002-03			
Total juvenile alleged offenders	no.	1 424	22 194
Juvenile cautions	no.	198	6 524
Proportion of juveniles cautioned	**%**	**13.9**	**29.4**

a Indigenous status is derived from the racial appearance of the offender which is a subjective assessment of the police officer.

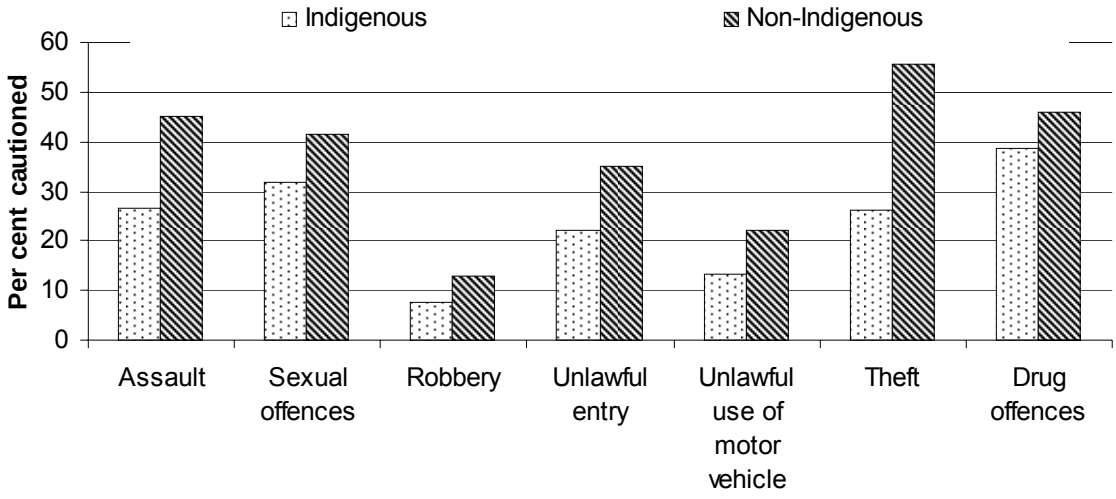
Source: Victoria Police (unpublished); tables 7A.4.5–8.

- In 2005-06, the proportion of non-Indigenous juvenile alleged offenders in Victoria who received a caution was 2.7 times as high as the proportion of Indigenous juvenile alleged offenders cautioned (26.4 per cent compared to 9.8 per cent) (table 7.4.2).
- Table 7.4.2 shows that the proportion of Indigenous juvenile alleged offenders cautioned by police in Victoria decreased from 2002-03 to 2005-06 (13.9 per cent in 2002-03 compared to 9.8 per cent in 2005-06). The proportion of non-Indigenous juveniles cautioned by police also decreased over this period.
- The highest number of cautions issued to Indigenous and non-Indigenous juvenile alleged offenders in Victoria in 2004-05 and 2005-06 were for 'theft' (stealing from a shop) (tables 7A.4.9 and 7A.4.10).
- In 2004-05 and 2005-06, the proportion of Indigenous juvenile alleged offenders in Victoria who received a caution was highest in outer regional areas (13.3 per cent in 2005-06) compared with 9.3 per cent in major cities and 8.5 per cent in inner regional areas (tables 7A.4.11 and 7A.4.12). A similar

pattern was observed for non-Indigenous juvenile alleged offenders in outer regional areas.

Queensland

Figure 7.4.1 **Queensland, proportion of Indigenous and non-Indigenous juvenile alleged offenders receiving a caution, by type of offence, 2004-05[a, b, c, d]**



a Proportions are calculated using data in table 7A.4.13. The number of cautions are divided by the sum of the number of arrests, cautions, referrals to community conference, notices to appear, summons, warrants and 'other' methods of processing juvenile alleged offenders used by Queensland Police, multiplied by 100. **b** Indigenous status is based on self-identification by the juvenile. **c** Only those offenders whose age and sex were identified are included. **d** 'Theft' excludes unlawful entry.

Source: Queensland Police Services 2004-05; table 7A.4.13.

- Figure 7.4.1 shows that in Queensland, a greater proportion of non-Indigenous juveniles received cautions for assault, sexual offences, robbery, unlawful entry, unlawful use of a motor vehicle, theft, and drug offences than Indigenous juveniles in 2004-05.
- In Queensland, the most common caution for Indigenous juveniles was for drug offences, at 38.7 per cent of apprehensions. The most common caution for non-Indigenous juveniles, on the other hand, was for theft, at 55.4 per cent of apprehensions (figure 7.4.1).
- The smallest number of cautions in Queensland were issued for robbery, at 7.6 per cent and 12.8 per cent of Indigenous and non-Indigenous apprehensions, respectively (figure 7.4.1).

To accompany figure 7.4.1, table 7A.4.13 presents a detailed breakdown of the number of arrests, cautions, referrals to community conferences, notices to appear, summonses and warrants issued by Queensland Police, by offence type in 2004-05.

Western Australia

Table 7.4.3 **WA, number and proportion of contacts with the juvenile justice system, by type of contact, 1995–2002[a, b, c]**

	Unit	*Indigenous*	*Non-Indigenous*
Cautioned	no.	17 167	62 555
Referred to juvenile justice teams by police	no.	4 489	11 000
Total number of juveniles diverted	**no.**	**21 656**	**73 555**
Dealt with by court			
Dismissed/no penalty	no.	4 153	4 629
Fine	no.	1 910	5 477
Community-based order	no.	6 399	8 580
Detention	no.	2 565	1 851
Referred to juvenile justice teams	no.	3 068	7 608
Total	**no.**	**39 751**	**101 700**
Proportion of juveniles diverted	**%**	**54.5**	**72.3**

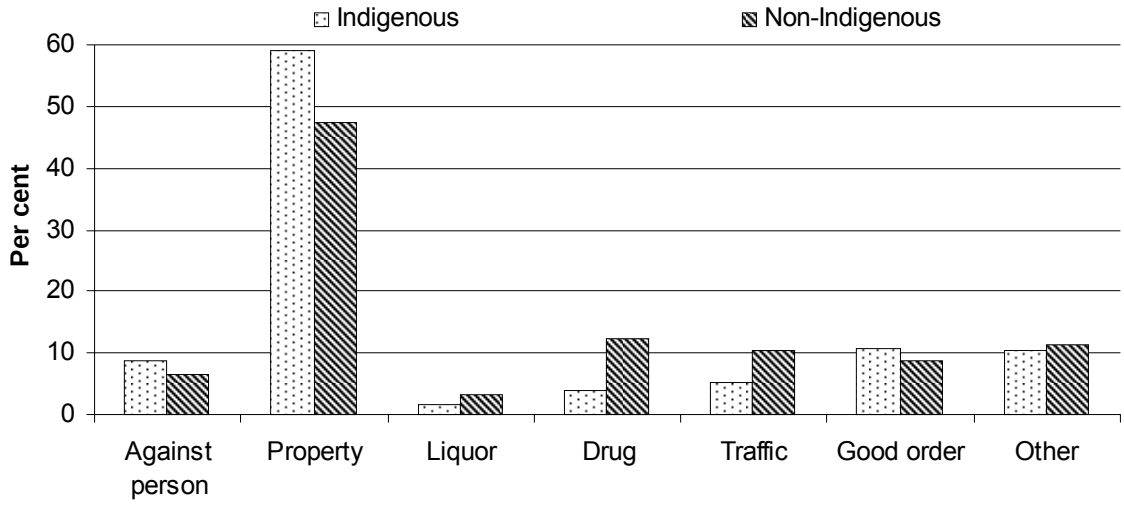
a A 'contact' was counted for every event in which a juvenile was cautioned or referred to a juvenile justice team, irrespective of the number of offences for which the caution or referral was made. **b** A diversion includes both cautioning and referral to juvenile justice teams by the police. Juvenile justice teams handle juveniles who have committed minor offences, or who are in the early stages of offending. **c** Indigenous status is based on the attending officer's subjective assessment of the offender's appearance and is recorded for operational purposes only.

Source: University of Western Australia Crime Research Centre 2004a; table 7A.4.14.

- For Indigenous juveniles, about half (54.5 per cent) of those formally dealt with by the WA Police were diverted between 1995 and 2002, while the proportion of non-Indigenous juveniles diverted was greater at 72.3 per cent (table 7.4.3).
- The number of cautions and referrals to juvenile justice teams in WA (by police) issued to non-Indigenous juveniles were 3.6 times and 2.5 times greater, respectively, than the number issued to Indigenous juveniles between 1995 and 2002 (table 7.4.3).

To support table 7.4.3, tables 7A.4.15 and 7A.4.16 present the number and proportion of juvenile diversions (i.e. cautioning and police referrals) between 1995 and 2002 by sex and type of offence.

Figure 7.4.2 **WA, Indigenous and non-Indigenous juvenile cautions, by type of offence, 2004[a]**



[a] Indigenous status is based on the attending officer's subjective assessment of the offender's appearance and is recorded for operational purposes only.

Source: University of Western Australia Crime Research Centre 2004b; table 7A.4.17.

- In 2004, Indigenous juveniles received a greater proportion of cautions for three of the seven types of offences presented in figure 7.4.2 ('against person', 'property' and 'good order').
- The greatest disparity between the proportion of cautions by offence type issued to Indigenous and non-Indigenous juveniles was for drug related offences (12.2 per cent for non-Indigenous juveniles compared to 4.0 per cent for Indigenous juveniles).
- Offences against property received the greatest number of cautions for both Indigenous and non-Indigenous juveniles at 59.0 per cent and 47.2 per cent of the total cautions issued, respectively.

An annual breakdown of the number and proportion of juvenile cautions issued in WA from 1994 to 2004 is presented in table 7A.4.18. For Indigenous juveniles, there has been an upward trend in the number of cautions issued from 1994 to 2004. For non-Indigenous juveniles, however, there was an upward trend in the number of cautions issued from 1994 to 2000, but a gradual decline in cautions issued in the four years following the peak of 2000.

Table 7A.4.19 shows the number and proportion of Indigenous and non-Indigenous juveniles cautioned in WA in 2004 by sex and single-year age groups (from 10 to 17 years).

South Australia

Table 7.4.4 **SA, Indigenous and non-Indigenous juvenile apprehensions and diversions[a, b]**

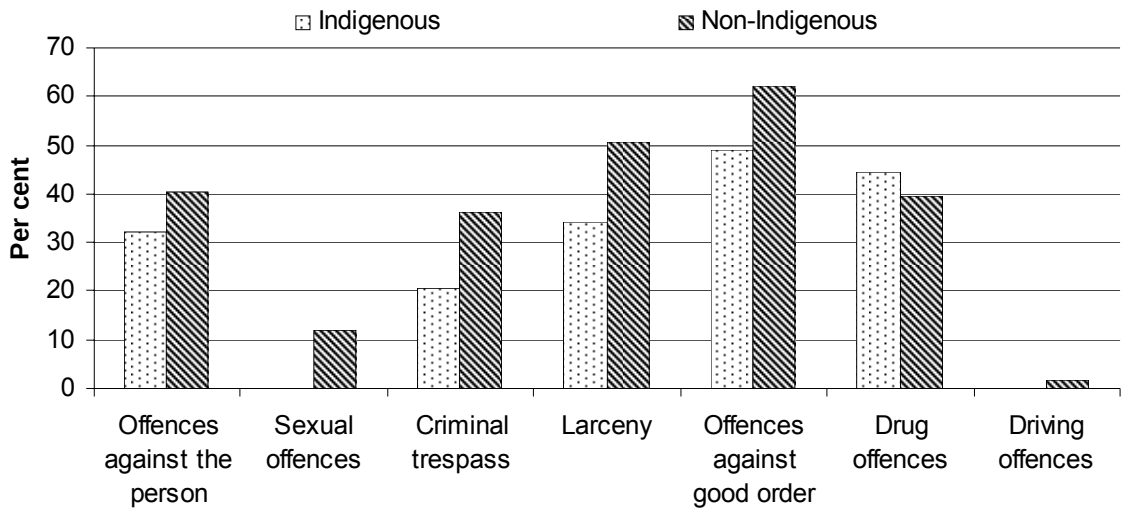
	Unit	*Indigenous*	*Non-Indigenous*
1 January to 31 December 2005			
Juvenile apprehensions[c]	no.	1 248	4 439
Formal caution	no.	258	1 257
Transfer to family conference	no.	186	751
Proportion diverted	**%**	**35.6**	**45.2**
1 January to 31 December 2004			
Juvenile apprehensions[c]	no.	1 054	4 018
Formal caution	no.	200	1 247
Transfer to family conference	no.	181	837
Proportion diverted	**%**	**36.1**	**51.9**

[a] Aboriginal appearance, derived from police apprehension reports, reflects the opinion of the apprehending officer. [b] Juvenile diversions include both formal cautions and transfers to a family conference. [c] Numbers of juvenile apprehensions exclude those offences with an unknown method of processing.

Source: Office of Crime Statistics and Research (2005 and 2006); table 7A.4.20.

- Table 7.4.4 shows that a smaller proportion of Indigenous juveniles were diverted via formal caution and transfer to family conference in 2004 and 2005 than non-Indigenous juveniles.
- In 2005, the proportion of Indigenous juveniles in SA diverted from court decreased slightly to 35.6 per cent of Indigenous juvenile apprehensions compared to 2004 (table 7.4.4).

Figure 7.4.3 **SA, proportion of Indigenous and non-Indigenous juvenile alleged offenders diverted, by type of offence, 2005[a, b]**



a Proportions are calculated using data in table 7A.4.22. The number of juvenile diversions (that is, cautions and transfers to family conference) are divided by the total number of apprehensions and multiplied by 100. **b** Aboriginal appearance, derived from police apprehension reports, reflects the opinion of the apprehending officer.

Source: Office of Crime Statistics and Research (2006); table 7A.4.22.

- Figure 7.4.3 shows that for each offence category except drug offences, the proportion of Indigenous juvenile alleged offenders in SA diverted from court (via formal cautions or transfers to a family conference) was lower than the proportion of non-Indigenous juvenile alleged offenders diverted by the same methods of processing.
- For sexual offences and driving offences, no Indigenous juvenile alleged offenders received a formal caution or transfer to a family conference in SA in 2005.
- In 2004 and 2005, the highest numbers of formal cautions issued to Indigenous juvenile alleged offenders in SA were for 'larceny from shops' and 'disorderly/offensive behaviour' (tables 7A.4.21 and 7A.4.22). The highest numbers of transfers to family conference issued to Indigenous juvenile alleged offenders were for 'criminal trespass' in 2004 and 'larceny from shops' in 2005 (tables 7A.4.21 and 7A.4.22, respectively).

Northern Territory

Table 7.4.5 **NT, Indigenous and non-Indigenous juvenile apprehensions and diversions, 1 January to 31 December 2005[a, b]**

	Indigenous	*Non-Indigenous*	*Total*
Juvenile apprehensions (number)			
Male	780	302	1 082
Female	124	78	202
Total	**904**	**380**	**1 284**
Declined or denied participation in diversion (number)[c]			
Male	582	141	723
Female	40	18	58
Total	**622**	**159**	**781**
Participated in diversion (number)			
Male	198	161	359
Female	84	60	144
Total	**282**	**221**	**503**
Proportion diverted (%)			
Male	25.4	53.3	33.2
Female	67.8	76.9	71.3
Total	**31.2**	**58.2**	**39.2**

a Data refers to apprehension cases rather than individual persons, therefore, there may be a number of cases that relate to one person. **b** Indigenous data are based on self-identification by the juvenile. **c** Where cases did not result in a diversion, these cases either proceeded to court or were resolved in some other manner (it is not an indicator of the number of matters referred to the courts).

Source: NT Police (unpublished); table 7A.4.24.

- In 2005, the proportion diverted was lower for Indigenous than non-Indigenous juvenile cases (31.2 per cent compared with 58.2 per cent). For both Indigenous and non-Indigenous juvenile cases, a greater proportion of females than males were diverted (table 7.4.5).
- Of the total apprehensions for the period (1284), 39.2 per cent participated in diversion (table 7.4.5).
- The proportion of Indigenous juveniles diverted from 1 January to 31 December 2002 was 42.9 per cent of apprehensions (table 7A.2.23). From 2002 to 2005, there was a decrease in the proportion of Indigenous juveniles diverted (tables 7A.4.23 and 7A.4.24).
- The proportion of non-Indigenous juvenile diversions fluctuated between 2002 and 2005, but were still consistently greater than the proportion of Indigenous diversions during this period (tables 7A.4.23 and 7A.4.24).

7.5 Transition from school to work

Box 7.5.1 **Key messages**

- In 2004-05, for young people aged 18 to 24 years:
  - a higher proportion of Indigenous young people than non-Indigenous young people were not employed and not studying, for both males and females in all remoteness areas (figures 7.5.1 and 7.5.2)
  - a higher proportion of Indigenous young people living in very remote areas were not employed and not studying, (51.5 per cent), compared with those in major cities (33.6 per cent) (figure 7.5.1)
  - both Indigenous and non-Indigenous young females were more likely than their male counterparts to be neither employed nor studying (figure 7.5.2).
- In 2004-05, for people aged 18 years and over:
  - both labour force participation and employment rates for Indigenous people were lower than for non-Indigenous people whether or not they had achieved a certificate level 3 or higher qualification (table 7.5.1)
  - for both Indigenous and non-Indigenous people, those with a certificate level 3 or higher qualification were more likely to participate in the labour force than those with lower levels of qualifications or without qualifications (table 7.5.1).

This indicator reports on the status of young Indigenous people's participation in either the work force or the education/training system. As one of the components of the 'Positive Childhood and Transition to Adulthood' strategic area for action, it identifies those young Indigenous people who are potentially at risk of long term disadvantage.

Two approaches are used to examine the transition from education to work — the 'at risk' and the 'outcome from education' approaches. The 'at risk' approach examines the number of Indigenous people aged 15 to 24 years who are not participating in education and training, and who are not employed. These people are considered as being at risk of long term disadvantage. The 'outcome from education' approach looks into labour force outcomes for those Indigenous people aged 18 years and over who have achieved a certain level of education.

Although there is no research specifically focusing on Indigenous young people during their transition from education to work, several recent studies have been using data collected in the *Longitudinal Surveys of Australian Youth* which examine patterns of transition from education to work for Australian youth in general.

A study by McMillan and Marks (2003) found that young people who are not achieving well at secondary school and leave without a school qualification may

have few opportunities for work. As time passes, their chances of gaining employment or re-entering full time education appear to decline even further.

Studies examining labour market outcomes of graduates and non-graduates from university or TAFE concluded that the transition from study to work was generally smoother for graduates, and that tertiary qualifications worked to protect young people from many of the difficulties involved with making this transition (Lamb 2001; Lamb and McKenzie 2001). The authors also found that university and TAFE graduates earned significantly more than those who entered the workforce directly from school. Most students who moved into employment immediately after completing Year 12 were in low level positions, primarily in the areas of retail trades, accommodation, cafes and restaurant, and manufacturing (Thomson 2005).

Sections 3.3 and 7.2 contain more information on secondary school retention for Indigenous students. Unemployment and labour force participation for Indigenous people aged 18 to 64 years are discussed in section 3.5. More information related to employment undertaken by Indigenous people, including employment by full time and part time status, by sector, industry and skill level are examined in section 11.1. Self employment and Indigenous business are reported in section 11.2.

The main sources of data for this indicator are ABS surveys, including the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Health Survey (NHS), and the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and General Social Survey (GSS). Data for people aged 18 to 24 years who were not participating in education and training and not employed are reported to enable comparisons of outcomes in 2004-05 with those in 2002.

This Report includes, for the first time, data from the Longitudinal Surveys of Australian Youth (LSAY), a research program jointly managed by the Australian Council for Educational Research (ACER) and the Department of Education, Science and Training (DEST). LSAY studies the progress of several groups of young Australians as they move from school into post-secondary education and work. This Report includes data from the 1995 and 1998 LSAY cohorts, two groups of students who were at Year 9 in 1995 and at Year 9 in 1998, respectively. LSAY has followed each group of participants by annual telephone interview. There were originally 13 613 participants in the 1995 cohort including 389 Indigenous people, and 14 117 participants in the 1998 cohort including 458 Indigenous people. It should be noted that Indigenous people accounted for 3 per cent of the LSAY samples in both cohorts, which is slightly higher than the proportion of Indigenous students among the total Year 9 population. It is possible that young Indigenous people are more likely than non-Indigenous people to leave school before year 9

(see section 7.2 Retention at year 9). Therefore, the findings from the survey may not apply to all of the Indigenous population.

Box 7.5.2 **'Things that work' — Queensland Education to Employment scheme**

The Aboriginal and Torres Strait Islander Education to Employment Scheme began in 1998. It is coordinated by the Queensland Department of Main Roads and is a joint venture between 15 Queensland government departments. The aim is to increase training and employment opportunities for Indigenous youth in Queensland by encouraging them to complete year 12 and then progress to tertiary education and/or employment in their chosen vocation.

The Scheme provides Indigenous students who commit to participate fully in the program with the opportunity of financial assistance and practical support in their schooling.

- In the first year of the program, 3 scholarships were awarded, and since then almost 100 scholarships have been awarded.
- A total of 918 students have applied for scholarships since inception of the Scheme, with 242 successfully graduating.

A recent decision by the Queensland Government's Interdepartmental Taskforce on Indigenous Education has recommended that the scheme be expanded by a further 50 placements across the Queensland public sector and another 50 places secured on the scheme via private sector sponsorship.

Source: Queensland government (http://www.reconciliation.qld.gov.au/stories/employment.html); Queensland Government (unpublished).

The 'at risk' approach

This approach looks at the participation in the work force and education system of people aged 18 to 24 years. It examines the proportion of people in this age group who are neither in full or part time employment, nor in full or part time study.

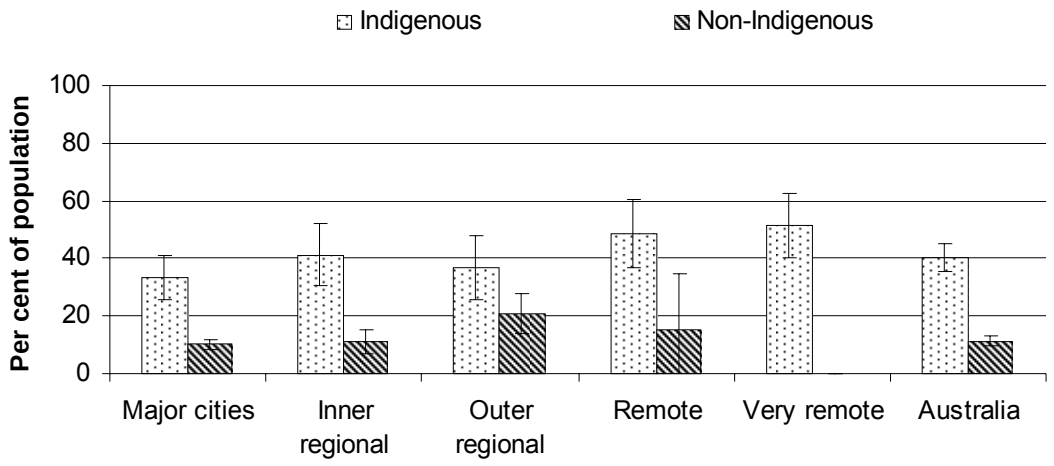
Young people who spend extended periods of time outside the work force and full time education may be missing out on employment experience, the development of work skills and familiarity with new technologies, all of which decrease their chances of finding employment in the future.

A research report based on the Longitudinal Surveys of Australian Youth (LSAY) found that over 64 per cent of the young people who participated in the LSAY spent some time outside the labour force and full time education over the years they were surveyed (from 1997 up to the end of 2003). For the majority of young people, the

period of time outside the labour force and full time education was quite short, around one month. Young people who had not achieved highly at secondary school, did not have a Year 12 certificate, were female, or who had a health problem or disability were more likely to report extended periods of time (longer than 12 months) outside the labour force and full time education (Hillman 2005).

Young Indigenous females are more likely to be outside the labour force and full time education due to home duties. In 2005, the teenage fertility rate of Indigenous women aged 15 to 19 years (69 babies per 1000 women) was more than four times the fertility rate of all teenage women (16 babies per 1000 women) (ABS 2006).

Figure 7.5.1 **Proportion of people aged 18 to 24 years who were not employed and not studying, 2004-05[a, b, c]**



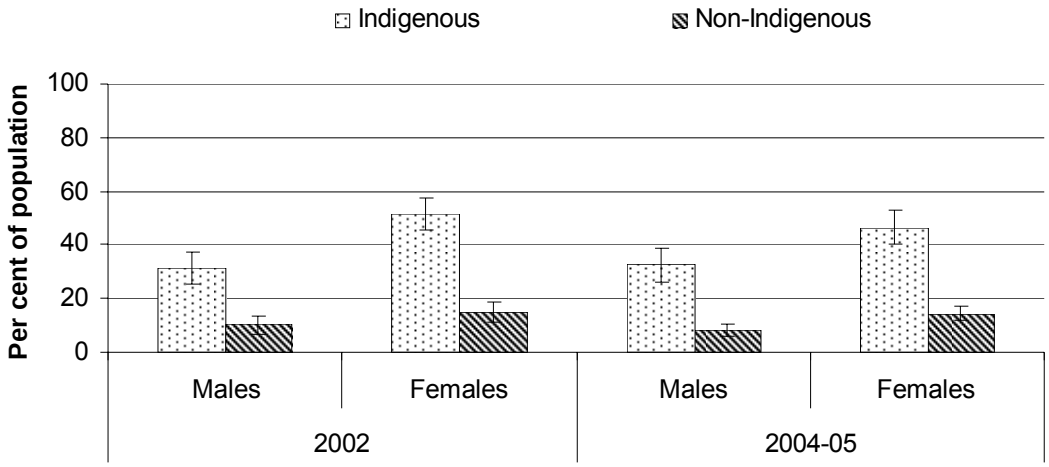
a Not employed comprises people unemployed or not in the labour force. **b** Non-Indigenous data for very remote areas are not provided by the ABS as they are considered too small to produce reliable estimates, but these data have been attributed appropriately to national estimates. **c** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 7A.5.1.

- Nationally, in 2004-05, 40.1 per cent of Indigenous people aged 18 to 24 years were not employed (unemployed or not in the labour force) and not studying, compared with 11.2 per cent of non-Indigenous people of the same age group (figure 7.5.1).
- For Indigenous people, in 2004-05, a higher proportion of young people aged 18 to 24 years in very remote areas (51.5 per cent) were not employed and not studying, compared with those in major cities (33.6 per cent).
- Between 2002 and 2004-05, there were no statistically significant differences in the proportion of people aged 18 to 24 years who were not employed and not

studying, for both Indigenous and non-Indigenous people, across remoteness areas. It is important, however, to keep in mind that a proportion of Indigenous people are CDEP participants (who are classified as employed) (for 2004-05, 28.8 per cent of those aged 15 to 24 years in remote areas) (tables 7A.5.2 and 3A.5.4).

Figure 7.5.2 **Proportion of people aged 18 to 24 years who were not employed and not studying[a, b, c]**



[a] Not employed comprises people unemployed or not in the labour force. [b] Non-Indigenous data for remote and very remote areas are not provided by the ABS as they are considered too small to produce reliable estimates, but these data have been attributed appropriately to national estimates. [c] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS, 2002 NATSISS and GSS (unpublished); table 7A.5.2.

In 2004-05:

- The proportions of both Indigenous males and females aged 18 to 24 years who were not employed (unemployed or not in the labour force) and not studying were around three times higher than for their non-Indigenous counterparts (figure 7.5.2).
- For both Indigenous and non-Indigenous people aged 18 to 24 years, females were more likely than males to be not employed and not studying.
- From 2002 to 2004-05, there was no statistically significant change in the proportions of Indigenous and non-Indigenous males and females aged 18 to 24 years who were not employed and not studying. However, this does not take into account the proportion of Indigenous people who were engaged in CDEP and therefore classified as employed (in 2004-05, 8.8 per cent of those aged 15 to 24 years) (figure 7.5.2; table 3A.5.5).

State and Territory data on people aged 18 to 24 year who were not employed and not studying are included in table 7A.5.3.

Figure 7.5.3 **Main activities of 1995 cohort participants in the fifth to eighth years of LSAY**

Source: ACER *Longitudinal Surveys of Australian Youth* (unpublished); table 7A.5.4.

Figure 7.5.3 shows the main activities of 1995 cohort participants in the fifth to eighth years of LSAY. During these four years, when the participants were aged approximately from 18 to 21 years:

- Indigenous young people were less likely than their non-Indigenous counterparts to be engaging in studies (including secondary and post secondary studies) (figure 7.5.3).
- A higher proportion of Indigenous young people in the cohort than their non-Indigenous counterparts were not studying and not employed (figure 7.5.3).

- Similar patterns to those in the 1995 cohort are also observed from the Indigenous and non-Indigenous participants in the 1998 cohort (table 7A.5.5).
- In both the 1995 and 1998 cohorts, Indigenous young people were more likely than non-Indigenous people to be undertaking vocational education and training, including study at a TAFE institution or in an apprenticeship or traineeship, but less likely to be studying in universities (tables 7A.5.4 and 7A.5.5). This is consistent with the results reported in section 3.4, Post-secondary education — participation and attainment.

The 'outcome from education' approach

This approach examines the labour force status of people who have and have not achieved a qualification of certificate level 3 or higher. It shows the relationship between employment outcomes and attainment of a certain level of educational qualification.

Table 7.5.1 **Labour force status, people aged 18 years and over, age standardised, 2004-05[a]**

	Indigenous			*Non-Indigenous*		
	Males	*Females*	*Persons*	*Males*	*Females*	*Persons*
Labour force participation as a proportion of the population aged 18 years and over (%)						
Certificate level 3 or higher	79.3	69.6	74.3	80.9	72.3	77.1
Balance of population[b]	57.6	37.5	46.8	71.9	54.4	61.9
All people[c]	62.6	44.5	52.9	76.5	60.8	68.5
Employed people as a proportion of the labour force (%)						
Certificate level 3 or higher	91.5	91.9	91.8	97.2	97.6	97.3
Balance of population[b]	90.7	89.2	90.0	95.6	95.7	95.6
All people[c]	90.7	89.9	90.3	96.4	96.6	96.5

a Excludes people still at school. **b** Includes Certificate 1 and 2 and non-school qualifications. **c** Includes inadequately described and not stated.

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 7A5.6.

In 2004-05:

- For both Indigenous and non-Indigenous people aged 18 years and over, the labour force participation rate for those with a certificate level 3 or higher was much higher than for those with lower levels of qualifications (than certificate 3) or without qualifications; however, the employment rates for those with higher and lower qualifications were similar (table 7.5.1).

- Both labour force participation and employment rates for Indigenous people were lower than for non-Indigenous people, whether or not they had achieved a certificate level 3 or higher qualification (table 7.5.1).
- The category 'certificate level 3 or higher' includes a range of intermediate to advanced qualifications and the gap in employment rates between Indigenous and non-Indigenous people may partly reflect a lower proportion of Indigenous compared to non-Indigenous people with more advanced qualifications (including certificate 4, diploma, advanced diploma as well as university degrees) in this category (see section 3.4 for more information on post-secondary education, participation and attainment).

From 2002 to 2004-05, there was a significant increase in the employment rates for both Indigenous and non-Indigenous people (table 7A.5.6). The increase of employment opportunities over this period was greater for those with a low level of qualification (certificates 1 and 2) or without a qualification than those with a certificate level 3 or higher qualification.

- The employment rate for Indigenous people with qualifications lower than certificate 3 or without qualifications increased from 79.4 per cent in 2002 to 90.0 per cent in 2004-05.
- The rate for non-Indigenous people in the same group increased from 92.3 per cent in 2002 to 95.6 per cent in 2004-05.
- There were no significant changes in the employment rates for both Indigenous and non-Indigenous people with a certificate level 3 or higher qualification between 2002 and 2004-05 (table 7A.5.6).

Tables 7A.5.7 and 7A.5.8 provide data on labour force status by level of qualifications for each State and Territory. Table 7A.5.9 contains information on employment of people in Community Development Employment Projects (CDEP) and non-CDEP employment by level of qualification.

Examples of successful programs in increasing Indigenous higher education attainment are described in box 3.4.2 in chapter 3. Box 11.1.2 in chapter 11 provides some examples of successful programs in improving Indigenous employment outcomes.

7.6 Future directions in data

Years 5 and 7 literacy and numeracy

(As for year 3) Indigenous learning outcomes data in future reports will need to be improved through the inclusion of more timely data and data by remoteness areas.

Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies

Currently, there are very limited data on Indigenous curriculum and staff, with no change in available data since the 2003 Report. The ABS standard definition for the collection and reporting on Indigenous staffing has become part of the NSSC reporting requirements. For some jurisdictions, these data may be collected and released in 2008.

Juvenile diversions as a proportion of all juvenile offenders

Further work in the area of juvenile diversions is needed to improve the comparability of data across jurisdictions. For two jurisdictions (Tasmania and the ACT) there are currently no data available because there is either no Indigenous identifier currently in place or data are not of sufficient size or quality to publish.

Transition from school to work

Since the 2005 Report, data on young people aged 18 to 24 years at risk of long-term disadvantage have become available at national and state level through the 2002 NATSISS and GSS, and the 2004-05 NATSIHS and NHS.

This Report includes data from the 1995 and 1998 cohorts of the Longitudinal Surveys of Australian Youth (LSAY), a research program jointly managed by the Australian Council for Educational Research (ACER) and the Department of Education, Science and Training (DEST). LSAY studies the progress of several groups of young Australians from the compulsory years of schooling into their mid-twenties, which provides additional insights into pathways of young people in transition from school to work. However, the Indigenous sample is relatively small compared to the non-Indigenous sample in the survey, which limits the usefulness of the data for Indigenous and non-Indigenous comparisons. The 2003 and 2006 cohorts of LSAY have larger relative samples of Indigenous young people, which will allow greater analysis of the transition in future years.

7.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 7A.3.2 is table 2 in the attachment tables for section 7.3). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

7.1 Years 5 and 7 literacy and numeracy

See section 6.3 for attachment tables

7.2 Retention at year 9

See section 3.3 for attachment tables

7.3 Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies

Table 7A.3.1	Indigenous employment in schools
Table 7A.3.2	Aboriginal and Islander Education Workers in government and Catholic schools who have completed or are undertaking professional development leading to formal qualifications

7.4 Juvenile diversions as a proportion of all juvenile offenders

Table 7A.4.1	NSW, alleged juvenile offenders (aged 10−17 years) proceeded against by police, by offence type, 2004
Table 7A.4.2	NSW, alleged juvenile offenders (aged 10−17 years) proceeded against by police, by offence type, 2005
Table 7A.4.3	NSW, juvenile diversions, 2004
Table 7A.4.4	NSW, juvenile diversions, 2005
Table 7A.4.5	Victoria, method of processing juvenile alleged offenders, 2002-03
Table 7A.4.6	Victoria, method of processing juvenile alleged offenders, 2003-04
Table 7A.4.7	Victoria, method of processing juvenile alleged offenders, 2004-05
Table 7A.4.8	Victoria, method of processing juvenile alleged offenders, 2005-06
Table 7A.4.9	Victoria, method of processing juvenile alleged offenders, by type of offence, 2004-05
Table 7A.4.10	Victoria, method of processing juvenile alleged offenders, by type of offence, 2005-06
Table 7A.4.11	Victoria, method of processing juvenile alleged offenders, by remoteness area, 2004-05

7.5 Transition from school to work

7.8 References

7 Positive childhood and transition to adulthood

ABS and AIHW (Australian Bureau of Statistics and Australian Institute of Health and Welfare) 2005, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Cat. no. 4704.0, ABS, Canberra.

Bourke, C.J., Rigby K. and Burden, J. 2000, *Better Practice in School Attendance. Improving the School Attendance of Indigenous Students*, Monash University, Melbourne, http://www/dest.gov.au (accessed 28 April 2003).

Harslett M., Harrison B., Godfrey J., Partington G. and Richer, K. 1998, Promoting success in schooling for Indigenous students: long term programs, Quality Schools for Aboriginal Students Research Project paper, Edith Cowan University and Education Department of Western Australia, http://www.eddept.wa.edu.au/Abled/quality/quality.htm (accessed 29 April 2003).

MCEETYA (Ministerial Council on Education, Employment, Training and Youth Affairs) 2000, National Statement of Principles and Standards for More Culturally Inclusive Schooling in the 21st Century, http://www.curriculum.edu.au/mceetya (accessed 30 April 2003).

—— 2001, *Exploring Multiple Pathways for Indigenous Students*, MCEETYA Taskforce on Indigenous Education, Discussion Paper, MCEETYA, Melbourne, http://www.curriculum.edu.au/mctyapdf/exploringmultiplepathways.pdf (accessed 12 July 2003).

Purdie N., Tripcony P., Boulton-Lewis G., Fanshawe J. and Gunstone A. 2000, *Positive Self-identity for Indigenous Students and its Relationship to School Outcomes*, Queensland University of Technology, Brisbane, http://www.dest.gov.au (accessed 28 April 2003).

Royal Commission into Aboriginal Deaths in Custody 1991, *National Report*, volume 4, http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/ (accessed 19 June 2003).

7.1 Years 5 and 7 literacy and numeracy

ACER (Australian Council for Educational Research) 2004, *What do we Know about the Experiences of Australian Youth?*, Victoria.

MCEETYA (Ministerial Council on Education, Employment, Training and Youth Affairs) 2007, *National Report on Schooling in Australia 2005: Preliminary*

Paper National Benchmark Results Reading, Writing and Numeracy Years 3, 5 and 7, Melbourne.

OECD (Organisation for Economic Co-operation and Development) 2004, *Learning for Tomorrow's World — First Results from PISA 2003*, France.

Ou, S., and Reynolds, A.J. 2004, 'Preschool education and school completion', in Tremblay, R.E., Barr, R.G. and Peters, R.DeV. (eds), *Encyclopaedia on Early Childhood Development*, Montreal, Centre of Excellence for Early Childhood Development, http://www.excellence-earlychildhood.ca/documents/Ou-ReynoldsANGxp.pdf (accessed 2 November 2006).

Reynolds, A.J., Temple, J.A., Robertson, D.L. and Mann, E.A. 2001, 'Long-term effects of an early childhood intervention on educational achievement and juvenile arrest — a 15-year follow-up of low-income children in public schools', *Journal of the American Medical Association*, vol. 285, pp. 2339–2346.

Schwab, R.G. and Sutherland, D. 2004, *Literacy for Life: A Scoping Study for a Community Literacy Empowerment Project*, The Fred Hollows Foundation and the Centre for Aboriginal Economic Policy Research, Australian National University.

Schweinhart, L.J. 2005, *The High/Scope Perry Preschool Study Through Age 40 Summary, Conclusions, and Frequently Asked Questions*, Ypsilanti, High/Scope Press.

Thomson, S., McKelvie, P. and Murnane, H. 2006, *Achievement of Australia's Early Secondary Indigenous Students: Findings from TIMSS 2003*, Australian Council for Educational Research, Camberwell.

Zubrick, S.R., Silburn, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Dalby, R.B., Mitrou, F.G., Lawrence, D.M., Hayward, C., Pearson, G., Milroy, H., Milroy, J. and Cox, A. 2006, *The Western Australian Aboriginal Child Health Survey: Improving the Educational Experiences of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

7.2 Retention at year 9

ABS (Australian Bureau of Statistics) 2007, *Schools Australia, 2006*, Cat. no. 4221.0, Canberra.

ACER (Australian Council for Educational Research) 2002, *Education Participation and Outcomes by Geographic Location*, Research Report 26, Victoria.

Purdie, N. and Corrigan, M. 2004, Completing twelve years of schooling, Paper presented at the 3rd National Australian Indigenous Education Conference, Ballarat, 15–18 November.

Zubrick, S.R., Silburn, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Dalby, R.B., Mitrou, F.G., Lawrence, D.M., Hayward, C., Pearson, G., Milroy, H., Milroy, J. and Cox, A. 2006, *The Western Australian Aboriginal Child Health Survey: Improving the Educational Experiences of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

7.3 Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies

DEST (Department of Education, Science and Training) 2006, *National Report to Parliament on Indigenous Education and Training 2004*, Canberra.

O'Callaghan, K. 2005, *Indigenous Vocational Education and Training: At a Glance*, NCVER, Adelaide.

SCRGSP (Steering Committee for the Review of Government Service Provision 2007, *Framework for Reporting on Indigenous Disadvantage (Report on Consultations 2006)*, Productivity Commission, Melbourne.

7.4 Juvenile diversions as a proportion of all juvenile offenders

Cameron, M., and MacDougall, C. 2000, *Crime Prevention through Sport and Physical Activity*, Trends and Issues in Crime and Criminal Justice, no. 165, Australian Institute of Criminology, Canberra.

Mason, G. and Wilson, P 1988, *Sport, Recreation and Juvenile Crime: an Assessment of the Impact of Sport and Recreation upon Aboriginal and non-Aboriginal Youth Offenders*, Australian Institute of Criminology, Canberra.

Morris, L., Sallybanks, J. and Willis, K. 2003, *Sport, Physical Activity and Antisocial Behaviour in Youth*, Research and Public Policy Series, no. 49, Australian Institute of Criminology, Canberra.

OCSAR (Office of Crime Statistics and Research) 2005, *Crime and Justice in South Australia - Juvenile Justice 2004*, Adelaide.

—— 2006, *Crime and Justice in South Australia - Juvenile Justice 2005*, Adelaide.

Queensland Police Service 2006, *Annual Statistical Review 2004-05*, Brisbane.

Randell, N. (ed.) 2002, *Including the Arts: Preventing Youth Offending*, Report of the First National Conference on the Role of the Arts in Preventing Youth Offending, The Arts Council of England, the Paul Hamlyn Foundation and the Youth Justice Board.

Rowland, B. and Toumbourou, J. W. 2004, *Preventing Drug-Related Harm in Indigenous Australian Communities, Prevention Research Evaluation Report*, Druginfo Clearing House, Australian Drug Foundation and the Victorian Premier's Drug Prevention Council (http://www.druginfo.adf.org.au).

University of Western Australia 2004a, *Pathways through justice: A Statistical Analysis of Offender Contact with the WA Juvenile Justice System*, Crime Research Centre, Perth.

—— 2004b, *Crime and Justice Statistics for Western Australia*, Crime Research Centre, Perth.

7.5 Transition from school to work

ABS (Australian Bureau of Statistics) 2006, *Births, Australia 2005*, Cat. no. 3301.0. Canberra.

Hillman, K. 2005, *Young People outside the Labour Force and Full-time Education: Activities and Profiles*, LSAY Research Report no. 45, ACER, Melbourne.

Lamb, S. 2001, *The Pathways from School to Further Study and Work for Australian Graduates*, LSAY Research Report no. 19, ACER, Melbourne.

Lamb, S. and McKenzie, P. 2001, *Patterns of Success and Failure in the Transition from School to Work in Australia*, LSAY Research Report no. 18, ACER, Melbourne.

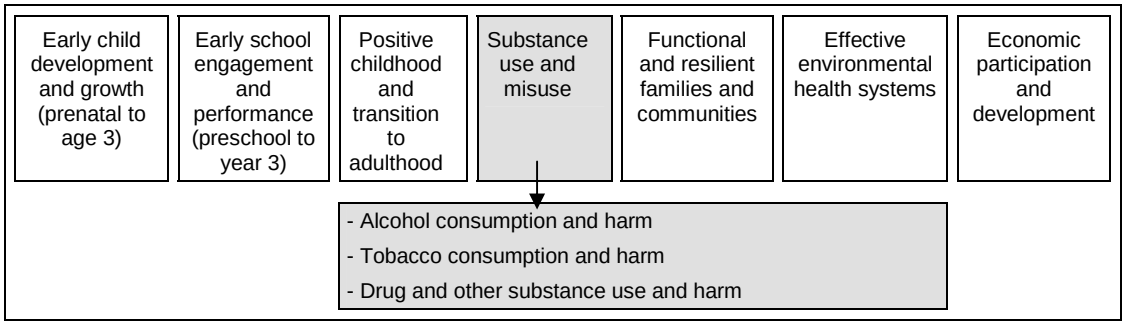
McMillan, J. and Marks, G. N. 2003, *School Leavers in Australia: Profiles and Pathways*, LSAY Research Report no. 31, ACER, Melbourne.

Thomson, S. 2005, *Pathways from School to Further Education or Work: Examining the Consequences of Year 12 Course Choices*, LSAY Research Report no. 42, ACER, Melbourne.

Queensland Government, Reconciliation Queensland. 2007, *Education to employment scheme*, http://www.reconciliation.qld.gov.au/stories/employment.html (accessed 3 April 2007).

8 Substance use and misuse

Strategic areas for action



Substance use and misuse has the potential to affect all the headline indicators discussed in this Report. Reducing substance misuse can significantly reduce the level of assaults and homicides and the level of disability, while improving the overall health and wellbeing of a population. A reduction in substance use might also increase children's educational attainment, household and individual income levels, and reduce crime and imprisonment rates.

Health risk behaviours, such as smoking, excessive alcohol consumption and illicit drug use, are strongly associated with many aspects of socioeconomic disadvantage. Health risk behaviours are particularly prevalent in lower socioeconomic groups. The 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) showed that reported rates of substance use among Indigenous people aged 15 years and over in non-remote areas were significantly higher for those without employment. The Survey also showed an increased rate of tobacco use for those over 15 years with lower household income, lower levels of education and who were unemployed (ABS and AIHW 2005).

Poor economic and social conditions can lead to alcohol dependence, drug use and cigarette smoking, In turn, use and misuse of these substances intensifies the factors that first led to their use. Risk factors for problem drug use include family disruption and dependence problems in the family, poor performance at school, social deprivation, young age of onset of substance use, and depression and suicidal behaviour during adolescence (Lloyd 1998). Richard and Payne (2005) also found that risk factors, including childhood abuse and neglect, drug and alcohol abuse among family members, and troubled school education, were all highly interrelated

and important correlates of criminal offending and high frequency substance abuse among 371 juvenile offenders.

A study by Loxley, Toumbourou and Stockwell (2004) found that:

- Social disadvantage particularly as reflected in factors such as unemployment, homelessness or insecure housing and poverty — is clearly linked to health-damaging behaviours, including the misuse of alcohol and other drugs. (p.14)
- Drug use, both licit and illicit, is associated with high health, legal and social costs to communities and families, as well as to users. It is associated with crime and violence, sexual assault and domestic violence. Crime is strongly associated with alcohol and drug use, particularly alcohol with violence and heroin with property crime. Drug use has impacts on families, the workforce and road trauma; and it affects public safety and amenity, not only through perceived threat, but through disturbances such as noise, litter and public intoxication. (p.3)

The relative socioeconomic disadvantage experienced by Indigenous Australians compared with other Australians may place them at greater risk of ill health, which in turn can exacerbate their already disadvantaged socioeconomic positions. Indigenous people generally experience high levels of harm as a result of alcohol, tobacco and other drug use. According to AIHW (2006), which provided data collected from 635 alcohol and other drug treatment agencies across Australia, Indigenous people accounted for almost 10 per cent of total clients who sought treatment for drug and alcohol use in 2004-05.[1] This was almost five times the proportion of Indigenous people in the Australia population [2], Compared with non-Indigenous clients, Indigenous clients were more likely to be in the youngest group (10–19 years), and more likely to nominate alcohol as the principle reason for seeking treatment.

A study by Ridolfo and Stevenson (2001) estimated that in 1998 the use of tobacco, alcohol and other (illicit) drugs caused about 25 per cent (7 000) of the deaths of Australians under 65 years old, among which over 2 000 deaths were related to alcohol (which include alcohol related road injuries), about 4 200 related to smoking and 1 000 related to illicit drug use. However, there is no information available regarding Indigenous status in this study.

[1] The proportion may be even higher because of the relatively high proportion of treatment periods where Indigenous status was 'not stated' (5 per cent) and because the majority of dedicated substance use services for Aboriginal and Torres Strait Islander people were not included in the collection.

[2] These data are not age standardised and consequently do not take into account the larger proportion of younger people in the Indigenous population and the effect this might have on rates of people seeking drug and alcohol treatment.

This chapter examines patterns in, and harms related to, the use and misuse of alcohol, tobacco and other drugs among Indigenous and non-Indigenous people.

Following feedback and comments from consultation on the 2005 Report, this chapter has been restructured. In the 2003 and 2005 Reports patterns in alcohol and tobacco consumption were reported in one section, and alcohol and tobacco related harms in another. This chapter now reports three indicators by type of substance, covering patterns in use and related harms for each type of substance. The three indicators are:

- 8.1 Alcohol consumption and harm
- 8.2 Tobacco consumption and harm
- 8.3 Drug and other substance use and harm.

New data on hospitalisations related to tobacco use and drug influenced homicides are included for the first time in this Report.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 8A.1.1). A list of attachment tables is in section 8.5. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

8.1 Alcohol consumption and harm

Box 8.1.1 **Key messages**

- In 2004-05, after adjusting for age differences, survey results indicated that:
  - a higher proportion of Indigenous adults reported that they did not drink or had never drunk alcohol (53.4 per cent) compared to non-Indigenous adults (36.1 per cent) (table 8.1.2).
  - among those who drank alcohol, the reported rate of long term risky to high risk drinking for Indigenous people was similar to that for non-Indigenous people (figure 8.1.2); the rate of short term risky to high risk drinking for Indigenous people (17 per cent) was nearly double the rate for non-Indigenous people (8 per cent) (table 8.1.3).
- Among Indigenous people living in non-remote areas more Indigenous women reported long term risky to high risk alcohol consumption in 2004-05 (13.9 per cent) than in 1995 and 2001 (6.3 and 9.0 per cent respectively) (figure 8.1.3). There was little change in long term risky to high risk alcohol consumption by Indigenous men over the same periods.
- Over the period from 1999-2000 to 2004-05, Indigenous homicides were more than three times as likely as non-Indigenous homicides to have involved both the offender and victim having consumed alcohol at the time of the offence (figure 8.1.4). However, the overall level of alcohol involvement in Indigenous homicides fell from 85.0 to 70.6 per cent over the period (figure 8.1.5).

Box 8.1.2 **'Things that work' — reducing alcohol consumption and harm**

Groote Eylandt Liquor Management Plan (NT)

In June 2005, the Groote Eylandt Liquor Management Plan was developed in an effort to reduce the number and resultant harm of liquor related incidents on Groote Eylandt and Bickerton Island. Initiated by the President of the Anindilyakwa Land Council, the Plan was developed in collaboration with leaders from Aboriginal communities on Groote Eylandt and Bickerton Island and with representatives from government and community organisations.

Groote Eylandt, like a number of other Northern Territory Aboriginal communities, has experienced unacceptable levels of alcohol related violence and harm for some time. The operation of two licensed premises in Groote Eylandt's largest township (Alyangula) meant that a steady supply of liquor was available in the mining township and the three smaller surrounding Aboriginal communities (Angurugu, Umbakumba and Milyakburra).

(Continued next page)

Box 8.1.2 (continued)

The Plan restricts alcohol consumption on Groote Eylandt and Bickerton Island through the use of a permit system that controls the takeaway of alcohol from licensed premises. Although permits are issued by the Northern Territory Licensing Commission, it is the responsibility of the Management Committee — comprising local community and stakeholder representatives — to recommend when to issue, revoke or place conditions on a permit.

Impacts of the Plan to date have been:

- decreased alcohol related incidents attended by police
- reduced police callouts, especially to the Angurugu community in the evenings
- reduced overtime payments to police officers in Alyangula
- decreased callouts, especially after hours, involving the main health clinic ambulance
- reduced absenteeism within the mining company's Indigenous workforce, with sick leave for Indigenous employees declining from 7.1 per cent before the Plan commenced in 1 July 2005, to 2.4 per cent since.

While details of the full impact of the Plan are yet to be evaluated, it is already clear that progress has been made through community and government groups working together in a sustained and organised manner to develop and implement a community alcohol management plan.

The Northern Territory Office of Alcohol Policy and Coordination is currently organising a consultancy to formally evaluate the Plan.

Source: NT Government Treasury (unpublished).

Alcohol consumption has health and social consequences through intoxication (drunkenness), alcohol dependence and other biochemical effects. In addition to chronic diseases that may affect drinkers after many years of heavy use, excessive alcohol consumption increases the risk of heart, stroke and vascular diseases, liver cirrhosis and several types of cancers (AIHW 2005). It also contributes to disability and death through accidents, violence, suicide and homicide. Alcohol misuse also has impacts that extend to people other than the individual concerned. Apart from directly harming an individual's health, excessive alcohol consumption at the family and community levels contributes to workplace-related problems, child abuse and neglect, financial problems (poverty), family breakdown, interpersonal/domestic violence, and crime (WHO 2000, 2004).

This section examines patterns of alcohol consumption and alcohol related harms, including alcohol influenced crime and alcohol related hospitalisations and deaths.

Patterns of alcohol consumption

The National Health and Medical Research Council (NHMRC) Australian Alcohol Guidelines (2001) outlines drinking patterns associated with risk of alcohol related harm. The low risk level defines a level of drinking at which there is only minimal risk of harm and, for some, the likelihood of health benefits. The risky levels are those at which risk of harm is significantly increased beyond any possible benefits. High risk drinking levels are those at which there is substantial risk of serious harm, and above which risk continues to increase rapidly.

Data on the relative risk levels of alcohol consumption are sourced from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the 2004-05 National Health Survey (NHS). The two surveys collected data on a person's average daily alcohol consumption in the seven days prior to the interview and then grouped them into relative risk levels as defined by the NHMRC (2001) (table 8.1.1).

Table 8.1.1 **Average daily alcohol consumption and associated risk levels**

	Males		*Females*	
	No. of standard drinks[a]	*Volume of alcohol (ml)*	*No. of standard drinks*[a]	*Volume of alcohol (ml)*
Risk of short term harm				
Low risk	Up to 6	<75	Up to 4	<50
Risky	7–10	75–125	5-6	50–70
High risk	11 or more	>137.5	7 or more	>75
Risk of long term harm				
Low risk	Up to 4	<50	Up to 2	<25
Risky	5-6	50-70	3-4	25-50
High risk	7 or more	>75	5 or more	>50

[a] A standard drink is defined as a full serve of alcoholic beverages containing 10 grams of alcohol, equivalent to 12.5 millilitres (ml) of alcohol. For example, a 375 ml can/bottle of mid-strength beer, or a 100 ml glass of wine. All alcoholic beverage containers, by law, state on the label the number of standard drinks they contain.

Source: NHMRC (2001); ABS (2006).

Short term risk is the risk of harm in the short term associated with given levels of alcohol consumption on any one occasion. Long term risk is associated with regular daily patterns of alcohol consumption and defined by the average daily intake of alcohol over the seven days of the reference week. Both short term and long term alcohol misuse can cause harms including illnesses, injuries and deaths. The last section of this indicator, 'Alcohol related hospitalisations and deaths', discusses harms associated with alcohol consumption at short and long term risk levels.

Table 8.1.2 **Alcohol consumption at long term risky to high risk levels, people aged 18 years and over, age standardised, 2004-05[a]**

	Indigenous	*Non-Indigenous*
Alcohol consumption and relative risk level[b]	%	%
Low risk	29.7	49.2
Risky/high risk	15.3	13.5
Total drank alcohol	45.0	62.7
Did not drink alcohol	42.0	27.3
Never consumed alcohol	11.4	8.8

a Data exclude 'time since last consumed alcohol' not known and alcohol risk level not known **b** Data are based on a person's average daily alcohol consumption in the seven days prior to the interview.

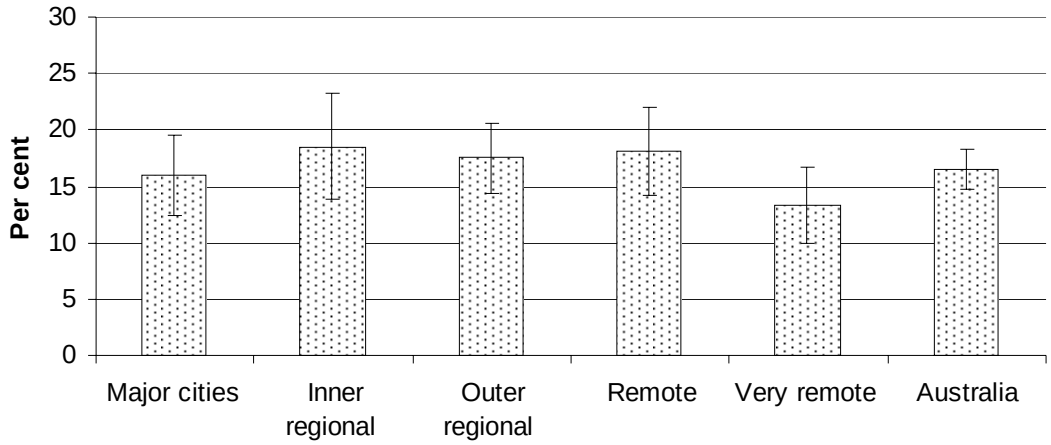
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.1.1.

In 2004-05, around half (49 per cent) of all Indigenous adults (aged 18 years and over) reported having consumed alcohol in the week prior to the interview, of whom one third (16 per cent) reported drinking at risky to high risk levels in the long term (ABS 2006).

After adjusting for age differences in 2004-05, survey results indicated that (table 8.1.2):

- A higher proportion of Indigenous people reported that they did not drink alcohol in the week prior to the interview (42.0 per cent) compared to non-Indigenous people (27.3 per cent).
- A lower proportion of Indigenous people (29.7 per cent) reported that they drank alcohol at the long term low risk level compared to non-Indigenous people (49.2 per cent). The level of long term risky to high risk drinking reported by Indigenous adults was similar to that of non-Indigenous adults (table 8.1.2).

Figure 8.1.1 **Alcohol consumption at long term risky to high risk levels, Indigenous people aged 18 years and over, 2004-05[a]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

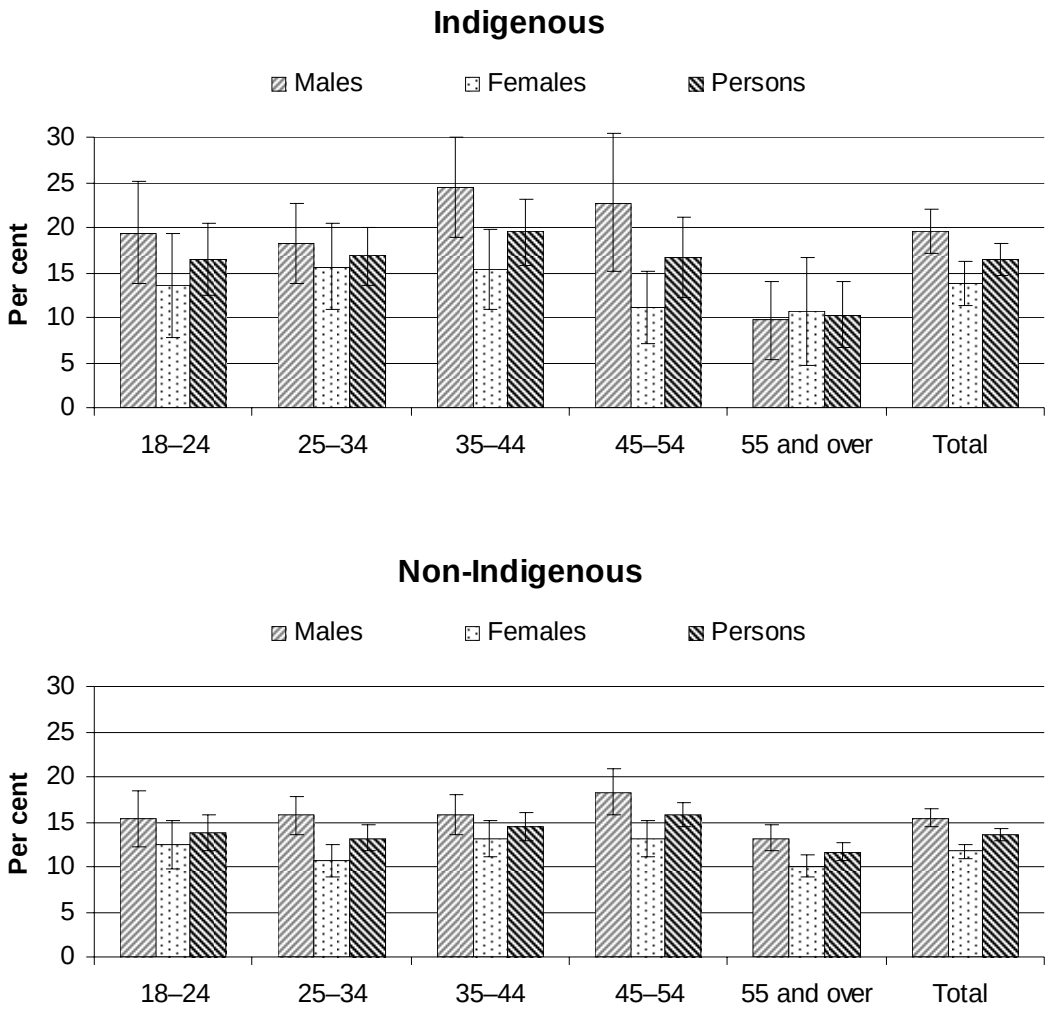
Source: ABS 2004-05 NATSIHS (unpublished); table 8A.1.10.

- In 2004-05, there was little variation in the level of reported long term risky to high risk alcohol consumption by Indigenous people across remoteness areas (figure 8.1.1).

Indigenous and non-Indigenous comparisons are not possible for very remote areas as non-Indigenous data for very remote areas were not collected in the 2004-05 NHS.

- Across remoteness areas (including major cities, inner and outer regional areas and remote areas) for which data are available on a comparable basis, in 2004-05, the level of reported long term risky to high risk drinking among Indigenous adults was similar to that among non-Indigenous adults (table 8A.1.2).

Figure 8.1.2 **Alcohol consumption at long term risky to high risk levels, people aged 18 years and over, 2004-05[a, b]**



a Totals are not age standardised and are not directly comparable between Indigenous and non-Indigenous people. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

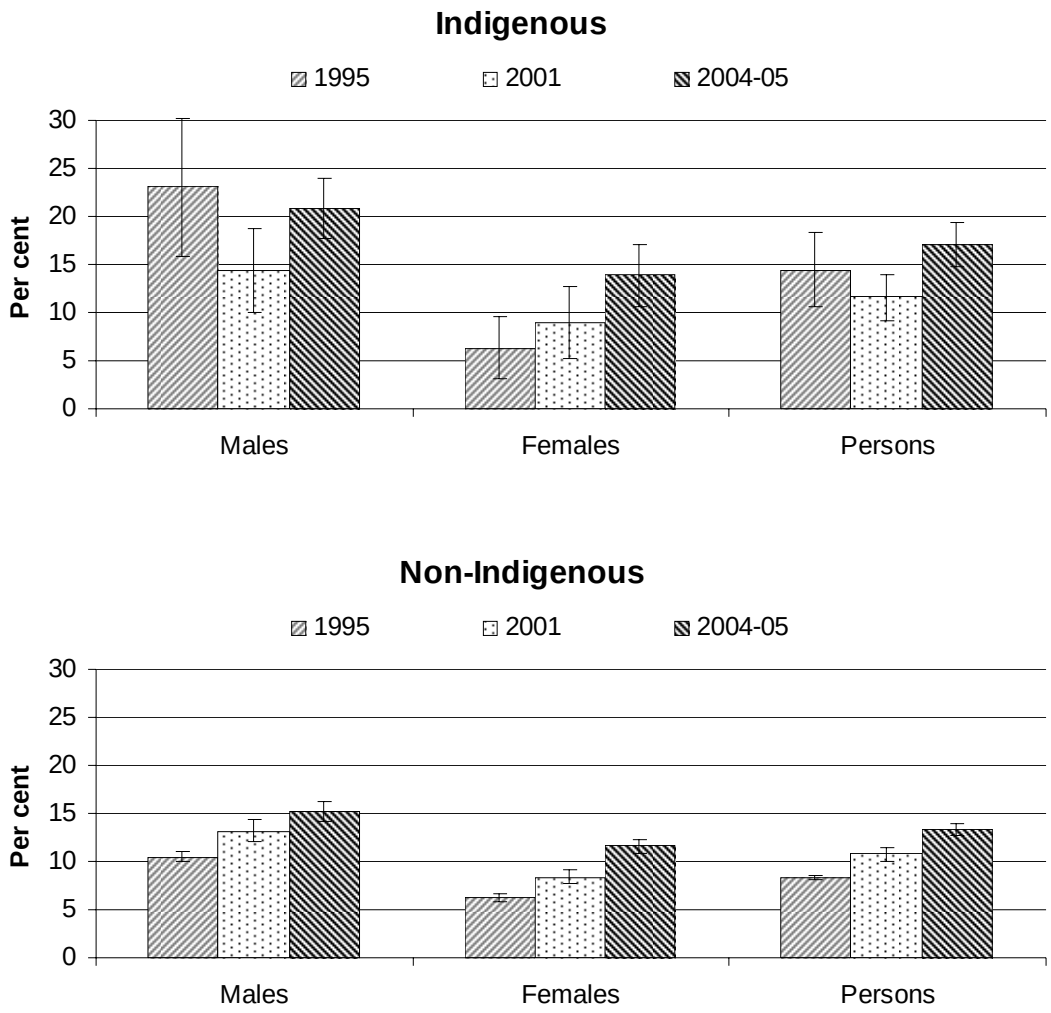
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.1.11.

In 2004-05:

- Reported rates of long term risky to high risk alcohol consumption in the week prior to the interview for Indigenous and non-Indigenous adults were similar across all age groups for both males and females, except males aged 35 to 44 years where the reported rate for Indigenous people was significantly higher than for non-Indigenous people (24.4 per cent compared to 15.8 per cent) (figure 8.1.2).

- For both Indigenous and non-Indigenous people, men were more likely than women to report consumption of alcohol at long term risky to high risk levels (19.5 per cent compared with 13.8 per cent for Indigenous people and 15.4 per cent compared with 11.7 per cent for non-Indigenous people).

Figure 8.1.3 **Alcohol consumption at long term risky to high risk levels, people aged 18 years and over living in non-remote areas[a, b]**



a Data are not age standardised and are not directly comparable between Indigenous and non-Indigenous people. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2001 NHS(I) and NHS, ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.1.3.

- Nationally, the proportion of Indigenous adults living in non-remote areas who reported drinking at long term risky to high risk levels was higher in 2004-05 (17.1 per cent) than in 2001 (11.6 per cent), but was not statistically significantly different to that in 1995 (14.4 per cent) (figure 8.1.3).

- For Indigenous women living in non-remote areas, the reported rate of long term risky to high risk alcohol consumption increased from 6.3 per cent in 1995 to 13.9 per cent in 2004-05, while the rate reported by Indigenous men did not change significantly over the same period.
- By comparison, the proportion of non-Indigenous adults in non-remote areas who reported drinking at long term risky to high risk levels increased continually from 1995 to 2004-05, for both men and women.

Short term risky to high risk alcohol consumption is mainly associated with 'binge' drinking.

In 2004-05:

- Over half (55 per cent) of Indigenous people adults (aged 18 years and over) reported drinking alcohol at short term risky/high risk levels at least once in the 12 months prior to the interview (table 8.1.3).
- The reported rate of alcohol consumption at short term risky/high risk levels at least once a week was higher for Indigenous people than non-Indigenous people in all age groups.
- After adjusting forage differences in the two populations, the rate of alcohol consumption at short term risky/high risk levels at least once a week reported for Indigenous people (17 per cent) was twice the rate for non-Indigenous people (8 per cent) (table 8.1.3).

Table 8.1.3 **Alcohol consumption at short term risky to high risk levels, people aged 18 years and over, 2004-05**

	Age ranges (years)						
	18–24	*25–34*	*35–44*	*45–54*	*55 +*	*Total*	*AS Total*
Indigenous							
At least one occasion in last 12 months (%)	64	64*	59*	45*	22	55*	47*
At least once a week in the last 12 months (%)	23*	20*	22*	16*	9*	19*	17*
Total[a] (%)	100	100	100	100	100	100	100
Total[a] ('000)	56.7	69.8	5.9	39.6	33.2	258.3	na
Non-Indigenous							
At least one occasion in last 12 months (%)	63	56*	46*	35*	16	39*	40*
At least once a week in the last 12 months (%)	15*	9*	9*	8*	4*	8*	8*
Total[a] (%)	100	100	100	100	100	100	100
Total[a] ('000)	1857.1	2761.4	2899.6	2705.6	4529.7	14753.3	na

AS= Age standardised. *Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons.

a Total include people who did not drink alcohol in the last 12 months, those who reported time since last drank alcohol as 'not known' and those who drank alcohol in the last 12 months, but the risk levels were reported as 'not known'. **na** Not available.

Source: ABS 2004-05 NATSIHS (unpublished).

In 2004-05:

- Both Indigenous and non-Indigenous males were reported to be more likely than their female counterparts to consume alcohol at short term risky/high risk levels (table 8A.1.12).
- After adjusting for age differences in the two populations, the reported rates of alcohol consumption at short term risky/high risk levels was higher for both Indigenous women and men than their non-Indigenous counterparts. Indigenous women (14 per cent) were almost three times as likely as non-Indigenous women (5 per cent) to consume alcohol at short term risky/high risk levels at least once a week (table 8A.1.12).

Alcohol influenced crime

Research from Australia and overseas suggests there is a strong association between alcohol and violence, crime and anti-social behaviour (Smith 1983 and AIC 1990). One study conducted by the NSW and Queensland police services found that high proportions of street offences (for example, offensive behaviour), assault, malicious damage, domestic violence and noise complaints were related to alcohol use (Ireland 1993).

In a report on the drug and alcohol use and criminal behaviour of 371 juveniles aged 10 to 17 years who were in detention centres in all Australian jurisdictions in 2003-04, Richard and Payne (2005) found that:

- at the time of their last offence, 46 per cent of these juvenile offenders were under the influence of alcohol
- compared with non-regular offenders, regular violent and regular property offenders were three times more likely to be regular users of alcohol.

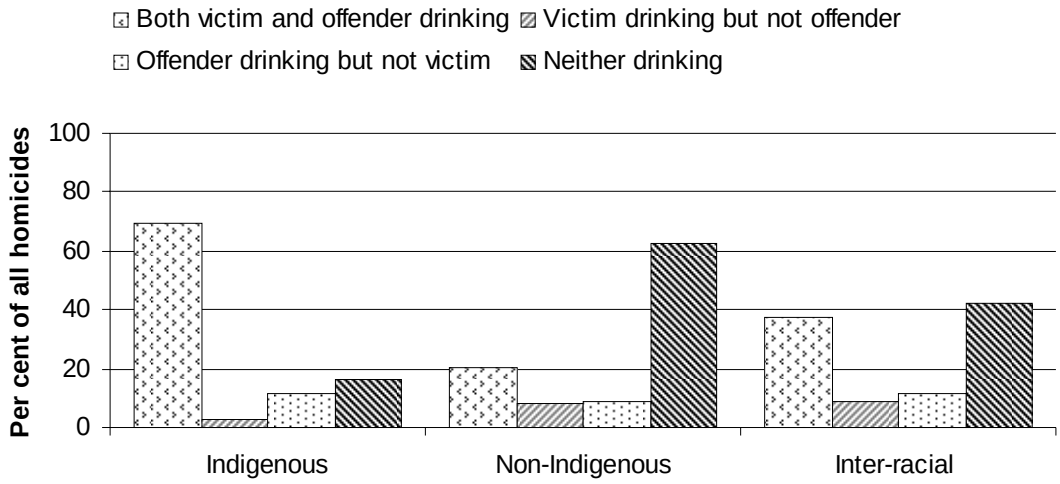
An analysis of data from the Drug Use Monitoring in Australia (DUMA) program in 2004 showed that, among police detainees in seven urban police stations or watch-houses in NSW, Queensland, WA and SA, there was a more pronounced association between alcohol and offending among Indigenous male offenders than their non-Indigenous counterparts (Putt, Payne and Miller 2005).

Box 8.1.2 provides examples of how alcohol related crime and violence is being addressed in some communities.

There are no reliable data on the overall extent of alcohol related crime. This section examines alcohol related homicides.

Data sourced from the Australian Institute of Criminology (AIC) National Homicide Monitoring Program (NHMP) only include alcohol related homicides and no information on offences that do not result in the death of the victim. Other limitations of the NHMP data are discussed in appendix 3.

Figure 8.1.4 **Alcohol involvement in Indigenous and non-Indigenous homicides, total recorded 1999-2000 to 2004-05** [a, b, c, d]



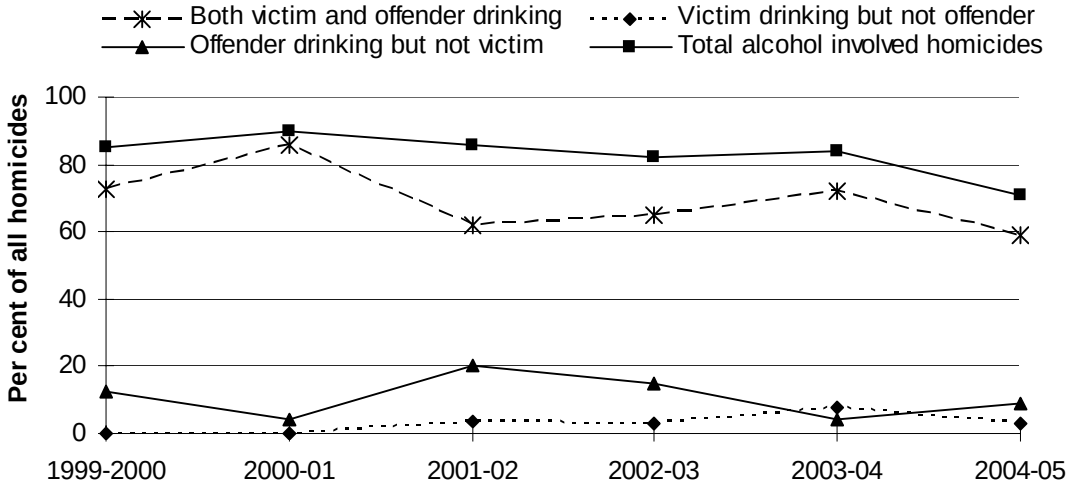
[a] Homicide includes murder and manslaughter, but excludes driving causing death. [b] Indigenous homicides are where both victims and offenders of homicide are Indigenous. [c] Non-Indigenous homicides are where both victims and offenders are not Indigenous, including victims and offenders who are Caucasian, Asian and Maori/Pacific Islanders. [d] Inter-racial homicides are where either the victim or the offender is Indigenous, including homicides involving: an Indigenous offender and non-Indigenous victim, and non-Indigenous offender and an Indigenous victim.

Source: AIC NHMP (unpublished); table 8A.1.5.

Among the total recorded homicides over the period from 1999-2000 to 2004-05:

- 69.6 per cent of Indigenous homicides involved both the victim and offender having consumed alcohol at the time of the offence (figure 8.1.4). In contrast, 20.4 per cent of non-Indigenous homicides involved both the victim and offender being under the influence of alcohol at the time of the incident .
- Where only the offender was under the influence of alcohol in a homicide, the proportion was slightly higher for Indigenous homicides (11.4 per cent) than non-Indigenous homicides (9.0 per cent) (figure 8.1.4).

Figure 8.1.5 **Alcohol involvement in Indigenous homicides, 1999-2000 to 2004-05[a]**



a Total alcohol involved homicides are the aggregate of three categories of homicides involving alcohol: both the 'victim and offender drinking',' victim drinking but not offender', and 'offender drinking but not victim'.

Source: AIC NHMP (unpublished); table 8A.1.5.

The overall level of alcohol involvement in Indigenous homicides fell from 85.0 per cent in 1999-2000 to 70.6 per cent in 2004-05, with a significant decrease between 2003-04 (84.0 per cent) and 2004-05 (figure 8.1.5). This is due to a decrease in Indigenous homicides involving 'both the victim and offender having consumed alcohol' at the time of the offence over the same period (72.5 per cent in 1999-2000, 72.0 per cent in 2003-04 and 58.8 per cent in 2004-05).

Alcohol related hospitalisations and deaths

Both short term and long term alcohol misuse can cause harm including illnesses, injuries and deaths. Short term risk of harm (particularly injury or death) is associated with levels of drinking on any one occasion. Episodes of drinking to intoxication can cause injuries or deaths from violence, falls, road crashes and drowning. Long term alcohol misuse can cause a series of chronic illnesses (for example, various cancers, liver diseases, and chronic gastritis), Some suicides and strokes may be attributable to both short and long term alcohol misuse.

Alcohol use during pregnancy is linked to fetal alcohol syndrome and to a range of other effects, known as fetal alcohol effects. Fetal alcohol syndrome is characterised by various combinations of growth restriction of the fetus, facial anomalies, microcephaly and central nervous system impairment, including intellectual

disability and behaviour problems (World Bank 2000). Foetal-alcohol syndrome, is more prevalent in Aboriginal infants than non-Aboriginal infants (GSA 2003).

There are few data available on alcohol consumption by Indigenous females during pregnancy. One study gathered data through a survey administered as part of a health screening program conducted from 1998 to 2000 at 45 rural and remote locations in north Queensland. The 'Well Persons Health Check' found that 45 per cent of Indigenous women between the ages of 15 and 44 reported having drunk alcohol at hazardous and harmful levels in the week prior to survey. Furthermore, 25 per cent of pregnant Indigenous women continued to report drinking at hazardous and harmful levels (Queensland Health Tropical Population Health Network unpublished).

According to AIHW (2005), alcohol was the second largest cause of drug-related deaths and hospitalisations in Australia (after tobacco) in 2004.

Data on hospitalisations related to alcohol use reported for this indicator are from the AIHW National Hospital Morbidity Database. These data only cover alcohol related illnesses resulting in admission to a hospital. Further data are only available for conditions directly attributable to alcohol consumption and do not include most of the conditions listed above, where alcohol may be a contributing factor but where the link is not direct and immediate. Lastly, identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of under-identification of Indigenous people (see chapter 2 and appendix 4 for more information). The limitations of using hospital statistics are discussed in appendix 3.

Table 8.1.2 **Hospitalisations related to alcohol use, Qld, WA, SA, and public hospitals in the NT, 2004-05 (per 1000 population)[a, b, c, d, e]**

	Male	*Female*	*All persons*
Indigenous			
Mental and behavioural disorders (F10)	8.7	3.9	6.1
Acute intoxication (F10.0)	3.8	2.4	3.0
Harmful use (F10.1)	0.4	0.2	0.3
Dependence syndrome (F10.2)	1.5	0.6	1.0
Other (F10.3–F10.9)	3.0	0.7	1.8
Alcoholic liver disease (K70)	1.3	1.2	1.2
Other inflammatory liver disease (K75)	0.1	0.1	0.1
Toxic effect of alcohol (T51)	0.1	–	0.1
Accidental poisoning by and exposure to alcohol (X45)	0.8	0.1	0.4
Intentional self-poisoning by and exposure to alcohol (X65)	0.2	0.2	0.2
Poisoning by and exposure to alcohol, undetermined intent (Y15)	0.1	0.1	0.1
***Non-Indigenous*[f]**			
Mental and behavioural disorders (F10)	1.7	1.1	1.4
Acute intoxication (F10.0)	0.5	0.3	0.4
Harmful use (F10.1)	0.1	–	0.1
Dependence syndrome (F10.2)	1.0	0.7	0.8
Other (F10.3–F10.9)	0.2	0.1	0.1
Alcoholic liver disease (K70)	0.3	0.1	0.2
Other inflammatory liver disease (K75)	0.1	0.1	0.1
Toxic effect of alcohol (T51)	–	–	–
Accidental poisoning by and exposure to alcohol (X45)	0.1	0.1	0.1
Intentional self-poisoning by and exposure to alcohol (X65)	0.2	0.3	0.2
Poisoning by and exposure to alcohol, undetermined intent (Y15)	–	–	–

a The hospital separation rates (per 1000 population) were directly age standardised to the Australian population as at 30 June 2001. **b** Hospital separation is the discharge, transfer, death or change of episode of care of an admitted patient (see glossary for a detailed definition). **c** Principal diagnoses of hospitalisations are based on codes of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). **d** Data are based on state of usual residence. **e** Overlapping may exist between separations by toxic effect of alcohol and separations based on external causes X45, X65, or Y15. **f** Non-Indigenous data include separations where Indigenous status was not reported.

– Nil or rounded to zero.

Source: AIHW National Hospital Morbidity Database (unpublished); table 8A.1.6.

Based on the data on hospitalisations related to alcohol from the four jurisdictions (Queensland, WA, SA, and the NT), in 2004-05:

- hospitalisation rates for all conditions related to alcohol use were consistently higher for Indigenous people than for non-Indigenous people, and the rates for both Indigenous and non-Indigenous males were consistently higher than females (table 8A.1.7 and table 8A1.8).
- For both Indigenous and non-Indigenous people, mental and behavioural disorders were the most common conditions for both males and females.
- Both Indigenous and non-Indigenous males were more likely to be hospitalised for alcohol-caused illness than females.
- Hospitalisations due to alcohol caused mental and behavioural disorders among Indigenous males (8.7 per 1000) were five times as high as for non-Indigenous males (1.7 per 1000). The rate for Indigenous females (3.9 per 1000) was almost four times as high as that for non-Indigenous females (1.1 per 1000).
- Acute alcohol intoxication was the most common type of mental and behavioural disorder for both Indigenous males and females, while alcohol dependence syndrome was the most common type of mental and behavioural disorder for non-Indigenous males and females.

No comparable Indigenous and non-Indigenous data on alcohol related deaths at the national level are available for this Report.

A study by Chikritzhs et al. (2007) estimated alcohol attributable mortality for Indigenous residents in each of the 17 former ATSIC zones and found that:

- Over the 5 year period from 2000 to 2004, an estimated 1 145 (4.85 per 10 000 population) Indigenous Australians died from alcohol attributable injury and disease caused by drinking.
- In 2004, alcohol attributable death rates for Indigenous people in the Central NT (14 per 10 000) and WA North (10 per 10 000) were more than double the national rate for Indigenous people (4.17 per 10 000) for that year.
- Suicide (19 per cent) and alcoholic liver cirrhosis (18 per cent) are the two most common causes of alcohol attributable death among Indigenous men.
- For Indigenous women, alcoholic liver cirrhosis (27 per cent), haemorrhagic stroke (16 per cent), and fatal injury caused by assault (10 per cent) were the most common causes of alcohol attributable death.
- The average age at death from the most common alcohol attributable conditions was 35 for Indigenous men and 34 for Indigenous women.

8.2 Tobacco consumption and harm

Box 8.2.1 **Key messages**

- Nationally, in 2004-05:
  - 50.0 per cent of Indigenous adults were current daily smokers (figure 8.2.1)
  - after adjusting for age differences, Indigenous adults were more than twice as likely as non-Indigenous adults to be daily smokers (46.3 per cent compared to 21.1 per cent) (table 8A.2.2).
- From 1995 to 2004-05, the proportion of current daily smokers among both Indigenous women and men living in non-remote areas remained constant (figure 8.2.3).

Tobacco use is an important contributor to premature death and ill health. In addition to the long term health risks, tobacco use among low income groups can have immediate, insidious effects, by diverting scarce family resources away from beneficial uses. If a breadwinner becomes ill as a result of tobacco use, the cost of health care and the loss of earnings and productivity can worsen poverty or push families living precariously into poverty.

According to WHO (2004), tobacco and poverty are inextricably linked worldwide. Poor families are more likely to include one or more smokers than richer families, and often allocate a substantial part of the families' total expenditures to these harmful products.

Tobacco use is often associated with other lifestyle related health risk factors, such as excessive alcohol drinking and dietary factors. ABS (2006) found that long term risky/high risk drinkers (both males and females) were more likely to be current smokers than those who drank at a low risk level. The effects of alcohol were often worsened by other risk factors, such as smoking and poor diet (NHMRC 2001).

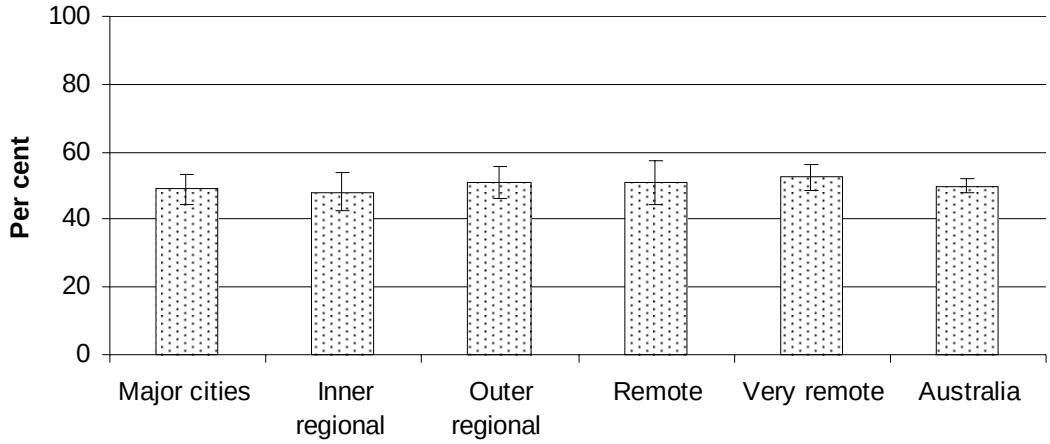
This section examines patterns of tobacco use and its related harm, including hospitalisations and deaths related to tobacco use.

Patterns of tobacco consumption

Data on the tobacco consumption in this chapter are sourced from several ABS surveys, including the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Health Survey (NHS), the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), and the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS).

Data on tobacco use in this section refer to smoking of tobacco, including manufactured (packet) cigarettes, roll-your-own cigarettes, cigars and pipes, but excludes chewing tobacco and smoking of non-tobacco products. Current daily smokers refer to people who smoked one or more cigarettes (or pipes or cigars) per day at the time of interview. Data in this section focus on current daily smokers aged 18 years and over.

Figure 8.2.1 **Current daily smokers, Indigenous people aged 18 years and over, 2004-05[a, b]**



a 'Current daily smokers' refers to people who smoked one or more cigarettes (or pipes or cigars) per day at the time of interview. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS; table 8A.2.8.

In 2004-05:

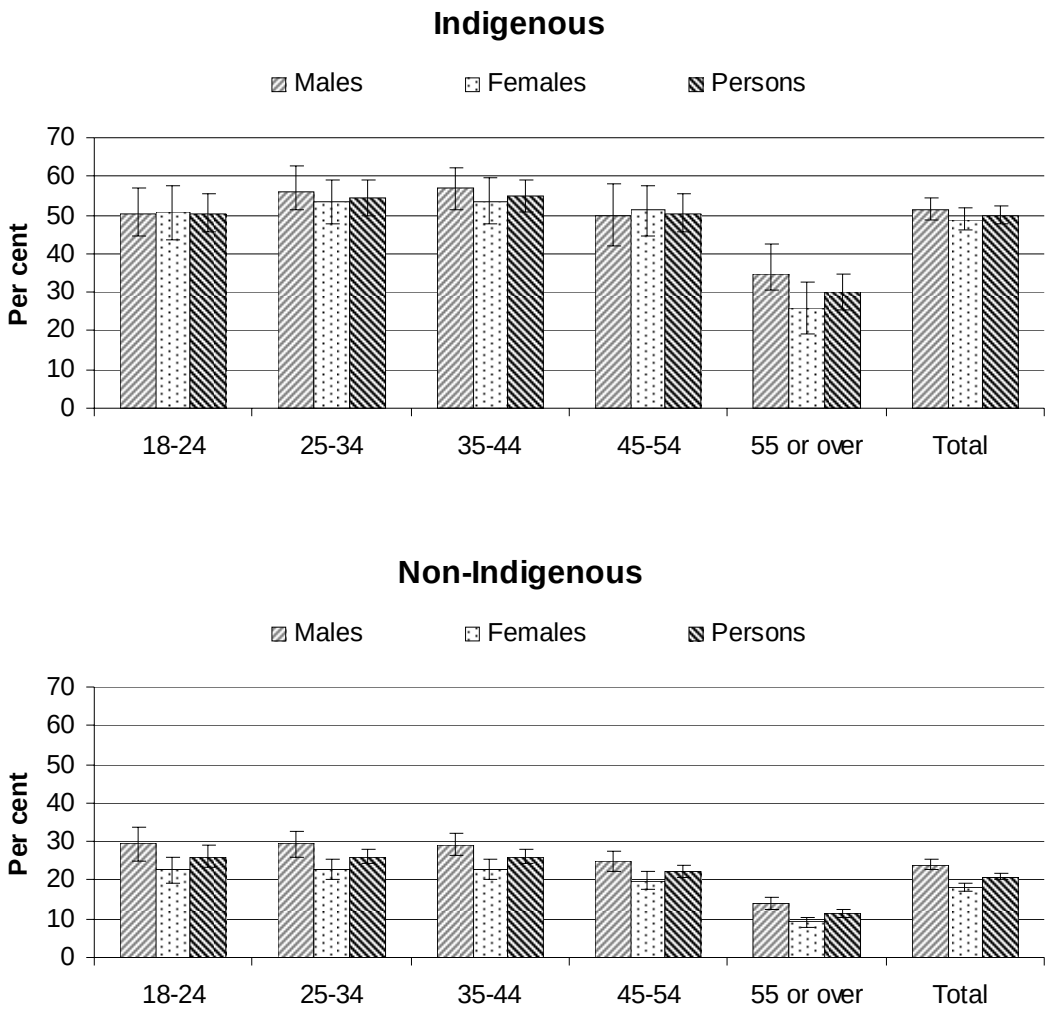
- Nationally, 50.0 per cent of Indigenous adults were current daily smokers (figure 8.2.1).
- The proportion of current daily smokers among Indigenous adults was similar across remoteness areas (figure 8.2.1).

After taking account of the different age structures of the Indigenous and non-Indigenous populations, in 2004-05:

- Nationally, Indigenous adults were more than twice as likely as non-Indigenous adults to be current daily smokers (46.3 per cent compared to 21.1 per cent) (table 8A.2.2).
- The proportion of current daily smokers among Indigenous adults was higher than that for non-Indigenous adults across four remoteness areas (major cities,

inner and outer regional areas and remote areas) for which data were available (table 8A.2.2).[3]

Figure 8.2.2 **Current daily smokers aged 18 years and over, 2004-05[a, b]**



a Totals are not age standardised and not directly comparable between Indigenous and non-Indigenous people. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.2.5.

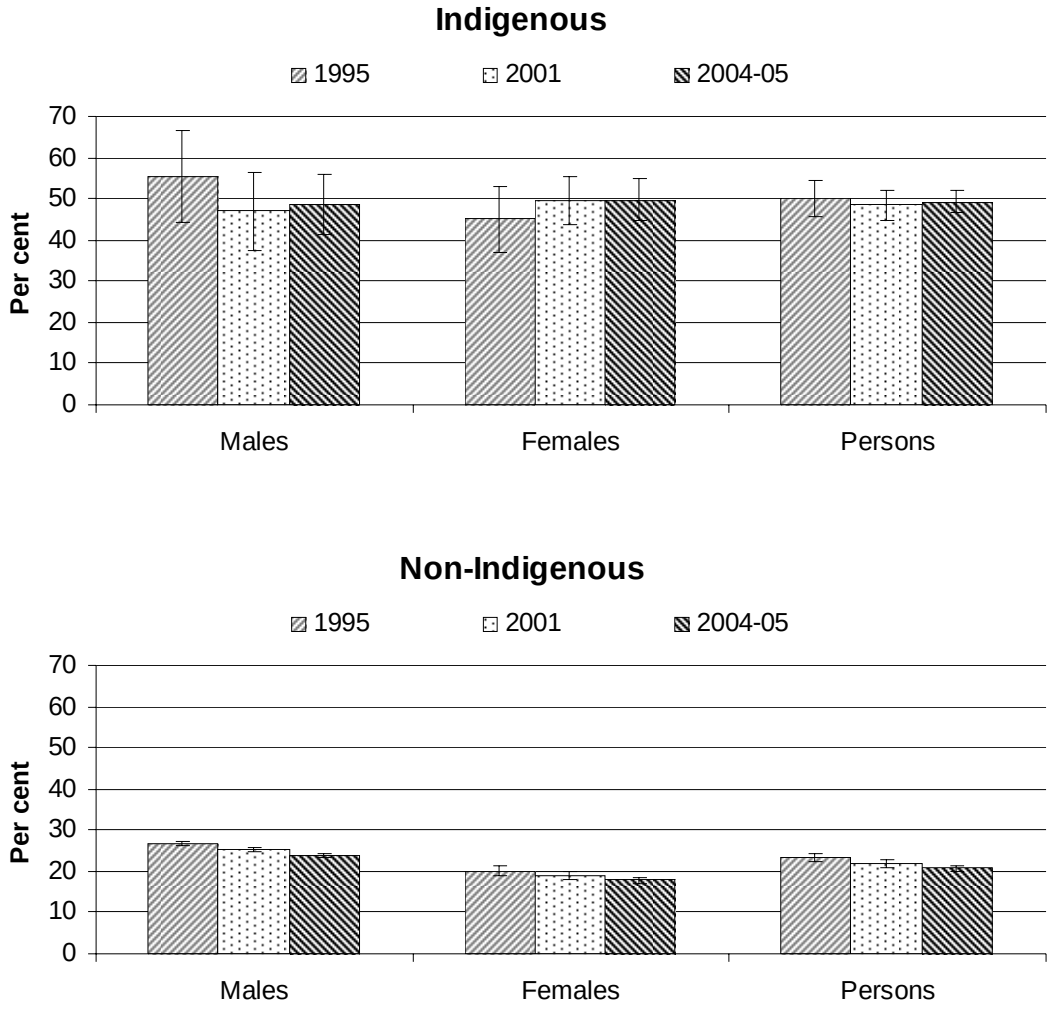
- Smoking was more prevalent among Indigenous adults than non-Indigenous adults, for both women and men, and for all age groups (figure 8.2.2).
- The proportions of current daily smokers among Indigenous women and men were similar. By comparison, non-Indigenous men were more likely to be

[3] Indigenous and non-Indigenous comparisons are not possible for very remote areas as non-Indigenous data for very remote areas were not collected in the 2004-05 NHS.

current daily smokers than non-Indigenous women (24.0 per cent compared to 18.0 per cent).

- Regardless of Indigenous status, smoking was less prevalent among people aged 55 years and over compared to all younger age ranges, although Indigenous people aged 55 years and over were more likely to be current daily smokers than non-Indigenous people in the same age range (30.1 per cent compared with 11.6 per cent) (figure 8.2.2).

Figure 8.2.3 **Current daily smokers, aged 18 years and over, living in non-remote areas[a, b, c]**



a Data are not age standardised and not directly comparable between Indigenous and non-Indigenous people. **b** Comparable data are only available for non-remote areas as data from remote areas were not collected in the 1995. **c** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2001 NHS(I) and NHS, ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.2.3.

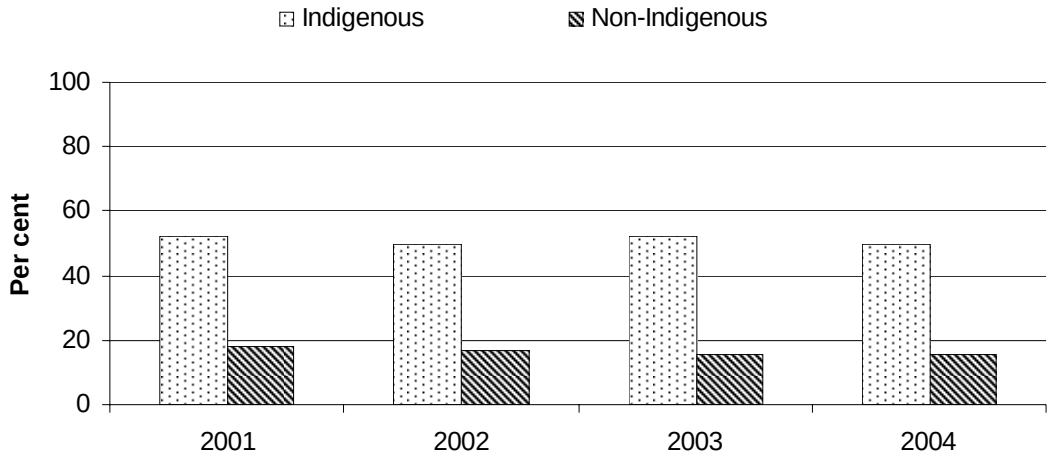
- The proportion of current daily smokers among both Indigenous women and men living in non-remote areas changed little over the period from 1995 to 2004-05 (figure 8.2.3).
- By comparison, the proportion of current daily smokers among non-Indigenous adults in non-remote areas decreased continually from 1995 (23.4 per cent) to 2004-05 (20.8 per cent). This occurred for both women and men.

Tobacco related hospitalisations and deaths

Tobacco smoking is the primary cause of premature and preventable death and disease in Australia. There is a strong causal relationship between tobacco consumption and multiple chronic diseases, including coronary heart disease, stroke, chronic respiratory tract diseases, and pregnancy-related conditions such as low birthweight. Further, passive smoking has been linked with higher rates of respiratory illness, sudden infant death syndrome (SIDS) and asthma in children, and lung cancer and heart disease in adults (DHA 2003, 2004).

Data on hospitalisations related to tobacco use reported for this indicator are sourced from the AIHW National Hospital Morbidity Database. These data only cover tobacco related illnesses resulting in admission to a hospital (figure 8.2.5). Further, data are only available for conditions directly attributable to tobacco and do not include most conditions where tobacco may be a contributing factor but where the link is not direct and immediate. Lastly, identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of under-identification of Indigenous people (see chapter 2 and appendix 4 for more information). The limitations of using hospital statistics are discussed in appendix 3.

Figure 8.2.4 **Mothers reporting smoking during pregnancy (NSW, WA, SA, the ACT and the NT)[a]**



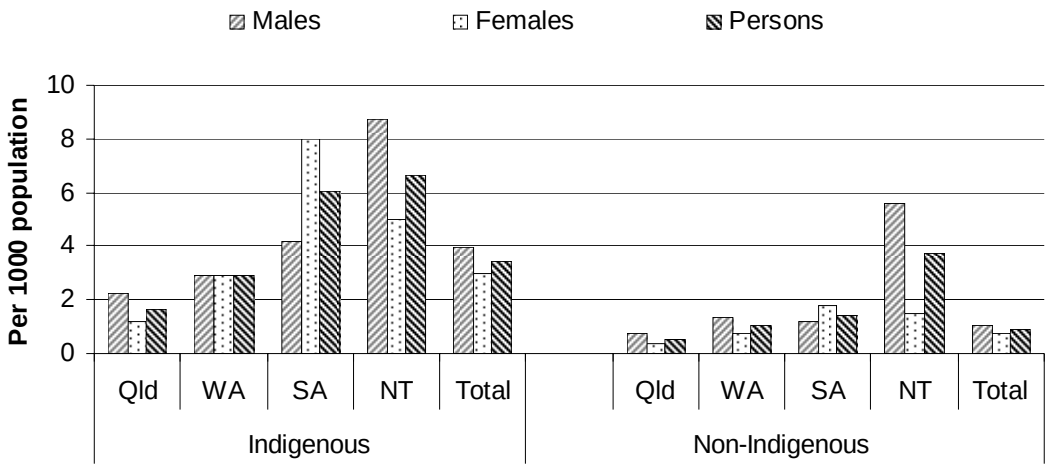
a Smoking during pregnancy data were only available for these five jurisdictions.

Source: AIHW National Perinatal Statistics Unit (2006a, 2006b); table 8A.2.7.

In NSW, WA, SA, the ACT and the NT:

- Indigenous mothers were about three times as likely as non-Indigenous mothers to smoke during pregnancy, in each of the four years from 2001 to 2004 (figure 8.2.4).
- The rate of smoking during pregnancy for non-Indigenous mothers decreased from 17.8 per cent in 2001 to 15.3 per cent in 2004.
- The rate for Indigenous mothers decreased slightly from 51.9 to 49.7 per cent between 2001 and 2004 (figure 8.2.4).

Figure 8.2.5 **Hospitalisations related to tobacco use in Qld, WA, SA, and public hospitals in the NT, 2004-05 (per 1000 population)** [a, b, c, d]



[a] The hospitalisation rates (per 1000 population) were directly age standardised to the Australian population as at 30 June 2001. [b] Principal diagnoses of hospitalisations are based on codes of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). [c] Non-Indigenous data include separations where Indigenous status were not reported. [d] Data are based on state of usual residence.

Source: AIHW National Hospital Morbidity Database (unpublished); table 8A.2.4.

In 2004-05:

- Across the four jurisdictions, Queensland, WA, SA, and public hospitals in the NT, the hospitalisation rates related to tobacco use for Indigenous people were consistently higher than those for non-Indigenous people (figure 8.2.5).
- The rates of hospitalisations related to tobacco use in the four jurisdictions for Indigenous people was almost 4 times as high as that for non-Indigenous people, for both males and females (3.9 per 1000 for Indigenous males compared with 1.0 per 1000 for non-Indigenous males; 3.0 per 1000 for Indigenous females compared with 0.8 per 1000 for non-Indigenous females).
- Regardless of Indigenous status, males were more likely to be hospitalised for tobacco-caused illness than their female counterparts in Queensland, WA, and the NT; however, in SA females had a higher rate of hospitalisations for tobacco caused illness than their male counterparts.

No comparable Indigenous and non-Indigenous data on smoking related deaths are available for inclusion in this Report.

8.3 Drug and other substance use and harm

Box 8.3.1 **Key messages**

- In 2004-05:
  - 28.0 per cent of Indigenous adults living in non-remote areas reported illicit substance use in the previous 12 months (table 8.3.1)
  - marijuana (22.5 per cent), amphetamines (7.3 per cent) and analgesics/sedatives (for non-medical purposes) (6.0 per cent) were the most commonly used substances (table 8.3.1).
- For all homicides recorded from 1999-2000 to 2004-05 a lower proportion of Indigenous homicides than non-Indigenous homicides occurred under the influence of drugs (22.5 per cent compared to 34.7 per cent) (figure 8.3.2).

Drug and other substance misuse is a contributing factor to illness and disease, accident and injury, violence and crime, family and social disruption, and workplace problems. Reducing drug related harm will improve health, social and economic outcomes at both individual and community levels.

Illicit substance use can be divided into two categories: use of substances which are illegal to possess (such as heroin) and misuse of substances which are legally available (such as petrol inhalation and misuse of prescription drugs).

In recent years, illicit drug consumption has played a significant role in Indigenous people's involvement in the criminal justice system. According to the Office of the Status of Women, there is a correlation between domestic violence and drug and alcohol use in Indigenous communities, with 70 to 90 per cent of assaults being committed while under the influence of alcohol and other drugs (DHA 2003).

The use of other substances such as inhalants (for example, petrol, glue, paint and butane gas) can lead to serious health consequences, including long term brain damage, disability or even death. It can also cause social alienation of sniffers, violence and crime (the Senate Community Affairs Committee 2006; Access Economics 2006).

Patterns of illicit drug use

It is difficult to obtain accurate prevalence data on the use of illicit drugs. Their illegality and their low prevalence makes them difficult to address with population surveys. Data from use of health systems or interaction with the criminal justice system tend to identify mainly heavy users and those who succumb to the drug's

effects; while the evidence suggests that the majority of illicit drug users use drugs infrequently without becoming addicted (Makkai and McAllister 1998).

In this Report, data on illicit drug use by Indigenous people aged 18 years and over in non-remote areas are from the ABS 2004-05 NATSIHS. No data on drug use by non-Indigenous people are available for direct comparison with these data. However, data sourced from the AIHW National Drug Strategy Household survey provide some comparison between illicit drug use by Indigenous and non-Indigenous people aged 14 years and over in non-remote areas (table 8.3.2)

Data on illicit drug use in the 2004-05 NATSIHS were collected in non-remote areas from private dwellings only, excluding people in institutions, such as hospitals, prisons and hotels, where substance use may be more prevalent. Data on illicit drug use from this survey may be subject to under-reporting.

Table 8.3.1 **Indigenous persons aged 18 years or over residing in non-remote areas: status of substance use (per cent), 2004-05**

	Males	*Females*	*Persons*
Used substance			
Used substances in last 12 months			
Analgesics and sedatives for non-medical use[a]	3.7	7.9	6.0
Amphetamines or speed	10.1	4.9	7.3
Marijuana, hashish or cannabis resin	28.6	17.5	22.5
Kava	1.6*	0.2*	0.8*
Total used substances in last 12 months[b]	32.4	24.4	28.0
Used substances but not in last 12 months	22.4	20.8	21.5
Total used substance[c]	55.6	45.6	50.1
Never used substances	42.4	52.7	48.0
Persons who accepted substance use form[d]	100.0	100.0	100.0
Persons who accepted substance use form (no.)	67 594	81 656	149 250
Persons who accepted substance use form as a proportion of all persons in the survey (%)	78.0	82.6	80.5

*indicates the relative standard error for the estimate is greater than 25 per cent and should be used with caution.

[a] Includes pain killers, tranquilisers and sleeping pills. [b] Includes heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants. Sum of components may be more than total as persons may have reported more than one type of substance used. [c] Includes 'whether used in last 12 months' not known. [d] Includes 'whether ever used substances 'not known' and 'not stated'.

Source: ABS 2004-05 NATSIHS (unpublished); table 8A.3.3.

In 2004-05, among Indigenous adults living in non-remote areas who accepted the substance use form, who accounted for 80.5 per cent of all persons in the survey:

- 28.0 per cent reported illicit substance use in the 12 months prior to the survey, which was similar to that reported in 2002 (table 8.3.1; table 8A.3.3).[4]
- 21.5 per cent reported illicit substance use at least once in their lifetime but not in the 12 months prior to the survey (table 8.3.1).
- The substances most commonly used were marijuana (22.5 per cent), amphetamines (7.3 per cent) and analgesics/sedatives (for non-medical purposes) (6.0 per cent) (table 8.3.1).

Table 8.3.2 **Illicit drug use, people aged 14 years and over living in non-remote areas, by Indigenous status, 2004[a]**

		Indigenous	*Non-Indigenous*
Illicit drugs, including marijuana/cannabis			
Ever used	%	44.4	36.8
Used in the last 12 months	%	24.3	14.7
Illicit drugs, excluding marijuana/cannabis			
Ever used	%	22.8*	18.0*
Used in the last 12 months	%	10.3*	8.0*
Marijuana/cannabis			
Ever used	%	21.6	18.8
Used in the last 12 months	%	14.0	6.7
Total sample	**no.**	**463**	**28 982**

* indicates Indigenous and non-Indigenous data are significantly different at the 5 per cent statistical significance level.

a Illicit drugs include: illegal drugs (marijuana/cannabis, heroin, cocaine, LSD/synthetic hallucinogens, natural hallucinogens, ecstasy and other designer drugs, and any injected drugs); volatile substances (inhalants) used inappropriately; and pharmaceuticals used for non-medical purposes. The survey included the following drugs as illicit when used for non-medical purposes: pain-killers/analgesics, tranquillisers/sleeping pills, steroids, barbiturates, amphetamines, methadone (for non-maintenance program) and other opiates.

Source: AIHW National Drug Strategy Household Survey (unpublished); table 8A.3.4.

In the 2004 AIHW Drug Strategy Household Survey, which collected data for people aged 14 years and over living in non-remote areas:

- A higher proportion of Indigenous people than non-Indigenous people reported using illicit drugs (including marijuana/cannabis) in the months prior to the survey (24.3 per cent compared to 14.7 per cent) (table 8.3.2).

4 Questions in the 2004-05 NATSIHS are based on those used in the 2002 NATSISS. However, the difference in non-response should be considered, with the NATSIHS having 22 per cent non-response compared to 10 per cent for the NATSISS.

- Excluding marijuana/cannabis, the proportions of people who reported using illicit drugs in the 12 months prior to the survey were similar for Indigenous and non-Indigenous people.
- Indigenous people were more likely than non-Indigenous people to use marijuana/cannabis (14.0 per cent compared to 6.7 per cent) (table 8.3.2).

The use of other substances such as inhalants (for example, petrol and glue) can lead to serious health consequences, including long term brain damage, disability or even death (MCDS 2006). It can also cause social alienation of sniffers, violence and reduced self-esteem (DHA 2003).

Petrol sniffing is a form of substance abuse that affects a considerable proportion of Indigenous youth in remote areas, particularly in the Western corridor of Central Australia and the Tri State region of SA, WA and the NT. Studies (AIHW 2002, Clough et al. 2002 and 2004) have found that petrol sniffing has been occurring in some remote and urban communities alongside other forms of substance use, notably cannabis, kava and alcohol, and that past inhalant use is a predictor of other substance use.

It is difficult to estimate the prevalence of petrol sniffing in Australia as there is no reliable national data on the number of people involved and the extent of resulting damage to individuals and communities.

Access Economics (2006) estimated that, in 2005, there were 612 sniffers among the Indigenous population of 21 935 in a large region of Central Australia[5], and found that:

- the majority were males
- petrol sniffing was more prevalent among 12-13 years olds than among older teenagers
- there had been an increase in petrol sniffing, especially in the remote regions.

There are also variations within and between, Indigenous communities. Some studies (Burns et al. 1995; Campbell and Stojanovski 2001) have suggested that, associated with the introduction of alternative fuels and community-based

5 The region was defined by the Access Economics for the study on Cost Benefits of Opal Fuel. It covers parts of Northern Territory, SA and WA, comprising the Census statistical areas of Tennant Creek and Central NT in the Northern Territory, the Far North area of SA, and Laverton, Ngaanyatjarraku, Halls Creek, and the communities of Kiwirrkurra and Kunawarritji in WA. The total number of people in the region in 2005 was estimated as 65 037 of whom 21 935 were Aboriginal.

interventions, there had been a reduction in petrol sniffing in some communities where it had been prevalent for a long time (see box 8.3.2 for more information).

Excessive consumption of kava is a concern in some Indigenous communities, as it can lead to health problems such as liver damage and malnutrition. Kava can also have a negative impact on families and communities. Some Indigenous communities have expressed concern that kava consumption is linked to neglecting family and community duties, and spending household income on kava instead of on necessities like food (DHA 2003, DHA 2004, Clough and Jones 2004).

Prescription drugs used in combination with other substances such as alcohol can compound the social, physiological and psychological problems faced by people with a mental illness. Through a consultation process with rural Indigenous communities, the Aboriginal Drug and Alcohol Council of SA found that some Indigenous communities were concerned about the misuse of prescription drugs. These communities stated that prescription drugs such as serapax, codeine and panadeine forte were easily accessible by Indigenous people, and that some doctors freely prescribed these drugs (DHA 2003).

Box 8.3.2 **'Things that work' — reducing drug and other substance use**

Introduction of alternative fuels

The introduction of alternative fuels with low aromatics in some remote Indigenous communities in Central Australia has been successful in reducing the incidence of and harm from petrol sniffing. It is believed that aromatics contained in fuels are what give the "high" when sniffed. Alternative fuels with low levels of aromatics and other toxic ingredients reduce the incidence of sniffing as well as the potential for toxic effects associated with both acute and chronic exposure to aromatic compounds. It has also been recommended that to make it effective in the long term, this strategy needs to be introduced on a regional basis to prevent access to harmful petrol available outside communities. It also needs to be combined with the introduction of sporting and educational activities in remote communities (LANT 2004).

- Since the introduction of Opal fuel in the eleven communities on the Anangu Pitjantjatjara Yankunytjatjara Lands in 2005, the incidence of petrol sniffing on the Lands has fallen by 68 per cent. A survey commissioned by Nganampa Health Council identified 70 petrol sniffers in 2006 compared with 222 in 2004 (SA Government unpublished).

(Continued next page)

Box 8.3.2 (continued)

- As of March 2007, there were 68 communities, 26 roadhouses and service stations and 3 pastoral properties using Opal fuel across Australia. Anecdotal information suggests a 95 per cent decrease in petrol sniffing in the western desert communities in the Northern Territory.
- A recent article in the *Australian* reported that the incidence of petrol sniffing is declining in central Australia (north of the Northern Territory border), with currently around 20 petrol sniffers believed to be present. This is a small fraction of an estimated 600 petrol sniffers eighteen months ago (Wilson 2007).

Mount Theo Program

The Mount Theo program is based out of Yuendumu, a remote Aboriginal community 300 km northwest of Alice Springs, NT. Yuendemu is the largest Aboriginal community in Central Australia, with a total Indigenous population of 585 (based on the ABS 2001 Census).

Petrol sniffing became an increasingly serious problem among the young people of Yuendumu from the 1970s. By 1993, there were up to 70 sniffers in Yuendumu, and the community was plagued with problems caused by the petrol sniffers, including violence and damage to property.

In 1994, after many community meetings, Yuendumu Warlpiri elders decided to send young petrol sniffers to Mt Theo outstation, 160 km northwest in the Tanami Desert. Traditional owners moved out to Mt Theo to help the young people and teach them traditional culture. At Mt Theo, young people were geographically isolated and had no access to petrol, so they had a chance to recover from the effects of sniffing, while people in Yuendumu had some respite from the destructive behaviour of the sniffers.

Around the same time, a program of activities collaborating with Yuendumu School and Youth Challenge Australia was started in Yuendumu to ensure that young people have alternative activities and opportunities when they return from Mt Theo to the community. The Jaru Pirrjirdi (Strong Voices) project engaged young people as leaders, working on community development projects. Night School provided youth development and educational activities. Many of the past clients of the outstation are engaged in Night School as part of the Mt Theo follow-up and after care program.

The Mt Theo Program has been successful in reducing the number of regular petrol sniffers in Yuendumu from 70 to zero within a decade. The success of this program lies in giving young people traditional culture and respite from sniffing at Mt Theo, with diversion through education and recreational activities in the home community of Yuendumu. It has also been attributed to a strong partnership of Indigenous and non-Indigenous skills, drawing strength and experience from both cultures.

Source: Preuss and Napanangka Brown 2006; the Senate Community Affairs Committee 2006; DHA and DIMIA 2006; Wilson 2007.

Drug related crime

Broadly speaking, there are three types of drug related crime: violence associated with illegal drug markets; crimes committed by individuals under the influence of drugs; and petty crime committed by drug users to pay for their drug purchases.

Although the link between drug use and crime is complex, many studies have found that there is clear evidence that drug use and crime tend to be associated — that is, co-existing in the same populations (Richard and Payne 2005; Makkai and Payne 2003; Johnson 2004, Loxley et al 2004, Stevens et al. 2005). Many persistent offenders frequently use illicit drugs, and drug dependence may amplify offending. Both crime and problematic drug use are linked to other factors, including socio-economic deprivations.

Wilczynski and Pigott (2004) found that illicit drugs were associated with both violent and property crime, but most strongly with property crime.

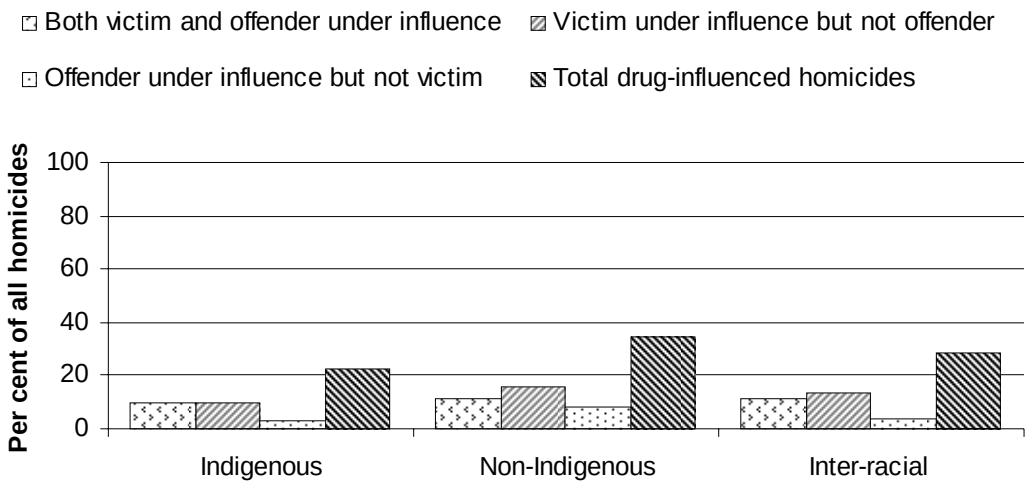
Richard and Payne (2005) found that there was a connection between drug and alcohol use and criminal offending among 371 juveniles aged 10 to 17 years who were in detention centres in all Australian jurisdictions in 2003-04. They found that:

- at the time of their offence, 48 per cent of these juvenile offenders were under the influence of drugs
- 44 per cent of burglars attributed their crimes to the need to obtain money to buy drugs
- almost one third of youths who had been charged with assaulting others attributed the offences to being drunk or high at the time of the offence
- compared with non-regular offenders, regular violent and regular property offenders were twice as likely to be regular users of cannabis
- Indigenous and non-Indigenous youths used similar substances at similar frequencies, although non-Indigenous detainees were significantly more likely to have used amphetamines and ecstasy
- Indigenous youths were more likely to attribute their criminal offending to substance use (35 per cent) than non-Indigenous youths (29 per cent).

An analysis of data from the Drug Use Monitoring in Australia (DUMA) program has shown that among the police detainees in seven urban police stations or watch houses in NSW, Queensland, WA and SA, urban Indigenous adult male offenders have similar experiences with illicit drugs as their non-Indigenous counterparts, including intravenous use, dependency and involvement in the illicit drug trade (Putt, Payne and Miller 2005).

Data on drug influenced crimes from the AIC National Homicide Monitoring Program (NHMP) are included for the first time in this Report. It should be noted that these data may not reflect the full extent of crimes under the influence of drugs as they do not include other forms of crime involving drugs, such as robberies, burglaries and assaults. Other limitations of the NHMP data are discussed in appendix 3.

Figure 8.3.1 **Drug influenced Indigenous and non-Indigenous homicides, 1999-2000 to 2004-05[a, b ,c, d, e]**

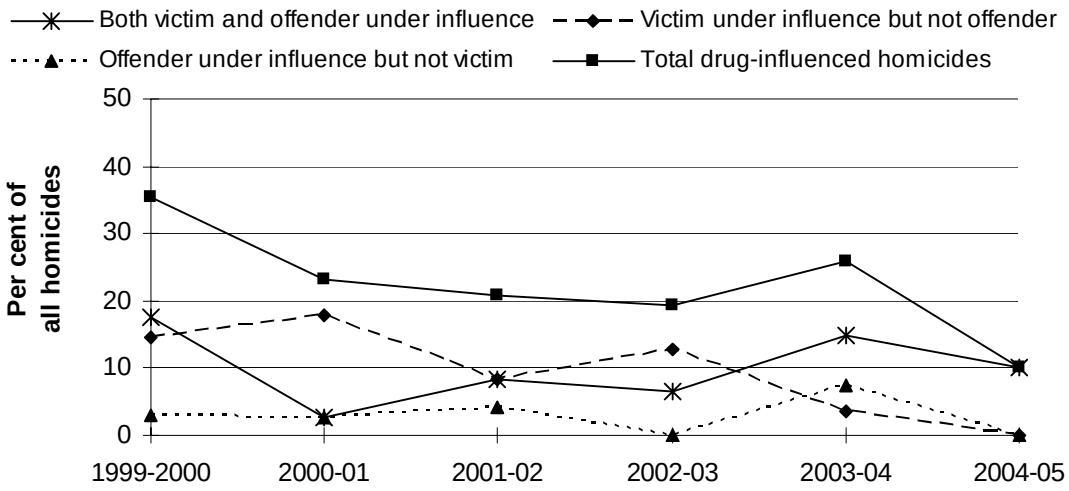


a Homicide includes murder and manslaughter, but excludes driving causing death. **b** Indigenous homicides are where both victims and offenders of homicide are Indigenous. **c** Non-indigenous homicides are where both victims and offenders are not Indigenous, including victims and offenders who are Caucasian, Asian and Maori/Pacific Islanders. **d** Inter-racial homicides are where either the victim or the offender is Indigenous, including homicides involving: an Indigenous offender and non-Indigenous victim, and non-Indigenous offender and an Indigenous victim. **e**Total drug influenced homicides are the aggregate of three categories of homicides under influence of drugs: both the 'victim and offender under the influence',' victim under the influence but not offender', and 'offender under the influence but not victim'

Source: AIC NHMP (unpublished); table 8A.3.5.

- Among all homicide recorded in the AIC NHMP database between 1999-2000 to 2004-05, a lower proportion of Indigenous homicides than non-Indigenous homicides were associated with the use of drugs at the time of the offence (22.5 per cent compared to 34.7 per cent) (figure 8.3.1).

Figure 8.3.2 **Drug influenced Indigenous homicides, 1999-2000 to 2004-05[a]**



a Totals are the aggregate of three categories of homicides under influence of drugs: both the 'victim and offender under the influence',' victim under the influence but not offender', and 'offender under the influence but not victim'.

Source: AIC NHMP (unpublished); table 8A.3.5.

- The overall level of drug-influenced Indigenous homicides fell from 35.3 per cent in 1999-2000 to 10.0 per cent in 2004-05, with significant decreases occurring between 2003-04 and 2004-05, and between 1999-2000 and 2000-01 (figure 8.3.2).

Drug related hospitalisations and deaths

Data on hospitalisations related to drug use reported for this indicator are sourced from the AIHW National Hospital Morbidity Database. These data only cover drug related illnesses resulting in admission to a hospital. Further, data are only available for conditions directly attributable to drug use and do not include most conditions where drug use may be a contributing factor but where the link is not direct and immediate. Lastly, identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of under-identification of Indigenous people (see chapter 2 and appendix 4 for more information). The limitations of using hospital statistics are discussed in appendix 3.

Based on data from four jurisdictions (Queensland, WA, SA and the NT), in 2004-05 (table 8A.3.1):

- The most common hospitalisations related to drug use for both Indigenous and non-Indigenous people were poisoning, mental and behavioural disorders, and accidental poisoning.
- The rates of hospitalisations for the three common drug related conditions for Indigenous people were all higher than those for non-Indigenous people.
- In particular, Indigenous people (1.5 per 1000) were twice as likely as non-Indigenous people (0.6 per 1000) to be hospitalised for mental and behavioural disorders caused by drug use.

Data on hospitalisations due to drug use by jurisdiction and sex are reported in table 8A.3.2.

Illicit drugs are a direct cause of death as well as being risk factors for conditions such as HIV/AIDS, hepatitis, low birthweight, inflammatory heart disease, poisoning and suicide and self-inflicted injuries. However, no data on illicit drug use related deaths by Indigenous status are available for inclusion in this Report.

8.4 Future directions in data

There are limited data regarding patterns of substance use. In this Report, data on substance use (including tobacco, alcohol and illicit drugs) are sourced from several ABS surveys. Direct comparison of illicit drug use between Indigenous and non-Indigenous people is not possible in this Report, as 2004-05 data on illicit drug use by non-Indigenous people were not collected in the 2004-05 NHS. Comparable data on changes in substance use over time are only available for alcohol and tobacco use in this chapter, with some data available on substance use.

The report, *Drug Use among Aboriginal and Torres Strait Islander Peoples: an Assessment of Data Sources*, was released by AIHW in October 2006. This report suggested many ways to improve current AIHW collections of data on substance use, among which the following are relevant to this chapter:

- continue to improve accurate identification of Indigenous status across all data sources
- improve estimates of substance use among Indigenous people, particularly in relation to illicit substance use in rural and remote locations
- improve information about the number of Indigenous people accessing alcohol and other treatment services, the types of treatment they receive and its outcomes

- develop an appropriate methodology for gathering information about emerging issues relevant to Indigenous substance use, such as petrol sniffing.

This provides some hope for being able to report data with improved quality and comparability in the future when these suggested improvements are in place.

Data on smoking during pregnancy are available for five jurisdictions (NSW, WA, SA, the ACT and NT), but few data on alcohol consumption during pregnancy were available for the Report (although some are available for Queensland). In Victoria, reported alcohol use and smoking status during pregnancy will be part of the Aboriginal Child Health, Development and Wellbeing Survey which is currently being designed. This will enable Victoria to report data on smoking and alcohol use by Indigenous women during pregnancy in Victoria for future Reports.

8.5 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 8A.2.2 is table 2 in the attachment tables for section 8.2). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

8.1 Alcohol consumption and harm

Table 8A.1.1	Alcohol consumption for people aged 18 years or over, age standardised, 2004-05
Table 8A.1.2	Risky to high risk alcohol consumption for persons aged 18 years or over, age standardised
Table 8A.1.3	Risky to high risk alcohol consumption for persons aged 18 years or over, non-remote areas only
Table 8A.1.4	Risky to high risk alcohol consumption for people aged 18 years or over, age standardised 2004-05
Table 8A.1.5	Alcohol involvement in Indigenous and non-Indigenous homicides
Table 8A.1.6	Hospital separations related to alcohol use (per 1000 population), Qld, WA, SA, and public hospitals in NT
Table 8A.1.7	Hospital separations related to alcohol use (per 1000 population), Qld, WA, SA, and public hospitals in NT
Table 8A.1.8	Hospital separations related to alcohol use (per 1000 population), Qld, WA, SA, and public hospitals in NT
Table 8A.1.9	Tobacco and alcohol consumption for Indigenous people aged 18 years or over, age standardised

Table 8A.1.10 Risky to high risk alcohol consumption, Indigenous people aged 18 years or over, by sex and remoteness, 2004-05

Table 8A.1.11 Risky to high risk alcohol consumption for people aged 18 years or over, by sex and age, 2004-05

Table 8A.1.12 Alcohol consumption at short term risky to high risk levels, people aged 18 years or over, 2004-05

8.2 Tobacco consumption and harm

Table 8A.2.1 Tobacco consumption for people aged 18 years or over, age standardised, 2004-05

Table 8A.2.2 Current daily smokers aged 18 years or over, by sex and remoteness, age standardised

Table 8A.2.3 Current daily smokers aged 18 years or over, by sex and age, non-remote areas only

Table 8A.2.4 Current daily smokers aged 18 years or over, age standardised, 2004-05

Table 8A.2.5 Current daily smokers aged 18 years or over

Table 8A.2.6 Age standardised hospital separations related to tobacco use (per 1000 population), Qld, WA, SA and public hospitals in NT

Table 8A.2.7 Mothers reporting smoking during pregnancy (per cent)

Table 8A.2.8 Current daily smokers, Indigenous people aged 18 years or over, 2004-05

8.3 Drug and other substance use and harm

Table 8A.3.1 Main types of hospital separations related to drug use, Qld, WA, SA, and public hospitals in NT

Table 8A.3.2 Age standardised hospital separations related to drug use, Qld, WA, SA, and public hospitals in NT

Table 8A.3.3 Substance use for Indigenous persons aged 18 years and over in non-remote areas, age standardised

Table 8A.3.4 Illicit drug use for people aged 14 years and over living in non-remote areas

Table 8A.3.5 Drug involvement in Indigenous and non-Indigenous homicide

8.6 References

8 Substance use and misuse

ABS (Australian Bureau of Statistics) and AIHW (Australian Institute of Health and Welfare) 2005, *The Health and Welfare of Australian's Aboriginal and Torres*

Strait Islander Peoples 2005, ABS Cat. no. 4704.0, AIHW Cat. no. IHW14, Canberra.

AIHW 2006, *Alcohol and Other Drug Treatment Services in Australia 2004–05: Report on the National Minimum Data Set*, Drug Treatment Series no. 5, Cat. no. HSE 43, Canberra.

Lloyd C. 1998, 'Risk Factors for Problem Drug Use: Identifying Vulnerable Groups', *Drugs Education, Prevention and Policy*, 5, pp. 217–232.

Loxley W., Toumbourou J., Stockwell T. 2004, *The Prevention of Substance Use, Risk and Harm in Australia: a Review of the Evidence*, Australian Government Department of Health and Ageing, Canberra.

Ridolfo B. and Stevenson C. 2001, *The Quantification of Drug-caused Mortality and Morbidity in Australia, 1998* (Drug Statistics Series no. 7), AIHW Cat. no. PHE 29, Canberra.

Richard J. and Payne J. 2005, 'Alcohol, Drugs and Crime: A Study of Juveniles in Detention', *Research and Public Policy Series*, No. 67, Australian Institute of Criminology.

8.1 Alcohol consumption and harm

ABS (Australian Bureau of Statistics) 2006, *Alcohol Consumption in Australia: A Snapshot, 2004-05,* Cat. no. 4832.0.55.001, 4832.0.55.001.

AIC (Australian Institute off Criminology) 1990, *Directions for Australia*, National Committee on Violence, Australian Institute off Criminology, Canberra.

AIHW (Australian Institute of Health and Welfare) 2005, 2004 *National Drug Strategy Household Survey: Detailed findings*, Cat. no. PHE 66, Canberra.

DHA (Department of Health and Ageing) 2001, *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services to Aboriginal and Torres Strait Islander Australians*, http://www.health.gov.au/internet/wcms/Publishing.nsf /Content/health-oatsih-pubs-bhcs.htm (accessed 4 May 2005).

Chikritzhs, T., Pascal, R., Gray, D., Stearne, A., Saggers, S and Jones, P. 2007, "Trends in alcohol-attributable deaths among Indigenous Australians, 1998-2004", *National Alcohol Indicators, Bulletin* no. 11, January 2007, Perth: National Drug Research Institute, Curtin University of Technology, Perth.

GSA (Government of South Australia) 2003, *Better Choices, Better Health, Final Report of the South Australian Generational Health Review,* http://www.sahealthreform.sa.gov.au/Portals/57ad7180-c5e7-49f5-b282-c6475cdb7ee7/GHR_Summary_WEB.pdf (accessed 15 August 2003).

Ireland, S. (Inspector from NSW Police Service) 1993, *Alcohol and its Contribution to Violence: New Directions for Policing Alcohol Related Violence, Crime and Anti-Social Behaviour in New South Wales*, presented to the Second National Conference on Violence, conducted by the Australian Institute of Criminology (AIC), http://www.aic.gov.au/conferences/ncv2/ireland.pdf (accessed 7 October 2003).

NHMRC (National Health and Medical Research Council) 2001, *Australian Alcohol Guidelines, Health Risks and Benefits*, Australian Government, Canberra, http://www.nhmrc.gov.au/publications/synopses/ds9syn.htm, (accessed 30 March 2005).

Putt J., Payne J. and Milner L. 2005, "Indigenous male offending and substance abuse", *Trends & Issues in Crime and Criminal Justice*, no. 293, Australian Institute of Criminology.

Richard J. and Payne J. 2005, 'Alcohol, Drugs and Crime: A Study of Juveniles in Detention', *Research and Public Policy Series*, no. 67, Australian Institute of Criminology.

Rowland, B. and Toumbourou, J. W. 2004, *Preventing Drug-Related Harm in Indigenous Australian Communities, Prevention Research Evaluation Report*, Druginfo Clearing House, Australian Drug Foundation and the Victorian Premier's Drug Prevention Council (http://www.druginfo.adf.org.au).

Smith D. I. 1983, Indices for the Use and Abuse of Alcohol: a literature Review, West Australia Alcohol and Drug Authority, Perth.

WHO (World Health Organization) 2000, *International Guide for Monitoring Alcohol Consumption and Related Harm*, http://www.who.int/substance_abuse/PDFfiles/guidemontr_alcohlconsum.pdf (accessed 7 October 2003).

WHO (World Health Organization) 2004, *Global Status Report on Alcohol 2004*, Geneva.

World Bank 2000, *Health, Nutrition and Population, Sourcebook for the Poverty Reduction Strategy Paper*, Part 2, Technical Notes, 5 June 2000, http://www.worldbank.org/poverty/health/library/hnptechnotes.pdf (accessed 15 August 2003).

8.2 Tobacco consumption and harm

ABS (Australian Bureau of Statistics) 2006, *Alcohol Consumption in Australia: A Snapshot, 2004-05*, Cat. no. 4832.0.55.001, 4832.0.55.001.

AIHW (Australian Institute of Health and Welfare) National Perinatal Statistics Unit 2006a, *Smoking and Pregnancy*, AIHW Cat. no. PER 33, Sydney.

—— 2006b, *Australia's Mothers and Babies 2004*, AIHW Cat. no. PER 34, Sydney.

DHA (Department of Health and Ageing) 2003, *National Drug Strategy, Aboriginal and Torres Strait Islander Peoples, Complementary Action Plan 2003-2006*, Canberra.

DHA (Department of Health and Ageing) 2004, *The National Drug Strategy: Australia's Integrated Framework 2004-2009*, Canberra.

NHMRC (National Health and Medical Research Council) 2001, *Australian Alcohol Guidelines, Health Risks and Benefits*, Australian Government, Canberra, http://www.nhmrc.gov.au/publications/synopses/ds9syn.htm, (accessed 30 March 2005).

Ridolfo B. and Stevenson C. 2001, *The Quantification of Drug-caused Mortality and Morbidity in Australia, 1998* (Drug Statistics Series no. 7), AIHW Cat. no. PHE 29, Canberra.

WHO (World Health Organization) 2004, *The Millennium Development Goals and Tobacco Control: An Opportunity for Global Partnership*, Geneva, Switzerland, http://www.who.int/tobacco/research/economics/publications/mdg_book/en/index.html (accessed 29 August 2006).

8.3 Drug and other substance use and harm

ABS (Australian Bureau of Statistics) 2004, *National Aboriginal and Torres Strait Islander Social Survey 2002*, Cat. no. 4714.0, Canberra.

Access Economics, 2006, *Opal Cost Benefit Analysis*, Report by Access Economics Pty Ltd for the Opal Alliance.

AIHW (Australian Institute of Health and Welfare) 2002, *2001 National Drug Strategy Household Survey, Detailed Findings*, Cat. no. PHE 41, Canberra.

Burns, C., Currie, B., Clough, A. and Wuridjal, R. 1995, 'Evaluation of Strategies used by a Remote Aboriginal Community to Eliminate Petrol Sniffing', *Medical Journal of Australia*, 163 (2), pp.82–86.

Campbell L. and Stojanovski A. 2001, 'Warlpiri Elders Working with Petrol Sniffers, Yuendumu', *Indigenous Law Bulletin*, 5(6), pp. 8–11.

The Senate Community Affairs Committee 2006, *Beyond Petrol Sniffing: Renewing Hope for Indigenous Communities*, report by the Community Affairs Reference

Committee to the Inquiry into Petrol Sniffing in Remote Aboriginal Communities of the Parliament of Australia Senate, June 2006, Canberra.

Clough A. R., Burns C. B., Guyula T., Yunupingu M. 2002, 'Diversity of Substance Use in Eastern Arnhem Land (Australia): Patterns and Recent changes', *Drug and Alcohol Review*, 21, pp. 349–356.

Clough A. R. and Jones P. 2004, 'Policy Approaches to Support Local Community Control Over the Supply and Distribution of Kava in the Northern Territory (Australia)', *Drug and Alcohol Review*, 23(1), pp. 117–126.

Clough A. R., D'Abbs P., Cairney S., Gray D., Maruff P., Parker R. and O'Reilly B. 2004, 'Emerging Patterns of Cannabis and other Substance Use in Aboriginal Communities in Arnhem Land, Northern Territory: A Study of Two Communities', *Drug and Alcohol Review*, 23(4), pp. 381-390.

DHA (Department of Health and Ageing) 2003, *Background Paper: National Drug Strategy, Aboriginal and Torres Strait Islander Peoples, Complementary Action Plan 2003-2006*, Canberra.

DHA (Department of Health and Ageing) 2004, *An Evaluation of the Comgas Scheme*, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing, Canberra.

DHA (Department of Health and Ageing) 2006, Roll Out of OPAL Fuel to Help Combat Petrol Sniffing, media releases, The Hon Tony Abbott MHR, Minister for Health and Ageing, 11 September 2006, Canberra, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/MediaReleases-1(accessed 21 September 2006).

DHA and DIMIA (Department of Health and Ageing and Department of Immigration and Multicultural and Indigenous Affairs) 2006, *Submission to Inquiry into Petrol Sniffing in Remote Aboriginal Communities of the Parliament of Australia Senate*, Submission No. 25, June 2006, http://www.aph.gov.au/senate/committee/clac_ctte/petrol_sniffing/submissions/sublist.htm (accessed 26 June, 2006).

Johnson H. 2004, *Drugs and Crime: a Study of Incarcerated Female offenders*, Research and Public Policy Series no. 63, Australian Institute of Criminology.

LANT (Legislative Assembly of the Northern Territory) 2004, *Petrol Sniffing in Remote Northern Territory Communities*, Select Committee on Substance Abuse in the Community, Legislative Assembly of the Northern Territory, October 2004, http: //www.nt.gov.au/lant/parliament/committees/substance (accessed 10 March, 2005).

Makkai T. and McAllister I. 1998, *Patterns of drug use in Australia 1985–95*, Commonwealth Department of Health and Family Services, Canberra.

Makkai T. and Payne J. 2003, *Drugs and Crime: a Study of Incarcerated Male offenders*, Research and Public Policy Series no. 52, Australian Institute of Criminology.

MCDS (Ministerial Council on Drug Strategy) 2006, *National Directions on Inhalant Abuse: Final Report of the National Inhalant Abuse Taskforce*, Ministerial Council on Drug Strategy.

Preuss K. and Napanangka Brown J. 2006, 'Stopping Petrol Sniffing in Remote Aboriginal Australia: Key Element of the Mt Theo Program', *Drug and Alcohol Review* , 25 (5), pp.189–193.

Putt J., Payne J. and Milner L. 2005, "Indigenous male offending and substance abuse", *Trends & Issues in Crime and Criminal Justice*, no. 293, Australian Institute of Criminology.

Richard J. and Payne J. 2005, 'Alcohol, Drugs and Crime: A Study of Juveniles in Detention', *Research and Public Policy Series*, No. 67, Australian Institute of Criminology.

Ridolfo B. and Stevenson C. 2001, *The Quantification of Drug-caused Mortality and Morbidity in Australia, 1998* (Drug Statistics Series no. 7), AIHW Cat. no. PHE 29, Canberra.

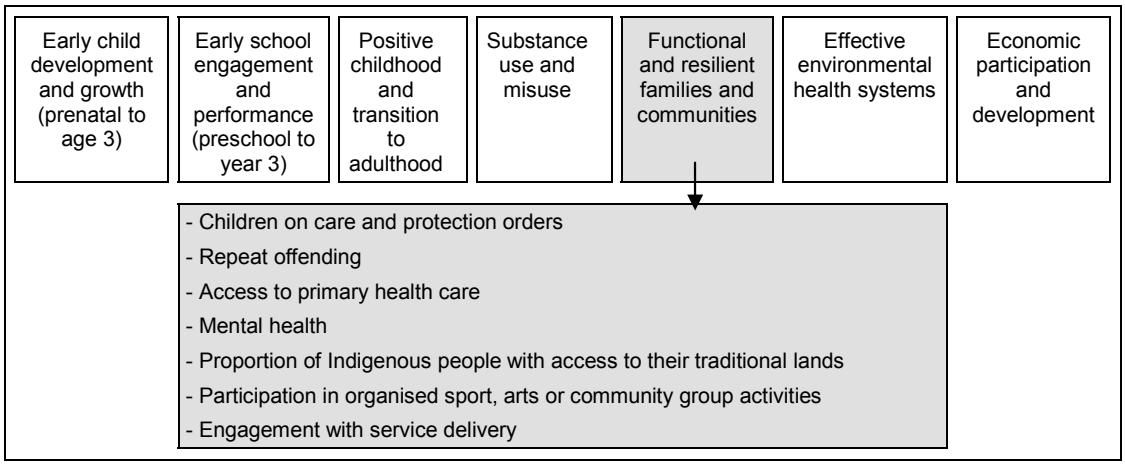
Stevens A., Trace M. and Bewley-Taylor D. 2005, *Reducing Drug Related Crime: an Overview of the Global Evidence*, the Beckley Foundation Drug Policy Programme, Report 5 (http://www.internationaldrugpolicy.net/publications.htm) accessed 24 August 2006.

Wilczynski A. and Pigott R. 2004, *The relationship Between Drugs and Crime*, Australian Government Attorney-General's Department, Canberra (prepared for National Law Enforcement Policy Branch by Uris Keys Young, Funded by the National Illicit Drug Strategy).

Wilson, A. 2007, 'Petrol sniffing in central Australia is over', *The Australian*, 17 March 2007, (http://theaustralian.news.com.au/story/0,20867,21396576-2702,00.html?from=public_rss) (accessed 10 April 2007).

9 Functional and resilient families and communities

Strategic areas for action



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

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

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

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

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

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

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

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

As explored in more detail in section 3.11:

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

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

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

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

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

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

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

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

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

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

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

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

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

Lake Tyers Community Renewal Program (Victoria)

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

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

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

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

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

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

Source: Victorian Government (unpublished).

Attachment tables

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

9.1 Children on care and protection orders

Box 9.1.1 **Key messages**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a Non-Indigenous includes Indigenous status not stated.

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

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

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

Placement in accordance with the Aboriginal Child Placement Principle

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

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

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

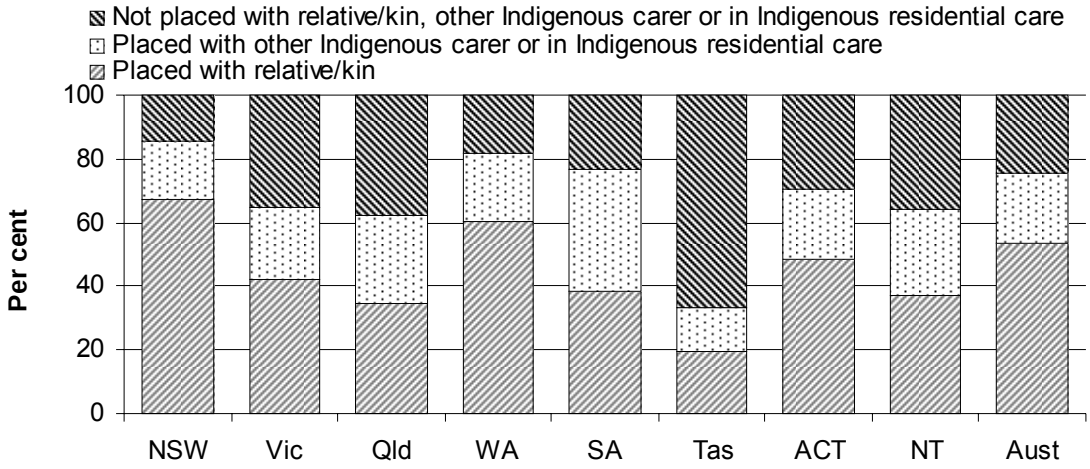
All jurisdictions have adopted this principle, either in legislation or policy.

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

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

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

Figure 9.1.1 **Placement of Indigenous children in out-of-home care, 30 June 2006[a, b]**



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

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

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

9.2 Repeat offending

Box 9.2.1 **Key messages**

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

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

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

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

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

Box 9.2.2 **'Things that work' — Circle Sentencing Courts in NSW**

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

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

(Continued next page)

Box 9.2.2 **(continued)**

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

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

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

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

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

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

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

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

Source: Victorian Government (unpublished).

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

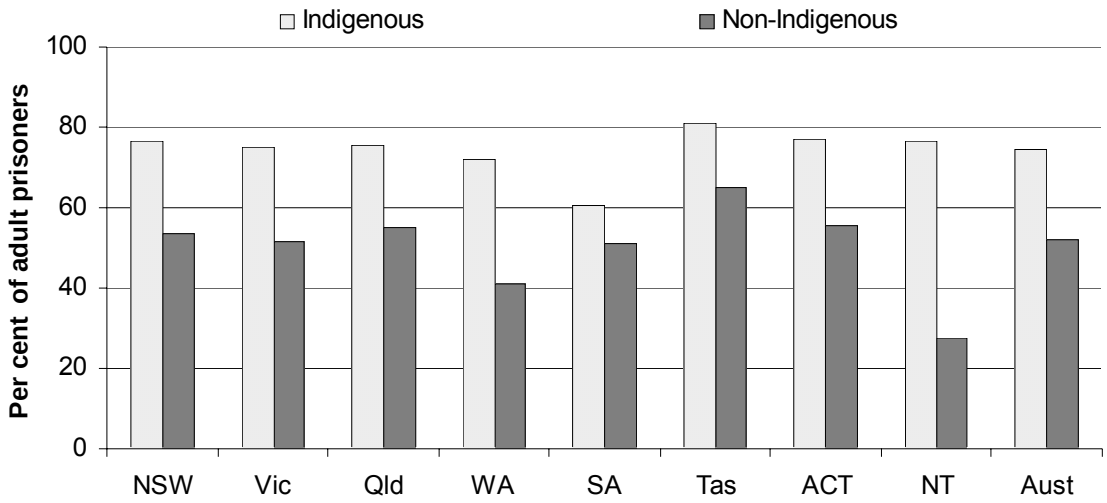
Data on the prior imprisonment of adults sourced from the ABS *Prisoners in Australia* series need to be interpreted with caution. The data are subject to the following caveats:

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

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

Adult repeat offending

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



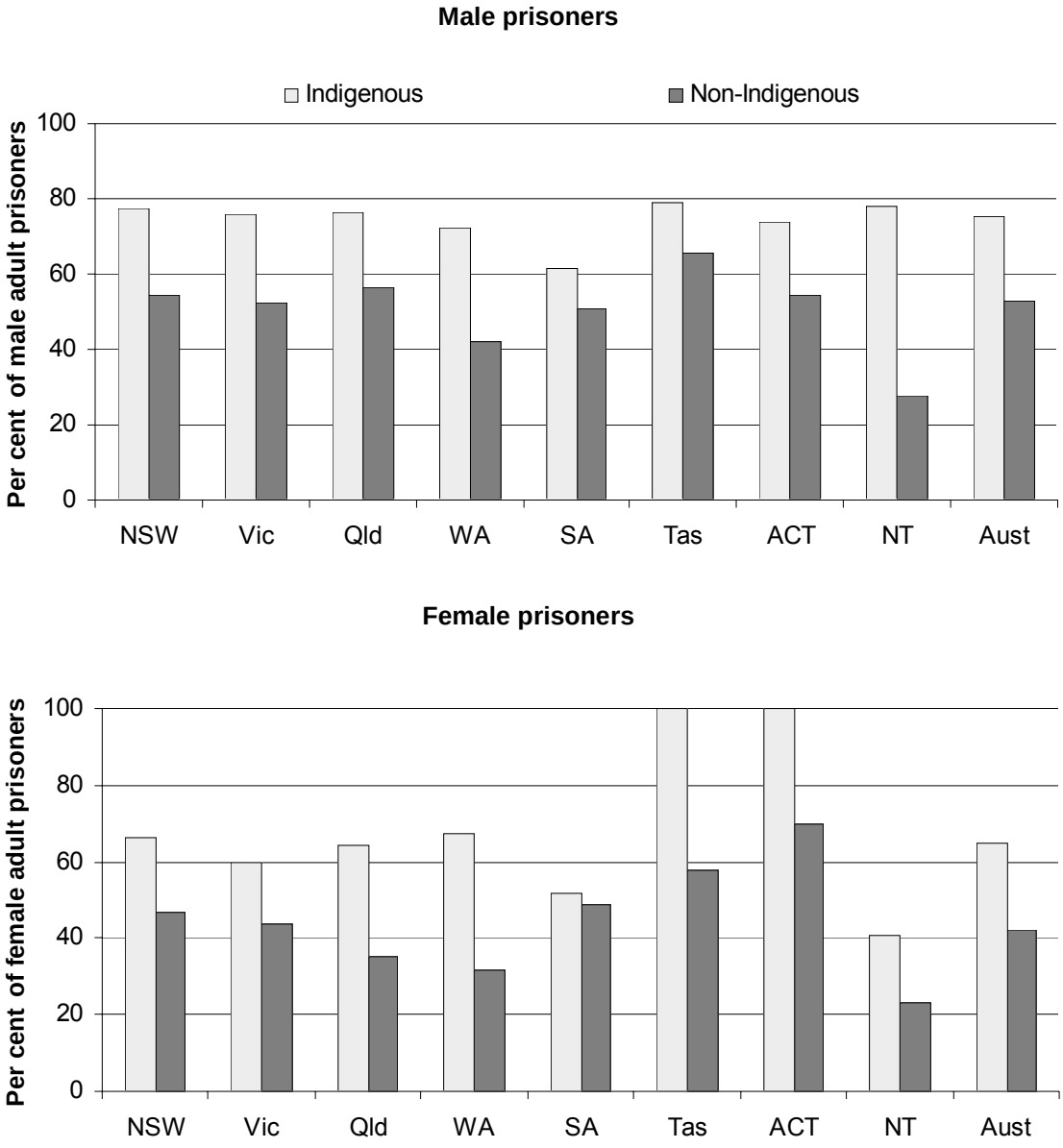
a Persons known to have had prior imprisonment under sentence in a gazetted adult prison. A prior sentence of periodic detention is included as prior imprisonment. Some states and territories may also include episodes on remand as prior imprisonment. Prisoners who have had previous adult imprisonment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

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

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

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

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



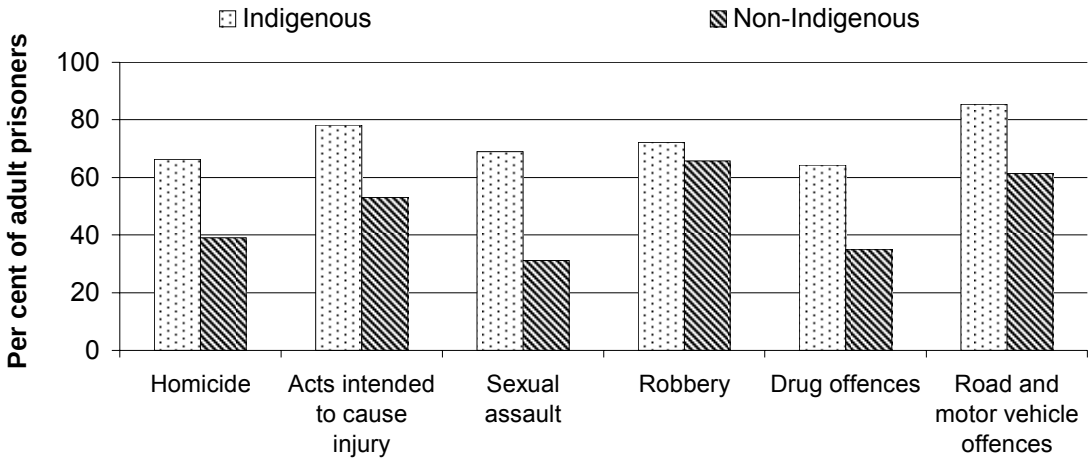
a Persons known to have had prior imprisonment under sentence in a gazetted adult prison. A prior sentence of periodic detention is included as prior imprisonment. Some states and territories may also include episodes on remand as prior imprisonment. Prisoners who have had previous adult imprisonment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

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

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

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

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



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

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

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

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

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

Juvenile repeat offending

New South Wales

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

Queensland

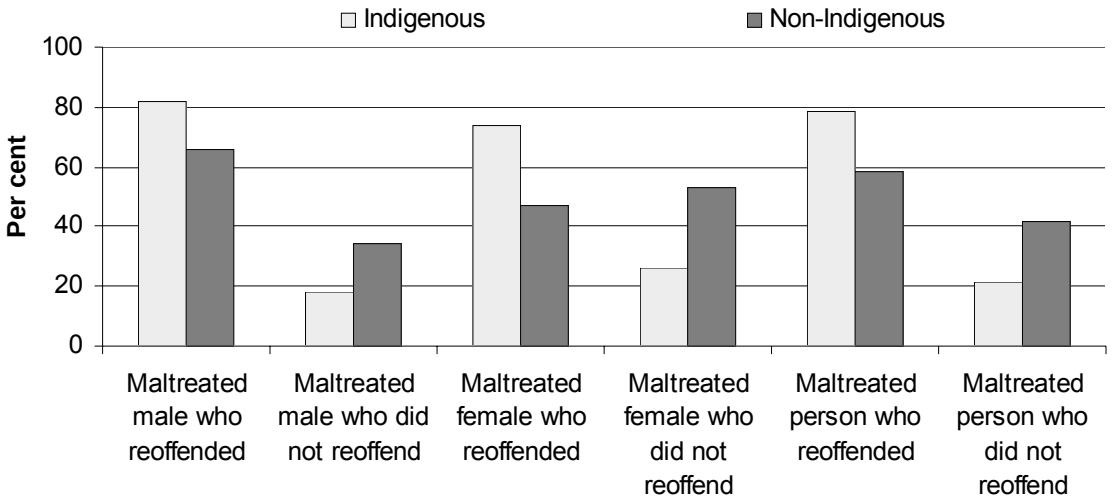
Data from Queensland are sourced from a report published by Griffith University School of Criminology and Criminal Justice (2005) which examines the link between child maltreatment, police cautioning and juvenile repeat offending. The study follows all children born in a 1983 birth cohort through any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

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

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

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

Figure 9.2.4 **Queensland, repeat offending rates for maltreated juveniles who received a police caution, by sex, 1983 birth cohort[a, b]**



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

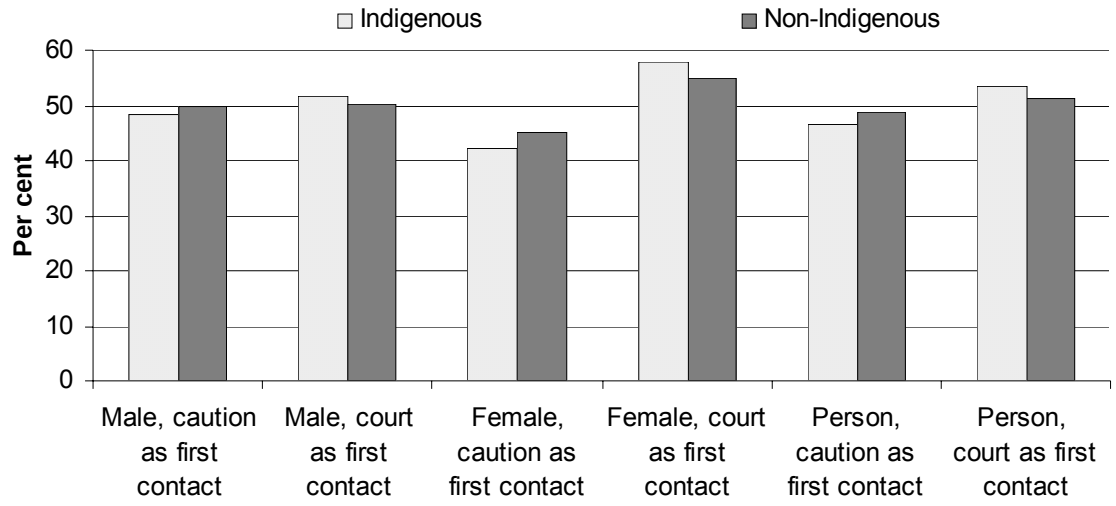
Source: Griffith University (2005); table 9A.2.7.

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

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

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

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



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

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

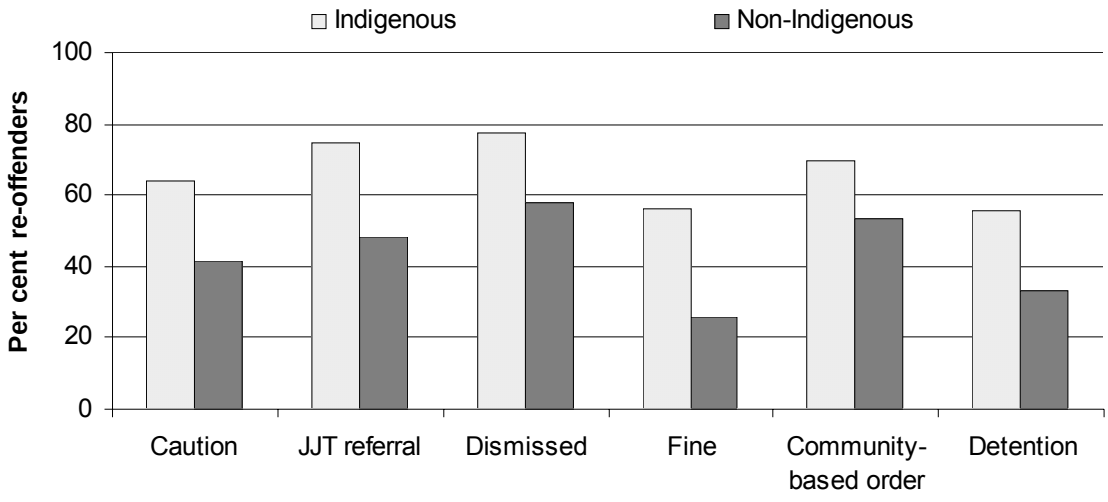
- The proportion of juvenile repeat offenders who had a finalised court appearance after receiving a caution was similar for Indigenous and non-Indigenous males and females in the 1983 Queensland birth cohort (figure 9.2.5). For Indigenous and non-Indigenous males, 48.2 per cent and 49.9 per cent, respectively,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

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

Western Australia

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

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



JJT Juvenile justice team.

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

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

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

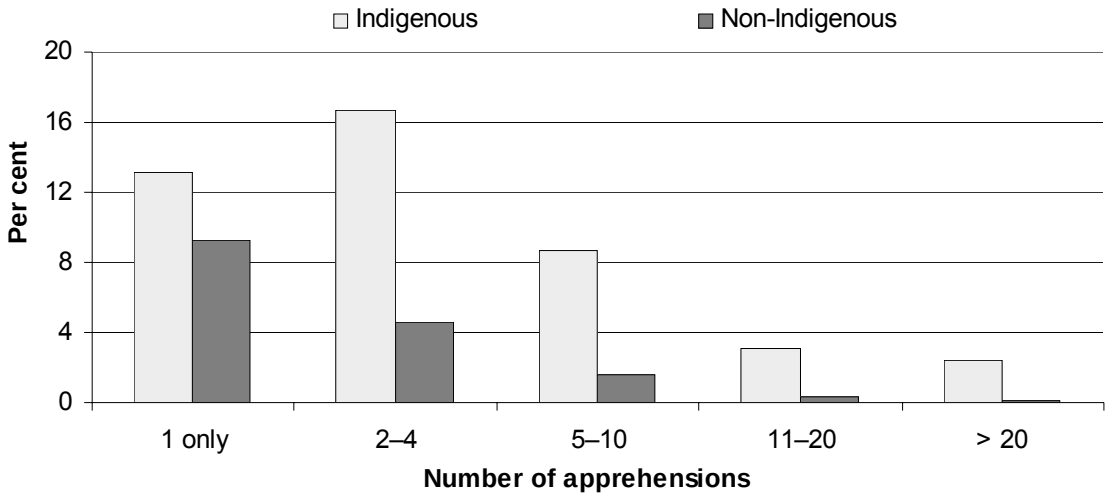
- The greatest difference between the proportion of Indigenous and non-Indigenous re-offenders was for juveniles receiving a fine as their first contact with the justice system (56.0 per cent of Indigenous juveniles re-offended after receiving a fine compared to 25.8 per cent of non-Indigenous juveniles)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

South Australia

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

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

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



a Excludes 18 year olds.

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

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

9.3 Access to primary health care

Box 9.3.1 **Key messages**

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

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

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

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

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

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

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

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

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

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

Box 9.3.2 **'Things that work' — Marrang Aboriginal Child and Family Health Model**

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

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

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

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

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

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

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

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

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

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

Box 9.3.4 **'Things that work' — Jirrawun Health**

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

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

Expenditure on health care services for Indigenous people

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

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

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

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

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

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

Source: AIHW (2005a).

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

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

Hospitalisations for potentially preventable conditions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

		Indigenous	*Non-Indigenous*[d]	*Total*
Syphilis	rate	59.3	2.4	3.9
Gonococcal infection	rate	53.3	0.8	3.3
Chlamydial infection	rate	28.0	2.2	3.5
Other sexually transmitted diseases	rate	68.0	21.6	23.5

[a] Hospitalisation rates are directly age standardised using the 2001 Australian population. [b] Data are based on state of usual residence. [c] Includes principal or additional diagnosis based on ICD-10-AM classification. [d] Non-Indigenous includes hospitalisations of people identified as not Indigenous as well as those with a 'not stated' Indigenous status.

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

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

Indigenous people accessing primary health care services

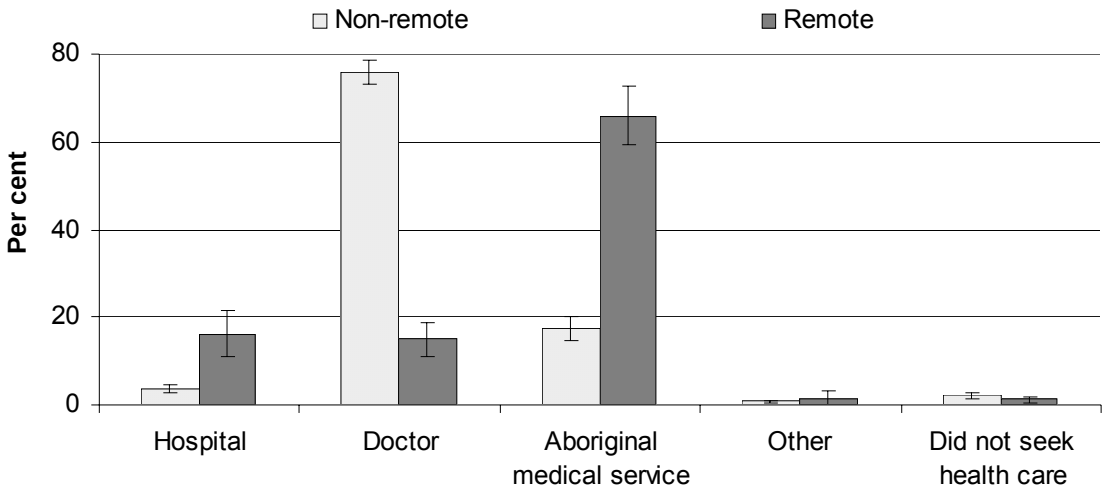
Due to cultural differences, language barriers and racism, some Indigenous people feel more comfortable seeing Indigenous health professionals and accessing Indigenous-controlled medical services. However, Indigenous people represent a small proportion (0.9 per cent) of people working in health-related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

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

Survey data from the ABS 2004-05 NATSHIS

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

Figure 9.3.1 **Health care services Indigenous people sought when they had a health problem, 2004-05[a, b, c]**



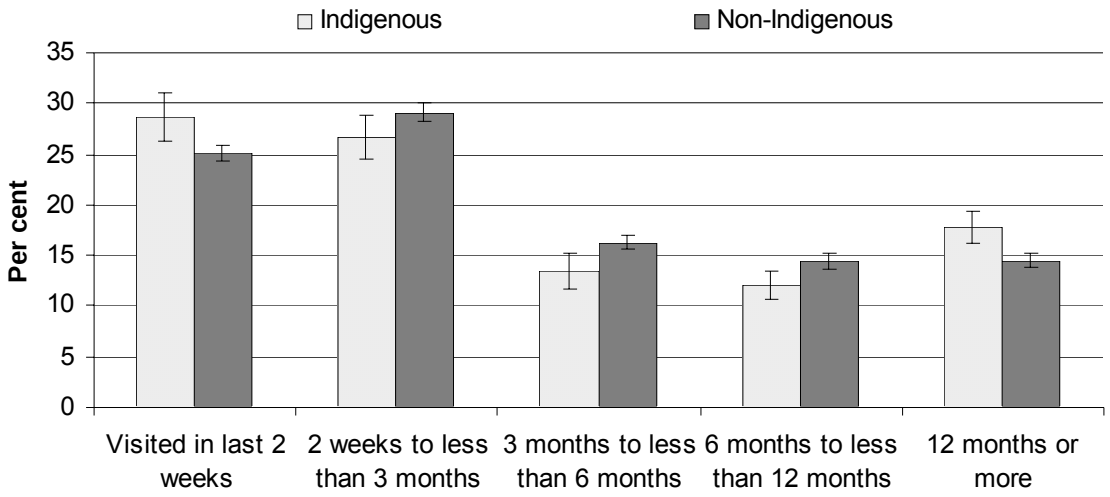
a Error bars represent 95 per cent confidence intervals around each estimate. **b** 'Other' includes traditional healers. **c** Data presented above is for the whole population.

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

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

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

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



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

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

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

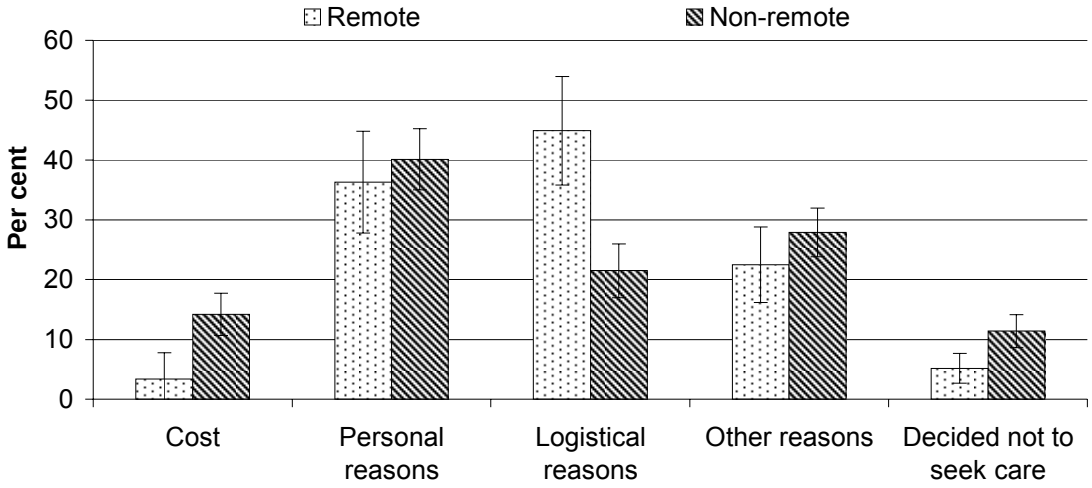
- In 2004-05, the overall pattern of times since Indigenous and non-Indigenous adults had last consulted a GP/specialist was similar (figure 9.3.2).
- A higher proportion of Indigenous than non-Indigenous adults had visited a GP/specialist in the two weeks prior to the survey (28.7 per cent compared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

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

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

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

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



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

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

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

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

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

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

Survey data from the ABS 2006 CHINS

The ABS 2006 CHINS collected information on the number of Aboriginal primary health care centres and state-funded community health centres located in discrete Indigenous communities[1]. Information was also collected on access to medical professionals and whether any Indigenous health workers visited or worked within these communities (ABS 2007). Data were collected from a total of 1187 discrete Indigenous communities with a combined population of approximately 92 960 people.

Number of health care centres for discrete Indigenous communities

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

Distance to health care centres for discrete Indigenous communities

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

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

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

Access to Indigenous health workers and medical professionals

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

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

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

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

Source: ABS 2006 CHINS.

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

9.4 Mental health

Box 9.4.1 **Key messages**

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

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

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

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

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

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

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

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

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

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

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

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

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

Box 9.4.2 **'Things that work' — improving mental wellbeing**

Apunipima Cape York Health Council Family Wellbeing Empowerment Program

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

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

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

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

(Continued next page)

Box 9.4.2 **(continued)**

Aboriginal Mental Health Workforce Training Program

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

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

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

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

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

Mental health, wellbeing and prevalence of mental disorders

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

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

Survey data

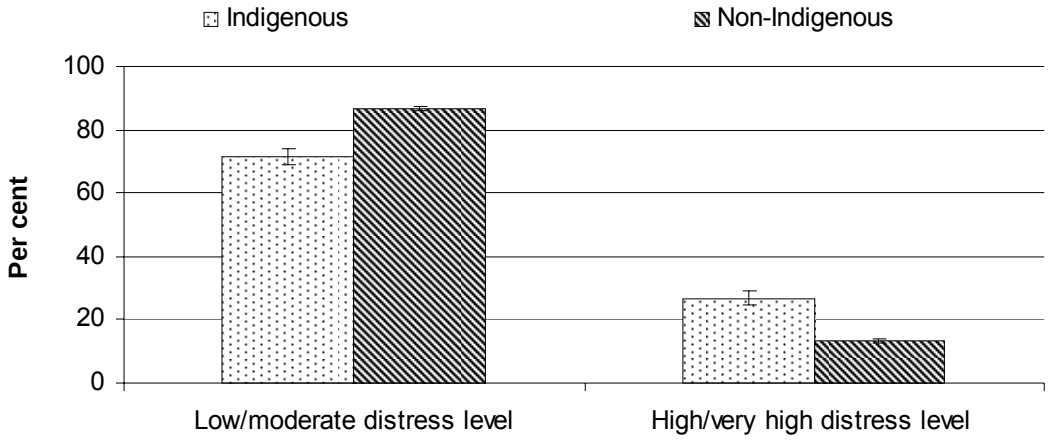
The 2004-05 NATSIHS included for the first time selected questions from two international survey instruments, the Kessler Psychological Distress Scale–10 (K10) and the Medical Outcome Short Form (SF–36) Health Survey.

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

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

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

Figure 9.4.1 **K5 level of psychological distress, people aged 18 years and over, age standardised, 2004-05[a, b, c]**



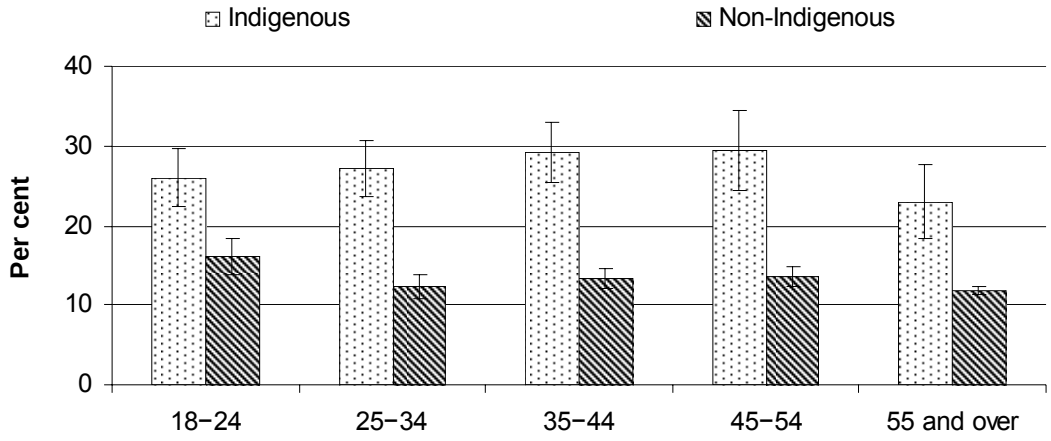
a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). **b** Low/moderate distress level represents a K5 score of 5–11. **c** High/very high distress level represents a K5 score of 12–25.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

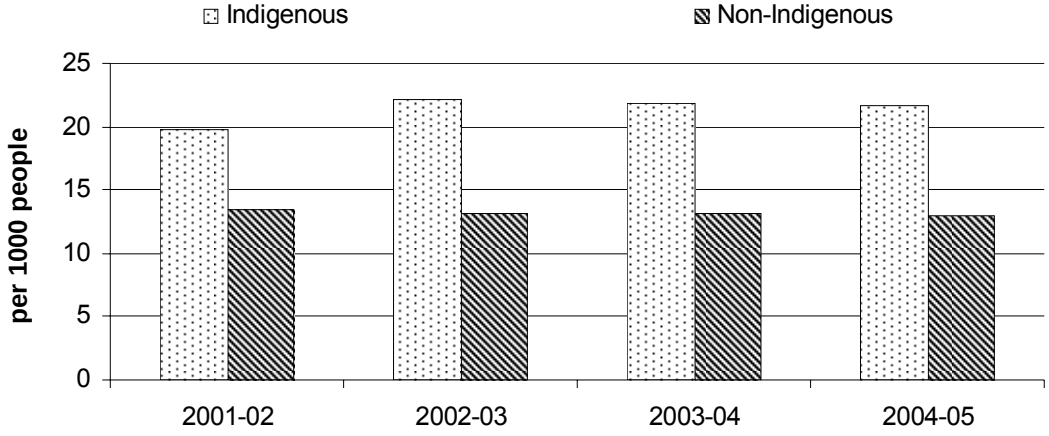
- 47.2 per cent of Indigenous people reported that they had a lot of energy all or most of the time (table 9A.4.13).

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

Hospitalisations for mental and behavioural disorders

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

Figure 9.4.3 **Age standardised hospitalisations for mental and behavioural disorders, Qld, WA, SA, and public hospitals in the NT[a, b, c, d]**



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

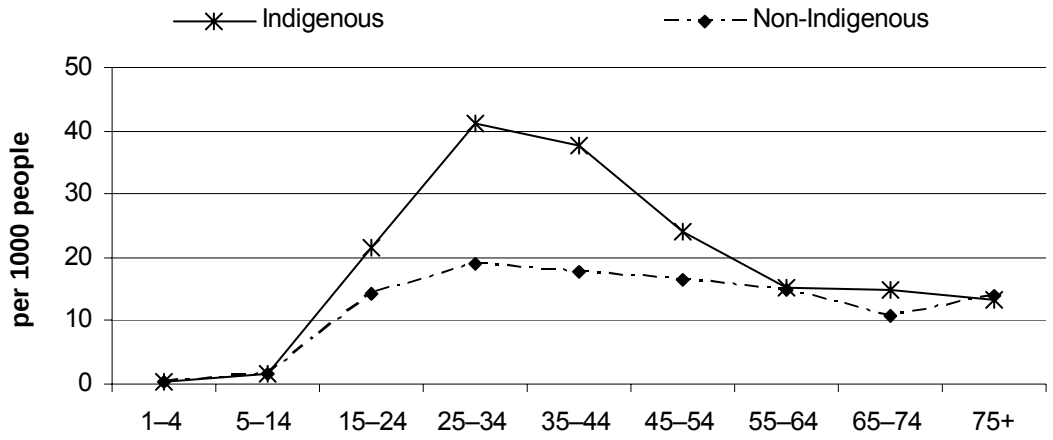
Source: AIHW National Hospital Morbidity Database (unpublished); tables 9A.4.18, 9A.4.24, 9A.4.30 and 9A.4.36.

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

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

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

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



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

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

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

Table 9.4.2 Indigenous standardised hospitalisation ratios for mental and behavioural disorders, 2004-05[a, b]

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

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

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

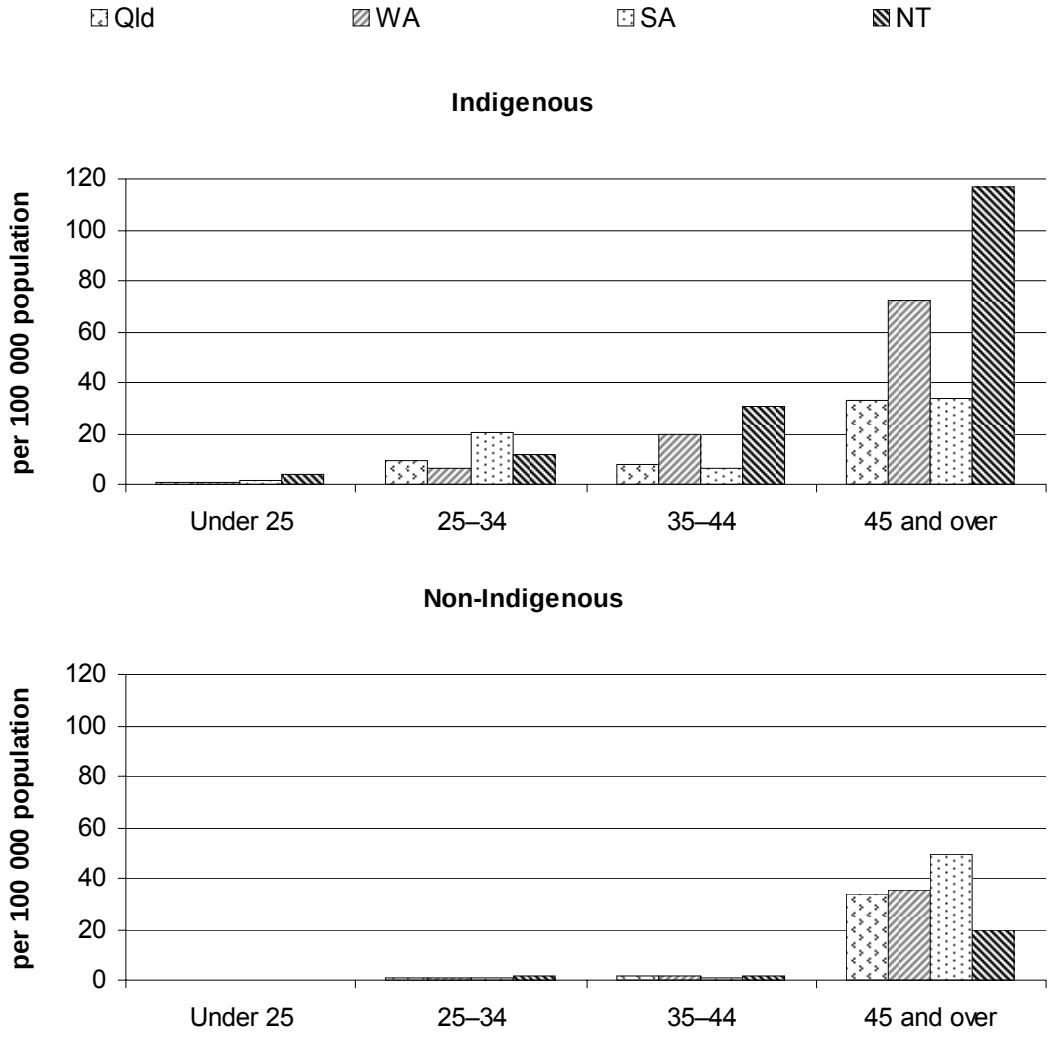
Source: AIHW National hospital morbidity database (unpublished); table 9A.4.21.

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

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

Death rates for mental and behavioural disorders

Figure 9.4.5 **Death rates for mental and behavioural disorders by age, 2001–2005[a, b, c]**



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

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

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

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

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

Mental health of prisoners and juveniles in detention

Prisoners

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

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

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

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

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

Some of the findings from the WA study include:

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

Juveniles in detention

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

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

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

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

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

Mental wellbeing of children

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

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

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

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

9.5 Proportion of Indigenous people with access to their traditional lands

Box 9.5.1 **Key messages**

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

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

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

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

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

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

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

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

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

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

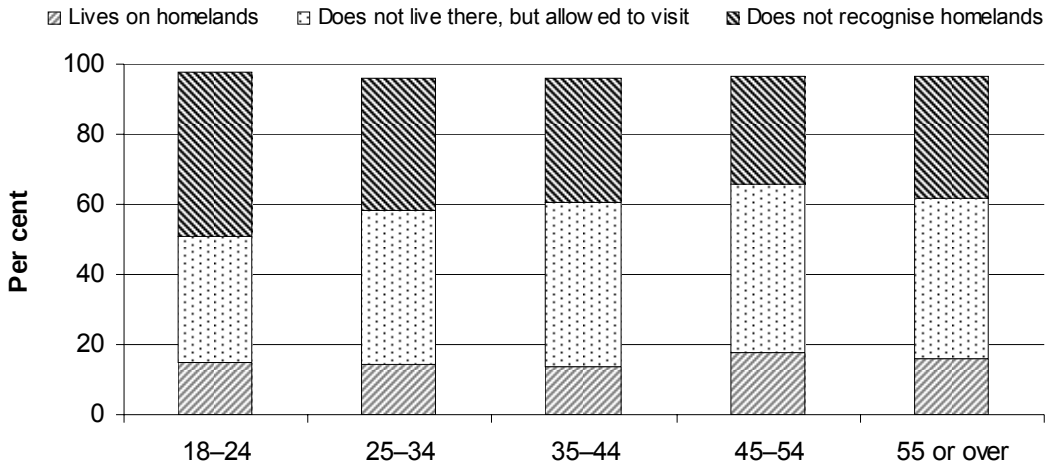
Figure 9.5.1 **Proportion of Indigenous people aged 18 years and over living on, or allowed to visit, their homelands, by remoteness area, 2004-05[a, b]**

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

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

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

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



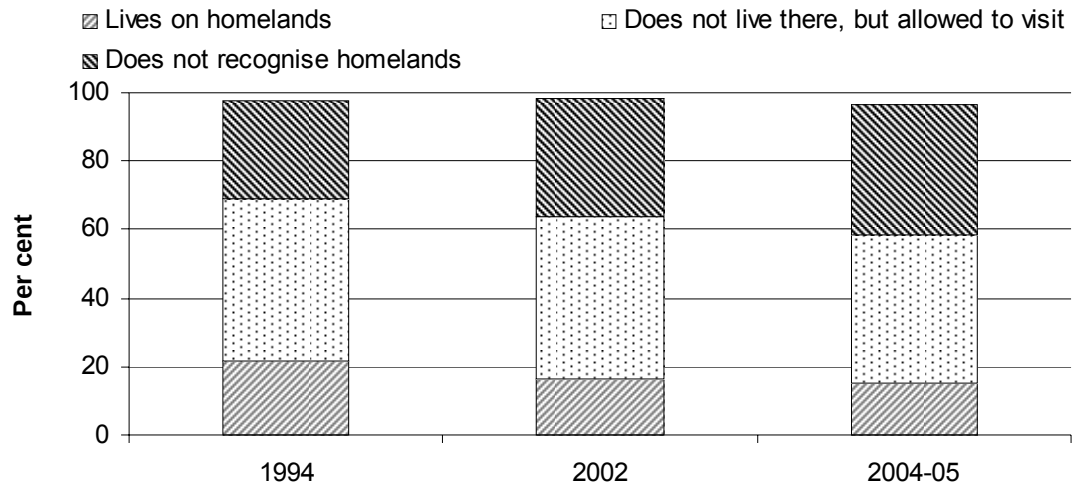
a The NATSIHS does not provide data for this indicator for remote or very remote areas in Australia. **b** The total does not add up to 100 per cent because the category 'Not allowed to visit homelands' is not shown in the graph (ranged from 0–1.3 per cent). Also excluded are the people who refused to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

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

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

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

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



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

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

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

9.6 Participation in organised sport, arts or community group activities

Box 9.6.1 **Key messages**

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

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

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

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

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

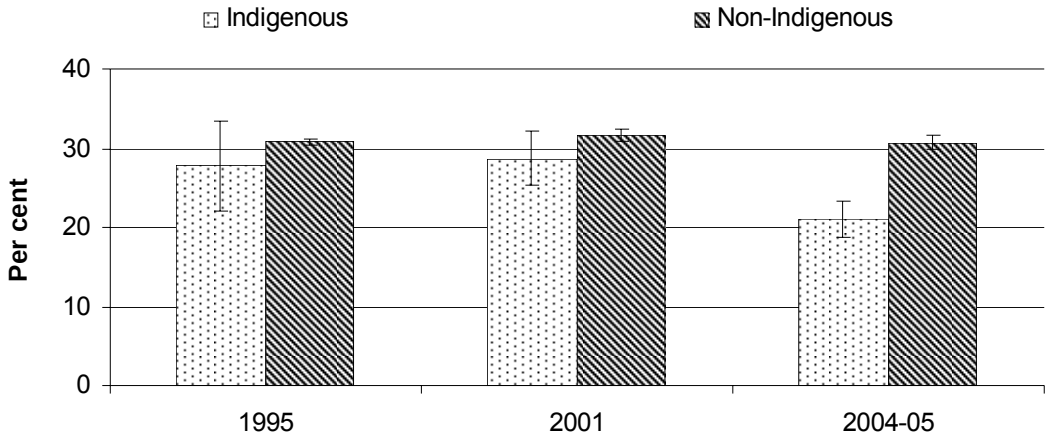
were judged by their teachers to be more socially skilled and less shy than students who did not participate in organised sports (Bush et al. 2001)

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

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

Participation in sport, recreation or fitness

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

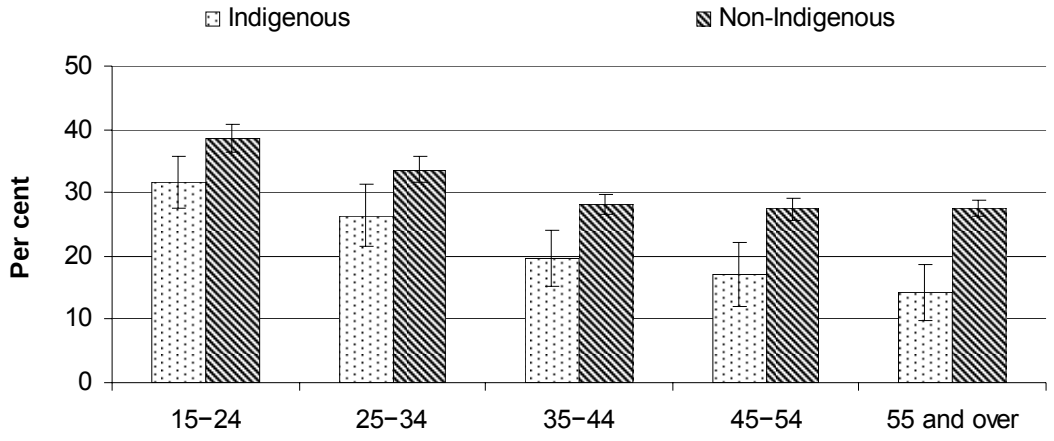


a Based on frequency, intensity and duration of exercise in the two weeks prior to the interview (moderate and high exercise participation levels). **b** Includes not stated responses.

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

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

Figure 9.6.2 **Participation in exercise at moderate/high levels, by age group in non-remote areas, 2004-05[a, b, c]**



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

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

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

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

Participation in arts and cultural activities

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

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

- more traditional forms of Indigenous arts or cultural involvement.

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

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

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

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

Case studies on sports, arts and community programs

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

Box 9.6.2 **Youth disco programs**

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

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

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

Box 9.6.3 **Little Yuin Aboriginal Preschool holiday program**

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

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

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

Source: Bega Valley Shire Council (unpublished).

Box 9.6.4 **Swan Nyungar Sports Education Program**

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

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

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

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

Source: WA Government (unpublished).

Box 9.6.5 **The Rumbalara Football and Netball Club**

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

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

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

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

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

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

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

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

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

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

Source: Australian Prospect 2006; University of Melbourne 2006.

Box 9.6.6 **Athletics Australia 'Athletics for the Outback' Program**

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

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

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

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

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

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

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

Source: Athletics Australia 2006.

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

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

Yirra Yaakin Noongar Theatre has three main areas of activity:

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

Source: WA Government (unpublished).

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

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

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

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

(Continued next page)

Box 9.6.8 (continued)

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

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

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

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

9.7 Engagement with service delivery

Box 9.7.1 **Key messages**

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

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

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

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

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

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

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

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

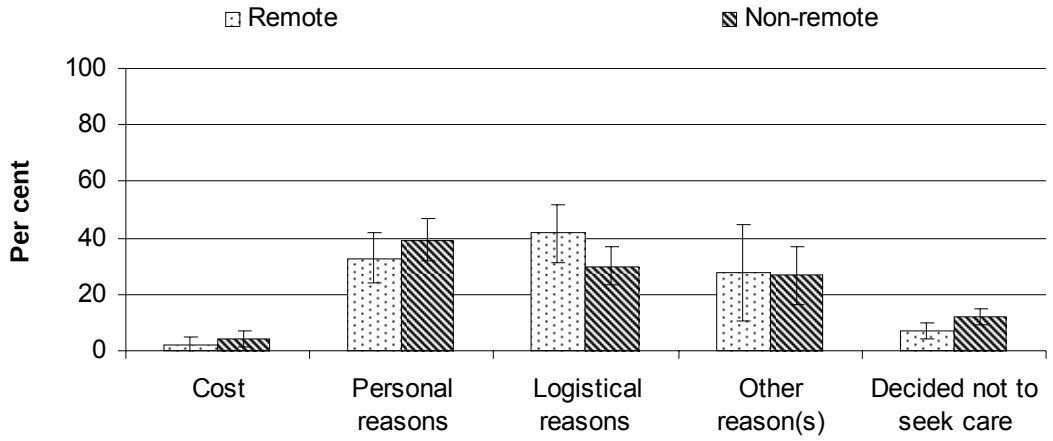
Improving service accessibility and service delivery methods can be expected to lead to better outcomes for Indigenous people. This section includes:

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

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

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

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



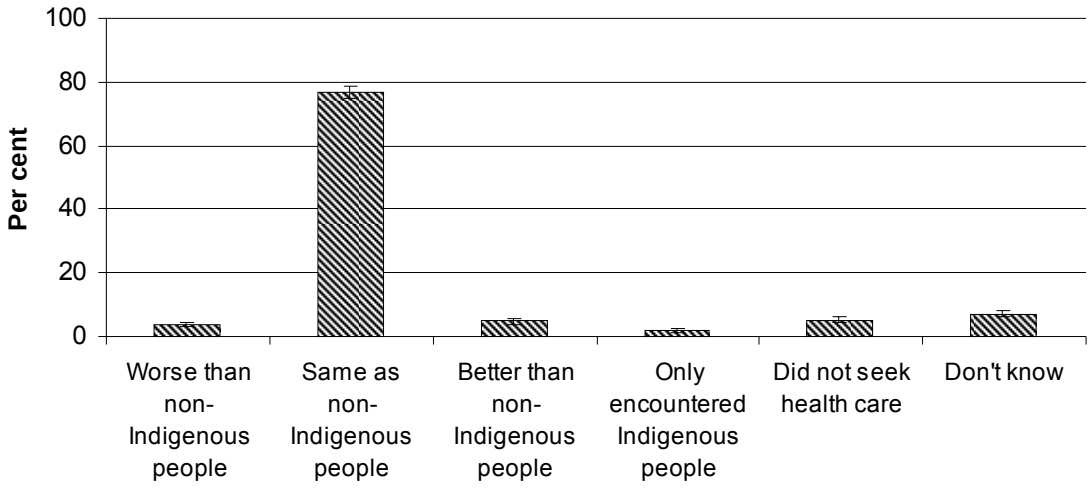
a Error bars represent 95 per cent confidence intervals around each estimate. **b** Personal reasons include: too busy (work, personal or family responsibilities), discrimination, service not culturally appropriate, language problems, dislikes service or health professional, afraid, embarrassed, or felt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

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

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

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

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

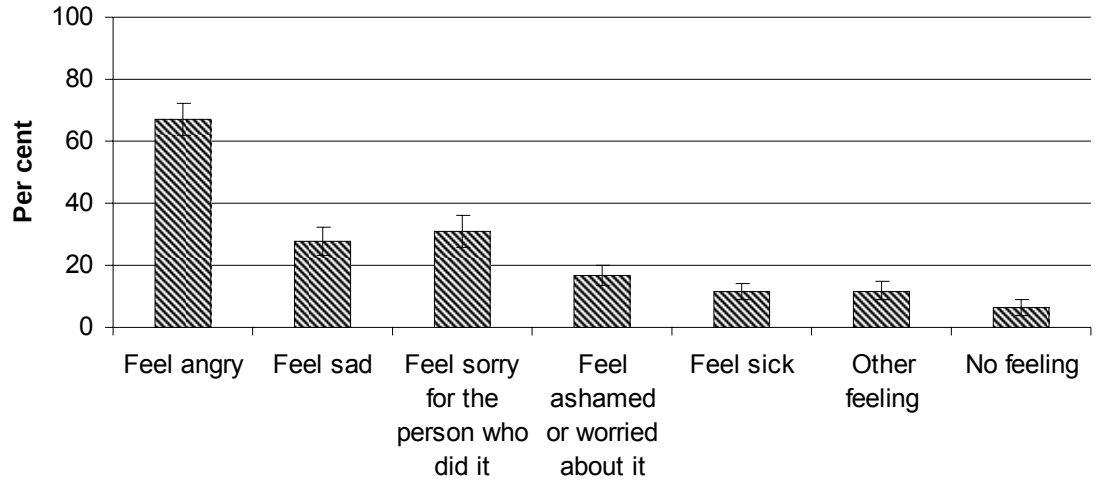


a Indigenous people aged 18 years and over. **b** Error bars represent 95 per cent confidence intervals around each estimate.

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

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

Figure 9.7.3 **How Indigenous people felt after they had been discriminated against because of their Indigenous status, 2004-05[a, b, c]**

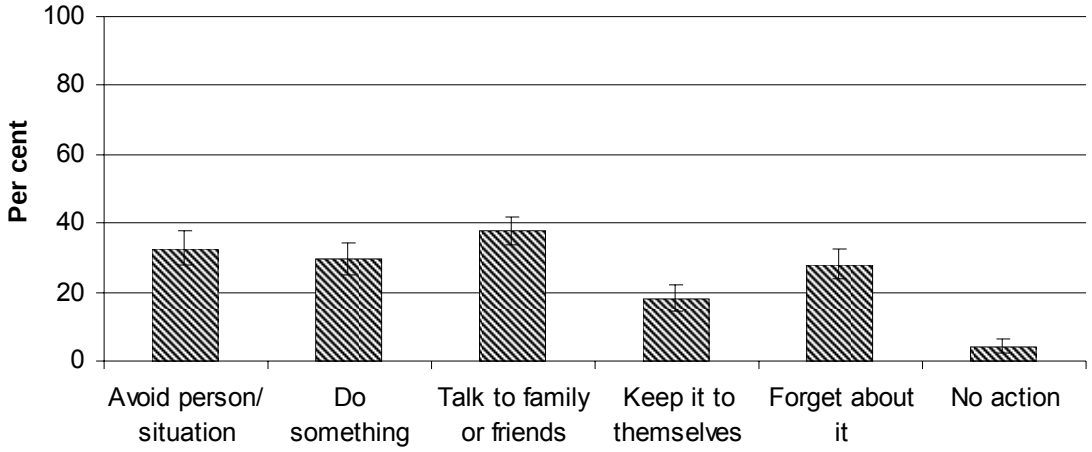


a Indigenous people aged 18 years and over who felt discriminated against in any situation. **b** Error bars represent 95 per cent confidence intervals around each estimate. **c** Components do not add to 100 per cent because people may have provided more than one response.

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

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

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

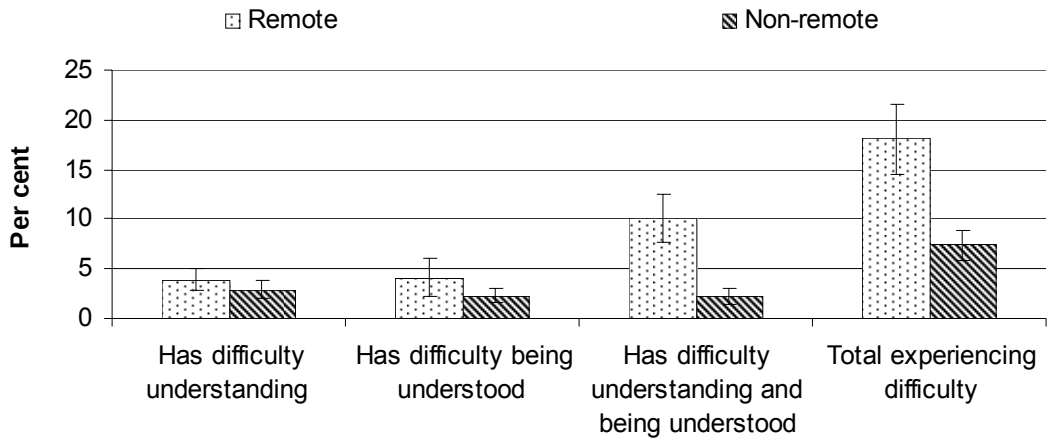


a Indigenous people aged 18 years and over. **b** Error bars represent 95 per cent confidence intervals around each estimate. **c** Components do not add to 100 per cent because people may have provided more than one response.

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

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

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



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

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

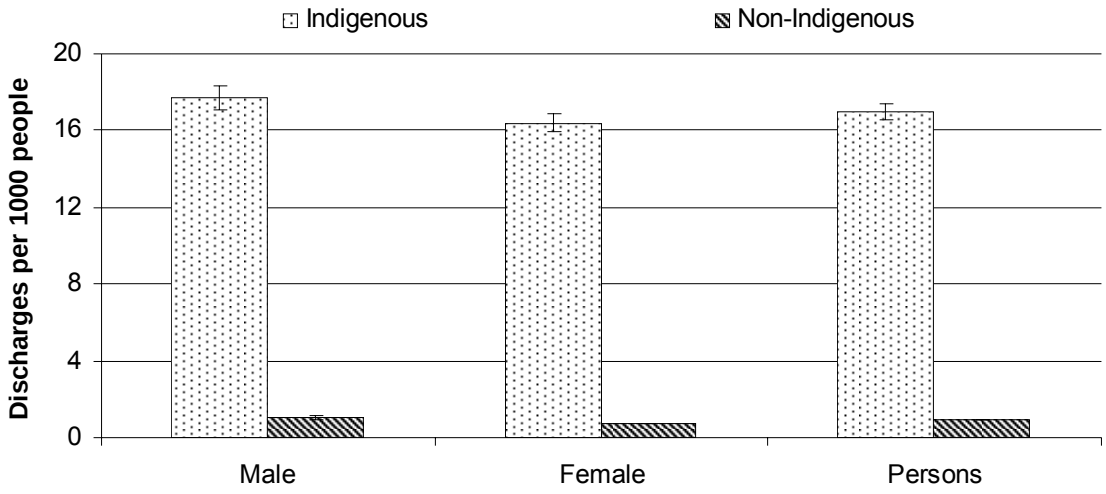
- Indigenous people living in remote areas in 2002 were more likely to report difficulty communicating with service providers (18.1 per cent) than Indigenous people living in non-remote areas (7.4 per cent) (figure 9.7.5).
- In 2002, Indigenous people living in remote areas were approximately five times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

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

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

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

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



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

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

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

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

Indigenous communities.[2] The 2006 CHINS collected data concerning 1187 discrete Indigenous communities with a combined reported population of 92 960[3] (ABS 2007). Some of the findings from the 2006 CHINS include:

Education

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

Health

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

Public transport to nearest town with major services

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

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

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

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

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

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

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

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

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

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

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

- The proportion of primary carers of Aboriginal children who reported being happy with access to community services and facilities[4] was, in most cases, significantly below that reported by carers of non-Aboriginal children in the 1993 WA CHS (Silburn et al. 2006).
- For primary carers of Aboriginal children, rates of reported satisfaction for services such as a place where teenagers can get together, after school or vacation care and child care facilities were all at or below 30 per cent (Silburn et al. 2006).
- As the level of relative isolation[5] increased, the proportion of carers of Aboriginal children who were satisfied with access to a community or child health clinic increased. This pattern was not present among carers of non-Aboriginal children (Silburn et al. 2006).
- The levels of satisfaction with access to Aboriginal Medical Services increased as the level of relative isolation increased (Silburn et al. 2006).

Case studies on service engagement

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

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

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

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

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

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

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

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

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

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

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

Box 9.7.3 **Health Education Unit — Jalaris Aboriginal Corporation**

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

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

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

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

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

Source: AIFS 2003.

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

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

(Continued next page)

Box 9.7.4 (continued)

ICAP encourages:

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

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

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

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

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

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

Source: Victorian Department of Human Services (unpublished).

Box 9.7.5 **Interpreter accreditation — Port Augusta**

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

Source: South Australian Government (unpublished).

Box 9.7.6 **Improvements to Medicare service access**

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

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

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

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

Some of the initiatives implemented since 1997 include:

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

(Continued next page)

Box 9.7.6 (continued)

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

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

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

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

Source: Urbis Keys Young 2006.

Box 9.7.7 **'Yarning about Mental Health'**

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

Source: Menzies School of Health Research 2006.

Box 9.7.8 **Pre-hospital care in remote Queensland communities**

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

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

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

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

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

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

Box 9.7.9 **Northern Territory Aboriginal Interpreter Service**

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

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

(Continued next page)

Box 9.7.9 (continued)

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

Source: NT Government (unpublished).

9.8 Future directions in data

Mental health

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

Proportion of Indigenous people with access to their traditional lands

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

Participation in organised sport, arts or community group activities

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

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

Engagement with service delivery

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

9.9 Attachment tables

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

9.1 Children on care and protection orders

Table 9A.1.1	Children aged 0–17 years on care and protection orders at 30 June
Table 9A.1.2	Children aged 0–17 years on care and protection orders at 30 June 2006
Table 9A.1.3	Children aged 0–17 years on care and protection orders at 30 June 2005
Table 9A.1.4	Children aged 0–17 years on care and protection orders at 30 June 2004

9.2 Repeat offending

9.3 Access to primary health care

Table 9A.3.1 Standardised hospitalisations for potentially preventable chronic conditions, per 100000 people, by Indigenous status, Queensland, WA, SA, and public hospitals in the NT, 2001-02, 2002-03

Table 9A.3.2 Standardised hospitalisations for potentially preventable chronic conditions, per 100000 people, by Indigenous status, Queensland, WA, SA, and public hospitals in NT, 2003-04, 2004-05

Table 9A.3.3 Standardised hospitalisations for type 2 diabetes mellitus as principal diagnosis by complication, per 100000 people, Queensland, WA, SA, and public hospitals in the NT, by Indigenous status, 2003-04, 2004-05

Table 9A.3.4 Standardised hospitalisations for potentially preventable acute conditions, per 100000 people, by Indigenous status, Queensland, WA, SA, and public hospitals in the NT, 2001-02, 2002-03

Table 9A.3.5 Standardised hospitalisations for potentially preventable acute conditions, per 100000 people, by Indigenous status, Queensland, WA, SA, and public hospitals in the NT, 2003-04, 2004-05

Table 9A.3.6 Standardised hospitalisations for vaccine preventable conditions, per 100000 people, by Indigenous status, Queensland, WA, SA, and public hospitals in the NT, 2001-02 to 2004-05

Table 9A.3.7 Standardised hospitalisations for infections with a predominantly sexual mode of transmission, per 100000 people, by Indigenous status, Queensland, WA, SA, and public hospitals in the NT

Table 9A.3.8 Health care services Indigenous people sought when they had a health problem, by remoteness, 2004–05

Table 9A.3.9 Time since last consulted GP/specialist, people aged 18 years and over, age standardised, by Indigenous status and remoteness, 2001, 2004-05

Table 9A.3.10 Time since last consulted dentist, people aged two years and over, age standardised, by Indigenous status and remoteness, 2001, 2004-05

Table 9A.3.11 Reasons for not going to a GP in the last 12 months, Indigenous people aged 18 years and over, by remoteness, 2004–05

Table 9A.3.12 Reasons for not going to a dentist in the last 12 months, Indigenous people

aged 18 years and over, by remoteness, 2004–05

Table 9A.3.13 Reasons for not going to other health professionals in the last 12 months, Indigenous people aged 18 years and over, by remoteness, 2004–05

9.4 Mental health

Table 9A.4.1 K5 level of psychological distress, people aged 18 years and over, by State and Territory, 2004-05

Table 9A.4.2 K5 level of psychological distress, people aged 18 years and over, by age groups, Australia, 2004–05

Table 9A.4.3 K5 level of psychological distress, people aged 18 years and over, age standardised, by remoteness areas, Australia, 2004–05

Table 9A.4.4 K5 level of current psychological distress, by reported stressor in the last 12 months, Indigenous people aged 18 years and over, 2004-05

Table 9A.4.5 K5 level of psychological distress, people aged 18 years and over, age standardised, Australia, 2004-05

Table 9A.4.6 How often physical health problems were the main cause of negative feelings in the last four weeks, Indigenous people aged 18 years and over, Australia, 2004-05

Table 9A.4.7 Whether had days unable to work/carry out normal activities due to negative feelings in last four weeks, Indigenous people aged 18 years and over, Australia, 2004-05

Table 9A.4.8 Number of days unable to work/carry out normal activities because of negative feelings in the last four weeks, Indigenous people aged 18 years and over, Australia, 2004-05

Table 9A.4.9 Selected indicators of psychological distress, people aged 18 years and over, age standardised, by State and Territory, 2004-05

Table 9A.4.10 Selected indicators of psychological distress, people aged 18 years and over, age standardised, by sex, Australia, 2004–05

Table 9A.4.11 Selected indicators of psychological distress, people aged 18 years and over, by age groups, Australia, 2004–05

Table 9A.4.12 Selected indicators of psychological distress, people aged 18 years and over,

9.7 Engagement with service delivery

Table 9A.7.1 Reasons for not going to a hospital in the last 12 months, Indigenous people aged 18 years and over, by remoteness, 2004–05

Table 9A.7.3 How Indigenous people felt after they had been discriminated against because of their Indigenous status, 2004-05

Table 9A.7.2 Indigenous people's perception of their treatment when seeking health care in the previous 12 months, compared to treatment of non-Indigenous people, 2004–05

Table 9A.7.4 What Indigenous people did after they had been discriminated against because of their Indigenous status, 2004–05

Table 9A.7.5 Communication with service providers, Indigenous persons aged 15 years or over, by sex, 2002

Table 9A.7.6 Communication with service providers, Indigenous persons aged 15 years or over, by State and Territory 2002

Table 9A.7.7 Communication with service providers, Indigenous persons by age, 2002

Table 9A.7.8 Discharges from hospital against medical advice, by Indigenous status and sex (excluding mental and behavioural disorders), Queensland, WA, SA and public hospitals in the NT, July 2002 to June 2004

9.10 References

9 Functional and resilient families and communities

ANCD (Australian National Council on Drugs) 2003, *Diversion of Aboriginal and Torres Strait Islander Youth from Juvenile Detention: A Report to the Australian National Council on Drugs*, Canberra.

AGD (Australian Government Attorney-General's Department) 2001, *Violence in Indigenous Communities*, Crime Prevention Branch, Canberra.

Royal Commission into Aboriginal Deaths in Custody 1991, *National Report*, http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/ (accessed 19 June 2003).

SHRG (Social Health Reference Group) 2003, *Consultation Paper for Development of the Aboriginal and Torres Strait Islander National Strategic Framework for Mental Health and Social and Emotional Well Being 2004–2009*, Commonwealth Department of Health and Ageing, Canberra.

9.1 Children on care and protection orders

AIHW (Australian Institute of Health and Welfare) 2006, *Child Protection Australia 2004-05*, Cat. no. CWS-24, Canberra.

NLRC (NSW Law Reform Commission) 1997, *The Aboriginal Child Placement Principle*, Research Report no. 7, Sydney.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2003, *Efficiency Measures for Child Protection and Support Pathways*, Reforms in Government Service Provision, Productivity Commission, Canberra.

9.2 Repeat offending

ABS (Australian Bureau of Statistics) 2006, *Prisoners in Australia*, Cat. no. 4517.0, ABS, Canberra.

Attorney General's Department of New South Wales 2005, *Circle Sentencing.* November Factsheet, NSW Crime Prevention Division, Sydney.

BOCSAR (Bureau of Crime Statistics and Research) 2005, *The Transition from Juvenile to Adult Criminal Careers*. Crime and Justice Bulletin no. 86, Sydney.

Borzycki, M., Baldry, E. 2003, *Promoting Integration: The Provision of Prisoner Post-Release Services*. Trends and Issues in Crime and Criminal Justice no. 262, Australian Institute of Criminology, Canberra.

Drabsch, T. 2006, *Reducing the Risk of Recidivism*. Briefing paper no. 15/06, NSW Parliamentary Library Research Service, Sydney.

Griffith University 2005, *Juvenile Offending Trajectories: Pathways from Child Maltreatment to Juvenile Offending and Police Cautioning in Queensland.* School of Criminology and Criminal Justice, Brisbane.

OCSAR (Office for Crime Statistics and Research) 2005, *Young People Born in 1984: Offending Behaviour of Juveniles Apprehended at Least Once*. Government of South Australia, Adelaide.

Potas, I., Smart, J., Brignell, G., Thomas, B., Lawrie, R. and Clarke, R. 2003, *Circle Sentencing in New South Wales: A Review and Evaluation*. Judicial Commission of New South Wales, Sydney.

Standing Committee on Law and Justice 1999, *Crime Prevention through Social Support, First Report*, Report no. 12, Legislative Council, Parliament of NSW, Sydney.

—— 2000, *Crime Prevention through Social Support, Second Report*, Report no. 14, Legislative Council, Parliament of NSW, Sydney.

University of Western Australia 2004, *Pathways through Justice: A Statistical Analysis of Offender Contact with the WA Juvenile Justice System*. Crime Research Centre, Perth.

Woodward, R. 2003, *Families of Prisoners: Literature Review on Issues and Difficulties*, Occasional Paper no. 10, Australian Government Department of Family and Community Services, Canberra.

9.3 Access to primary health care

Australian Health Ministers' Advisory Council 2006, *Aboriginal and Torres Strait Islander Health Performance Framework*, Department of Health and Ageing, Canberra.

ABS (Australian Bureau of Statistics) 2002, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia 2001*, Cat no. 4710.0, Canberra.

—— 2006, *National Aboriginal and Torres Strait Islander Health Survey 2004-05*, Cat no. 4715.0, Canberra.

ABS and AIHW 2003, *Health and Community Services Labour Force, 2001*, National Health Labour Forces Series No. 27, AIHW Cat. no. HWL-27, ABS Cat. no. 8936.0, Canberra.

—— 2005, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, AIHW Cat. no. IHW14, Cat no. 4704.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2005a, *Expenditures on Health for Aboriginal and Torres Strait Islander Peoples 2001-02*, Cat. no. HWE 23, AIHW Australian Department of Health and Aged Care, AIHW, Canberra.

—— 2005b, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Cat. no. HSE 101, Canberra.

Cutcliffe, T. 2004, *Take it or Leave it*, Eureka Project, Melbourne.

Marie Stopes International Australia 2005, *Condom Social Marketing Initiative*, http://www.mariestopes.org.au/country-aust-proj2.html (accessed 29 March 2007)

9.4 Mental health

ABS (Australian Bureau of Statistics) 1998, *Mental Health and Wellbeing: Profile of Adults, Australia, 1997*, Cat. no. 4326.0, Canberra.

—— 2006, *National Aboriginal and Torres Strait Islander Health Survey: Users' Guide*, Cat. no. 4715.0, Canberra.

AHMAC (Australian Health Ministers' Advisory Council) 2004, *National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009*, South Australia.

AMA (Australian Medical Association) 2006, *Undue Punishment? Aboriginal and Torres Strait Islanders in Prison: An Unacceptable Reality*, AMA Report Card, Canberra.

AIHW (Australian Institute of Health and Welfare) 2001, *A Prisoner Health Information System*, Cat. no. PHE 32, Canberra.

—— 2004, *Juvenile Justice: A New National collection*, AIHW Cat. no. AUS 52, Canberra.

—— 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Cat. no. HSE 101, Canberra.

—— 2006, *Towards a National Prisoner Health Information System*, Cat. no. PHE 79, Canberra.

Australian Health Ministers 1991, *Mental Health Statement of Rights and Responsibilities*, Canberra.

Blair, E., Zubrick, S. and Cox, A. 2005, 'The Western Australian Aboriginal Child Health Survey: findings to date on adolescents', *The Medical Journal of Australia*, vol. 183, no. 8, pp. 433–435.

BMA (British Medical Association) 2006, *Child and Adolescent Mental Health: A Guide for Healthcare Professionals*, United Kingdom.

Brooke, D., Taylor, C., Gunn, J. and Maden, A. 1996, 'Point prevalence of mental disorder in unconvicted male prisoners in England and Wales', *British Medical Journal*, vol. 313, pp. 1524–1527.

Butler, T. 1997, *Preliminary Findings of the New South Wales Inmate Health Survey*, Corrections Health Service, Sydney.

—— and Allnutt, S. 2003, *Mental Illness Among New South Wales' Prisoners*, Corrections Health Service, Sydney.

—— and Milner, L. 2003, *The 2001 New South Wales Inmate Health Survey*, Corrections Health Service, Sydney.

DHA (Department of Health and Ageing) 2002, *National Mental Health Report 2002*, Australian Government, Canberra.

DHAC (Australian Government Department of Health and Aged Care) and AIHW (Australian Institute of Health and Welfare) 1999, *National Health Priority Areas Report: Mental Health 1998*, AIHW Cat. no. PHE 13, Canberra.

Fazel, S. and Danesh, J. 2002, 'Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys', *The Lancet*, vol. 359, pp. 545–550.

Fasher, A.M., Dunbar, M., Rothenbury, B.A., Bebb, D.K. and Young S.J.W. 1997, 'The health of a group of young Australians in a New South Wales juvenile justice detention centre: a pilot study', *Journal of Paediatrics and Child Health*, vol. 33, pp. 426–442.

Harris, E.C. and Barraclough, B. 1997, 'Suicide as an outcome for mental disorders: a meta-analysis', *The British Journal of Psychiatry*, vol 170, pp. 205–28.

Hobbs, M., Krazlan, K., Ridout, S., Mai, Q., Knuiman, M. and Chapman, R. 2006, *Mortality and Morbidity in Prisoners After Release from Prison in Western Australia 1995–2003*, Trends and Issues in Crime and Criminal Justice, No. 320, Australian Institute of Criminology, Canberra.

Hockings, B.A., Young, M., Falconer, A. and O'Rourke, P.K. 2002, *Queensland Women Prisoners' Health Survey*, Department of Corrective Services, Brisbane.

James, M. 2004, Strategies to Support Indigenous Young People, *Australian Prospect*, http://www.australianprospect.com.au (accessed on 29 April 2004).

Kenny, D.T., Nelson, P., Butler, T., Lennings, C., Allerton, M., and Champion, U. 2006, *NSW Young People on Community Orders Health Survey 2003-2006: Key Findings Report*, The University of Sydney, Sydney.

Kessler, C. 2002, 'Need for attention to mental health of young offenders: commentary', *The Lancet*, vol. 359, pp. 1965–7.

Moscicki, E.K. 1997, 'Identification of suicide risk factors using epidemiologic studies', *Psychiatric Clinics of North America*, vol. 20, no. 3, pp. 499–517.

NATSIHC (National Aboriginal and Torres Strait Islander Health Council) 2003, *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, Australian Health Ministers' Advisory Council, Canberra.

—— 2004, *National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009*, Australian Health Ministers' Advisory Council, Canberra.

NSW Department of Juvenile Justice 2003, *NSW Young People in Custody Health Survey. Key Findings Report, 2003*, NSW.

Procter, N. 2005, 'Parasuicide, self-harm and suicide in Aboriginal people in rural Australia: a review of the literature with implications for mental health nursing practice', *International Journal of Nursing Practice*, vol. 11, no. 5, pp. 237–241.

Rajkumar, S. and Hoolahan, B. 2004, 'Remoteness and issues in mental health care: experience from rural Australia', *Epidemiologia e Psichiatria Sociale*, vol. 13, no. 2, pp. 78–82.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2007, *Report on Consultations*, Productivity Commission, Canberra.

Select Committee on Substance Abuse in the Community 2004, *Petrol Sniffing in Remote Northern Territory Communities*, Legislative Assembly of the Northern Territory, Darwin.

Siegel, N. 2003, The interaction between petrol sniffers and bush court in Aboriginal communities, paper presented at the Inhalant Use and Disorder Conference convened by the Australian Institute of Criminology, Townsville, 7–8 July.

Silburn, S.R. 2006, The inter-generational effects of forced separation on the social and emotional wellbeing of Aboriginal children and young people, AIFS Seminar Presentation, Melbourne, 25 May.

Silburn, S.R., Zubrick, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Mitrou, F.G., Dalby, R.B., Hayward, C. and Pearson, G. 2006, *The Western Australian Aboriginal Child Health Survey: Strengthening the Capacity of Aboriginal Children, Families and Communities*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

Swan, P. and Raphael, B. 1995, *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*, Australian Government Publishing Service, Canberra.

Tsey, K., Whiteside, M., Daly, S., Deemal, A., Gibson, T., Cadet-James, Y., Wilson, A., Santhanam, R. and Haswell-Elkins, M. 2005, 'Adapting the "Family Wellbeing" empowerment program to the needs of remote Indigenous school children', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 2, pp. 112–116.

Vermeiren, R. 2003, 'Psychopathology and delinquency in adolescents: a descriptive and developmental perspective', *Clinical Psychology Review*, vol. 23 no. 2, pp. 277–318.

Victorian Department of Justice 2003, *Victorian Prisoner Health Study*, Department of Justice, Melbourne.

Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J., Milroy, H., De Maio, J.A., Cox, A. and Li, J. 2005, *The*

Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

9.5 Proportion of Indigenous people with access to their traditional lands

SCRGSP (Steering Committee for the Review of Government Service Provision) 2005, *Overcoming Indigenous Disadvantage: Key Indicators 2005*, Productivity Commission, Melbourne.

9.6 Participation in organised sport, arts or community group activities

ABS (Australian Bureau of Statistics) 2004, *National Aboriginal and Torres Strait Islander Social Survey 2002*, Cat. no 4714.0, Canberra.

—— 2006, *Aboriginal and Torres Strait Islander Australians: Involvement in Arts and Culture*, Cat. no 4721.0, Canberra.

ACF (Administration for Children and Families) 2002, *Early Head Start Benefits Children and Families: Research Brief*, ACF, United States Department of Health and Human Services, Washington, D.C., June.

Athletics Australia 2006, *Athletics for the outback*, Media release, http://www.athletics.com.au (accessed June 2006).

Australian Prospect 2006, 'More than a sporting club', *Australian Prospect*, Summer, pp. 1–15.

Barber, B.L., Eccles, J.S. and Stone, M.R. 2001, 'Whatever happened to the jock, the brain, and the princess?: Young adult pathways linked to adolescent activity involvement and social identity', *Journal of Adolescent Research*, vol. 16, no. 5, September.

Bush, L., McHale, J., Vinden, P., Richer, D., Shaw, D. and Smith, B. 2001, 'Functions of sport for urban middle school children', paper presented at the American Psychological Association's 109th Annual Conference, San Francisco, California, 25 August.

Cameron, M. and MacDougall, C. 2001, *Crime Prevention Through Sport and Physical Activity*, Trends and Issues in Crime and Criminal Justice, no. 165, Australian Institute of Criminology, September.

Carinduff, S. 2001, *Sport and Recreation for Indigenous Youth in the Northern Territory*, Cooperative Research Centre for Aboriginal and Tropical Health and the Australian Sports Commission.

Daly, A.E. 2001, *Implications of Developments in Telecommunications for Indigenous People in Remote and Rural Australia*, Centre for Aboriginal Economic Policy Research, Discussion Paper no. 219, Canberra.

DCITA (Department of Communications, Information Technology and the Arts) 2005, *Indigenous Television Review Report*, Canberra.

Mason, G. and Wilson, P. 1988, *Sport, Recreation and Juvenile Crime*, Australian Institute of Criminology, Canberra.

Nelson, E. 2006, 'Funds to flow for increased Indigenous television broadcasting', *Data Communications Magazine*, May, p. 9.

Productivity Commission 2000, *Broadcasting*, Report no. 11, Canberra.

Silburn, S.R., Zubrick, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Mitrou, F.G., Dalby, R.B., Hayward, C. and Pearson, G. 2006, *The Western Australian Aboriginal Child Health Survey: Strengthening the Capacity of Aboriginal Children, Families and Communities*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

UNICEF (United Nations Children's Fund) 2004, *Sport, Recreation and Play* United Nations Children's Fund Division of Communication, New York, August.

University of Melbourne 2006, 'Community benefits from University partnerships', *Goulburn Valley Uni News*, vol. 3, no. 1, Melbourne, http://uninews.unimelb.edu.au/articleid_3393.html (accessed 26 February 2007).

Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J., Milroy, H., De Maio, J.A., Cox, A. and Li, J. 2005, *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

9.7 Engagement with service delivery

ABS (Australian Bureau of Statistics) 2002, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia 2001*, Cat no. 4710.0, Canberra.

—— 2004, *National Aboriginal and Torres Strait Islander Social Survey 2002*, Cat. No. 4714.0, Canberra.

—— 2007, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia 2001*, Cat no. 4710.0, Canberra.

AIFS (Australian Institute of Family Studies) 2003, *Building Strong and Healthy Families in Derby*, Stronger Families Fund Learning Exchange Bulletin, no. 3, Winter, pp. 24–28.

Byrne, J. 2003, *Indigenous Witnesses and the Native Title Act 1993 (Cth)*, National Native Title Tribunal Occasional Papers Series no. 2/2003, National Native Title Tribunal, Perth.

Cass, A., Lowell, A., Christie, M., Snelling, P. L., Flack, M., Marrnganyin, B. and Brown, I. 2002, 'Sharing the True Stories: Improving communication between Aboriginal patients and healthcare workers', *Medical Journal of Australia*, vol. 176, pp. 466–470.

CGC (Commonwealth Grants Commission) 2001, *Report on Indigenous Funding 2001*, Canberra.

Cooke, M. 2002, *Indigenous Interpreting Issues for Courts*, Australian Institute of Judicial Administration Incorporated, Melbourne.

Coulehan, K., Brown, I., Christie, M., Gorham, G., Lowell, A., Marrŋanyin, and Patel, B., 2005, *Sharing the True Stories: Improving Communication between Health Staff and Aboriginal Patients*, Final Project Report, Cooperative Research Centre for Aboriginal Health, Darwin.

Craze, L. and Lucas, S. 1998, *The Establishment of a Pre-Hospital Care Model for Isolated Aboriginal and Torres Strait Islander Communities — Project Report*, Queensland Ambulance Service, Brisbane.

Eades, D. 1997, 'Language in court: the acceptance of linguistic evidence about Indigenous Australians in the criminal justice system', *Australian Aboriginal Studies*, vol. 1, pp. 15–27.

Koch, H. 1985, 'Non-standard English in an Aboriginal land claim', in Pride, J.B. (ed), *Cross Cultural Encounters: Communication and Mis-Communication*, River Seine Publications, Melbourne.

Lowell, A. and Devlin, B. 1998, 'Miscommunication between Aboriginal students and their non-Aboriginal teachers in a bilingual school', *Language, Culture and Curriculum*, vol. 11, no. 3, pp. 67–89.

Lowell, A., Brown, I., Marrŋanyin, B., Flack, M., Christie, M., Snelling, P. and Cass, A., 2005, *Sharing the True Stories: Improving Communication between Health Staff and Aboriginal Patients*, Stage 1, Interim Project Report, Cooperative Research Centre for Aboriginal Health, Darwin.

Malcolm, I. 1982, 'Speech events of the Aboriginal classroom', *International Journal of the Sociology of Language*, vol. 36, pp. 115–34.

Menzies School of Health Research 2006, *'Yarning about Mental Health' during International Mental Health Week*, Media release, NT, 11 October.

Morgan Disney & Associates Pty. Ltd, Tracey Whetnall Consulting and Wis-Wei Consulting Pty Ltd 2007, *Synopsis Review of the COAG Trial Evaluations, Report to the Office of Indigenous Policy Coordination (OIPC) November 2006*, Canberra, http://oipc.gov.au/publications/default.asp.

Siegel, N. 2002, Bush Court: administering criminal court process and corrective services in remote Aboriginal communities, paper presented at the Crime Prevention Conference convened by the Australian Institute of Criminology and the Crime Prevention Branch, Commonwealth Attorney-General's Department, Sydney, 12–13 September.

Silburn, S.R., Zubrick, S.R., De Maio, J.A., Shepherd, C., Griffin, J.A., Mitrou, F.G., Dalby, R.B., Hayward, C. and Pearson, G. 2006, *The Western Australian Aboriginal Child Health Survey: Strengthening the Capacity of Aboriginal Children, Families and Communities*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

SCRGSP (Steering Committee for the Review of Government Service Provision 2007, *Framework for Reporting on Indigenous Disadvantage (Report on Consultations 2006)*, Productivity Commission, Melbourne.

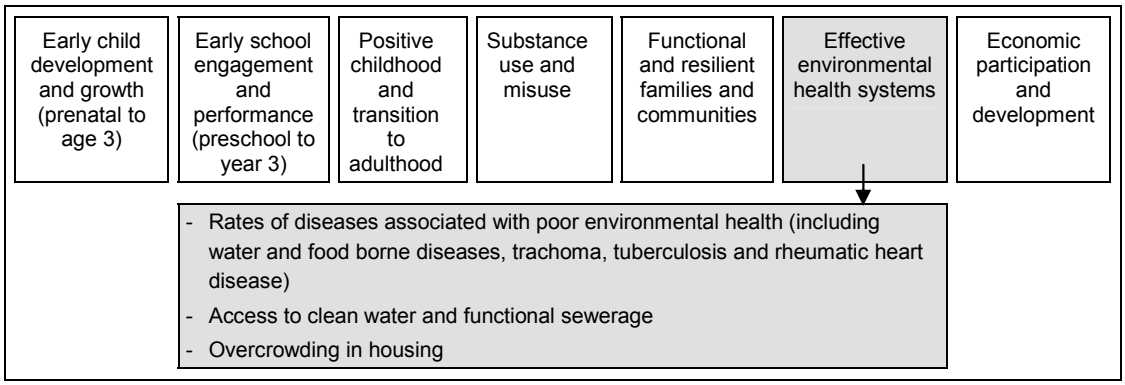
Trudgen, J. 2000, *Why Warriors Lie Down and Die: Towards an Understanding of Why the Aboriginal People of Arnhem Land Face the Greatest Crisis in Health and Education since European Contact : Djambatj Mala*, Aboriginal Resource and Development Services, Darwin.

Urbis Keys Young 2006, *Aboriginal and Torres Strait Islander Access to Major Health Programs*, Medicare Australia and the Department of Health and Ageing, Canberra.

Zubrick, S.R., Silburn, S.R., Lawrence, D.M., Mitrou, F.G., Dalby, R.B., Blair, E.M., Griffin, J., Milroy, H., De Maio, J.A., Cox, A. and Li, J. 2005, *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

10 Effective environmental health systems

Strategic areas for action



A wide range of factors influence people's health and wellbeing. This section covers some of the key environmental influences on health, such as access to clean water, functional sewerage and appropriate housing conditions. These factors are sometimes referred to as 'health hardware' (DFACS 2003), and were identified, along with food supplies, as the key determinants of Indigenous ill health in the National Environmental Health Strategy (DHAC 1999). Many other environmental factors also influence health; for example, air quality, noise pollution, occupational health, food quality and pest control.

Some of the diseases that tend to have environmental causes are tuberculosis, rheumatic heart disease, respiratory diseases, urinary tract infections, kidney stones, intestinal worms, trachoma and intestinal infectious diseases (DHAC 1999; Pholeros, Rainow and Torzillo 1993). Social and biological factors also play a role (for example, vaccination against influenza, and nutrition and diabetes for general immunity to bacterial infections). Data on environment related diseases are examined in section 10.1.

A clean, sufficient and reliable supply of water is needed for drinking, hygienic food preparation and washing of people, clothes and bedding. Functional sewerage systems ensure that sewage does not contaminate drinking water supplies and is disposed of appropriately to prevent contact with people. Access to clean water and functional sewerage requires a combination of both functioning community

infrastructure as well as functioning household hardware such as taps, tubs and toilets. Section 10.2 contains information on access to clean water and functional sewerage.

Overcrowding in housing can have negative consequences not only for health, but also for education and family relationships. During consultations on the indicator framework for this Report, many Indigenous people spoke of the effect that overcrowding has on children's education and how it can contribute to family violence. Overcrowded houses are harder to keep clean and may suffer more wear and tear. With large numbers of people in a house, the bathroom, kitchen and laundry facilities may be inadequate for people to wash themselves, their food and kitchen utensils, and clothes and bedding as often as they would like. Washing and cleaning helps to prevent the spread of infectious diseases (see section 10.2). Section 10.3 contains information on overcrowding.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3.3). A list of attachment tables is in section 10.5. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

10.1 Rates of diseases associated with poor environmental health

Box 10.1.1 **Key messages**

- Indigenous people had higher hospitalisation rates than non-Indigenous people for all diseases associated with poor environmental health (table 10.1.1).
- Between 2001-02 and 2004-05, hospitalisation rates for the 0–14 age group decreased for intestinal infectious diseases (24.5 per cent decrease), scabies (32.0 per cent decrease), acute upper respiratory infections (14.3 per cent decrease), and influenza and pneumonia (31.0 per cent decrease) (figure 10.1.3).
- Between 2001-02 and 2004-05, hospitalisation rates for older Indigenous people (65 years and over) increased for bacterial disease (9.9 per cent increase), influenza and pneumonia (31.8 per cent increase) and acute upper respiratory infections (16.6 per cent increase) (table 10A.1.2).
- In the four jurisdictions for which data are available, death rates from diseases associated with poor environmental health were much higher for Indigenous people (between 112.7 and 230.4 deaths per 100 000) than for non-Indigenous people (between 25.1 and 39.6 deaths per 100 000) (table 14A.1.4).

During the late 1800s and early 1900s, most public health efforts focused on the control of infectious diseases, particularly epidemics. Improvements in sanitation, drinking water quality, food safety, disease control and housing conditions resulted in big improvements to public health and longevity for most Australians (DHAC 1999).

However, many rural and remote Indigenous communities still struggle to achieve the basic level of environmental health that has been achieved for the rest of the population (DHAC 1999). Hospitalisation data indicate that diseases associated with poor environmental health are much more common among Indigenous people than non-Indigenous people (table 10.1.1). For example, some diseases, like trachoma, acute rheumatic fever and scabies continue to exist in Indigenous communities with very few occurrences evident in hospitalisations data for the non-Indigenous population.

The data used in this section are for hospitalisations, defined by the AIHW as discharges, transfers, deaths or changes in care type. Hospitalisations data reflect more serious cases of diseases, but do not necessarily show overall incidence of disease. Many people may not go to a hospital for all treatments. In addition, a patient in a remote area may be admitted to hospital whereas in an urban area the same patient could be managed as an outpatient. Hospital data can also include

some duplication, as patients can have multiple admissions for some chronic conditions, as well as changes in conditions (such as transfer from a medical ward to a rehabilitation centre within a hospital) (AIHW 2004).

Table 10.1.1 Age standardised hospitalisation rates (per 10 000) for selected types of diseases associated with poor environmental health, by Indigenous status, Queensland, WA, SA, and public hospitals in the NT, 2004-05[a, b, c]

	Indigenous			*Non-Indigenous*[d]			*Total Australians*		
ICD-10-AM diagnosis codes and descriptions	Males	Females	Total	Males	Females	Total	Males	Females	Total
Intestinal infectious diseases (A00–A09)	58.6	61.0	60.3	20.5	21.8	21.1	22.9	23.9	23.4
Tuberculosis (A15–A19)	6.4	1.5	3.7	0.5	0.3	0.4	0.6	0.4	0.5
Bacterial disease (A20–A49)	85.8	91.8	89.2	23.7	16.0	19.6	25.1	17.8	21.2
Diphtheria (A36)	0.5	0.2	0.4	–	–	–	–	–	–
Whooping cough (A37)	1.7	1.2	1.4	0.3	0.4	0.4	0.4	0.5	0.4
Meningococcal infection (A39)	0.4	0.6	0.5	0.2	0.2	0.2	0.3	0.2	0.2
Trachoma (A71)	–	0.6	0.4	–	–	–	–	–	–
Acute hepatitis A (B15)	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Acute hepatitis B (B16)	1.0	1.4	1.2	0.2	0.1	0.1	0.2	0.2	0.2
Scabies (B86)	35.1	41.0	38.1	0.3	0.2	0.2	1.5	1.7	1.6
Acute rheumatic fever (I00–I02)	2.0	3.9	3.0	0.1	–	–	0.2	0.2	0.2
Chronic rheumatic heart diseases (I05–I09)	4.1	8.0	6.1	1.0	1.2	1.1	1.2	1.5	1.3
Acute upper respiratory infections (J00–J06)	26.8	40.9	34.8	17.8	15.6	16.7	18.3	16.4	17.4
Influenza and pneumonia (J10–J18)	171.8	152.9	161.3	32.0	25.0	28.1	35.6	28.7	31.7

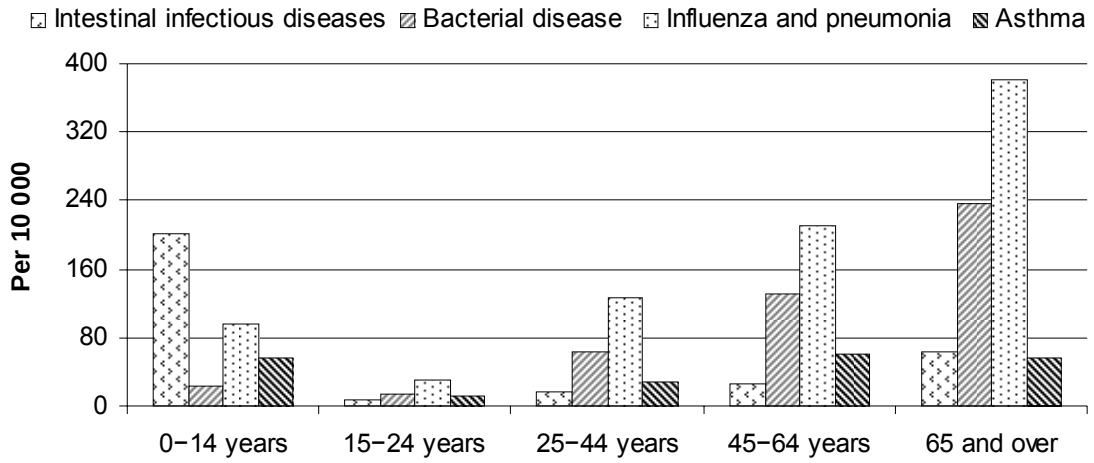
[a] Any diagnosis was used to select the infectious diseases (ICD-10-AM codes A00–B99), principal diagnosis was used to select the other conditions. [b] Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information). [c] Data are based on state of usual residence. [d] Non-Indigenous includes hospitalisations identified as not Indigenous as well as those with a 'not stated' Indigenous status. – Nil or rounded to zero.

Source: AIHW National Hospital Morbidity Database (unpublished); table 10A.1.1

After adjusting for age differences in the Indigenous and non-Indigenous populations, in those jurisdictions for which data were available, in 2004-05:

- Hospitalisation rates for all diseases associated with poor environmental health were higher for Indigenous than non-Indigenous people (table 10.1.1).
- The hospitalisation rate for influenza and pneumonia was 161.3 per 10 000 for Indigenous people — 5.7 times higher than for non-Indigenous people (28.1 per 10 000) (table 10.1.1).
- The hospitalisation rate for bacterial disease was 89.2 per 10 000 for Indigenous people — 4.5 times as high as the hospitalisation rate for the non-Indigenous population (19.6 per 10 000).
- The hospitalisation rate for intestinal infectious diseases for Indigenous people was almost three times the rate for non-Indigenous people — 60.3 per 10 000 compared with 21.1 per 10 000 for the non-Indigenous population.
- The biggest rate of difference recorded in hospitalisations between Indigenous and non-Indigenous people was for scabies. Indigenous people were 190 times more likely to present with scabies (38.1 per 10 000) than non-Indigenous people (0.2 per 10 000).
- Indigenous people also had much higher hospitalisation rates for chronic rheumatic heart diseases (6.1 per 10 000 compared with 1.1 per 10 000). Acute rheumatic fever appears to be a problem only in the Indigenous population (3.0 per 10 000 people) with almost no occurrences evident in hospitalisations data for non-Indigenous people.
- Acute upper respiratory infections were a problem for both the Indigenous and non-Indigenous populations, however, they were more prevalent for Indigenous people, where the hospitalisation rate was more than double that for non-Indigenous people (34.8 per 10 000 compared with 16.7 per 10 000).

Figure 10.1.1 **Hospitalisation rates for selected diseases associated with poor environmental health, Indigenous people, by age group, Queensland, WA, SA, and public hospitals in the NT, 2004-05[a, b]**



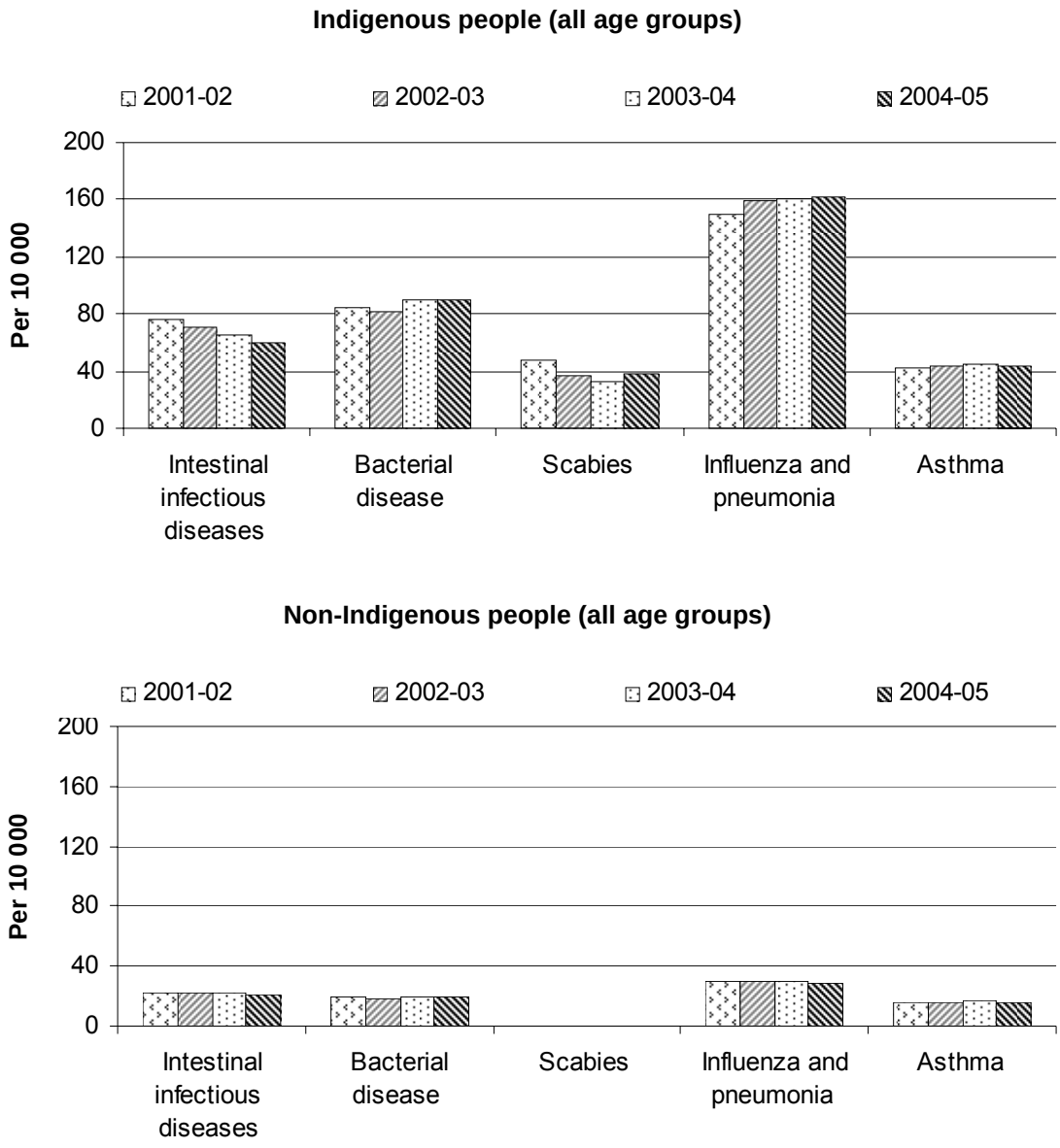
[a] Any diagnosis was used to select the infectious diseases (ICD-10-AM codes A00-B99), principal diagnosis was used to select the other conditions. [b] Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information).

Source: AIHW National Hospital Morbidity Database (unpublished); table 10A.1.1.

In those jurisdictions for which data were available:

- For the most common infectious diseases associated with poor environmental health, Indigenous children (0–14 years) and the elderly (65 years and over) had higher hospitalisation rates than other age groups in 2004-05 (figure 10.1.1). These age groups were also the most at risk in the non-Indigenous population (table 10A.1.1).
- Indigenous children had high rates of intestinal infectious diseases (200.6 per 10 000) compared to the older age groups in 2004-05 (figure 10.1.1).
- For older Indigenous people, influenza and pneumonia were most prevalent (381.2 per 10 000), followed by bacterial diseases (235.2 per 10 000) in 2004-05 (figure 10.1.1).
- While the hospitalisation rates for asthma were higher for the very young and the old, admissions for this cause was more even across age groups in 2004-05.

Figure 10.1.2 **Age standardised hospitalisation rates for selected diseases associated with poor environmental health, Queensland, WA, SA, and public hospitals in the NT[a, b]**



a Any diagnosis was used to select the infectious diseases (ICD-10-AM codes A00-B99), principal diagnosis was used to select the other conditions. **b** Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information).

Source: AIHW National Hospital Morbidity Database (unpublished); table 10A.1.2.

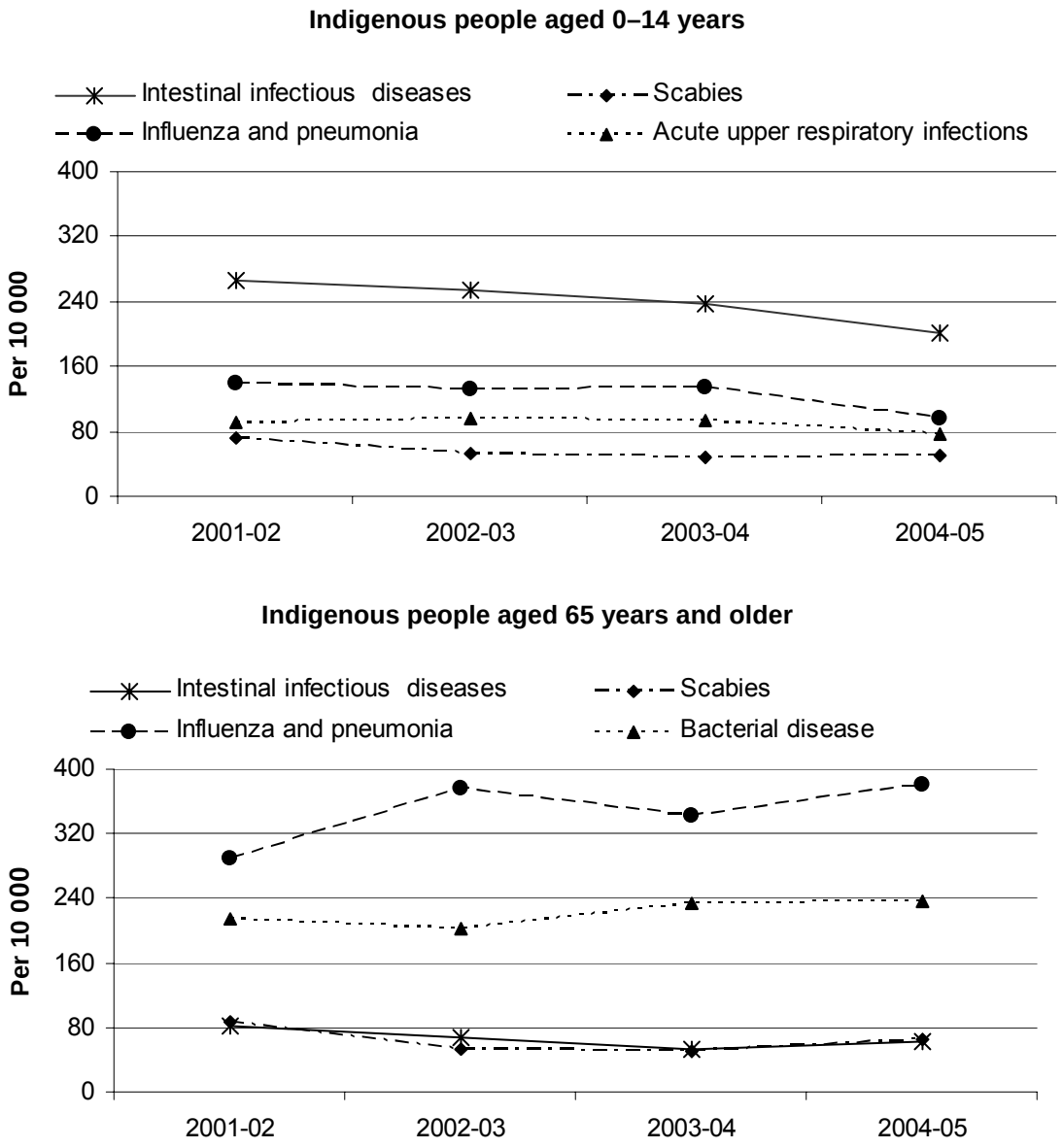
In those jurisdictions for which data were available:

- Figure 10.1.2 shows that hospitalisation rates for selected diseases associated with poor environmental health were much higher for Indigenous people than

non-Indigenous people between 2001-02 and 2004-05. Over time, the fluctuation in rates of the most common environmentally based diseases has been greater for Indigenous than non-Indigenous people. This may reflect the smaller size of the Indigenous population, where relatively small changes in the number of cases can make rates fluctuate more widely.

- Between 2001-02 and 2004-05, there was a decrease in hospitalisations for intestinal infectious diseases (21.2 per cent decrease) and scabies (19.9 per cent decrease) for Indigenous people.
- The number of Indigenous hospitalisations increased for bacterial diseases (6.3 per cent increase) and for influenza and pneumonia (7.8 per cent increase).
- Rates of acute upper respiratory infections and asthma remained steady between 2001-02 and 2004-05 for both Indigenous and non-Indigenous people, though the rates of disease were considerably higher for Indigenous people (table 10A.1.2).

Figure 10.1.3 **Hospitalisation rates for selected diseases associated with poor environmental health, vulnerable age groups of Indigenous people, Queensland, WA, SA, and public hospitals in the NT[a, b]**



a Any diagnosis was used to select the infectious diseases (ICD-10-AM (3rd edition) codes A00-B99), principal diagnosis was used to select the other conditions. **b** Identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of Indigenous under-identification (see chapter 2 and appendix 4 for more information).

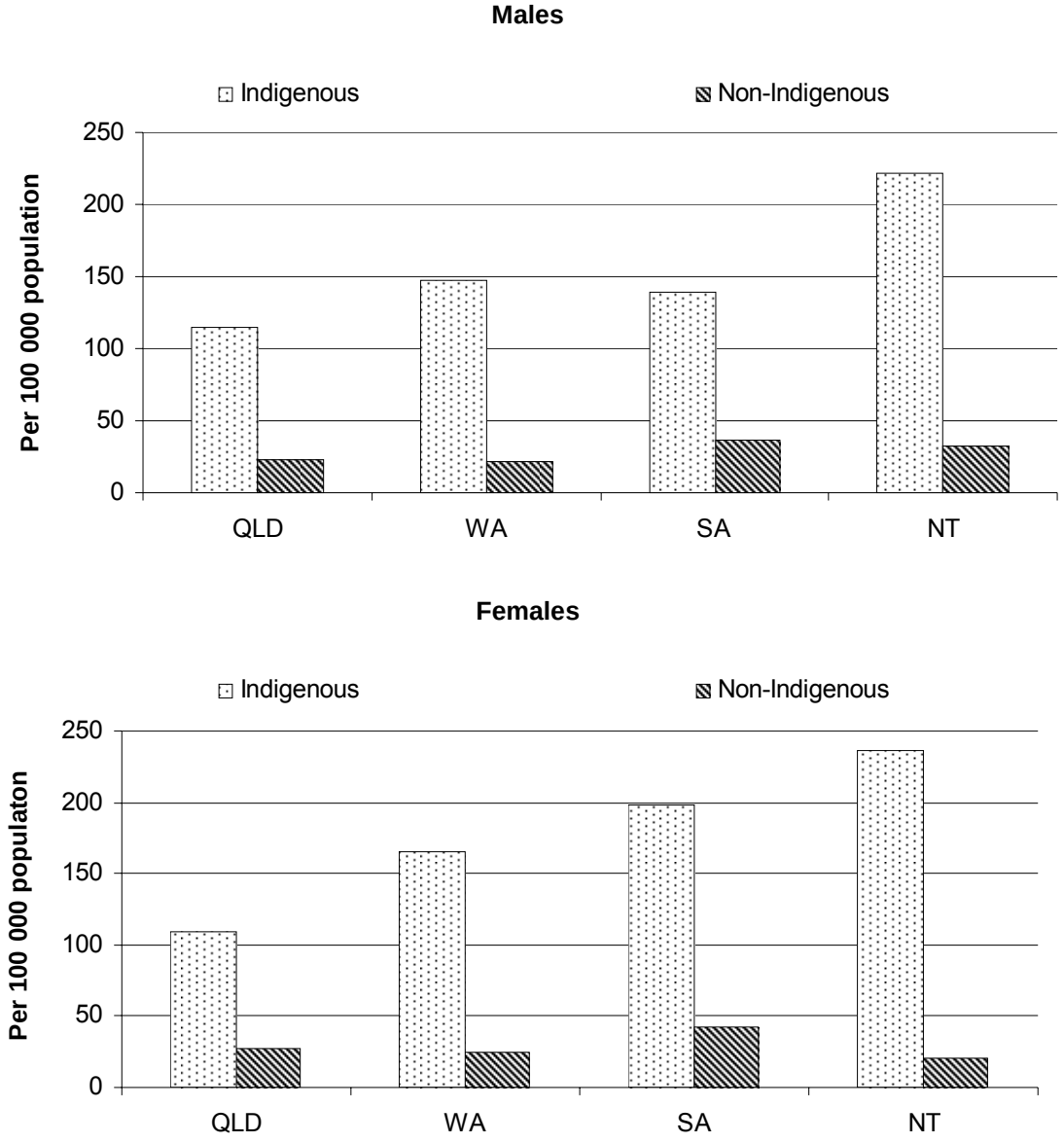
Source: AIHW National Hospital Morbidity Database (unpublished); table 10A.1.2.

In those jurisdictions for which data were available:

- Figure 10.1.3 shows hospitalisation rates for the four most commonly occurring diseases associated with poor environmental health for the two most vulnerable Indigenous age groups (0–14, and 65 and older) between 2001-02 and 2004-05.
- For the 0–14 age group, hospitalisation rates decreased for intestinal infectious diseases (24.5 per cent decrease), scabies (32.0 per cent decrease), acute upper respiratory infections (14.3 per cent decrease), and influenza and pneumonia (31.0 per cent decrease).
- Indigenous children (0–14 years) also showed a 10.7 per cent decrease in hospitalisation rates for bacterial disease, but hospitalisation rates for asthma increased by 6.2 per cent between 2001-02 and 2004-05 (table 10A.1.2).
- Older Indigenous people (65 years and over) showed increased hospitalisation rates for bacterial disease (9.9 per cent increase), influenza and pneumonia (31.8 per cent increase) and acute upper respiratory infections (16.6 per cent increase) between 2001-02 and 2004-05 (table 10A.1.2).
- The 65 years and over age group had decreased hospitalisation rates for intestinal infectious diseases (22.6 per cent decrease), scabies (26.8 per cent decrease) and asthma (17.5 per cent decrease) (table 10A.1.2).

Between 2001-02 and 2004-05, Indigenous males had higher rates of influenza and pneumonia than women. However, as hospitalisation rates for these diseases increased during the period for Indigenous women, the difference between the sexes diminished. Rates of bacterial diseases and scabies have fluctuated over time between the sexes. Men and women suffered roughly similar rates of intestinal infectious diseases between 2001-02 and 2004-05 (table 10A.1.3).

Figure 10.1.4 **Death rates from diseases associated with poor environmental health, age standardised, 2001–2005**[a, b, c]



a Care should be exercised when using these data as the rates are based on a small number of deaths. **b** Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. **c** Data are subject to a degree of uncertainty and apparent differences in mortality estimates between jurisdictions may not be statistically significant.

Source: ABS Causes of Deaths 2005, Cat. no. 3303.0 (unpublished); table 10A.1.4.

In those jurisdictions for which data were available:

- Death rates from diseases associated with poor environmental health were much higher for Indigenous people (between 112.7 and 230.4 deaths per 100 000) than for non-Indigenous people (between 25.1 to 39.6 deaths per 100 000) (table 14A.1.4).
- Taking into account the different age structures of the Indigenous and non-Indigenous populations, between 2001 and 2005, Indigenous males had much higher death rates from diseases associated with poor environmental health (between 115.3 and 222.2 per 100 000) than non-Indigenous males (between 21.8 and 36.3 per 100 000) (figure 10.1.4).
- The death rates from diseases associated with poor environmental health were also much higher for Indigenous females than non-Indigenous females (between 108.9 and 237.0 per 100 000, compared with 21.0 to 42.9 per 100 000).

10.2 Access to clean water and functional sewerage

Box 10.2.1 **Key messages**

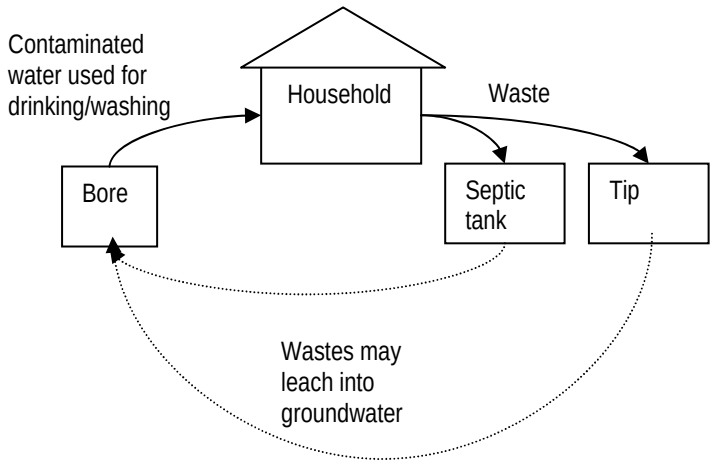
- The number of discrete Indigenous communities without an organised sewerage system decreased from 91 in 2001, to 25 in 2006 (table 10A.2.4).
- In 2006, of the 322 discrete Indigenous communities with a reported usual population of 50 or more in 2006:
  - 165 (51.2 per cent) had experienced water supply interruptions in the previous 12 months (table 10A.2.2)
  - 130 (40.4 per cent) had experienced sewerage overflows or leakages in the previous 12 months (table 10A.2.5).

This indicator complements the indicator of rates of diseases associated with poor environmental health. To prevent disease, a community needs a clean, adequate and reliable supply of water for drinking, cooking and washing. A functional sewerage system prevents sewage from contaminating drinking water and food.

Many Indigenous people live in urban areas where the water supply and sewerage systems are shared by all members of the community. While performance varies across Australia, cities and large towns generally monitor the quality of the drinking water and there are reticulated sewerage systems where wastes are collected and treated at central treatment plants.

In rural and remote areas, there is more reliance on individual household systems, like septic tanks and drinking water sourced from bores and rainwater tanks. If households are overcrowded and/or if these systems are not adequately maintained, wastes can leach into the groundwater and contaminate the drinking water, as shown in figure 10.1 below.

Figure 10.1 **Environmental health risks from inadequate or poorly maintained environmental health hardware**



Source: Adapted from ABS and AIHW 2005.

The Bureau of Rural Sciences has identified the two most important water quality risks as microbiological contamination and chemical contamination. Microbiological contamination is most commonly caused by septic waste discharges and/or livestock waste leaching into the waterway that supplies a bore. If this occurs, there is a risk that illness, usually infection, breaks out in the community. Chemical contamination is more likely to occur with surface water than groundwater and happens when chemicals like arsenic, uranium and nitrates leach into the water. Some chemicals and heavy metals occur naturally in soils and waters, but become hazardous to human health and the environment if concentrations become too high. Chemical contamination of drinking water usually causes chronic rather than acute health effects (Bureau of Rural Sciences 2005).

The 2005 Report used ABS 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) results to examine access to working water and sewerage facilities within households. Data from the ABS 2006 Community Housing and

Infrastructure Survey (CHINS) were released in mid-April 2007, and it has only been possible to include preliminary analysis of the data in this Report. More detailed exploration of the data may be possible in future Reports.

Box 10.2.2 **'Things that work' — the Aboriginal Communities Development Program**

In NSW, the Aboriginal Communities Development Program (ACDP) is investing $240 million over ten years to raise the health and living standards of selected, priority Aboriginal communities where major environmental health needs have been identified. Twenty-two Aboriginal priority communities are participating in a comprehensive program of capital works, which includes new housing, refurbishing and upgrading of existing housing, and upgrading essential safety infrastructure such as roads, footpaths and street lighting.

The Housing for Health program is a component of the ACDP, and focuses on immediate housing repairs to resolve health and safety concerns. By February 2007, 808 houses had been repaired under Housing for Health. Community people have been involved in surveying the houses and assisting local trades where possible.

The water and sewerage component of the ACDP is being undertaken with collaboration between state and local governments and Aboriginal people. The Tingha and Boggabilla communities have received new water and sewerage systems, which the local councils have agreed to maintain and service.

The ACDP has also resulted in 222 Aboriginal apprentices/trainees being employed within the 22 priority communities and 13 Aboriginal building companies being set up to employ the apprentices.

In 2006, ACDP won the NSW Premier's gold award for community development.

Source: NSW Cabinet office (unpublished).

Source of drinking water supply

In 2004-05, there were 384 water providers in the water supply industry in Australia. Of these, 235 were minor urban (fewer than 10 000 connections), 61 were non-major urban (between 10 000 and 50 000 connections), 29 were major urban (greater than 50 000 connections) and 59 were irrigation/rural (businesses that supply predominantly to agriculture) (ABS 2005). People who live outside areas serviced by utilities rely on other sources for their drinking water. While most Indigenous people live in cities and towns and receive the same water and sewerage services as non-Indigenous people, some live in small, discrete Indigenous communities.

In June 2006, an estimated 510 000 Indigenous people lived in Australia (ABS 2004). At the time of the 2006 CHINS, 92 960 people (which includes some non-Indigenous people)[1] lived in 1187 discrete Indigenous communities.[2]

Table 10.2.1 **Reported usual population in discrete Indigenous communities, by remoteness area 2006[a]**

	Communities with a population of:						
Remoteness area	*Less than 50*	*50–99*	*100–199*	*200–499*	*500–999*	*All communities*	*Reported usual population*
Major cities	2	–	2	–	–	4	346
Inner regional	5	5	8	1	–	19	1870
Outer regional	20	9	16	4	–	52	10 254
Remote	71	14	8	7	2	104	11 237
Very remote	767	95	58	59	17	1008	69 253
Australia	**865**	**123**	**92**	**71**	**19**	**1187**	**92 960**

a A community's usual population was generally estimated by the community representative without reference to community records. This methodology is considered to be less reliable than a population count as undertaken in the 2006 Census of Population and Housing. – Nil or rounded to zero.

Source: ABS 2006 CHINS, Cat. no. 4710.0.

In Australia in 2004-05, most (96 per cent) of the water supplied by the Australian water supply industry originated from inland surface water. Groundwater accounted for 4 per cent of the total water supplied. Most (89 per cent) of the total water consumed by households was distributed by an organised water supply, and 11 per cent was water from a self-extracted source (such as rainwater tanks and direct extraction from surface or groundwater) (ABS 2005).

In 694 discrete Indigenous communities (58.5 per cent), the most common source of drinking water is bore water, a decrease from 784 communities (64.5 per cent) in 2001. Between 2001 and 2006, the number of Indigenous communities that were connected to a town water supply increased from 186 to 209. Less common sources of drinking water (not part of a mainstream town supply) included rain water, rivers or reservoirs, wells or springs (ground water), carted water or some other organised supply. The number of communities with no organised water supply decreased from 22 (1.7 per cent) to 9 (0.8 per cent) between 2001 and 2006 (table 10A.2.1).

1 CHINS population data include both Indigenous and non-Indigenous people living in discrete Indigenous communities.

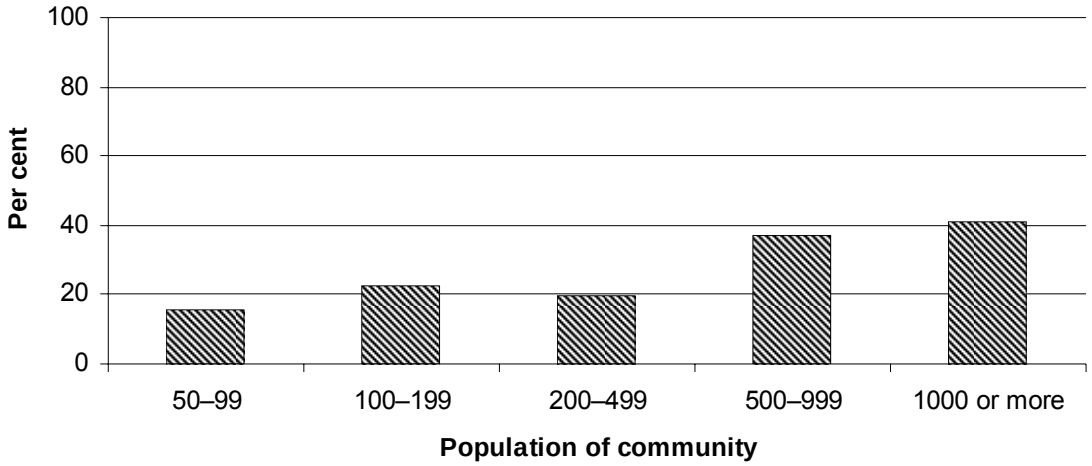
2 Discrete Indigenous communities are defined by the ABS as geographic locations inhabited by or intended to be inhabited predominantly (greater than 50 per cent of usual residents) by Aboriginal or Torres Strait Islander peoples, with housing or infrastructure that is managed on a community basis.

Reliability and adequacy of water supply

A reliable and adequate supply of water is essential for drinking, washing and hygienic food preparation and handling.

In 2006, the CHINS collected data on water restrictions and interruptions to water supply in discrete Indigenous communities.

Figure 10.2.1 **Experienced water restrictions, by reported usual population 2006,** [a, b, c]

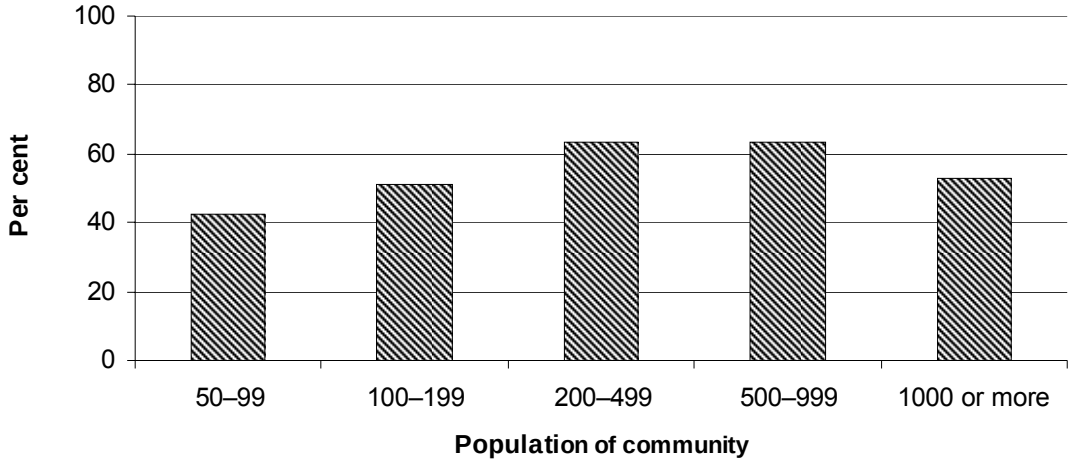


[a] In the 12 months prior to the survey. [b] Only a small proportion of communities with fewer than 50 people responded to this question, and the data are not included in the chart. [c] Cause of 'water restrictions' include 'drought', 'normal dry season', 'lack of storage containment', 'poor water quality' and 'other reasons'.

Source: ABS 2006 CHINS, Cat. no. 4710.0; table 10A.2.2.

- Water restrictions were more common in discrete Indigenous communities with larger populations. For example, 14 out of 36 Indigenous communities with a population of 500 or more (38.8 per cent), reported water restrictions in the previous 12 months (figure 10.2.1).
- Discrete Indigenous communities that had experienced water restrictions had a total reported usual population of 25 557 (table 10A2.2).

Figure 10.2.2 **Experienced water interruptions, by reported usual population 2006,** [a, b, c]



[a] In the 12 months prior to the survey. [b] Only a small proportion of communities with less than 50 people responded to this question, and the data are not included in the chart. [c] Causes of 'water interruptions' include 'equipment breakdown', 'ran out of water', 'lack of power', 'poor water quality', 'planned interruption' and 'other reasons'.

Source: ABS 2006 CHINS, Cat. no. 4710.0; table 10A.2.2.

- Figure 10.2.2 shows that in 2006, between 42.3 and 63.4 per cent of discrete Indigenous communities (depending on the size of the community) reported water interruptions in the previous 12 months.
- 165 communities with a reported usual population of 50 or more (51.2 per cent) had experienced water supply interruptions in the previous 12 months (table 10A.2.2).
- The total reported usual population of discrete Indigenous communities reporting water supply interruptions was 44 563 (table 10A.2.2).
- Of the 182 communities that reported water supply interruptions, 69 (37.9 per cent), with a total population of 21 291, had experienced five or more interruptions in the previous 12 months (table 10A.2.2).

Water quality

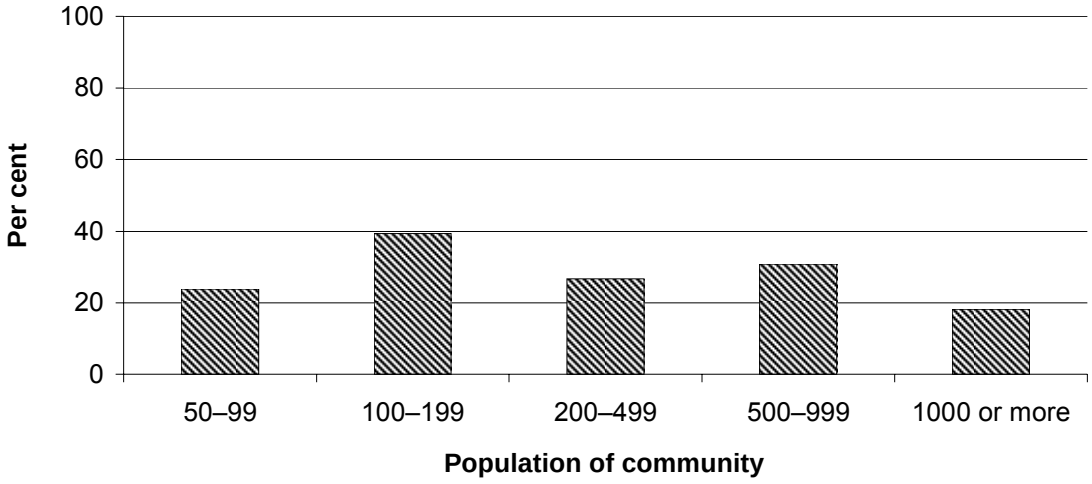
Data on testing of drinking water are included here as an indicator of the quality of water.

Most drinking water in Australia is regularly tested to measure its compliance with guidelines and standards, which have been established to ensure that drinking water is safe for human consumption.

Data on water testing and treatment in discrete Indigenous communities are only available for those communities that are not connected to a nearby mainstream town supply, and data were not collected in 'administered' communities with a population of fewer than 50.

The definition for the CHINS data item for water test failures does not specify whether one sample failed testing, all samples failed testing or whether water was outside the failure rates permitted by the various water quality guidelines. Therefore, results should be interpreted with caution.

Figure 10.2.3 **Testing of drinking water failed, in discrete Indigenous communities not connected to town supply, by reported usual population, 2006** [a, b]



[a] In the 12 months prior to the survey. [b] Excludes communities connected to town supply. Data not collected in 'administered' communities with a population of fewer than 50. Totals include 'not stated'.

Source: ABS 2006 CHINS, Cat. no. 4710.0; table 10A.2.3.

- In discrete Indigenous communities not connected to town supply, where water was sent away for testing in 2006, between 18.2 per cent and 39.4 per cent (depending on the size of the community) failed the testing (figure 10.2.3).
- In 2006, there were 194 Indigenous communities with populations of 50 or more that were not connected to a town water supply. Three-quarters of these (149 communities) had drinking water sent away for testing (table 10A.2.3).
- Of the 149 communities that had drinking water sent away for testing, 48 communities (28.8 per cent) failed the testing. These communities had a combined population of 12 059 people (table 10A.2.3).

Types of sewerage systems

In the 2006 CHINS, 25 discrete Indigenous communities reported having no organised sewerage system, an improvement from 91 communities in 2001 (table 10A.2.4). The total usual population of communities without organised sewerage facilities was 1 969 (ABS 2007).

Septic tanks, both with common effluent disposal and leach drains, and pit toilets continue to be the main sewerage systems in small communities. In discrete Indigenous communities, a total of 593, or half of the communities, reported the use of a septic system with a leach drain in 2006, and 202 communities reported using pit toilets. (table 10A.2.4).

Between 2001 and 2006, the number of communities connected to a nearby mainstream town system increased from 89 to 121 (from 7.3 per cent to 10.2 per cent of all communities) (table 10A.2.4). By 2006, a total population of 32 256 people in discrete Indigenous communities were connected to a mainstream town sewerage system (ABS 2007).

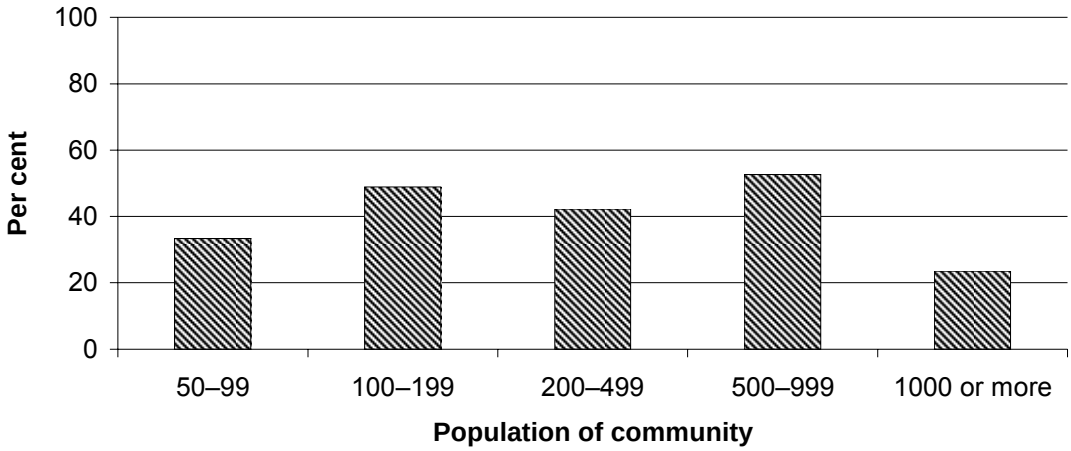
Numbers of community water-borne systems also increased slightly, with 108 communities reporting the use of such systems in 2006, compared to 96 in 2001 (table 10A.2.4). Community water-borne systems involve flush toilets and closed sewerage pipe systems using gravity and pumping stations to a common sewerage treatment plant (ABS 2007).

In communities with populations of 50 or more people, sewerage systems were reported to be connected to all permanent dwellings. A total of 192 small communities with a population of fewer than 50 people reported that a sewerage system was not connected to all permanent dwellings, of which 69 were located in Western Australia, 61 in the Northern Territory, 51 in Queensland and 10 in South Australia (ABS 2007).

Sewerage system overflows and leakages

Sewerage system leaks and overflows create potential health risks to people living in their vicinity and can also contaminate drinking water sources.

Figure 10.2.4 **Sewerage system overflows or leakages in discrete Indigenous communities, by usual population [a, b]**



a In the 12 months prior to the survey. **b** Data not collected in 'administered' communities with a population of less than 50.

Source: ABS 2006 CHINS, Cat. no. 4710.0; table 10A.2.5.

- Figure 10.2.4 shows that between 23.5 and 52.6 per cent of discrete Indigenous communities (depending on the size of the community) experienced sewerage overflows or leakages in the previous 12 months.
- In 2006, 130 of the 322 discrete Indigenous communities with a population of 50 or more (40.4 per cent) had experienced sewerage overflows or leakages in the previous 12 months (table 10A.2.5).
- In 2006, 142 communities reported sewerage overflows or leakages. Blocked drains (95 communities) and equipment failure (62 communities) accounted for the largest proportion of overflows and leakages. The total population in communities affected by sewerage overflows or leakages was 30 140 people (table 10A.2.5).
- Of the 142 communities that reported sewerage overflows or leakages, 31 (21.8 per cent) had experienced 10 or more overflows or leakages in the previous 12 months (table 10A.2.6).

Access to cooking, washing and toilet facilities

In 2006, 14 028 (89.6 per cent) of Indigenous Housing Organisation (IHO) managed permanent dwellings[3] had access to their own cooking, washing and toilet facilities (ABS 2007).

The proportion of IHO managed permanent dwellings that had access to their own cooking, washing and toilet facilities varied across remoteness areas. Non-remote areas had the highest proportion (94.6 per cent) of houses with access to these facilities, compared with 87.5 per cent in remote and 89.0 per cent in very remote areas (ABS 2007).

A total of 161 communities reported access to public toilet facilities within the community. Of these 125 communities (77.6 per cent) reported all toilets in working order (ABS 2007).

10.3 Overcrowding in housing

Box 10.3.1 **Key messages**

- In 2004-05, 25.0 per cent of Indigenous people aged 15 years and over lived in overcrowded housing (figure 10.3.1 and table 10A.3.3). There have been no statistically significant changes in the rates of overcrowding since 2002.
- In 2004-05, overcrowding was most common in very remote areas, where 63.4 per cent of Indigenous people lived in overcrowded households (figure 10.3.2).

Overcrowding places pressure on the household infrastructure that supports health (like septic tanks, sewerage pipes, washing machines, etc.), and can be a contributor to poor health, poor educational outcomes and family violence. A much higher proportion of Indigenous people live in overcrowded conditions than other Australians (SCRGSP 2003).

[3] ABS defines an 'IHO managed permanent dwelling' as: "Permanent dwellings located in discrete Indigenous communities, towns or other localities which are managed by an Indigenous organisation that provides housing to Aboriginal and Torres Strait Islander peoples. This includes permanent dwellings which are owned by State or Territory housing authorities, but managed by an Indigenous Housing Organisation (IHO). Excluded are dwellings in discrete Indigenous communities which are not managed by an IHO" (ABS 2007).

Reasons for overcrowding

There are cultural and social factors that influence the way housing is used in Indigenous communities. Household and community populations may fluctuate quite dramatically for social, cultural or seasonal reasons. Indigenous people are often mobile, and sharing homes with visiting relations and kin is common (ABS 2004). A 1993 study in the north west of South Australia found that some houses had relatively stable numbers of residents, while others had wide variations in numbers. The numbers in one house varied from zero to 32 at various times of the year (Pholeros, Rainow and Torzillo 1993). While such fluctuations may result in an overcrowded household, living in large family groupings is not always considered a problem; it can be the cultural norm (Keys Young 1998).

Taylor (2004), in a study of Wadeye and the Thamarrurr Regional Council area in the NT, reported both short-term and long-term variations in the numbers of people living in each house as people moved between houses, to and from outstations, and in and out of the region. There were seasonal movements of people from outstations into the Wadeye town during the wet season. The average number of people per house was 16, with one residence having an average occupancy of 22. Houses in the Thamarrurr region averaged three bedrooms each, giving an average occupancy rate of approximately five people per bedroom.

Overcrowding can also be due to inadequate, inappropriate or poorly maintained housing stock (DHAC 1999). In remote and very remote areas in particular, it is more expensive and logistically more difficult to construct and maintain infrastructure.

Data issues

Overcrowding data in this Report were derived using the Canadian National Occupancy Standard (box 10.3.2), which is the usual standard used by the ABS to measure overcrowding.

This occupancy standard was not developed specifically for Indigenous people. However, no housing occupancy standard can reflect the housing needs and preferences of all Indigenous people. For example, it does not account for the influence of climate and culture (in rural areas people may live outside houses rather than inside and the standard does not allow for verandahs or larger shared living spaces) (Pholeros, Rainow and Torzillo 1993). Indigenous cultures and lifestyles vary widely across Australia, as do climates. The occupancy standard used here will reflect the culture and preferences of some but not all Indigenous people.

The occupancy standard determines overcrowding by comparing the number of bedrooms with the number and characteristics of people in a dwelling. However, the numbers of bathrooms and toilets, and the size of kitchens, bedrooms and other living spaces may be as important as, or more important than, the number of bedrooms, particularly in larger households.

Box 10.3.2 **Housing occupancy standard used by ABS**

There is no single standard measure for housing overcrowding. The ABS uses a standard[a] which is sensitive to both household size and composition. Where this standard cannot be met, households are considered to be overcrowded.

The following criteria were used to assess bedroom requirements:

- there should be no more than two persons per bedroom
- a household of one unattached individual may reasonably occupy a bed-sit (that is, have no bedroom)
- couples and parents should have a separate bedroom
- children less than five years of age of different sexes may reasonably share a bedroom
- children five years of age or over of the opposite sex should not share a bedroom
- children less than 18 years of age and of the same sex may reasonably share a bedroom
- single household members aged 18 years or over should have a separate bedroom.

[a] Based on the Canadian National Occupancy Standard for housing appropriateness.

Source: ABS (2004).

The quality and condition of housing also influence health outcomes. If a house has sufficient working taps, tubs, showers, toilets, insect screens and protection from the weather it will be much better able to prevent the disease transmission that can occur in crowded households.

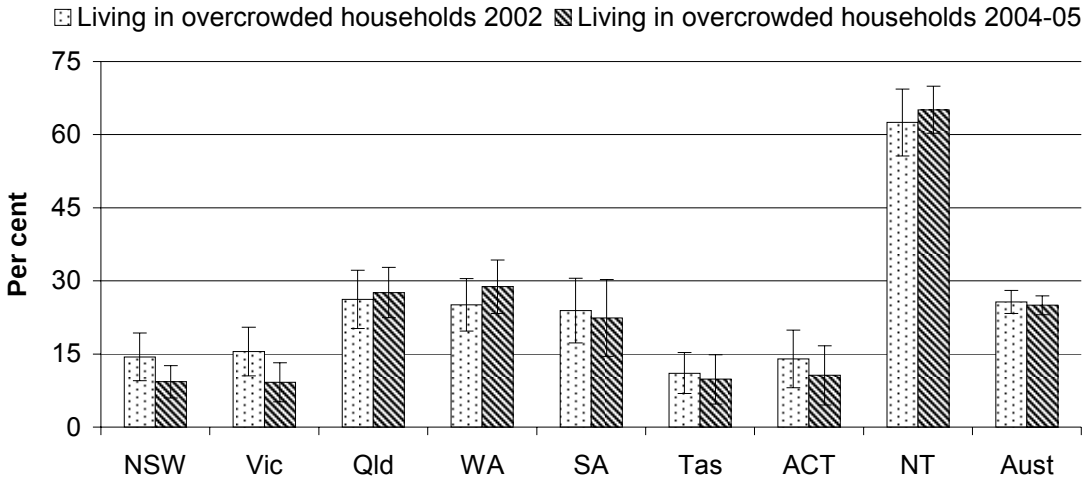
Overcrowding in housing is reported here using data from the ABS National Aboriginal and Torres Strait Islander Social Survey 2002 (NATSISS), the ABS National Aboriginal and Torres Strait Islander Health Survey 2004-05 (NATSIHS). Data on the rates of overcrowding experienced by non-Indigenous people were not available for this Report.

The NATSISS only reported data for those aged 15 years and older, whereas the NATSIHS collected data for children as well. Consequently, data presented as a time series between 2002 and 2004-05 cover only people aged 15 years and over, whereas data presented for 2004-05 alone, cover all age groups.

This Report also includes data on Indigenous peoples' reporting of overcrowding as a 'stressor'. These data come from the 2002 NATSISS and the 2004-05 NATSIHS and cover Indigenous people 18 years and older. As discussed above, there are social and cultural aspects to consider when defining 'overcrowding'. The data on stressors may better present Indigenous peoples' perceptions of overcrowding.

All data presented are based on the number of residents in households with at least one Indigenous person. A household with one or more Indigenous persons may also contain non-Indigenous people. Therefore, data reported for the proportion of people in overcrowded households may reflect the presence of some non-Indigenous people who were living in households with Indigenous people.

Figure 10.3.1 **Proportion of Indigenous people 15 years and over living in overcrowded housing, by State/Territory, 2002 and 2004-05[a, b]**



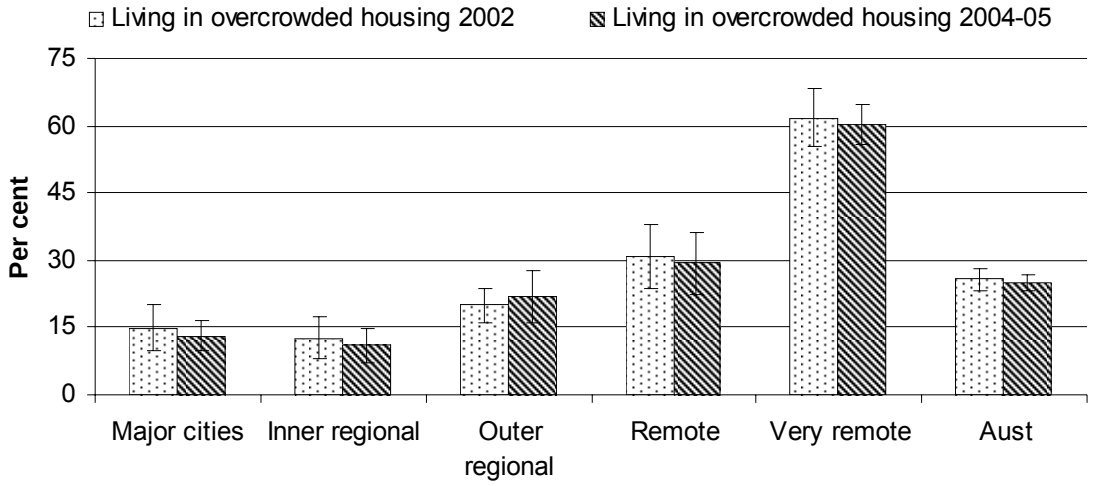
a Based on the Canadian National Occupancy Standard for housing appropriateness. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2002 NATSISS; ABS 2004-05 NATSIHS; table 10A.3.3.

- Figure 10.3.1 shows that in 2004-05, 25.0 per cent of Indigenous people 15 years and over in Australia lived in overcrowded houses.
- In 2004-05, an estimated 128 300 Indigenous people of all ages (27.0 per cent) lived in overcrowded housing in Australia (table 10A.3.1).
- The proportion of Indigenous people living in overcrowded housing varied between states and territories (table 10A.3.3).
- Between 2002 and 2004-2005, there were no significant differences in the rates of overcrowding for Indigenous people aged 15 years and over at the State and Territory or national levels.

- There were no statistically significant differences in overcrowding rates between Torres Strait Islander people and Aboriginal people in 2004-05 (tables 10A.3.1–10A.3.4).

Figure 10.3.2 **Proportion of Indigenous people 15 years and over living in overcrowded housing, by remoteness area, 2002 and 2004-05[a, b]**

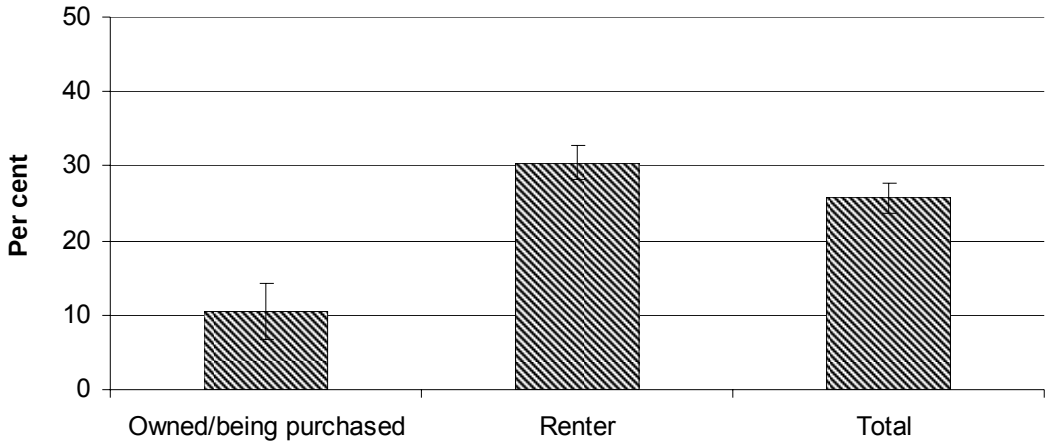


a Based on the Canadian National Occupancy Standard for housing appropriateness. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2002 NATSISS; ABS 2004-05 NATSIHS; tables 10A.3.2.

- Figure 10.3.2 shows that, between 2002 and 2004-05, there were no significant changes in the proportions of Indigenous people aged 15 years and over living in overcrowded households.
- Very remote and remote areas have the highest incidence of overcrowding. In 2004-05, 30.8 per cent of Indigenous people aged 15 years and over in remote areas lived in overcrowded households. In very remote areas, 60.4 per cent of Indigenous people aged 15 years and over lived in overcrowded households. Including children aged 0–14, the proportion in very remote areas was higher still (63.4 per cent) (table 10A.3.2).
- In major cities and regional areas, the incidence of overcrowding for Indigenous people aged 15 years and over ranged from 11.0 per cent (inner regional areas) to 21.9 per cent (outer regional areas) in 2004-05.

Figure 10.3.3 **Proportion of Indigenous people aged 15 years or over living in overcrowded housing, by housing tenure, 2004-05** [a, b, c]

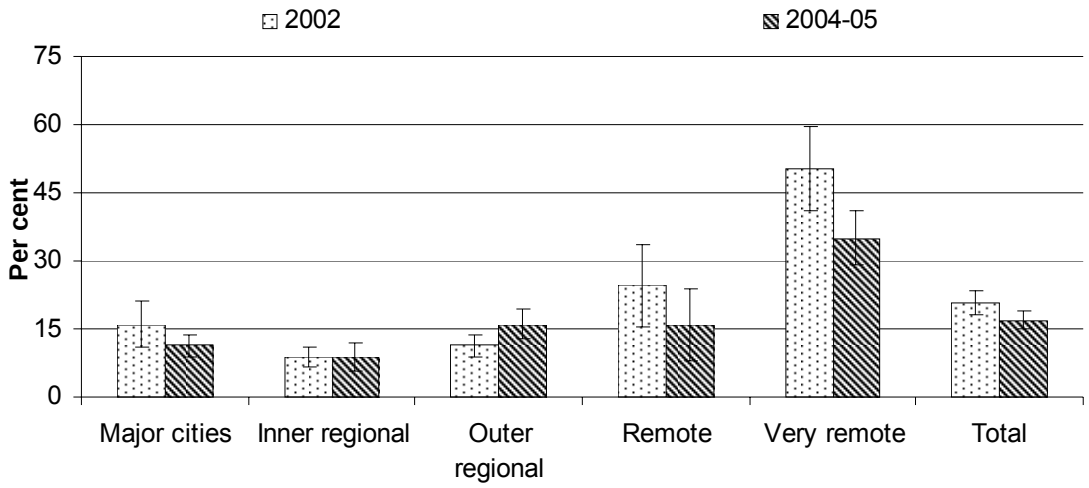


[a] Based on the Canadian National Occupancy Standard for housing appropriateness. [b] 'Owned/being purchased' includes being purchased under a rent/buy scheme. [c] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS; table 10A.3.4.

- Figure 10.3.3 shows that in 2004-05, the proportion of Indigenous people 15 years and over living in overcrowded housing varied significantly by housing tenure. Those in rental accommodation were significantly more likely to live in overcrowded households than those in homes which were 'owned or being purchased' (30.4 per cent compared with 10.4 per cent).
- In 2004-05, the majority Indigenous people who lived in overcrowded housing, lived in rented accommodation (63 900 out of a national estimate of 73 400) (table 10A.3.4).

Figure 10.3.4 **Proportion of Indigenous people 18 years and over who reported overcrowding as a stressor in the last 12 months, by remoteness area, 2002 and 2004-05[a]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2002 NATSISS; ABS 2004-05 NATSIHS; table 10A.3.5.

- Figure 10.3.4 shows that the proportion of Indigenous adults reporting overcrowding as a stressor varied according to geographic remoteness. Indigenous adults in very remote areas were most likely to report this stressor (50.2 per cent in 2002 and 35.0 per cent in 2004-05) while those in inner regional areas were least likely to report it (around 9 per cent in both years).

10.4 Future directions in data

Rates of diseases associated with poor environmental health

The ABS is working with states and territories to improve the quality of Indigenous mortality data, while the AIHW is working with states and territories to improve data on Indigenous hospitalisations. See chapter 2 and appendix 4 for more information.

Access to clean water and functional sewerage

During 2001-02, the Bureau of Rural Sciences undertook an audit of the current status of the potable water supplies in rural and remote communities across Australia. For many of these communities, including the 348 Indigenous

communities identified in the audit, there were no data available regarding water quality and water quality testing regimes. It would be useful if this audit could be undertaken again, to provide a more accurate picture of the water quality in rural, remote and Indigenous communities.

The AIHW is developing a National Reporting Framework for Indigenous Housing, which aims to provide comparable administrative data on indicators such as the proportion of communities and dwellings not connected to water, sewerage and electricity, and the proportion of dwellings meeting the nine Fixing Houses for Better Health healthy living standards.

Overcrowding in housing

Direct comparisons of overcrowding between Indigenous and non-Indigenous people could not be derived from the results of the ABS National Health Survey 2004-05. The 2006 Census will provide a comparable data source on overcrowding for future Reports, and will be available in 2007.

10.5 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3.3 is table 3 in the attachment tables for section 10.3). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

10.1 Rates of diseases associated with poor environmental health

Table 10A.1.1	Hospitalisation rates on selected types of environmentally based diseases (per 10 000 population), age standardised, by gender, age and Indigenous status, Qld, WA, SA, and public hospitals in NT 2004-05
Table 10A.1.2	Hospitalisation rates on selected types of environmentally based diseases (per 10 000 population), age standardised, by gender, age and Indigenous status, Qld, WA, SA, and public hospitals in the NT, 2001–2004
Table 10A.1.3	Hospitalisation rates on selected types of environmentally based diseases (per 10 000 population), by gender, age and Indigenous status 2001–2005, Qld, WA, SA, and public hospitals in NT
Table 10A.1.4	Deaths from diseases associated with poor environmental health (per 100 000 population), age standardised, 2001-2005

10.2 Access to clean water and functional sewerage

Table 10A.2.1	Main source of drinking water, discrete Indigenous communities, by remoteness area, 2001, 2006
Table 10A.2.2	Water restrictions and interruptions, in discrete Indigenous communities, by reported usual population 2006
Table 10A.2.3	Testing of drinking water in discrete Indigenous communities, by reported usual population, 2006
Table 10A.2.4	Type of sewerage systems in discrete Indigenous communities, by remoteness area, 2001, 2006
Table 10A.2.5	Sewerage system overflows or leakages in discrete Indigenous communities, by usual population, 2006
Table 10A.2.6	Frequency of sewerage system overflows or leakages in discrete Indigenous communities, by State and Territory, 2006

10.3 Overcrowding in housing

Table 10A.3.1	Persons living in overcrowded households, by Indigenous status, 2002, 2004-05
Table 10A.3.2	Indigenous people living in overcrowded households, by remoteness, 2004-05
Table 10A.3.3	Indigenous people: living in overcrowded households, by State and Territory, 2004-05
Table 10A.3.4	Indigenous people aged 15 years or over: living in overcrowded households, by tenure and landlord type, 2004-05
Table 10A.3.5	Indigenous people 18 years and over who reported overcrowding as a stressor in the last 12 months, by Remoteness Areas, 2002 and 2004-05

10.6 References

10 Effective environmental health systems

DFACS (Commonwealth Department of Family and Community Services) 2003, *National Indigenous Housing Guide*, Canberra.

DHAC (Commonwealth Department of Health and Aged Care) 1999, *The National Environmental Health Strategy*, Canberra.

Pholeros P., Rainow S. and Torzillo P. 1993, *Housing for Health: Toward a Healthy Living Environment for Aboriginal Australia*, Health Habitat, Sydney.

10.1 Rates of diseases associated with poor environmental health

AIHW (Australian Institute of Health and Welfare) 2004, *Australian Hospital Statistics 2002-03*, Cat. no. HSE 32, Health Services Series no. 22, Canberra.

DHAC (Commonwealth Department of Health and Aged Care) 1999, *The National Environmental Health Strategy*, Canberra.

10.2 Access to clean water and functional sewerage

ABS (Australian Bureau of Statistics)

ABS (Australian Bureau of Statistics) 2007, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia, 2006*, Cat. no. 4710.0, Canberra.

— 2005, Water Account, Australia, 2004-05, Cat. no. 4610.0, Canberra http://www.abs.gov.au/ausstats/abs@.nsf/b06660592430724fca2568b5007b8619/9f319397d7a98db9ca256f4d007095d7!OpenDocument (accessed on 16 April 2007).

— 2004, Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians, Cat. no. 3238.0, Canberra.

— 2002, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia, 2001*, Cat. no. 4710.0, Canberra.

ABS (Australian Bureau of Statistics) and AIHW (Australian Institute of Health and Welfare) 2005, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, ABS Cat. no. 4704.0, AIHW Cat. no. IHW14, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2003, *Overcoming Indigenous Disadvantage: Key indicators 2003*, Melbourne.

10.3 Overcrowding in housing

ABS (Australian Bureau of Statistics) 2004, 'The design and construction of Indigenous housing: the challenge ahead' *Year Book Australia 2004*, Canberra.

AIHW (Australian Institute of Health and Welfare) 2003, *National Housing Assistance Data Dictionary Version 2*, Cat. no. HOU-89, Canberra.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2003, *Overcoming Indigenous Disadvantage: Key Indicators 2003*, Productivity Commission, Canberra.

enHealth Council 2002, *Accountability in Indigenous Environmental Health Services –Australia 2002*, the Department of Health and Ageing, Canberra.

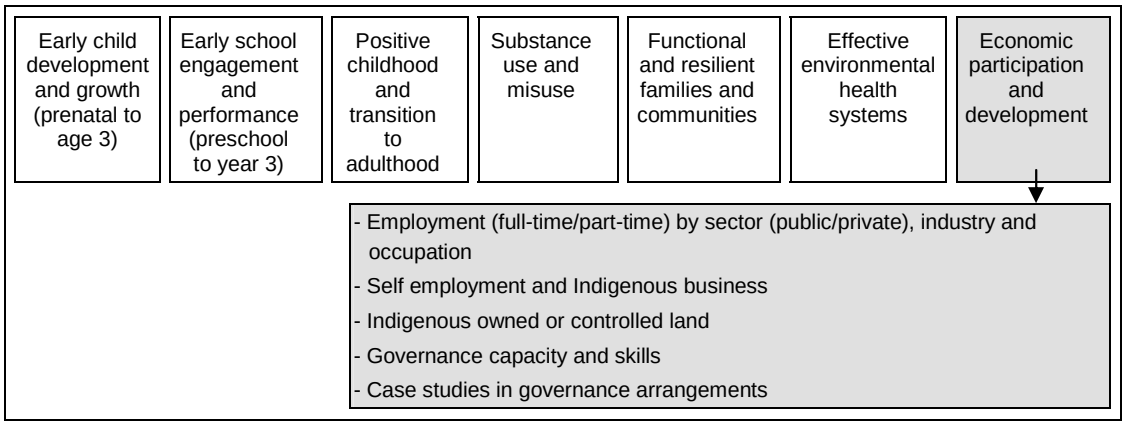
Keys Young 1998, *Homelessness in the Aboriginal and Torres Strait Islander Context and its Possible Implications for the Supported Accommodation Assistance Program* (SAAP), Sydney.

Pholeros P., Rainow S. and Torzillo P. 1993, *Housing for Health: Toward a Healthy Living Environment for Aboriginal Australia*, Health Habitat, Sydney.

Taylor, J. 2004, *Social Indicators for Aboriginal Governance: Insights from the Thamarrurr Region, Northern Territory*, Research monograph no. 24, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

11 Economic participation and development

Strategic areas for action



The extent to which people participate in the economy is closely related to their living standards, and affects many aspects of their wellbeing. This Report examines economic participation and development through employment opportunities, influence over land and sea resources, and aspects of good governance and the capacity to govern.

Many aspects of work affect people's wellbeing, such as hours worked, job satisfaction and security, levels of remuneration, opportunities for self development and interaction with people outside the home. Having a job or being involved in a business activity not only leads to improved incomes for families and communities (which has a positive influence on health, education of children etc), it also enhances self-esteem and reduces social alienation.

Some issues associated with unemployment and labour force participation are discussed in section 3.5. This chapter examines in greater detail the types of employment undertaken by Indigenous people, including employment by full time and part time status, by sector, industry and occupation (section 11.1), and self employment and Indigenous business (section 11.2).

During consultations, Indigenous people said that land was important to them for a range of cultural, social and economic reasons. The extent to which a parcel of

Indigenous owned land yields economic benefits will depend on geographic factors such as climate, soil type and location, the strength of landowners' property rights, the skills and governance arrangements of landholding bodies, and the aspirations of the Indigenous landowners. Section 11.3 examines data on Indigenous owned and controlled land.

Although there was strong feedback during the consultations that governance was an important element of the framework, there are difficulties in finding appropriate indicators of governance. It has not been possible to develop meaningful quantitative indicators that could be reported consistently with comparable data across jurisdictions. It may be possible to improve quantitative reporting in future years.

In the 2003 and 2005 Reports, a proxy indicator 'Accredited training in leadership, finance or management' was included in the framework to report on capacity building in governance. Following feedback and comments from consultation on the 2005 Report, this indicator has been renamed 'Governance capacity and skills' (section 11.4). It complements the case studies in governance arrangements in section 11.5.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.1.3). A list of attachment tables is in section 11.7. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

11.1 Employment (full time/part time) by sector (public/private), industry and occupation

Box 11.1.1 **Key messages**

- The full time employment rate for Indigenous people increased from 44.5 to 52.2 per cent between 1994 and 2004-05, and the part time employment rate increased from 25.5 to 34.9 per cent over the same period (figure 11.1.6).
- In 2004-05, after adjusting for age differences:
  - Indigenous people in the labour force were more likely than non-Indigenous people to be employed part time (35.4 per cent compared to 27.7 per cent) and less likely to be employed full time (53.6 per cent compared to 68.5 per cent) (table 11A.1.2)
  - a higher proportion of Indigenous people than non-Indigenous people were employed in lower skilled occupations, including elementary clerical, sales and service workers and labourers, and related workers (25.6 per cent compared to 16.1 per cent) (figure 11.1.9).
- For Indigenous people in 2004-05:
  - full time employment decreased with remoteness, while part time employment increased with remoteness (figure 11.1.2)
  - CDEP participation comprised a significant proportion of Indigenous employment in remote and very remote areas, accounting for 63.5 per cent of Indigenous employment in the public sector and 47.6 per cent of Indigenous employment in the private sector (figure 11.1.7).

Employment is an important indicator of Indigenous economic participation. Outcomes commonly associated with employment include increased income levels, better health and improved education outcomes, leading to enhanced self esteem and increased social integration. A number of issues associated with unemployment and labour force participation are discussed in section 3.5. This indicator examines employment in more detail by full time and part time status, sector, industry and occupation.

The types of employment that people are engaged in may influence their wellbeing, by affecting remuneration and job satisfaction. Employment in certain industries and occupations could also provide an indication of people's skill levels and education attainments. High levels of part time employment could mask high levels of underemployment. Underemployment has been found to be particularly common among Indigenous employees (Hunter 2002).

Box 11.1.2 provides examples of some positive steps that have been taken to improve Indigenous employment outcomes.

Box 11.1.2 **'Things that work' — Improving Indigenous employment outcomes**

Moree Aboriginal Employment Strategy (NSW)

The Aboriginal Employment Strategy (AES) is a community strategy working in cooperation with key Aboriginal leaders and in partnership with government and the corporate sector. Originally driven by former Reconciliation Australia director, Dick Estens, in the cotton town of Moree in the north west of NSW, it aimed to create jobs for Aboriginal people to break down their reliance on welfare, create social stability and end a long history of racial trouble in the town.

By helping Aboriginal people into jobs, the project also became an instrument of social transformation, achieving a shift in self-perception and wellbeing of Moree's residents.

The project has dramatically increased Aboriginal employment in Moree and has been expanded to seven offices in NSW, four offices in regional NSW and three offices in Sydney.

- In 2005-06 AES found jobs for more than 500 Aboriginal people.
- In 2006-07, AES expects to secure more than 800 job placements for Aboriginal people.

The AES School Based Traineeship program targets Aboriginal students in the last two years of high school, offering part time traineeships during their schooling so students will have jobs to move into after high school. Partner organisations include banks and local councils.

- In 2006, 10 of the 12 Aboriginal students successfully completed the School Based Traineeship Program in the ANZ and Commonwealth banks in Sydney.
- In 2007, 81 Aboriginal School Based trainees commenced their two-year certificate II business services traineeship.

The AES has trainees located in NSW and WA and plans to expand this further to other states in Australia from 2008.

Source: (ABC 7.30 Report http://www.abc.net.au/7.30/content/2006/s1823591.htm; Reconciliation Australia http://www.reconciliation.org.au/i-cms.isp?page=145; AES unpublished).

The Accor Asia Pacific Corporate Leaders for Indigenous Employment Project

The Corporate Leaders for Indigenous Employment Project encourages private sector companies to generate job opportunities. It encourages them to use elements of the Australian Government's Indigenous Employment Programme to develop and tailor their Indigenous employment strategies to meet their business needs.

(Continued next page)

Box 11.1.2 (continued)

One example is Accor Asia Pacific, which won the Outstanding Organisation category at the Corporate Leaders for Indigenous Employment Awards for two consecutive years (2003 and 2004).

Accor's Indigenous Employment Program aims to encourage more Indigenous Australians to take up jobs in the tourism industry. Accor has developed a number of hospitality Job Start programmes with DEWR and Job Network for Indigenous job seekers registered with Job Network. The one-week programme gives a first-hand view of the hospitality industry and employer expectations, and is delivered with the support of human resource managers who can recruit applicants directly from the course. As a Registered Training Organisation, Accor is also able to give Indigenous employees the opportunity to complete a Certificate 2 or 3 in Hospitality Operations or a Diploma in Hospitality Management.

Accor has also extended its internal marketing, maintained a commitment to an Indigenous Employment Co-ordinator and the delivery of cross cultural awareness training, and ensured that culturally appropriate staff support services are available to Indigenous staff.

The Accor Indigenous Employment Program operates in over 90 Accor properties across Australia. In 2004 it recruited more than 100 Indigenous employees. Retention rates of Indigenous employees are the same as those of non-Indigenous staff and are in line with industry benchmarks.

Source: (DEWR: http://www.workplace.gov.au/workplace/Individual/IndigenousAustralians/; DEWR unpublished)

Sunraysia Area Consultative Committee Structured Training and Employment Project (Victoria)

The Sunraysia Area Consultative Committee (ACC) Structured Training and Employment Project (STEP) was established in 2003. Through a partnership between the Sunraysia ACC, the Department of Employment and Workplace Relations (DEWR) and the Mildura community, Indigenous job seekers in the local area are placed into work. The project focuses on achieving full time employment for Indigenous Australians in skilled or professional areas.

Since 1 July 2003, the project has placed 168 Indigenous people into work through two STEP consecutive contracts, with:

- 140 job placements achieved in the first contract (from 1 July 2003 to 30 June 2006)
- 28 job placements so far in the current contract (from 1 July 2006 to 30 June 2008).

(Continued next page)

Box 11.1.2 (continued)

The success of the project has been ensured by engaging local employers and generating private sector support of, and engagement with, the initiative.

In addition to job placements, the project also provides ongoing mentoring and job skills training to participants following their job placements, which increases retention rates. Cross cultural awareness training is also provided to employers.

Source: DEST (unpublished).

Port Hedland Regional Partnership Agreement: Minerals Council of Australia (WA)

The Port Hedland Regional Partnership Agreement is a commitment to bring about demonstrable improvements in Indigenous employment outcomes. Arising from a strategic partnership between the Australian Government and the Minerals Council of Australia, a five-year Memorandum of Understanding (MOU) was signed in June 2005.

The MOU established a platform for Government and industry to work with Indigenous people to build sustainable and prosperous communities in which Indigenous people could create and take up employment and business opportunities in mining regions beyond the life of the mines.

One of eight pilot sites for implementation of the MOU is Port Hedland, where activities focus on increasing employment and economic development outcomes for Indigenous people in the Pilbara region through a work readiness programme, creating employment opportunities through establishment of Indigenous business, and through education and training.

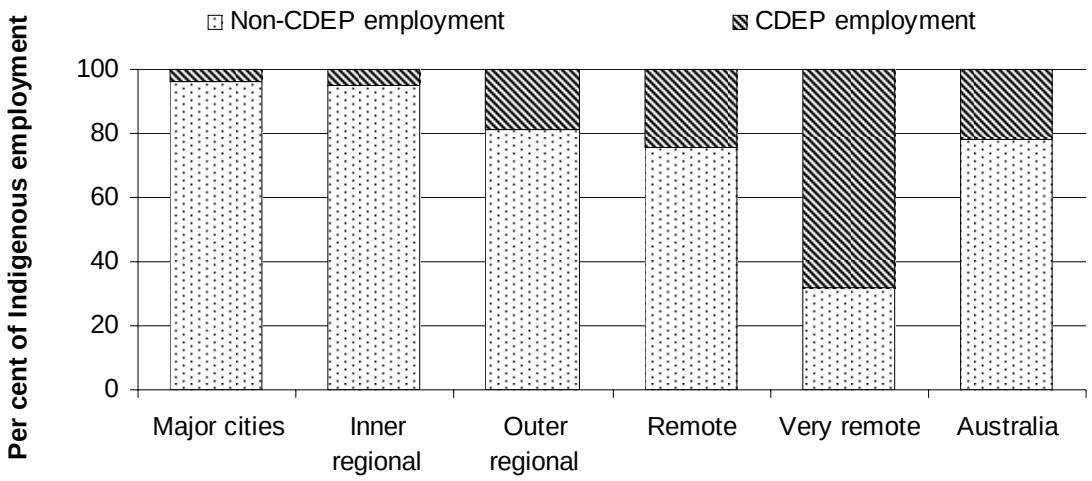
Source: DEST (unpublished).

The employment data in this Report are from several ABS surveys, including the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Health Survey (NHS), the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and General Social Survey (GSS), and the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS).

The employment data used in this chapter are influenced by the Community Development Employment Projects (CDEP) program (see section 3.5 for more detailed discussion). The ABS classifies participants in CDEP as employed rather than as unemployed or not in the labour force. In 2004-05, the CDEP program accounted for 21.8 per cent of all Indigenous employment, ranging from 4.0 per cent in major cities to 68.0 per cent in very remote areas (figure 11.1). While CDEP employment and participation are beneficial for Indigenous people (Hunter 2004), there are greater economic and employment opportunities for Indigenous people, particularly in non-remote areas, in the mainstream economy.

Data in this Report are not affected by changes to CDEP introduced in July 2006.

Figure 11.1.1 **CDEP and non-CDEP employment as proportions of total employment, Indigenous people aged 18 to 64 years, by remoteness area, 2004-05[a]**



a Data are not age standardised.

Source: ABS NATSIHS 2004-05 (unpublished); table 11A.1.1.

The employment rates in this chapter are calculated as a proportion of the labour force unless otherwise specified. The labour force comprises those who are employed (including CDEP participants for Indigenous people) and those who are unemployed and looking for work.

Data for people aged 18 to 64 years are reported to enable comparisons of outcomes in 2004-05 with those in 1994 and 2002.

When comparing Indigenous and non-Indigenous employment rates in this Report, some data are age standardised to take account of the different age structures of the Indigenous and non-Indigenous populations. Where data are reported for Indigenous people only, or where age ranges are being compared, age standardisation is not required.

Indigenous and non-Indigenous comparisons are not possible for very remote areas, as data for non-Indigenous people in very remote areas were not collected in the 2004-05 NHS.

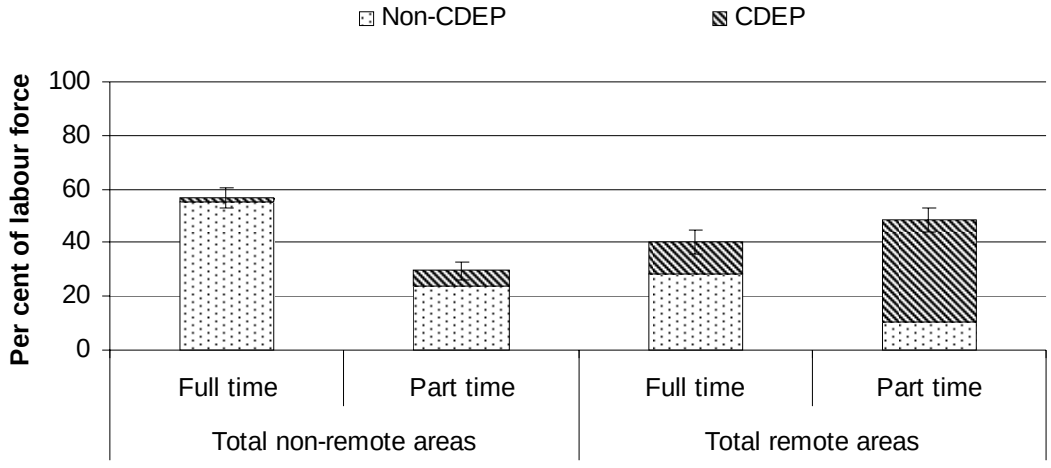
Employment by full time/part time status

Full time employment is defined as 35 or more hours of work in the reference week. Part time employment includes working for one hour or more during the reference week, but fewer than 35 hours.

After taking into account the different age structures of the Indigenous and non-Indigenous populations, in 2004-05:

- The rate of full time employment for Indigenous people was lower than that for non-Indigenous people (53.6 per cent compared to 68.5 per cent). The largest differences were in outer regional areas (55.9 compared with 68.8 per cent) and in major cities (58.8 compared with 69.2 per cent) (table 11A.1.2).
- Part time employment was more common for Indigenous people (35.4 per cent of the labour force) than for non-Indigenous people (27.7 per cent of the labour force).
- Indigenous people in major cities were more likely to be employed part time (33.5 per cent of the labour force) than non-Indigenous people (27.2 per cent of the labour force). There were no significant differences for other remoteness areas (table 11A.1.2).

Figure 11.1.2 **Full time and part time employment, Indigenous people aged 18 to 64 years, 2004-05**[a, b, c, d]



[a] Full time employment is defined as 35 or more hours of work in the reference week. Part time employment is defined as work for one hour or more during the reference week, but fewer than 35 hours. [b] Total non-remote includes major cities, inner regional and outer regional areas; total remote includes remote and very remote areas. [c] Error bars represent 95 per cent confidence intervals around each estimate (that is the total Indigenous employment rate, which includes CDEP and non-CDEP employment) (see chapter 2 for more information). [d] CDEP is a part time employment program, however, CDEP projects may have funding to provide 'top up' employment to some participants giving them an equivalent of full time work.

Source: ABS 2004-05 NATSIHS (unpublished); table 11A.1.3.

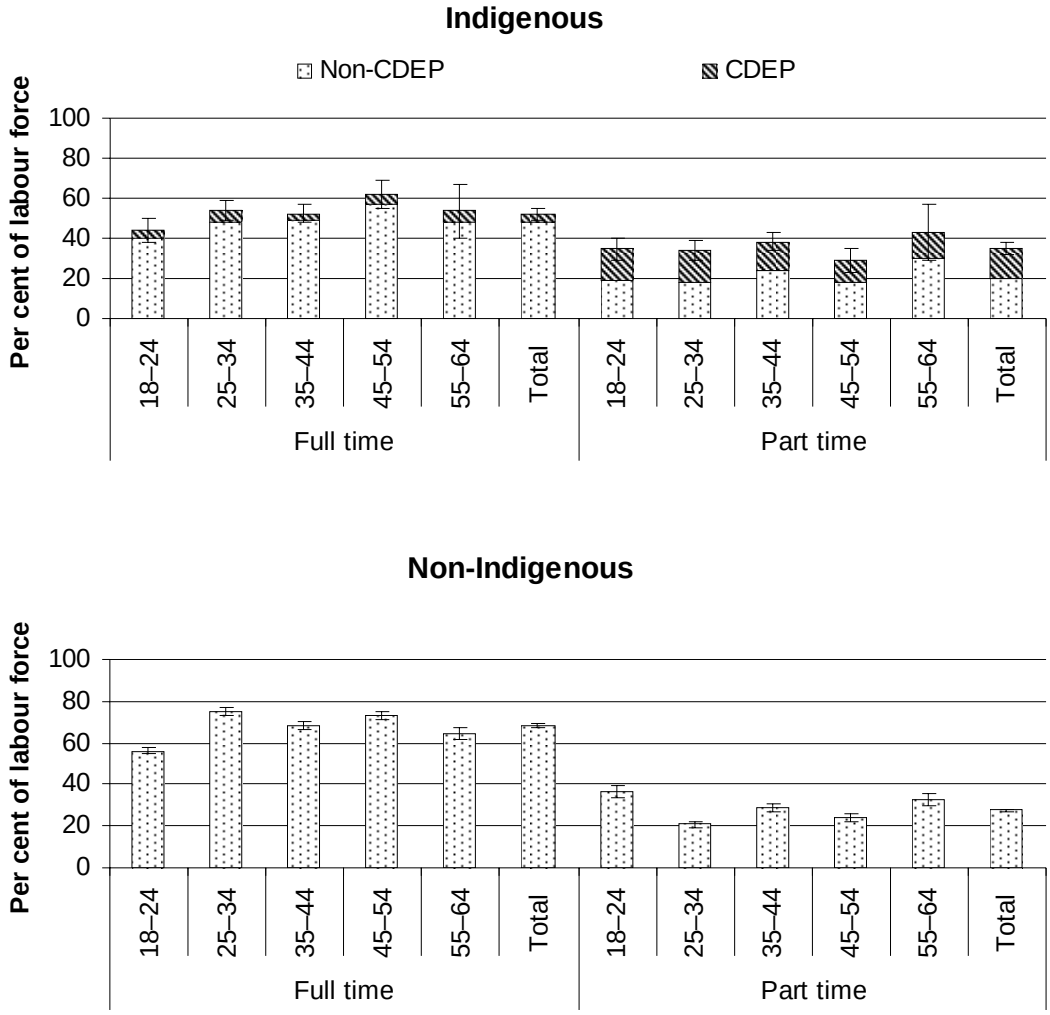
Indigenous data on full time and part time employment by CDEP participant status in the five remoteness areas have been aggregated into two broad categories, 'total remote' and 'total non-remote' (figure 11.1.2). Data on each single category of the five remoteness areas for Indigenous people have high standard errors which would limit the usefulness of such data. 'Total remote' comprises very remote and remote areas. 'Total non-remote' comprises major cities and inner and outer regional areas (see Glossary for detailed definitions of the remoteness areas).

CDEP employment was predominantly part time in 2004-05, as would be expected for a program designed to provide work for two days per week. Full time CDEP employment represents CDEP participants who were able to obtain extra 'top up' employment (on top of normal CDEP hours) to bring their total working hours up to full time. The part time nature of CDEP is particularly significant when considering data on remote area employment, which has a higher proportion of CDEP participation than in non-remote areas.

In 2004-05:

- The proportion of Indigenous adults in full time employment (including CDEP participation) decreased with remoteness (56.8 per cent for 'total non-remote areas' compared to 40.2 per cent for 'total remote areas') (figure 11.1.2).
- The proportion of Indigenous adults in part time employment (including CDEP participation) increased with remoteness (29.7 per cent for 'total non–remote areas' compared to 48.5 per cent for 'total remote areas') (figure 11.1.2).
- CDEP participation in 'total remote areas' accounted for about a third of full time Indigenous employment (11.7 out of 40.2 per cent) and over three quarters of part time Indigenous employment (38.0 out of 48.5 per cent) (figure 11.1.2).
- Rates of non-CDEP full time and part time employment were higher for Indigenous people living in total 'non-remote areas' than those living in 'total remote areas' (figure 11.1.2).

Figure 11.1.3 **Full time and part time employment, people aged 18 to 64 years, 2004-05**[a, b, c]



a Full time employment is defined as 35 or more hours of work in the reference week. Part time employment is defined as work for one hour or more during the reference week, but fewer than 35 hours. **b** Data are not age standardised. **c** Error bars represent 95 per cent confidence intervals around each estimate (for Indigenous data they are for the total Indigenous employment rate for each age group, which includes CDEP and non-CDEP employment) (see chapter 2 for more information).

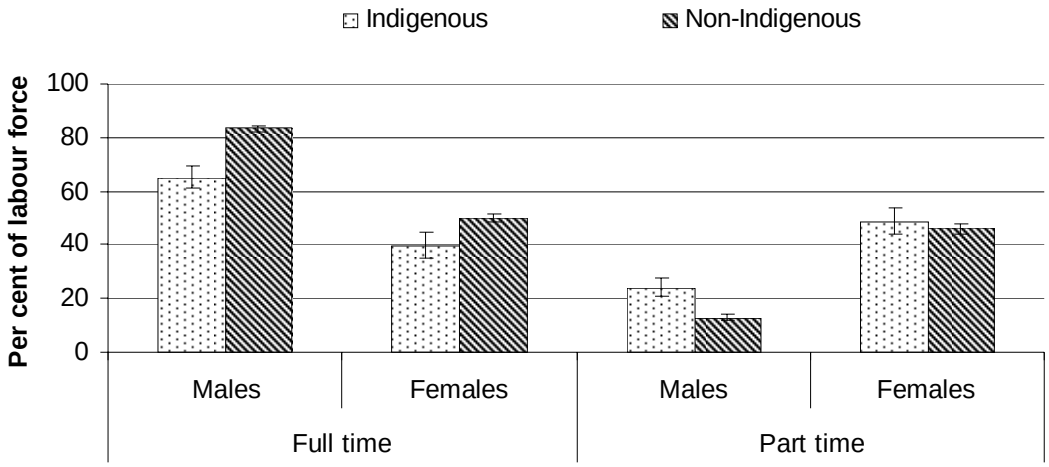
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 11A.1.3.

In 2004-05:

- Indigenous people aged 25 to 44 years were significantly more likely to be in part time employment and less likely to be in full time employment than non-Indigenous people in the same age range (figure 11.1.3).
- The full time and part time employment rates for Indigenous people aged 18 to 24 years and those aged 55 to 64 years were not statistically significantly

different to the rates for non-Indigenous people in the same age groups (figure 11.1.3).

Figure 11.1.4 **Age standardised full time and part time employment, people aged 18 to 64 years, 2004-05[a, b]**



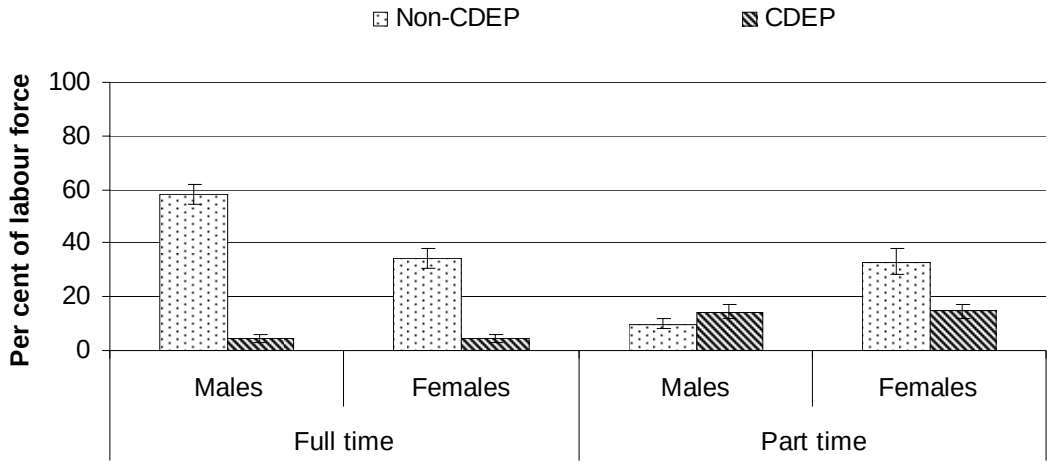
a Full time employment is defined as 35 or more hours of work in the reference week. Part time employment is defined as work for one hour or more during the reference week, but fewer than 35 hours. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 11A.1.2.

After taking into account the different age structures of the Indigenous and non-Indigenous populations, in 2004-05:

- Indigenous men in the labour force were almost twice as likely as non-Indigenous men to be employed part time (24.2 per cent compared to 12.9 per cent) and less likely to be employed full time (65.3 per cent compared to 83.3 per cent) (figure 11.1.4).
- The full time employment rate for Indigenous women (39.8 per cent) was lower than that for non-Indigenous women (50.2 per cent) (figure 11.1.4).
- For both Indigenous and non-Indigenous people, men were more likely than women to be in full time employment and women were more likely than men to be in part time employment (figure 11.1.4).

Figure 11.1.5 **Full time and part time employment, Indigenous people aged 18 to 64 years, 2004-05[a, b]**



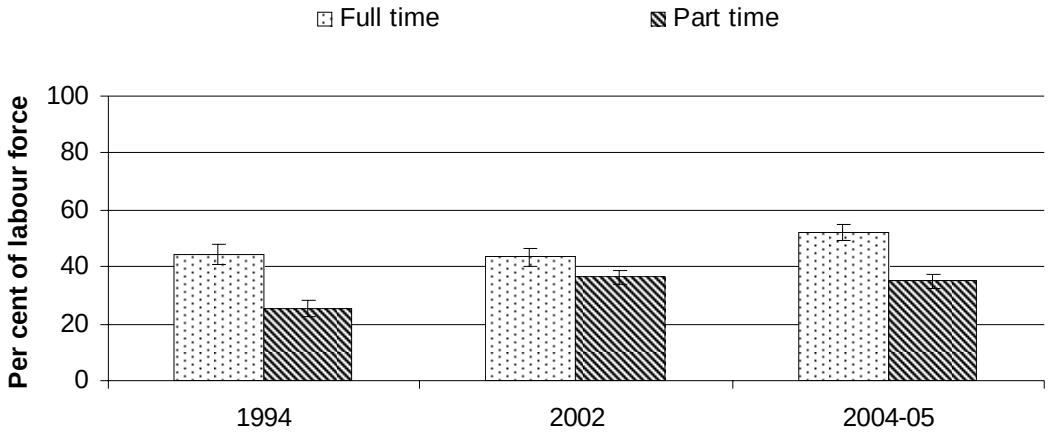
a Full time employment is defined as 35 or more hours of work in the reference week. Part time employment is defined as work for one hour or more during the reference week, but fewer than 35 hours. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS (unpublished); table 11A.1.3.

In 2004-05,

- Rates of both full time and part time CDEP participation for Indigenous men and women were similar (figure 11.1.5).
- The rate of non-CDEP full time employment was significantly higher for Indigenous men (58.5 per cent of the labour force) than for Indigenous women (34.4 per cent of the labour force) (figure 11.1.5).
- Conversely, 33.2 per cent of the Indigenous female labour force was in part time non-CDEP employment compared with 10.0 per cent for Indigenous men (figure 11.1.5).

Figure 11.1.6 **Full time and part time employment, Indigenous people aged 18 to 64 years**[a, b]



a Full time employment is defined as 35 or more hours of work in the reference week. Part time employment is defined as work for one hour or more during the reference week, but fewer than 35 hours. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 1994 NATSIS, 2002 NATSISS, 2004-05 NATSIHS (unpublished); tables 11A.1.4.

- Nationally, the full time employment rate for Indigenous people increased from 44.5 to 52.2 per cent between 1994 and 2004-05. The part time employment rate for Indigenous people increased from 25.5 to 34.9 per cent between 1994 and 2004-05 (figure 11.1.6).
- Increases in Indigenous full time and part time employment over the period from 1994 to 2004-05 are consistent with increases in employment of the total Australian labour force over that period. The full time employment rate for the total Australian population aged 15 years and over increased from 91.9 per cent in 1995-96 to 94.7 per cent in 2004-05. For most of this period, part-time employment increased at a greater rate than full time employment. Between 1999-2000 and 2004-05, part time employment increased from 24.6 to 27.0 per cent of the labour force; while full time employment increased from 67.8 to 68.9 per cent of the labour force (ABS 2002, 2006).
- The increases in Indigenous employment also reflect increases in numbers of CDEP participants over this period. In 1996 there were 28 422 CDEP places, increasing to 35 182 in 2002 and 34 775 in 2004-05 (DEWR 2005; ATSIC 2003).[1]

1 The 2004-05 NATSIHS estimated 30 600 Indigenous people on CDEP in 2004-05, which was much lower than the number of participants according to administrative data; for example, DEWR (2005) reported 34 775 CDEP participants as at 30 June 2005.

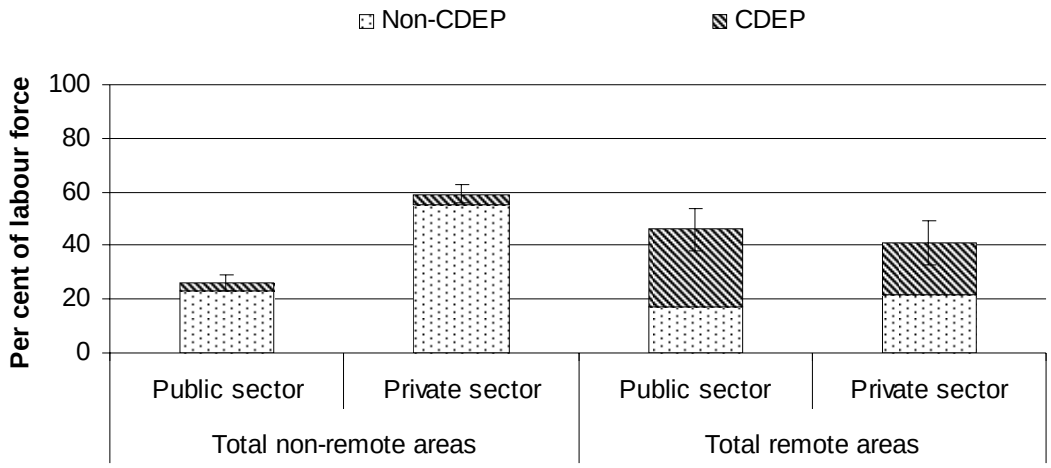
Data on full time and part time employment by State and Territory are reported in table 11A.1.2.

Employment by public/private sector, industry and occupation

After taking into account the different age structures of the Indigenous and non-Indigenous populations, in 2004-05:

- Indigenous people were significantly more likely to be employed in the public sector (33.1 per cent of the labour force) compared to non-Indigenous people (16.5 per cent of the labour force) (table 11A.1.6).
- Non-Indigenous people were significantly more likely to be employed in the private sector (78.5 per cent of the labour force) than Indigenous people (54.8 per cent of the labour force) (table 11A.1.6).

Figure 11.1.7 **Employment by public/private sector, Indigenous people aged 18 to 64 years, 2004-05[a, b]**



a Total non-remote includes major cities, inner regional and outer regional areas; total remote includes remote and very remote areas. **b** Error bars represent 95 per cent confidence intervals around each estimate (that is the total Indigenous employment rate, which includes CDEP and non-CDEP employment) (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS (unpublished); table 11A.1.7.

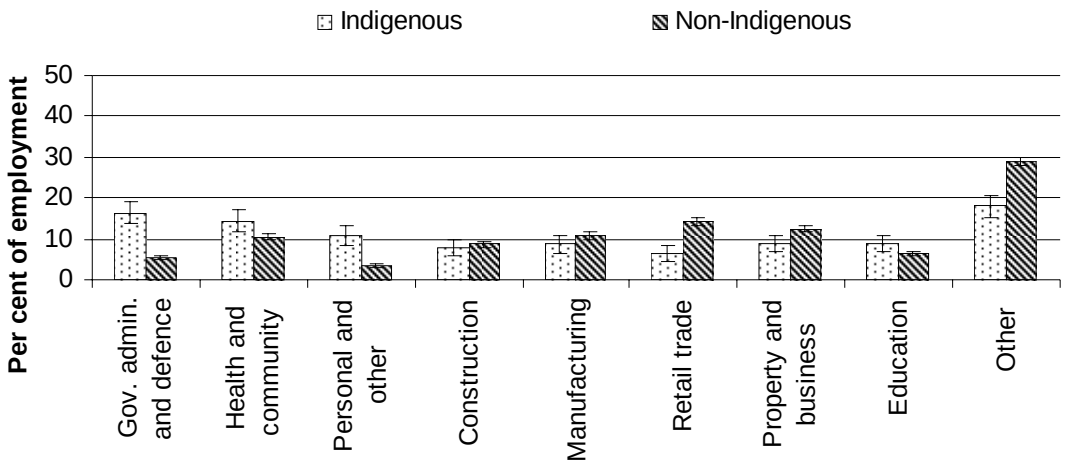
In 2004-05:

- Indigenous employment in the private sector (including CDEP participation) decreased with remoteness. The employment rate in the private sector was 59.3 per cent for Indigenous people living in 'total non-remote areas' compared to 41.2 per cent for those in 'total remote areas' (figure 11.1.7).

- Indigenous employment in the public sector (including CDEP) increased with remoteness. The employment rate in the public sector was 26.1 per cent for Indigenous people living in 'total non-remote areas' compared to 45.8 per cent for those in 'total remote areas' (figure 11.1.7).
- CDEP comprised a significant proportion of Indigenous employment in 'total remote areas', where CDEP participation accounted for 63.5 per cent of Indigenous employment in the public sector and 47.6 per cent of Indigenous employment in the private sector (figure 11.1.7).

Data on employment by public/private sector and by age and sex are reported in table 11A.1.7.

Figure 11.1.8 **Age standardised employment by industry, people aged 18 to 64 years, 2004-05[a, b]**



a Other industries include: transport and storage; culture and recreational services; agriculture, forestry and fishing; accommodation, cafes and restaurants; finance and insurance; wholesale trade; communication services; mining; electricity, gas and water supply. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

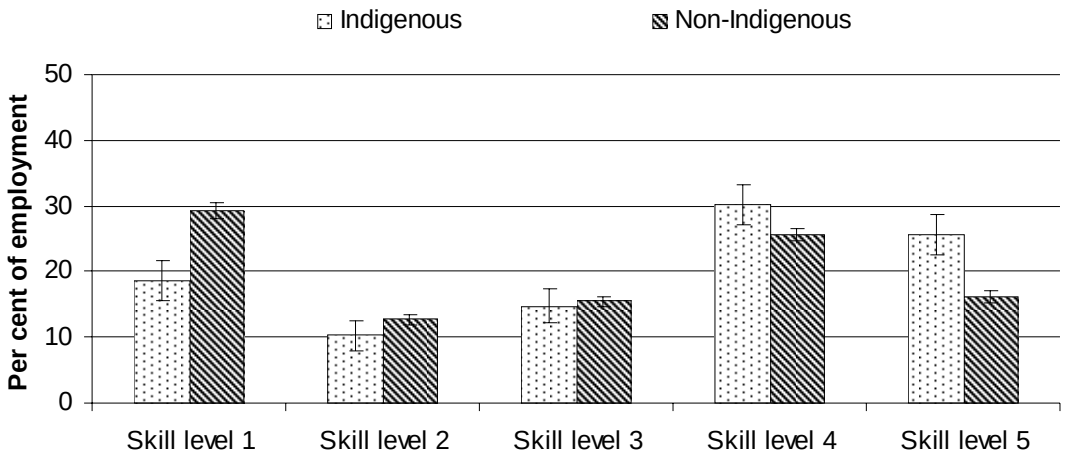
Source: ABS 2004-05 NATSIHS and NHS (unpublished); tables 11A.1.8 and 11A.1.9.

After taking into account the different age structures of the Indigenous and non-Indigenous populations, in 2004-05:

- Indigenous people were more likely than non-Indigenous people to be employed in the industries of government administration and defence (16.4 compared to 5.3 per cent of total employed people), health and community services (14.4 compared to 10.4 per cent of total employed people), personal and other services (10.7 compared to 3.4 per cent), and education (8.9 compared to 6.2 per cent of total employed people) (figure 11.1.8).

- CDEP participation accounted for a significant proportion of Indigenous employment in the public sector, particularly in remote and very remote areas (figure 11.1.7). Government administration and defence, health and community services, personal and other services, and education are the major components of the public sector.
- Non-Indigenous people were more likely than Indigenous people to be employed in retail trade (14.1 compared to 6.4 per cent of total employed people), and property and business services (12.3 compared to 8.8 per cent of total employed people) (figure 11.1.8).

Figure 11.1.9 **Age standardised employment by skill level of occupations, people aged 18 to 64 years, 2004-05[a]**



Skill level 1 — managers and administrators and professionals; Skill level 2 — associate professionals; Skill level 3 — tradespersons and related workers and advanced clerical and service workers; Skill level 4 — intermediate production and transport workers and intermediate clerical, sales and service workers; Skill level 5 — elementary clerical, sales and service workers and labourers and related workers.

a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 11A.1.10.

Data on skill levels reported in this chapter are based on the ABS Australian Standard Classification of Occupations (ASCO) Second Edition, which classifies occupations, their associated skill levels and skill specialisations. Skill levels are measured by formal education and training, and previous experience usually required for entry into an occupation. A collection of jobs which are sufficiently similar in their main tasks is grouped together for the purposes of classification. The ASCO assigns nine major occupation groups to five skill levels: Skill level 1 — managers and administrators and professionals; Skill level 2 — associate professionals; Skill level 3 — tradespersons and related workers and advanced clerical and service workers; Skill level 4 — intermediate production and transport

workers and intermediate clerical, sales and service workers; Skill level 5 — elementary clerical, sales and service workers and labourers and related workers.

After taking into account the different age structures of the Indigenous and non-Indigenous populations, in 2004-05:

- A significantly higher proportion of Indigenous people than non-Indigenous people were employed in occupation groups that require relatively lower levels of skills: skill level 4 — intermediate production and transport workers and intermediate clerical, sales and service workers (30.1 compared to 25.6 per cent); and skill level 5 — elementary clerical, sales and service workers and labourers and related workers (25.6 compared to 16.1 per cent) (figure 11.1.9).
- A significantly lower proportion of Indigenous people than non-Indigenous people (18.6 compared to 29.3 per cent) were employed in the occupation group that requires the highest level of skills: skill level 1 — managers and administrators and professionals (figure 11.1.9).

11.2 Self employment and Indigenous business

Box 11.2.1 **Key messages**

- In non-remote areas in 2004-05, the rate of self employment for Indigenous people was markedly lower than that for non-Indigenous people (table 11A.2.1).
- The most recent nationally comparable data that can be reported for the Indigenous self employment and business indicator are the ABS 2001 Census data that were published in the 2003 Report.
- The 2003 Report noted that the difference between the rates of self employment between non-Indigenous and Indigenous people varied significantly across remoteness areas; the largest difference was found in very remote areas, where non-Indigenous people were nine times as likely as Indigenous people to be self employed.

Self employment is an important part of the economic participation and development of both Indigenous and non-Indigenous people. Following suggestions from consultation on the 2005 Report, this indicator has been expanded to include information on Indigenous business, which also has the potential to contribute to economic participation and development for Indigenous people.

Self employment and participation in ownership of enterprises can allow people to reduce reliance on government welfare and improve self sufficiency. It also can improve the overall level of economic participation, which affects many aspects of

people's wellbeing (see section 11.1 for detailed discussion). The IBA (2003) noted that the number of Indigenous people who are self employed as a proportion of the Indigenous labour force is significantly lower than for the rest of the population. Australia's Indigenous people also lag behind New Zealand's Maori people in terms of self employment. Those Indigenous people who are self employed tend to be employed in trade and lower skilled occupations such as plant and machinery operators and labourers (Hunter 1999).

There are several reasons for low rates of self employment and ownership of enterprises for Indigenous people in Australia. Hunter (1999) has noted that governments have typically emphasised business opportunities at the Indigenous community level rather than self employment. Indigenous people are more likely than non-Indigenous people to have poor education and training in relation to business enterprises (see sections 3.3, 3.4 and 11.4). For a variety of reasons, Indigenous people can have difficulty accessing capital and infrastructure and business opportunities are often limited in remote areas.

This Report includes data on self employment for Indigenous and non-Indigenous people living in non-remote areas. These data are from several ABS surveys, including the 2001 National Health Survey: Aboriginal and Torres Strait Islander Results (NHS(I)), the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), and the 2001 and 2004-05 National Health Surveys (NHS). Data on self employment for remote and very remote areas were not collected in these surveys. The most recent nationally comparable data that can be reported for the Indigenous self employment and business indicator are the ABS 2001 Census data that were published in the 2003 Report.

For people living in non-remote areas, in 2004-05:

- The age standardised rate of self employment (comprising employers and own account workers) among all employed Indigenous people was much lower than for non-Indigenous people regardless of sex, age and remoteness area (table 11A.2.1).
- For non-Indigenous people, men (14.9 per cent of total employed) were more likely to be self employed than women (10.6 per cent of total employed) (table 11A.2.1).
- There was no statistically significant difference in the self employment rate between Indigenous men and women (table 11A.2.1).

Figure 11.2.1 **Age standardised self employment as a proportion of total employed, people aged 18 to 64 years, non-remote areas** [a, b, c, d]

[a] Self employment data comprise employers and own account workers. [b] Data on self employment for remote and very remote areas were not available for this comparison. [c] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). [d] 2001 data for Indigenous males and females have relative standard errors of 25 per cent to 50 per cent and should be used with caution. 2004-05 data for Indigenous females have a relative standard error of 25 per cent to 50 per cent and should be used with caution.

Source: ABS 2001 NHS(I), 2004-05 NATSIHS, and 2001 and 2004-05 NHS; table 11A.2.1.

For people living in non-remote areas:

- Between 2001 and 2004-05, there were no statistically significant changes in the self employment rates for Indigenous people, for both men and women.
- By comparison, the self employment rate for all employed non-Indigenous people fell from 21.0 per cent in 2001 to 13.0 per cent in 2004-05, for both men and women.

Based on data from the ABS 2001 Census, the 2003 Report noted that the difference between the rates of self employment between non-Indigenous and Indigenous people varied significantly across remoteness areas; the largest difference was found in very remote areas, where non-Indigenous people were nine times as likely to be self employed than Indigenous people.

In the absence of new national data on self employment, case studies of Indigenous business are presented in boxes 11.2.2, 11.2.3 and 11.2.4.

Box 11.2.2 **Walking Tourism Business (Qld)**

Through a small, Indigenous owned enterprise, Wujal Wujal Walker Family Tours provide guided walking tours through the Daintree Rainforest in Queensland. Operating since 2003, visitors learn about the history of the Kuku Yalanji people, bush medicine and bush tucker from the traditional owners of the Wujal Wujal region. The enterprise works in partnership with non-Indigenous tourism businesses in the region. Balkanu's Business Hub and Westpac helped the business with business plans, marketing and business negotiations.

In 2005, Walker Family Tours:

- won the Queensland Premier's Reconciliation Business Award
- conducted 399 tours for over 2200 customers.

Customer numbers have grown substantially since 2005 and the business currently attracts over 15 per cent of the 20 000 people who visit the Bloomfield Falls each year.

A further grant assisted in expanding the business with a motorised food and beverage outlet which is set up at the Bloomfield Falls walk to sell food and drinks, and to act as a ticket office for sales of the walking tours to passing self-drive tourists.

Source: Indigenous Stock Exchange 2004; Queensland Government (unpublished).

Box 11.2.3 **Ngarda Civil and Mining (WA)**

Ngarda Civil and Mining (Ngarda) is a contract mining business based in Port Hedland, Western Australia. The company was established in 2001 as a joint venture between Henry Walker Eltin, the Ngarda Ngarli Yarndu Foundation and Indigenous Business Australia, which has 25 per cent ownership. The business has an Indigenous employment target of at least 50 per cent of its workforce.

In its first year of operation (2001-02), Ngarda obtained contracts worth $6.8 million and created 65 jobs for Indigenous people, predominantly from the Pilbara region of Western Australia. In 2005-06, Ngarda obtained contracts worth $44 million, performed by a workforce of 142 permanent staff of whom 81 are Indigenous. As at June 2006, approximately 59 per cent of Ngarda's staff were Indigenous, an Indigenous staffing rate not seen elsewhere in the mining sector.

Indigenous Business Australia (IBA) develops programs to assist Indigenous groups, families and individuals to participate in commercial enterprises through investments with the private sector and/or IBA. The programs also assist Indigenous partners to participate on boards of management and boards of directors, to build capacity in corporate governance. Ngarda Civil and Mining is a successful business, and won the Prime Minister's Award for Excellence in Community Business Partnerships in 2003.

Box 11.2.4 **Indigenous Business Australia — IBA Enterprises**

Indigenous Business Australia's (IBA) Business Development Programme, known as IBA Enterprises, directly assists Indigenous individuals, families and partnerships to succeed in business. This is achieved through support for clients preparing to go into business, and the provision of business loans and mentoring to Indigenous business people.

IBA Enterprises also undertakes economic development initiatives to encourage Indigenous people into business and to provide them with information and training. IBA Enterprises' holistic approach provides a continuum of support that helps Indigenous individuals to get into business and to succeed.

Nationally, business support approvals by IBA Enterprises totalled:

- $3 211 890 in 2004-05
- $4 226 972 in 2005-06
- $6 595 620 for 2006-07 (to February 2007).

Nationally, loan approvals by IBA Enterprises totalled:

- $5 578 595 in 2004-05
- $14 189 312 in 2005-06.

Source: Indigenous Business Australia (unpublished)

11.3 Indigenous owned or controlled land

Box 11.3.1 **Key messages**

- Indigenous (and non-Indigenous) people obtain a variety of economic, social and cultural benefits from land they own or control.
- In June 2006, native title had been determined to exist in full or part in 8.2 per cent of the total area of Australia, compared with 4.7 per cent in June 2004 (figure 11.3.3). The national increase was around 264 210 km^2, with the major increase occurring in WA.
- The number of registered Indigenous Land Use Agreements (ILUAs) increased from 84 in June 2003 to 250 in June 2006 (figure 11.3.4). Over this period, the total land area subject to ILUAs grew from 239 219 km^2 to 812 866.3 km^2, or 10.6 per cent of the total area of Australia.
- Indigenous land interests are also protected under various forms of legislation that enable the grant or purchase of land by governments for Indigenous ownership or use. The Indigenous Land Corporation (ILC) has acquired 201 properties across Australia, covering more than 5.5 million hectares. Examples of State and Territory grants and transfers of land to Indigenous people are also included in this section.

Ownership and control of land can provide a range of benefits to Indigenous people. Land ownership may lead to greater autonomy and economic independence, increased commercial leverage and political influence. It can also deliver commercial benefits like increased income, employment and profits (Altman and Dillon 2004).

Indigenous owned or controlled land is included in this Report as an indicator of economic participation and development. It is, however, also important in terms of the social and cultural relationships between Indigenous peoples and their land, which is discussed in section 9.5.

Over the past 200 years, many Indigenous people have moved or have been moved from the traditional country of their ancestors. In some cases, Indigenous people may have negotiated access to, or derived benefits, from their traditional land without owning or controlling that land (access to traditional land is discussed further in section 9.5).

Indigenous people may own or control land in a variety of ways. Individuals may buy, or otherwise gain freehold title to land (see section 3.7 on home ownership). In contrast, many of the processes and programs to protect Indigenous land interests result in communal ownership or control of land. For instance, the Indigenous Land Corporation purchases land on behalf of Indigenous groups. Examples include

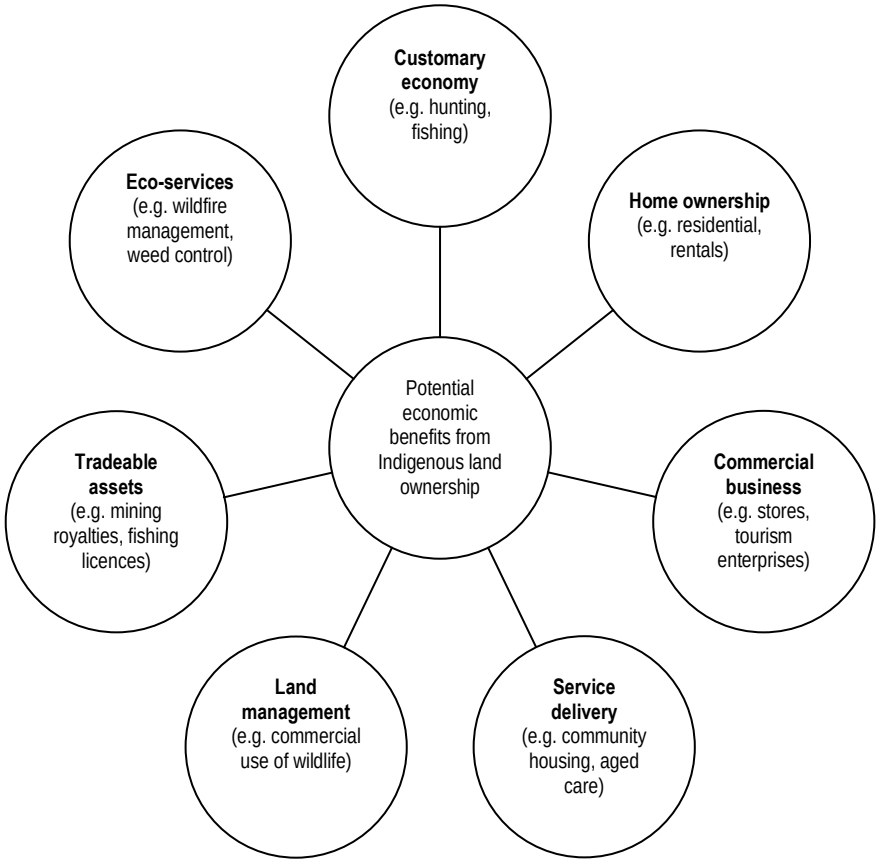
buying a building in Sydney for Indigenous aged care support, and acquiring rural land to boost Indigenous involvement in the pastoral industry. The rights and interests that accrue to Indigenous people under native title and Indigenous Land Use Agreements (ILUAs) are also communally held, and provide varying levels of control and management of lands.

In September 2006, the Australian Government passed the *Aboriginal Land Rights (Northern Territory) Amendment Act*. The Act is intended to encourage individual property rights in town areas on Indigenous communally owned land in the NT. The Act enables 99 year head leases to government entities, which can subsequently make sub-leases.

The economic benefits of land

Figure 11.3.1 outlines the potential economic benefits that may accrue to Indigenous people from owning and/or controlling land.

Figure 11.3.1 **Potential economic benefits from Indigenous owned or controlled land**



Source: Adapted from Altman and Dillon (2004).

The potential to derive economic benefits from activities on land depends on a number of aspects, including:

- the location of the land — remoteness from markets and population centres adds to the costs of delivering products and services from some Indigenous communities
- the nature of the land — opportunities to profit from mining, agriculture and tourism depend, respectively, on the presence of certain minerals, rainfall and soil fertility, and places and activities that appeal to tourists
- the extent of ownership and control over the land — some land is held communally and/or with a restricted title, which may limit certain economic activities (for example, leasing or selling the land to others, or restrictions on land use).

Communal land ownership and native title rights and interests can provide Indigenous people with negotiation rights over land. The bargaining power of Indigenous landholders depends on the property, resource and negotiation rights Indigenous people have under law, as well as the negotiating skills and resources at their disposal.

The customary economy

The customary economy (fishing, hunting and gathering) can provide Indigenous people with fresh and healthy food, and remains an important part of some Indigenous communities, particularly for those living in the tropical savannas and wetlands (Altman 2001).

A study conducted of residents of Utopia and other outstations in central Australia found that the outstation residents had lower rates of diabetes, cardiovascular risk factors, hospitalisations and deaths compared to those living in centralised communities (McDermott et al. 1998). One of the reasons for this comparatively good health was the dependence on bush tucker (native foods). Those who hunted and gathered exercised more and had a more varied diet than those who depended on store-bought food (McDermott et al. 1998).

In SA, the Kuka Kanyini project, on Anangu Pitjantjatjara Land, maintains culture, manages traditional country, conserves biodiversity and improves the social, economic and emotional wellbeing of local people. The project maintains traditional fire management regimes to avoid fires that can destroy the local mulga woodlands (from which foods and traditional medicines are hunted and gathered). The fire management regime also contributes to pest control. The project employs a

minimum of 12 people full time, and the increased physical activity has assisted in the control of diabetes (SA Government unpublished).

Residential use and home ownership

Ownership and/or control of land can provide people with a place to live. Many Indigenous people live in community housing which has been built on Indigenous land (see section 3.7). Section 9.5 provides some information on the numbers of Indigenous people who live on their homelands or traditional country (but, as explained in section 9.5, this is not necessarily the same as the numbers of people living on Indigenous owned or controlled land). People who own their homes may gain economic benefits from living in, renting out, selling or borrowing against the property.

Commercial business

Commercial businesses sell goods or services to the general public and include enterprises like shops and eco-tourism ventures.

The ILC operates and manages 10 commercial businesses throughout Australia, and in 2005-06 employed 194 Indigenous people in a range of roles. These businesses are mainly large scale beef cattle enterprises, but also include tourism businesses and two orchards. The ILC is currently focusing its programs on employment, training and education opportunities, particularly in the pastoral and tourism industries.

The Lundin Warra Aboriginal Corporation, an Indigenous-owned enterprise, runs Wujal Wujal Walker Family Tours, providing guided walking tours through the Daintree Rainforest in Queensland (see box 11.2.2 for more information).

Service delivery

Land can be used to site and deliver services to Indigenous communities (such as community housing, aged care and postal services).

The Wunan Foundation is a not-for-profit Indigenous organisation in the East Kimberley (WA). It provides a range of services aimed at improving socio-economic outcomes for Indigenous people, including:

- training and development programs for Indigenous people
- a wilderness adventure tourism business in partnership with Australian Pacific Touring.

- land-based investments for capital growth and the provision of community housing (Wunan Foundation 2006).

The Larrakia Development Corporation (LDC) was established in 2002 with the assistance of the Northern Land Council, to manage the development of land exchanged as part of a native title claim settlement with the NT Government. The LDC has completed a housing development on land in Palmerston in the NT. The Corporation is debt free and has returned dividends of $250 000 in grants to the Larrakia people. Income is divided evenly between the Larrakia Development Trust (established to coordinate community projects for the Larrakia people) and the LDC. In addition, the LDC has generated employment and training opportunities for local Aboriginal people both through its own development activities and through its employment placement agency.

Land management/tradeable assets

Agreements have been reached with governments and others (for example, mining companies and pastoralists) over land use. These agreements can yield economic and other benefits, including monetary payments; support for community services, facilities and infrastructure; employment and training programs; and protection of cultural sites. Some agreements have provided substantial benefits for Indigenous people, while the benefits from others have been more modest (see O'Faircheallaigh and Corbett 2005, O'Faircheallaigh 2006, and Altman and Levitus 1999).

Altman and Smith (1994, 1999) provide some examples of how different approaches have influenced the economic benefits of mining royalties to Indigenous people. Sections 11.4 and 11.5 explore some aspects of governance and capacity building that can affect the way royalties are negotiated and used.

Many Australian, State and Territory government programs recognise and employ Indigenous peoples' land management skills. For example:

- In NSW, the *National Parks and Wildlife Act 1974* provides for Aboriginal people to be owners and joint managers of certain conservation reserves. By February 2007, four conservation reserves had been handed to Aboriginal ownership and control (NSW Government unpublished).
- In SA, Cooperative Management Agreements have been created with local Aboriginal groups for three parks, one which is located on Indigenous freehold land. In addition to cultural and environmental benefits, these agreements provide for the employment and training of local Aboriginal people in the management of the parks (Government of South Australia 2006).

- In the NT, an agreement between the NT and Australian governments provides for Indigenous management over land and sea country. The agreement also aims to boost employment and economic development through natural resource management activities and associated industries (NT Government unpublished).

Eco-services

Eco-services are aimed at supporting sustainable natural resource management and include feral animal control, quarantine inspection, bush fire management and weed eradication programs (Altman and Dillon 2004).

In the NT, the Carpentaria Ghost Nets Programme seeks to address the problem of fishing nets that have been lost or abandoned at sea. Ghost nets travel the ocean, continually fishing indiscriminately. Indigenous Sea Rangers noted that many turtles were being captured in ghost nets that were washing up on the beaches. The Ghost Nets Programme is funded to clean the coastline in the Gulf of Carpentaria of existing nets to stop them re-entering the ocean.

In the NT, the Arnhem Land Bushfire Council District applies Indigenous knowledge and skills to fire management on land owned and controlled by the traditional owners. Indigenous membership on the Northern Territory Bushfires Council has expanded and an Indigenous Fire Controller has been appointed. Benefits to Indigenous people have included improved community access to equipment and training.

Box 11.3.2 presents the Indigenous Pastoral Program in the NT. The program is run as a commercial business that incorporates land management and eco-service activities on Indigenous land.

Box 11.3.2 **'Things that work' — the Indigenous Pastoral Program**

The Indigenous Pastoral Program (IPP) was established in 2003 by the Indigenous Land Corporation, the NT Government and Northern and Central Land Councils to:

- increase the level of sustainable pastoral production on Indigenous land
- increase the level of Indigenous involvement in the pastoral industry through training and employment.

The IPP aims to generate 1000 new Indigenous jobs in the pastoral industry over the next 10 years.

(Continued next page)

Box 11.3.2 (continued)

In 2006, funding for the IPP was extended for a further 5 years and the program expanded to involve the NT Cattleman's Association and the Department of Employment and Workplace Relations. By 2007, 26 properties were involved in the program, and benefits included:

- an increase of 28 500 cattle run on Indigenous land
- agreements under negotiation, or in place, with the capacity to run a further 40 000 cattle
- more than 14 500 km² of land under new agreements that allow for improved economic and environmental management
- 53 seasonal and contracting jobs in stock camps and infrastructure development
- 28 successful traineeships through the Barkley Indigenous Pastoral Traineeship Scheme
- over 72 participants attending pastoral training workshops in Central Australia
- more than 100 company directors and land owners engaged in corporate governance training on 10 properties with funding secured through FarmBis.

One of the key learning outcomes has been the important role of mentors throughout the training and employment phase, which has improved employment retention. Increasing the level of Indigenous involvement in the industry is an important outcome. IPP will also benefit Indigenous land and operations as skilled people can return to Indigenous land and enterprises.

In addition to the economic benefits derived from increased pastoral activity, there are substantial environmental and cultural benefits through improved management of weeds, fire and feral animals, and increased access to country because of the reestablishment of pastoral infrastructure.

Source: Indigenous Land Corporation (unpublished).

Measuring areas of Indigenous owned or controlled land

Land area alone is an imperfect indicator of the benefits Indigenous people derive from owning land. The commercial value of land varies widely and much of the Indigenous owned or controlled land in Australia is of low commercial value. There are only limited data on the extent to which Indigenous people use their land for various economic or other purposes and the benefits they obtain from it.

Land areas and proportions reported for this indicator are for communally owned or controlled Indigenous land. Communally owned Indigenous land can be identified from land registers and other sources. Some Indigenous individuals and families also own land in their own right, but no data are available on the ownership of land

by individual Indigenous people, as State and Territory land registers do not contain an Indigenous identifier. The only data on ownership of land by individual Indigenous people are data on home ownership, which are included earlier in this Report under the headline indicator on home ownership (section 3.7).

There are various forms of tenure for Indigenous communal lands under various Australian, State and Territory legislation, including reserves, leases, alienable freehold and inalienable freehold. The strongest (and most widespread) form of tenure of Indigenous land is inalienable freehold, which cannot be 'alienated' by selling or mortgaging it, so that continuing Indigenous ownership is protected. The sections below outline the most common forms of assigning Indigenous ownership and/or control over land.

Land subject to native title rights and interests

The National Native Title Tribunal (NNTT) manages the legal process to register native title claims and mediate outcomes. Claims to land are determined through the court system. Native title is a bundle of rights rather than a form of underlying title, that may in certain circumstances amount to exclusive possession, but often manifests through co-existing rights and interests with the underlying title holder. The NNTT (2002b) defines native title as follows:

> Native title is the recognition in Australian law that Indigenous people had a system of law and ownership of their lands before European settlement. Where that traditional connection to land and waters has been maintained and where government acts have not removed it, the law recognises aspects of this as native title. The native title of a particular group will depend on the traditional laws and customs of those people. The way native title is recognised and practised may vary from group to group.

The types of native title rights recognised in a determination of native title vary according to both the rights and interests under the relevant group's traditional laws and customs, and the extent to which a government has created or asserted rights that are inconsistent with any claimed native title right. Over time, the courts interpret whether particular acts concerning the land have the effect of extinguishing native title in full or in part. The courts have determined, for example, that granting of freehold title completely extinguishes native title on that land. On the other hand, when a pastoral lease does not give a lessee exclusive possession, native title is only partially extinguished (for further information, see NNTT 2002a, 2003).

Indigenous Land Use Agreements

Indigenous Land Use Agreements (ILUAs) are agreements about the use and management of land and waters, made between one or more native title groups and other people.

ILUAs are made possible by the *Native Title Act 1993*, but are less formal and less time consuming than the process of a native title determination. ILUAs are used in a variety of ways. They may be:

- a step on the way to a native title determination
- used in place of a native title determination
- made about matters such as mining developments, sharing land and exercising native title rights and interests (NNTT 2006).

While ILUAs lack the formality of native title, they have the advantages of allowing for more flexible, relatively speedy and less costly resolutions between land users. Indigenous people may negotiate agreements that lead to economic benefits, like employment and compensation (NNTT 2006). ILUAs are not costless, however. Hooke (2004) has outlined some of the costs incurred by mining companies in meeting their own costs (and often those of the native title representative bodies representing Indigenous claimants) in negotiating agreements.

The number and coverage of ILUAs are included later in this chapter. However, this provides only limited information on the economic and social benefits to Indigenous people from such agreements.

Other legal Indigenous land interests

'Other legal Indigenous land interests' refers to land that has been granted, or purchased, by governments for Indigenous ownership, or is held by governments for Indigenous use under various forms of government legislation. These legal Indigenous land interests are distinct from native title. Pollack (2001) and the ILC (2001a–g) explain in some detail the legislative basis and government programs for Indigenous land ownership in each jurisdiction.

Nationally, the ILC exists to purchase land on behalf of Indigenous people and assists in land management, including capacity building. The ILC has a legislated responsibility to develop and review regularly a National Indigenous Land Strategy (NILS). A new NILS for 2007 to 2112 was approved by the ILC Board in February 2007.

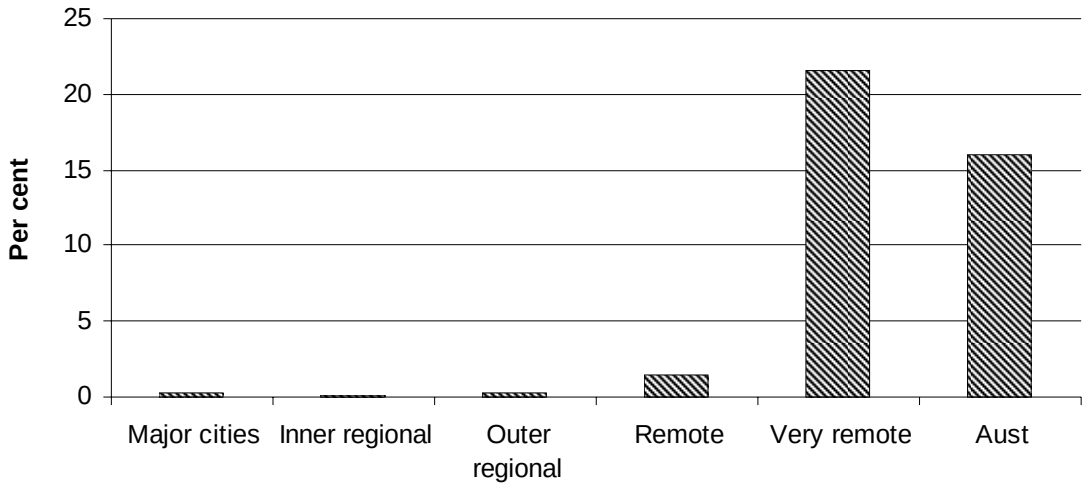
An example of State/Territory legislative regimes is the *Aboriginal Lands Act 1995* in Tasmania, which was enacted to return Aboriginal land. By 2006, 55 597 hectares of land had been returned under the Act, including the culturally significant sites Wybalenna, Cape Barren Island and Clarke Island. The land is vested in the Aboriginal Land Council of Tasmania as freehold land in perpetuity, and cannot be mortgaged.

Area of Indigenous owned or controlled land

Indigenous owned or controlled land is either held by Indigenous communities or held by governments on behalf of Indigenous people. Land held by Indigenous communities is usually owned by an Indigenous corporation, controlled by Indigenous people. Data on Indigenous landholdings by different forms of tenure are reported in tables 11A.3.1 and 11A.3.2.

The area and distribution of Indigenous owned or controlled land in Australia date back to the decisions of governments in the 1970s and 1980s. In recent years, the rate of land grants has slowed. However, native title decisions, ILC land purchases and other land rights programs continue to add to the total amount of land owned or controlled by Indigenous people.

Figure 11.3.2 **Indigenous owned land as a proportion of the area of each remoteness area, December 2006**



Source: ILC (unpublished); table 11A.3.2.

- Nationally, in 2006, Indigenous owned or controlled land comprised 16.0 per cent of the area of Australia (figure 11.3.2).

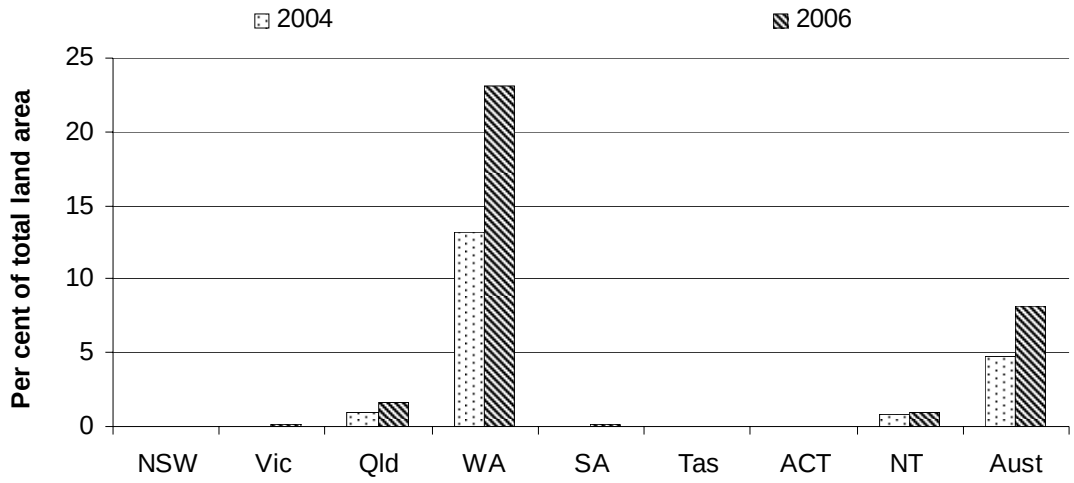
- Indigenous owned or controlled land comprised 21.5 per cent of the combined land area of very remote areas of Australia in 2006, but only 0.1 per cent of inner regional areas and 0.2 per cent of major cities (figure 11.3.2).
- Nearly all (98.6 per cent) Indigenous owned or controlled land is in very remote areas of Australia (table 11A.3.2).
- The bulk of Indigenous owned or controlled land is in the NT (49.1 per cent), WA (29.6 per cent) and SA (16.5 per cent) (table 11A.3.1).
- Indigenous owned or controlled land makes up 44.8 per cent of the NT, but less than 1 per cent of the area of NSW, Victoria, Tasmania and ACT (table 11A.3.1).
- Between 2005 and 2006, there was little or no change to the proportions of Indigenous owned or controlled land.
- Between 1995 and 2006, the ILC acquired 201 properties in remote, rural and urban locations covering more than 5.5 million hectares, at a total cost of nearly $170 million (see table 11A.3.11 for a map of the ILC's land acquisition activity).

Determinations of native title

The majority of native title applications that have been lodged by Indigenous people are yet to be determined by the Federal Court of Australia. As at March 2007, 540 active native title claimant applications were in the system, and 91 native title determinations had been made (NNTT unpublished).

Data are not readily available to compare areas with native title giving exclusive possession of land with areas where native title may have been partially extinguished.

Figure 11.3.3 **Determinations that native title exists**[a, b c, d, e, f]



[a] At 30 June. [b] Areas are based on the geographic extent of the determination area as per the court's decision. Parts of these determinations may not be included on the National Native Title Register at this time. Where native title has been extinguished within a determination area and it has been possible to map these areas then they have been included in the calculations. [c] Area for SA includes areas subject to appeal. [d] Total land areas of states and territories include islands adjacent to the mainland — figures sourced by the NNTT from Geoscience Australia. [e] Australian total includes Jervis Bay Territory and Commonwealth waters where determinations of native title have been made. [f] As at 30 June 2006, native title had been found to exist in full or in part on 0.1 km^2 of land in NSW, which is not large enough to show on this graph.

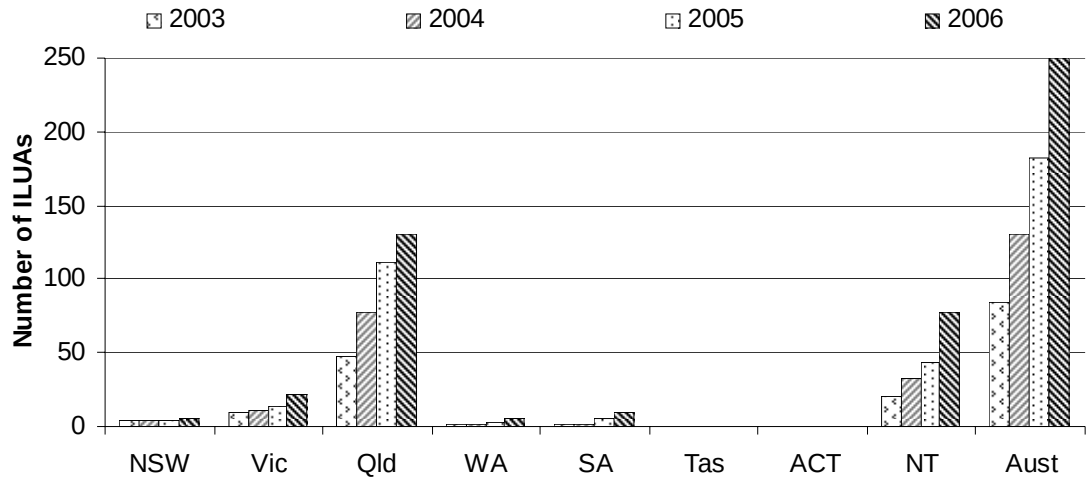
Source: NNTT (unpublished); table 11A.3.3.

- In June 2006, native title had been determined to exist in full or in part in 8.2 per cent of the total area of Australia, compared with 4.7 per cent in June 2004 (figure 11.3.3). The national increase was around 264 210 km^2, with the major increase occurring in WA.
- In 2006, native title had been determined to exist in full or in part in 23.0 per cent of WA but there had been no determinations that native title exists in Tasmania or the ACT.
- Most land where native title had been determined to exist in full or in part in 2006 was in very remote areas (99.7 per cent). Native title had been found to exist in 11.1 per cent of land in very remote areas (table 11A.3.4).
- Tables 11A.3.7 and 11A.3.8 show maps of determinations of native title by State/Territory and remoteness area.

Indigenous Land Use Agreements

The number of ILUAs agreed since 2003 is shown in figure 11.3.4.

Figure 11.3.4 **The growth of Indigenous Land Use Agreements (cumulative)[a]**

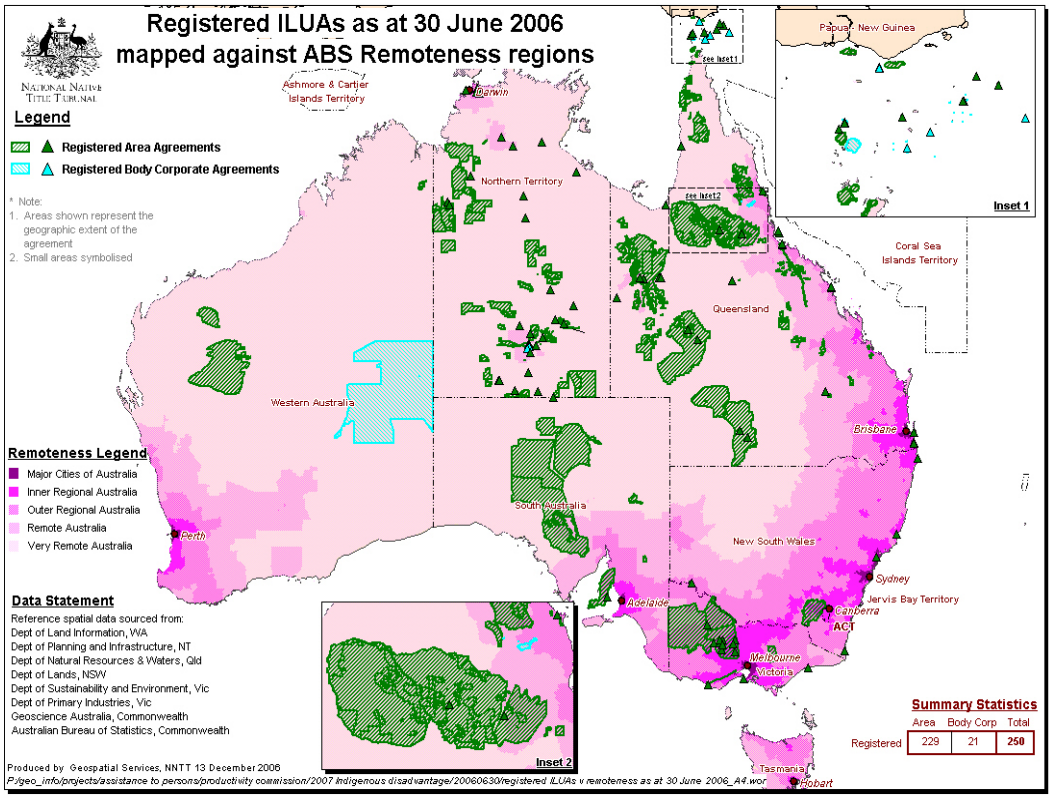


a Total number of ILUAs in place as at 30 June in each year; totals are cumulative.

Source: NNTT (unpublished); table 11A.3.5.

- The number of registered Indigenous Land Use Agreements (ILUAs) increased from 84 in June 2003 to 250 in June 2006 (figure 11.3.4). Over this same period, the total land area covered by registered ILUAs (not counting overlapping ILUAs), grew from 239 219 km² to 812 866.3 km², or 10.6 per cent of the total area of Australia (table 11A.3.6).
- In 2006, most of the ILUAs were in Queensland (131) and the NT (78). Other states and territories had small numbers, and Tasmania and the ACT had none (table 11A.3.5).
- Most of the area of land covered by registered ILUAs in 2006 (91.1 per cent) was in remote and very remote areas (table 11A.3.6).
- Figure 11.3.5 and tables 11A.3.9 and 11A.3.10 contain maps showing the areas covered by registered ILUAs.

Figure 11.3.5 **Registered Indigenous Land Use Agreements by remoteness area**



Source: NNTT (unpublished); table 11A.3.10.

11.4 Governance capacity and skills

Box 11.4.1 **Key messages**

- In 2005, lower proportions of Indigenous than non-Indigenous students enrolled in university and TAFE courses relevant to governance and management (figures 11.4.1 and 11.4.3).
- Both Indigenous and non-Indigenous male students were more likely than females to enrol in university courses relevant to governance and management (figure 11.4.2).
- Both Indigenous and non-Indigenous female students were more likely than males to enrol in TAFE courses relevant to governance and management (figure 11.4.4).

Governance generally refers to the way that a society formally structures decision making, distributes authority and rights, and organises individual and collective behaviours. It consists of the structures and institutions that guide individual, group

and corporate behaviour, and describes who has the authority to make decisions in a community, how those decisions are to be carried out and how different members of the community are included in the making, implementation and communication of those decisions.

The effective exercise of governance effects all levels of society and plays an essential part in people's personal lives and their communities. Recent studies (Reconciliation Australia 2002 and 2006) emphasised the importance of governance capacity to the social and economic development of Indigenous people. Research by Hunt and Smith (2006), analysing thirteen case studies of Indigenous community governance, found that:

- The development of governance capacity does appear to be a fundamental factor in generating sustained economic development and social outcomes.
- Economic outcomes appear to be best achieved where effective Indigenous and non-Indigenous governance coexist.
- Successful governance appears to require basic prerequisites, such as housing, water, sanitation, education and health to be in place. Only then can a community organisation focus on economic development as its goal, rather than prioritising and being consumed with essential service delivery. (p.72)

The capacity of people, groups, organisations and whole societies to govern consists of governance skills, abilities, knowledge, behaviours, values, motivations, institutions, resources, powers and so on, which are determined by a combination of human, social, cultural, infrastructure and resource capital. Without an effectively resourced capacity for governance, there is unlikely to be sustained community or regional development. For example, sound organisational governance requires access to professional expertise. An understanding of financial management, and corporate and administrative systems is a basic ingredient of effective governance (Dodson and Smith 2003; Sanders 2004; Smith and Armstrong 2005).

A House of Representatives inquiry into capacity building and service delivery in Indigenous communities supported dual public management and community development approaches to capacity building (HOR 2004).

The public management approach emphasises the need to develop a community's governance, administration, managerial and leadership structures and skills in order to meet accountability requirements (Gerritson 2001). This approach has strong links with the 'governing institutions' and 'leadership' determinants of good governance (see section 11.5).

The community development approach is concerned with the empowerment of communities so that they can participate in their own policy-making and implementation, in the development of their own effective and culturally informed governance structures, and in developing the skills to take effective responsibility

and control over their own issues and futures (Gerritson 2001). This approach is closely linked with the 'self-determination' aspect of good governance (see section 11.5).

In the 2003 and 2005 Reports, a proxy indicator 'Accredited training in leadership, finance or management' was included in the framework to report on capacity building in governance. Following suggestions from consultation on the 2005 Report, the indicator has been renamed 'Governance capacity and skills' and reports on governance capacity and skills more broadly. This indicator complements the case studies in governance arrangements in section 11.5, which discuss examples of Indigenous governance in various organisations and communities.

As there is little quantitative data available on governance capacity and skills, this section reports data on participation in particular types of training courses. Training in the fields reported here is a significant component of the capacity building and leadership aspects of governance reported in more detail in section 11.5. Formal and informal governance training is one useful means for individuals, groups and organisations to build on their strengths and address their weaknesses in organisational management and community governance. Information on participation in relevant training can also provide an indication of the available governance resources — people who have the motivation to seek knowledge in organisation and community governance.

While other forms of training are equally valuable, training in the areas of leadership, finance or management is potentially relevant to management, governance and the Australian business and government environment. Such training may also assist Indigenous people to function successfully in both Indigenous and non-Indigenous environments. For the purpose of this indicator, this type of training is represented by the fields of management and commerce, business law, and economics and econometrics at the university and VET levels.

Section 3.4 shows that Indigenous people are much less likely than non-Indigenous people to be studying at universities but more likely than non-Indigenous people to be studying at other types of colleges (including colleges of Technical and Further Education (TAFE)).

Box 11.4.2 gives examples of accredited training programs that are strengthening governance capacity and skills of Indigenous communities and organisations.

Box 11.4.2 'Things that work' — Increasing governance capacity and skills

Office of the Registrar of Aboriginal Corporations (ORAC) governance training

The Office of the Registrar of Aboriginal Corporations (ORAC) has provided a range of corporate governance training programs for Indigenous corporations and their governing committees/boards for three years. ORAC's training programs include:

- one and two-day information sessions and three-day introductory workshops in corporate governance, which act as a bridge to the accredited training
- accredited Certificate 4 in Business (Governance).

The information sessions provide information and advice, ranging from what is required by law for incorporation under the Aboriginal Councils and Associations Act 1976 (to be replaced by the Corporations (Aboriginal and Torres Strait Islander) Act 2006 in July 2007) to specific governance issues the corporation may be experiencing, including board meetings, annual general meetings and special general meetings.

The participants in three-day introductory corporate governance workshops sign joint learning agreements. Upon completing the workshop, participants are encouraged to continue with accredited training, including the Certificate 4 in Business (Governance) and the Diploma in Business (Governance).

Certificate 4 in Business (Governance) is a nationally recognised training package developed specifically for Indigenous people who wish to attain recognised skills in corporate governance and management. It is a competency-based training program that requires participants to demonstrate their competence in a range of skills relevant to corporate governance.

ORAC programs are currently running in Victoria, Queensland, the NT and WA.

During 2004-05, more than 600 people attended the information sessions and the three-day introductory workshops. Fifty-seven graduates received their Certificate 4 in Business (Governance) in the year to 30 June 2004. The Certificate 4 in Business (Governance) had a retention rate of 93 per cent. This was well above the national average retention rate of 86 per cent for Indigenous students in Vocational Education and Training (VET).

Queensland has demonstrated good rates of progression to Certificate 4:

- Of those enrolled in the Cairns and Townsville workshops, 42 and 33 per cent, respectively, began the Certificate 4 course
- Female participants made up 54 per cent of those enrolled in the workshop and 76 per cent of those proceeding to the accredited Certificate 4 program.

(Continued next page)

Box 11.4.2 (continued)

'Managing in Two Worlds' — Governance Training Program (Vic)

The Managing in Two Worlds Governance Training Program aims to strengthen the management capacity of Victorian Aboriginal community organisations and improve service delivery in the community sector. The program has been built on the suite of governance training developed by ORAC and is being managed and funded by Aboriginal Affairs Victoria in partnership with ORAC, Consumer Affairs Victoria and Swinburne University. The program is available to board members and key staff from Victorian Indigenous community organisations.

The pilot phase of the program was conducted in 2005-06 and comprised:

- three three-day introductory workshops covering generic governance skills and practices, roles of board members and management training
- a four week residential accredited TAFE training program in all aspects of governance providing participants with a Certificate 4 in Business (Governance).

An independent review of the workshop component of the program found that the workshops were successful in addressing governance-related Indigenous capacity building needs. Feedback during, and at the conclusion of, the workshops showed that participants found the content and presentation of the workshops met their needs. A follow-up survey demonstrated the practical impact of the training, which has included sharing information with other board members, constitutional changes, changes to policies and procedures and scheduling of board planning days.

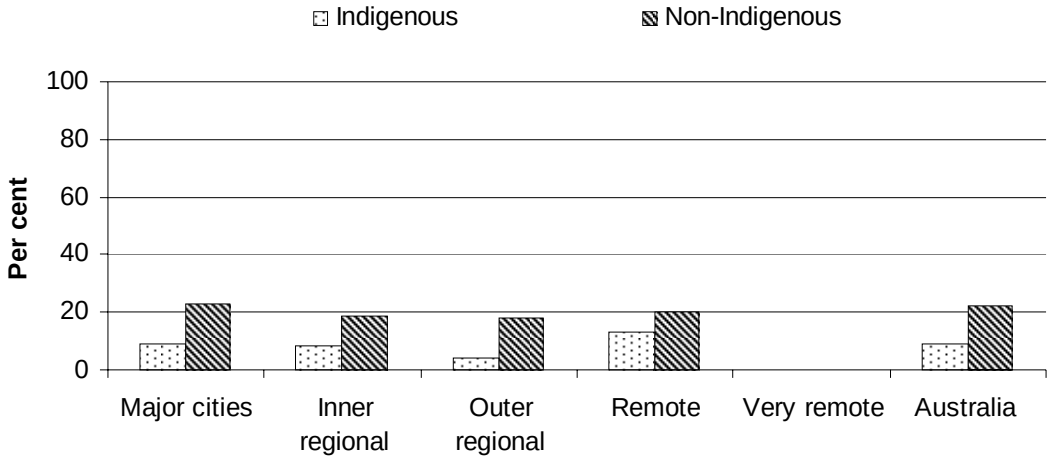
The pilot phase of the program saw:

- 68 people complete the workshops, with a completion rate of 98 per cent
- 14 people graduate from the Certificate 4, with a completion rate of 100 per cent.

The Program has been extended into 2006-07 and it is expected that a further 120 people (4–5 workshops) will complete the workshops and over 40 people (3 courses) will complete the Certificate 4.

Source: ORAC (www.orac.gov.au); Aboriginal Affairs Victoria, Department for Victorian Communities (unpublished).

Figure 11.4.1 **Proportion of university students studying management or commerce, business law, economics or econometrics, 2005[a, b, c]**



a Management, commerce, business law, economics and econometrics defined as field of education codes, 08,090901, and 0919, from the ABS Australian Standard Classification of Education. **b** Data are derived based on the number of students whose Indigenous status was identified in the DEST data collection. There are a large number of students in the 'Indigenous status unknown or not stated' category. For example, in 2005, 3.6 per cent of all students were classified as 'Indigenous status unknown', compared to 1.2 per cent who identified as Indigenous. 'Indigenous status unknown' records are separately identified in the attachment tables. **c** Allocation of students to geographic regions was done using the postcode of the student's home address.

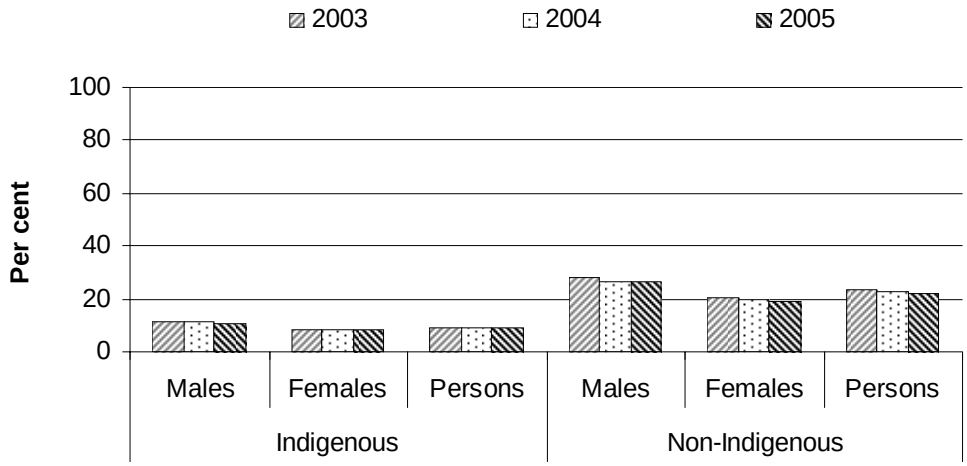
Source: DEST Higher Education Student Collection (unpublished); tables 11A.4.2 and 11A.4.5.

In 2005:

- Nationally, 9.0 per cent of Indigenous university students were enrolled in courses in management, commerce, business law and economics (including econometrics) compared with 22.1 per cent of non-Indigenous university students (figure 11.4.1; table 11A.4.8).
- A lower proportion of Indigenous students than non-Indigenous students were enrolled in university courses relevant to management and governance (including management, commerce, business law and economics) across remoteness areas (except in very remote areas where no university students were recorded) (figure 11.4.1).
- For both Indigenous and non-Indigenous university students, those whose home addresses were in major cities and remote areas were more likely than those in regional areas to enrol in courses relevant to management and governance. However, data for Indigenous students in remote areas need to be interpreted with caution as there are only small numbers of university students in remote areas (see tables 11A.4.2 and 11A.4.5)

- Indigenous university students comprised 0.5 per cent of university students studying management, commerce, business law and economics. Indigenous university students comprised 1.2 per cent of university students in all courses (table 11A.4.8).

Figure 11.4.2 **Proportion of university students studying management or commerce, business law, economics or econometrics, 2003–2005[a, b, c]**



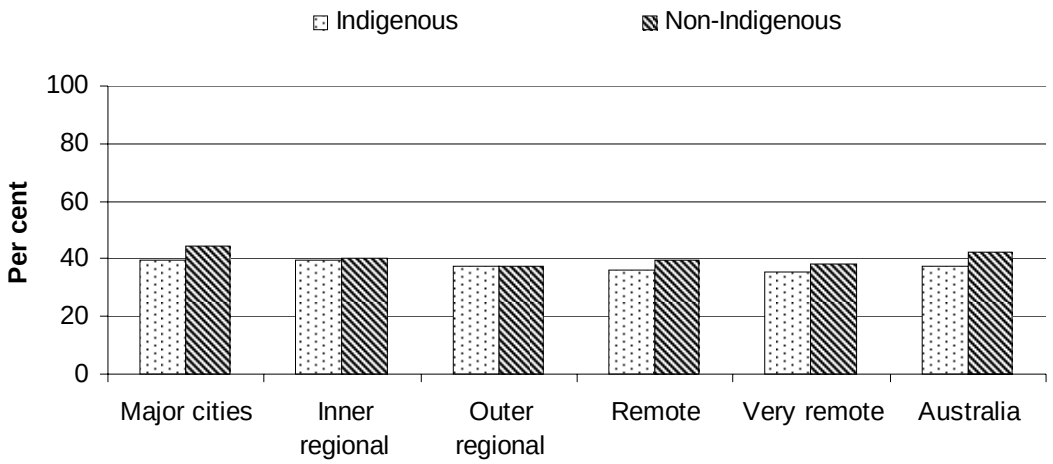
a Management, commerce, business law, economics and econometrics defined as field of education codes, 08,090901, and 0919, from the ABS Australian Standard Classification of Education **b** Data are derived based on the number of students whose Indigenous status was identified in the DEST data collection. There are a large number of students in the 'Indigenous status unknown or not stated' category. For example, in 2005, 3.6 per cent of all students were classified as 'Indigenous status unknown', compared to 1.2 per cent who identified as Indigenous. 'Indigenous status unknown' records are separately identified in the attachment tables.

Source: DEST Higher Education Student Collection (unpublished); tables 11A.4.1 and 11.4.4

- In each year from 2003 to 2005, for both Indigenous and non-Indigenous university students, males were more likely than females to enrol in university courses relevant to management and governance (including management, commerce, business law and economics) (figure 11.4.2).
- In each year from 2003 to 2005, a lower proportion of Indigenous students than non-Indigenous students enrolled in university courses relevant to management and governance, regardless of gender.
- The number of Indigenous university students studying management, commerce, business, law and economics declined from 809 in 2002 to 753 in 2005. The number of non-Indigenous students of these subjects also declined (from 156 556 to 151 361) (table 11A.4.1).
- There were no significant changes in the proportion of Indigenous university students enrolled in university courses relevant to management and governance,

while the proportion of non-Indigenous students enrolled in these courses decreased slightly from 23.8 per cent in 2003 to 22.1 per cent in 2005 (figure 11.4.2; table 11A.4.8).

Figure 11.4.3 **Proportion of TAFE students studying management or commerce, business law, economics or econometrics, 2005[a, b,.c]**



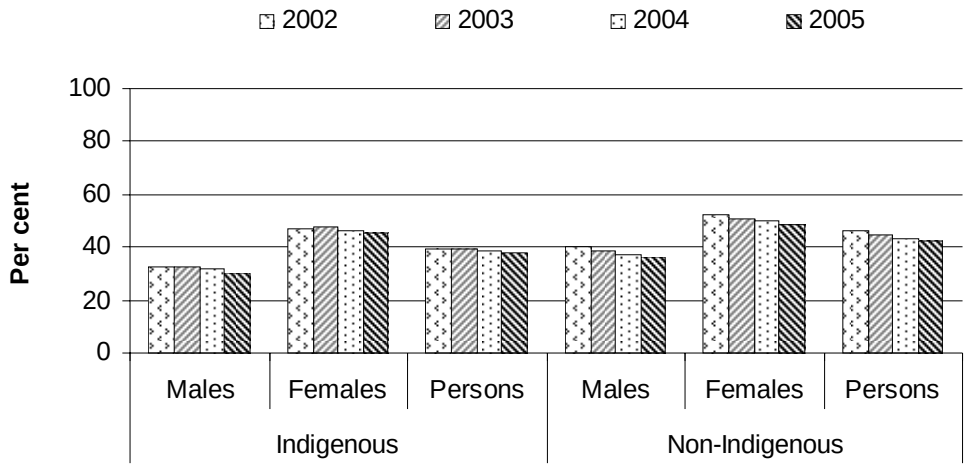
a Management, commerce, business law, economics and econometrics defined as field of education codes, 08,090901, and 0919, from the ABS Australian Standard Classification of Education. **b** Data are derived based on the number of students whose Indigenous status were identified in the NCVER data collection. There are a large number of students in the 'Indigenous status unknown or not stated' category. For example, in 2005, 17.6 per cent of all students were classified as 'Indigenous status unknown', compared to 3.8 per cent who identified as Indigenous. 'Indigenous status unknown' records are separately identified in the attachment tables. **c** Allocation of students to geographic regions was done using the postcode of the student's home address.

Source: NCVER (unpublished); tables 11A.4.2 and 11.4.5.

In 2005:

- Nationally, 37.6 per cent of Indigenous TAFE students were studying management, commerce, business law or economics compared with 42.2 per cent of non-Indigenous students (figure 11.4.3; table 11A.4.8).
- A lower proportion of Indigenous than non-Indigenous TAFE students were studying management, commerce, business law or economics in major cities, remote areas and very remote areas. In inner and outer regional areas similar proportions of Indigenous and non-Indigenous students were studying management, commerce, business or economics (figure 11.4.3).

Figure 11.4.4 **Proportion of TAFE students studying management or commerce, business law, economics or econometric, 2002–2005[a, b]**



a Management, commerce, business law, economics and econometrics defined as field of education codes, 08,090901, and 0919, from the ABS Australian Standard Classification of Education. **b** Data are derived based on the number of students whose Indigenous status was identified in the NCVER data collection. There are a large number of students in the 'Indigenous status unknown or not stated' category. For example, in 2005, 17.6 per cent of all students were classified as 'Indigenous status unknown', compared to 3.8 per cent who identified as Indigenous. 'Indigenous status unknown' records are separately identified in the attachment tables.

Source: NCVER (unpublished); tables 11A.4.1 and 11A.4.4.

- In each year from 2002 to 2005, a lower proportion of Indigenous than non-Indigenous TAFE students enrolled in management, commerce, business law and economics courses.
- The number of Indigenous TAFE students studying management, commerce, business law and economics changed very little between 2002 and 2005 (23 440 in 2002 and 23 559 in 2005). The number of non-Indigenous students of these subjects declined from 592 533 to 544 927 over the same period (table 11A.4.1).
- The proportion of both Indigenous and non-Indigenous TAFE students enrolled in management, commerce, business law and economics courses gradually decreased over the period from 2002 to 2005 (39.3 to 37.6 per cent for Indigenous students and 46.1 to 42.2 per cent for non-Indigenous students) (figure 11.4.2; table 12A.4.8).
- In each year from 2002 to 2005, for both Indigenous and non-Indigenous TAFE students, females were more likely than males to enrol in management, commerce, business law and economics courses (figure 11.4.4).

State and Territory data on the number of university and TAFE students enrolled in management, commerce, business law and economics courses and the number of university and TAFE students in all courses are included in table 11A.4.1 and table 11A4.4 respectively. Tables 11A.4.3 and 11A.4.6 provide data on students by age.

Table 11.4.1 **Number of students in selected courses (governance), by Indigenous status, Australia, 2005**

	Indigenous	Non-Indigenous	Unknown	Total
Training Package				
Certificate 2 in Local Government (Governance and Administration)	48	97	8	153
Certificate 3 in Local Government (Governance and Administration)	0	65	27	92
Certificate 4 in Business (Governance)	550	49	61	660
Certificate 4 in Local Government (Governance and Administration)	1	65	79	145
Diploma of Local Government (Governance and Administration)	2	49	6	57
Courses				
Certificate 2 in Introduction to Community Governance	46	2	–	48
Certificate 3 in Community Governance Support	17	16	–	33

– Nil or rounded to zero.

Source: NCVER (unpublished); table 11A.4.7.

Training in local government is particularly relevant for discrete Indigenous communities where Indigenous people and organisations perform many or all of the functions of local government (either as formal local government entities or more informally).

- In 2005, the participation of Indigenous students in Certificate 4 in Business and Certificate 2 in Introduction to Community Governance was significantly higher than that of non-Indigenous students (550 Indigenous participants compared to 49 non-Indigenous participants) (table 11.4.1).
- The number of Indigenous participants in Certificate 4 in Business increased from 122 in 2003 and 322 in 2004 to 550 in 2005 (table 11A.4.7)

Indigenous people may also undertake non-accredited training in leadership, finance or management, from which they may learn useful skills. A number of universities, colleges and other organisations run courses for Indigenous people on Indigenous leadership.

11.5 Case studies in governance arrangements

Box 11.5.1 **Key messages**

- Six determinants have general application to good Indigenous governance, while allowing for the unique cultures of different organisations and communities:
  - governing institutions
  - leadership
  - self-determination
  - capacity building
  - cultural match
  - resources.
- No one determinant in isolation is enough to lead to good governance arrangements — all determinants are necessary for sustained success.
- A comprehensive picture of Indigenous governance should also consider 'government governance' — government engagement with Indigenous organisations and communities.

11.5.1 Introduction

This report adopts the definition of governance developed by the Indigenous Community Governance Project (a collaborative research project being conducted by the Centre for Aboriginal Economic Policy Research (CAEPR) and Reconciliation Australia — see box 11.5.2):

> … the dynamic processes, relationships, institutions and structures by which a group, community or society organise themselves to represent and negotiate their rights and interests, and make decisions about:
>
> - how they are constituted as a group — who are 'they'; who is the 'self' in self-government
> - how they manage their affairs and negotiate with outsiders
> - who has authority within their group, and over what
> - what their agreed rules are to ensure that authority is exercised properly
> - who enforces the decisions they make
> - how their decision-makers are held accountable
> - what are the most effective arrangements for achieving their goals (CAEPR and RA 2004).

Consultations with both Indigenous people and governments for this Report emphasised that good governance arrangements have a positive impact on Indigenous outcomes (SCRGSP 2007b). However, a key preliminary finding of the Indigenous Community Governance Project was that, although there are significant

areas of agreement, 'governments and Indigenous people have different criteria for evaluating governance effectiveness':

> Both governments and Indigenous people want community organisations to deliver reasonable levels of services, and provide sound financial management and accountability. The key areas of difference relate to the Indigenous processes and relationships at the heart of many organisations which emphasise internal accountability and communication, and governments' emphasis on 'upwards' accountability, risk avoidance, financial micro-management and compliance reporting. (Hunt and Smith 2006, p. 6)

Box 11.5.2 **Collaborative research project on Indigenous governance**

The Indigenous Community Governance Project is a partnership between the Centre for Aboriginal Economic Policy Research (CAEPR) at the Australian National University and Reconciliation Australia, to undertake research on Indigenous community governance. The project is funded by the Australian, NT and WA governments, each of which also collaborates with the research.

The Project is exploring:

- the current state of community governance, including its cultural, social, economic, legal, policy, service delivery, and historical contexts
- the different models of governance emerging in communities, and the governance processes, institutions, structures, powers and capacities involved
- the factors influencing culturally legitimate community governance arrangements
- the shortfalls in governance skills and capacities, as well as governance strengths
- the wider 'governance environments' and policy networks within which community governance operates, including the impact of government policy and service delivery on the effectiveness of community governance.

Source: CAEPR 2006

Consultations with Indigenous people highlighted the role of culture in Indigenous governance. Each community and organisation has unique historical and cultural characteristics that are reflected in its governance arrangements. This was also noted by the Indigenous Governance Project:

> Governance and decision-making in Indigenous community governance is shaped by multiple historical, cultural and political relationships. … the family connections, land ownership relationships and governance histories associated with particular communities and sets of regionally linked communities, are fundamental to community governance dynamics and arrangements. (Hunt and Smith 2006, p. 1)

Drawing on the Harvard Project On American Indian Economic Development in the USA (The Harvard Project 2003-04), the Indigenous Community Governance

Project and broad consultations with Indigenous communities and organisations, the 2005 Report identified five key determinants of good Indigenous governance. The consultations demonstrated broad agreement that those determinants could have general application, while allowing for the unique cultures of different organisations and communities. Further consultations after the release of the 2005 Report identified an additional key determinant of good governance — 'resources' — covering inputs such as economic and technical infrastructure as well as human resources. This Report addresses the following six determinants of good Indigenous governance:

- governing institutions
- self- determination
- leadership
- capacity building
- cultural match
- resources.

The 2005 Report discussed the determinants using two examples, the Koorie Heritage Trust and the Thamarrurr Regional Council. This Report adopts a different reporting structure, discussing each key determinant in turn, with a range of examples. This approach allows the Report to illustrate the depth of good governance in Indigenous communities and organisations.

Many Indigenous bodies provide important services to their communities, with various degrees of formal recognition or status. Generally speaking, *community governance* refers to the ways Indigenous people come together to deal with community affairs, and *organisational governance* refers to governance of Indigenous bodies established to undertake social, economic and cultural activities.

Consultations following the 2005 Report emphasised that a comprehensive picture of Indigenous governance should also consider governments' engagement with Indigenous organisations and communities. The following section explores the relationship between government and Indigenous groups, using the term *government governance*. Good relations between Indigenous people and governments requires effective communication and engagement. Information on Indigenous people's engagement with service delivery is reported in section 9.7.

11.5.2 Government governance

The 'governance of governments' matters to the governance of Indigenous communities and organisations (Hunt and Smith 2006, p. 5). Indigenous organisations operate within a web of Australian, State, Territory and local government institutions, policies, legislation and procedures. Indigenous bodies deal with numerous departments, funding arrangements and government officials. These arrangements can either facilitate or impede Indigenous governance.

Indigenous organisations, by and large, have relatively limited administrative capability. Dealing with multiple government bodies, processes and reports imposes significant demands on these limited resources. This places a strong onus on governments to minimise the burden placed on Indigenous communities and organisations.

The new *Corporations (Aboriginal and Torres Strait Islander) Act 2006* commenced on 1 July 2007. The new law aims to reduce red tape by streamlining reporting by Indigenous organisations. Small and medium sized corporations are likely to have reduced reporting requirements. While some parts of the new law mirror those in the Corporations Act, it also has parts that apply only to Aboriginal and Torres Strait Islander organisations, so that they can design rules better suited to their circumstances (ORAC 2006).

The Australian Government's Office of Indigenous Policy Coordination (OIPC) commissioned an evaluation of the administrative burden imposed by government funding programs on Indigenous organisations. The evaluation, undertaken between mid-2005 and January 2006, identified the following aspects of government red tape that stretched Indigenous governance capacity:

- Indigenous organisations use many sources of funds from two levels of government, each with discrete reporting requirements and discrete contact staff.
- Large numbers of small grants are treated the same as much larger grants, with similar reporting frequency and large numbers of performance indicators.
- Organisations receive little feedback on their reports, and funding departments appear to make relatively limited use of the information being collected, which is not likely to be useful in managing the activity or organisation well, or informing future policy and program settings (OIPC 2006, pp. 5–7).

The OIPC evaluation also found clashes of 'organisation culture', particularly a focus by funding agencies on rigid compliance. A 'compliance paradigm' was evident in the application of 'standard procedures', such as standard contracts, or standard performance indicators, which did not match the project activity or purpose (OIPC 2006, p. 8).

Australian governments have made a number of collective commitments to improve government governance, including establishing the 'COAG trials', commissioning this Report and agreeing to the 'National Framework of Principles for Government Service Delivery to Indigenous Australians' (box 11.5.3).

Box 11.5.3 **COAG initiatives**

COAG Trials

In 2002, COAG agreed to a trial of a whole-of-government cooperative approach in up to 10 communities or regions. The aim of these trials was to improve the way governments interact with each other and with communities to deliver more effective responses. The lessons learnt from these cooperative approaches will be able to be applied more broadly. This approach will be flexible in order to reflect the needs of specific communities, build on existing work and improve the compatibility of different State, Territory and Commonwealth approaches to achieve better outcomes.

Overcoming Indigenous Disadvantage: Key Indicators

In 2002, COAG agreed to commission a regular report against key indicators of Indigenous disadvantage. This report will help to measure the impact of changes to policy settings and service delivery and provide a concrete way to measure the effect of COAG's commitment to reconciliation through a jointly agreed set of indicators.

National Framework of Principles for Government Service Delivery to Indigenous Australians

In 2004, COAG agreed to a National Framework of Principles for Government Service Delivery to Indigenous Australians. The principles address sharing responsibility, harnessing the mainstream, streamlining service delivery, establishing transparency and accountability, developing a learning framework and focussing on priority areas. COAG committed to Indigenous participation at all levels and a willingness to engage with representatives, adopting flexible approaches and providing adequate resources to support capacity at the local and regional levels.

Source: COAG 2002; 2004.

The COAG trials commenced in 2002. Government commissioned evaluations of the trials were published in February 2007, and lessons learnt are to be incorporated into the new 'place-based approach' to government interaction with indigenous communities (Brough 2007). Lessons relevant to 'government governance' included:

- Governments and Indigenous communities must be willing to understand and work respectfully with each other in productive and lasting relationships.
- Government staff need training in how to engage with respect for the protocols and processes in Indigenous communities.
- There cannot be a one size fits all approach. Solutions should be responsive to local circumstances and reflect a whole of government, as opposed to single agency, initiative.

- Coordination and decision making mechanisms need to be effective and differentiated from each other and decision making needs to be timely. More widespread reward and recognition for good whole of government practice is needed. Staff engaged in whole of government initiatives need training to provide them with the skills and knowledge on how to do whole of government work. Training is needed across all levels: senior executive, middle management and field staff.
- Consistency in government personnel helps in building effective relationships both between government agencies and with communities.
- Shared leadership at the Ministerial, senior executive and planning levels, and at the level of service delivery, assists in achieving both process and impact outcomes (Morgan Disney et al 2007, pp. 7-8).

The evaluations also identified significant lessons about Indigenous governance structures and processes and how governments can support them. These lessons broadly reflect the key determinants discussed below.

Such evaluations are crucial to avoid repeating the mistakes of the past. Governments are responsible for monitoring and evaluating policies and programs designed to address Indigenous disadvantage. Governments commissioned this Report in 2002 to measure the impact of changes to policy settings and service delivery and provide a concrete way to measure the effect of governments' commitment to reconciliation through a jointly agreed set of indicators (COAG 2002). Several states and territories are producing similar reports at the jurisdictional and even regional level (see appendix 2).

At the program level, many 'pilots' and 'trials' are commissioned, implemented, run their course and then cease, with no formal, public evaluation. Opportunities to learn from experience are lost. Often, monitoring and evaluation are hampered by inadequate data collections and performance information systems. For example, there is limited information on the use of mainstream services by Indigenous peoples (see the Indigenous Compendium of data from the Report on Government Services for available data (SCRGSP 2007a)) and very little information on the barriers to access and use Indigenous people face (see section 9.7 on Indigenous engagement with service delivery).

This Report supports the Indigenous Community Governance Project recommendation for governments at all levels to: better coordinate internally; reduce the number of separate departmental and program-specific consultations with communities; rationalise government program delivery; undertake a community-development approach to governance building; reduce the large number

of different funding mechanisms and give more broad-based, longer-term funding linked to broad community development goals (Hunt and Smith 2006, p. 5).

The Aboriginal Health Promotion and Chronic Care partnerships in Victoria have facilitated a partnership approach between the Victorian Aboriginal Health Service and independent community health services (box 11.5.4).

Box 11.5.4 **'Things that work' — government governance**

The Aboriginal Health Promotion and Chronic Care Partnership (AHPACC) has facilitated partnerships between community health services and Aboriginal organisations in two regions in Victoria.

The Northern Consortium is a partnership between the Victorian Aboriginal Health Service (VAHS) and four independent community health services: Darebin Community Health, Plenty Valley Community Health Services, Dianella Community Health and North Yarra Community Health.

The partnership is structured in two distinct parts.

1. The AHPACC Reference Group comprising of VAHS, the four community health services and the North & West Regional Office of the Department of Human Services. The main function of this group is the overarching planning, guiding, monitoring and evaluation of the Consortium's AHPACC Program.
2. Four sub-committees —local partnerships between VAHS and each of the four community health services for more detailed scoping, planning and implementing local AHPACC interventions.

The partnership governance structure is underpinned by a set of principles that emphasise recognition and respect for the central role VAHS plays in the Aboriginal community and in the development and provision of culturally appropriate health and well being care to Aboriginal people. Mutual trust and respect is formalised in a Memorandum of Understanding.

In the Eastern Metropolitan Region, Eastern Access Community Health Inc., (EACH) and the Aboriginal communities of the Eastern Region have established a partnership to achieve health benefits for the Aboriginal community.

EACH and community elders met over a long period, developing the 'EACH Statement of Reconciliation', which sets out the values and beliefs underpinning a respectful and constructive relationship for both groups working together. This statement is supplemented by an 'Enduring Partnership Agreement', and the Mullum Mullum Indigenous Gathering Place (MMIGP) Management Committee and EACH Board have reciprocal membership.

(Continued next page)

Box 11.5.4 (continued)

The Board of EACH assisted the establishment of the MMIGP, including management, staffing and infrastructure support pending its establishment as an independent entity. In turn, MMIGP assisted EACH to develop a cultural sensitivity workforce strategy, and facilitated community consultation processes and participation in Aboriginal community events such as National Aboriginal and Islander Day Observance Committee (NAIDOC) Week.

In supporting MMIGP, the Board recognised that many conventional governance codes would need to be set aside in favour of partnership and mutual trust.

Source: Victorian Government (unpublished).

11.5.3 Key determinants

This section discusses the six agreed determinants of good Indigenous governance. The determinants are inter-dependent. No one principle in isolation will lead to good governance — all determinants are necessary for sustained success. One Indigenous organisation demonstrating sustained success is the Koorie Heritage Trust. The Trust was highlighted in the 2005 Report, and was the inaugural winner of the Indigenous Governance Awards. It has since overcome significant changes to its funding arrangements to continue to provide a range of cultural services to Koorie people (box 11.5.5).

Box 11.5.5 **Koorie Heritage Trust**

The Koorie Heritage Trust was established in 1985 and aims to protect, preserve and promote the living culture of the Indigenous people of south-eastern Australia. (See the 2005 Report for a detailed description of the Trust, its history and its governance.)

The Trust has a history of continued growth in size and scope of activities, which include a cultural centre, an oral history unit and an education program for both Indigenous and non-Indigenous people.

The Trust's governance arrangements are adaptable to the community's needs and aspirations, but have a high level of transparency and accountability. The arrangements focus on capacity building within the Board's membership and incorporate a core of trained Indigenous staff.

(Continued next page)

Box 11.5.5 (continued)

The Trust has won many awards, for example, the Sir Rupert Hamer Award for Excellence and Innovation in Records Management for the Koorie Heritage Archive; the Minister's Encouragement Award at the 2004 Victorian Tourism Awards; and the Best Learning Award from the Australian Interactive Media Industry for 'Mission voices'. In 2005 the Trust won the inaugural Indigenous Governance Award. It has also won Victorian Tourism Awards in 2005 and 2006 for Aboriginal and Torres Strait Islander Tourism; the 2006 National Indigenous Tourism Conference Gnukai Award; and the 2006 Wurreker Community Based Employer Award.

In late 2005, significant changes were imposed on the Trust's funding. Despite 14 years of annual funding from one program, the Trust learned at short notice that it would no longer be funded for work with 'moveable culture' (that is, its extensive collection). The Trust was advised to apply to another department for support, but no arrangements had been made between the departments and no support was available. The Trust successfully lobbied for interim funding, undertook extensive fund raising and diversified its activities to qualify for alternative sources of funds. The Trust continues to work on longer term strategies to address the ongoing funding issue.

The loss of funding greatly affected the Trust's administrative capacity, as funds were diverted from management to maintain vital programs. Only strong governance has allowed the Trust to continue to provide valuable services to Koorie and non-Indigenous people in Victoria while dealing with fragmented, uncertain funding arrangements.

Source: Koorie Heritage Trust (unpublished).

The following discussion draws on the preliminary findings of the Indigenous Community Governance Project (box 11.5.2), and the Reconciliation Australia/BHP Billiton Indigenous Governance Awards (boxes 11.5.6 and 11.5.7).

Box 11.5.6 **Indigenous Governance Awards**

The ***Indigenous Governance Awards*** are a partnership project between Reconciliation Australia and BHP Billiton, established in 2005, to encourage, reward and promote best practice in Indigenous governance.

The Awards are open to all Indigenous community organisations incorporated under legislation. In 2006, separate awards were made for organisations over and under 10 years of age. Applications are assessed against the following criteria:

1. How legitimate, representative and accountable is the governing body?
2. How effective is the administration function?

(Continued next page)

Box 11.5.6 (continued)

3. Are effective dispute resolution systems in place?
4. What is the level of commitment to leadership development?
5. How does the organisation's governance model reflect the cultural norms and values of its members?
6. What is the level of strategic planning ability?

Gary Banks, Chairman of the Productivity Commission and of the Steering Committee for the Review of Government Service Provision, was a judge for the 2006 Awards.

Source: Reconciliation Australia 2006a.

Box 11.5.7 **Indigenous Governance Awards finalists**

2005

- *Winner* — Koorie Heritage Trust (Melbourne)
- *Highly commended* — Central Australian Aboriginal Congress (Alice Springs)
- *Highly commended* — Sunrise Health Service (Katherine)
- Goldfields Land and Sea Council (Kalgoorlie)
- Institute for Aboriginal Development (Alice Springs)
- North Coast Aboriginal Corporation for Community Health (Maroochydore)
- Maari Ma Health Aboriginal Corporation (Broken Hill)
- Tiwi Islands Local Government (Northern Territory)

2006

Organisations under 10 years of age

- *Winner* — Gannambarra Enterprises (Wagga Wagga)
- *Highly commended* — Wunan Foundation (Kununurra)
- Muru Mittigar Aboriginal Cultural and Education Centre (Penrith)
- Nyirranggulung Mardrulk Ngadberre Regional Council (Katherine)

Organisations over 10 years of age

- *Winner* — WuChopperen Health Service Limited (Cairns)
- *Highly commended* — Yirra Yaakin Aboriginal Corporation (Perth)
- Wangka Maya Pilbara Aboriginal Language Centre (Port Hedland)
- Yarrabah Shire Council (Queensland)

Source: Reconciliation Australia 2006a.

Governing institutions

Governing institutions establish the framework within which Indigenous bodies function. These 'institutions' are made up of both formal mechanisms (such as policies, rules, constitutions, legal and judicial systems) and informal ways of doing

things (such as taboos, gender norms, religious beliefs, values, kinship and marriage systems) (Hunt and Smith 2006, p. 3). The preliminary findings of the Indigenous Community Governance Project emphasised the importance of allowing internal governance arrangements to evolve before formalising them:

> The institutions and representative structures of governance should not be too quickly concretised … by formal legal, constitutional and technical mechanisms; early experiments need time to be refined and evolve. (Hunt and Smith 2006, p. 3)

Indigenous governance structures can be undermined without recognition and support from the formal statutory and regulatory arrangements, but at the same time can be ineffective without community support (see 'self determination' below). The institutions of governance can be actively built, and building these institutions creates a strong internal 'governance culture'. It assists in designing workable forms of culture match, and provides a strong foundation for sustained good governance (Hunt and Smith 2006, p. 3).

The SA Government has worked intensively with the people of the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands to develop appropriate governing institutions (box 11.5.8).

Box 11.5.8 **Anangu Pitjantjatjara Yankunytjatjara (APY) Lands**

The APY Lands cover over 100 000 square kilometres in north-western SA and are home to about 3000 Aboriginal people. Approximately 11 communities range in size from 60 to 450 people, with a number of small homeland settlements of a few houses.

In March 2004, an APY Task Force was established to address the issues confronting Anangu people and the provision of services to their communities. Working groups of relevant officials were established in the key areas of community safety, health and wellbeing, education employment and training, infrastructure and governance. Central oversight of funding by the Aboriginal Affairs and Reconciliation Division (AARD) within the SA Department of the Premier and Cabinet provided whole of government perspective and leadership.

The Task Force based more government employees on or near the Lands to provide strong leadership, coordination of services and confirmation that programs were being delivered. Six full-time employees of the Department for Families and Communities work on or near the Lands together with two Drug and Alcohol Services SA employees.

The SA Government also undertook a review of the Pitjantjatjara Land Rights Act to improve the governance on the Lands. Extensive consultations were undertaken with Anangu communities, with transport assistance to assist more remote community members to attend meetings. Consultation meetings were broadcast live on radio.

(Continued next page)

Box 11.5.8 (continued)

The Pitjantjatjara Land Rights (Executive Board) Amendment Bill 2004 was passed in July 2004. Changes to the Act resulted in an APY Executive and Chairperson democratically elected by Anangu for a period of three years. In November 2005, the SA Electoral Commissioner oversaw fresh elections for the APY Executive Board.

Two additional formal structures assist in the coordination of services on the AP Lands:

- Tjunjunjku Kuranyukutu Palyantjaku (TKP), which means 'Together, towards the future', is the peak body responsible for planning and overseeing services on the Lands. TKP is made up of senior people including Nganampa Health, PY media, the NPY Women's service, AP Services and the State and Commonwealth Governments.
- The Wiru Palyantjaku (WP) is a cooperative body consisting of representatives of the major Anangu service organisations and community council representatives. WP's objective is to improve the delivery of services to Anangu living on the APY lands by working together to achieve better outcomes.

Source: SA Government (unpublished).

Good governance requires both:

> capable institutions with clear ground rules (constitutions, rules for decision making etc.) which are informed by culturally-endorsed standards of what constitutes right and wrong behaviour, of who has legitimate knowledge, and who has the 'right' or authority to represent community residents and regional interests (IGA 2006, p. 4)

and:

> effective financial management and administrative systems so that organisations are managed in a professional way with integrity and consistency. (IGA 2006, p. 4)

Many of these features are illustrated in the approaches to decision making of Indigenous Governance Awards applicants (box 11.5.9):

Box 11.5.9 **Decision making**

The Muru Mittigar Aboriginal Cultural and Education Centre constitution clearly sets out the decision-making process, and Board minutes and decisions are recorded, with identified responsibility and time lines for completion. Established reporting processes mean that information is circulated effectively to staff and Board members. Information is disseminated to community groups through an Annual Report and website.

(Continued next page)

Box 11.5.9 (continued)

The Wunan Foundation board holds regular meetings to discuss identified issues with majority decision-making. Meeting minutes are circulated to all Board members. Decisions are recorded with identified responsibility and time lines for completion. Information about Board activities is publicly available through the Annual Report and website identifies several different business streams with both long term and short term goals.

North Coast Aboriginal Corporation for Community Health has developed a comprehensive set of policy statements that provide the executive officer with a framework for operational decision-making. As the board develops new policies, these are added to the framework to inform future decisions. A decision-making matrix ensures that all decisions observe best practice guidelines, and are made to serve the entire community in their area. Unlike many organisations, North Coast stated traditional authority is not used in the decision-making process, preferring to evaluate issues within the framework of their health delivery model.

Wangka Maya Pilbara Aboriginal Language Centre has two levels of committee — the Executive Committee deals with financial, personnel and organisational projects and the general Committee deals with planning and policy issues. Decision-making is transparent, and stakeholders are informed of issues through an Annual Report and regular newsletters. There is regular consultation with community stakeholders.

WuChopperen Health Service Ltd has annual elections for board members and clear distinctions between the roles of the board and management. It has well-established procedures and systems for carrying out administrative functions and conducts regular planning workshops with the board.

Maari Ma Health Aboriginal Corporation has a comprehensive Board Level Strategic Directions Statement which sets out the organisation's purpose, values/ philosophy and its future vision. All decisions made by the organisation must be consistent with the Statement. The organisation also has 11 specific policies regarding delegation by the CEO, to help the execution or followthrough of its decision-making process.

More information on these and other successful Indigenous organisations can be found on the Reconciliation Australia website at: www.reconciliation.org.au/igawards

Source: IGA 2006.

Good governance institutions do not just spontaneously arise. They are the result of often lengthy processes of developing capacity and leadership (each discussed below) and ongoing training and development. The Indigenous Governance Awards found that 'board and staff training and development is important, as is compulsory governance training for board members' (IGA 2006, p. 44). Examples of governance training by Indigenous Governance Award applicants are summarised in box 11.5.10.

Box 11.5.10 **Governance training**

Wunan Foundation has its own management committee handbook which sets out clear protocols to facilitate decision-making. Before each meeting, committee members participate in a thorough training session with the CEO or a special advisor to ensure familiarity with the issues. Each training session also involves the use of the Wunan Game about a specific governance issue. This board game was developed as an in-house practical training tool for board members.

Yorganop Child Care Aboriginal Corporation requires all its board members to undertake governance training as part of their responsibilities.

Murrin Bridge Advance Aboriginal Corporation insists that all of its board members undertake the Indigenous Governance Program at the local TAFE.

Goldfields Land and Sea Council Aboriginal Corporation provides a kit of information to all newly elected board members explaining standing orders, voting procedures and their public obligations.

Warlayirti Artists Aboriginal Corporation uses a governance training program as a key part of the development of leaders within the organisation.

More information on these and other successful Indigenous organisations can be found on the Reconciliation Australia website at: www.reconciliation.org.au/igawards

Source: IGA 2006.

Drawing on the Indigenous Governance Awards examples and research by the Indigenous Community Governance Project, some common characteristics of successful Indigenous governing institutions can be identified, many of which have close links with other determinants of good governance:

- clearly articulated vision, values, and goals, and the structures, processes and programs to achieve them
- legitimacy and authority of those with decision-making power (also see discussion of 'leadership' below)
- accountability of those in positions of responsibility
- stable institutional arrangements and effective administrative systems
- sound dispute resolution processes that provide fair and effective means of resolving disputes
- adequate capacity (including resources) to deliver core business (also see discussions of 'capacity building' and 'resources' below).

Leadership

Leadership has been described as 'the process through which an individual influences group members to attain group or organisational goals' (Smillie and Hailey 2001). Leadership is closely related to other determinants of good governance. Effective leadership depends on governing institutions that provide leaders with legitimacy and authority. In turn, effective leaders contribute to communities' and organisations' scope for self-determination. Sustained leadership also requires capacity building to build leadership skills, and is reliant on adequate resources for implementing decisions.

The preliminary findings of the Indigenous Community Governance Project noted that leadership is critical to the development of a strong governance culture within organisations and communities, but cautioned that 'the concept and style of leadership and decision-making in Indigenous cultures appears to be significantly different from those familiar to governments' (Hunt and Smith 2006, p.4). There is a specific cultural aspect to Indigenous leadership. In his 1998 Williamson Community Leadership Program lecture, Patrick Dodson said:

> For Aboriginal leaders, the social and moral obligation that comes with community leadership is life-long. Those who lead, who have authority, must care for and look after those who come behind. (Dodson 1998)

Different leadership models or styles are appropriate for different situations, and different attributes might be required for leadership in different governance contexts. Formal education is not necessarily a requirement for 'people who contribute to the community, gain respect and act as role models'. It is most appropriate for Indigenous communities themselves to recognise, foster, promote and nurture this type of leadership (HOR 2004:141).

Many Indigenous people who demonstrate this sort of leadership also take on formal roles leading Indigenous community organisations. At this level, more formal capacity building is required to build up leadership attributes such as:[2]

- accountability and administration
- communication, consultation and representation
- negotiation, mediation and conflict resolution
- interacting with authorities at all levels of government
- integrity

[2] These characteristics were derived from the content of the Certificate in Leadership program conducted by the Australian Indigenous Leadership Centre.

- strategic policy and evaluation skills
- cross cultural awareness.

Leadership needs to be nurtured. Leaders require training and support to help them fulfil their responsibilities. Box 11.5.11 provides examples of Indigenous Governance Awards applicants' approaches to developing leaders' skills.

Box 11.5.11 **Leadership development**

Derbarl Yerrigan Health Service provides leadership training for key Indigenous staff members, including modules in leadership styles, initiative, management structures and communication.

Kooljaman at Cape Leveque (Bardina Pty Ltd) takes new board members to functions, workshops and conferences, and experts are brought into board meetings to develop knowledge of specific issues.

South West Aboriginal Land and Sea Council (SWALSC) has employed consultants to carry out a governance audit, to identify specific requirements for a governance training program. It is also developing a governance toolkit that can be used by all Noongar organisations.

West Australian Indigenous Tourism Operators Committee (WAITOC) provides training as well as matching new board members with experienced members until they feel confident to participate on their own. The Chair conducts a skills audit at each quarterly board meeting to identify areas for improvement.

More information on these and other successful Indigenous organisations can be found on the Reconciliation Australia website at: www.reconciliation.org.au/igawards

Source: IGA 2006.

Sustained leadership requires succession planning, so new people can take over from current leaders over time. The preliminary findings of the Indigenous Community Governance Project noted that succession of leadership is often neglected to the detriment of communities and their organisations (Hunt and Smith 2006, p. 4). This is a particular issue for some Indigenous communities, where a small pool of current leaders face growing demands on their time and resources. Box 11.5.12 provides examples of Indigenous Governance Awards applicants' approaches to succession planning.

Box 11.5.12 **Succession planning**

The Koorie Heritage Trust Board's Human Resources Governance Committee has a program for succession planning that involves developing people's skills to take on senior roles within the organisation.

Kooljaman at Cape Leveque (Bardina Pty Ltd) has a leadership development program, through which likely future leaders are invited to participate in meetings and events with an eye to their joining the board at a future time.

Murrin Bridge Advance Aboriginal Corporation changed its board election from a yearly cycle to a triennial one, because the high turnover of members did not allow for experienced/trained members to contribute to the management process. It also has two deputy chairs to allow for the absence of the chair.

Yirra Yaakin Aboriginal Corporation has a model of governance involving male and female Elder representation and youth and community representation. It has a three-year, two-year and one-year rotational system for board members, to ensure that governance memory is retained and departure of board members is staggered.

Sunrise Health Service has a number of health committees made up of Elders and service representatives, which provide advice and act as a pool of future board members.

More information on these and other successful Indigenous organisations can be found on the Reconciliation Australia website at: www.reconciliation.org.au/igawards

Source: IGA 2006.

Developing the next generation of leaders is a specific aspect of succession planning. Several Indigenous Governance Awards applicants have specific programs to develop youth leaders (box 11.5.13).

Drawing on the Indigenous Governance Awards examples and research by the Indigenous Community Governance Project, some lessons for developing leadership and succession planning can be identified:

- developing competent, highly skilled staff with plenty of opportunity for training, leadership and personal and professional development (IGA 2006, p. 7)
- establishing with systems for board continuity and skill retention, such as staggered elections, mentoring new board members, developing potential board members and board succession planning (IGA 2006, p. 44)
- nurturing future leaders by providing young people with communication skills, self-confidence, role models, mentoring and experience.

Box 11.5.13 **Developing youth leaders**

Wunan Foundation runs an Indigenous management cadetship program to provide vocational pathways for local people.

Kooljaman at Cape Leveque (Bardina Pty Ltd) provides placements for 40 work experience students every year to learn about the operations and role of the board.

Geraldton Streetwork has established an Indigenous Youth Council, now in its fifth year. Its primary purpose is to give young people leadership and role model qualities, and an opportunity to gain training and attend workshops, forums and conferences. Youth Council members develop skills by organising community events (including fund-raising for other institutions), representing the Indigenous youth of Geraldton and attending training camps.

Nari Nari Tribal Council has a youth committee which meets independently of the main committee to discuss issues directly related to young people.

Coolgaree Aboriginal Corporation and Tangentyere Council encourage young people to nominate for positions on their executive committees, where experienced members mentor them.

Yabur Yulgan CDEP has two young people on the governing body who are mentored by the general manager.

Wangka Maya Pilbara Aboriginal Language Centre targets young people for their board, sometimes in shadowing roles allowing them time to learn the role and move into leadership positions when they are confident, prepared and ready.

Kari Aboriginal Resources Inc. has implemented an Enrichment Program: Youth Transitions, which offers 15 annual, ongoing scholarships to Indigenous high school students in Southwest Sydney who are doing well and trying hard to achieve. All students involved in the program are offered ongoing support and mentoring, and are seen as future leaders.

Anyinginyi Health has an Active Life Program that encourages young people to build their confidence and achieve goals, and opens doors through exposure to training, workshops and other institutions.

Brisbane Indigenous Media Association oversees the operations of 4 Triple A Training. This training empowers young people (many of whom are unemployed or at risk) by giving them communication skills, self-confidence and experience working in a professional team environment.

Mutawintji Local Aboriginal Land Council encourages its youth to develop and demonstrate their skills by coordinating day visitor activities and guided tours to the Mutawintji National Park, and conducting holiday programs and general meetings.

More information on these and other successful Indigenous organisations can be found on the Reconciliation Australia website at: www.reconciliation.org.au/igawards

Source: IGA 2006.

Self-determination

Self-determination is a complex concept, with its roots in human rights. Wehmeyer (2002) states that 'self-determined people are actors in their own lives instead of being acted upon by others'.

For many Indigenous people, self-determination has close links with issues of customary law, land rights and economic development. In this Report, the focus is on Indigenous communities or organisations having the right and ability to determine their own priorities and design their own instruments of governance, within broad 'external' governing institutions. There is also a distinction between 'self-determination' and 'selfishness'. The Indigenous Governance Awards noted that the features of good governance included:

> Limitation and separation of powers so that self-determination does not mean 'selfish' determination, by ensuring a separation between the powers and responsibilities of leaders and Boards, and the daily management of community businesses and services. (IGA 2006, p. 4)

Self-determination has significant practical, as well as philosophical and symbolic importance. The Harvard Project found that self-determination led to improved outcomes for North American Indigenous people:

> When [Indigenous people] make their own decisions about what approaches to take and what resources to develop, they consistently out-perform [non-Indigenous] decision-makers. (The Harvard Project 2003-04)

The Aboriginal and Torres Strait Islander Social Justice Commissioner considered that much of the failure of service delivery to Indigenous people and communities was a direct result of the failure to engage with Indigenous people and to support and build the capacity of Indigenous communities:

> Put simply, governments risk failure if they develop and implement policies about Indigenous issues without engaging with the intended recipients of those services. Bureaucrats and governments can have the best intentions in the world, but if their ideas have not been subject to the 'reality test' of the life experience of the local Indigenous peoples who are intended to benefit from this, then government efforts will fail. (Calma 2006)

The Human Rights and Equal Opportunity Commission (Aboriginal and Torres Strait Islander Commissioner 2006) strongly endorses the principle of free, prior and informed consent, which supports the full and effective participation of Indigenous peoples in decisions which directly or indirectly affect them. This principle has recently received international endorsement by the United Nations General Assembly:

> Free, prior and informed consent recognizes indigenous peoples' inherent and prior rights to their lands and resources and respects their legitimate authority to require that

> third parties enter into an equal and respectful relationship with them, based on the principle of informed consent. (UN 2005, p. 1)

The Indigenous Community Governance Project found that the extent of self-determination in Indigenous organisations was dependent upon the external governing institutions:

> The system under which Indigenous organisations and communities operate largely determines the extent to which Indigenous people can exert control over decision-making. (ICGP 2006, p. 5)

The Indigenous governance environment is as complex as the government environment, with 'complex systems of representation and leadership, overlapping constituencies, networks of families and groups associated with organisations, and complex systems of mandate, accountability and authority' (Hunt and Smith 2006, p. 5). Despite (or perhaps because of) this complexity, the Indigenous Community Governance Project found that successful governance structures should be based on locally relevant Indigenous relationships and forms of representation:

> Working through Indigenous relationships and systems of representation thus becomes the basis for working out organisational structures, institutions and procedures. (Hunt and Smith 2006, p. 1)

The Indigenous Governance Awards made similar findings:

> The relationship between the formal governance body and the wider community, and traditional decision-making arrangements must be clear for that body to have the legitimacy it needs to function. (IGA 2006, p. 44)

Box 11.5.14 illustrates some Indigenous Governance Awards applicants' approaches to ensuring cultural legitimacy. The examples illustrate the potential for the following governance characteristics to contribute to self-determination:

- culturally legitimate participation and control of decision-making
- community participation in community governance institutions
- specific programs to meet the needs of specific communities, for example, community courts, community policing and Indigenous schools
- flexible funding arrangements that facilitate (and not hinder) the development of appropriate programs at the community level.

Box 11.5.14 **Cultural legitimacy**

Larrakia Nation Aboriginal Corporation draws two members from each of the representative eight family groups identified in their constitution.

Tiwi Islands Local Government draws eight of its board members from the Tiwi Aboriginal Land Trust (representing the traditional landowners) and nine members from each of its four community management boards (representing the traditional skin groups).

Malabam Health Board Aboriginal Corporation draws board representatives from its two major constituencies: the 'town people' and the 'outstation people'. Each group elects its own chair and takes turns to chair monthly board meetings, creating what they describe as an effective system where two heads are better than one. There is scope to add three members by co-option in order to reflect particular interests or skills.

Brisbane Indigenous Media Association, Central Australian Aboriginal Congress and Institute for Aboriginal Development reserve positions on the board for representatives of particular local or related groups (such as a council of elders, native title holders' body or land trust) or for an elected staff or student representative.

Aboriginal Legal Rights Movement board members are appointed by a board appointment committee against selection criteria detailed in the constitution. Each member represents one of three regions. The chair is independent.

More information on these and other successful Indigenous organisations can be found on the Reconciliation Australia website at: www.reconciliation.org.au/igawards

Source: IGA 2006, pp. 20–21.

Capacity building

There is no universally agreed definition of capacity building (see section 11.4). The 'public management' approach to capacity building emphasises the need to develop a community's ability to meet accountability requirements, and has strong links with the 'governing institutions' and 'leadership' determinants of good governance. The community development approach emphasises empowering communities to take responsibility and control over their own futures, and is closely linked with the 'self-determination' aspect of good governance (Gerritson 2001).

'Capacity building' also has close links to the 'resources' determinant of good governance. In this Report, 'capacity building' focuses on the social factors that contribute to the knowledge, ability and commitment essential to good governance, while 'resources' focuses on the economic factors necessary to underpin successful governance arrangements.

The OIPC red tape evaluation (OIPC 2006, pp. 45-46) examined the capacity of Indigenous organisations included in the study — although the results might present an overly positive picture, as the majority of the organisations included were considered 'more capable than average'. The evaluation found that:

- Only half the organisations indicated they were satisfied with the skills and staff they had available. Others noted a lack of resources for local skills training, poor recruitment outcomes, and inadequate succession planning, particularly in the replacement of key personnel.
- Inadequate financial management skills or processes were cited as a major risk for organisations.
- Five of the 22 organisations visited did not believe that they had the skills to apply for grants, or to manage and report on the grants.
- A further two indicated that they currently have capacity, but that succession planning and the capacity of the council are major risks.
- Even those who believed they had adequate skills cited lack of time to complete all duties
- Less than 30 per cent of organisations employed Indigenous managers or senior staff, so that Indigenous capacity was not being developed.
- All organisations reported appropriate access to essential administrative equipment (computers, printers, fax machines, photocopiers and vehicles).
- Most organisations had some knowledge, understanding and use of information technology, including e-mail and websites (OIPC 2006, p. 68).

The OIPC evaluation confirmed anecdotal evidence that, for many Indigenous organisations, 'human capital' is much more of an issue than basic administrative equipment. Box 11.5.15 provides some examples of capacity building by Indigenous organisations from the 2006 Indigenous Governance Awards.

The Registrar of Aboriginal Corporations is an independent statutory office holder who administers the *Aboriginal Councils and Associations Act 1976* (replaced by the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* from June 2007). The Office of the Registrar of Aboriginal Corporations (ORAC) supports and regulates the corporations that are incorporated under the Act. It does this in a variety of ways, for example, by advising them on how to incorporate, by training board members and key staff in good corporate governance, and by making sure they comply with the law and intervening when needed. An example of ORAC's contribution to capacity building is provided in section 11.4.

Box 11.5.15 **Building capacity**

Gannambarra Enterprises won the Indigenous Governance Award for an organisation that had been established for fewer than 10 years. Gannambarra develops sustainable businesses and provides opportunities for local Indigenous people to find employment in their preferred fields. The judging panel commented that the strategic risk of losing staff has been realised and active steps are being taken to address the issue through career development opportunities. The emphasis is on teamwork at all levels — board, management and staff, and there is good, strong and candid engagement with participants.

WuChopperen Health Service won the Indigenous Governance Award for an organisation that had been established for more than 10 years. Formed in Cairns in 1979 as an essential health care service provider, its services include specialist clinics and chronic disease management, oral health, and social health and wellbeing. It also oversees the establishment of medical services and clinics in remote regions. The judging panel commented that:

- there is a continuous improvement ethos and effective processes to identify and implement change
- innovative and creative approaches by staff are supported and encouraged
- there are good processes for communicating views and decisions
- stakeholders endorsed the quality of the organisation and its role as a leader and model in a range of areas
- there is a focus on generational change and effective actions to achieve it.

Source: Reconciliation Australia 2006b.

Cultural match

Cultural match is not about 'cultural appropriateness'. As noted by the Indigenous Governance Project, it refers to the degree of 'common ground' that can be achieved between the types of governing structures and procedures a group want to develop, and the culturally-based standards and values of its members' (CAEPR and RA 2004, p. 5). There are close links between the 'cultural match' and 'governing institutions' determinants of good governance.

While cultural match is essential for achieving legitimacy with Indigenous people, it is also essential that the organisation works and that it is able to achieve its objectives (see 'governance institutions'). 'What matters is not that things be done in the old ways. It is that things are done in ways — old or new — that win the support, participation, and trust of the people, *and get things done*. Some will be

old. Some will be new' (Cornell and Begay 2003). Approaches to cultural match by applicants to the Indigenous Governance Awards are summarised in box 11.5.16.

Box 11.5.16 **Cultural norms**

Malabam Health Board Aboriginal Corporation cited traditional authority and consensus as their over riding *modus operandi*. At times, certain groups/individuals carry more weight e.g. the traditional owners have authority on issues of land, and the Indigenous mental health worker would have authority on mental health issues.

Yamatji Marlpa Barna Baba Maaja Aboriginal Corporation, one of the native title representative bodies, has an innovative working group structure. Native title working groups have the authority to make decisions on a community's behalf utilising their own traditional laws and customs. However, they must also follow the instruction of the wider claim group.

Malabam Health Board Executive Committee is made up of ceremony leaders and elders from eight language groups, as well as outsiders. Elders have traditional authority to ensure the right people are involved in decision-making. A desire to keep culture strong underpins all decisions.

Waltja Tjutangku Palyapayi Aboriginal Corporation Management Committee supports tradition, law and culture in remote communities. Its board is made up of respected senior women nominated by their communities.

Bunuba Inc. councillors are democratically elected but, in line with traditional practice, serve at the discretion of their clan elders through an unwritten code. All decisions relating to land require prior consent of the traditional elders belonging to that country.

Nari Nari Tribal Council clan representation methods within the organisation are reviving traditional roles within Aboriginal society. Nari Nari involves the local community in decision-making by consulting on each proposal.

Warlayirti Artists has developed with the cultural values of the Indigenous artists it represents. These artists advise staff on important cultural issues and the board respects the responsibility which senior people with cultural authority carry, whether or not they are members of the committee.

Institute for Aboriginal Development hosts the Regional Aboriginal Language and Maintenance Advisory Committee, which comprises elders who provide advice on cultural matters and determine funding allocations for language and cultural programs.

Aboriginal Drug and Alcohol Council has a funded elder position in its organisation.

Link-up NSW board is composed of senior people nominated on the basis of merit/respect. Board members work together under the direction of a community leader; gender issues in male and female business are respected; and decisions are directed by the traditional philosophy of the community, not hierarchical practices.

Source: IGA 2006, pp. 37–39.

Cultural match is more than symbolic — it can have a significant impact on a range of outcomes for Indigenous people. The Harvard Project on American Indian Economic Development found that 'successful [Indigenous] economies stand on the shoulders of culturally appropriate institutions of self-government that enjoy legitimacy among tribal citizens' (The Harvard Project 2003-04).

Drawing on the Indigenous Governance Awards examples, the following successful approaches to address cultural match can be identified:

- ensuring specific sectors of their community (for example, language, skin or clan groups), especially elders, were represented on their board or offered guidance/supervision
- using broad community consultation methods, and in particular consulting with elders about key issues
- consulting with the appropriate traditional owners where land, cultural heritage or cultural practices are concerned
- reflecting cultural norms in the design and operation of programs and projects, including the separation of men's and women's business where this is culturally required (IGA 2006, p. 37).

Resources

During consultations on the 2005 Report, a number of Indigenous communities supported the addition of 'resources' to the determinants of good governance. Resources, which encompass financial, physical and human resources, were regarded as major factors in successful governance arrangements.

The 'resources' determinant has close links to capacity building (discussed earlier) but each of the determinants has a different focus — 'resources' on the economic factors necessary to underpin successful governance arrangements; and 'capacity building' on the social factors that contribute to the 'knowledge, ability and commitment' essential to good governance.

Indigenous organisations may gather resources from a range of sources, including self-generated funds (from Indigenous-owned businesses or royalties), donations from private corporations, charities or individuals (including their own members), and different levels of government. Many of these sources, including government funding, can be unpredictable or uncertain, making future planning and long term investment difficult. The OIPC red tape evaluation found that 66 per cent of grants from government programs continue year after year, with little change in the

circumstances or risk profile of the funded organisations. However, annual applications are still required (OIPC 2006, p. 6).

'Resources' also has close links to the 'self-determination' aspect of good governance. Access to alternative sources of resources can give Indigenous organisations a degree of independence from government and enable Indigenous organisations to run programs as Indigenous people want them to be run (IGA 2006, p. 41). The Indigenous Governance Awards noted that financial diversity and greater self-reliance were goals for many organisations. Box 11.5.17 provides examples of some IGA applicants pursuing financial independence.

Box 11.5.17 **Resources**

Wangka Maya Pilbara Aboriginal Language Centre aims to achieve a measure of financial independence by combining grants from the Australian and WA governments with self-generated income earned from running cultural awareness workshops.

Gannambarra Enterprises was launched in 2001 to develop sustainable businesses and to increase employment opportunities for the Indigenous people of Wagga Wagga. It currently runs four businesses — Deadly Detailers, a car detailing service; Wiradjuri Natives, a nursery; an arts and crafts centre; and Gannambarra Pottery.

The Muru Mittigar Aboriginal Cultural and Education Centre was established in 1998. It has several business streams, including a cultural centre, professional land rehabilitation crew, cafe, retail gallery, accredited wholesale nursery, environmental monitoring services and a range of employment and training programs.

Aboriginal Drug and Alcohol Council generates four dollars in additional funds for each dollar received from their main government funder.

Jawoyn Association is entirely self-funded, with a range of businesses including Nitmiluk National Park Joint Venture, a roadhouse, two caravan parks and a tourist kiosk, as well as developing a facility to provide social services to Jawoyn people.

Warlayirti Artists' Art Centre is entirely self-funded from commissions from the sale of art works, and has recognised the need for added reserves for future sustainability.

Yirra Yaakin Aboriginal Corporation was established in Perth in 1993 to tell the stories of Aboriginal communities through Indigenous determined performing arts. The company has a world-wide reach with major national and international tours. It has achieved 60 per cent earned income and is seeking to increase this proportion.

Yulella Aboriginal Corporation has four successful businesses which provide local training and employment opportunities, with profits supporting a youth employment project and an employment placement initiative.

More information on these and other successful Indigenous organisations can be found on the Reconciliation Australia website at: www.reconciliation.org.au/igawards

Source: IGA 2006, p. 42

The Larakia Development Corporation has been particularly successful at generating its own resources. Unable to rely on mining royalties, the Larakia people have established business ventures which provide the twin benefits of sustainable revenue streams into the future, and employment and skills transfer opportunities for the local Indigenous community (box 11.5.18).

Box 11.5.18 **Larrakia Development Corporation**

The Larrakia Development Corporation (LDC) was established in 2002 with the assistance of the Northern Land Council to manage the development of land exchanged as part of a settlement with the NT Government over a long running native title claim. The LDC has since completed a housing development on land at the Darla Subdivisions in Palmerston in the NT.

The LDC was established without direct government funding, although it accesses specific Australian Government programmes, such as the Community Development Employment Projects programme and a start up loan of $494 000 from the Enterprises Programme, which was repaid in 2004. The LDC's first commercial operation (totalling over $10 million) in the Darla subdivision was funded through commercial banks.

The LDC has won numerous business and management awards and is recognised by many organisations including Defence Housing as being a well run and efficient partner. The LDC is debt free and has returned dividends of $250 000 in grants to the Larrakia people. Income is divided evenly between the Larrakia Development Trust (established to coordinate community projects for the Larrakia people) and the LDC. In addition, the LDC has generated employment and training opportunities for local Aboriginal people both through its own development activities and through its own employment placement agency.

Two new businesses have recently been established:

- Larrakia Homes, an incorporated company within the Larrakia Development Corporation, whose prime objective is to develop commercial and employment opportunities
- Larrakia Environmental Services, which provides an opportunity for Larrakia people to participate in the commercial landscaping workforce.

The LDC demonstrates the power of establishing a commercial corporate body with profit motives to support the charitable objectives of an Indigenous Community Trust. It also highlights that good governance practices are attractive to commercial lending institutions.

Source: Larrakia Development Corporation (unpublished).

11.6 Future directions in data

Employment

The employment data in this Report are from several ABS surveys, including the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the 2004-05 National Health Survey (NHS), the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), and the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS).

Comparisons between Indigenous and non-Indigenous employment are not possible for very remote areas, as non-Indigenous data for very remote areas were not collected in the 2004-05 NHS. There are no comparable Indigenous and non-Indigenous self employment data at the national level other than those in the 2001 Census.

Along with the other improvements to Indigenous employment data collection, data need to be regularly collected on Indigenous self employment to allow adequate reporting of relevant indicators.

Indigenous owned or controlled land

Some data on the area of Indigenous owned or controlled land are available. However, area is an imperfect measure of the value or benefits to Indigenous people of their land. Further work is needed to research and record the social and economic benefits that flow from Indigenous ownership and control of land.

The National Native Title Tribunal, the Indigenous Land Corporation and the Centre for Aboriginal Economic Policy Research have worked to develop a map-based dataset to show the entire 'Indigenous estate' (that is, all land that is owned or controlled by Indigenous people). This could be a useful addition to the Report. However, completing the project would require some central coordination, to address definitional and intellectual property issues. Further, such a project would need cooperation and collaboration with State and Territory government agencies responsible for recording and mapping areas of the Indigenous estate.

Case studies in governance arrangements

There has been significant progress in examining good Indigenous governance since the first Report in 2003. The introduction of the Indigenous Governance Awards has helped identify and highlight the many examples of good practice. The Indigenous

Community Governance Project by CAEPR and Reconciliation Australia is bringing greater academic rigour to the examination of current governance practices. Among governments, the OIPC Indigenous Red Tape evaluation helped identify aspects of government governance that can assist or impede Indigenous governance, and the COAG evaluations have identified some significant lessons regarding the governance structures and processes developed and utilised in the trials.

That said, there is still more to be done before future Reports can include an objective measure of 'governance'. The Indigenous Community Governance Project is ongoing, and may contribute to the development of measurable indicators of good governance. It might be possible to measure the impact of the new *Corporations (Aboriginal and Torres Strait Islander) Act 2006* on Indigenous corporations.

11.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3.2 is table 2 in the attachment tables for section 11.3). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

11.1 Employment by sector, industry and occupation

Table 11A.1.1	Employment by remoteness area and CDEP status, Indigenous people aged 18–64 years, 2004-05
Table 11A.1.2	Full time and part time employment, people aged 18–64 years, by State and Territory, 2004-05, age standardised
Table 11A.1.3	Full time and part time employment by CDEP status, Indigenous people aged 18–64 years, 2004-05
Table 11A.1.4	Employment of Indigenous people aged 18 to 64 years, 1994, 2002, 2004-05
Table 11A.1.5	Full time and part time employment, Indigenous people aged 18–64 years, by sex, age and State and Territory, 2004-05
Table 11A.1.6	Employment by sector, people aged 18–64 years, age standardised, 2004-05
Table 11A.1.7	Employment by sector, Indigenous people aged 18–64 years, 2004-05
Table 11A.1.8	Employment by industry, Indigenous people aged 18–64 years, age standardised, 2004-05
Table 11A.1.9	Employment by industry, non-Indigenous people aged 18–64 years, age standardised, 2004-05

Table 11A.4.8 Students of governance-related courses: management, commerce, business law, economics and econometrics

11.8 References

11.1 Employment by full or part time status, by sector, industry and occupation

ABS (Australian Bureau of Statistics) 2002, *Year Book Australia 2002*, no. 84, Cat. no. 1301.0, Canberra.

——2006, *Year Book Australia 2006*, no. 88, Cat. no. 1301.0, Canberra.

ATSIC (Aboriginal and Torres Strait Islander Commission) 2003, *Annual Report 2003-04*, Canberra.

DEWR (Department of Employment and Work Relations) 2005, *Annual Report 2004-05*, DEWR, Canberra, http://www.annualreport.dewrsb.gov.au/2005/chapter2_3/1404.htm (accessed 17 February 2007).

Ganbina Koorie Economic Employment Training Agency, http://www.ganbina.com.au/ladders_to_success.html (accessed 3 May 2005).

Hunter, B. 2004, *Indigenous Australians in the Contemporary Labour Market*, Cat. no. 2052.0, ABS, Canberra.

——2002, *Institutional Factors Underpinning Indigenous Labour Force Participation: The Role of the CDEP Scheme and Education*, Working paper no. 14, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

11.2 Self employment and Indigenous business

Hunter, B. 1999, *Indigenous Self-employment: Miracle Cure or Risky Business*, Discussion paper no. 176, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

IBA (Indigenous Business Australia) 2003, *Report on Support for Indigenous Business*, Australian Government, Canberra.

Indigenous Stock Exchange 2004, News: Wujal Wujal Walker Family Tours, Cape York, http://www.isx.org.au/news/news/Walkwuj.html (accessed 1 March 2007).

11.3 Indigenous owned or controlled land

Altman, J.C. 2001, *Sustainable Development Options on Aboriginal Land: the Hybrid Economy in the Twenty-first Century*, Discussion Paper no. 226/2001, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Altman, J.C. and Dillon, M.C. 2004, *A profit-related investment scheme for the Indigenous estate*, Discussion Paper Discussion Paper no. 270/2004, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Altman, J.C. and Levitus, R.I. 1999, *The Allocation and Management of Royalties under the Aboriginal Land Rights (Northern Territory) Act: Options for Reform*, Discussion Paper no. 191/1999, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Altman, J.C. and Smith, D.E. 1994, *The Economic Impact of Mining Moneys: the Nabarlek Case, Western Arnhem Land*, Discussion Paper no. 63/1994, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

——1999, *The Ngurratjuta Aboriginal Corporation: a Model for Understanding Northern Territory Royalty Associations*, Discussion Paper no. 185/1999, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Government of South Australia 2006, Parks: Aboriginal Partnerships, Adelaide, www.http://www.parks.sa.gov.au/parks/aboriginal/index.htm (accessed 1 March 2007).

Hooke, M.S. 2004, Submission by the Minerals Council of Australia to the Parliamentary Joint Committee on Native Title Inquiry into Native Title Representative Bodies, http://www.aph.gov.au/senate/committee/ntlf_ctte/rep_bodies/submissions/sub20.pdf (accessed 5 April 2005).

ILC (Indigenous Land Corporation) 2001a, *Regional Indigenous Land Strategy 2001–2006: New South Wales*, Adelaide.

——2001b, *Regional Indigenous Land Strategy 2001–2006: Northern Territory*, Adelaide.

——2001c, *Regional Indigenous Land Strategy 2001–2006: Queensland*, Adelaide.

——2001d, *Regional Indigenous Land Strategy 2001–2006: South Australia*, Adelaide.

——2001e, *Regional Indigenous Land Strategy 2001–2006: Tasmania*, Adelaide.

——2001f, *Regional Indigenous Land Strategy 2001–2006: Victoria*, Adelaide.

——2001g, *Regional Indigenous Land Strategy 2001–2006: Western Australia*, Adelaide.

McDermott, R., O'Dea, K., Rowley, K., Knight, S. and Burgess, P, 1998, 'Beneficial impact of the homelands movement on health outcomes in central Australian Aborigines', *Australian and New Zealand Journal of Public Health*, vol. 22, no. 6, pp. 653–658.

NNTT (National Native Title Tribunal) 2002a, *10 Years of Native Title Information Kit*, Perth, http://www.nntt.gov.au/media/data/files/10_years_of_Native_Title .pdf_Title.pdf (accessed 6 August 2003).

——2002b, *What is native title?*, Fact Sheet No. 1a, http://www.nntt.gov.au/ publications/1035773354_1456.html, (accessed 6 August 2003).

——2003, *Native title on pastoral and agricultural leases*, Fact Sheet No. 1c, http://www.nntt.gov.au/publications/1046072853_2404.html (accessed 10 September 2003).

——2006, *What is an indigenous land use agreement (ILUA)?*, Fact Sheet No. 2b, http://www.nntt.gov.au/publications/1021435535_10212.html, (accessed 30 October 2006).

O'Faircheallaigh, C. 2006, 'Mining agreements and Aboriginal economic development in Australia and Canada', *The Journal of Aboriginal Economic Development*, vol. 5, no. 1, pp. 74–91.

O'Faircheallaigh, C. and Corbett, T. 2005, 'Indigenous participation in environmental management of mining projects: the role of negotiated agreements', *Environmental Politics*, vol. 14, no. 5, pp. 629–647.

Pollack, D.P. 2001, *Indigenous Land in Australia: A Quantitative Assessment of Indigenous Landholdings in 2000*, Discussion Paper no. 221/2001, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

Wunan Foundation 2006, Wunan Foundation: About us, Kununurra, http://www.wunan.org.au/about.html (accessed 1 March 2007).

11.4 Governance capacity and skills

Dodson, M. and Smith, D. E. 2003, *Good Governance for Sustainable Development: Strategic Issues and Principles for Indigenous Australian Communities*, Discussion Paper, no. 250, Centre for Aboriginal Economic Policy Research (CAEPR), the Australian National University (ANU), Canberra.

Gerritson, R. 2001, *Community Capacity Building: An ATSIC Discussion Paper*, cited in House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, June 2004, *Many Ways Forward*, Canberra, pp.12–13.

HOR (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs) 2004, *Many Ways Forward*, June 2004, Canberra, p.14–15.

Hunt, J. and Smith, D. E. 2006, *Building Indigenous Community Governance in Australia: Preliminary Research Findings*, Working Paper, no. 31/2006, Governance Project at the CAEPR, ANU, Canberra

Reconciliation Australia 2002, The Importance of Indigenous Governance to Social and Economic Development, Background Paper, Indigenous Governance Conference, Canberra, 2-5 April 2002.

Reconciliation Australia 2006, Summary of Preliminary Research Findings, Indigenous Community Governance Research project, Reconciliation Australia, June 2006.

Sanders, W. 2004, *Thinking about Indigenous Community Governance*, Discussion Paper, no. 262, CAEPR, ANU, Canberra.

Smith, D. E. and Armstrong L. 2005, 'From Little Things, Big Things Grow', *Community Governance*, 1 (2): pp. 1–2, Occasional Newsletter of the ICGP, CAEPR, ANU, Canberra.

11.5 Case studies in governance arrangements

Aboriginal and Torres Strait Islander Commissioner 2006, *Social Justice Report 2005*, HREOC, http://www.humanrights.gov.au/social_justice/sjreport05/index

Brough, M. 2007, *COAG Indigenous Trials*, The Hon Mal Brough MP, Minister for Families, Community Services and Indigenous Affairs, Minister Assisting the Prime Minister for Indigenous Affairs, Media Release 22 February 2007, http://www.atsia.gov.au/media/media07/220207_coag_trials.aspx

CAEPR (Centre for Aboriginal Economic Policy Research) and RA (Reconciliation Australia) 2004, *Annual Report 2004*, Australian National University, Canberra.

CAEPR (Centre for Aboriginal Economic Policy Research) 2006, *Indigenous Community Governance Project*, http://www.anu.edu.au/caepr/ICGP_home.php, accessed January 2007.

Calma, T. 2006, *Evaluating the external forces which exert an influence on government policy direction*, Collaborative Indigenous Policy Development Conference, 27 & 28 June 2006, http://www.humanrights.gov.au/speeches/social_justice/collaborative20060628.html

COAG (Council of Australian Governments) 2004, *Communiqué, 24 June 2004*, http://www.coag.gov.au/meetings/250604/index.htm#indigenous

COAG (Council of Australian Governments) 2002, *Communiqué, 5 April 2002*, http://www.coag.gov.au/meetings/050402/index.htm#reconciliation.

Cornell, S. and Begay, M. 2003, quoted by CAEPR and RA, *2004 Annual Report*, Australian National University, Canberra, p. 5.

Dodson, P. 1998, *On Leadership*, Williamson Community Leadership Program Lecture, 11 May 1998, Victoria, http://www.leadershipvictoria.org/ speeches speech_ dodson.html.

Gerritson, R. 2001, *Community Capacity Building: An ATSIC Discussion Paper*, cited in House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, June 2004, *Many Ways Forward*, Canberra, pp.12–13.

HOR (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs) 2004, *Many Ways Forward*, June 2004, Canberra, p.14–15.

Hunt, J. and Smith, D.E. 2006, *Ten Key Messages from the Preliminary Findings of the Indigenous Community Governance Project 2005*, Centre for Aboriginal Economic Policy Research, www.anu.edu.au/caepr/>

ICGP (Indigenous Community Governance Project) 2006, Community governance Research Update no. 1, March 2006, ANU, Canberra.

IGA (Indigenous Governance Awards) 2006, *Celebrating indigenous Governance: Success stories of the Indigenous Governance Awards*, Reconciliation Australia and BHP Billiton, Canberra.

Morgan Disney & Associates Pty. Ltd, Tracey Whetnall Consulting and Wis-Wei Consulting Pty Ltd 2007, *Synopsis Review of the COAG Trial Evaluations, Report to the Office of Indigenous Policy Coordination (OIPC) November 2006*, Canberra, http://oipc.gov.au/publications/default.asp.

OIPC (Office of Indigenous Policy Coordination) 2006, *A Red Tape Evaluation in Selected Indigenous Communities* (a report by Morgan Disney and Associates), OIPC, Canberra.

ORAC (Office of the Registrar of Aboriginal Corporations) 2006, 'At last a new act', *The Oracle*, December 2006, www.orac.gov.au.

Reconciliation Australia 2006a, *About the Awards*, http://iga.reconciliation.org.au/igawards/about.html, accessed 20 December 2006.

Reconciliation Australia 2006b, *2006 Indigenous Governance Awards*: *The Winners*, http://iga.reconciliation.org.au/igawards/winners.html, accessed 21 January 2007.

SCRGSP (Steering Committee for the Review of Government Service provision) 2007a, *Report on Government Services 2007, Indigenous Compendium*, Productivity Commission, Canberra.

SCRGSP (Steering Committee for the Review of Government Service provision) 2007b, *Report on Consultations*, Productivity Commission, Canberra.

Smillie, I. and Hailey, J. 2001, *Managing for Change: Leadership, Strategy and Management in Asian NGOs*, Earthscan, London.

The Harvard Project on American Indian Economic Development 2003-04, *Overview of the Harvard Project*, John F. Kennedy School of Government, Harvard university, USA, http://www.ksg.harvard.edu/hpaied/overview.htm

Wehmeyer, M. L. 2002, *Self-determination and the education of students with disabilities* (Digest No. E632). Reston, VA: ERIC Clearinghouse on Disabilities and Gifted Education. (ERIC Document Reproduction Service No. ED470036).

UN (United Nations) 2005, *Free Prior and Informed Consent and Beyond*, Division for Social Policy and Development, Secretariat of the Permanent Forum on Indigenous Issues, Department of Economic and Social Affairs presentation to the International Workshop on Methodologies regarding Free, Prior and Informed Consent and Indigenous Peoples, New York 17-19 January 2005, www.un.org/esa/socdev/unpfii/documents/FPIC_2005_IFAC.doc

12 Outcomes for Torres Strait Islander people

Box 12.1 **Key messages**

- Around 6 per cent of the Indigenous population identify as Torres Strait Islander only, while an additional 4 per cent identify as both Aboriginal and Torres Strait Islander.
- Fifty-nine per cent of Torres Strait Islander people live in Queensland.
- In 2004-05:
  - the proportions of Aboriginal and Torres Strait Islander adults with a long term health condition were similar (tables 12A.1.5 and 12A.1.6)
  - a higher proportion of Torres Strait Islander adults (21.7 per cent) than Aboriginal adults (13.6 per cent) had year 12 as their highest level of education (figure 12.1.1), but similar proportions had completed a post-secondary qualification of certificate level 3 or higher (table 12A.1.1)
  - the labour force participation rate for Torres Strait Islander people aged 18 to 64 years (69.7 per cent) was higher than for Aboriginal people (61.9 per cent) (figure 12.1.2). The proportions of people who were unemployed or who were participating in CDEP were similar (tables 12A.1.4 and 12A.1.6)
  - the median (mid point) weekly income of Torres Strait Islander adults ($400) was higher than for Aboriginal adults ($303) but lower than for non-Indigenous adults ($518) (figure 12.1.3).
  - the proportions of Aboriginal and Torres Strait Islander adults living in homes someone in their household owned or was purchasing were similar (table 12A.1.2).

12.1 Selected outcomes for Torres Strait Islander people

The estimated Indigenous population of Australia in at 30 June 2001 was 458 500, of whom 48 791 (10.6 per cent of the Indigenous population) were Torres Strait Islanders. People who identified solely as Torres Strait Islander comprised around 6 per cent of the Indigenous population, while the remaining 4 per cent identified as both Aboriginal and Torres Strait Islander. Fifty-nine per cent of Torres Strait Islander people lived in Queensland (ABS 2004).

Torres Strait Islander people comprise a small proportion of the Australian population (and of the Indigenous population), and it is difficult to extract reliable data on Torres Strait islander people from surveys and administrative data collections. The five-yearly ABS Census provides the most reliable data on Torres Strait Islander people. Data from the 2006 Census were not available for this Report but will be available for the next edition.

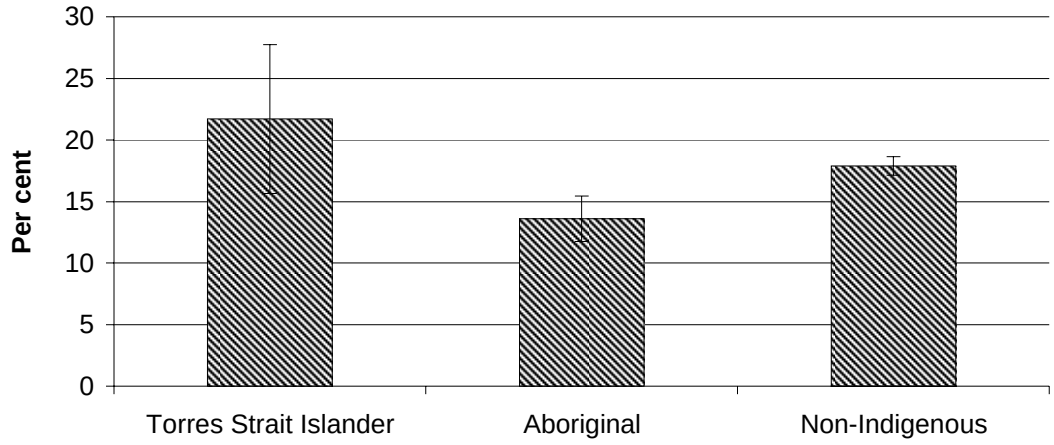
This chapter presents a selection of results from the ABS 2004-05 NATSIHS showing outcomes for Torres Strait Islander, Aboriginal and non-Indigenous people. In these data, 'Torres Strait Islander' includes both people who identified as 'Torres Strait Islander only' and people who identified as 'Aboriginal and Torres Strait Islander'. 'Aboriginal' includes people who identified as 'Aboriginal only'. More detailed results for Torres Strait Islander people in the Torres Strait area, Queensland and the remainder of Australia are included in tables 12A.1.1 to 12A.1.6.

Long term health conditions

- Similar proportions of Aboriginal and Torres Strait Islander people aged 18 years and over reported having a long term health condition in 2004-05 (tables 12A.1.5 and 12A.1.6). For more information on Indigenous people with a long term health condition and comparisons with non-Indigenous people, see section 3.2.

Education

Figure 12.5.1 **Proportion of people aged 18 or over whose highest level of education was year 12, 2004-05** [a, b]



[a] Excludes people still attending secondary school and people who have a post school qualification. [b] Torres Strait Islander includes persons who identified as being Torres Strait Islander only or of both Aboriginal and Torres Strait Islander origin. Aboriginal includes persons who identified as being of Aboriginal origin and not Torres Strait Islander origin.

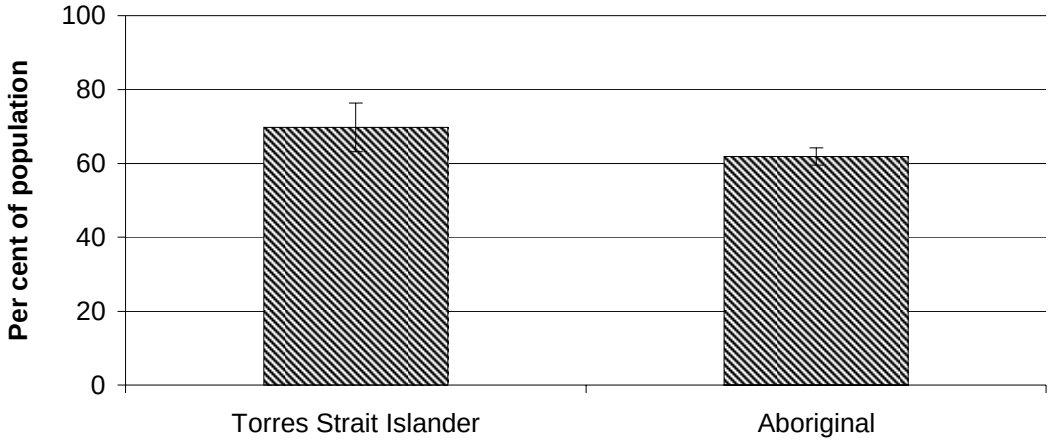
Source: ABS 2004-05 NATSIHS; ABS 2004-05 NHS; table 12A.1.1.

- In 2004-05, a higher proportion of Torres Strait Islander (21.7 per cent) than Aboriginal (13.6 per cent) people aged 18 years and over had year 12 as their highest level of education (figure 12.1.1).
- Similar proportions of Torres Strait Islander and Aboriginal people had completed a post-secondary qualification of certificate level 3 or higher in 2004-05 (table 12A.1.1).

For more information on year 10 and 12 participation and attainment and post-secondary education participation and attainment, including comparisons with non-Indigenous people, see sections 3.3 and 3.4.

Labour force participation and unemployment

Figure 12.1.2 **Labour force participation rate, 2004-05[a]**



a Torres Strait Islander includes persons who identified as being Torres Strait Islander only or of both Aboriginal and Torres Strait Islander origin. Aboriginal includes persons who identified as being of Aboriginal origin and not Torres Strait Islander origin.

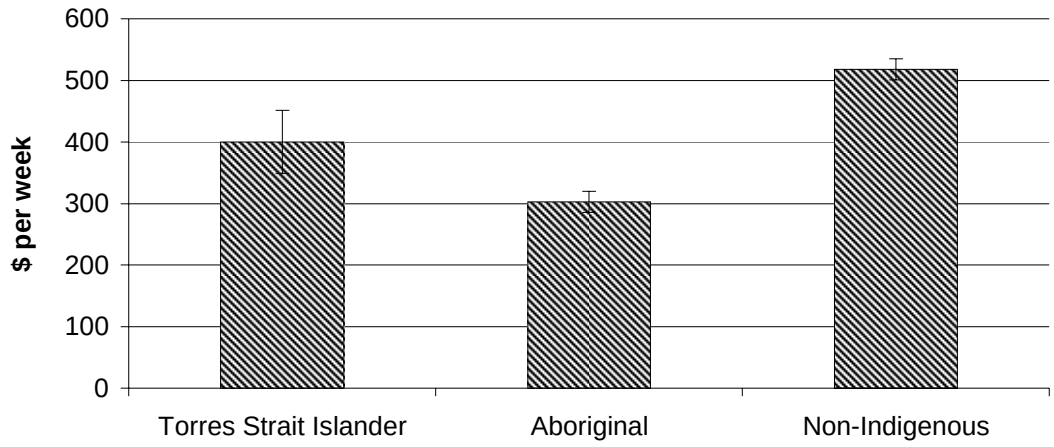
Source: ABS 2004-05 NATSIHS; table 12A.1.4.

- In 2004-05, the labour force participation rate for Torres Strait Islander people (69.7 per cent of the population) was higher than for Aboriginal people (61.9 per cent) aged 18 to 64 years (figure 12.1.2).
- In 2004-05, the proportions of people who were unemployed and proportions of people participating in CDEP were similar for Aboriginal and Torres Strait Islander people aged 18 to 64 years (tables 12A.1.4 and 12A.1.6).

For more information on labour force participation and unemployment for Indigenous and non-Indigenous people, see section 3.5.

Income

Figure 12.1.3 **Median individual income, people aged 18 years or over, 2004-05[a]**



[a] Torres Strait Islander includes persons who identified as being Torres Strait Islander only or of both Aboriginal and Torres Strait Islander origin. Aboriginal includes persons who identified as being of Aboriginal origin and not Torres Strait Islander origin.

Source: ABS 2004-05 NATSIHS; ABS 2004-05 NHS; table 12A.1.3.

- In 2004-05, the median weekly income of Torres Strait Islander people aged 18 years or over ($400) was higher than for Aboriginal people ($303) but lower than for non-Indigenous people ($518) (figure 12.1.3).

More information on household and individual incomes for Indigenous and non-Indigenous people is included in section 3.6.

Home ownership

- Similar proportions of Aboriginal and Torres Strait Islander people aged 18 years and over were living in homes someone in their household owned or was purchasing in 2004-05 (table 12A.1.2).

More information on home ownership by Indigenous and non-Indigenous people is included in section 3.7.

12.2 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.1.2 is table 2 in the attachment tables for

section 12.1). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

12 Outcomes for Torres Strait Islander people

Table 12A.1.1	Highest level of education completed by people aged 18 or over, by Indigenous status, 2004-05
Table 12A.1.2	Home ownership of people aged 18 or over, by Indigenous status, 2004-05
Table 12A.1.3	Individual weekly income of people aged 18 or over, by Indigenous status, 2004-05
Table 12A.1.4	Employment status of Indigenous people aged 18 to 64 years, 2004-05
Table 12A.1.5	Proportion of Indigenous people aged 18 years or over with a long term health condition, 2004-05
Table 12A.1.6	Selected indicators for people aged 18 or over, by Indigenous status, age standardised, 2004-05

12.3 References

ABS (Australian Bureau of Statistics) 2004, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2009,* Cat. no. 3238.0, Canberra.

13 Measuring multiple disadvantage

Box 13.1 **Key messages**

- In 2004-05, Indigenous people were markedly disadvantaged when compared with non-Indigenous people against the three measured headline dimensions — education, labour force and income. Different patterns of disadvantage were observed according to age, sex and remoteness areas (figures 13.1.1–13.1.3).
- Overcrowded housing is associated with most headline dimensions of disadvantage, including poor education and employment outcomes and low household and individual incomes (figure 13.3.3).
- Health risk behaviours among Indigenous people are associated with many headline dimensions of disadvantage — daily smoking is associated with poor outcomes in education, employment and income (figure 13.3.1), and illicit drug use is associated with unemployment and poor outcomes in home ownership (figure 13.3.2).

As noted across this Report, different aspects of disadvantage often seem to occur together — for example, poor education may be linked with poor employment outcomes, and both may be linked with poor income. This chapter uses comparable data from two ABS surveys to identify some aspects of disadvantage that tend to occur together. However, this information does not reveal cause and effect (that is, it does not say that disadvantage in one area is the *cause* of another poor outcome).

The ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Health Survey (NHS) that provided the data for this chapter do not provide information on all the indicators in this Report's framework, and some of the measures used in this chapter are proxies (not exact matches) for the framework indicators. Section 13.1 examines patterns of disadvantage against the proxy headline indicators according to age, sex and remoteness area, and compares patterns of outcomes for Indigenous and non-Indigenous people. Section 13.2 examines links between the proxy headline indicators and compares Indigenous and non-Indigenous results. Section 13.3 examines links between the proxy headline indicators and some proxy strategic change indicators. Data for this part of the analysis are available only for Indigenous people. Section 13.4 provides some technical information on how the analysis was done.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.1.1). A list of attachment tables is in section 13.5. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

13.1 Patterns of relative Indigenous disadvantage

In 2004-05, Indigenous people were markedly disadvantaged when compared with non-Indigenous people against all the proxy indicators. The following sections examine how this disadvantage varied according to age, sex and remoteness. This section analyses six measures from the NATSIHS and NHS that are closely aligned with some of this Report's headline indicators. Box 13.1.1 lists the measures used and the corresponding headline indicators.

Box 13.1.1 **Measuring relative Indigenous disadvantage**

The following measures for Indigenous and non-Indigenous populations from the 2004-05 National Aboriginal and Torres Strait Islander Health Survey and the National Health Survey are proxies for some of the Report's headline indicators:

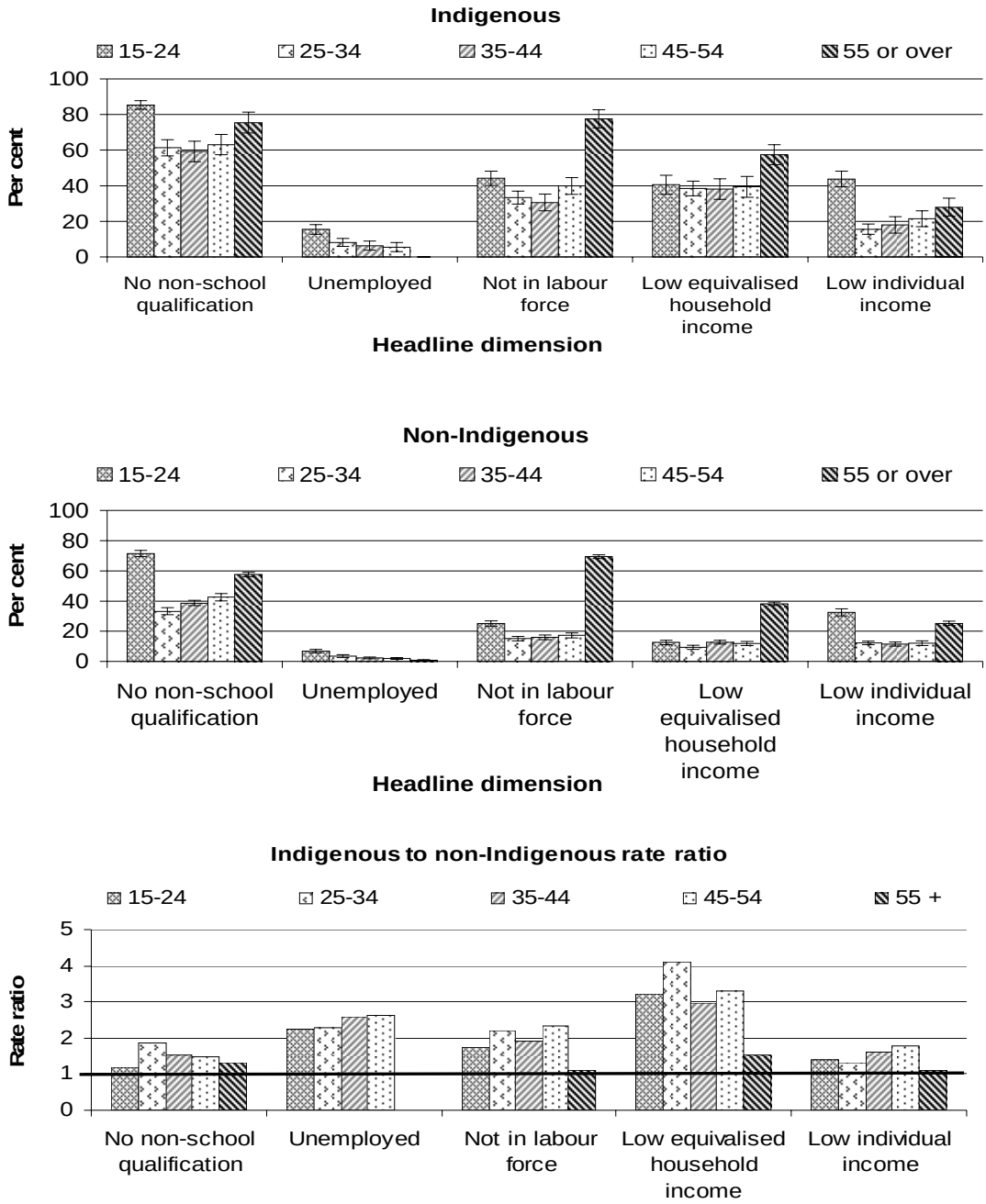
NATSIHS/NHS measure	*Headline indicator*
• without a non-school qualification (without a vocational or higher education qualification)	• Post-secondary education (attainment)
• not in the labour force • unemployed[1]	• Labour force participation and unemployment
• individual income in the lowest 20 per cent of income for the total Australian population • equivalised household income in the lowest 20 per cent of income for the total Australian population[2]	• Household and individual income
• not living in a house being owned or purchased by a member of the household (data available for Indigenous people only)	• Home ownership

1 For this analysis, unemployment figures are calculated as a proportion of the population, not of the labour force and, therefore, are different from those reported elsewhere in the Report.

2 Equivalised household income adjusts the actual incomes of households to make households of different sizes and composition comparable. It results in a measure of the economic resources available to members of a standardised household.

13.1.1 Differences across age groups

Figure 13.1.1 **Relative disadvantage by Indigenous status and age, 2004-05[a, b, c]**



[a] Non-school qualifications include vocational or higher education qualifications. For people aged 15-24 years, 25.2 per cent of Indigenous people and 26.2 per cent of non-Indigenous people were still at school. [b] 'Low' incomes are those in the lowest quintile (20 per cent) of income (see the 2004-05 NHS/NATSIHS User Guides for details). Proportions are calculated from the total of those who stated their incomes. [c] Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); tables 13A.1.1 and 13A.1.2.

Patterns of relative disadvantage between different age groups within the Indigenous and non-Indigenous populations were very similar, but Indigenous people in all age groups experienced greater relative disadvantage (figure 13.1.1). Box 13.1.2 explains how 'relative' Indigenous disadvantage is measured.

Box 13.1.2 **Measuring 'relative' Indigenous disadvantage**

'Relative' Indigenous disadvantage is measured by comparing the rate of Indigenous disadvantage (for example, the proportion of Indigenous people reporting they do not have a non-school qualification) with the rate for the non-Indigenous population. The 'rate ratio' is the rate for the Indigenous population divided by the rate for the non-Indigenous population. A rate ratio value greater than one (above the solid horizontal black line in some charts) implies that Indigenous people are disadvantaged compared to non-Indigenous people.

Non-school qualifications

In both the Indigenous and non-Indigenous populations, older people are less likely to have a non-school qualification than those in younger age groups (apart from those aged 15 to 24 years, of whom more than a quarter were still at school) (figure 13.1.1).

- Indigenous people in all age groups were less likely than their non-Indigenous counterparts to have a non-school qualification. The overall 'Indigenous to non-Indigenous rate ratio' for those without a non-school qualification was 1.4.
- Indigenous people aged 25 to 34 years were almost twice (1.8 times) as likely as their non-Indigenous counterparts to be without a non-school qualification.

Labour force participation and unemployment

Involvement in the workforce varies according to life stages. Participation typically increases with age, as young people move from education and training to full-time jobs. Participation remains relatively high for people in their thirties and forties, then declines towards retirement age. Labour force participation rates for both Indigenous and non-Indigenous populations reflect this pattern, but participation rates for Indigenous people are much lower than those for non-Indigenous people at all age ranges (although data are not available for Indigenous people over 55 years) (figure 13.1.1).

- Indigenous people were more likely to be unemployed than non-Indigenous people, regardless of age. The age standardised employment rate ratio between Indigenous and non-Indigenous people was 2.3.

- The ‘Indigenous to non-Indigenous rate ratio’ for unemployment was highest for those aged 35 to 54 years (2.6).
- Indigenous people aged 45 to 54 years were 2.3 times as likely as their non-Indigenous counterparts to be out of the labour force.

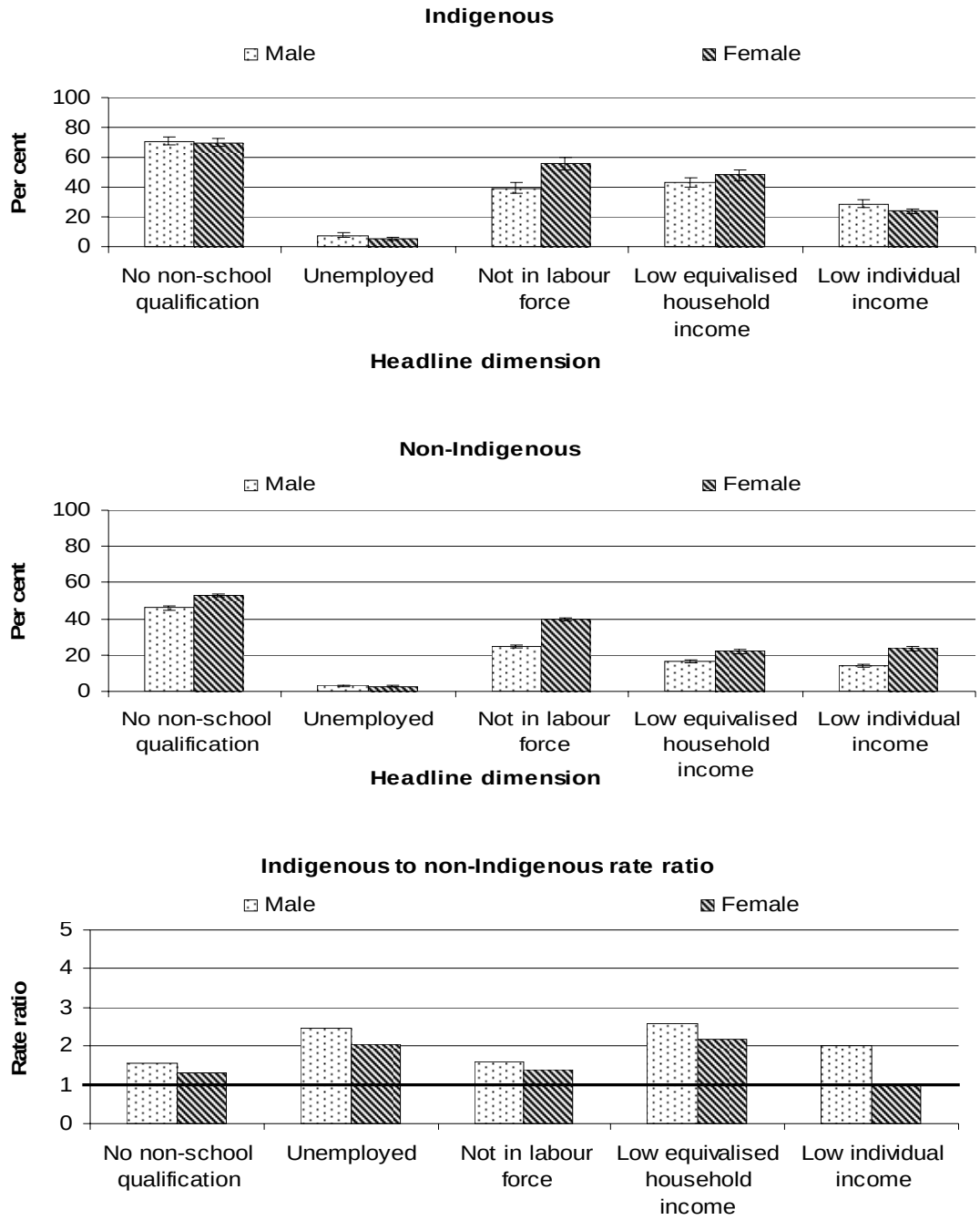
Low income

Age-related patterns in income tend to follow patterns in labour force participation (and employment). In both Indigenous and non-Indigenous populations, those aged 15 to 24 years were most likely to have *individual* incomes in the lowest 20 per cent, and those aged 55 years and over were most likely to have equivalised *household* incomes in the lowest 20 per cent (figure 13.1.1).

- In all age groups, Indigenous people were more likely to have low equivalised household incomes than non-Indigenous people. The overall age standardised Indigenous to non-Indigenous rate ratio was 2.4.
- Indigenous people aged 25 to 34 years were more than four times as likely as their non-Indigenous counterparts to have equivalised household incomes in the lowest 20 per cent.
- Indigenous people aged 45 to 54 years were nearly twice as likely as their non-Indigenous counterparts to have individual incomes in the lowest 20 per cent.

13.1.2 Differences between women and men

Figure 13.1.2 **Relative disadvantage of people aged 15 years and over, by Indigenous status and sex, 2004-05[a, b]**



a Labour force data have been age standardised. For data related to education, labour force and income, please refer to notes in figure 13.1.1. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); tables 13A.1.1 and 13A.1.2.

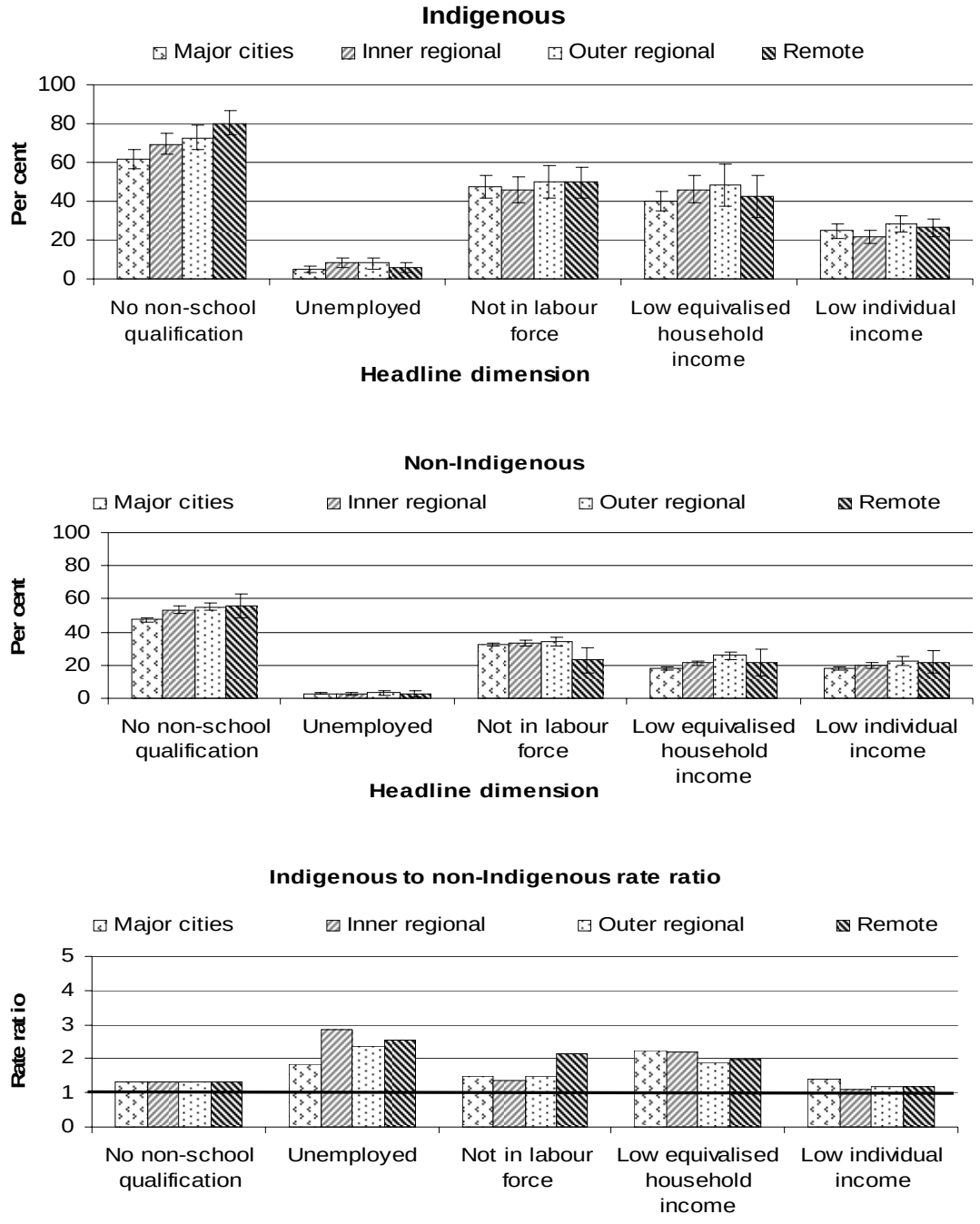
Unlike non-Indigenous people, there were no statistically significant differences between Indigenous women and men in poor educational attainment, low income, and unemployment. In the non-Indigenous population, women were more likely than men to be without a non-school qualification, and also more likely to have lower incomes (figure 13.1.2).

- The Indigenous to non-Indigenous rate ratios for not having a non-school qualification, unemployment, not participating in the labour force, and having low incomes were all higher for men than women. In particular, Indigenous men were twice as likely as non-Indigenous men to have low individual incomes, while there was no difference between the proportions of Indigenous and non-Indigenous women with low individual incomes (figure 13.1.2).

13.1.3 Differences by remoteness area

Both Indigenous and non-Indigenous populations have been grouped into subgroups based on the ABS Australian Standard Geographic Classification (ASGC) of remoteness areas: major cities, inner regional, outer regional, remote, and very remote. Non-Indigenous comparisons are not possible for very remote areas or for home ownership, as these data were not collected in the 2004-05 NHS.

Figure 13.1.3 **Relative disadvantage of people aged 15 years and over, by Indigenous status and remoteness, 2004-05[a, b]**



a Labour force data have been age standardised. For data related to education, labour force and income, please refer to notes in figure 13.1.1. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); tables 13A.1.1 and 13A.1.2.

Non-school qualifications

- In the four remoteness areas for which comparable data were available, Indigenous people were about 1.3 times as likely as their non-Indigenous counterparts to be without a non-school qualification (figure 13.1.3).
- For both Indigenous and non-Indigenous people, those living in more remote areas were less likely to have a non-school qualification.

Labour force participation and unemployment

- There were no statistically significant differences across the four remoteness areas in the proportions of Indigenous people not in the labour force or unemployed. The pattern was different for non-Indigenous people, where those living in remote areas were less likely than those living in other areas to be out of the labour force (figure 13.1.3).
- The rate ratio between Indigenous and non-Indigenous people not in the labour force was highest for those living in remote areas (2.2), and lowest for those living in inner regional areas (1.4).
- The rate ratio for unemployment was highest for those living in inner regional areas (2.8) followed by those in the remote areas (2.5). For those living in the major cities the ratio was 1.8.

Low income

- Indigenous people living in major cities were less likely than those living in the regional and remote areas to have low equivalised household incomes. The difference between major cities (39.9 per cent) and outer regional areas (48.5 per cent) was statistically significant (figure 13.1.3).
- Indigenous people living in outer regional areas were significantly more likely than those living in the inner regional areas to have low individual incomes (28.2 per cent compared with 21.6 per cent).
- The rate ratio between Indigenous and non-Indigenous people did not vary much according to remoteness.

Home ownership (Indigenous people only)

- Indigenous people in remote areas were least likely to be living in a house that was owned or being purchased by a member of their household (there are no comparable data on home ownership for non-Indigenous people from the 2004-05 NHS).

13.2 Associations between headline indicators

This section examines the associations between disadvantage in one dimension and disadvantage in another. For example, to what extent is a low level of educational attainment associated with a high level of unemployment, and do the Indigenous and the non-Indigenous populations follow different patterns?

The approach to measuring associations between the proxy headline indicators of disadvantage is described in box 13.2.1.

Box 13.2.1 **Measuring associations between the proxy headline indicators**

This analysis is based on the proxy headline indicators defined in box 13.1.1, using data from the 2004-05 NATSIHS and NHS.

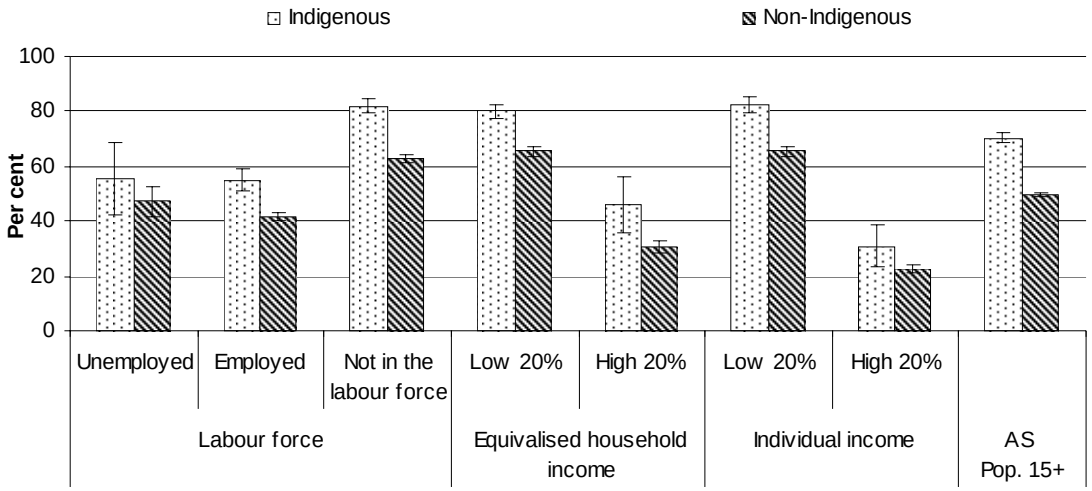
Associations between the headline indicators are identified by measuring the rate at which disadvantage in one headline indicator occurs together with disadvantage in other headline indicators.

For example, to examine whether poor education outcomes are associated with poor outcomes in employment and income, this study:

- classifies the population into various subgroups based on their employment and income status (for example, labour force characteristics — unemployed, employed and not in the labour force — and income
- compares the proportions of people in each population subgroup who have poor education outcomes (for example, no non-school qualification)
- identifies the population subgroups that have higher rates of poor education outcomes, when compared to other subgroups and the total population.

Although Indigenous people experience higher rates of disadvantage for all the headline dimensions, the patterns of association between the headline dimensions of disadvantage are similar for Indigenous and non-Indigenous people. For both Indigenous and non-Indigenous people, poor education outcomes, low levels of labour force participation and employment, and low incomes are interrelated (figures 13.2.1–13.2.5).

Figure 13.2.1 **People aged 15 years and over with no non-school qualifications, as a proportion of populations with certain labour force and income characteristics, 2004-05[a, b]**

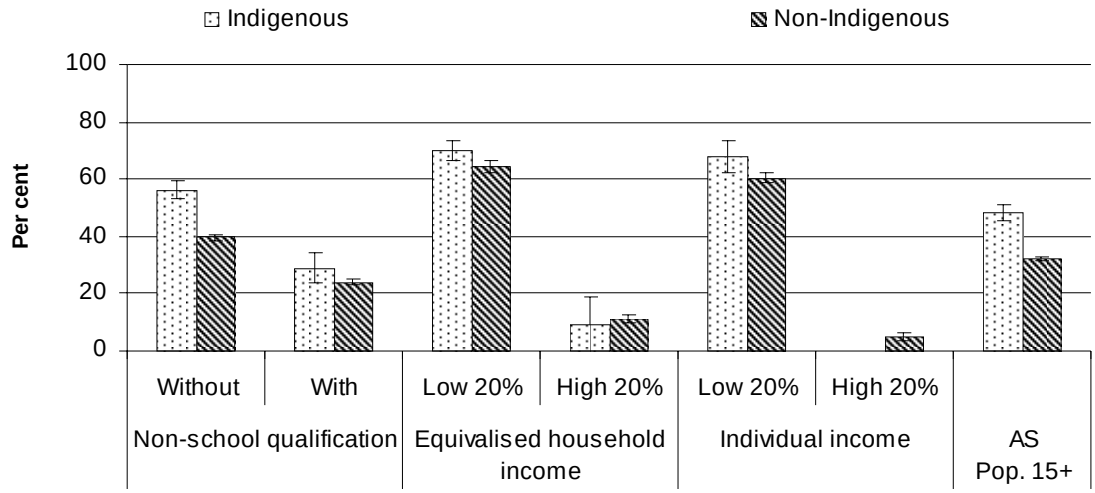


a Labour force data have been age standardised. For data related to education, labour force and income, please refer to notes in figure 13.1.1. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 13A.2.1.

- Among those aged 15 years and over, 70.3 per cent of Indigenous people had no non-school qualifications, compared with 49.5 per cent of non-Indigenous people (figure 13.2.1).
- Indigenous people who were not in the labour force or who had low incomes were more likely than other Indigenous people to lack non-school qualifications. They were also more likely than non-Indigenous people with the same characteristics to lack non-school qualifications (figure 13.2.1).

Figure 13.2.2 **People aged 15 years and over not in the labour force as a proportion of populations with certain educational and income characteristics, 2004-05[a, b, c]**



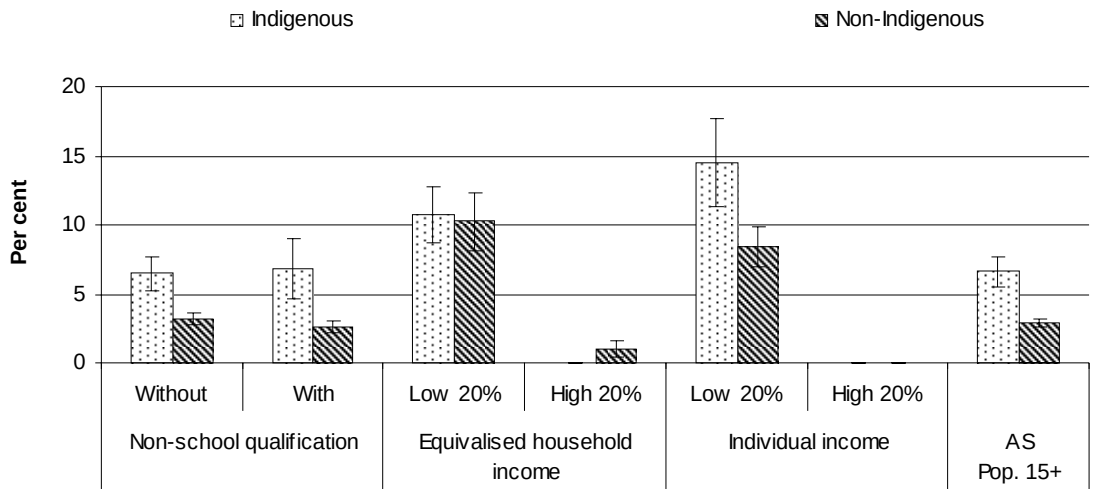
AS Age standardised.

a Labour force data have been age standardised. For data related to education, labour force and income, please refer to notes in figure 13.1.1. **b** Indigenous data for high equivalised household income has a relative standard error greater than 50 per cent and is considered too unreliable for general use. **c** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 13A.2.1.

- The age standardised proportion of Indigenous people aged 15 years and over who were not in the labour force was 1.5 times as high as the non-Indigenous rate (48.1 per cent compared with 32.4 per cent). In both populations, being out of the labour force was positively related to a lack of non-school qualifications and low income (figure 13.2.2).
- High proportions of Indigenous people with low incomes were out of the labour force (70.0 per cent of those with low equivalised household incomes and 67.8 per cent of those with low individual incomes). More than half (56.1 per cent) of Indigenous people who lacked non-school qualifications were out of the labour force (figure 13.2.2).

Figure 13.2.3 **People aged 15 years and over not employed, as a proportion of populations with certain educational and income characteristics, 2004-05[a, b, c]**

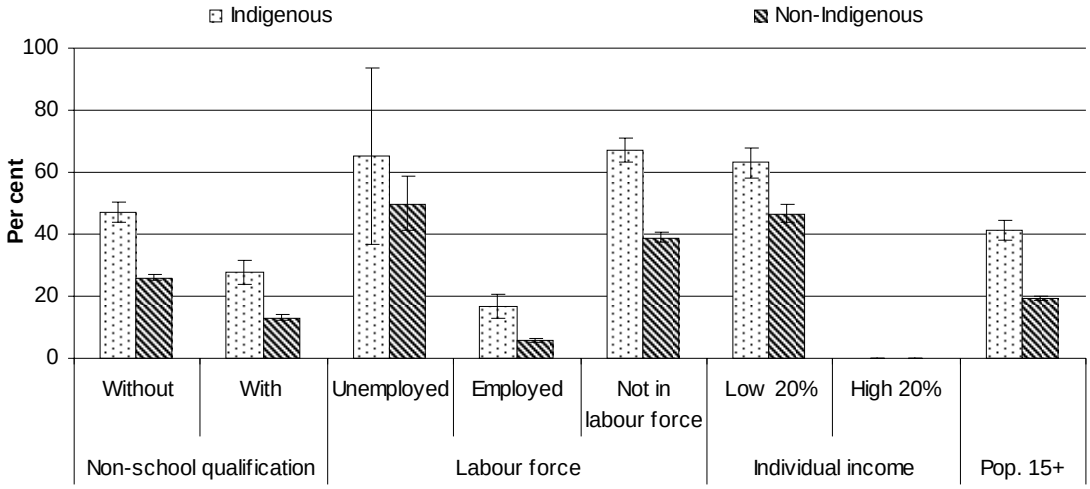


a Labour force data have been age standardised. For data related to education, labour force and income, please refer to notes in figure 13.1.1. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information). **c** Indigenous data for high equivalised household income has a relative standard error greater than 50 per cent and is considered too unreliable for general use.

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 13A.2.1.

- Indigenous people were more than twice as likely as non-Indigenous people to be unemployed (6.6 per cent compared with 2.9 per cent, age standardised). In both the Indigenous and non-Indigenous populations, those with low incomes were most likely to be unemployed (figure 13.2.3).

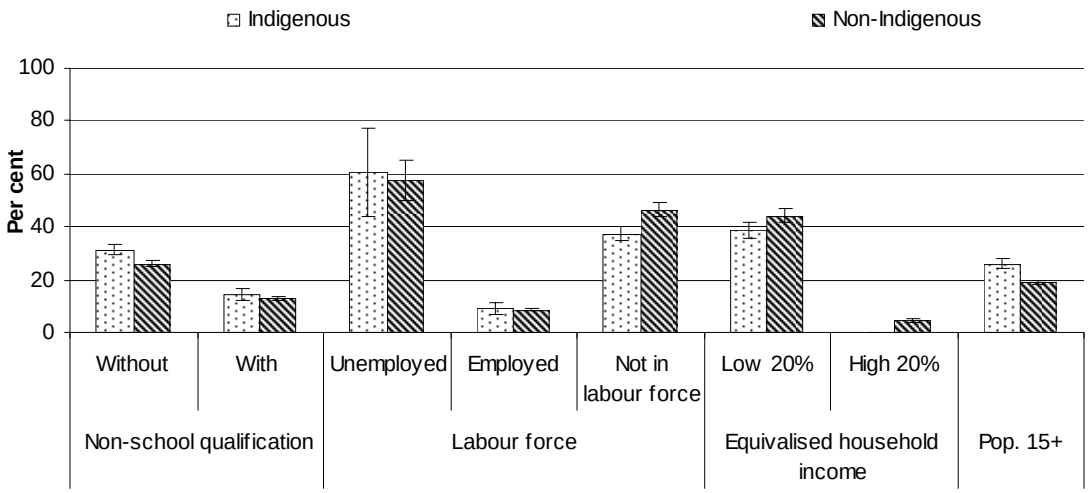
Figure 13.2.4 **People aged 15 years and over with low equivalised household incomes, as a proportion of populations with certain educational, labour force and individual income characteristics, 2004-05[a, b]**



a For data related to education, labour force and income, please refer to notes in figure 13.1.1. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 13A.2.1.

Figure 13.2.5 **People aged 15 years and over with low individual incomes, as a proportion of populations with certain educational, labour force and household income characteristics, 2004-05[a, b]**



a For data related to the education, labour force and income, please refer to notes in figure 13.1.1. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 13A.2.1.

- In both the Indigenous and non-Indigenous populations, the unemployed and those not in the labour force were more likely than others to have low incomes (both equivalised household income and individual income) (figure 13.2.5).

13.3 Associations between headline indicators and strategic change indicators

The approach to measuring associations between the proxy headline indicators and strategic change indicators is described in box 13.3.1.

Box 13.3.1 **Measuring associations between headline indicators and strategic change indicators**

In addition to the proxy headline indicators described in box 13.1.1, this section uses the following measures from the 2004-05 NATSIHS which are closely linked to strategic change indicators in the Report framework:

NATSIHS measure	*Strategic change indicator*
• the proportion of the population who were current daily smokers	• Tobacco consumption and harm
• the proportion of the population who consumed alcohol at risky to high risk levels in the seven days prior to the interview	• Alcohol consumption and harm
• the proportion of the population who used illicit drugs in the 12 months prior to the interview	• Drug and other substance use and harm
• the proportion of the population living in crowded housing conditions	• Overcrowding in housing
• the proportion of the population living on traditional lands	• Proportion of Indigenous people with access to their traditional lands

Comparisons between Indigenous and non-Indigenous populations are not possible, as many of the above measures were not collected for the non-Indigenous population.

Associations between headline indicators and strategic change indicators are identified by measuring the rate at which disadvantage in the strategic change areas occurs together with disadvantage in the headline indicators.

(Continued next page)

Box 13.3.1 (continued)

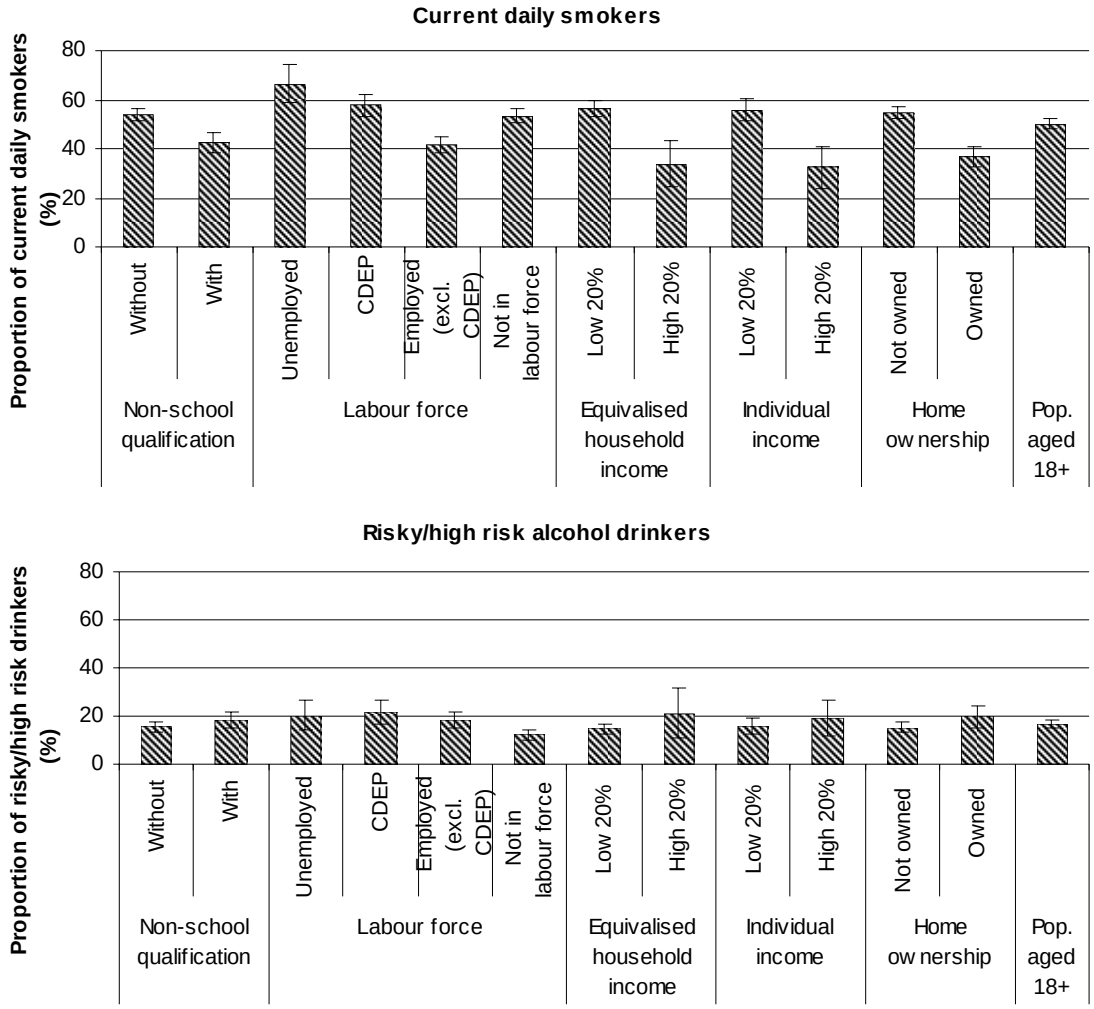
For example, to examine whether a health risk behaviour, such as smoking, is related to poor education, employment and income outcomes, this study:

- classifies the population into various subgroups based on their education, employment and income characteristics
- compares the proportion of current daily smokers in the various population subgroups

identifies the population subgroups with higher proportions of current daily smokers, when compared to other subgroups and the total population.

Overall, health risk behaviours among Indigenous people appear to be associated with many headline dimensions of disadvantage. In particular, those who smoke daily often also have poor outcomes in education, employment and income. Those who use illicit drugs often have poor outcomes in home ownership (not living in a house being owned or purchased by a member of the household). Poor housing conditions (overcrowded housing) are associated with most headline dimensions of disadvantage, including poor education and employment outcomes as well as low household and individual incomes (figures 13.3.1–13.3.3).

Figure 13.3.1 **Prevalence of tobacco and alcohol use among Indigenous people aged 18 years and over, by educational, labour force and income characteristics, 2004-05[a, b, c, d]**



a 'Current daily smokers' are people who smoked one or more cigarettes (or pipes or cigars) per day at the time of interview. **b** The alcohol risk levels are based on average daily intake of alcohol over the 7 days of the reference week prior to the interview, which follow the Australian Alcohol Guidelines (NHMRC 2001) outlining drinking patterns associated with risk of alcohol related harm. The average daily consumption of alcohol associated with the risky/high risk levels are: risky for males - more than 50ml, up to 75ml, for females - more than 25ml, up to 50ml; high risk for males - more than 75ml, and for females - more than 50ml. **c** For data related to education, labour force and income, please refer to notes in figure 13.1.1. **d** Error bars present 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS (unpublished); tables 13A.3.1 and 13A.3.2.

Smoking appears to be associated with most headline dimensions of disadvantage. In 2004-05, daily smoking was:

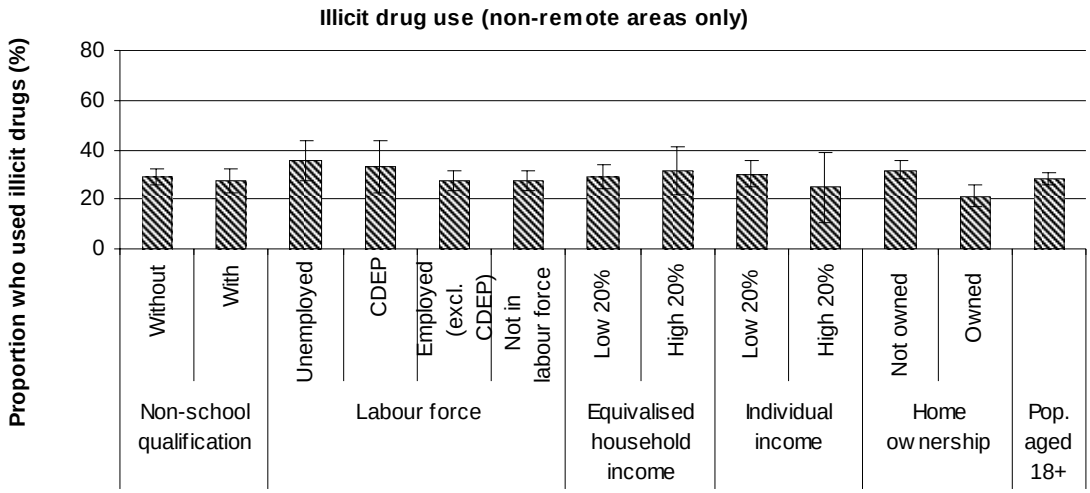
- more common among Indigenous people without non-school qualifications than among those with a non-school qualification

- more common among unemployed people, CDEP participants and those not in the labour force, than among the employed
- more common among people with low incomes than those with high incomes
- more common among people living in a house not owned or being purchased by a member of their household than among those living in a house that was owned or being purchased by a member of their household (figure 13.3.1).

In 2004-05 risky to high risk drinking was least common among Indigenous people who were not in the labour force (figure 13.3.1). Both these indicators are strongly associated with age — labour force participation and risky drinking both decline with age. There were no statistically significant differences in the prevalence of risky to high risk consumption across other characteristics (figure 13.3.1).

Other research has found strong correlations between alcohol consumption and health outcomes for Indigenous Australians (see section 8.1 on Alcohol consumption and harm).

Figure 13.3.2 **Indigenous people aged 18 years and over living in non-remote areas who used illicit drugs as a proportion of populations with certain educational, labour force and income characteristics, 2004-05[a, b, c, d]**



a Illicit drugs Include heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants. **b** Data are based on those who responded to substance use questions (22 per cent did not respond). **c** For data related to education, labour force and income, please refer to notes in figure 13.1.1. **d** Error bars present 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

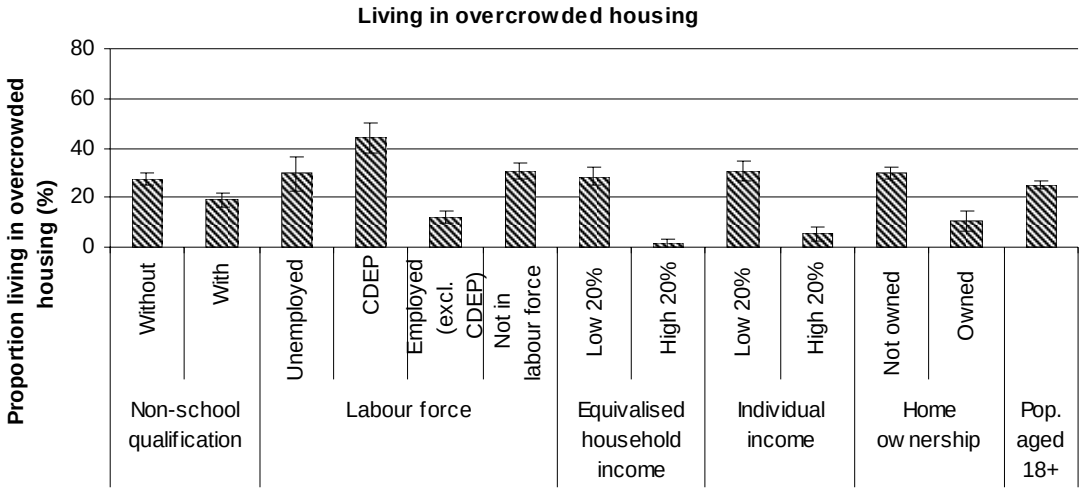
Source: ABS 2004-05 NATSIHS (unpublished); tables 13A.3.1 and 13A.3.2.

In 2004 05, for Indigenous people living in non-remote areas:

- Illicit drug use was highest among unemployed people (35.4 per cent).

- Indigenous people living in a house not owned or being purchased by a member of their household were significantly more likely to report illicit drug use (31.8 per cent) than those living in a house that was owned or being purchased by a member of their household (21.3 per cent) (figure 13.3.2).

Figure 13.3.3 **Indigenous people aged 18 years and over living in overcrowded housing, as a proportion of populations with certain educational, labour force, income and home ownership characteristics, 2004-05**[a, b, c, d]



[a] Data on overcrowded housing are based on the Canadian National Occupancy Standard for housing appropriateness, which specifies the number of bedroom(s) required for households of different sizes and compositions. Households that require two or more additional bedrooms to meet the standard are considered to be overcrowded [b] For data related to education, labour force and income, please refer to notes in figure 13.1.1. [c] Data for high equivalised household income has a relative standard error greater than 50 per cent and is considered too unreliable for general use. Data for high individual income has a relative standard error of 25 to 50 per cent and should be used with caution. [d] Error bars present 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS (unpublished); tables 13A.3.1 and 13A.3.2.

- Overcrowded housing appears to be associated with most headline dimensions of disadvantage. In 2004-05, high proportions of Indigenous people with low income, or who were without non-school qualifications, unemployed, CDEP participants or not in the labour force lived in overcrowded housing conditions (figure 13.3.3).

13.4 Notes on methodology

The analysis in this chapter is built on the Overcoming Indigenous Disadvantage indicator framework. It aims to:

- identify differences in patterns of disadvantage within the Indigenous population and between the Indigenous and non-Indigenous populations against proxy measures for selected headline indicators
- explore associations between indicators of disadvantage, including:
  - associations between selected headline indicators
  - associations between selected headline indicators and strategic change indicators.

The Report framework covers a wide range of socioeconomic dimensions, but the analysis in this chapter is limited to where comparable data items were available from two ABS surveys:

- for Indigenous data, the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)
- for non-Indigenous data, the 2004-05 National Health Survey (NHS).

Definitions of indicators and associated data have been kept as consistent as possible with those used elsewhere in this Report.

The output categories of this analysis are kept to a relatively broad level to produce statistically significant (meaningful) results. More disaggregated data could potentially give more detailed information, but would often be unusable due to the high standard errors associated with these disaggregated estimates in the surveys.

The 2004-05 NATSIHS was conducted by face-to-face interviews and only in private dwellings (excluding people in institutions such as hospitals, prisons and hotels). This will have an impact on data measuring substance use issues, which may be subject to under estimation. The lack of confidentiality/privacy of face-to-face interviews, which may be conducted with other household members present, may affect the responses to particular questions, such as those on substance use (including alcohol and tobacco use).

13.5 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.1.2 is table 2 in the attachment tables for section 13.1). The files containing the attachment tables can also be found on the

Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

13.1 Patterns of relative Indigenous disadvantage

Table 13A.1.1	Disadvantage among different subgroups by Indigenous status
Table 13A.1.2	Disadvantage among different subgroups by Indigenous status

13.2 Associations between headline indicators

Table 13A.2.1	Associations between different headline indicators of disadvantage, people aged 15 years and over

13.3 Associations between headline indicators and strategic change indicators

Table 13A.3.1	Associations between headline indicators and strategic areas for action (Indigenous population only)
Table 13A.3.2	Associations between headline indicators and strategic areas for action (Indigenous population only)

13.6 References

ABS (Australian Bureau of Statistics) 2006, *Measuring Australia's Progress*, Cat. no. 1370.0, Canberra.

NHMRC (National Health and Medical Research Council) 2001, *Australian Alcohol Guidelines, Health Risks and Benefits, Australian Government, Canberra,* http://www.nhmrc.gov.au/publications/synopses/ds9syn.htm, (accessed 30 March 2005).

Appendix 1 COAG Communiqués

Extract from COAG Communiqué 3 November 2000

ABORIGINAL RECONCILIATION

The Council thanked the Council for Aboriginal Reconciliation for its extensive work and contribution to the nation over the past nine years.

Reconciliation is an ongoing issue in the life of Australians and a priority issue for all governments that will require a concerted and sustained effort over many years. The Council acknowledged the unique status of Indigenous Australians and the need for recognition, respect and understanding in the wider community.

The Council agreed that many actions are necessary to advance reconciliation, from governments, the private sector, community organisations, Indigenous communities, and the wider community. Governments can make a real difference in the lives of Indigenous people by addressing social and economic disadvantage, including life expectancy, and improving governance and service delivery arrangements with Indigenous people.

Governments have made solid and consistent efforts to address disadvantage and improvements have been achieved. For example, Indigenous perinatal mortality rates have dropped from more than 60 per 1000 births in the mid-1970s to fewer than 22 per 1000 births in the mid-1990s. However, much remains to be done in health and the other areas of government activity.

Drawing on the lessons of the mixed success of substantial past efforts to address Indigenous disadvantage, the Council committed itself to an approach based on partnerships and shared responsibilities with Indigenous communities, programme flexibility and coordination between government agencies, with a focus on local communities and outcomes. It agreed priority actions in three areas:

- investing in community leadership initiatives;

- reviewing and re-engineering programmes and services to ensure they deliver practical measures that support families, children and young people. In particular, governments agreed to look at measures for tackling family violence, drug and alcohol dependency and other symptoms of community dysfunction; and

- forging greater links between the business sector and Indigenous communities to help promote economic independence.

The Council agreed to take a leading role in driving the necessary changes and will periodically review progress under these arrangements. The first review will be in twelve months. Where they have not already done so, Ministerial Councils will develop action plans, performance reporting strategies and benchmarks.

The Ministerial Council on Aboriginal and Torres Strait Islander Affairs will continue its overarching coordination and performance monitoring roles, including its contribution to the work of the Review of Commonwealth/State Service Provision.

Extract from COAG Communiqué 5 April 2002

RECONCILIATION

The Council reaffirmed its continuing commitment to advance reconciliation and address the social and economic disadvantages experienced by many Indigenous Australians.

The Council considered a report on progress in implementing the reconciliation framework agreed by the Council in November 2000 (will be available at www.dpmc.gov.au/docs/comm_state_index.cfm). The report shows that all governments have made progress in addressing the COAG priorities of leadership, reviewing and re-engineering programmes to assist Indigenous families and promoting Indigenous economic independence. Ministerial councils have also made progress in developing action plans and performance reporting strategies, although this has been slower than expected.

To underpin the commitment to reconciliation and to drive future work, the Council agreed to a trial of a whole-of-governments cooperative approach in up to 10 communities or regions. The aim of these trials will be to improve the way governments interact with each other and with communities to deliver more effective responses to the needs of Indigenous Australians. The lessons learnt from

these cooperative approaches will be able to be applied more broadly. This approach will be flexible in order to reflect the needs of specific communities, build on existing work and improve the compatibility of different State, Territory and Commonwealth approaches to achieve better outcomes. The selection of communities and regions will be discussed between the Commonwealth, States and Territories, the communities and the Aboriginal and Torres Strait Islander Commission and be announced by mid 2002.

The Council also agreed to commission the Steering Committee for the Review of Commonwealth/State Service Provision to produce a regular report against key indicators of Indigenous disadvantage. This report will help to measure the impact of changes to policy settings and service delivery and provide a concrete way to measure the effect of the Council's commitment to reconciliation through a jointly agreed set of indicators.

The Council noted that it would continue to review progress under the reconciliation framework, and that the next detailed report on progress achieved by governments and ministerial councils would be provided to the Council no later than the end of 2003.

Extract from COAG Communiqué 14 July 2006

INDIGENOUS ISSUES

Generational Commitment

COAG agreed that a long-term, generational commitment is needed to overcome Indigenous disadvantage. COAG agreed the importance of significantly closing the gap in outcomes between Indigenous people and other Australians in key areas for action as identified in the *Overcoming Indigenous Disadvantage: Key Indicators Report* (OID) released by COAG in 2003.

COAG's future work will focus on those areas identified for joint action which have the greatest capacity to achieve real benefits for Indigenous Australians in the short and long term.

COAG has agreed to establish a working group to develop a detailed proposal for generational change including specific, practical proposals for reform which reflect the diversity of circumstances in Australia.

The working group will consider how to build clearer links between the OID framework, the National Framework of Principles for Delivering Services to Indigenous Australians, the COAG Reconciliation Framework and the bilateral agreements between the Commonwealth and State and Territory Governments. The working group will report back to COAG by December 2006.

Extract from COAG Communiqué 13 April 2007

INDIGENOUS ISSUES

Indigenous Generational Reform

COAG reaffirmed its commitment to closing the outcomes gap between Indigenous people and other Australians over a generation and resolved that the initial priority for joint action should be on ensuring that young Indigenous children get a good start in life.

COAG requested that the Indigenous Generational Reform Working Group prepare a detailed set of specific, practical proposals for the first stage of cumulative generational reform for consideration by COAG as soon as practicable in December 2007. National initiatives will be supported by additional bi-lateral and jurisdiction specific initiatives as required to improve the life outcomes of young Indigenous Australians and their families.

COAG also agreed that urgent action was required to address data gaps to enable reliable evaluation of progress and transparent national and jurisdictional reporting on outcomes. COAG also agreed to establish a jointly-funded clearing house for reliable evidence and information about best practice and success factors.

COAG requested that arrangements be made as soon as possible for consultation with jurisdictional Indigenous advisory bodies and relevant Indigenous peak organisations.

Appendix 2 Implementation of the framework

Jurisdictions' comments

The following jurisdictions provided comments on the implementation of the framework:

Australian Government

New South Wales

Victoria

Queensland

Western Australia

South Australia

Tasmania

Australian Capital Territory

Northern Territory

Australian Government comments

The focus of the Australian Government's new arrangements in Indigenous affairs is on ensuring effective and coordinated service delivery based on partnerships with Indigenous Australians. These arrangements are built on an integrated whole of government approach at all levels.

Responsibility for strategic direction and high level coordination of policy development and government investment is the responsibility of the Ministerial Taskforce on Indigenous Affairs. The Ministerial Taskforce is responsible for preparation of a coordinated budget process for Indigenous affairs that allows resources to be targeted more effectively as priorities and circumstances change. Currently the Ministerial Taskforce has identified three key priorities which encapsulate the seven strategic areas for action under the Overcoming Indigenous Disadvantage framework:

- early childhood intervention, a key focus of which will be improved mental and physical health, and in particular primary health, and early educational outcomes
- safer communities (which includes issues of authority, law and order, but necessarily also focuses on dealing with issues of governance to ensure that communities are functional and effective)
- building Indigenous wealth, employment and entrepreneurial culture, as these are integral to boosting economic development and reducing poverty and dependence on passive welfare.

Policy development in the Ministerial Taskforce priority areas is informed by the Overcoming Indigenous Disadvantage framework, the COAG National Framework of Principles for Delivering Services to Indigenous Australians and advice from a range of sources, including the National Indigenous Council.

Coordinated delivery of Australian Government services and programmes to Indigenous Australians is through the thirty Indigenous Coordination Centres (ICCs) in urban, regional and remote locations. The Australian Government is working in partnership with Indigenous communities and families and State and Territory governments to shape service delivery and respond to community priorities. The partnership is captured through Shared Responsibility Agreements (SRAs) which set out the contributions of each of the partners in achieving change.

SRAs include performance measures to allow all partners to monitor implementation and outcomes. It is intended that, as far as possible, SRA local level performance indicators will mirror the strategic change indicators in the Overcoming Indigenous Disadvantage reporting framework. To date, 208 SRA's have been signed. A number of other Australian Government initiatives such as the collection of Baseline Community Profiles in strategic communities and the Whole of Government Evaluation Framework are also based on the Overcoming Indigenous Disadvantage framework.

New South Wales Government comments

The NSW Government has undertaken a number of significant measures in recent years to reduce the gap in outcomes between Aboriginal and non-Aboriginal Australians, across the seven strategic areas in the Overcoming Indigenous Disadvantage framework.

A New Direction for NSW: the NSW State Plan (2006–2016)

The Government's 10 year strategic plan for improved service delivery contains priorities and targets for action that will result in improved outcomes for residents of NSW. It also includes targets that are specific to Indigenous people, with a focus on improved health and educational results. This plan builds on commitments made under existing plans such as *Two Ways Together*.

Two Ways Together

Two Ways Together, the Aboriginal Affairs Plan 2003–2012, is the NSW Government's 10 year plan to improve outcomes for Aboriginal people and communities. Through *Two Ways Together*, the NSW Government has established a framework for coordinating whole of government action across the key national strategic change areas. The framework incorporates the *Overcoming Indigenous Disadvantage* (OID) indicators as well as NSW-specific measures.

Under *Two Ways Together* a funding boost of $40 million in funding over four years is being provided by the NSW Government for practical initiatives to:

- reduce incarceration and break the cycle of family violence
- improve year 3 to 5 literacy and numeracy and school retention rates
- minimise the impact of otitis media on school children up to six years old
- increase Aboriginal employment
- improve living conditions in Aboriginal communities.

These programs respond to areas of need identified for NSW in the 2003 OID report, and are improving Aboriginal wellbeing by:

- providing 2000 children with assistance for learning in primary school
- providing 640 scholarships to assist Aboriginal students in years 9 to 12 to remain in school
- testing over 65 000 children for middle ear infections
- providing 80 new teaching and nursing positions through Aboriginal cadetships

- improving electrical and plumbing safety and functionality in 670 homes.

In recognition that the needs of Aboriginal clients are the responsibility of all agencies, under *Two Ways Together* the CEOs of NSW Government agencies are required to report on requirements to increase the representation of Aboriginal people in the public service, increase the representation of Aboriginal people on agency boards and committees, increase Aboriginal participation in agency planning, and develop partnerships with Aboriginal people in service delivery.

NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006–2011

Tackling the high incidence of child sexual assault in Aboriginal communities is a challenge that confronts all States and Territories, including NSW. The NSW Government launched its *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006–2011* in January 2007. The Plan contains 88 actions aimed at reducing the incidence of child sexual assault through a range of measures spanning law enforcement, child protection, early intervention and prevention and Aboriginal leadership and support. A key element of the plan focuses on improving the way the NSW Government works with Aboriginal communities as partners to address the problem of child sexual assault.

Schools in Partnership Program

The Schools in Partnership and associated programs are targeted at schools with significant Aboriginal student populations. These programs focus on improving literacy, numeracy and participation outcomes of students through school communities forming genuine partnerships with the local Aboriginal Education Consultative Group and the Aboriginal community, establishing targets in school planning and reporting to improve the performance of Aboriginal students, and developing Personalised Learning Plans for Aboriginal students with their parents.

NSW Aboriginal Justice Plan

The Aboriginal Justice Plan aims to reduce Aboriginal overrepresentation in the criminal justice system and develop safer communities for Aboriginal people. The plan focuses on achieving outcomes negotiated between government and Aboriginal communities, establishing mechanisms to achieve greater cooperation and resource sharing at state, regional and local levels, and developing ways to empower Aboriginal communities to devise local solutions to local problems.

Victorian Government comments

In October 2006, following further consultation with Victoria's Indigenous community, the Victorian Government released the final *Victorian Indigenous Affairs Framework* (VIAF).[1] The VIAF comprises four elements, which are designed to achieve the Government's overarching goal to raise life expectancy and quality of life for Indigenous Victorians.

1. Principles for Reform

The VIAF Principles for Reform guide practice and implementation. They describe the spirit in which government departments will work together and with Indigenous communities, and include government coordination principles and government-community partnership principles.

2. Strategic Policy Framework

The VIAF Strategic Policy Framework sets in place the goal, priority outcomes and Victorian strategic areas for action. Focused effort on the strategic areas for action in the short to medium term will lay the ground work for achieving sustainable, long term improvements in the three priority outcomes:

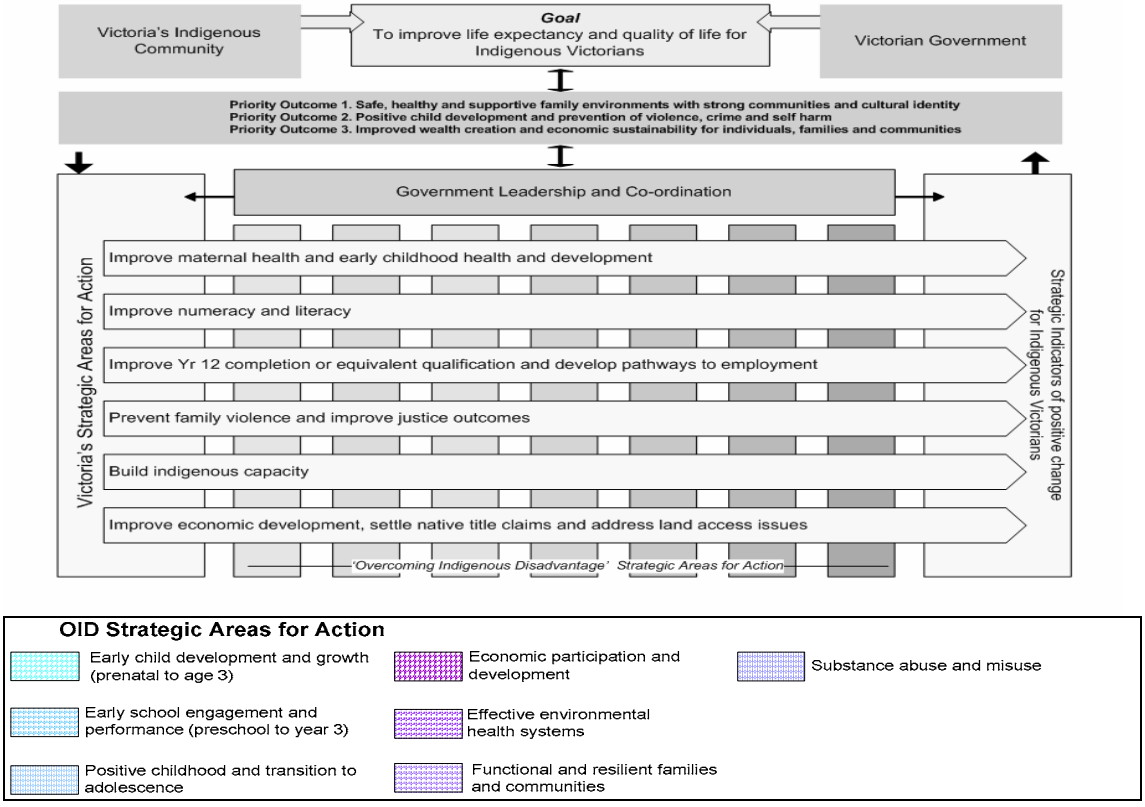
- safe, healthy and supportive family environments with strong communities and cultural identity
- positive child development and prevention of violence, crime and self-harm
- improved wealth creation and economic sustainability for individuals, families and communities.

The three priority outcomes mirror the Overcoming Indigenous Disadvantage framework outcomes and link to the Overcoming Indigenous Disadvantage headline indictors to guide effort over the longer term.

3. Performance Framework

The VIAF Performance Framework commits the Victorian Government to achieve improvements against a series of strategic change indicators, which have been selected as markers of progress towards the longer term objective of reducing Indigenous disadvantage. The strategic change indicators match the Victorian strategic areas for action against which improvements can be made over a five, ten, and fifteen year period.

[1] http://www1.dvc.vic.gov.au/aav/docs/Vic_IndigenousAffairsFramework.pdf



4. Partnership Coordination and Management Framework

The Partnership Coordination and Management Framework creates the authorising environment for community and government policy leadership. From the Government's perspective this leadership is centred with the Premier and the Ministerial Taskforce for Aboriginal Affairs. Whole of government coordination is overseen by the Secretaries Group for Aboriginal Affairs. From the community perspective, the establishment of local Indigenous networks, linked to Regional Indigenous Councils and through them to the Premier's Aboriginal Advisory Council, is a graduated three tier structure for Indigenous Governance to be implemented by 2008-09.

A Fairer Victoria — Progress and Next Steps

In June 2006, the Victorian Government released *A Fairer Victoria — Progress and Next Steps*, providing an update on initiatives funded as part of the Government's promise to build a new partnership with Indigenous Victorians.[2] The report announced additional investment of $61.7 million to implement further practical steps to build stronger communities, support healthy families, respect cultural heritage and deliver jobs and justice for Indigenous Victorians.

2 http://www.communitybuilding.vic.gov.au/cms/items/2006/08/00646-upload-00001.pdf

Queensland Government comments

The Queensland Government remains committed to improving social, health and economic outcomes for Aboriginal and Torres Strait Islander Queenslanders and to addressing the disadvantage identified by the Overcoming Indigenous Disadvantage (OID) framework.

In September 2005, the Queensland Government launched Partnerships Queensland, an initiative to deliver lasting improvements to the quality of life of Aboriginal and Torres Strait Islander Queenslanders. The Partnerships Queensland policy framework has four key goal areas:

- strong families, strong cultures
- safe places
- healthy living
- skilled and prosperous people and communities.

There is a close relationship between these goal areas and the priority outcomes of the OID framework.

Since the launch of Partnerships Queensland, the Queensland Government has developed a comprehensive performance reporting framework that includes, and expands on, the OID performance management framework. The Queensland Government released its first Baseline Report against the framework in February 2007. The report provides a comprehensive dataset to inform future policy and program development in Queensland and can be accessed online at: http://www.datsip.qld.gov.au/partnerships/partnerships-baseline-report.cfm.

A strategic overview of current Queensland Government activity to address Indigenous disadvantage is provided in the companion document to the Baseline Report, the *Partnerships Queensland Implementation Progress Report* 2006. This report is also publicly available and can be accessed at: http://www.datsip.qld.gov.au/partnerships/partnerships-progress-report.cfm.

The Queensland Government is focused on actions that deliver results. The implementation of Partnerships Queensland is designed to drive coordination and cooperation between governments and Indigenous communities and enable sound decision-making and effective service delivery to happen at all levels.

To ensure change is driven at the local level, and to further strengthen its existing place-based approach, the Government established the Government Coordination Office in late 2006. The office is led by a senior executive officer — the

Government Coordinator, Indigenous Service Delivery — with responsibility for: identifying required changes in service delivery approaches, with a particular focus on child well-being, alcohol management and family violence; driving those changes across-government; finding solutions to barriers in effective service delivery; and applying and communicating learnings on an ongoing basis.

Partnerships Queensland recognises, that to achieve and sustain improvement in Aboriginal and Torres Strait Islander peoples' quality of life, there must be a concerted and coordinated effort across all levels of government and from the non-government and private sectors. However, to achieve significant and lasting change, a key feature of Partnerships Queensland implementation will be to ensure that future initiatives embed a significant level of mutuality and shared responsibility at a government, community, family and individual level.

In addition to enhancing its approach to partnerships, the Queensland Government will continue to place a priority on improving Indigenous social and economic policy, addressing Indigenous governance and land issues and building confidence in the justice system.

Within that context, the Queensland Government continues to actively look at new ways to improve its response to Indigenous disadvantage. It is currently partnering with the Commonwealth Government in the design phase of the Cape York Institute for Policy and Leadership's welfare reform project. The project's objective is to rebuild basic social norms in four Cape York communities through the provision of rational incentives that encourage people into work and study and ensuring appropriate arrangements are in place to support people in that endeavour. A decision on whether to proceed to a trial of the project is expected later in 2007.

The Queensland Government is also an active participant in the Council of Australian Governments' (COAG) Indigenous Generational Reform (IGR) Working Group, which was established by COAG to develop a strategy in line with the OID framework and to develop specific reform proposals.

The Queensland Government will continue to place a priority on initiatives and programs that are directed to achieving the goals of Partnerships Queensland. A sustained and coordinated approach is required across governments, along with partnerships with the private and community sectors and, most importantly, with Aboriginal and Torres Strait Islander communities and organisations. Only such an approach can make a real and lasting difference to the life outcomes and opportunities of Aboriginal and Torres Strait Islander Queenslanders.

Western Australian Government comments

In the past 5 years the Western Australian Government has supported three major pieces of work that have independently changed the way in which government has responded to issues facing Indigenous people, families and communities. Not only are these pieces of work independently significant but have the collective potential to provide a solid basis for the development of the State Indigenous Services Framework and Action Plan.

- **'Putting People First'** *The Western Australian Governments Action Plan* for Addressing Family Violence and Child Abuse in Aboriginal Communities in response to the Gordon Inquiry provided a conceptual framework for agencies to work together in providing improved services to Indigenous families. The implementation of the Action Plan commenced in 2003 and is ongoing with an evaluation due to be completed in 2007.
- The Western Australian Government and the Australian Government joined with the Institute for Child Health Research to enable the collection and analysis of data to assist in understanding policy issues in relation to the needs of Indigenous people in Western Australia.

  The ***Western Australian Aboriginal Child Health Survey*** (WAACHS) has produced 4 volumes in which the State Government and the Institute for Child Health Research have worked closely to ensure that the analysis for this ground-breaking data can be utilised by policy makers in government agencies:

  Volume 1 *The Health of Aboriginal Children and Young People*

  Volume 2 *The Social and Emotional Wellbeing of Aboriginal Children and Young People*

  Volume 3 *Improving the Educational Experience of Aboriginal Children and Young People*

  Volume 4 *Strengthening the Capacity of Aboriginal Children, Families and Communities.*

The WAACHS volumes draw attention to the Overcoming Indigenous Disadvantage framework as an 'important advance in which both form and content of policy are directed at improving Aboriginal circumstances'.

- In 2005 the Western Australian Government provided the first State Report based directly on the Overcoming Indigenous Disadvantage framework. This report entitled ***Overcoming Indigenous Disadvantage in Western Australia*** provided the basis for government to have a useful tool to support actions that can deliver positive outcomes for Indigenous People.

  'It offers a sound basis for the development of a whole of government state strategy for Indigenous Affairs that is based on well grounded research and evidence on what works, so that improvements can be achieved and measured in the coming years'.

Western Australian priorities

1. The Western Australian Government and the Australian Government signed a ***Bilateral Agreement on Indigenous Affairs*** in 2006 that provides a framework and establishes priorities for the governments to work together to deliver improvements for Indigenous children, families and communities.

The work undertaken by both governments in negotiating a way forward under this bilateral is fundamental to delivering better outcomes for Indigenous families and communities. Although one aspect of this bilateral addresses the transference for some responsibilities from the Australian Government to the State the overarching intent is based upon achieving better outcomes.

The OID Western Australian Report provides an important baseline through which the Western Australian, Australian Government and Indigenous stakeholders can measure the effectiveness of those strategies that both governments agree to embark upon.

A specific example is the use of the Overcoming Indigenous Disadvantage framework as the basis for the development of performance indicators for the Ngaanyatjarra Regional Partnership Agreement.

2. ***State Early Years Strategy*** is being developed by utilising the basic framework of the Overcoming Indigenous Disadvantage as a basis to tease out the key outcomes, indicators and strategic areas for action. Whereas the Overcoming Indigenous Disadvantage framework looks to the multiplicity of issues involving Indigenous persons the framework has application when addressing part of the lifespan dimension as with the early years.

South Australian Government comments

South Australia's Strategic Plan

The South Australian Government's Strategic Plan has been a key component in guiding government action and priorities, The headline indicators of the Plan for Aboriginal wellbeing are life expectancy, unemployment rates, school retention rates, and imprisonment rates. These are closely aligned to those in the *Overcoming Indigenous Disadvantage* report.

An independent Audit Committee was established to report on the progress against the plan's targets. Outcomes for South Australia's Aboriginal population have deteriorated relative to the rest of South Australia's population in relation to life expectancy and imprisonment and improved in school retention rates in 2003 to 2005. The committee was also of the view that the indicators are only likely to change in the long term and that for life expectancy generational change is required. This is recognized by the COAG Indigenous Generational Reform Working Group in developing strategies to impact Aboriginal wellbeing.

In developing the 2007 Plan a comprehensive, community engagement program was conducted in South Australia. An Aboriginal update group was established to review the indicators and suggest changes or identify new targets. A member of the *Overcoming Indigenous Disadvantage* secretariat was invited to a workshop to assist in the development of the plan.

The updated plan also gives increased prominence to Aboriginal people. This reflects the unequivocal call from the South Australian community to address Aboriginal disadvantage in all areas of life. It also reflects the positive contribution that the Aboriginal community makes to South Australia by including new targets for attaining sustainability and fostering creativity. Only comprehensive and coordinated effort sustained over many years will begin to narrow the gap between conditions experienced by Aboriginal and non-Aboriginal South Australians. It requires policy and action to be informed by measurable results and community views, coordinated across all levels of government and monitored at the highest level.

One overarching target to improve Aboriginal wellbeing has been retained to provide a central focal point. In addition at least one target specific to Aboriginal South Australians has been included in each of the objective areas (as well as data from other targets that can be disaggregated on the basis of Aboriginality). The

data produced from these sources will provide the information on how Aboriginal populations are faring in the state, so that resources can be directed and responses tailored to ensure there is a positive and enduring impact.

Future Directions Paper and Aboriginal Strategic Plan for South Australia

The South Australian Government is developing a policy position paper which outlines the Government's agenda and priorities in Aboriginal Affairs. Some of these priorities include Aboriginal leadership, community safety and prosperity. The policy contained within the Future Directions in Aboriginal Affairs will underpin the way government implements the Aboriginal Strategic Plan. This Plan is being jointly developed by South Australian and Australian Government agencies to deliver on the targets within South Australia's Strategic Plan and targets aiming to improve overall Aboriginal wellbeing.

Aboriginal Economic Development

The South Australian Government is considering strategies to provide support to Aboriginal organisations, families or individuals to establish and manage viable enterprises. These strategies would be developed in collaboration with key Aboriginal groups and peak organisations and with relevant federal agencies.

Tasmanian Government comments

The Tasmanian Government's commitment to improving the well being of Tasmanian Aborigines is delivered through a mix of programs aimed at addressing both the fundamental causes and symptoms of Indigenous disadvantage with a focus on breaking intergenerational cycles. These programs address key elements of the Overcoming Indigenous Disadvantage framework and include:

Stolen Generation Legislation

The *Stolen Generations of Aboriginal Children Act 2006* enables the Tasmanian Government to provide ex gratia payments to members of the stolen generations. The payments recognise that the State played a role in the removal of some Aboriginal children from their families and are an important part of acknowledging, apologising and making reparation for the wrongs of the past.

The return of Aboriginal land

The Tasmanian Government's *Aboriginal Lands Act 1995* provides for the return of land to the Aboriginal community. Title for the Crown land returned is held by the Aboriginal Land Council of Tasmania (ALCT), whose members are elected by Aboriginal people. Since 1995 a number of culturally significant sites have been vested in the ALCT, including Cape Barren Island and Clarke Island. Currently the ALCT have title to a total of 55 597 hectares. The Tasmanian Government provides funding of $223 984 per year to the ALCT for administration costs and to manage the land.

'Safe at Home' and ya pulingina kani

Enacted in 2005, *Safe at Home* is Tasmania's whole of government initiative aimed at reducing the level of family violence. It is concerned with improving the safety of adult and child victims in their own homes and also changing the behaviour of perpetrators. *Safe at Home* is a mainstream service and applied universally. Consisting of Aboriginal women, the *ya pulingina kani* Working Group was established as an advisory group on *Safe at Home.*

Aboriginal Employment in the Tasmanian Government

The Tasmanian Government operates an Aboriginal Employment and Career Development Program aimed at improving the recruitment, retention and career development of Aborigines in the public sector. This program includes identifying particular positions for Aborigines throughout the public service.

Aboriginal Early Years Program

The Tasmanian Government employs four Aboriginal Early years Liaison Officers (AEYLOS) to promote families' engagement with early childhood education through the delivery of culturally appropriate services. The AEYLOs conduct home visits and provide families with teaching and learning resources, books, activities and cultural excursions.

Aboriginal Students Retention Program

The aim of this program is to increase the participation rate and attendance of students in Years 7 to 10 and to support Aboriginal students in the key transitions from primary to secondary school and from secondary school to years 11 and 12. The program is implemented through eight full-time Aboriginal Education Officers (AEOs) based in a number of schools across the state. The AEOs are identified Aboriginal positions.

'pakana tunapri' — Cape Barren District High School

In 2005, an education facility for secondary students was erected at the site of the Cape Barren Island Primary School on Cape Barren Island. Secondary students can now stay living on the island and have access to quality education that is delivered within a culturally appropriate school environment. *pakana tunapri* was officially launched in March 2007. It caters for students from kindergarten to year 12.

'ninjina tunapri' — Aboriginal perspectives through the educational curriculum

In 2007, the Tasmanian Government will be implementing a set of Aboriginal perspectives through the Tasmanian curriculum for students from kindergarten to year 10. *ningina tunapri* is aimed at deepening all student's awareness of Aboriginal culture, as well as encouraging positive participation and improved educational outcomes for Aboriginal and Torres Strait Islander students.

The Women's Karadi Aboriginal Corporation

The Tasmanian Government funds the Women's Karadi Aboriginal Corporation to provide neighbourhood house services. Some of the activities provided by *Karadi* include cultural awareness sessions, a school holiday program, literacy and numeracy programs, mutual obligation programs and information sessions from government departments and job search assistance providers.

Australian Capital Territory Government comments

The ACT Government is continually refining an ACT Framework that covers the overriding national reporting frameworks for Overcoming Indigenous Disadvantage, reconciliation, service delivery and prevention of violence, as well as the ACT Government's reporting requirements relating to the Canberra Social Plan and the ACT Human Rights Act.

The ACT Government recently established a Taskforce on Indigenous Affairs to drive the delivery of improved services and outcomes for Aboriginal and Torres Strait Islander people of the ACT.

The Taskforce:

- co-ordinates the ACT Government's Indigenous policies and reports to the Minister for Indigenous affairs on directions and priorities
- is required to pay particular attention to the needs of children and young people throughout its deliberations
- will report to the Minister for Indigenous Affairs bi-monthly and in accordance with the ACT Government budget cycle requirements
- is currently examining options for mapping all ACT Government programs, policies and services against the national Overcoming Indigenous Disadvantage key indicators framework, identifying gaps in service delivery and outcomes, and planning a framework for whole-of-government integrated service delivery for Indigenous residents of the ACT.

The outcomes to date include:

Health

- the implementation of: A New Way: The ACT Aboriginal and Torres Strait Islander Health and Wellbeing Plan 2006–2011 and the Cultural Respect Implementation Plan 2006–2009
- the Aboriginal and Torres Strait Islander Health Improvement Program
- improving Aboriginal and Torres Strait Islander health data quality continues to be a priority
- working in partnership to develop an 'Integrated Indigenous Service Delivery Project'.

Education

- the implementation of a range of programs to meet the needs of Indigenous students.

Specific programs include:

- Koori Preschool program for Indigenous children aged 3 to 5
- The Indigenous Literacy and Numeracy initiative
- Indigenous Home/School Liaison Officer support
- Individual learning plans for each Indigenous child.

Housing

- the ACT government does not receive any funds specifically for Indigenous housing through the Commonwealth-State Housing Agreement
- the ACT does not have a discrete Indigenous housing program, however, it is committed to addressing Indigenous housing needs and disadvantage in a coordinated and integrated way. In this regard, public housing outcomes are achieved for Indigenous people under the *ACT Strategic Plan* and *Operational Plan for Indigenous Housing*.

Early childhood intervention and safer communities

Implementation of a number of Indigenous-specific services including:

- Indigenous Family Support Services
- Aboriginal and Torres Strait Islander Foster Care Services
- Indigenous Supported Accommodation Service.

Providing funds to non-Government organisations for support services to Aboriginal and Torres Strait Islander people including:

- Indigenous Family Support
- funding has been provided for family support and community building to Aboriginal and Torres Strait Islander families.

Representative body for Aboriginal and Torres Strait Islander people.

Throughout 2005-2006 the ACT Government supported an initial consultation process involving the Aboriginal and Torres Strait Islander communities around whether the community wanted a community-based body to represent its interests and, if so, what sort of body it should be and what it should do. Further work will be done during 2006-2007 in partnership with the Aboriginal and Torres Strait Islander communities to develop a structure and constitution for the new body that reflect priorities expressed during the initial community consultation process.

Northern Territory Government comments

The Northern Territory Government has a long-standing commitment to addressing Indigenous disadvantage in its myriad forms. By investing in Indigenous potential, the entire Territory will benefit from a stronger economy, more skilled and well-paid jobs, greater social cohesion, and a rich artistic and cultural life. The Northern Territory Government has developed and implemented a number of initiatives.

Office of Indigenous Policy

The Office of Indigenous Policy provides high level whole-of-government strategic policy advice on Indigenous issues. The primary focus of the Office is ensuring that the Government's commitment to overcoming Indigenous disadvantage is a fundamental consideration across government, and that capacity is built across the Northern Territory Public Sector to address Indigenous issues. The Office is also coordinating the development of policies and strategies to resolve outstanding and future land issues; communicating the Government's policies to the Indigenous and the wider community; and monitoring progress in overcoming Indigenous disadvantage.

Overarching Agreement on Indigenous Affairs

The Overarching Agreement on Indigenous Affairs between the Commonwealth of Australia and the Northern Territory of Australia 2005–2010 (the Overarching Agreement) was signed in April 2005 by the Prime Minister and the Chief Minister. It sets out a collaborative approach by the Northern Territory and Australian Governments to working with Indigenous communities to improve government service delivery and achieve better outcomes for Indigenous people in the Northern Territory.

Bilateral schedules are being progressively attached to the Overarching Agreement to set out how the governments will work together. The first three schedules — 'Sustainable Indigenous Housing', 'Strengthening and Sustaining the Indigenous Arts Sector' and 'Regional Authorities' were attached at the signing of the Agreement. Two additional schedules — 'Boosting Indigenous Employment and Economic Development' and 'Healthy Country, Healthy People' were formally attached to the Agreement in March and September 2006 respectively and it is expected that further schedules will be developed. Information on the Overarching Agreement can be found at the following address:

http://www.dcm.nt.gov.au/dcm/people/agreement.html

Agenda for Action

The Agenda for Action is a whole-of-government Indigenous Affairs policy for the Northern Territory. It sets out the Government's Indigenous affairs priorities for 2005–2009, and will coordinate policy development across all Northern Territory agencies. The Agenda also reflects the commitments made in the *Overarching Agreement on Indigenous Affairs*.

The Agenda for Action reaffirms the Northern Territory Government's strong commitment to work with Indigenous communities in relationships built on mutual respect and confidence. Sharing responsibility for improving Indigenous education, health, employment, safety, housing and self-governing ability empowers Indigenous communities to develop their own solutions to social and economic issues, and to work more effectively with Government.

The Agenda for Action outlines the six main Indigenous affairs priorities of the Northern Territory Government. The six priority areas are to:

1. Establish and maintain a 'whole-of-government' approach — whereby all Government agencies work together to achieve good results for Indigenous Territorians.
2. Invest in the Territory's future by assisting young Indigenous Territorians to a good start in life, a strong education, and skills necessary to reach their full potential.
3. Foster further Indigenous economic development, by creating more local jobs for local people and using land rights to boost community economies.
4. Develop Indigenous peoples' ability to govern their own communities, and encourage other community-building activities.
5. Build on the strong progress made over the past four years to improve housing, roads, communications infrastructure (i.e. access to telephones and the internet), and other essential services in Indigenous communities.
6. Ensure all Indigenous Territorians feel safe living and working in their communities.

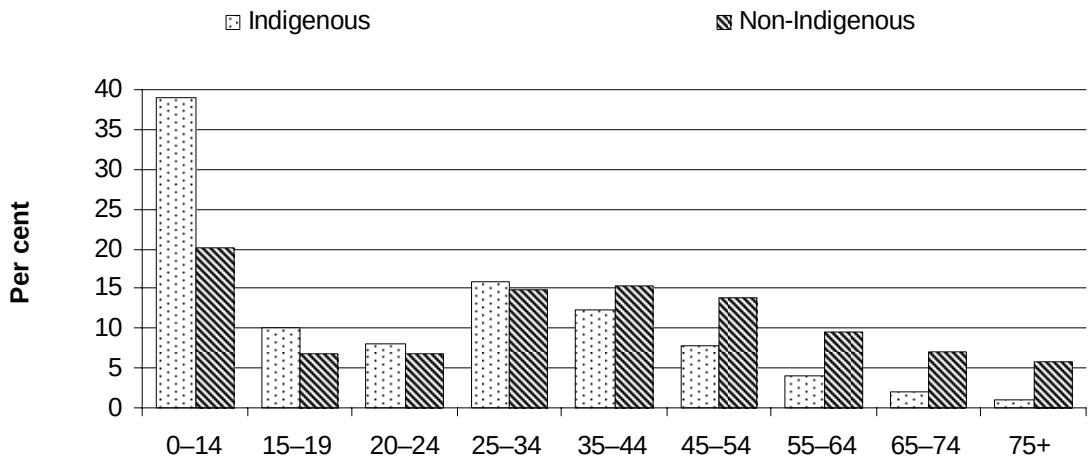
A copy of the Agenda for Action can be found at the following website:

http://www.dcm.nt.gov.au/dcm/people/pdf/200603AgendaForAction.pdf

Appendix 3 Composition of the Indigenous population

Throughout this Report, the term 'Indigenous' is used to refer to Aboriginal and Torres Strait Islander peoples, with the exception of references to specific organisations, people or programs.

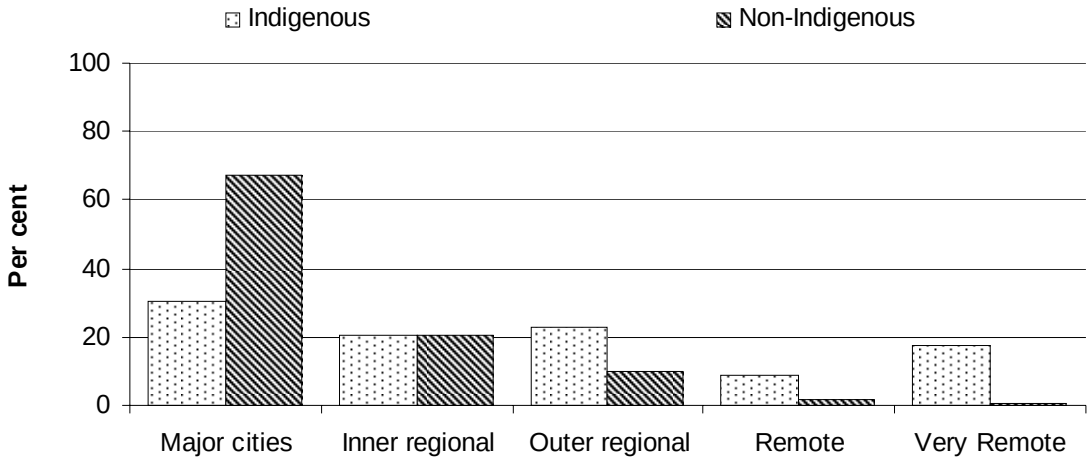
Figure A3.1 **Proportion of the population in each age category, 2001**



Source: ABS 2001 ERP; table A.5.

- The Indigenous population has a significantly different structure to the non-Indigenous population. It tends to be younger, with 39.3 per cent of the Indigenous population being 14 years or under, compared to 20.4 per cent for the non-Indigenous population (figure A3.1).
- Moreover, the proportion of the Indigenous population over the age of 75 years is only 0.9 per cent, compared to 5.6 per cent for the rest of the population (figure A3.1).

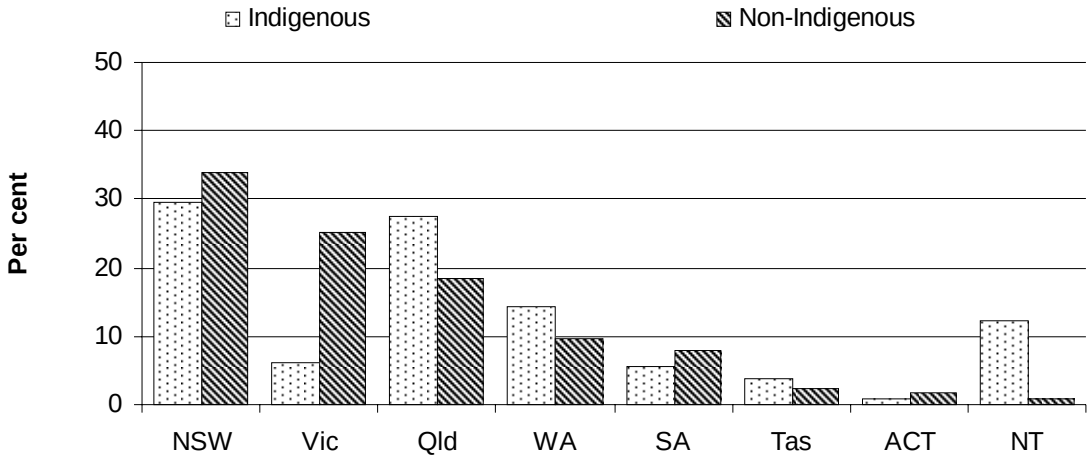
Figure A3.2 **Proportion of the population in each remoteness area, 2001**



Source: ABS 2001 ERP; table A.6.

- The two populations also differ in their geographic distribution. Both Indigenous and non-Indigenous people tend to live predominantly in major cities and regional areas (figure A3.2).
- However, a much higher proportion of the Indigenous population live in remote and very remote areas: 26.4 per cent, compared to 2.0 per cent for non-Indigenous people (figure A3.2).

Figure A3.3 **Proportion of the population in each State and Territory, 2001**

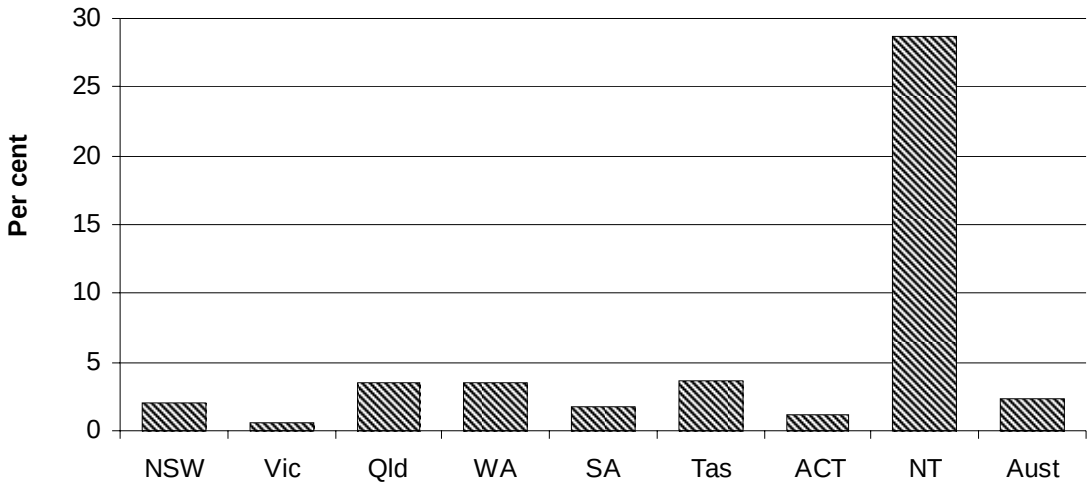


Source: ABS 2001 ERP; table A.5.

- The proportion of the population who are Indigenous also differs across jurisdictions. A higher proportion of the Indigenous and non-Indigenous

populations live in NSW than other states (29.2 per cent 33.5 per cent respectively). A relatively high proportion of the Indigenous population also lives in Queensland, WA and the NT (figure A3.3).

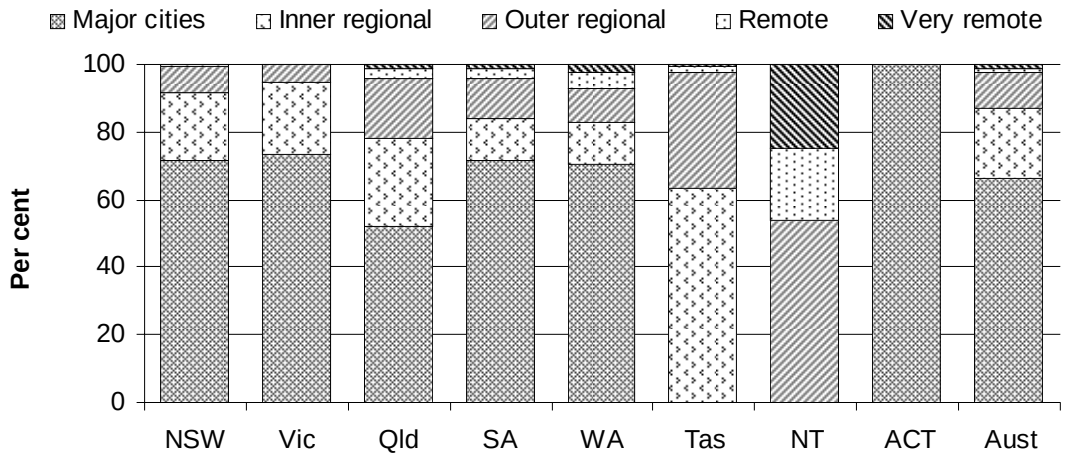
Figure A3.4 **Proportion of the population who are Indigenous by State and Territory, 2001**



Source: ABS 2001 ERP; table A.5.

- As a proportion of the population *within* each state and territory, the NT has the highest proportion of Indigenous people (28.8 per cent), with Victoria having the lowest (0.6 per cent) (figure A3.4).

Figure A3.5 **Indigenous population across remoteness areas, 2001**



Source: ABS 2001 ERP; table A.6.

- The proportion of the Indigenous population living in different remoteness areas also varies across jurisdictions. The ACT has the highest proportion of its Indigenous population living in major cities (99.8 per cent) and the NT has the highest living in remote and very remote areas (81.2 per cent) (figure A3.5)

Attachment tables

Attachment tables are identified in references throughout this appendix by an 'A' prefix (for example, table A.6 is table 6 in the attachment tables for this appendix). The files containing the attachment tables can be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Appendix 3 — Composition of the Indigenous population

Table A.1	Population (number), by age and sex, 2001
Table A.2	Population (number), by remoteness areas and sex, 2001
Table A.3	People who speak an Australian Indigenous language at home, 2001
Table A.4	People who speak an Australian Indigenous language at home, 2001
Table A.5	Estimated resident population, 2001
Table A.6	Estimated resident population, 2001
Table A.7	Experimental projections of the Indigenous population, 2000 to 2009 (number)

Appendix 4 Data limitations

ABS mortality data

Excessively precise analysis based on Indigenous death registrations, Indigenous deaths coverage or projected Indigenous deaths needs to be avoided.

The registration of deaths is the responsibility of registrars in individual states and territories. It is based on information supplied by a relative, another person acquainted with the deceased, a funeral director, or an official of the institution where the death occurred, and on information about the cause of death supplied by a medical practitioner. State and territory registrars supply this information to the ABS for compilation into aggregate mortality statistics for its publications.

Although it is considered that most Indigenous deaths are registered, it is estimated that only 56 per cent of Indigenous deaths are registered accurately as Indigenous (ABS 2006a). There are several data collection forms on which people are asked to state whether they are of Indigenous origin, and the results are not always consistent. The likelihood that a person will be identified in administrative collections as Indigenous is influenced by factors including: whether the person is asked the question; who completes the form (for example, a relative, an official or a funeral director); the perception of how the information will be used; education programs about identifying as Indigenous; and emotional reaction to identifying as Indigenous.

Survey data

This Report makes extensive use of data from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the ABS 2004-05 National Health Survey (NHS), the ABS 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), the ABS 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS) and the ABS 2002 General Social Survey (GSS). Data from surveys conducted by other organisations are also included where relevant.

Surveys provide useful data for many indicators but their accuracy is limited by the number of people interviewed. Sample size also limits the extent to which data can

be disaggregated by different factors such as geography, age and sex, particularly for characteristics that are not widespread across the population. More information on using and interpreting survey data is in ABS (2006b). As a guide to readers, survey data in this Report are presented in charts with error bars to show 95 per cent confidence intervals and relative standards errors (RSE) are included in the attachment tables accompanying the Report on the Review website.

Hospitalisations data

Hospitalisations data are from the National Hospital Morbidity Database (NHMD), a national collection of hospitalisation records maintained by the Australian Institute of Health and Welfare (AIHW). Health departments in all states and territories provide information on the characteristics, diagnoses and care of admitted patients in public and private hospitals to the AIHW. Hospitalisations include admissions that result in discharges, transfers, deaths or changes in type or episode of care (defined in the database as hospital separations). A record is included for each hospitalisation, not for each patient, so patients who are admitted more than once in a year have more than one record in the database.

The availability of hospitalisation data for Indigenous people is significantly reduced in the 2007 Report compared to previous Reports. AIHW analyses into the quality of Indigenous identification of hospital admitted patient statistics has shown that while the quality is good in some jurisdictions, in other jurisdictions it is not sufficiently comprehensive or robust (AIHW 2005). Consequently, Indigenous hospitalisation data are only available for Queensland, WA, SA and the NT. Data from NSW, Victoria, Tasmania and the ACT were considered to be of insufficient robustness. The AIHW is working with these states and territories to improve the quality of Indigenous identification in their hospitalisations data.

Data relating to admitted patients are included from almost all hospitals, including public acute and psychiatric hospitals, private acute and psychiatric hospitals, and private free-standing day hospital facilities.

The AIHW and the data providers jointly validate the morbidity database to ensure data quality. When data are supplied using nonstandard definitions or classifications, the AIHW maps them to the National Health Data Dictionary definitions, where possible, in collaboration with the data providers.

Limitations of the data

The following should be used to guide interpretation of the hospitalisations data.

- Although the National Health Data Dictionary definitions form the basis of the database, the actual definitions used may vary among the data providers and from one year to another. In addition, admission practices and the detail of the scope of the data collections may vary among the states and territories and from year to year.
- Each State and Territory has a demographic structure that differs from other states and territories, and factors such as age and Indigenous status can have an effect on the nature of health care delivery amongst states and territories. The frequency of particular procedures, for example, can be affected by the demographic composition of the population.
- Although data on hospitalisations from the NHMD can reflect an aspect of the burden of disease in the community, they do not usually provide measures of the incidence or prevalence of conditions. This is because not all people with a type or degree of illness are treated in hospital and there are multiple admissions for some chronic conditions. Also, the number and pattern of hospitalisations can be affected by differing admission practices, and differing levels and patterns of service provision.
- Analysis of hospital morbidity collections for Indigenous people is complicated by difficulties in estimating both the numbers of Indigenous patients admitted to hospital and the numbers in the overall population. Information about the numbers of Indigenous patients in hospital is limited by the accuracy with which they are identified in hospital records. Problems associated with identification will result in an understatement of morbidity patterns among Indigenous people. Assessments of the level of completeness of Indigenous identification in hospital morbidity collections are provided annually by each jurisdiction to the AIHW and have been explored in detail in AIHW (2005).

Australian Institute of Criminology (AIC) homicide data and other police data

Limitations of the National Homicide Monitoring Program (NHMP) data, collected by the AIC, are discussed below.

- The data are derived from police records, which depend on the police accurately recording the Indigenous status of the victim and offender. In some jurisdictions this involves the police making a subjective assessment based solely on the victim's or offender's appearance, which might lead to errors and inconsistencies. In others, Indigenous status is determined by police administering a standard question. In a proportion of cases where determination of Indigenous status is based on external appearance, this might not readily identify them as Indigenous. Similarly, not all Indigenous people may choose to

identify when asked by police. Hence, results reported from this data source might under represent the true extent of Indigenous homicide in Australia.

- Nevertheless, a 1998-99 study conducted by the ABS on assessing the quality of Indigenous status and racial appearance data collected by NSW police indicated that:
  - When racial appearance data were compared with the Indigenous status data asked by the police, the data quality of Indigenous status based on racial appearance was fairly good for Aboriginal people, but the data quality for Torres Strait Islanders was poor (SCRCSSP 2001, p. 382).

In addition to data from the AIC National Homicide Monitoring Program, police data from individual states and territories are included in sections 3.11 (Family and community violence) and 7.4 (Juvenile diversions as a proportion of all juvenile offenders).

References

ABS (Australian Bureau of Statistics) 2006a, *Deaths, Australia 2005*, Cat. no. 3302.0, Canberra

—— 2006b, *National Aboriginal and Torres Strait Islander Health Survey: Users' Guide*, Cat. no. 4715.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Cat. no. HSE 101, Canberra.

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2001, *Report on Government Services 2001*, Productivity Commission, Canberra

Appendix 5 Measures and data sources

Introduction

The following table summarises the major measures and data sources used to report against the indicators in the Report. Unless otherwise noted, all measures are:

- disaggregated by Indigenous status (Indigenous/non-Indigenous or Indigenous/total population)
- reported at a national (Australian total) level.

Many rates were calculated by combining data from various sources with Indigenous population figures (published and unpublished) from the ABS (2004), *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians 30 June 1991 to 30 June 2009*, using the 'low series' estimates.

References to data sources are summarised in the table. Many data sources are referenced as 'unpublished'. This means that the particular data items cited in the Overcoming Disadvantage Report are not included in a standard publication but have been made available on request by the data providers.

A list of acronyms and full references for data sources are provided at the end of the appendix.

Indicators	Measures	Data sources
3 Headline indicators		
3.1 Life expectancy at birth	Estimated life expectancy at birth, Indigenous 1996–2001, total population 1998-2000, by sex	ABS (2004), *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians 30 June 1991 to 30 June 2009*
	Median age at death, 2005, by sex	ABS (2006a), *Deaths Australia 2005*
	Age specific death rates, 2001–2005, by sex	ABS (2006a), *Deaths Australia 2005*
	Causes of death, 2001–2005, age standardised, (Qld, WA, SA, NT)	ABS (2007a), *Causes of death 2005*
3.2 Disability and chronic disease	Proportion of people with selected long term conditions, 2004-05, by sex, age-standardised	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Proportion of people with one or more long term condition(s), 2004-05, by age group	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Indigenous people with selected long term health conditions, by remoteness, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Proportion of people with diabetes/high sugar levels who find the condition interferes with usual daily activities, 2004-05, age-standardised	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Rates of Indigenous people aged 18 years and over with selected long term conditions, by type of personal stressor experienced by self, family or friends, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Hospitalisation rate ratios for selected long term health conditions, 2004-05, by sex, age standardised, (Queensland, WA, SA and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)

Indicators	Measures	Data sources
3.3 Years 10 and 12 retention and attainment	School participation rates, full time students aged 12–19 years, all schools, 2006, by jurisdiction	ABS (2007a), *Schools Australia 2006* (unpublished)
	Apparent retention rates from year 7/8 to years 9, 10, 11 and 12, full time secondary students, all schools, 2002 to 2006	ABS (2007a), *Schools Australia 2006* (unpublished)
	Apparent retention rates from year 7/8 to years 10 and 12, full time secondary students, all schools, 2006, by jurisdiction	ABS (2007a), *Schools Australia 2006* (unpublished)
	Students who achieved a year 12 certificate (as a proportion of students who were enrolled in year 11 in the previous year), government and Catholic systems, 2001 to 2005	DEST (unpublished)
	Students who achieved a year 12 certificate in 2005 (as a proportion of students who were enrolled in year 11 in 2004), government and Catholic systems, by jurisdiction	DEST (unpublished)
3.4 Post-secondary education – participation and attainment	Participation in post secondary education, persons aged 18 years and over, 2002 and 2004-05	ABS 2002 NATSISS, 2002 GSS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Post secondary participation at higher education institutions, 2002–2005	DEST Selected Higher Education Statistics (unpublished)
	Post secondary attainment of certificate level 3 or above, persons aged 18 years and over, 1994, 2002, 2004-05	ABS 1994 NATSIS, 2002 NATSISS, 2002 GSS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	VET load pass rate, 2002–2005	National 2002–2005 VET provider collections (unpublished)
	VET load pass rate by course level, 2005	National 2002–2005 VET provider collections (unpublished)
	Higher education success rate, 2001–2004	DEST Selected Higher Education Statistics (unpublished)
3.5 Labour force participation and unemployment	CDEP participation, unemployment and labour force participation for Indigenous population aged 15 to 64 years, 2004-05, by remoteness	ABS 2004-05 NATSIHS (unpublished),
	CDEP participation, Indigenous people aged 18–64 years, 1994, 2002, 2004-05	ABS 1994 NATSIS, 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
	Labour force participation as a proportion of the population aged 15 to 64 years, 2004-05, by Indigenous status, age standardised	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)

Indicator	Measure	Data source
3.5 Labour force participation and unemployment (*continued*)	Labour force participation as a proportion of the population aged 15 to 64 years, 2004-05, by Indigenous status, sex and age group	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Labour force participation as a proportion of the Indigenous population aged 15 to 64 years, 2004-05, by remoteness	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Labour force participation as a proportion of the population aged 18 to 64 years, 1994, 2002, 2004-05, by Indigenous status and sex	ABS 1994 NATSIS, 2002 NATSISS, 2002 GSS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Unemployment rate of people aged 15 to 64 years, 2004-05, by Indigenous status and jurisdiction, age standardised	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Unemployment rate of people aged 15 to 64 years, 2004-05, by Indigenous status and age group	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Unemployment rate of Indigenous people aged 15 to 64 years, 2004-05, by remoteness	ABS 2004-05 NATSIHS (unpublished)
	Unemployment rate of people aged 18 to 64 years, Indigenous 1994, 2002, 2004-05, non-Indigenous 2002, 2004-05, by sex	ABS 1994 NATSIS; 2002 NATSISS, 2002 GSS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Long term unemployment, people aged 15 to 64 years, 2004-05, by Indigenous status, age, sex	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Long term unemployment for Indigenous people aged 18 to 64 years, 1994, 2002, 2004-05	ABS 1994 NATSIS, 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
3.6 Household and individual income	Median gross weekly equivalised household income, people aged 18 years and over, 2004-05, by Indigenous status and jurisdiction	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Median and mean real gross weekly equivalised household income, Indigenous people aged 18 years and over (2004-05 dollars), 1994, 2002, 2004-05	ABS 1994 NATSIS, 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
	Quintile distribution of gross weekly equivalised household incomes, people aged 18 years and over, 2004-05, by Indigenous status	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Median gross weekly individual income, 2004-05, by Indigenous status and age	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Quintile distribution of gross weekly individual income, people aged 18 years and over, 2004-05, by Indigenous status	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Main sources of individual gross weekly income, people aged 18 years and over, 2004-05, by Indigenous status and remoteness	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)

Indicator	Measure	Data source
3.7 Home ownership	Proportion of Indigenous people aged 18 years and over living in home owner/purchaser households, 1994, 2002, 2004-05, by jurisdiction	ABS 1994 NATSIS, 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
	Proportion of Indigenous people aged 18 years and over living in home owner/purchaser households, 2002, 2004-05, by remoteness areas	ABS 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
	Proportion of people aged 18 years and over living in home owner/purchaser households, 2004-05, Aboriginal and Torres Strait Islander	ABS 2004-05 NATSIHS *(*unpublished)
3.8 Suicide and self-harm	Intentional self-harm (suicide) death rate, 2001–2005, by Indigenous status, age standardised (Qld, WA, SA, NT)	ABS (2007b), *Causes of Death 2005* (unpublished)
	Intentional self-harm (suicide) death rate, 2001–2005, by Indigenous status and age group (Qld, WA, SA, NT)	ABS (2007b), *Causes of Death 2005* (unpublished)
	Average annual suicide death rates 2001–2005, by Indigenous status and sex, age standardised (Qld, WA, SA, NT)	ABS (2007b), *Causes of Death 2005* (unpublished)
	Non-fatal hospitalisations for intentional self-harm, 2004-05, by Indigenous status and sex, age standardised (Qld, SA, WA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Non-fatal hospitalisations for intentional self-harm, 2001-02 to 2004-05, by Indigenous status and sex, age standardised (Qld, SA, WA, and public hospitals in NT)	AIHW National Hospital Morbidity Database (unpublished)
3.9 Substantiated child abuse and neglect	Rate per 1000 children aged 0–16 years who were the subject of substantiations, 1999-2000 to 2005-06, by jurisdiction	AIHW, Child Protection Notifications, Investigations and Substantiations, Australia, data collection, (unpublished)
	Children aged 0–16 years who were the subject of a substantiation by type of abuse or neglect, 2001-02 to 2005-06	AIHW, Child Protection Notifications, Investigations and Substantiations, Australia, data collection (unpublished)
	Number of diagnoses of chlamydia, gonorrhoea and syphilis in children by age group, 2001–2005 (Vic, WA, SA, NT)	National Notifiable Diseases Surveillance System (2006)

Indicator	Measure	Data source
3.10 Deaths from homicide and hospitalisations for assault	Homicide death rates, 2001–2005, age standardised (Qld, WA, SA, NT)	ABS (2007b), *Causes of Death 2005* (unpublished)
	Homicide death rates 2001–2005, by age (Qld, WA, NT)	ABS (2007b), *Causes of Death 2005* (unpublished)
	Homicide death rates, 2001–2005, by Indigenous status and sex, age standardised (Qld, WA, SA, NT)	ABS (2007b), *Causes of Death 2005* (unpublished)
	Comparative statistics on homicides, 2004-05, by sex, employment status, motive, relationship	AIC (2006), *National Homicide Monitoring Program 2004-2005*
	Trends in key factors associated with Indigenous homicide, 1999-2000 to 2004-05, by alcohol, employment, domestic altercation	AIC (2006), *National Homicide Monitoring Program 2004-2005*
	Homicide rate, 1999-2000 to 2004-05, by remoteness	AIC (2006), *National Homicide Monitoring Program 2004-2005* (unpublished)
	Non-fatal hospitalisation rates for assault, 2001-02 to 2004-05, by sex (Qld, WA, SA, NT)	AIHW National Hospital Morbidity Database (unpublished)
3.11 Family and community violence	SAAP support periods, main reason clients sought support, 2005-06, total and women	AIHW SAAP NDCA (unpublished)
	Victims recorded by NSW Police for domestic violence related assault, 2002 to 2005	NSW Bureau of Crime Statistics and Research (unpublished)
	Relationship of offender to victim recorded by NSW Police for victims of domestic violence related assault, 2005	NSW Bureau of Crime Statistics and Research (unpublished)
	Victims recorded by Victoria Police for domestic violence related assault, 2002-03 to 2005-06	Victoria Police (unpublished)
	Victim-offender relationships recorded by Victoria Police for selected offences against the person, 2005-06	Victoria Police (unpublished)
	Victims recorded by Queensland Police for selected offences against the person, 2005-06	Queensland Police (unpublished)
	Victim-offender relationships recorded by Queensland Police for selected offences against the person, 2005-06	Queensland Police (unpublished)
	Victims recorded by the NT Police for selected offences against the person, 2005	NT Police (unpublished)
	Victim-offender relationships recorded by the NT Police for selected offences against the person, 2005-06	NT Police (unpublished)

Indicator	Measure	Data source
3.12 Imprisonment and juvenile detention rates	Imprisonment rates per 100 000 adult population, 30 June 2006, by jurisdiction, age standardised	ABS (2006b), *Prisoners in Australia 2006*
	Imprisonment rates per 100 000 adult population, 2000 to 2006, age standardised	ABS (2006b), *Prisoners in Australia 2006*
	Crude imprisonment rates, 30 June 2006, by Indigenous status, sex and jurisdiction	ABS (2006b), *Prisoners in Australia 2006* (unpublished)
	Sentenced prisoners by most serious offence, 30 June 2006, by Indigenous status	ABS (2006b), *Prisoners in Australia 2006*
	Juvenile detention rates, aged 10–17 years, 2001 to 2005, by Indigenous status	Taylor (2006), *Juveniles in Detention in Australia, 1981–2005*
	Juvenile detention rates, aged 10–17 years, 30 June 2005, by Indigenous status, sex and jurisdiction	Taylor (2006), *Juveniles in Detention in Australia, 1981–2005*
5 Early child development and growth (prenatal to aged 3)		
5.1 Injury and preventable diseases	Potentially preventable hospitalisations for children aged less than 4 years, 2004-05, (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Deaths from external causes and preventable diseases as a proportion of total population for children aged less than five years, 2001–2005, (Qld, WA, SA, and the NT)	ABS (2007b), *Causes of Death 2005,* (unpublished)
5.2 Infant mortality	Indigenous infant mortality, 1997–99 to 2003–05, (NSW, Qld, WA, SA and the NT)	ABS (2006a), *Deaths Australia 2005* (published and unpublished)
	Infant mortality, 2003–2005, (NSW, Qld, WA, SA and the NT)	ABS (2006a), *Deaths Australia 2005*
	Indigenous infant mortality by sex, 2003–2005, (NSW, Qld, WA, SA and the NT)	ABS (2006a), *Deaths Australia 2005*
5.3 Birthweight	Birthweight, by live births and fetal deaths, 2002–2004	AIHW National Perinatal Data Collection (unpublished)
5.4 Hearing impediments	Prevalence of hearing conditions in children aged 0–14 years, 2001, 2004-05	ABS 2001 NHS, 2004-05 NHS, 2004-05 NATSIHS (all unpublished)

Indicator	Measure	Data source
5.5 Children with tooth decay	Children's mean number of teeth with decay, by remoteness and age group (4–14 years), selected years between 2000 and 2003, (NSW, SA and the NT combined)	Jamieson, Armfield and Roberts-Thomson (2006a)
	Proportion of children with decay-free teeth, by remoteness and age group (4–14 years), selected years between 2000 and 2003, (NSW, SA and the NT combined)	Jamieson, Armfield and Roberts-Thomson (2006a)
	Children's mean number of teeth with decay, by age group (4–13 years), 2002-03, (NT)	Jamieson, Armfield and Roberts-Thomson (2006b)
	Children's mean number of teeth with decay, by age group (4–15 years), 2002 (SA)	Ellershaw, Spencer and Slade (2005)
	Proportion of children with calculus and gingival bleeding, by age group (6-15 years), 2002 (SA)	Ellershaw, Spencer and Slade (2005)
	Hospital dental procedure rates for children aged 2–14 years, per 100 000 children, by type of procedure and sex, 2002-03	Jamieson and Roberts-Thomson (2006)
	Hospital dental procedure rates for children aged 2–9 years, per 100 000 children, by type of procedure and age, 2002-03	Jamieson and Roberts-Thomson (2006)
	Hospital dental procedure rates for children aged 2–14 years, per 100 000 children, by type of procedure and remoteness area, 2002-03	Jamieson and Roberts-Thomson (2006)
6 Early school engagement and performance (preschool to year 3)		
6.1 Preschool and early learning	Participation rates in preschool for 3,4 and 5 year old children, 2005	DEST (2006a), *National Indigenous Preschool Census 2005* (unpublished)
6.2 School attendance	School participation rates for 5 to 8 year old full time students, 2006	ABS National Schools Statistics Collection (unpublished)
6.3 Year 3 literacy and numeracy	Proportion of year 3 students who achieved reading and writing benchmarks (1999–2005), and numeracy benchmarks (2000–2005)	MCEETYA (2007), *National Report on Schooling in Australia 2005*
	Proportion of year 3 students who achieved the reading, writing and numeracy benchmarks, by jurisdiction, 2005	MCEETYA (2007), *National Report on Schooling in Australia 2005*

Indicator	Measure	Data source
7 Positive childhood and transition to adulthood		
7.1 Years 5 and 7 literacy and numeracy	Proportion of year 5 students who achieved reading and writing benchmarks (1999–2005), and numeracy benchmarks (2000–2005)	MCEETYA (2007), *National Report on Schooling in Australia 2005*
	Proportion of year 7 students who achieved reading, writing and numeracy benchmarks (2001–2005)	MCEETYA (2007), *National Report on Schooling in Australia 2005*
	Proportion of years 5 and 7 students who achieved the reading, writing and numeracy benchmarks, by jurisdiction, 2005	MCEETYA (2007), *National Report on Schooling in Australia 2005*
	Proportion of year 3 students in 2001, year 5 students in 2003 and year 7 students in 2005 who achieved the reading, writing and numeracy benchmarks	MCEETYA (2007), *National Report on Schooling in Australia 2005*
7.2 Retention at year 9	School participation rates of full time students aged 14 years, all schools, by jurisdiction, 2006	ABS (2007a) *Schools Australia 2006* (unpublished)
	Apparent retention rates of full time secondary students to year 9, all schools, by sex and jurisdiction, 2006	ABS (2007a) *Schools Australia 2006* (unpublished)
7.3 Indigenous cultural studies in school curriculum and involvement of Indigenous people in development and delivery of Indigenous studies	Indigenous employment in government and Catholic schools, 2001 to 2005	DEST (2002–06b), *Indigenous Education Strategic Initiatives Programme Performance Reports 2001–2006* (unpublished)
7.4 Juvenile diversions as a proportion of juvenile offenders	Number and proportion of juveniles diverted, 2005, (NSW)	NSW Bureau of Crime Statistics and Research (unpublished)
	Juvenile alleged offenders and cautions, 2002-03 to 2005-06, (Vic)	Victoria Police (unpublished)
	Proportion of juvenile alleged offenders receiving a caution, by type of offence, 2004-05 (Qld)	Queensland Police Service (2006), *Annual Statistical Review 2004-05*
	Number and proportion of contacts with the juvenile justice system, by type of contact, 1995–2002, (WA)	University of WA Crime Research Centre (2004a)
	Juvenile cautions, by type of offence, 2004, (WA)	University of WA Crime Research Centre (2004b)
	Juvenile apprehensions and diversions 2004, 2005, (SA)	OCSAR (2005a), (2006)
	Juvenile diversions, by offence type, 2005, (SA)	OCSAR (2006)
	Juvenile apprehensions and diversions, by sex, 2005, (NT)	NT Police (unpublished)

Indicator	Measure	Data source
7.5 Transition from school to work	Proportion of people aged 18 to 24 years who were not employed and not studying, by remoteness, 2004-05	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Proportion of people aged 18 to 24 years who were not employed and not studying, by sex, 2002, 2004-05	ABS 2002 NATSISS, 2002 GSS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Main activities of 1995 cohort participants in the fifth to eighth years of the Longitudinal Surveys of Australian Youth	ACER Longitudinal Surveys of Australian Youth (unpublished)
	Labour force status, people aged 18 years and over, age standardised, by sex, 2004-05	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
8 Substance use and misuse		
8.1 Alcohol consumption and harm	Alcohol consumption at long term risky to high risk levels, people aged 18 years and over, age standardised, 2004-05	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Alcohol consumption at long term risky to high risk levels, by Indigenous people 18 years and over, by remoteness, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Alcohol consumption at long term risky to high risk levels, people aged 18 years and over, by sex and age group, 2004-05	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Alcohol consumption at long term risky to high risk levels, people aged 18 years and over living in non-remote areas, by sex, 1995, 2001, 2004-05	ABS 2001 NHS(I), 2001 NHS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Alcohol consumption at short term risky to high risk levels, people aged 18 years and over, by age group, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Alcohol involvement in homicides, total recorded 1999-2000 to 2004-05	AIC National Homicide Monitoring Program (unpublished)
	Alcohol involvement in Indigenous homicides, 1999-2000 to 2004-05	AIC National Homicide Monitoring Program (unpublished)
	Hospitalisations related to alcohol use, 2004-05 (per 1000 population), (Qld, WA, SA, and public hospitals in the NT)	AIC National Homicide Monitoring Program (unpublished)

Indicator	Measure	Data source
8.2 Tobacco consumption and harm	Current daily smokers, Indigenous people aged 18 years and over, by remoteness, 2004-05	ABS 2004-05 NATSIHS
	Current daily smokers aged 18 years and over, by age group and sex, 2004-05	ABS 2004-05 NATSIHS, 2004-05 NHS
	Current daily smokers, aged 18 years and over, living in non-remote areas, by sex, 1995, 2001, 2004-05	ABS 2001 NHS(I), 2001 NHS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	Mothers reporting smoking during pregnancy, 2001 to 2004 (NSW, WA, SA, the ACT and the NT)	AIHW National Perinatal Statistics Unit (2006a, 2006b)
	Hospitalisations related to tobacco use (per 1000 population), 2004-05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
8.3 Drug and other substance use and harm	Indigenous persons aged 18 years or over residing in non-remote areas: status of substance use (per cent), 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Illicit drug use, people aged 14 years and over living in non-remote areas, 2004	AIHW Drug Strategy Household Survey (unpublished)
	Drug influenced homicides, 1999-2000 to 2004-05	AIC National Homicide Monitoring Program (unpublished)
	Drug-influenced Indigenous homicides, 1999-2000 to 2004-05	AIC National Homicide Monitoring Program (unpublished)
9 Functional and resilient families and communities		
9.1 Children on care and protection orders	Children (0–17 years) on care and protection orders, by jurisdiction, 30 June 2006	AIHW Children on Care and Protection Orders, Australia data collection (unpublished)
	Placement in accordance with the Indigenous Child Placement Principle, 30 June 2006	AIHW Children on Care and Protection Orders, Australia data collection (unpublished)

Indicator	Measure	Data source
9.2 Repeat offending	Proportion of prisoners with known prior adult imprisonment under sentence, by jurisdiction and sex, 30 June 2006	ABS (2006b), *Prisoners in Australia 2006*
	Proportion of prisoners with known prior adult imprisonment under sentence, by most serious offence/charge, 30 June 2006	ABS (2006b), *Prisoners in Australia 2006*
	Court and custodial appearances for juveniles, 1995 to 2003 (NSW)	Bureau of Crime Statistics and Research (2005)
	Repeat offending rates for maltreated juveniles who received a police caution, by sex, 1983 birth cohort (Qld)	Griffith University (2005)
	Proportion of juvenile repeat offenders who had a finalised court appearance, by nature of first contact with the juvenile justice system and sex, 1983 birth cohort (Qld)	Griffith University (2005)
	Proportion of juveniles re-offending, by type of first contact with the juvenile justice system, 1995 and 2000 cohorts, (WA)	University of Western Australia (2004a)
	Proportion of juveniles in the 1984 cohort which were apprehended as juveniles (0–17 years), by the number of apprehensions (SA)	OCSAR (2005b)
9.3 Access to primary health care	Expenditure on health care services, by type of health good or service, current prices, 2001-02	AIHW (2005), *Expenditures on Health for Aboriginal and Torres Strait Islander Peoples 2001-02*
	Age standardised hospitalisation rates for potentially preventable chronic conditions, per 100 000 people, 2004–05 (Qld, WA, SA and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Age standardised hospitalisation rates for Type 2 diabetes as principal diagnosis by complication, per 100 000 people, 2004–05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Age standardised hospitalisation rates for potentially preventable acute conditions, per 100 000 people, 2004-05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Age standardised hospitalisation rates for vaccine-preventable conditions, per 100 000 people, 2001-02 to 2004-05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Age standardised hospitalisation rates for infections with a predominantly sexual mode of transmission, per 100 000 people, 2004-05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)

Indicator	Measure	Data source
9.3 Access to primary health care (*continued*)	Health care services Indigenous people sought when they had a health problem, by remote/non-remote, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Time since last consulted GP/specialist, people aged 18 years and over, by Indigenous status, age standardised, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Reasons for not going to a GP in the last 12 months, Indigenous people aged 18 years and over, by remote/non-remote, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Number of health care centres and distance to health care centres for discrete Indigenous communities, 2006	ABS (2007c), 2006 CHINS
	Number and proportion of discrete Indigenous communities that reported having Indigenous health workers and medical professionals visit or work within their community, 2006	ABS (2007c), 2006 CHINS
9.4 Mental health	K5 level of psychological distress, people aged 18 years and over, age standardised, 2004-05	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	High to very high level of psychological distress, by age group, 2004-05	ABS 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
	K5 level of current psychological distress, by reported stressor in the last 12 months, Indigenous people aged 18 years and over, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Age-standardised hospitalisations for mental and behavioural disorders, 2001-02 to 2004-05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Hospitalisations for mental and behavioural disorders, by age groups, 2004-05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Age standardised hospitalisation ratios for mental and behavioural disorders, 2004-05 (Qld, WA, SA, and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Death rates for mental and behavioural disorders by age, 2001–2005 (Qld, WA, SA, NT)	ABS Deaths Registration Database (unpublished)
	Health problems and the use of health services by a cohort of prisoners released in WA between 1995 and 2001 (WA)	Hobbs et al. (2006)
	Physical and mental health needs, young people in custody (NSW)	NSW Department of Juvenile Justice (2003)
	Risk for clinically significant emotional or behavioural difficulties of Indigenous children (WA)	Telethon Institute for Child Health, Western Australian Aboriginal Child Health Survey 2001, 2002

Indicator	Measure	Data source
9.5 Proportion of Indigenous people with access to their traditional lands	Proportion of Indigenous people aged 18 years and over living on, or allowed to visit, their homelands, by remoteness area, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Proportion of Indigenous people living on, or allowed to visit, their homelands, non-remote areas, by age group, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Proportion of Indigenous people aged 18 years and over in non-remote areas, living on, or allowed to visit, their homelands, 1994, 2002, 2004-05	ABS 1994 NATSIS; 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
9.6 Participation in organised sport, arts or community group activities	Participation in exercise at moderate/high levels by persons aged 15 years and over in non-remote areas, age standardised, 1995, 2001, 2004-05	ABS 1995 NHS(I), 2001 NHS(I), 2004-05 NHS, 2004-05 NATSIHS (all unpublished)
	Participation in exercise at moderate/high levels, by age group in non-remote areas, 2004-05	ABS 2004-05 NHS, 2004-05 NATSIHS (all unpublished)
	Participation in arts and cultural activities, Indigenous people over 15 years, 2002	ABS 2002 NATSISS
9.7 Engagement with service delivery	Reasons for not going to a hospital in the last 12 months, Indigenous people aged 18 years and over, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Indigenous people's perceptions of their treatment when seeking health care in the previous 12 months, compared to treatment of non-Indigenous people, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	How Indigenous people felt after they had been discriminated against because of their Indigenous status, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Some of the actions taken by Indigenous people after they had been discriminated against because of their Indigenous status, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Communication with service providers, Indigenous people aged 15 years or over, by remote/non-remote, 2002	ABS 2002 NATSISS (unpublished)
	Rates of discharge from hospital against medical advice, by sex, per 1000 people, July 2002 to June 2004, (Qld, WA, SA and public hospitals in the NT)	AIHW National Hospital Morbidity Database (unpublished)
	Health, education and public transport services available in discrete Indigenous communities, 2006	ABS (2007c), 2006 CHINS

Indicator	Measure	Data source
10 Effective environmental health systems		
10.1 Rates of diseases associated with poor environmental health	Hospitalisation rates (per 10 000), selected types of diseases associated with poor environmental health, age standardised and by age groups, 2004-05 (Qld, WA, SA, and public hospitals in NT)	AIHW National Hospital Morbidity Database (unpublished)
	Hospitalisation rates, selected diseases associated with poor environmental health, age standardised and ages 0–14 and over 65, 2001-02 to 2004-05 (Qld, WA, SA, and public hospitals in NT)	AIHW National Hospital Morbidity Database (unpublished)
	Death rates from diseases associated with poor environmental health, by sex, age standardised, 2001–2005 (Qld, WA, SA, and the NT)	ABS (2007b), *Causes of Death 2005*
10.2 Access to clean water and functional sewerage	Source, reliability and adequacy of drinking water supply, (restrictions, interruptions and quality), discrete Indigenous communities, 2006	ABS (2007c), 2006 CHINS
	Type of sewerage systems, overflows and leakages, discrete Indigenous communities, 2006	ABS (2007c), 2006 CHINS
	Access to cooking, washing and toilet facilities by Indigenous Housing Organisation managed permanent dwellings, by remoteness, 2006	ABS (2007c), 2006 CHINS
10.3 Overcrowding in housing	Proportion of Indigenous people 15 years and over living in overcrowded housing, by jurisdiction, 2002 and 2004-05	ABS 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
	Proportion of Indigenous people 15 years and over living in overcrowded housing, by remoteness area, 2002 and 2004-05	ABS 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
	Proportion of Indigenous people aged 15 years or over living in overcrowded housing, by housing tenure, 2004-05	ABS 2004-05 NATSIHS (all unpublished)
	Proportion of Indigenous people 18 years and over who reported overcrowding as a stressor in the last 12 months, by remoteness area, 2002 and 2004-05	ABS 2002 NATSISS, 2004-05 NATSIHS (all unpublished)

Indicator	Measure	Data source
11 Economic participation and development		
11.1 Employment by full-time or part-time status, by sector, industry and occupation	CDEP and non-CDEP employment, Indigenous people aged 18 to 64 years, by remoteness area, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Full time and part time employment, by CDEP status, Indigenous people aged 18 to 64 years, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Full time and part time employment, people aged 18 to 64 years, by age group, 2004-05	ABS 2004-05 NHS, 2004-05 NATSIHS (all unpublished)
	Age standardised full time and part time employment, people aged 18 to 64 years, by sex, 2004-05	ABS 2004-05 NHS, 2004-05 NATSIHS (all unpublished)
	Full time and part time employment, Indigenous people aged 18 to 64 years, by CDEP status and sex, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Full time and part time employment, Indigenous people aged 18 to 64 years, 1994, 2002, 2004-05	ABS 1994 NATSIS, 2002 NATSISS, 2004-05 NATSIHS (all unpublished)
	Employment by public/private sector, and CDEP status, Indigenous people aged 18 to 64 years, 2004-05	ABS 2004-05 NATSIHS (unpublished)
	Age standardised employment by industry, people aged 18 to 64 years, 2004-05	ABS 2004-05 NHS, 2004-05 NATSIHS (all unpublished)
	Age standardised employment by skill level of occupations, people aged 18 to 64 years, 2004-05	ABS 2004-05 NHS, 2004-05 NATSIHS (all unpublished)
11.2 Self employment and Indigenous business	Age standardised self employment as a proportion of total employed, people aged 18 to 64 years in non-remote areas, by sex, 2001, 2004-05	ABS 2001 NHS(I), 2001 NHS, 2004-05 NATSIHS, 2004-05 NHS (all unpublished)
11.3 Indigenous owned or controlled land	Indigenous owned land as a proportion of the area of each remoteness area, December 2006	ILC (unpublished)
	Determinations that native title exists, by jurisdiction, 2004, 2006	NNTT (unpublished)
	The growth of Indigenous Land Use Agreements (cumulative), by jurisdiction, 2003 to 2006	NNTT (unpublished)
	Registered Indigenous Land Use Agreements by remoteness area, 30 June 2006	NNTT (unpublished)

Indicator	Measure	Data source
11.4 Governance capacity and skills	Proportion of university students studying management or commerce, business law, economics or econometrics, by remoteness area, 2005	DEST Higher Education Student Collection (unpublished)
	Proportion of university students studying management or commerce, business law, economics or econometrics, by sex, 2003–2005	DEST Higher Education Student Collection (unpublished)
	Proportion of TAFE students studying management or commerce, business law, economics or econometrics, by remoteness, 2005	NCVER (unpublished)
	Proportion of TAFE students studying management or commerce, business law, economics or econometrics, by sex, 2002–2005	NCVER (unpublished)
	Number of students in selected courses (governance) 2005	NCVER (unpublished)

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACER	Australian Council for Educational Research
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
BOCSAR	Bureau of Crime Statistics and Research (NSW)
CHINS	Community Housing and Infrastructure Needs Survey
DEST	Department of Education, Science and Training
GSS	General Social Survey
ILC	Indigenous Land Corporation
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
NCVER	National Centre for Vocational Education Research
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSIS	National Aboriginal and Torres Strait Islander Survey
NHS	National Health Survey
NHS(I)	National Health Survey Indigenous Supplement
NNTT	National Native Title Tribunal
OCSAR	Office of Crime Statistics and Research (SA)
SAAP NDCA	Supported Accommodation Assistance Program National Data Collection Agency
VET	vocational education and training

References

ABS (Australian Bureau of Statistics) 2007a, *Schools Australia 2006*, Cat. no. 4221.0, Canberra.

—— 2007b, *Causes of Death, Australia, 2005*, Cat. no. 3303.0, Canberra.

——2007c, *Housing and Infrastructure in Aboriginal and Torres Strait Islander Communities, Australia, 2006*, Cat. no. 4710.0, Canberra.

—— 2006a, *Deaths Australia 2005*, Cat. no. 3302.0, Canberra.

—— 2006b, *Prisoners in Australia 2006*, Cat. no. 4517.0, Canberra

—— 2006c, *National Aboriginal and Torres Strait Islander Health Survey 2004-05*, Cat. no. 4715.0, Canberra.

—— 2006d, *National Health Survey 2004-05*, Cat. no. 4362.0, Canberra.

—— 2004, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians 30 June 1991 to 30 June 2009*, Cat. no. 3238.0, Canberra.

—— 2002, National Health Survey: Aboriginal and Torres Strait Islander Results, Australia, 2001, Cat. no. 4715.0, Canberra.

—— 1995, *National Aboriginal and Torres Strait Islander Survey*, Cat. no. 4190.0, Canberra.

AIC (Australian Institute of Criminology) 2006, *National Homicide Monitoring Program Annual Report 2004-2005*, Research and public policy series no. 72, Canberra.

AIHW (Australian Institute of Health and Welfare) National Perinatal Statistics Unit 2006a, *Smoking and Pregnancy*, AIHW Cat. no. PER 33, Sydney.

—— 2006b, *Australia's Mothers and Babies 2004*, AIHW Cat. no. PER 34, Sydney.

—— 2005, *Expenditures on Health for Aboriginal and Torres Strait Islander Peoples 2001-02*, Cat. no. HWE 23, Canberra.

BOCSAR (Bureau of Crime Statistics and Research) 2005, *The Transition from Juvenile to Adult Criminal Careers*, Crime and Justice Bulletin no. 86, Sydney.

DEST 2006a, *National Preschool Census 2005 Aboriginal and Torres Strait Islanders and All Students: Technical Report*, DAA (Data Analysis Australia), Canberra.

—— 2002, 2003, 2004, 2005, 2006b *Indigenous Education Strategic Initiatives Programme Performance Reports 2001–2005*, DEST, Canberra.

Ellershaw, A., Spencer, A.J., Slade, G.D. 2005, *Oral Health in South Australia 2004*, Australian Research Centre for Population Oral Health, University of Adelaide.

Griffith University 2005, *Juvenile Offending Trajectories: Pathways from Child Maltreatment to Juvenile Offending and Police Cautioning in Queensland.* School of Criminology and Criminal Justice, Brisbane.

Hobbs, M., Krazlan, K., Ridout, S., Mai, Q., Knuiman, M. and Chapman, R. 2006, *Mortality and Morbidity in Prisoners After Release from Prison in Western*

Australia 1995–2003, Trends and Issues in Crime and Criminal Justice, No. 320, Australian Institute of Criminology, Canberra.

Jamieson, L., Roberts-Thomson, K.F., 2006, 'Indigenous children and receipt of hospital dental care in Australia', *International Journal of Paediatric Dentistry*, vol. 16, pp. 327–34.

Jamieson, L., Armfield, J.A., Roberts-Thomson, K.F., 2006a, 'The role of location in Indigenous and non-Indigenous child oral health', *Journal of Public Health Dentistry*, vol. 66, pp. 123–30.

Jamieson, L., Armfield, J.A., Roberts-Thomson, K.F., 2006b, 'Oral health inequalities among Indigenous and non-Indigenous children in the Northern Territory of Australia', *Community Dentistry and Oral Epidemiology*, vol. 34, pp. 267–76.

MCEETYA (Ministerial Council on Education, Employment, Training and Youth Affairs) 2007, *National Report on Schooling in Australia 2005: Preliminary Paper National Benchmark Results Reading, Writing and Numeracy Years 3, 5 and 7*, Melbourne.

National Notifiable Diseases Surveillance System, cited in National Centre in HIV Epidemiology and Clinical Research) 2006, *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia, Annual Surveillance Report 2006*, NCHECR, The University of New South Wales and AIHW, Sydney.

NSW Department of Juvenile Justice 2003, *NSW Young People in Custody Health Survey. Key Findings Report, 2003*, NSW.

OCSAR (Office of Crime Statistics and Research) 2006, *Crime and Justice in South Australia - Juvenile Justice 2005*, Adelaide.

—— 2005a, *Crime and Justice in South Australia — Juvenile Justice 2004*, Adelaide.

—— 2005b, *Young People Born in 1984: Offending Behaviour of Juveniles Apprehended at Least Once*, Government of South Australia, Adelaide.

Queensland Police Service 2006, *Annual Statistical Review 2004-05*, Brisbane.

Taylor, N. 2006, *Juveniles in Detention in Australia, 1981–2005*, Technical and Background Paper, no. 22, Australian Institute of Criminology, Canberra.

University of Western Australia 2004a, *Pathways through Justice: A Statistical Analysis of Offender Contact with the WA Juvenile Justice System*, Crime Research Centre, Perth.

—— 2004b, Crime and Justice Statistics for Western Australia, Crime Research Centre, Perth.